Bundle Trust Board Meeting in Public Session 5 November 2019

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

1 Introduction, Welcome, Chair's Opening Remarks and Health and Safety
Chair

2 Public Questions
Chair

3 Apologies for Absence
Chair

4 Declarations of Interest
Chair

5 Minutes of the meeting held on 1 October 2019
Chair
Item 5 Public Board Minutes OCTOBER 2019 v2.docx

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

7 Chief Executive Horizon Scan Including STP
Chief Executive
Item 7 Chief Executive's Report.doc

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

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

9 Care Quality Commission Report Publication
Chief Executive

Fr
Item 9 TB paper CQC QSIP process.docx
Item 9 CQC Report.pdf
Item 9 Final United_Lincolnshire_Hospitals_NHS_Trust_Use_of_Resources_published_17_October_2019.pdf

10 BREAK

11 Strategic Objectives

12 Providing consistently safe, responsive, high quality care SO1

12.1 Assurance and Risk Report Quality Governance Committee
Chair of Quality Governance Committee
Item 12.1 QGC Upward report October 2019 v1.doc

13 Providing efficient and financially sustainable services SO2

13.1 Assurance and Risk Report Finance, Performance and Estates Committee
Chair of FPEC
Item 13.1 FPEC Upward Report Oct 19 v1.1.doc

13.2 EU Exit
Chief Operating Officer
Item 13.2 Trust Board - EU Exit Contingency Planning Report - November 2019.docx
Item 13.2 Appendix I - EU Exit Risk - October 2019.pdf
Item 13.2 Appendix II - Chief Commercial Officer letter - 8 October 2019.pdf

13.3 Winter Plan
Chief Operating Officer

Item 13.3 Winter Plan v2.8 ET Front Sheet Included.doc

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

14.1 Assurance and Risk Report Workforce, Organisational Development and Transformation Committee

For information - verbal update given at October meeting

Item 14.1 WODT Upward Report - September 2019 v1.docx

14.2 Flu vaccination Self-assessment

Director of Nursing

Item 14.2 Front Sheet for Flu 10-10-19.docx

Item 14.2 ULHT NHSi Flu Assurance 19.20.docx

14.3 Freedom to Speak Up Quarterly Report

Freedom to Speak Up Guardian

Item 14.3 FTSU Update Report.docx

Item 14.3 FTSU Append 1 Case Review North West Ambulance Service NHS Trust.pdf

Item 14.3 FTSU Append 1 University Hospitals NHS Trust.pdf

Item 14.3 FTSU Append 2 Board guidance.pdf

Item 14.3 FTSU Append 3 Index-report-2019-final2.docx

14.4 Feedback from Hearing Lincolnshire's Hidden Voices - Race Equality Conference

Item 14.4 Briefing_November_Trust_Board_Lincs_Race_Equality_Conference_15102019.docx

Item 14.4 Briefing_November_Trust_Board_Lincs_Race_Equality_Conference_15102019_Front_Page.doc

15 Providing seamless integrated care with our partners SO4

16 Performance

Item 16 Integrated Performance Report - Trust Board.pdf

17 Risk and Assurance

17.1 Risk Management Report

Item 17.1 Trust Board - Corporate Risk Report - November 2019.pdf

Item 17.1 Appendix I - Very high & High Corporate Risks - November 2019.pdf

Item 17.1 Appendix II - High Operational Risk Summary - November 2019.pdf

Item 17.1 Appendix III - Risk Scoring Guide - July 2019.pdf

17.2 Board Assurance Framework

Item 17.2 BAF 2019-20 Front Sheet November 2019.docx

Item 17.2 BAF 19-20 v28.10.19.xlsx

17.3 Assurance and Risk Report Audit

Item 17.3 Audit Upward Report October 2019.docx

18 Strategy and Policy

18.1 Finance Strategy

Director of Finance and Digital

To follow

Item 18.1 TB Finance Strategy Front Sheet.doc

Item 18.1 TB Finance Strategy.docx

19 Board Forward Planner

Trust Secretary
For Information

Item 19 Public TB Board Forward Planner 2019 v 4.doc

20 ULH Innovation

Assistant Director Communications
For Information

Item 20 Innovation Front Sheet - November.doc

Item 20 Innovation report - November.docx

21 Any Other Notified Items of Urgent Business

22 The next meeting will be held on Tuesday 3 December 2019

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

Agenda Item 5

United Lincolnshire Hospitals NHS Trust

Minutes of the Public Trust Board Meeting

Held on 1st October, 2019

Boardroom, Lincoln County Hospital

Present

Voting Members:
Mrs Elaine Baylis, Chair
Dr Chris Gibson, Non-Executive Director
Mrs Liz Libiszewski, Non-Executive Director
Mrs Sarah Dunnett, Non-Executive Director
Mrs Victoria Bagshaw, Director of Nursing
Mr Paul Matthew, Director of Finance and Digital
Mr Geoff Hayward, Non-Executive Director
Mrs Gill Ponder, Non-Executive Director
Mr Andrew Morgan, Chief Executive
Dr Neill Hepburn, Medical Director
Mr Mark Brassington, Chief Operating Officer

Non-Voting Members:
Mr Paul Boocock, Director of Estates and Facilities
Mr Martin Rayson, Director of HR &OD

In attendance:
Mrs Jayne Warner, Trust Secretary
Mrs Karen Willey, Deputy Trust Secretary (Minutes)
Mrs Anna Richards, Associate Director of Communications
Mr Tim Couchman, Equality, Diversity and Inclusion Lead (Items 13.2, 13.3, 13.4 & 13.5)

1438/19 **Item 1 Introduction**

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

1439/19 **Item 2 Public Questions**

Q1 from Jody Clark

I was extremely upset to read about medical work force issues, especially relating to Grantham Hospital, in the agenda for today. Our preferred future proposal under the Healthy Conversations, is including medical intake!

If this is about Locums, then Lincoln Hospital have far more Locums than Grantham, but services still run? And why move our registrar from Grantham to Lincoln, after closing our overnight service, due to taking our staff to manage staffing issues at the other sites, which 3 and a half years later, is still ongoing!

It is not fair to keep expecting us to be the ones always losing out. We have lost enough already and you need to find a way to provide medical services to continue at Grantham under the new model.

I would like to know, excluding current recruitment, when did you last advertise for a substantive post in respiratory medicine for Grantham?

The Medical Director responded:

The Trust were in agreement that the future of Grantham Hospital should include medical admissions as an essential part of the role in the community.

United Lincolnshire Hospitals NHS Trust has a high proportion of temporary medical staff and locums, circa 24%. Temporary staffing was a Trust wide issue and a concern to the Trust due to the ability to provide sustainable, safe and quality services. This is one of the key areas that the Trust faces in service improvement. The solution identified would need to be a Trust wide solution to reflect the issue.

The move of the Registrar from Grantham was due to the overnight closure of the Accident and Emergency department. The movement of locums is not a solution to the issue faced and the Trust recognised the need for a Trust wide solution.

The Trust do not feel that Grantham has lost out due to the changes in service, this is supported by the move of elective surgery to Grantham Hospital. Instead of having services at the site that could not be provided the Trust had moved services to the site that were able to be provided. By making changes to the services delivered at Grantham this ensures the safety of services and ensures that the site remains sustainable.

In response to the advertising of posts to Grantham, a risk summit had been held regarding the site and as a result a post is currently out to advert with interviews due to take place in November. Prior to this there had not be a substantive post advertised for three years.

The Chief Executive advised that the deferred question from Mrs Wilson at the October meeting had been addressed through a meeting held with the questioner.

1440/19 **Item 3 Apologies for Absence**

There were no apologies for absence

1441/19 **Item 4 Declarations of Interest**

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

1442/19 **Item 5 Minutes of the meeting held on 3rd September 2019 for accuracy**

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

1379/19 – Should read – Full lockdown can be achieved at site level, but sites cannot yet be locked down in zones.

1443/19 **Item 6 Matters arising from the previous meeting/action log**

827/19 - Assurance in respect of H&S actions reported to Finance, Performance and Estates Committee (FPEC) - Paper provided to August FPEC.

Further detail requested. Work was underway to populate Electronic Staff Record (ESR) with historical and current training records. Recruitment in to team to increase training. Work underway to provide data to give visibility on training levels. Manual update of ESR system, more granular information expected back to FPEC at October meeting. ESR update to be completed, plan for delivery of the training runs through in to 2020.

884/19 – National urgent care pathway changes – National update not available as at 24 Sept 2019, defer to November

1004/19 – Finding relating to sepsis within the Care Quality Commission (CQC) report – Revised dashboard data agreed by QGC in September. Metrics updated to be more comprehensive, sepsis now covered in detail to provide transparency to Quality Governance Committee (QGC) – Complete

1016/19 – CQC feedback letters June 2019 – Review of Quality Safety Improvement Programme (QSIP) content and process underway

1062/19 – People Strategy – Strategy being considered at 30 Sept Workforce and Organisational Development Committee (W&OD). Useful discussion at W&OD, next steps would be to take strategy through cycle of Executive Team /Trust Management Group. Publication of CQC report awaited to ensure actions are captured

1186/19 – Quality Governance Committee Assurance report – Proposal to increase frequency of window cleaning being developed to be presented to Capital Revenue Investment Group for funding in October, Board to receive update at November meeting.

1248/19 – Workforce, Organisational Development and Transformation Committee Assurance report – Agreed that the refresh of the leadership development programme would be conducted at Board Development session – Complete

1274/19 – Integrated Performance Report (IPR) – Discussed at Finance, Performance and Estates Committee. Further clarity requested. Included as escalation slide in IPR, will be tracked through IPR – complete

1317/19 – BAF – System delivery reports to be shared with Board. Agreement needed to be reached on how these could be reported. Difficulty in obtaining papers, as an interim measure the LCB system report would be circulated to Board members as an addition to the minutes.

Action – Trust Secretary, 5 November 2019

1333/19 – Chief Executive Horizon scan – Agenda item

1387/19 – Annual Plan update – To be built in to future Board Development Session programme – Complete

1422/19 – Integrated Performance Report – To be built in to future Board Development Session programme – Complete

1426/19 – Risk Management Report - Risk Manager invited to Executive Team meeting where discussed divisional risk, will now attend Trust Management Group to have wider discussion with divisions. – Complete

1444/19 **Item 7 Chief Executive Horizon Scan including STP**

The Chief Executive presented the report to the Board detailing both system and Trust specific issues.

<u>System Issues:</u>

1445/19 The Chief Executive had been in attendance for the first day of new students arriving at the University of Lincoln Medical School. The day was also attended by the Health Minister Edward Argar and a number of local NHS Trust Chief Executive Officers and Medical Directors.

1446/19 The ground breaking for the new medical school to be built took place on the 23rd September and the official opening of the school would be taking place shortly. Further work would be undertaken with the University to ensure positive development of the relationship.

1447/19 Work continues to progress on the Lincolnshire Long Term Plan for the system which would require finalisation prior to the end of the year. The Chief Executive anticipated that the Board would receive the plan at the December public Board meeting.

1448/19 The Trusts performance in relation to urgent and emergency care had drawn attention at a regional level, escalation meetings were being held and had been received positively. The issues faced by the Trust were ambulance conveyance numbers, handover delays and work with the Clinical Assessment Service.

Trust Specific issues:

1449/19 The Chief Executive reported that the draft Care Quality Commission report had been received and had been reviewed for factual accuracy. This would be submitted to the Care Quality Commission for review of the comments made and the published report would be expected in the coming weeks.

1450/19 The financial position for the Trust reported as off plan, detailed discussion would be held by the Board, this had been predominantly in relation to pay however work was underway to address this.

1451/19 Recruitment to the Director of Finance and Digital substantive post was underway and the process for the recruitment to the Director of Nursing post would commence imminently.

The Trust Board:

- **Received the report**

1452/19 **Item 8 Patient/Staff story**

Patient Cath Koutna attended the Board with Deputy Chief Nurse Jennie Negus to present her experience of communication during treatment for breast cancer at the Trust and the impact that communication styles had on her experience.

1453/19 Ms Koutna was also supported by Cancer Programme Manager at Lincolnshire West Clinical Commissioning Group Louise Jeannes, Macmillan Living With and Beyond Cancer Community Facilitator Fiona Roche and ULTH Macmillan Lead Cancer Nurse Bev Duncan.

1454/19 Ms Koutna advised the Board that she had been diagnosed with primary breast cancer last year and had been thrust in to treatment. Whilst the majority of the experience with clinicians had been positive there had been one particular clinician who had not considered Ms Koutna's psychological well being.

1455/19 It became apparent early on in the treatment that Ms Koutna had responded well, even though the tumour had been fast growing. The clinician advised early on that there might be a need to perform a mastectomy however due to the positive response to treatment a lumpectomy became a realistic option. By the end of the chemotherapy treatment the tumour

was no longer visible on scans and Ms Koutna attended an appointment to discuss surgical options.

1456/19 At this point Ms Koutna had prepared for a lumpectomy to be the preferred surgical option however the clinical offered a further mammogram and scan to confirm the surgical option. Once these had been completed there was confirmation that there had been a positive response to treatment however due to the tumour being multifocal a mastectomy was still the recommended option.

1457/19 Ms Koutna explained to the Board that the tumour being multifocal had not been explained to her previously and this had been a shock to hear. The result of the additional tests had changed the potential surgical option, had this been explained earlier during the treatment this may have prepared Ms Koutna for the need for the mastectomy.

1458/19 Ms Koutna undertook the surgery and a follow up post mastectomy with the clinician where the relationship was most strained resulted in her being asked why she had chosen to have a mastectomy as this had not been needed due to the positive response to treatment. Ms Koutna explained that she felt shocked by this comment and was unable to focus on the remainder of the conversation.

1459/19 Ms Koutna stated that there had been no consistency in the communication and decision about the kind of surgery to be recommended, there was not a full explanation of the evidence to allow an informed decision to be taken by the patient.

1460/19 The Chair thanked Ms Koutna for sharing her story with the Board in such an articulate manner. There was a need for patients being treated to have confidence in the clinicians treating them. Experience had shown that further work was needed especially to work on the development of holistic care plans.

1461/19 The Board were advised by the staff in attendance that the Trust and Clinical Commissioning Group were conducting a wider piece of work in relation to breast and prostate cancers to improve the experience and communication, this had been as a result of patient experiences.

1462/19 The Deputy Chief Nurse would provide a future update to the Board on the focused work of the pathways to ensure lessons were learnt.

Action – Deputy Chief Nurse, 3 December 2019

1463/19 The Director of Human Resources and Organisational Development asked what actions were being taken to address the evidence to support the need to improve empathy and communication by clinicians.

1464/19 The Deputy Chief Nurse advised that this was a large piece of work to address and that this encompassed communication style and level. There were a number of actions in place including communications first and the staff charter, these clearly were not having the desired impact.

1465/19 Confirmation was provided to the Board that the Division were addressing the issues raised with the clinician identified.

1466/19 The Director of Nursing advised that there would be a need to ensure other members of the multidisciplinary team were conducting the role of advocacy and picking up on non-verbal cues during difficult conversations. It was important that the wider team wrap around to support patients and ensure that the patient voice was heard.

The Trust Board:

- **Received the staff story**

9 BREAK

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

1467/19 **Item 11.1 Assurance and Risk Report Quality Governance Committee**

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

1468/19 The Quality and Safety Oversight Group continued to develop and there had been demonstrated a stronger grip on the divisional work required.

1469/19 Both Hospital Standardised Mortality Rates and Standardised Hospital Mortality Indicators continue to improve and the Trust are no longer required to conduct monthly NHS Improvement mortality meetings.

1470/19 The Medical Device Group had advised the Committee that they were not confident to move the improvement work stream to business as usual on the Quality and Safety Improvement Programme and as such the Committee requested assurance on how the actions required would be reported in future.

1471/19 Increased medicine incidents had been attributed to an increase in reporting however the Medicines Optimisation Group had been asked to review. A recent Never Event would be reviewed by the Committee in due course.

1472/19 The Committee were advised of the improved Quality Impact Assessment (QIA) process however had yet to receive the QIA in relation to the Lincoln reconfiguration.

1473/19 The Committee reviewed the objectives through the Board Assurance Framework noting that there had been no change and the ratings would remain amber.

1474/19 A revised performance dashboard was received by the Committee and it was noted that the release of the NHS Oversight Framework had resulted in the inclusion of further metrics. A number of staff metrics would be passed to the Workforce, Organisational Development and Transformation Committee.

1475/19 The Committee received the NHS Improvement feedback from the observation of the Medicines Optimisation and Safety Group, the comments received were constructive and the Chair of the group was working to implement the recommendations. The Committee requested a fully consolidated action plan of all relevant reports.

1476/19 The Committee received the reports prepared for the Care Quality Commission in response to the section 29a and 31 notices received by the Trust.

1477/19 The Committee noted that the Quality Strategy had not yet been approved by the Committee, as such the Committee requested the permission of the Board to present this to the December meeting.

1478/19 The Chief Operating Officer advised that the QIA for the Lincoln reconfiguration had been considered and a stock take meeting had been undertaken. Following the stock take meeting and planned reconfiguration workshop the QIA was likely to be amended. The first move would take place on the 8th November and this would be a clinic move, not a ward. This

would need to go through the appropriate process however discussions held had identified this as low risk. The first ward based change would take place at the end of November.

1479/19 The Director of Nursing recognised the work that had been undertaken however advised that the Committee wished to have sight of the overarching QIA and the principles of how the changes would be undertaken.

1480/19 Mrs Dunnett asked why there had been such a delay in receiving the Quality Strategy. The Director of Nursing advised that there had been a change in the approach and consideration of the ambitions that had been included along with links to the STP relationship. Feedback from the People Strategy was also being considered to aid the completion of the strategy.

1481/19 Mrs Libiszewski had agreed to support the development and completion of the strategy and would be working with the Director of Nursing and Associate Director of Clinical Governance.

The Trust Board:

- **Received the update**

Item 12 Providing efficient and financially sustainable services SO2

1482/19 **Item 12.1 Assurance and Risk Report Finance, Performance and Estates Committee**

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

1483/19 The Committee were not assured on the Financial position of the Trust and the Committee were concerned by the overspend on agency by £4.9m, pace would be required to bring the Trust back in line with plan.

1484/19 The Committee were assured in order to support revenue borrowing for November and had recommended approval to the Board.

1485/19 In order to bring the Trust back in line with the control total the Committee requested that the Executive Team take action.

1486/19 There had been a lack of assurance regarding the Financial Efficiency Programme due to this being reported as behind plan. Assurance was requested on actions being taken to bring the plans through from idea to delivery.

1487/19 Assurance had been provided by the Information Governance Group upward report and a plan had been put in place to recover those areas that remained non-compliant in respect of the Data Protection Toolkit. The group had escalated to the Committee the non-assurance of the health records destruction policy. The Health Records Group had been asked to complete the policy by November. Concerns were raised regarding Freedom of Information requests and Subject Access Request which were not being responded to within timescale. There had been increased interest from the Information Commissioners Office. Processes to improve were due to be developed by November.

1488/19 The Committee were assured in respect of Cyber Security and Phishing. The phishing audit had identified a number of gaps but due to the size of the Trust this was to be expected. Further communications regarding the risks of phishing had been requested and a wider campaign would be completed.

1489/19 The update from Estates had not provided assurance to the Committee. The critical failure of mechanical infrastructure would need to come back to the Committee to identify how the risks

were being managed. There had been inconsistency within the estates dashboard and the risk register. Further work had been requested to review the dashboard and risk register.

1490/19 The Committee received the Progress Housing Contract update, May and June 2019 had not attracted occupancy payments due to increased occupancy as a result of increased overseas recruitment. Work was ongoing to reconfigure some of the accommodation to make this more attractive to families.

1491/19 A verbal update had been received regarding fire, the Committee noted that the fire doors continue to be manufactured and the Fire Service had confirmed the positive progress that the Trust were making.

1492/19 The Committee received an update on the level of carbon savings not being met. A request for further borrowing had been made, this would be discussed by the Board in a subsequent paper.

1493/19 The update received on Emergency and Urgent Care had not provided assurance to the Committee with the August trajectory having been missed by 8%. Ambulance conveyances remained high and a trial with the community services was underway in order to direct lower acuity patients through the Clinical Assessment Service. Actions were being taken to reduce conveyances and the Committee requested assurance that the actions were having the required impact.

1494/19 The Trust achieved 3 out of 9 cancer standards during July, a reduction from the previous month where 7 had been achieved. The availability of staff and equipment remains a risk to the achievement of the standards.

1495/19 The Committee received assurance on the A&E Clock Stops, an issue had been identified through the audit of the Quality Account regarding incorrect counting. This had been rectified and the Committee noted that had this been counted correctly initially reporting would have been marginally worse. Audits had now been put in place to ensure continual monitoring.

1496/19 The Committee received an update from the national EU Exit meeting and the contingency plans in place. A key risk to the Trust would be disruption and delay however national plans were in place, the Trust may require additional resource.

1497/19 The Director of Estates and Facilities advised the Board that a review with Progress Housing was being undertaken to make changes to the occupancy types for the accommodation at Grantham. This would bring occupancy types in line with Lincoln and Boston and would allow greater occupancy in future.

1498/19 The Chief Operating Officer advised that the A&E Clock Stops had been a specific issue following the introduction of GP Streaming where a number of patients had not been recorded on the clock stop for the point of access at GP streaming but rather on their return to A&E.

1499/19 Mrs Dunnett questioned if the A&E trajectory was correct due to the Trust not achieving the trajectory in the last 12 month. The Chief Operating Officer advised that the trajectory had been set at the beginning of the year and had been correct at the time however there had been a number of changes in year.

1500/19 There had been an increase in the acuity of patients attending along with an increase in activity and working against a constrained bed base across all sites. These factors were impacting and driving the under delivery against the trajectory.

1501/19 The assumptions had come from the system and not just the assumptions of the Trust and the need for Lincolnshire to deliver the STP. There would be system work required to pull this back to trajectory.

1502/19 The Chief Executive advised that as part of his role as the Chair of the Urgent Care Board a decision would need to be made in order to determine how the trajectory would be delivered. The system was more aligned and the issue was being owned however the increased escalation was in place due to the recognition of the difficulties. The plan is correct however this requires work to deliver.

1503/19 The Chief Operating Officer advised of a recent review that had been undertaken of the Urgent Care Improvement Programme detailing the assumptions and current position. This would be reported to the Finance, Performance and Estates Committee to give assurance.

Action – Chief Operating Officer, 24th October 2019

The Trust Board:

- **Received the update**

1504/19 **Item 12.2 EU Exit Contingency Planning**

The Chief Operating Officer presented the report to the Board noting that he had assumed the Senior Responsible Officer role for EU Exit.

1505/19 The risks nationally and locally had not changed with 4 high priority areas including medicines supply, medical devices and consumables, workforce and finance. The Trust would be reliant on the significant national plans in place for the medicines supply. A national memorandum of understanding had been developed to ensure that medicines could be moved between organisations more easily and the Trust would be part of this work with an expectation that the memorandum would be signed up to.

1506/19 Key messages from the event had been that prescribing behaviours for medicines should not change and organisations would not need to store or increase stocks due to the national plan.

1507/19 Medical devices and consumables would be reliant on a supply chain from the European Union with cardiology and radiology particular areas that relied on this supply chain.

1508/19 The impact on workforce was currently unknown nationally and there had not been a clear steer of the expected impact, DBS checks for EU nationals may change including the extension of checks.

1509/19 Workforce was an area of concern to the Trust in relation to the change in availability of short-term staff from the EU, this could impact on agency and locum supply. The Trust would be disproportionately affected if there became an issue and the Trust would need to be mindful of the emerging risk.

1510/19 The capacity of the overseas visitor screening team may require strengthening and work was underway to review the additional arrangements that may be required. As yet there had not been any additional costs to the organisation identified as a result of the EU Exit.

1511/19 The Trust were working closely with colleagues in the North of the County due to a potential change of supplier routes. Immingham docks would play a more substantial role in the supply chain for the NHS which could result in more traffic in the area affecting movement of goods and a potential knock on effect to patient flow and staffing. A review of where staff reside was being undertaken in order to be able to understand and if required use of the national

memorandum for staff flow to enable staff are able to move freely. The risks would continue to be monitored.

1512/19 Dr Gibson requested clarity on the supply chain process in relation to radio-isotopes. It was explained that this was an ongoing challenge and understanding locally of the risk and clarity over the priority receipt of these would be undertaken should an issue arise.

1513/19 The Board were advised that all Business Continuity Plans were in place across the organisation for critical areas and those impacted by the EU Exit. A review of the workforce impact on the wider system was being considered due to the number of beds and patients treated by social care services.

1514/19 The Chair asked if there was more that could be done to further support the Trusts own staff during the EU Exit as the Trust want them to stay. The Chief Operating Officer advised that the original message would be repeated and would welcome others thoughts and ideas on how to further support staff.

The Trust Board:

- **Received the report**

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

1515/19 **Item 13.1 Assurance and Risk Report Workforce, Organisational Development and Transformation Committee**

The Chair of the Workforce, Organisational Development and Transformation Committee, Mr Hayward, provided a verbal report on the assurance received by the Committee at the September meeting.

1516/19 Mr Hayward advised that due to the timing of the Committee the written report would be presented for information to the Board at the November meeting.

Action – Deputy Trust Secretary, 5 November 2019

1517/19 The Committee reviewed the 6 month position against the annual plan with the milestone reports provided. A review of the People Strategy was undertaken, this continues to develop and required clearer data in order to track outputs. The strategy would be presented to the Executive Team to ensure that the objectives were challenging enough prior to presentation to the Board in its final form.

1518/19 The Committee received the relevant key performance indicators noting the improving quality of the statistics.

1519/19 The Committee had seen that the medical recruitment pipeline was strong and the Trust would soon be having the new nursing recruits commencing. This had demonstrated evidence of actions taking place. The Board were advised to be cautious regarding overseas recruitment as medics take longer to come in to post from overseas and this had been one of the issues of putting staff in place.

1520/19 The Committee were not assured that the timescales regarding the new recruits would enhance the establishment or impact on the financial performance for the current year.

1521/19 The Committee reviewed the relevant areas of the Financial Efficiency Programme, there was assurance that a sound review of all workforce plans had been undertaken. The Committee noted that the plans had been miss-rated and the challenge remained that they had not been

risk rated. The Board were advised that the risk adjusted figures were not 100% confirmed. The Committee were not assured on the achievement of the plan due to the number of risks in some areas.

1522/19 There had been an improvement in recruitment and the Committee were assured that there were more permanent staff within the Trust however the vacancy rate had worsened by a small amount. This appeared to be due to a rise in establishment.

1523/19 The Committee could not be assured that the recruitment actions in place would be effective at resolving the issues faced by the Trust, progress was being made but this had not been significant enough.

1524/19 The Committee were not assured in respect of medical capacity and activity management due to the financial efficiency programme having been significantly reduced due to concerns. The position should improve however the programme and milestones were not complete due to a number being overdue. Assurance had been received regarding agency spend due to the programme focussing on the reduction in the price of agency, there were less milestones overdue. The Trust had however used more than the planned numbers of agency workers and as such the Committee were not assured that the rate reduction would show improvement due to the numbers of agency being employed.

1525/19 The retention deep dive had provided assurance that the initiatives had commenced and some success had been seen. It was too soon for full assurance to be received and it was hoped that impacts would be seen towards the end of the year.

1526/19 The Committee discussed the international recruitment partner and whilst the Committee were happy to support the concept there was a lack of assurance as the paper was presented due to the method of selection of the preferred partner through the procurement process. The Committee had requested that further work be conducted to confirm that due process had been followed.

1527/19 The Committee were assured that the nurse establishment reviews had taken place however there was concern that the recommendations from the review had not been actioned. Work had commenced and it was hoped that further assurance could be provided at the next reviewed. Monitoring of the nurse establishment would continue.

1528/19 The Committee were pleased that the policy review for Just Culture had commenced and that work was ongoing to adopt core policies, these would need to include equality and diversity to ensure they were complete. The Committee however were not assured that the work would be completed in a timely manner and timescales may slip.

1529/19 Preparations for the annual staff survey were underway with the Trust trying to increase engagement.

1530/19 The Committee were assured that action plans were in place and had been developed regarding medical engagement however progress on delivery would need to be seen. A dedicate resource had been put in place however a key area of concern continued to be the rotas of Junior Doctors. There would also need to be further transparency of the excellence award, this was being progressed.

1531/19 The development programme of support for the medics continued to be developed and Quality and Safety Improvement Programme training was being offered as part of the programme.

1532/19 The Committee received the Equality, Diversity and Inclusion report for which the Committee were assured that the reporting requirements had been completed. The Committee were recommending to Board for sign off however wished to note the declining areas of the assessment. The Workforce Race Equality Standard had shown improvements in those indicators which the Trust had control of however national data demonstrated a decline, this was a consistent picture with other Trusts nationally.

1533/19 The Committee received the quarterly Guardians of Safe Working report noting a key area for improvement as the Junior Doctor rotas however assurance was provided that the Trust were aware of issues. Actions were in place to address non-assurance however there was still progress to be made.

1534/19 The Committee reviewed both the risk register and Board Assurance Framework noting that the risks correctly linked to the framework and the ratings provided.

The Trust Board:

- **Received the verbal update**

1535/19 **Item 13.2 Equality, Diversity and Inclusion Annual Report**

The Director of Human Resources and Organisational Development presented the report to the Board advising that this was a priority for the Trust as part of the True North work as well as being a responsibility for the Trust and public sector. The Equality, Diversity and Inclusion Lead was in attendance to support the presentation of the reports to the Board.

1536/19 The Trust recognise the significance of equality and diversity and the ability to provide services to patients. The Trust had been on a pathway to move from responding to equality and diversity to including this within planning and delivery processes. The report outlines the 'You Said, We Did' in order to respond to issues identified within the Trust.

1537/19 The Trust had engaged with patients through the Hearing Lincolnshire's Hidden Voices engagement events to ensure that all parts of the community were engaged and listened to. The Trust had continued to grow and strengthen the staff networks to ensure engagement with staff.

1538/19 Dr Gibson noted that the report had been received at the Quality Governance Committee and commended the content and clear layout including the roadmaps. These gave the opportunity to suggest improvements however it also demonstrate the concerning national data recently in relation to maternal deaths for black mothers. The report was strong but did not contain much information regarding health outcomes that may be different in different groups. It would be positive to see the health outcomes based on ethnicity and other characteristics.

1539/19 The Equality, Diversity and Inclusion Lead advised that it was planned that this would form part of future reports and work was underway with the IT department in order to have the capability to produce the data including equality monitoring. This would be disaggregated by Divisions and Clinical Services, further work would be required to ensure data quality.

1540/19 The Chief Operating Officer asked if the objective for 2019/20 were sufficient to address the experiences of people with protected characteristics within the organisation and what else should the Board be doing. There did not appear to be a connection between the completion of the objectives against self-reporting from staff.

1541/19 The Director of Human Resources and Organisational Development advised that there was a need to firstly understand what had caused people to report in the way that had, this was

being completed. Whilst BAME staff scored more poorly work was being undertaken with the staff network to understand what sits behind the data. Once this was understood actions would be determined to move this forward.

1542/19 The Chair expressed her agreement with the challenge that had been given by Board members and agreed that there was a need to consider how this was taken forward, the Board would need to influence this through the annual plan.

1543/19 The Chief Executive questioned if more could be done across the system through joint working and offered as the Chair of the System Executive Team to provide support to system working.

1544/19 The Equality, Diversity and Inclusion Lead advised that whilst the leads within the provider organisations worked closely together there had been difficulties trying to achieve a system wide approach from the STP.

1545/19 The Chief Executive requested that work continued with provider colleagues and agreed to pursue the support from STP colleagues.

Action – Chief Executive, 5 November 2019

1546/19 The Chair celebrated the achievement of the report and the staff networks and was pleased that the impact of these was starting to be seen. It was also noted by the Board that the Commissioners had moved the Trust's rating from developing to achieving.

1546/19 The Chair congratulated the Equality, Diversity and Inclusion Lead for the completion of the work and for his appointment to the NHS Improvement Equality Group.

The Trust Board:

- **Received the report**
- **Approved the report for publication**

1547/19 **Item 13.3 NHS Workforce Race Equality Standard**

The Director of Human Resources and Organisational Development presented the report to the Board identifying that there were two aspects to the Workforce Race Equality Standard.

1548/19 The report demonstrated an improving picture due to the focus provided to the standard and an improvement in data quality. The Trust had identified that need to focus attention on bullying and harassment issues and would pursue and consider action to be taken whilst using the model employer framework.

1549/19 The Equality, Diversity and Inclusion Lead stated that the model employer information was awaited by the Trust and that this would provide a suite of aspirations that would support progression across all areas. Once received this would be received and the Trust would consider how the aspirations would be delivered.

1550/19 The report demonstrated that there was still progress to be made and that feedback from staff would be translated in to actions to ensure that an impact was made.

The Trust Board:

- **Received the report**
- **Approved the report for publication**

1551/19 **Item 13.4 NHS Workforce Disability Equality Standard**

The Director of Human Resources and Organisational Development presented the report to the Board advising that this had been the first year of reporting the Workforce Disability Equality Standard.

1552/19 The Trust acknowledged that work around disability in the organisation was not as well developed as the race equality standard however one of the areas of concern had been the low self-declaration rates.

1553/19 There would be a primary focus moving forward to encourage staff to come forward in order to develop a staff network and to ensure there was a community to enable dialogue and identify how this could be progressed.

1554/19 The Equality, Diversity and Inclusion Lead stated there is currently a small Mental and Physical Lived Experience (MAPLE) staff network, the network has an executive sponsor however meets virtually through a closed Facebook group. There had been national recognition that disability groups are more difficult to establish however work would be undertaken to widen engagement.

1555/19 Currently national benchmarking in not available however there would be an expectation that as this progresses there would be similar data available to the Workforce Race Equality Standard. The Trust have in place data analyst support in order to ensure data capture and reporting.

1556/19 The Chair endorsed the actions identified for improvement regarding self-disclosure rates and the continued support of the MAPLE staff network.

The Trust Board:

- **Received the report**
- **Approved the report for publication**

1557/19 **Item 13.5 Rainbow Badge Board Pledge**

The Equality, Diversity and Inclusion Lead presented the paper to the Board identifying that the national scheme had launched in early 2019 and the Trust had conducted a soft launch through the LGBT+ staff network in early September.

1558/19 In under 3 weeks the Trust had seen 700 staff sign up to the scheme, equivalent to just below 10% of the workforce. The scheme would be voluntary however staff would be required to make a pledge when signing up.

1559/19 The Trust officially launched the scheme on the 27 September where an additional 65 senior leaders signed a pledge. The Equality, Diversity and Inclusion Lead was ensuring that pledges made were sufficient and where required had pushed back to strengthen the pledge being made.

1560/19 A pledge from the Board had been sought in order to commit the organisation to develop and grown LGBT+ inclusion.

1561/19 The Trust Board accepted the pledge on behalf of the organisation.

1562/19 The Director of Nursing enquired as to whether there would be a plan to share the pledges across the organisation. It was confirmed that linked to the official launch at the end of September the Communications team had supported the development of the intranet site.

Work was underway to identify the positive messages that would be public facing and an internet site would support this. Work would be undertaken with different teams to continue promotion. It would take some time to work through the pledges made and identify key schemes.

1563/19 The scheme is also for patients and as such there would need to be a way to communicate with patients so that they were aware who they can approach and what this would mean. The prime areas to focus for patients would initially be accident and emergency and outpatients.

The Trust Board:

- **Signed the Rainbow Badge Pledge**

1564/19 **Item 13.6 Smoke Free United Lincolnshire Hospitals NHS Trust**

The Director of Human Resources and Organisational Development presented the report to the Board identifying that the consultation period had been conducted earlier in the year. The Board were now being presented with a firm proposal for the Trust to become a Smoke Free organisation from 6 January 2020.

1565/19 A key issue for the Trust, as others had experienced would be the enforcement of a smoke free site. The consultation outcome had been in favour of the Trust being smoke free and the intention would be to enforce this from January 2020. The January implementation data enables the Trust time to run effective communications and campaigns around the intention to be smoke free as well as increase efforts to support patients, carers and staff to stop smoking.

1566/19 The policy indicates that staff should be able to enforce the policy but only to the extent that they would feel safe in doing so, the Trust however expect that this would have a limited impact. Consideration had been given to additional staff to support the enforcement of the policy however this would be prohibitive. Existing security staff and community officers would be utilised to support the Trust in being smoke free.

1567/19 Additional signage would be installed across the sites however it would be expected that peer pressure would have the most impact on stopping people from smoking outside the hospital frontages. The priority focus would be to stop smoking outside the front entrances to the Trust sites.

1568/19 Consideration to exceptions had been given for inclusion in the policy, whereby people in stressful situations would be allowed to smoke as this could calm a situation. It was agreed however that this would not be included within the policy, however it had been recognised that there was the potential for limited circumstances where it may be appropriate. Staff in that instance would use discretion.

1569/19 The Chair noted that communications would need to be managed well in order to limit the potential for reputational impact on the Trust but the Board were keen to implement the National Institute for Health and Care Excellence guidance in clinical areas of the business.

1570/19 There was recognition that smoking was a personal choice however this would need to be done appropriately when visiting the hospital sites. The Chair asked what the impact would be on staff with the increased expectation to discuss smoking cessation with patients and also the potential costs associated with offering nicotine replacement therapy.

1571/19 The Medical Director advised that it was the duty of staff to offer support to patients to stop smoking however this had been the most neglected aspect of the health agenda. There would be an impact however this was a role that staff should be currently fulfilling.

1572/19 The Director of Nursing stated that the organisation should be supporting people to stop smoking and that these messages come through Every Contact Counts, the Trust should be enabling staff to carry out this aspect of the health agenda and consider pre-operative opportunities.

1573/19 The Board noted the length of the policy and discussed the possibility of producing a policy at a glance in order to ensure clear communication. The policy included a communications plan which was the intended method to ensure that people understood the key elements of the policy however this would be reviewed.

Action – Director of Human Resources and Organisational Development, 5 November 2019

1574/19 The Board discussed the continuing challenge of vaping and if this would be allowed on site, some Trusts had continued to allow vaping to be carried out. The Trust had taken the view that vaping would be allowed due to NHS England viewing this as an alternative to smoking.

1575/19 The Chief Executive stated that this had been the right approach for the Trust to take and that the issues with enforcement had been noted. Implementation would take time and there would be a reliance on others to support people to stop smoking.

1576/19 The Trust Board approved the policy and move to smoke from sites from 6 January 2020. A post implementation review would be conducted at 6 months and presented to the Board.

Action – Director of Human Resources and Organisational Development, 7 April 2020

The Trust Board:

- **Approved the Smoke Free Policy**

Item 14 Providing seamless integrated care with our partners SO4

1577/19 **Item 14.1 Fragile Services**

The Medical Director presented the paper to the Board in order to raise awareness of the impact of medical vacancies at Grantham Hospital and in Stroke Services Trust wide.

1578/19 Grantham Hospital currently provides acute medical admissions along with some elective specialty activity. Grantham had 3839 acute admissions in the past year which represented a significant amount of activity that could not be transferred to alternative sites. The contribution of specialty activity from the site was circa 5% with elective work representing around 1% of admissions, this was a relatively small portion of activity. Acute medical services remain under pressure with the pressure on the workforce being seen across all sites.

1579/19 There remained a reliance of temporary staffing to deliver the service, this had been reviewed as part of the risk summit for Grantham in order to consider the safety and sustainability of the service.

1580/19 The summit had identified that medicine services were currently safe however the sustainability of the service due to the dependence on temporary staff had been identified as an issue. Although the reliance on temporary staffing was across all sites this had been felt more acutely at Grantham due to the small size of the team.

1581/19 Staffing issues were discussed during the summit with a number of actions to be taken that could result in a more reliable and sustainable service. It had become clear that vacant posts had been advertised as locum posts and not substantive roles. Work would be undertaken to review the posts and develop them to ensure the roles advertised were more attractive.

1582/19 Due to the uncertainty of the site and feedback received a review of the current model would be undertaken. This would ensure a clear future vision with the development of the intermediate care offer and improve sustainability. Acute medicine would continue however the Trust would look to improve the quality of work, cross site working and increase of job plans and posts to make this a more attractive offer.

1583/19 Mrs Dunnett highlighted that the paper appeared to demonstrate gaps at the Lincoln site and not Grantham and asked if the approach being discussed would be Trust wide.

1584/19 The Medical Director confirmed that the figures at Lincoln were lower due to there being no substantive consultations in post and these had been supported by specialist consultants. Grantham was not uniquely vulnerable and as such there was a need to consider Trust wide issues and respond to these.

1585/19 Further work would be undertaken to develop recruitment of substantive roles. Following on from the previous discussion regarding fragile services there had been a cross check of the activity in hand and the support from the HR Resourcing and Speciality Recruitment Teams. The review had demonstrated strong pipelines for a number of areas however others would require support. Consideration of HR summits to review workforce challenges prior to the need for a service risk summit would be given.

1586/19 The Chair noted that the positive outcome from the summit had been that services were safe and continued to be delivered and that discussions were being held prior to services reaching a critical stage.

1587/19 Stroke services had been identified as highlighting relative fragility with only 2 substantive consultants in post, lessons learnt from medicine would be used to develop the approach to stroke services. The Acute Services Review model would mean that the service would move to one site which could cause some issues. The rehabilitation services and ability to discharge patients to the community services would require development. The lessons learnt from acute medicine would be mirrored across the stroke service to ensure that the service would not become unsustainable.

The Trust Board:

- **Received the report**

1588/19 **Item 14.2 Medical School Update**

The Medical Director presented the report to the Board identifying that there were a number of elements to the paper however this was about ensuring that the Trust were in a position to receive medical students to carry out their practice once qualified.

1589/19 The Trust must ensure that there are the appropriate teaching facilities available to support medical students. Currently the Lincoln site does not have suitable facilities to teach and support the number of medical students coming through.

1590/19 Work to prepare a bid and business case to draw down funds to support building works had commenced to ensure that the facilities could be improved.

1591/19 Alongside the development of the facilities there would need to be strengthened staffing to ensure consistent delivery. A basic plan had been set out in the paper to ensure those staff delivering teaching were able to meet a set standard.

1592/19 The structuring and provision of the education would need to be considered with further development work due to the level of responsibility for the medical students by the Trust. The offer for Doctors that were not on conventional training routes would require development, this would allow for overseas doctors to obtain a certificate of specialist registration. Previously this had been done on a small scale however this would now increase. The Trust would be responsible for the development and delivery and would not be able to rely on others to develop the workforce. This would provide an opportunity for quality improvement within the Trust.

1593/19 Staffing would result in 2 professor posts that would be split half time between the Trust and Education and would be a joint endeavour with the Universities of Lincoln and Nottingham. The job descriptions had been agreed and would be out to advert in the near future.

1594/19 Discussions had been held with the University of Lincoln regarding funding for further posts that could be Trust based with some honorary sessions at the University, further discussion would be had with NHS England.

1595/19 The posts would be focused on the areas that face the most pressure with an aim to improve the educational offer in addition to the Trust brining in high quality clinicians to improve care. In order that the Trust could see an improvement the clinical commitment would be required to be undertaken within the Trust.

1596/19 The Chair highlighted that this was an exciting opportunity for the Trust and that there had been positive conversations with the University. The investment being made in the facilities was welcomed and the outline business case would be expected to the Board in December.

Action – Medical Director, 3 December 2019

1597/19 Dr Gibson enquired as to whether there were currently any staff who were already engaged on the course to strengthen the teaching skills of staff.

1598/19 The Medical Director confirmed that there were some staff who had self-funded their attendance and one member of staff who had secured Higher Education East Midlands funding for the course. The Trust were however funding all teaching fellows to undertake the training.

1599/19 The Chief Operating Officer raised concerns regarding the financial figures included within the report identifying that it had suggested a further £500k of capital would be required.

1600/19 The Director of Finance and Digital advised that upon receipt of the original case a number of assumptions had been made due to the timing and pace of the project. The reality had been that additional monies would be required. This would now be worked through based on the options presented and profiled across the years. There would be the possibility to reclaim some of the VAT which would help to address some of the funding gap.

1601/19 There would be a full review of the education offer and a restructure of the Education Team to ensure that the establishment required was suitable, the business case would support both the building and staffing of the medical school to demonstrate affordability.

1602/19 A discussion was held regarding the Trusts research department and need to review the current and future offers. The Chief Executive confirmed that this would be a wider

discussion with the University of Lincoln as there would be a suit of areas that could be improved by working with the university.

The Trust Board:

- **Received the report**

1603/19 **Item 14.3 Healthy Conversations Feedback**

The Chief Executive presented the paper to the Board advising that all Boards and governing bodies would be receiving the paper during October, this provided a position statement to the Board.

1604/19 Engagement activities had included the Acute Services Review survey and Health Conversations events, work had now progressed to the development of the Lincolnshire Long Term Plan. Publication of the Long Term Plan should enable the thread of issues to be seen along with the commonality across the work that had been conducted.

1605/19 The paper demonstrates the phases of healthy conversations, as the system move in to the Long Term Plan arena the healthy conversations phase will ensure, this is due to be at the end of October. A number of the processes and events had been detailed along with the communication methods utilised.

1606/19 The Chief Executive had received feedback from members of the public about the lack of attendance at the healthy conversations events however this had not been the only method of engagement and this had been summarised within the paper.

1607/19 The report summarised the feedback provided by key service area and key headline issues, the mostly focused on transport and travel particularly in the rural parts of the county. Issues regarding access to 111 had been raised, some of this had been about perception of access against the reality. The capability and capacity of the ambulance service to cope with alternative service models and distances had also been raised through the engagement events. The ability of the Lincoln hospital site to manage with services being concentrated there had also been an issue.

1608/19 The report provided a current position statement, there would be 2 further healthy conversation events taking place once these had been completed the focus would move to the Long Term Plan.

1609/19 The Board recognised that not all of the feedback received had been positive of supportive but it had been helpful to have a focus and this would ensure the ability to demonstrate that the system had listened to feedback.

The Trust Board:

- **Received the report**

Item 15 Performance

1610/19 **Item 15 Integrated Performance Report**

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

1611/19 The Trust continues to remain below the expected HSMR limit at 89.19 and SHMI is reporting in band 2 within expected limits. Work continues to develop divisional dashboard to provide insights.

1612/19 Incident reporting remains consistent with an average of 1149 patient incidents reported per month. There had been a high number of patient behaviour incidents as well as a high number of Blood/Plasma incidents during August. The Blood/Plasma incidents appear to be due to technology issues, both of the areas are under further review by the Patient Safety Group.

1613/19 The Trust had declared 8 Serious Incidents during August and 32 Serious Incidents were open at the end of August, none were overdue. The Trust were in the position of being able to sustain the ability to manage these in a timely manner.

1614/19 Verbal Duty of Candour compliance for July reported at 96%, one incident was non-compliant, written notifications were at 88%.

1615/19 Overall Referral to Treatment had grown however this was a reduced level of growth compared to previous months, this still remained off trajectory. There were no disproportionate areas however the largest growths were seen in Gastroenterology, General Surgery and Maxillofacial.

1616/19 Referral to Treatment in 18 weeks remains static with 1 patient in July waiting more than 52 weeks for treatment. The Trust have a tolerance of zero, the patient had now been treated.

1617/19 The external support provided by pathway management specialists would ensure improvements in data quality whilst also increasing the Trusts ability to sustain the 18 week performance.

1618/19 In July the Trust achieved 3 of the 9 cancer standards, the ability to sustain the increased performance seen in June had been identified as a concern.

1619/19 The Trusts backlog for 104+ had reduced to 12 patients with plans in place to reduce this further. The Trust remains in the top 15 of the largest providers of cancer treatments in the country.

1620/19 August data had demonstrated that there had been the achievement of 93% against the national standard cancer treatment.

1621/19 The Trusts financial position had deteriorated with year to date performance £3.2m adverse to plan. In the first 4 months of the year the Trust had utilised non-recurrent items to mitigate slippage however this was now exhausted. The deficit was manifesting directly in the bottom line.

1622/19 The level of activity in non-elective had been significantly over the contracted planned levels, this had driven the level of cost in the organisation as this had not been planned, additional factors had resulted in the Trust being £4.9m adverse to plan on agency staffing.

1623/19 Income reported slightly favourable to plan and a review was underway to determine how the contract works and to take stock as there would be an impact due to the over performance in elective activity.

1624/19 To date the Financial Efficiency Plan had delivered £5.9m, £1m less than planned. Plans were not delivering at the scale of pace expected. At month 6 there was a narrowing ability to recover the position. The ability to deliver the required actions had caused concern. There had been improved working as a system and there is an intent by the system to ensure delivery. Non delivery would result in the system being unable to achieve the circa £30m of funding from the centre.

1625/19 The vacancy rate for the Trust improved in August by 0.3%, the impact on the financial position is yet to flow through and the Divisions had provided a level of reassurance to the Executives. There would be an expectation of a reduced agency bill in month 6.

1626/19 The sickness absence rate, rolling 12 months, increased slightly to 4.9% in July.

1627/19 The Director of Nursing advised the Board that as further work is completed on the quality dashboard with the Information Team it is hoped that the previous months data would be populated to provide a current position. The spike in pressure ulcers demonstrated in the report were due to damage sustained externally to the Trust. Reporting of pressure ulcers and review of data enables this to now be understood within the Trust. Discussions would be held with the Commissioners to ensure that learning regarding pressure damage is passed back to the providers that it originated from.

1628/19 The Medical Director reiterated the positive achievement against the mortality and Serious Incident figures. There would be a refocusing of clinical governance towards out of theatre procedures to address issues raised through National Audits due to the Trust remaining as an adverse outlier. The Clinical Governance Team would be refocussed to lower level issues.

1629/19 The Chief Operating Officer highlighted the growth of waiting lists which had grown by 10% for new patients, the follow up waiting list had grown by nearly 30%. Growth had been driven due to the availability of workforce.

1630/19 The Chief Executive advised that the biggest area for continued focus would be to achieve the financial plan, there were 6 months remaining to rectify the deficit. The system were support of the Trust however did not negate the need for the Trust to be in control of base costs. Pay would be the top area to be tackled and efforts had been made to discuss this issue within the Divisions. The focus had been both substantive and agency pay.

The Trust Board:

- **Received the report**

Item 16 Risk and Assurance

1631/19 **Item 16.1 Risk Management Report**

The risk report was presented to the Board and it was noted that there had been a reduction in the number of estates risks along with the reduction of risk ratings for both the risk of critical failure of electrical and mechanical infrastructure and fire works.

1632/19 There had been no material changes to the high risks and the corporate risks remain the same. The Board noted the movement and reduction in the estates risks however it was noted more work was required to mitigate risks.

The Trust Board:

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

1633/19 **Item 16.2 BAF 2019/20**

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

1634/19 The Board held discussion of each of the strategic objectives noting that objective 1b and 2a would require the narrative to be updated to reflect the discussion held at the Board.

1635/19 Improved narrative and a review of the assurance gaps would be required for objective 2b with consideration given to the management of the gaps and controls.

1636/19 In respect of objectives 3a and 3b the Chair noted that there had been a number of papers regarding staffing, recognising the challenges faced and that the control gaps had been identified along with those areas where assurance had not been provided. Actions were in place and being taken.

1637/19 Objective 4a would require improved narrative and a review of assurance gaps again considering the management of gaps and controls.

1638/19 The Chair requested that the lead Executives review the objectives for which they held responsibility.

Action – Deputy Trust Secretary/ Executive Directors, 5 November 2019

The Trust Board:

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

1639/19 **Item 16.3 NHS Improvement Board Observations and Actions**

The Chair presented the observation and actions to the Board noting that the feedback had been reviewed and an action plan developed with the Trust Secretary.

1640/19 The Board were asked to receive the feedback noting that this had been positive. The action plan had a number of individuals leading improvement actions and endorsement was sought that the Board were focusing correctly. The leads with actions were requested by the Chair to move these forward.

1641/19 An update of the action plan would be presented to the Board in December.

Action – Trust Secretary, 3 December 2019

1642/19 The Chair requested that the Audit Committee receive the reports and action plans in order to ensure that the governance process had been completed.

Action – Trust Secretary, 10 January 2020

The Trust Board:

- **Received the report**

Item 17 Strategy and Policy

1643/19 **Item 18 Board Forward Planner**

For information

1644/19 **Item 19 ULH Innovation**

For information

1645/19 **Item 20 Any Other Notified Items of Urgent Business**

None

The next meeting will be held on Tuesday 5 November 2019, Boardroom, Lincoln County Hospital, Lincoln

Voting Members	30 Nov 2018	7 Jan 2019	5 Feb 2019	5 Mar 2019	2 Apr 2019	7 May 2019	4 June 2019	2 July 2019	6 Aug 2019	3 Sept 2019	1 Oct 2019
Elaine Baylis	X	X	X	X	X	X	X	X	X	X	X
Chris Gibson	X	X	X	X	X	X	X	X	X	X	X
Geoff Hayward	X	A	A	A	X	A	X	X	X	A	X
Gill Ponder	X	X	X	X	A	X	X	X	X	A	X
Jan Sobieraj	X	X	X	X	X	X	X				
Neill Hepburn	X	X	X	X	X	X	X	X	X	A	X
Michelle Rhodes	X	A	X	X	A	X	X	A	A	X	
Kevin Turner	X	X	X	X	X	X	X	X	A		
Sarah Dunnett	X	X	X	X	X	X	X	X	A	X	X
Elizabeth Libiszewski	X	X	X	X	X	X	X	X	X	X	X
Alan Lockwood	X	X	X	A							
Paul Matthew	X	X	X	X	X	X	X	X	A	X	X
Andrew Morgan								X	X	A	X
Victoria Bagshaw											X

PUBLIC TRUST BOARD ACTION LOG

Agenda item: 6

Trust Board date	Minute ref	Subject	Explanation	Assigned to	Deadline	Completed
4 June 2019	827/19	Assurance in respect of H&S actions reported to FPEC	Clarity required in relation to training etc and metrics on actions following historic regulation/prosecution	Boocock, Paul	~~02/07/2019~~ 03/09/2019	Work to populate ESR with historical and current training records. Recruitment in to team to increase training. Work underway to provide data to give visibility on training levels. More granular information expected back to FPEC at October meeting. Delivery of the training would run in to 2020.
4 June 2019	884/19	National urgent care pathway changes	Board to receive update when available.	Brassington, Mark	~~30/09/2019~~ 5/11/2019	National update not available as at 24 Sept 2019
2 July 2019	1004/19	Finding relating to sepsis within the CQC report	Consideration of what needs to change to address the issues highlighted and how this doesn't align to data that Board had previously seen	Rhodes, Michelle	06/08/2019	Revised dashboard data agreed by QGC in September. Metrics updated to be more comprehensive, sepsis now covered in detail to provide transparency to QGC – Complete

PUBLIC TRUST BOARD ACTION LOG

Agenda item: 6

2 July 2019	1016/19	CQC Feedback letters June 2019	QSIP not having the impact would have wanted. Need review of this and where we get assurances from. How we prevent these issues arising rather than responding to problems after the event	Morgan, Andrew	06/08/2019	Review of QSIP content and process underway.
2 July 2019	1062/19	People Strategy	Develop some ambitious outcomes, built up with colleagues within the divisions. Through ET in first instance. Develop forward plan for rest of this year. Strategy back when ready	Rayson, Martin	~~06/08/2019~~ 01/10/19	Strategy being considered at 30 Sept W&OD. Useful discussion at W&OD, next steps would be to take strategy through cycle of ET/TMG. Publication of CQC report awaited to ensure actions are captured
6 August 2019	1186/19	QGC Assurance report	Review of window cleaning impact on cleanliness audit	Boocock, Paul	03/09/2019	Proposal to increase frequency of window cleaning being developed to be presented to CRIG for funding in October, Board to receive update at November meeting.
6 August 2019	1248/19	W,OD&T Assurance report	Refresh of the leadership development programme to be presented to the Board.	Rayson, Martin	01/10/2019	Agreed to be conducted at BD session - Complete

PUBLIC TRUST BOARD ACTION LOG

Agenda item: 6

6 August 2019	1274/19	Integrated Performance Report	Performance data to be reported to FPEC in relation to fractured neck of femur patients being treated within 24 and 48 hours	Brassington, Mark	03/09/2019	Discussed at FPEC. Further clarity requested. Included as escalation slide in IPR, will be tracked through IPR - complete
6 August 2019	1317/19	BAF	System delivery reports to be presented to Board members and ensure upward reporting through Committees	Brassington, Mark	03/09/2019	System delivery reports to be shared with Board. As an interim measure the LCB system report would be circulated to Board members as an addition to the minutes.
3 September 2019	1333/19	Chief Executive Horizon Scan	Progress towards achievement of being a teaching hospital and how this would be supported by the University of Lincoln to be reported to the Board	Hepburn, Neill	01/10/2019	Agenda item Complete
3 September 2019	1387/19	Annual Plan update	Board Development session to be arranged to support development and planning process	Warner, Jayne	01/10/2019	To be built in to future Board Development session programme – Complete
3 September 2019	1422/19	Integrated Performance Report	Board Development session to be arranged to review totality of operational performance	Warner, Jayne	01/10/2019	To be built in to future Board Development session programme – Complete
3 September 2019	1426/19	Risk Management Report	Risk Manager to be invited to the Board to ensure detailed discussion of divisional risks	Warner, Jayne	01/10/2019	CEO invited Risk Manager to ET

						discussed divisional risk, will then attend TMG to have wider discussion with divisions. Operational issue to be resolved – Complete
1 October 2019	1443/19	Matters arising/action log	LCB system report to be circulated with minutes to Board members	Warner, Jayne	05/11/2019	Complete
1 October 2019	1462/19	Patient/Staff Story	The Deputy Chief Nurse would provide a future update to the Board on the focused work of the pathways to ensure lessons were learnt.	Negus, Jennie	03/12/2019	
1 October 2019	1503/19	FPEC Assurance Report	Urgent Care Improvement programme assumptions and current position to be reported to FPEC	Brassington, Mark	24/10/2019	Agenda item Oct FPEC. Complete
1 October 2019	1516/19	W,OD & T Assurance Report	Written report would be presented for information to the Board at the November meeting	Willey, Karen	05/11/2019	Agenda Item Complete
1 October 2019	1545/19	Equality, Diversity and Inclusion Annual Report	Pursue support from STP	Morgan, Andrew	05/11/2019	
1 October 2019	1573/19	Smoke Free ULHT	Review of communications plan to ensure clarity of implementation	Rayson, Martin	05/11/2019	
1 October 2019	1576/19	Smoke Free ULHT	Post implementation review to be presented to the Board	Rayson, Martin	07/04/2020	
1 October 2019	1596/19	Medical School update	Medical School business case to be presented to the Board	Hepburn, Neill	03/12/2019	
1 October 2019	1638/19	BAF	Review and update of narrative	Willey, Karen/Executive Team	05/11/2019	Complete

PUBLIC TRUST BOARD ACTION LOG

Agenda item: 6

1 October 2019	1641/19	NHS Improvement Board Observations and actions	Updated action plan to be presented to the Board	Warner, Jayne	03/12/2019	
1 October 2019	1642/19	NHS Improvement Board Observations and actions	Audit Committee to receive reports and action plans	Warner, Jayne	14/10/2019	Audit Committee agreed to review progress at January 2020 meeting

Excellence in rural healthcare

NHS
United Lincolnshire Hospitals
NHS Trust

To:	Trust Board
From:	Andrew Morgan, Chief Executive
Date:	5 November 2019
Healthcare standard	

Title:	Chief Executive's Report

Author/Responsible Director: Andrew Morgan, Chief Executive

Purpose of the report:

To provide an overview of key strategic and operational issues.

The report is provided to the Board for:

Information	√	Assurance	
Discussion	√	Decision	

Summary/key points:

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

Recommendations:

The Trust Board is asked to:

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

Strategic risk register	**Performance KPIs year to date**
Resource implications (eg Financial, HR)	
Assurance implications	
Patient and Public Involvement (PPI) implications	
Equality impact	
Information exempt from disclosure	
Requirement for further review?	

System Issues

a) The System remains under increased scrutiny from NHSE/I on Urgent and Emergency Care (UEC) performance. A stocktake meeting was held on 8 October 2019 and there has also been a further teleconference with the National Director of UEC. The focus for the System remains on CAS and alternative pathways; ambulance conveyances and handover delays; streaming; minors; same day emergency care; flow; long lengths of stay; staffing; flu vaccinations; 7 day delivery; winter plans. The Urgent and Emergency Care Delivery Board remains the key focus for co-ordinated system planning.

b) Brexit planning is continuing and the EU Exit sitrep reporting system to NHSE/I went live on 21 October 2019.

c) The next iteration of the Lincolnshire System Long Term Plan is due to be submitted to NHSE/I on Friday 1 November 2019. This is not yet a public document as it will undergo further scrutiny and assurance by NHSE/I. It is anticipated that the plan will go into the public domain before the end of December.

d) The Joint Working Executive Group, involving NHS, LCC and voluntary sector representatives, is continuing to meet to plan the ICS for Lincolnshire. It is anticipated that a Development Plan for moving to an ICS by April 2021 will be available in January. Lincolnshire has been one of the national field pilot sites for work relating to the role of Integrated Care Systems in supporting and developing the NHS workforce. The initial findings and recommendations were fed back to SET on 23 October.

e) The next System Assurance Meeting with NHSE/I will be on 20 November 2019. Dale Bywater, the Regional Director of the Midlands, has also put in place monthly regional meetings with CEOs/AOs.

f) Lincolnshire County Council are in the process of developing their Corporate Plan. NHS partners are being asked for their views on the plan. Comments will be gathered via SET and the LCB.

g) The Lincolnshire Health Awards ceremony takes place on 19 November.

h) NHSE/I have approved in principle the creation of a single CCG for Lincolnshire with effect from 1 April 2020. Further work is now underway on all the actions that are necessary to formally establish the new CCG. NHSE/I will need to be satisfied that all the necessary work has happened before formal approval is given to the new CCG.

Trust specific issues

a) The Trust has now received the report from the CQC following the inspection carried out in June and July 2019. The Trust's overall rating

remains unchanged at Requires Improvement and the Trust will remain in Special Measures. A detailed report is available elsewhere on the Board agenda. Despite lots of hard work from staff, this is a disappointing outcome. The Trust is not where it needs to be and more work is needed to change our ratings.

b) At M6, the year to date financial position was a deficit of £27.1m which is £27k favourable to plan. This position includes a number of appropriate accruals and technical adjustments. However, the underlying position is a year to date adverse variance of circa £11.5m. This means that concerted effort is required for the remainder of the year if the Trust is to achieve its control total.

c) The Trust has been advised of its new Improvement Director by the National Intensive Support Team. Cathy Geddes, who is a senior nurse by background, has now joined the Trust and will provide input and support for 3 days per week.

d) The interviews for the Director of Finance and Digital will take place on 14 November 2019. The advert for the Director of Nursing vacancy closes on 28 October 2019. Interviews are planned for 17 December 2019.

e) The Trust has been informed that it can bid for capital funding for the replacement of imaging equipment that was 10 years old (or older) as at 31 March 2019. The funding provides capital to replace any CT or MRI scanners and mammography equipment used for both symptomatic/assessment breast services and breast screening. NHSE/I believe that the Trust has 1 CT and 1 MRI machines that fall into this category. The Trust is checking this information and will then work with NHSE/I to access the capital and follow the agreed procurement process.

f) Work is underway to strengthen the relationship with Trades Unions and to enhance Staff-Side input into the work that is needed to improve the Trust. One aspect of this will be the negotiation of a new Recognition Agreement with Trades Unions.

g) A “Big Conversation” has commenced with staff about a new travel plan for the Trust. This will address green travel issues as well as seeking resolution to staff car parking problems.

h) The National Staff Survey 2019 is now live and efforts are underway to encourage as many staff as possible to fill in the survey.

i) The Trust has become a “menopause-friendly” employer, underlining its commitment to creating a positive, supportive and productive work environment for female staff. This means that staff will have access to specialist consultant and menopause nurse referrals, in-house support groups and bespoke training packages.

j) The Trust has become the first Trust in the country to be accredited by The Academy of Fabulous Stuff. This is a social movement for sharing health and social care ideas, services and solutions that work.

Agenda Item 9

NHS
United Lincolnshire Hospitals
NHS Trust

To:	**Trust Board**
From:	Victoria Bagshaw, Director of Nursing
Date:	22 October 2019
Healthcare standard	

Title:	CQC Report

Author: Victoria Bagshaw, Director of Nursing

Responsible Director: Director of Nursing

Purpose of the Report: Update Trust Board on the recent publication of the Trust CQC Inspection report and provide an overview of the proposed altered governance process for delivering and monitoring quality improvements

The Report is provided to the Board for:

Decision		Discussion	x
Assurance		Information	X

Summary/Key Points:

The Care Quality Commission (CQC) inspected the Trust during June 2019. A separate 'well-led' assessment took place during July 2019. The NHSI review of

Not all services were inspected but all sites were. The services inspected included:

- urgent and emergency care at Lincoln and Pilgrim hospitals
- medical care at Lincoln and Pilgrim hospitals
- critical care at Lincoln and Pilgrim hospitals
- maternity services
- children and young people's services inspected at Pilgrim,

The CQC found the Trust to have remained with an overall rating of 'requires improvement'. Two of the four hospital locations are rated as 'good' overall and following an improvement in the ratings of Pilgrim Hospital two as 'requires

improvement'. The CQC rates organisations on five domains as shown below. The four domains of safe, effective, responsive and well-led were rated as 'requires improvement', caring rated as 'good'.

The CQC report details a mix of positive improvements and current challenges for the Trust, many of which were identified within the Trust prior to the inspection and formed part of the ongoing Quality and Safety Improvement Plan. Whilst improvements have been made in some areas, the depth and breadth of change has not made to the level wanted and expected to deliver the sustainable improvements to the quality of patient care and staff experience through the Quality and Safety Improvement Plan (QSIP) that the Trust Board expected. As a result, the Trust will not progress out of quality special measures.

There is a recognition the programmes of work within the QSIP were broadly correct however a refocus is required and detail within the 2019/20 QSIP and the importantly the process by which the plan is delivered, monitored and assured. Future programmes needs to be incorporated into the Trust corporate governance process and give trust Board through Quality Governance Committee improved visibility and assurance of delivered sustainable improvements.

Recommendations:
Discussion of the attached CQC documents and proposed QSIP monitoring process.

Strategic Risk Register	**Performance KPIs year to date**
Improved delivery through the QSIP should improve the risk rating of issues on the risk register	Improvement is measured through the QGC dashboard

Resource Implications (eg Financial, HR)
Delivery of the QSIP will require, as in previous year, staff and financial resource some of which was previously provided by NHS Improvement.

Assurance Implications
Limited assurance currently related to the delivery and impact of the QSIP, changed governance monitoring process will strengthen transparency and assurance

Patient and Public Involvement (PPI) Implications
Improved delivery of the QSIP will have a positive impact on the quality and safety of patient care and experience

Equality Impact -

Information exempt from Disclosure -

Requirement for further review?

Agenda Item 9

1. CQC Inspection Reports

The CQC found the Trust to have remained with an overall rating of 'requires improvement'. Two of the four hospital locations are rated as 'good' overall and following an improvement in the rating of Pilgrim Hospital, two as 'requires improvement'.

Overall, individual ratings for each hospital site are:

- Lincoln County Hospital – requires improvement
- Pilgrim Hospital Boston – requires improvement
- Grantham and District Hospital – good
- County Hospital, Louth – good

Overall ratings for the Trust in each of the five domains have remained the same at this 2019 inspection.

In their inspection report the CQC identified examples of outstanding practice and exemplary care across our services. This was recognised through the progress at Pilgrim hospital where the overall rating moved from 'Inadequate' to 'Requires Improvement' in addition the report overwhelmingly recognised how great our staff are identifying the care and compassion the inspectors witnessed during their visits. The report also recognised the significant improvements to reducing mortality within the Trust with the Hospital Standardised Mortality Rate (HSMR) being consistently below 100.

However, the CQC highlighted concerns related to structural issues including governance, staffing shortages, estates issues, lack of digital maturity and financial pressures. The Trust recognises there is additional a requirement to focus on recruitment, leadership, staff training and competencies, staff engagement and addressing workforce inequalities going forward.

2. Trust progress

The CQC found a number of areas had significantly improved since their last visit and these were identified throughout the report with some specific aspects identified as 'outstanding'. Examples of these included:

- Critical care on at both Lincoln and Pilgrim Hospitals were identified as delivering exemplary care and teamwork. Bespoke care plans, patient follow up clinics and information for patients as areas where cited as example of how staff considered how they individualise and personalise care.
- The maternity services who were congratulated by inspectors for the bereavement care and support given to women and families.
- Older people's care praised for focus on dementia patients particularly the dignity campaign and the trusts development and utilization of dementia practitioners.
- Inspectors highlighted that most staff provided good care and treatment and worked well together for the benefit of patients.
- Most staff understood the vision and values and how to apply them in their work.

3. Identified challenges

CQC has told the trust to make a number of improvements. These were all challenges that were known to the Trust and the CQC report acknowledges that the Trust had already commenced improvement work. Specific areas of concern included:

- Urgent and emergency care at both Pilgrim Hospital and Lincoln Hospital was of significant concern. The rating for whether services were safe at Pilgrim Hospital is now Inadequate, where previously it was Requires Improvement, and the ratings in urgent and emergency care at Lincoln County Hospital have also declined, with the department being rated Inadequate overall.
- Children and young people's services at Pilgrim Hospital remained Inadequate.

As a result of their findings, the CQC imposed conditions on the trust's registration with regard to the emergency departments at both Lincoln County and Pilgrim Hospital and issued a warning with regard to its children and young people's services. Improvement related to these areas has been ongoing through the QSIP. Further actions commenced at the time of the CQC visit, when concerns were raised, and significant improvements have already been made. This work will continue and be monitored through QSIP structure.

In their inspection report, the CQC identified a number of 'must do's' and 'should do's'. These have been mapped into the Quality and Safety Improvement Plan (QSIP) and where appropriate other improvement programmes being delivered within the Trust. Monitoring of progress will be through the Quality and Safety Improvement Board.

The use of resources report relates to a separate meeting that conducted with NHS Improvement, which now forms part of the CQC's 2019 well-led process. Whilst Quality Governance Committee will monitor the progress of improvements identified through the QSIP both more generally and specifically against the CQC hospital Inspection Reports, the expectation is monitoring of improvement actions will take place through the Finance Performance and Estates Committee.

4. Quality Structure to Deliver Quality & Safety Improvement Plan (QSIP)

The *Quality Strategy*, when finalised, will describe the quality ambitions and aspirations of the Trust. This includes an ambition for our services to be rated as outstanding by the CQC across all five domains.

The *Quality & Safety Improvement Plan* is the annual plan, which describes in detail how the various work programmes are aligned to the Quality Strategy will be achieved and monitored. Specific milestones both in year and annually, will demonstrate progression towards our ambitions. The plan is currently being revised, and is supported externally by the system and regulators. It include specific areas of focus related to our performance against the CQC inspection reports, regulatory requirements and warning notices detailing specific improvement actions being taken.

Assurance of the QSIP is the responsibility of Trust Board through the Quality Governance Committee (QGC) through the Trust's corporate governance process. Whilst it is recognised that teams within the Trust have worked hard to deliver improvements these have not had the

impact required to improve the quality of care and experience of our patients through our services. As a result the process by which the Quality and Safety Improvement Plan is managed has been altered as described below.

Oversight of the work programmes, accountability monitoring and assurance needs to be more transparent and delivery of the programmes be aligned to the working groups who in the current governance structure already hold responsibility for ensuring safe, high quality care is delivered. This will ensure that there is:

- Greater ownership of both challenges and improvements to our frontline teams, managers and leaders through our new Trust Operating Model (TOM).
- Better accountability of improvements by Divisions and through the Divisional governance processes.
- A focus on improved outcomes for patients and in some situations staff which is aligned to the quality dashboard monitored by Quality Governance Committee (QGC) rather than delivery of processes.
- Clear monitoring arrangements, aligned to Divisions or meeting groups, to ensure achievement of ‘must’ and ‘should’ do’s with assurance of achievement monitored by QGC.
- Simple alignment between improvement work and embedding this to deliver sustainable ‘business as usual’.
- A structured route to review and confirm evidence of achieved improvements that is triangulated with the QGC quality dashboard.

Quality & Safety Oversight Group (QSOG) will be the main structure through which the QSIP is monitored. Delivery will be through the sub meeting structure which reports to QSOG. QSOG will have responsibility to ensure transparency of the QSIP work programmes and give better assurance to QGC.

The governance structure has been reviewed by the, Director of Nursing, Medical Director and Associate Director of Governance. To enable delivery in the manner described above a number of changes to the meeting structure, Terms of Reference are required of QSOG and the subgroup meetings, these include:

- Terms of Reference of QSOG and sub meeting groups will be amended to include reference to CQC/QSIP requirements.
- All elements of QSIP will be aligned to a group within QSOG meeting structure
- All QSOG groups will have a requirement to discuss and report on CQC every meeting and escalate current position.
- QSIP is included in escalation report to QGC every month, within an agreed template.
- Review of the QSOG groups has identified and requirement for the addition of a Children and Young Peoples Group and that the Deteriorating Patient Group reports directly to QSOG.
- Divisional and QSOG sub-groups reports will include an update on all ‘must’ and ‘should’ do’s every time they report. It is recognised that the some of the ‘must’ do’s will be weighted more heavily than others for example those that relate to a regulatory sanction or improvement notice. Clear focus on the rapid delivery of these, in a sustained manner,

is critical and will remain an area of specific attention for assurance and monitoring as part of the QGC quality dashboard even after achievement, to prevent deterioration.

- A small number of work programmes may be aligned to a group, not QSOG, but sits at a similar level. Currently this is the Emergency Department improvement work and the Safety Culture work. An update on the progress against the milestones will need to be reported through to QGC without creating duplication.
- Evidence of sustained improvements will be agreed by QGC.

As in previous years whilst the overarching QSIP remains the responsibility of the Director of Nursing, all work programmes within QSIP will have an Executive Director as the SRO and a named programme lead. The SRO will be accountable for supporting the programme lead and associated group to achieve the improvements identified in the work programmes against agreed timescales.

5. Recommendations.

Trust Board is asked to note the published CQC inspection reports and the proposed changes to the governance of the QSIP, which aims to further strengthen both the delivery and assurance to improve the quality of patient experience, safety and outcomes.

Victoria Bagshaw
Director of Nursing

United Lincolnshire Hospitals NHS Trust

Inspection report

Greetwell Road
Lincoln
Lincolnshire
LN2 5QY
Tel: 01522512512
www.ulh.nhs.uk

Date of inspection visit: 11 Jun to 18 Jul 2019
Date of publication: xxxx> 2017

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

Ratings

Overall rating for this trust	Requires improvement
Are services safe?	**Requires improvement**
Are services effective?	**Requires improvement**
Are services caring?	**Good**
Are services responsive?	**Requires improvement**
Are services well-led?	**Requires improvement**

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Summary of findings

Background to the trust

United Lincolnshire Hospitals NHS Trust was formed in April 2000 by the merger of the three former acute hospital trusts in Lincolnshire, creating one of the largest trusts in the country. The trust provides a range of hospital-based medical, surgical, paediatric, obstetric and gynaecological services to the 720,000 people of Lincolnshire. It has three emergency departments.

The trust operates acute hospital services from four main hospital sites:

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

The trust also provides services from four other registered locations.

The trust employs around 8,500 staff and has an income of £446.3m for the current financial year 2018/19, with a projected deficit of £86.2m. The trust was placed into financial special measures in September 2017 by NHS Improvement. The trust has been in quality special measures since 2017.

The trust has 51 wards across the four hospital sites; 1213 inpatient beds, 231 day-case beds, 139 maternity beds and 58 children's beds. Each week the trust runs 2021 outpatient clinics. (Source: Provider Information Request 2018)

The trust's main CCG (Clinical Commissioning Group) is Lincolnshire East CCG, however as four hospitals are in different areas, the trust works with four CCGs: Lincolnshire East, Lincolnshire West, South Lincolnshire, and South West Lincolnshire. NHS England Leicestershire and Lincolnshire area team also commissioned specialist services at this trust.

Overall summary

Our rating of this trust stayed the same since our last inspection. We rated it as Requires improvement

What this trust does

The trust provides a range of hospital-based medical, surgical, paediatric, obstetric and gynaecological services. It has three emergency departments.

Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

Summary of findings

What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

Between 11 June 2019 and 20 June 2019, we inspected a total of five core services provided by the trust across two locations. At Lincoln County Hospital, we inspected urgent and emergency care, medical care (including older peoples care), critical care, maternity and children and young people's care. Urgent and emergency care and medical care were rated as requires improvement at our last inspection. We returned to check on progress within these services. Maternity was rated as requires improvement at our 2017 inspection at this time it was a combined inspection with gynaecology, children and young peoples care was rated as good also at our 2017. Critical care was rated as good in our 2015 inspection. We inspected these services this time as part of our continual checks on the safety and quality of healthcare services and to check on improvements within these services. At Pilgrim Hospital we inspected inspected urgent and emergency care, medical care (including older peoples care), critical care, maternity and children and young people's care. At our last inspection urgent and emergency care and children and young people services were rated as inadequate and medical care as requires improvement. We returned to check on progress within these services. Maternity was rated as requires improvement at our 2017 inspection at this time it was a combined inspection with gynaecology and critical care was rated as good. We inspected this service this time as part of our continual checks on the safety and quality of healthcare services.

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish. Our findings are in the section is this organisation well-led? We inspected the well led question between 16 and 18 July 2019.

We did not inspect Lincoln County Hospital and Pilgrim Hospital outpatients' services which were previously rated requires improvement because the services were still working towards making the necessary improvements as set out in the action plan the trust sent us after the last inspection. We are monitoring the progress of improvements to services and will re-inspect them as appropriate.

What we found

Overall trust

Our rating of the trust stayed the same. We rated it as requires improvement because:

- We rated safe, effective, responsive and well-led as requires improvement, and caring as good.
- In rating the trust, we took into account the current ratings of the 14 services not inspected this time.
- We rated three of the core services we inspected at this inspection inadequate overall, four as requires improvement and three as good.
- We rated well-led for the trust overall as requires improvement.

Are services safe?

Our rating of safe stayed the same. We rated it as requires improvement because:

Summary of findings

- Some services did not always have enough staff to care for patients and keep them safe. In three out of five services some staff had not had training in key skills. Some services did not always control infection risk well. Staff did not always assess risks to patients, act on them and keep good care records. Not all services managed safety incidents well and learned lessons from them.

However:

- Most staff understood how to protect patients from abuse.

Are services effective?

Our rating of effective stayed the same. We rated it as requires improvement because:

- Managers did not routinely monitor the effectiveness of services and did not always achieve good outcomes for patients. Managers did not always make sure staff were competent. Issues, identified at our last inspection, threatening the safety and effectiveness of care, had not been not progressed in an acceptable timeframe. Staff had access to information however, this was not always up to date. In some services key services were not available seven days a week.

However:

- Most staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives and supported them to make decisions about their care.

Are services caring?

Our rating of caring stayed the same. We rated it as good because:

- Most staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.

Are services responsive?

Our rating of responsive stayed the same. We rated it as requires improvement because:

- Services did not always plan care to meet the needs of local people or take account of patients' individual needs. People could not always access some services when they needed it and had to wait too long for treatment.

However:

- Services made it easy for people to give feedback.

Are services well-led?

Our rating of well-led stayed the same. We rated it as requires improvement because:

- Leaders did not always run services well using reliable information systems. Not all staff felt respected, supported and valued, were clear about their roles and accountabilities and supported to develop their skills. Services did not always engage well with patients and the community to plan and manage services and not all staff were committed to improving services continually.

However:

- Most staff understood the service's vision and values, and how to apply them in their work. Most staff were focused on the needs of patients receiving care.

Summary of findings

Click or tap here to enter text.

Ratings tables

The ratings tables show the ratings overall and for each key question, for each service, hospital and service type, and for the whole trust. They also show the current ratings for services or parts of them not inspected this time. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account factors including the relative size of services and we used our professional judgement to reach fair and balanced ratings

Outstanding practice

We found examples of outstanding practice in Medical care (including older peoples care), Critical Care and Maternity at both Lincoln County Hospital and Pilgrim Hospital.

For more information, see the Outstanding practice section of this report.

Areas for improvement

We found areas for improvement including six breaches of legal requirements that the trust must put right. We found 56 things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

For more information, see the Areas for improvement section of this report.

Action we have taken

Under Section 31 of the Health and Social Care Act 2008, we imposed conditions on the registration of the provider in respect to three regulated activities. We took this urgent action as we believed a person would or may haven be exposed to the risk of harm if we had not done so. Imposing conditions means the provider must manage regulated activity in a way which complies with the conditions we set. The conditions related to the emergency department at Pilgrim Hospital, Boston and the emergency department at Lincoln County Hospital. We also issued a section 29a warning notice to the trust as we found significant improvement was required to the governance in children and young people services. The section 29a notice has given the trust three months to rectify the significant improvements we identified.

We also issued six requirement notices to the trust. That meant the trust had to send us a report saying what action it would take to meet these requirements.

Our action related to breaches of legal requirements in trust overall, urgent and emergency care, medicine including older peoples care and children and young people's services.

For more information on action we have taken, see the sections on Areas for improvement and Regulatory action.

What happens next

As a result of insufficient improvement made for the trust to be able to exit special measures, the chief inspector of hospitals has recommended to the Secretary of State for Health and Social Care that United Lincolnshire Hospitals NHS Trust remains in special measures. Trusts are placed in special measures when there are concerns about the quality of care they provide.

We will check that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

Summary of findings

Outstanding practice

We found the following areas of outstanding practice:

Lincoln County Hospital

Medical care (including older peoples care)

- Staff on the endoscopy suite were very engaged with the community and attended a local show where they promoted breast and bowel cancer screening.
- Staff had utilised translation services and provided this to help aid recovery to one patient where they had a translator daily. Staff had also attempted to learn the language themselves to help make the patients experience better by being able to communicate basic needs.

Critical Care

- The service developed best interest care plans for level two and level three patients who could not give consent. The plans were bespoke to individual preferences, culture and traditions, and ensured patients were supported when they lacked capacity.
- The unit offered a follow up clinic, in a number of ways to support patients with a range a needs following their care on the unit. Since our last inspection in 2014, the service had widened the patient group the follow up clinic was offered to. The follow up clinic provided people with the opportunity to revisit the unit, if appropriate, and supported them to come to terms with their experience in critical care.

Maternity

- The trust offered a birth afterthought service. This offered women and their families the opportunity to access an experienced midwife for up to one year following the birth of their baby and to take part in the debrief of their birth experience.
- They found some babies were so small, it was difficult to find clothing and families couldn't cuddle their babies easily. The bereavement midwife campaigned for women to donate their wedding dresses to the service and were overwhelmed with the response. Volunteers made clothes of every size and made small, satin sleeping bags for tiny babies to be cuddled better.
- The trust stillbirth report had recently been completed and the service had done a lot to raise awareness of reduced fetal movements. The bereavement midwife arranged an event at a local football match to raise awareness amongst men. They had stands with information, made staff available for advice and had a local radio announcement to reach people travelling to the match.

Pilgrim Hospital

Medical care (including older peoples care)

- Staff on ward 6B had developed a bespoke dignity campaign for patients. This included quotes from previous patients and guidelines for staff on how to deliver care that ensured privacy, dignity and respect. For example, patients had said it was beneficial for them to wear their own clothes and to feel in control of how they looked.
- A physiotherapist had introduced a handover book on wards 6A and 6B to ensure continuity and consistency of handover documentation. Prior to this, staff had no tools to track daily patient updates and the handover book represented one of a number of improvement strategies the physiotherapy team planned to introduce. This included a 'grow your own' staffing plan to address shortages and to incentivise staff to develop professionally.

Summary of findings

- The team on ward 6B had refurbished a day room to a high standard. They had worked with patients and relatives to identify resources they would find useful and furnished it with mechanical chairs, which occupational therapists used to help build patients' independence and confidence. The team had also provided sensory lamps, reminiscence materials, a foosball table, a collection of books, and a piano. The room included an OT therapy kitchen for rehabilitation as well as games and toys and was designed with multiple needs in mind, including cognitive impairment.
- Dementia practitioners had substantially increased the resources and opportunities for patients to socialise and engage in meaningful activities. For example, practitioners had introduced dementia cafes for patients and their relatives. One practitioner had researched the benefits of music therapy and had introduced a range of initiatives in ward 6A to help patients relax and promote physical recovery. For example, they researched the music that was popular at the time of their patients' childhood and played this for them through online streaming music services. During our weekend unannounced inspection we saw this therapy had a significant, positive impact on patients. Patients recognised the music and they sang along to it.

Critical Care

- The service had recently received the trust's compassion and respect award. Staff told us they were happy and proud to receive the award. Staff explained it meant a lot to them because the unit had been nominated by a colleague in the hospital.
- Managers and staff had put into place improvements where issues were identified by incidents and audits. One example was suture removal reminder cards for tracheostomy patient to prevent pressure ulcers. Another example was the introduction of sleep pack for patients containing ear plugs and an eye mask following a sleep audit.

Maternity

- The trust offered a birth afterthought service. This offered women and their families the opportunity to access an experienced midwife for up to one year following the birth of their baby and to take part in the debrief of their birth experience.
- The new M1 maternity ward included separate gender neutral shower facilities that could be used by partners.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve

We told the trust that it must take action to bring services into line with six legal requirements. This action related to the trust overall, urgent and emergency care, medicine including older peoples care and children and young people's services.

Overall Trust

- The trust must ensure the executive leadership team have the capacity and capability to deliver current priorities and challenges. Regulation 17(2)
- The trust must ensure the leadership team have oversight of current priorities and challenges and are taking actions to address them. Regulation 17(1)

Summary of findings

- The trust must ensure leadership structures have a continued focus to ensure they embed across the organisation. Regulation 17(1)
- The trust must ensure staff understand how their role contributes to achieving the strategy. Regulation 17(1)
- The trust must ensure there is timely progress against delivery of the strategy and local plans continue to be monitored and reviewed. Regulation 17(1)
- The trust must ensure action is taken to ensure staff feel respected, supported and valued and are always focused on the needs of patients receiving care. Regulation 17(1)
- The trust must work at pace to ensure sufficient numbers of suitably qualified, competent, skilled and experienced medical and nursing staff across all services. Regulation 18(1)(2)
- The trust must ensure there are effective governance processes throughout the service and with partner organisations. Regulation 17(1)
- The trust must ensure systems to manage performance are embedded across the organisation. Regulation 17(1).
- The trust must ensure leaders and teams, across all services, always identify and escalate relevant risks and issues and identify actions to reduce their impact. Regulation 17(1)
- The trust must ensure all staff are committed to continually learning and improving services. Regulation 17(1)
- The trust must ensure systems or processes are established and operated effectively, across all services, in line with national guidance. Regulation 17(1)
- The trust must ensure premises across all services are suitable for the purpose for which they are being used and properly maintained. Regulation 15(1)

Lincoln County Hospital

Urgent and Emergency Care

- The trust must ensure all patients who attend the department are admitted, transferred and discharged from the department within four hours. Regulation 17(2).

Medical care (including older peoples care)

- The trust must ensure patients receive timely review by specialist consultants when required, including speech and language therapy. Regulation 14(1)
- The trust must ensure that processes are being followed related to proper and safe management of medicines. Regulation 12(2)

Children and Young people's services

- The trust must ensure there are suitable arrangements in place to support people who are in a transition phase between services and/or other providers. Regulation 17(1)

Pilgrim Hospital

Urgent and Emergency Care

- The trust must ensure information is readily available for patients to take away that details what signs or symptoms they needed to look out for that would prompt a return to hospital or seeking further advice. Regulation 12(1)

Medical care (including older peoples care)

Summary of findings

- The trust must ensure patients are treated with dignity and respect at all times. Regulation 10(1)
- Ensure beds ringfenced for non-invasive ventilation and for thrombolysis are available for these patients and have trained, competent staff always available. Regulation 12(1)(2)

Children and Young people's services

- The trust must ensure all staff comply with good hand hygiene practice. Regulation 12(2)

Action the trust SHOULD take to improve

Overall Trust

- The trust should ensure the causes of workforce inequality are sufficiently addressed to ensure staff from a BAME background are supported through their career development. Possible breach of regulation 17(1)(2)
- The trust should ensure there is an increased awareness of the role of the Freedom to Speak Up Guardian role. Possible breach of regulation 17(1)(2)
- The trust should ensure there is a clear process for the GOSW report to the board and that issues raised through the GOSW are appropriately addressed. Possible breach of regulation 17(1)(2)
- The trust should ensure divisional leads are fully engaged in decisions about financial improvement and have oversight of their divisional budgets. Possible breach of regulation 17(1)(2)
- The trust should ensure leaders and staff strive for continuous learning, improvement and innovation through participation in appropriate research projects. Possible breach of regulation 17(1)(2)

Lincoln County Hospital

Urgent and Emergency Care

- The trust should ensure governance and performance monitoring and management are strengthened at operational level. Possible breach of regulation 17(1)(2)
- The trust should ensure consistent arrangements for pain relief and nutrition are developed for patients who are in the emergency department. Possible breach of regulation 9(1)
- The trust should review pathways and processes in the emergency department to ensure they are efficient and communicate processes to staff so that there is a consistent understanding.
- The trust should consider training key staff in customer care skills.
- The trust should formulate a formal clinical audit plan with identified roles and responsibilities and review dates.

Medical care (including older peoples care)

- The trust should ensure an up to date policy and training to staff in the cardiac catheter lab is implemented for the use of conscious sedation for patients. Possible breach of regulation 18(2)
- The trust should ensure that patient notes and confidential information are stored securely. Possible breach of regulation 12(2)
- The trust should ensure that there is an inpatient adult pain team that is sufficiently staffed for patients to be referred to. Possible breach of regulation 18(1)
- The trust should ensure patients are appropriately assessed for self-administration of medicines and that their own medicines are in date. Possible breach of regulation 12(2)

Summary of findings

- The trust should establish a process that identifies patients on MEAU that require a specialist consultant review.
- The trust should consider reducing the amount of patient moves during the night.
- The trust should review arrangements for discharge to ensure that there are no delays due to transport or waits for to take away medications.

Critical Care

- The trust should ensure there is adequate pharmacist cover for the critical care unit at Lincoln Hospital. Possible breach of regulation 12(2)
- The trust should ensure a pharmacist attends multidisciplinary ward handover meeting daily. Possible breach of regulation 12(2)
- The trust should ensure therapist cover includes dietetics, physiotherapists and speech and language therapists seven days a week. Possible breach of regulation 18(1)
- The trust should ensure the new senior leadership team has oversight of the critical care unit, as this level was not currently robust. Possible breach of regulation 17(1)
- The trust should ensure finances for the ventilator replacement programme. Possible breach of regulation 15(1)
- The trust should consider identifying support with staff moves to improve morale on the unit.

Maternity

- The trust should ensure they continually review audits and implement measures to improve patient outcomes for low performance metrics. Possible breach of regulation 17(1)(2)
- The trust should ensure mandatory training is completed by medical staff in line with trust policy, in particular mental capacity and deprivation of liberty safeguarding training. Possible breach of regulation 18(2)
- The trust should ensure they implement systems to monitor waiting times in line with national standards. Possible breach of regulation 17(1)(2)
- The trust should ensure risks are clearly identified and documented in an appropriate format. Possible breach of regulation 17(1)(2)
- The trust should ensure they collect data relating to the percentage of women seen by a midwife within 30 minutes and if necessary by a consultant within 60 minutes during labour. Possible breach of regulation 17(1)(2)

Children and Young people's services

- The trust should ensure that they have robust procedures and processes that make sure that people are protected. Safeguarding must have the right level of scrutiny and oversight with overall responsibility held by the board. Possible breach of regulation 13(1)(2)
- The trust should ensure children's safeguarding lead is in receipt of regular one to one safeguarding supervision. Possible breach of regulation 13(1)(2)
- The trust should ensure staff are in receipt of regular group supervision. Possible breach of regulation 13(1)(2)
- The trust should ensure there is a medical lead for safeguarding. Possible breach of regulation 13(1)(2)

Pilgrim Hospital

Urgent and Emergency Care

- The trust should consider how sound levels might be reduced in the department.

Medical care (including older peoples care)

- The trust should ensure robust communication and referral standards in the IAC are established so that senior staff understand who is responsible for each patient and to reduce delays in specialist review. Possible breach of regulation 12(2)
- The trust should ensure the leadership team in the stroke service are supported to resolve the backlog of open incident reports. Possible breach of regulation 17(1)
- The trust should consider implementing more robust medical handover processes for patients being cared for as inpatients on haematology or oncology wards.
- The trust should review medical staffing on the IAC so that junior doctors have appropriate support and can provide care safely within their abilities.

Critical Care

- The trust should ensure staff record all patient care such as oral care and tissue viability assessments on the clinical information system to assure managers these have been carried out. Possible breach of regulation 12(2)
- The trust should ensure a pharmacist attends the Pilgrim Hospital critical care unit daily multidisciplinary handover meeting. Possible breach of regulation 12(2)
- The trust should ensure a critical care pharmacist attends the Pilgrim Hospital critical care unit for an agreed time each week to review patient medicines. Possible breach of regulation 12(2)
- The trust should ensure the on-call pharmacist is available to attend the Pilgrim Hospital critical care unit when necessary. Possible breach of regulation 12(2)
- The trust should ensure swallowing assessments are carried out to prevent delays with patient weaning. Possible breach of regulation 14(1)
- The trust should ensure policies and guidelines used by critical care staff are within review dates and dated to ensure they are in line with the most recent national guidance. Possible breach of regulation 17(1)
- The trust should consider administrative support for risk and governance for the Pilgrim Hospital critical care service.

Maternity

- The trust should ensure labour ward coordinators are supernumerary in line with national guidance. Possible breach of regulation 18(1)
- The trust should ensure mandatory training is completed by medical staff in line with trust policy, in particular mental capacity and deprivation of liberty safeguarding training. Possible breach of regulation 18(2)
- The trust should ensure systems to monitor waiting times in line with national standards are implemented. Possible breach of regulation 17(2)
- The trust should continually review audits and implement measures to improve patient outcomes for low performance metrics. This include still birth rates, proportion of women having induction of labour and proportion of blood loss (greater than 1500mls).

Children and Young people's services

- The trust should ensure plans are in place to assess staff adherence to infection prevention and control principles, in particular in relation to infection control high impact interventions. Possible breach of regulation 17(1)

Summary of findings

- The trust should ensure it improve the separation of children and young people from adults in the operating recovery areas. Possible breach of regulation 15(1)
- The trust should review the provision of paediatric emergency drugs in the operating theatres.
- The trust should improve processes for the communication of learning from incidents to ensure they are robust.
- The trust should improve facilities for children and young people visiting adult outpatient areas.
- The trust should improve systems for alerting staff to patients such as those with a learning disability, or autism, who may need adjustments to improve access to care and services.
- The trust should improve training of staff in the requirements of children and young people with learning disabilities and/or autism.

Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

Our rating of well-led at the trust stayed the same. We rated well-led as Requires Improvement because:

- Since our last inspection, the trust had had some further changes to its executive leadership team. Executive leaders were able to describe the key priorities and vision for the organisation. However, leaders were not always sighted on significant risks.
- Workforce and staffing issues posed a major risk for the trust and the impact on finance, quality and service continuity was significant. We found progress and ownership of this significant risk lacked pace.
- Since the last inspection, the trust had implemented a new operating model. Although there were some signs that this new model was improving leadership across the trust, there were still posts to fill and further work to do to embed this across the four new divisions.
- The trust had a vision and strategy in place which had been developed with local people and staff and was aligned to local plans within the wider health economy. However, we were not assured staff always understood how their role contributed to achieving the strategy.
- There had been some progress in delivering the strategy, but progress had been slow and improvements were often in their infancy. Whilst it was clear there was a collective understanding of the ongoing pressures the organisation, we found some leaders were normalising past and current challenges.
- The trust had a significant estates risk with high levels of back log maintenance some of which was critical infrastructure statutory/mandatory maintenance. Executive leaders cited the high risks within estates as one of their top concerns. We found evidence of how the estate risks were impacting on the quality and safety of patient care
- Since our last inspection, leaders had continued to address the culture in the trust. We did find some areas of the trust where staff felt more empowered and had higher levels of satisfaction. However, we also found staff who didn't always feel respected or valued and had low morale. The staff survey results remained poor with low levels of staff satisfaction and a lower than average staff engagement score.

Summary of findings

- Although there was a Freedom to Speak Up Guardian (FTSUG) in place, we found there was a lack of knowledge amongst staff about the role of the FTSUG or who it was.

However:

- The trust had sought to actively engage with people who were living with a learning disability and patients with physical disabilities.
- Most leaders supported staff to develop their skills and take on more senior roles. They were visible and approachable in the service for patients and staff.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.
- Since our last inspection, the arrangements for governance and performance had been reviewed. There was a clear governance structure in place but it had not yet had the time to be fully tested. The new trust operating model had a structure for overseeing performance, quality and risk.
- Since our last inspection the trust had made significant improvements to its serious incidents reporting and learning systems. The trust has allocated sufficient expert resources to ensure there was an effective system is in place. Previous backlogs of investigations had been dealt with.
- Since our last inspection, significant progress had been made with the development of the Board Assurance Framework.
- The trust had a ward accreditation programme which provided a framework of 13 quality standards which the wards were measured against.
- The trusts learning from death process had developed since the last inspection. Significant work had taken place to address mortality and nationally, the trust were in the top 22% for low Hospital Standardised Mortality Ratio (HSMR).
- The trust was engaged with the Academy of FAB NHS since its launch in 2015 .

Use of resources

Please see separate use of resources report.

Ratings tables

Key to tables					
Ratings	**Not rated**	**Inadequate**	**Requires improvement**	**Good**	**Outstanding**
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement ➔➔ Oct 2019	Requires improvement ➔➔ Oct 2019	Good ➔➔ Oct 2019	Requires improvement ➔➔ Oct 2019	Requires improvement ➔➔ Oct 2019	Requires improvement ➔➔ Oct 2019

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Lincoln County Hospital	Requires improvement ➔➔ Oct 2019	Requires improvement ➔➔ Oct 2019	Good ➔➔ Oct 2019	Requires improvement ➔➔ Oct 2019	Requires improvement ➔➔ Oct 2019	Requires improvement ➔➔ Oct 2019
Pilgrim Hospital	Inadequate ↓ Oct 2019	Requires improvement ➔➔ Oct 2019	Requires improvement ↓ Oct 2019	Requires improvement ↑ Oct 2019	Requires improvement ↑ Oct 2019	Requires improvement ↑ Oct 2019
Grantham and District Hospital	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
County Hospital, Louth	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Overall trust	Requires improvement ➔➔ Oct 2019	Requires improvement ➔➔ Oct 2019	Good ➔➔ Oct 2019	Requires improvement ➔➔ Oct 2019	Requires improvement ➔➔ Oct 2019	Requires improvement ➔➔ Oct 2019

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for Lincoln County Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate ↓ Oct 2019	Inadequate ↓ Oct 2019	Requires improvement ↓ Oct 2019	Inadequate ↓ Oct 2019	Inadequate ↓ Oct 2019	Inadequate ↓ Oct 2019
Medical care (including older people's care)	Requires improvement →← Oct 2019	Requires improvement ↓ Oct 2019	Good →← Oct 2019	Requires improvement →← Oct 2019	Requires improvement ↓ Oct 2019	Requires improvement →← Oct 2019
Surgery	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Critical care	Good →← Oct 2019	Good →← Oct 2019	Good →← Oct 2019	Outstanding →← Oct 2019	Good →← Oct 2019	Good →← Oct 2019
Maternity	Good Oct 2019	Good Oct 2019	Good Oct 2019	Good Oct 2019	Good Oct 2019	Good Oct 2019
Services for children and young people	Requires improvement →← Oct 2019	Requires improvement ↓ Oct 2019	Good →← Oct 2019	Requires improvement ↓ Oct 2019	Requires improvement ↓ Oct 2019	Requires improvement ↓ Oct 2019
End of life care	Requires improvement Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015
Outpatients	Requires improvement Jul 2018	N/A	Good Jul 2018	Requires improvement Jul 2018	Requires improvement Jul 2018	Requires improvement Jul 2018
Overall*	Requires improvement →← Oct 2019	Requires improvement →← Oct 2019	Good →← Oct 2019	Requires improvement →← Oct 2019	Requires improvement →← Oct 2019	Requires improvement →← Oct 2019

*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for Pilgrim Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate ➔➔ Oct 2019	Inadequate ➔➔ Oct 2019	Requires improvement ↑ Oct 2019	Inadequate ➔➔ Oct 2019	Requires improvement ↑ Oct 2019	Inadequate ➔➔ Oct 2019
Medical care (including older people's care)	Requires improvement ➔➔ Oct 2019	Requires improvement ↓ Oct 2019	Requires improvement ↓ Oct 2019	Requires improvement ↓ Oct 2019	Requires improvement ➔➔ Oct 2019	Requires improvement ➔➔ Oct 2019
Surgery	Good Jul 2018	Good Jul 2018	Good Jul 2018	Requires improvement Jul 2018	Good Jul 2018	Good Jul 2018
Critical care	Good ➔➔ Oct 2019	Good ➔➔ Oct 2019	Good ➔➔ Oct 2019	Good ➔➔ Oct 2019	Good ➔➔ Oct 2019	Good ➔➔ Oct 2019
Maternity	Good Oct 2019	Requires improvement Oct 2019	Good Oct 2019	Requires improvement Oct 2019	Requires improvement Oct 2019	Requires improvement Oct 2019
Services for children and young people	Inadequate ↓ Oct 2019	Requires improvement ➔➔ Oct 2019	Good ➔➔ Oct 2019	Requires improvement ↑ Oct 2019	Inadequate ➔➔ Oct 2019	Inadequate ➔➔ Oct 2019
End of life care	Good Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015
Outpatients	Requires improvement Jul 2018	N/A	Good Jul 2018	Requires improvement Jul 2018	Requires improvement Jul 2018	Requires improvement Jul 2018
Overall*	Inadequate ↓ Oct 2019	Requires improvement ➔➔ Oct 2019	Requires improvement ↓ Oct 2019	Requires improvement ↑ Oct 2019	Requires improvement ↑ Oct 2019	Requires improvement ↑ Oct 2019

*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for Grantham and District Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement Apr 2017	Good Apr 2017	Good Apr 2017	Good Apr 2017	Good Apr 2017	Good Apr 2017
Medical care (including older people's care)	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Surgery	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Critical care	Good Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015
Outpatients and Diagnostic Imaging	Good Mar 2015	N/A	Good Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015
Overall*	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018

*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for County Hospital, Louth

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Outpatients and Diagnostic Imaging	Good Mar 2015	N/A	Good Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015
Overall*	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018

*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Pilgrim Hospital

Sibsey Road
Boston
Lincolnshire
PE21 9QS
Tel: <xxxx xxxx
www.ulh.nhs.uk

Key facts and figures

Pilgrim Hospital, Boston serves the communities of south and south east Lincolnshire. It provides all major specialties and a 24-hour major accident and emergency service.

During the period March 2018 to February 2019 there were 46,387 inpatient admissions and 312,500 outpatient attendances.

We inspected Urgent and emergency services, Medical care (including older people's care), Critical care, Maternity and Services for children and young people.

Summary of services at Pilgrim Hospital

Requires improvement

Our rating of services improved. We rated it them as requires improvement because:

- Some services did not always have enough staff to care for patients and keep them safe. In three out of five services some staff had not had training in key skills. Some services did not always control infection risk well. Staff did not always assess risks to patients, act on them and keep good care records. Not all services managed safety incidents well and learned lessons from them.
- Managers did not routinely monitor the effectiveness of the service and make sure staff were competent. In services for children and young people action to address some of the issues threatening the safety and effectiveness of care, had not been not progressed in an acceptable timeframe. Staff had access to information however, this was not always up to date. In some services key services were not available seven days a week.
- Not all services planned care to meet the needs of local people or, took account of patients' individual needs. People could not always access services when they needed it and sometimes had to wait too long for treatment.
- Leaders did not always run services well using reliable information systems and support staff to develop their skills. Services did not always engage well with patients and the community to plan and manage services and not all staff were committed to improving services continually.

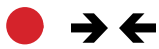
However:

- Staff understood how to protect patients from abuse. They managed medicines well. Staff collected safety information and used it to improve the service.

Summary of findings

- Most staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives and supported them to make decisions about their care.
- Most staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- Services made it easy for people to give feedback.
- Staff felt respected, supported and valued and were focused on the needs of patients receiving care. Most staff understood the service's vision and values, and how to apply them in their work. Staff were clear about their roles and accountabilities.

Urgent and emergency services

Inadequate 

Key facts and figures

Pilgrim Hospital, Boston is a large district general hospital located on the outskirts of Boston. At Pilgrim hospital, the urgent and emergency services consist of the emergency department (ED) and an Ambulatory Emergency Care (AEC) unit.

The ED has a waiting and reception area, two triage rooms, 10 major cubicles, three minor cubicles, one 'fit to sit' room, a see and treat room, a plaster room, a clean procedure room, four resus bays, three rapid assessment and treatment (RAT) cubicles, one waiting room and a quiet relative's room which was also used as a mental health assessment room.

AEC is open Monday to Friday, 08:30am to 10:30pm and has six beds and two seated areas

Pilgrim Hospital emergency department supports the treatment of patients presenting with minor, major and traumatic injuries. Serious traumatic injury patients receive stabilisation therapy, before transfer to the major trauma centre at a neighbouring NHS trust.

Summary of this service

Our rating of this service stayed the same. We rated it as inadequate because:

- The service did not have enough permanent staff to care for patients and keep them safe relying heavily on agency and locum staff. Staff had training in key skills but completion rates for the training was low. Nursing staff understood how to protect patients from abuse, and managed safety well but training completion rates for medical staff were low. The department was too small for the number of patients it dealt with and this impacted on patient care. Staff did not always assess risks to patients or act on those assessments.
- Staff did not demonstrate sufficient knowledge of the Mental Health Act 1983. Pain relief was not always given in a timely manner. Participation in national audit was low and lessons were not well learnt.
- People could not always access the service when they needed it because of limited capacity and they often had to wait too long for treatment.
- Staff were only starting to understand and manage the priorities and issues the service faced, the management team responsible for delivering this were very new in post and work was at an early stage. There were still issues with some staff's behaviours and the positive changes were not yet fully embedded.

However:

- The service controlled infection risk well. They did keep good care records and they managed medicines well. The service managed safety incidents and learned lessons from them.
- Staff provided care and treatment based on national guidance.
- Patients were given enough to eat and drink. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.

Urgent and emergency services

- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and encouraged people to give feedback.
- Leaders had the abilities to run the service and they were visible and approachable in the service for patients and staff. The service had a developing vision for what it wanted to achieve and was an emerging strategy to turn it into action, developed with all relevant stakeholders. Staff felt respected, supported and valued and they were focused on the needs of patients receiving care.

Is the service safe?

Inadequate 

Our rating of safe stayed the same. We rated it as inadequate because:

- The service provided no evidence of training in dementia or mental health awareness. Completion rates for mandatory training were poor with only three modules out of eight achieving the trust target for nursing staff and for medical staff no modules achieved their completion rate and the completion rate for some modules was very low.
- Staff were provided with training on how to recognise and report abuse but completion rates for medical staff were low.
- Recent infection prevention and control audits provided by the trust demonstrated that there had been variable compliance with trust infection control standards in recent months.
- The department was too small for the number of patients it dealt with and this impacted on how patient flow could be implemented. It also resulted in patients being treated in corridors or the central space of the department and having their dignity compromised. The department was not compliant with several standards. However, managers had thought carefully about how to best use the space and staff worked hard to minimise the effects on patients.
- Staff did not always complete risk assessments for each patient swiftly or correctly. Identified risks were not always removed or minimised and assessments were not always updated. Staff did not always identify patients at risk of deterioration nor act quickly to respond to these patient's circumstances.
- The service did not have enough permanent nursing staff with the right qualifications, skills, training and experience to keep patient's safe from avoidable harm and to provide the right care and treatment relying on substantial numbers of bank and agency staff.
- The service did not have enough permanent nursing staff with the right qualifications, skills, training and experience to keep patient's safe from avoidable harm and to provide the right care and treatment relying on substantial numbers of bank and agency staff.
- The service did not have enough permanently employed medical staff with the right qualifications, skills, training and experience to keep patient's safe from avoidable harm and to provide the right care and treatment.
- Staff did not always keep detailed records of patients' care and treatment. We saw examples of poor and incomplete record keeping particularly in respect of mental health assessments.

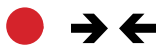
Urgent and emergency services

- The service used systems and processes to safely prescribe, administer, record and store medicines. However, there were occasions when controlled stationary was improperly stored and the Patient Group Directives (PGD) for the department were so out of date they were not being used.
- Managers had not investigated all patient safety incidents in a timely manner and there was a backlog.

However:

- The service provided mandatory training in most key skills including the highest level of life support training for all staff.
- Most staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- Staff were provided with training on how to recognise and report abuse. Completion rates for nursing staff were mostly met.
- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- The maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well.
- Managers continually reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.
- Managers regularly reviewed staffing levels and skill mix, recruited sufficient locum doctors and gave those locum staff a full induction.
- Records were easily available to all staff providing care.
- The service had systems to manage patient safety incidents. Staff recognised incidents and near misses, reported them appropriately and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Is the service effective?

Inadequate 

Our rating of effective stayed the same. We rated it as inadequate because:

- Staff did not demonstrate sufficient knowledge to protect the rights of patients subject to the Mental Health Act 1983.
- Staff did not always fully and consistently assess and monitor patients regularly to see if they were in pain. Because of out of date documents and inconsistent practice some patients waited too long in pain before receiving medicines. However, when pain relief was given it was administered and recorded properly.
- The service did not participate in all relevant national clinical audits. In those that it did participate, performance was variable across the standards. Information from the audits was not used to improve care and treatment.
- Supervision rates for nursing staff were very low.
- Staff did not always know how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health and did not always follow national guidance to gain consent from these patients. However, staff did support patients to make informed decisions about their care and treatment.

However:

Urgent and emergency services

- The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance.
- Staff gave patients enough food and drink to meet their needs. They used special feeding and hydration techniques when necessary.
- The service made sure staff were competent for their roles. Managers appraised medical staff's work performance and held supervision meetings with them to provide support and development.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Key services were available seven days a week to support timely patient care.
- Staff gave patients practical support and advice to lead healthier lives.
- Most patients were supported to make informed decisions about their care and treatment.

Is the service caring?

Requires improvement 

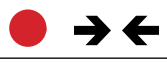
Our rating of caring improved. We rated it as requires improvement because:

- As a result of pressures in the department and ongoing staffing issues, care was not provided in a way that staff wanted.
- Staff did not always respect patients' privacy and dignity. The crowded nature of the department resulted in some conversations taking place with other patients present.

However:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Is the service responsive?

Inadequate 

Our rating of responsive stayed the same. We rated it as inadequate because:

- The service did not always plan and provide care in a way that met the needs of local people and the communities served. The department was constrained by its size and the premises were not suitable for the number of patients who attended.

- The service was not fully inclusive and did not take into account all patients' individual needs and preferences. Important information was not readily available as leaflets for patients to take away. Staff made reasonable adjustments when possible to help patients access services but there were not good systems in place to help them do this.
- People could not always access the service when they needed it and did not always received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards.

However:

- The service worked with others in the wider system and local organisations to plan care.
- The service coordinated care with other services and providers.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Is the service well-led?

Requires improvement 

Our rating of well-led improved. We rated it as requires improvement because:

- During our 2018 inspection of Pilgrim Hospital emergency department, the trust had been reactive to concerns we had raised resulting in improvements in caring and well led. However, the same leadership team had not had sufficient oversight or considered replicating actions taken at Pilgrim in Lincoln.
- Leaders were only starting to understand and manage the priorities and issues the service faced.
- The management team responsible for delivering the vision and strategy were very new in post and work was at an early stage.
- There were issues with some staffs' behaviours and the positive changes were not yet fully embedded. There was also limited opportunities for career development.
- There was not an integrated approach to the collection, analysis and use of information and it was not available to make day to day decisions.
- Staff showed commitment and enthusiasm for learning and for improving services. However, the opportunities were not always there for them. Understanding of quality improvement methods was low and there was little evidence of innovation and participation in research.

However:

- Leaders had the integrity, skills and abilities to run the service. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- The service had a developing vision for what it wanted to achieve and a strategy was emerging to turn it into action. The vision and strategy were to be focused on sustainability of services and aligned to local plans within the wider health economy. Leaders understood and knew how to deliver and monitor progress of the plans.

Urgent and emergency services

- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work. The service had an open culture where patients, their families and staff could raise concerns without fear.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.
- The service collected some data and analysed it. Staff could find some data they needed to manage the department on a day to day basis. The information systems were secure. Data or notifications were consistently submitted to external organisations as required.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Areas for improvement

We found two areas for improvement in this service. See the Areas for Improvement section above.

Medical care (including older people's care)

Requires improvement 

Key facts and figures

The trust provides medical care (including older people's care) at three sites: Grantham and District Hospital; Lincoln County Hospital; and Pilgrim Hospital. Services at all sites sit within the division of medicine and are managed through the cardiovascular and specialty medicine clinical business units.

The trust has 546 inpatient medical beds across Lincoln County Hospital and Pilgrim Hospital, with 300 of these beds being located at Lincoln County Hospital.

(Source: Routine Provider Information Request AC1 - Acute context)

The trust had 72,242 medical admissions from January to December 2018. Emergency admissions accounted for 33,181 (45.9%), 1,269 admissions (1.8%) were elective, and the remaining 37,792 (52.3%) were day case.

Admissions for the top three medical specialties were:

- General medicine: 31,313 admissions
- Clinical haematology: 7,985 admissions
- Clinical oncology: 7,447 admissions

(Source: Hospital Episode Statistics)

We last inspected medical care services between February 2018 and April 2018 and rated the service as requires improvement overall. This reflected ratings of requires improvement in safe and well led and good in effective, caring and responsive. At that inspection we told the trust they must:

- Urgently address the ongoing failure of staff to always follow care pathways and national requirements in relation to serious incidents.

We also told the trust they should:

- Ensure induction processes for nurses include meaningful, demonstrable competency checks and assurance that agency nurses have the willingness to deliver care.
- Review the processes used to manage the risk register to ensure risks are addressed in a timely manner with continual progress.
- Improve complaint response and resolution times.
- Continue to improve safety and care standards in relation to sepsis screening, non-invasive
- ventilation and nasogastric feeding.
- Improve the use of ward social spaces for patients at risk of social isolation or boredom, such as day rooms.
- Consider an action plan to address the significant shortfall of capacity in the speech and language therapy service.
- Carry out a review of all fire safety instructions, posters and signage.
- Implement a monitoring system to ensure fire doors are used correctly.

Medical care (including older people's care)

- Review compliance with National Institute of Health and Care Excellence standards on assessment for venous thromboembolism.

At this inspection we found the trust had addressed some of these issues although there was a need for further improvements to ensure they were consistent and sustained. Despite our previous findings and construction work to improve fire safety, fire instruction posters remained out of date and not fit for purpose and we saw staff failed to follow posted signs regarding fire doors.

To come to our ratings, we carried inspected every inpatient medical ward and the acute medical short stay unit (AMSS), the integrated assessment centre (IAC), the discharge lounge, the endoscopy unit and the chemotherapy and haematology suite. We spoke with 68 members of staff representing a wide range of roles and levels of responsibility. We reviewed the medical records of 23 patients and looked at over 100 other items of evidence, including governance records and training documentation.

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- The service did not always have enough staff to care for patients and keep them safe. Staff did not always maintain up to date training in key skills. The service did not always control infection risk well. Staff did not always assess risks to patients, act on them or keep good care records. The service did not always manage safety incidents well and did not always learn lessons from them.
- Not all key services were available seven days a week.
- Staff did not always treat patients with compassion and kindness, respect their privacy and dignity and take account of their individual needs.
- Local leaders supported staff to develop their skills, but trust resources were very limited. Staff did not always understand the service's vision and values, or how to apply them in their work.

However:

- Staff understood how to protect patients from abuse, and managed safety well. They managed medicines well. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.
- Staff provided emotional support to patients, families and carers. and helped them understand their conditions.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it.
- Leaders at a local level ran services well using reliable information systems and staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Medical care (including older people's care)

Is the service safe?

Requires improvement ● →←

Our rating of safe stayed the same. We rated it as requires improvement because:

- The service did not make sure all staff completed mandatory training in key skills. The number of staff who completed it did not meet trust targets.
- The service did not always control infection risk well.
- The service did not have enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction. However, such reviews were often superfluous as there were no reserves of staff to backfill posts.
- The service did not have enough medical staff in each specialty with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix and gave locum staff a full induction.
- The service did not always use systems and processes to safely prescribe, administer, record and store medicines.
- The trust did not supply a record of incidents in a format we could fully analyse. This meant we had limited oversight of standards of reporting over the previous 12 months.

However:

- Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- Staff completed and updated risk assessments for each patient and took action to remove or minimise risks. Staff identified and quickly acted upon patients at risk of deterioration.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.
- The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.
- The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

Is the service effective?

Requires improvement ● ↓

Medical care (including older people's care)

Our rating of effective went down. We rated it as requires improvement because:

- Staff were experienced and qualified but did not always have the right skills and knowledge to meet the needs of patients.
- Staff had limited opportunities to discuss training needs with their line manager and were not always supported to develop their skills and knowledge.
- Staff did not always know how to support patients who lacked capacity, or who were experiencing mental ill health, to make their own decisions.
- Staff did not always give patients enough food and drink to meet their needs and improve their health.
- Performance in national audits did not always meet national standards.

However:

- The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.
- Staff used special feeding and hydration techniques when necessary.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide care.
- Key services were available seven days a week to support timely patient care.
- Staff gave patients practical support and advice to lead healthier lives.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patient's consent.

Is the service caring?

Requires improvement 

Our rating of caring went down. We rated it as requires improvement because:

- Although staff treated patients with care and compassion during most of our inspection, there were some notable exceptions. This included staff on one ward referring to a patient as a "nuisance" and on another ward referring to a patient using an unkind description.
- It was evident pressures on ward teams sometimes resulted in a rushed service that meant patients who needed time to communicate were missed from non-clinical care, such as tea rounds.

However:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Medical care (including older people's care)

- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patient's personal, cultural and religious needs.
- Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Is the service responsive?

Requires improvement 

Our rating of responsive went down. We rated it as requires improvement because:

- People could not always access the service when they needed it and receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards.
- From March 2018 to February 2019 the trust's referral to treatment time (RTT) for admitted pathways for medicine was consistently lower than the England average. In the most recent month, February 2019, the trust performance was 76.8% compared to the England average of 87.2%.

However:

- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Is the service well-led?

Requires improvement 

Our rating of well-led stayed the same. We rated it as requires improvement because:

- Leaders at a local level had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles, although this was restricted by a lack of resources and senior trust input.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders understood and knew how to apply them and monitor progress but knowledge amongst staff was highly variable.
- Leaders and teams did not always use systems to manage performance effectively. They identified and escalated relevant risks and issues but actions to reduce their impact were not always taken.
- Leaders did not always actively or openly engage staff.

However:

Medical care (including older people's care)

- Leaders operated effective governance processes throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.
- Ward-based teams engaged with patients and colleagues to plan and manage services. They collaborated with partner organisations to help improve services for patients.
- All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Outstanding practice

We found four examples of outstanding practice in this service. See the Outstanding practice section above.

Areas for improvement

We found six areas for improvement in this service. See the Areas for Improvement section above.

Critical care

Good 

Key facts and figures

The trust had 25 critical care beds as reported to NHS England. There were two intensive care units to manage level 2 and level 3 patients at Lincoln County Hospital and Pilgrim Hospital.

The trust has a critical care outreach service which is provided 24 hours a day, seven days a week.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

We inspected Pilgrim Hospital which has a nine bed adult intensive care unit.

During our inspection we:

- visited the adult intensive care unit (AICU).
- spoke with three relatives and three patients.
- spoke with members of staff including ward managers, nurses, domestic staff, health care support workers, anaesthetists, a physiotherapist, consultants and junior doctors, a clinical nurse educator.
- looked at four sets of medical and nursing records.
- observed a ward handover and interactions between patients, relatives and staff.

Summary of this service

Our rating of this service stayed the same. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.

Critical care

- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However,

- Staff were not always completing patient records on the electronic clinical information system (CIS) such as oral care and tissue viability assessments.
- Speech and language therapists (SALT) were not always available to review patients for swallowing assessments which could cause a delay for patient weaning onto oral feeding.
- There was not adequate pharmacist cover for the critical care unit at Pilgrim Hospital. A pharmacist did not always attend the unit's multidisciplinary ward handover meeting each morning or attend the unit for the agreed one day a week. The out of hours on-call pharmacist was not always able to attend the unit from home.
- Some policies on the CIS were out of review date. The tracheostomy policy and sedation hold guidelines were out of review date. The enteral feed guideline was not dated.

Is the service safe?

Good  

Our rating of safe stayed the same. We rated it as good because:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well.
- Staff completed and updated risk assessments for each patient and took action to remove or minimise risks. Staff identified and quickly acted upon patients at risk of deterioration.
- The service had enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix.
- The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix.
- Staff kept detailed records of patients' care and treatment. Records were clear and easily available to all staff providing care.
- The service used systems and processes to safely prescribe, administer, record and store medicines.

Critical care

- The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.
- The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

However,

- Recent audits of electronic patient records on the Metavision system had found staff were not always completing patient records such as oral care and tissue viability assessments.
- There was not adequate pharmacist cover for the critical care unit at Pilgrim Hospital.
- A pharmacist did not always attend the multidisciplinary ward handover meeting each morning.
- A pharmacist did not always attend the unit for the agreed one day a week.
- The out of hours on-call pharmacist was not always able to attend the unit from home to dispense urgently required medicine.

Is the service effective?

Good

Our rating of effective stayed the same. We rated it as good because:

- The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave pain relief to ease pain.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Key services were available seven days a week to support timely patient care.
- Staff gave patients practical support and advice to lead healthier lives.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patient's consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures that limit patients' liberty appropriately.

However,

Critical care

- Some policies on the electronic clinical information system (CIS) were out of review date. The tracheostomy policy and sedation hold guidelines were out of review date. The enteral feed guideline was not dated.
- The service did not have administrative support for risk and governance, such as support for meetings and an audit trail of correspondence and actions.
- Staff told us there could sometimes be a delay with a speech and language therapist being able to assess patients.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patient's personal, cultural and religious needs.
- Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

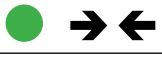
Is the service responsive?

Good 

Our rating of responsive stayed the same. We rated it as good because:

- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- People could access the service when they needed it and received the right care promptly. The service admitted, treated and discharged patients in line with national standards.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Is the service well-led?

Good 

Our rating of well-led stayed the same. We rated it as good because:

- Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.
- The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients and relatives.

Critical care

- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The service used a systematic approach to continually be improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.
- The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.
- The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.
- The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.
- The service was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.

Outstanding practice

We found two examples of outstanding practice in this service. See the Outstanding practice section above.

Areas for improvement

We found seven areas for improvement in this service. See the Areas for Improvement section above.

Maternity

Requires improvement

Key facts and figures

Maternity services provided by United Lincolnshire Hospitals NHS Trust (ULHT) are located on three hospital sites; Lincoln County Hospital, Pilgrim Hospital Boston and Grantham and District Hospital.

Services on all sites are run by one maternity and gynaecology management team.

Maternity services at Pilgrim Hospital included an antenatal clinic, an antenatal assessment unit, and a maternity ward (M1) consisting of 15 beds. The labour ward has eight rooms, one of which includes a birthing pool and two theatres.

Trust wide community midwife teams covered Skegness, Spalding, Grantham, Sleaford, Lincoln, Gainsborough and Boston.

The Early Pregnancy Assessment Unit (EPAU) was located within the gynaecology unit. The EPAU provided early scans and consultations for women experiencing problems in pregnancy between six and 20 weeks gestation.

There were 1585 births at Pilgrims Hospital between July 2018 and May 2019.

During our inspection, we visited all clinical areas and departments relevant to the service. We spoke to 21 members of staff including senior managers, service leads, midwives, maternity support workers, domestic staff, obstetricians, junior doctors and a student nurse. We spoke with 11 women and six family members. We observed care and treatment and reviewed 13 sets of medical records.

Summary of this service

We previously inspected maternity jointly with gynaecology so we cannot compare new ratings directly with previous ratings. We rated it as requires improvement because:

- Some of the problems we found during the previous inspection still existed; maternal choice for a midwife led delivery unit was limited. There was no designated bereavement area for families who had lost a baby. At the time of this inspection the labour ward did not have an electronic emergency call buzzer system.
- The labour ward co-ordinator was not always supernumerary. Local audits showed between December 2018 and May 2019, there were 243 occasions when the labour ward co-ordinator was not supernumerary equating to 22% of the time. However, an improvement plan was in place.
- Although the service achieved good outcomes for some patients, some areas required improvement. The still birth rate, proportion of women having induction of labour and proportion of blood loss (greater than 1500mls) were higher than trust targets or national average.
- The trust was only able to offer scans on four weekly basis to women identified as high risk for 'small for gestational age' (SGA) or fetal growth restriction (FGR). The trust was unable to offer routine scanning to women with BMI of 35 – 39.99. This was not in line with national guidance.
- The trust did not routinely audit waiting times to ensure they were in line with national standards.
- The service did not provide a designated midwifery led unit. There was no dedicated bereavement room available for women and families suffering a bereavement.

Maternity

- Systems used for identifying risks and planning to eliminate or reduce them were efficient. The risk register was revised in a board level format with an overarching title that was not appropriate for clinical risk.

However:

- There were effective systems to safeguard women and their babies from harm. Women identified as “high risk” where offered enhanced care by specialist midwives.
- There was a good culture of incident reporting and staff were open and honest with people when things went wrong.
- Patient records were comprehensive with appropriate risk assessments completed. Staff identified and quickly acted upon patients at risk of deterioration.
- The unit had specialist midwives, which ensured that women received specialist care suited to them.
- Feedback for the services inspected were mostly positive. Staff treated women with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- The service worked with commissioners and stakeholders to plan services. Community midwives covered specific geographical areas thereby ensuring women had access to midwives in their local area.
- Staff felt valued, were supported in their role and had opportunities for learning and development. Staff understood the service’s vision and values, and how to apply them at work. They were clear about their roles and responsibilities.
- The service had opened a new maternity ward with modern facilities to enhance patient care. Local goals were set for each of the metrics monitored on the maternity dashboard. The service carried out regular audits, with an action plan to improve patient outcomes.

Is the service safe?

Good

We previously inspected maternity jointly with gynaecology so we cannot compare new ratings directly with previous ratings. We rated it as good because:

- The service provided mandatory training in key skills to all staff.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them.
- Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.
- The service had enough midwifery and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave bank staff a full induction.

Maternity

- The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses.
- Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.
- The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

However:

- The local acuity tool audit demonstrated the labour ward coordinator was not always supernumerary.
- Hand hygiene audit results showed staff compliance with the trust standards were inconsistent for labour ward and M1 maternity ward.
- The labour ward did not have an electronic emergency call buzzer system. To mitigate this risk, staff used a draw string call bell which they pulled trice to alert other staff about an emergency during labour.

Is the service effective?

Requires improvement

We previously inspected maternity jointly with gynaecology so we cannot compare new ratings directly with previous ratings. We rated it as requires improvement because:

- Although the service achieved good outcomes for some patients, some areas required improvement. The still birth rate, proportion of women having induction of labour and proportion of blood loss (greater than 1500mls) were higher than the national average or trust targets.
- Routine scans for women identified as 'high risk' were not in line with national guidance even though the trust still birth report identified the risks as underlying factors for high still birth rate.
- The percentage of women smoking at birth was higher than the national standard.
- Medical staff did not meet the trust target for mental capacity training.

However:

- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Maternity

- Doctors, midwives and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Key services were available seven days a week to support timely patient care. Staff gave patients practical support and advice to lead healthier lives.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Is the service caring?

Good

We previously inspected maternity jointly with gynaecology so we cannot compare new ratings directly with previous ratings. We rated it as good because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Is the service responsive?

Requires improvement

We previously inspected maternity jointly with gynaecology so we cannot compare new ratings directly with previous ratings. We rated it as requires improvement because:

- The trust did not routinely audit waiting times to ensure they were in line with national standards. The trust did not collect data relating to the percentage of women seen by a midwife within 30 minutes and if necessary by a consultant within 60 minutes during labour.
- The service did not provide a designated midwifery led unit, although women who were deemed to be at low risk did receive midwifery led one-to-one care in labour in two rooms set aside for this purpose.
- There was no designated room for a woman to deliver a still born baby or spend time with a partner and baby.
- Some labour rooms did not have en-suite toilets, which could be inconvenient for women.

However:

- The percentage of women who booked their maternity appointment by 12 weeks plus six days of pregnancy was higher than the trust target and the national average.
- The trust had employed specialist midwives to provide extra support to women and families with more complex needs. The labour ward had facilities for women with low-risk pregnancies to give birth to their babies. This included a birthing pool, relaxing lighting, birthing balls and stools.

Maternity

- The service was inclusive and took account of most patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- Partners were allowed to stay overnight by women's bedside on the maternity ward. The new M1 maternity ward included separate gender neutral shower facilities that could be used by partners. Families were offered support towards the cost of parking.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Is the service well-led?

Requires improvement

We previously inspected maternity jointly with gynaecology so we cannot compare new ratings directly with previous ratings. We rated it as requires improvement because:

- The service did not have efficient systems for identifying risks and planning to eliminate or reduce them. The risk register was revised in a board level format with an overarching title that was not appropriate for clinical risk.
- The hospital had insufficient scanning capacity to monitor women identified as high risk for 'small for gestational age' (SGA) or fetal growth restriction (FGR). Interim measures were insufficient to mitigate the issues with scanning capacity.
- Some of the areas of improvement identified during the last inspection had not been addressed. This included lack of bereavement facilities and lack of a designated midwifery led unit.
- Leaders and teams did not always use systems to manage performance effectively. The service did not routinely audit waiting times. This meant the trust was not assessing this performance against national standards.

However:

- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.
- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Outstanding practice

We found two examples of outstanding practice in this service. See the Outstanding practice section above.

Maternity

Areas for improvement

We found five areas for improvement in this service. See the Areas for Improvement section above.

Services for children and young people

Inadequate 

Key facts and figures

The trust provides care for children and young people at Lincoln County Hospital and Pilgrim Hospital, Boston. Both hospitals provide paediatric services for children from newborn to 16 years of age including day case and emergency services.

There are 24 paediatric inpatient beds on Rainforest Ward at Lincoln County Hospital, an eight-bedded paediatric day case ward, one intensive care, two high dependency, 12 special care and four transitional care beds.

(Source: Routine Provider Information Request (RPIR) – Acute context)

At the time of the inspection there were eight paediatric assessment beds and four day case surgery beds on ward 4A at Pilgrim hospital and a neonatal unit with eight neonatal cots and four transitional care beds.

The Pilgrim hospital had 2,609 spells from January 2018 to December 2018.

Lincoln County hospital and Pilgrim hospital were visited as part of the inspection process and each location has a separate evidence appendix and report. Children's and young people's services were run by one management team and are regarded by the trust as one service ('Two sites, one model'). For this reason, it is inevitable there is some duplication contained within the two evidence appendices.

This report relates to children's and young people's service provided at the Pilgrim hospital.

We inspected the service from 11 to 13 June 2019. As part of the inspection we visited ward 4A (providing a paediatric assessment unit and day surgery beds), the neonatal unit, the children's outpatient department, radiology, operating theatres and adult outpatient departments where children are regularly seen.

During the inspection, we spoke with 26 staff of various grades, including ward and theatre managers, nurses, consultants, middle grade doctors, healthcare assistants, nursery nurses and administrative staff. We also met with the senior management team. We spoke with 12 children, young people and their family members, observed care and treatment and looked at 16 patient's medical records including some medicines charts. We received comments from people who contacted us to tell us about their experiences, and reviewed performance information about the hospital.

The service was last inspected in July 2018. At that inspection, it was rated 'inadequate' overall.

Summary of this service

Our rating of this service stayed the same. We rated it as inadequate because:

- Staff did not always assess risks to patients appropriately and did not always learn lessons and share learning from incidents. The service did not always have enough permanent medical staff to care for patients and keep them safe. Staff did not always have training in key skills such as safeguarding children. Staff did not consistently follow good hand hygiene practice, increasing the risk of infection.
- Managers did not ensure staff had access to up to date best practice guidance and carried out very few audits, to assess whether staff complied with national guidance. Staff did not follow best practice guidance to reduce the time fluids were withdrawn prior to surgery. Some key services were not available seven days a week. There were gaps in the management and support arrangements for staff, such as appraisal.

Services for children and young people

- Services did not always meet people's individual needs, as the environment in some departments children visited was not suitable and staff did not always make the adjustments needed to help patients access services. The operational policy of the paediatric assessment unit in relation to the transfer of patients was not always followed.
- Adequate action to address some of issues threatening the safety and effectiveness of care, had not been not progressed in an acceptable timeframe. Actions we advised the service to take following the inspection in March 2018 had not been fully addressed. The arrangements for governance and risk management were not fully effective, although a new governance framework was being implemented.

However:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service managed medicines well and kept good records of the care provided. There was a good culture of incident reporting and staff were open and honest with people when things went wrong.
- The service worked with stakeholders and commissioners to plan services and staff coordinated care with other services and providers. They listened to complaints and took them seriously.
- Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. Staff were focused on the needs of patients receiving care. They were clear about their roles and accountabilities.

Is the service safe?

Inadequate

Our rating of safe went down. We rated it as inadequate because:

- The service provided mandatory training in key skills to all staff but did not make sure everyone completed it. Medical staff did not always receive and keep up to date with their mandatory training.
- Staff did not always have training on how to recognise and report abuse. Trust data showed the percentage of medical staff receiving training did not meet trust targets.
- The service did not always control infection risk well. Staff did not always use control measures to protect children, young people, their families, themselves and others from infection. They did not always adhere to hand hygiene requirements and managers did not complete regular audits of procedures shown to reduce infection.
- The design and use of facilities, premises and equipment did not always keep people safe.
- Staff did not always complete and update risk assessments for each patient and did not always take action to remove or minimise risks. Staff did not always identify and quickly act upon patients at risk of deterioration.
- The service did not have enough substantive medical staff with the right qualifications, skills, training and experience to keep children, young people and families safe from avoidable harm and to provide the right care and treatment.
- They achieved safe care through high use of agency/locum staff, although the situation was fragile.
- The service did not always manage patient safety incidents well. Managers investigated incidents but did not always share lessons learned with the whole team and the wider service, as systems for sharing learning were not robust.

However:

Services for children and young people

- Staff used equipment to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- The service had enough nursing staff with the right qualifications, skills, training and experience to keep children, young people and families safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.
- Staff kept detailed records of children and young peoples' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- Equipment was maintained and staff managed clinical waste well.
- Staff recognised incidents and near misses and reported them appropriately. When things went wrong, staff apologised and gave children, young people and their families honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.
- The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, children, young people, their families and visitors.

Is the service effective?

Requires improvement 

Our rating of effective stayed the same. We rated it as requires improvement because:

- There was a risk the service did not provide care and treatment based on national guidance and best practice. Local guidance was sometimes past its review date and managers did not check to make sure staff followed national guidance.
- Staff did not always follow national guidelines to make sure patients fasting before surgery were not without food for long periods.
- Staff did not always monitor the effectiveness of care and treatment. They did not consistently use findings from monitoring to make improvements and achieve good outcomes for patients.
- Managers did not always appraise staff's work performance and hold supervision meetings with them to provide support and development.
- Key services were not always available seven days a week to support timely patient care. Access to key diagnostic tests were not always available on site.

However:

- Staff protected the rights of patients' subject to the Mental Health Act 1983.
- Staff assessed and monitored children and young people regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate, using suitable assessment tools and gave additional pain relief to ease pain.
- The service had gained stage one accreditation in the UNICEF Baby Friendly accreditation scheme.
- Staff gave patients enough food and drink to meet their needs and improve their health.
- The service made sure staff were competent for their roles.

Services for children and young people

- Doctors, nurses and other healthcare professionals worked together as a team to benefit children, young people and their families. They supported each other to provide good care.
- Staff gave children, young people and their families practical support and advice to lead healthier lives.
- Staff supported children, young people and their families to make informed decisions about their care and treatment. They knew how to support children, young people and families who lacked capacity to make their own decisions or were experiencing mental ill health.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good because:

- Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to children, young people and their families to minimise their distress. They understood patients' personal, cultural and religious needs.
- Staff supported and involved children, young people and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.

Is the service responsive?

Requires improvement 

Our rating of responsive improved. We rated it as requires improvement because:

- Although the service worked with others in the wider healthcare system it did not always plan and provide care in a way that met the needs of local people and the communities served.
- The service did not always take account of children, young people and their family's individual needs and preferences. Staff did not always make reasonable adjustments to help patients access services.
- Arrangements to transfer and discharge children and young people were not always in line with the operational policy of the unit. Information about waiting times from referral to treatment for planned surgery were not available.

However:

- Children and young people could access the service when they needed it urgently and received the right care promptly.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Is the service well-led?

Inadequate 

Our rating of well-led stayed the same. We rated it as inadequate because:

Services for children and young people

- Previous leaders had not always managed, or had lacked capacity or resources to manage, the priorities for improvement of the service.
- Leaders did not operate fully effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities but there was a wide variability in staff knowledge about clinical governance meetings and involvement in them.
- Leaders and teams did not always use systems to manage performance effectively. They did not always identify and escalate relevant risks and issues and identify actions to reduce their impact. Staff did not always contribute to decision-making to help avoid financial pressures compromising the quality of care.
- Staff did not always feel engaged in decision making about the service.
- All staff were committed to continually learning and improving services, although progress to improve services was slow. They did not always have a good understanding of quality improvement methods and the skills to use them. We found a lack of significant progress in addressing the issues identified in the last inspection.

However,

- The newly appointed leaders had the integrity, skills and abilities to run the service. They understood issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- The service had a vision for what it wanted to achieve and was developing a strategy to turn it into action, with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.
- Leaders and staff actively and openly engaged with patients, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.
- The service collected reliable data and analysed it. Staff could mostly find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were not fully integrated although were secure.

Areas for improvement

We found eight areas of improvement. See areas for improvement section above.

Lincoln County Hospital

Greetwell Road
Lincoln
Lincolnshire
LN2 5QY
Tel: <xxxx xxxx xxxx
www.ulh.nhs.uk

Key facts and figures

This district general hospital serves the city of Lincoln and the North Lincolnshire area. It provides all major specialties and a 24-hour major accident and emergency service.

For the reporting period March 2018 – February 2019 there were 67,266 inpatient admissions and 487,839 outpatient attendances on this site.

We inspected Urgent and emergency services, Medical care (including older people's care), Critical care, Maternity and Services for children and young people.

Summary of services at Lincoln County Hospital

Requires improvement ➔➔

Our rating of services stayed the same. We rated it them as requires improvement because:

- Some services did not always have enough staff to care for patients and keep them safe. In two out of five services some staff had not had training in key skills. Staff did not always assess risks to patients, act on them and keep good care records.
- Managers monitored the effectiveness of the service and used the findings to make improvements but did not always achieve good outcomes for patients. In some services not all key services were available seven days a week.
- Services did not always plan care to meet the needs of local people or take account of patients' individual needs. People could not always access some services when they needed it and had to wait too long for treatment.
- Not all leaders ran services well using reliable information systems. Not all staff felt respected, supported and valued or were clear about their roles and accountabilities. and not all staff were committed to improving services continually.

However:

- Most staff understood how to protect patients from abuse. Services controlled infection risk well and most services managed medicines well. Services managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.

Summary of findings

- Staff mostly provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Services mostly made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.
- Staff mostly treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- Services made it easy for people to give feedback.
- Most services supported staff to develop their skills. Most staff understood the service's vision and values, and how to apply them in their work. Most staff were focused on the needs of patients receiving care. Services engaged well with patients and the community to plan and manage services.

Urgent and emergency services

Inadequate 

Key facts and figures

Urgent and emergency services are provided by the trust at three sites across Lincolnshire.

The emergency departments based at Lincoln County Hospital and Pilgrim Hospital provide consultant-led emergency care and treatment 24 hours a day, seven days a week to people across Lincoln and the North Lincolnshire area. Grantham and District Hospital closes overnight. From January 2018 to December 2018 there were 147,382 attendances at the trust's urgent and emergency care services.

This inspection concerns Lincoln County Hospital, the largest of the trust's emergency departments.

After our last inspection of the hospital published in July 2018 we asked the trust to make the following improvements at Lincoln County Hospital:

- The trust must ensure all patients who attend the emergency department are triaged within 15 minutes of their arrival.
- The trust must ensure all patients brought in by ambulance are handed over to the department within 30 minutes and patients should wait no more than 1 hour from time of arrival to time of treatment.
- The trust must ensure all patients who attend the department are admitted, transferred and discharged from the department within four hours.
- The trust must ensure all clinical and non-clinical staff receive the appropriate level of safeguarding children training: as directed in the Intercollegiate guidance: Safeguarding Children and Young People: Roles and Competencies for Health Care Staff (March 2014).
- The trust must ensure all staff in the emergency department attend mandatory training in key skills in line with trust policy, to meet the trusts own targets.
- The trust must ensure staff in the emergency department are applying the principles of antimicrobial stewardship.
- The trust should ensure the backlog of incidents are investigated and lessons learnt cascaded as a matter of urgency.
- The trust should ensure there is a positive incident reporting culture where staff get appropriate and timely feedback.
- The trust should ensure consultant presence in the emergency department meets the Royal College of Emergency Medicine (RCEM) recommendation of 16 hours per day.
- The trust should ensure all resuscitation equipment in the emergency department is safe and ready and ready for use in an emergency.
- The trust should ensure plans to refurbish the quiet room to meet the Psychiatric Liaison Accreditation Network (PLAN) standards
- The trust should ensure the emergency department participate in more clinical audit to be able to evidence care is being provided in line with national recommendations and best practice.

Urgent and emergency services

We inspected the service between the 11th and 13th June 2019. The inspection comprised an emergency care consultant, a nurse and a CQC inspector. During the inspection we visited key areas in the emergency department such as majors, minors, resuscitation, the rapid assessment and treatment area, and the waiting area.

We spoke with ten nurses and nine doctors of various grades, eight managers, and seven people from outside the organisation who worked with the service on a daily basis. We spoke with nine patients. We reviewed 25 records, checked eight pieces of equipment and attended a bed meeting.

Summary of this service

Our rating of this service went down. We rated it as inadequate because:

- Staff did not identify all patients at risk of deterioration in a timely way. Not all patients at risk had a sepsis screen completed within the hour, and some patients received antibiotics well in excess of an hour after the trigger point. The service did not always triage children within 15 minutes. Staffing levels depended on a disproportionate amount of bank, agency and locum nursing and medical staff. Vacancy rates, turnover and sickness were high.
- The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Children did not always receive a clinical assessment within 15 minutes. They mixed with adult patients in the main waiting area and Rapid Access and Treatment corridor. The service did not meet Royal College of Paediatrics and Child Health (RCPCH) standards to keep children safe.
- The service did not have a comprehensive or systematic audit programme. Some evidence from serious incidents showed that staff were not always following good practice. Staff were not always able to ensure patients had enough to eat and drink, especially overnight. Checking pain and giving pain relief was also variable. Levels of medical and nursing staff competency were constrained by the high level of locum and agency staff
- Staff did not always inform patients about their care. We spoke to nine patients in the emergency department and waiting room. Three patients in the department told us they did not know what was happening, what the next stage was, or whether they were likely to stay in hospital overnight. Friends and Family test performance for urgent and emergency service in the trust overall was consistently worse than the England average from March 2018 to February 2019
- Patients could not access treatment in a timely way. Performance against national standards such as the four-hour target was poor. The week before we inspected the service 64% of patients were admitted, transferred or discharged within four hours at Lincoln County Hospital. Services were not systematically planned to meet local demand. The service had not reviewed or adapted its services to ensure that it met the needs of diverse patient groups such as patients with mental health difficulties, learning disabilities, autism or dementia.
- Leaders did not manage the priorities the service faced, for example, the management of patients at risk of deteriorating because of sepsis was weak. Systems and governance around performance management, including those for checking data quality although developing, had not led to sustainable solutions. Staff did not always feel respected, supported or valued. Strategic planning was not comprehensive or coordinated and lacked plans to meet the diverse range of patients and children.

Is the service safe?

Inadequate 

Urgent and emergency services

Our rating of safe went down. We rated it as inadequate because:

- Staff did not complete risk assessments for all patients swiftly. They did not always remove or minimise risks. Staff did not always identify or act upon patients at risk of deterioration. Not all patients at risk had a sepsis screen completed within the hour, and some patients received antibiotics well in excess of an hour after the trigger point. Not all ambulance handovers happened within 30 minutes. Risks to patients in the waiting area and who had left without being seen were not consistently managed.
- Staff did not always complete risk assessments for children swiftly. Children were not always clinically assessed within 15 minutes to determine priority category, supplemented by a pain score and a full record of vital signs.
- There was no audit trail which showed that consultants signed off patients at risk. Before discharging them from the service, consultants should see children under one, patients over 30 with chest pain, patients over 75 with abdominal pain and any patient who had returned after 72 hours to the department with the same condition.
- Staff did not always have an understanding of how to protect patients from abuse. Not all medical staff had training on how to recognise and report abuse.
- The service did not have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. The service depended on locums.
- The service did not always have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Vacancy rates, turnover and sickness were high for doctors and nurses.
- The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff were not always trained in the safe use of equipment. The service did not always used systems and processes to safely prescribe or administer medicines. Staff did not always keep detailed records of patients' care and treatment.
- Nursing and medical staff knowledge of mental capacity issues was not up to date. The trust did not meet the trust target for Mental Capacity Act training completion.

However:

- The service had improved its management of patient safety incidents. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service.
- The service provided mandatory training in many key skills and was improving the level of life support and paediatric skills for nurses. Leaders had acted to stabilise the level of nurse staffing.
- The service generally controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Is the service effective?

Inadequate 

Our rating of effective went down. We rated it as inadequate because:

- The service did not always provide care and treatment based on national guidance and evidence-based practice. Monitoring of the effectiveness of care and treatment was not fully developed.

Urgent and emergency services

- The service did not have complete arrangements to monitor the effectiveness of care and treatment. A lack of up to date clinical audits limited opportunities for staff to make improvements and achieve better outcomes for patients. The service had no accreditations under relevant clinical accreditation schemes.
- The service had not performed well in national clinical outcome audits. Previous audits showed the service did not meet standards.
- Staff did not always give patients enough food and drink to meet their needs and improve their health. They did not always assess and monitor patients regularly to see if they were in pain or give pain relief in a timely way.
- Working between the emergency department staff and other hospital departments although improving, had not led to a sustainable positive impact on flow when we inspected
- Not all key services were available seven days a week to support timely patient care. Pharmacy was only open for a short time on Sundays
- The service aimed to make sure staff were competent for their roles, but not many nurses were trained on blood gases and there were operational barriers to improving medical skills. Not all medical staff had completed mandatory training on the Mental Capacity Act

However:

- Managers appraised staff's work performance and held supervision meetings with them to provide support and development. The level of staff paediatric competency was improving, and there was an associated competency framework to help sustain skills levels.
- Staff mostly supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide care. Ambulance staff reported that the service was becoming easier to work with.

Is the service caring?

Requires improvement 

Our rating of caring went down. We rated it as requires improvement because:

- Patients were not always treated with compassion and kindness, or had their privacy and dignity respected, or their individual needs taken into account. Patients were not always treated with kindness at reception. Friends and Family test results showed the department scored below the England average between March 2018 and February 2019 when patients were asked whether they would recommend to their Friends and Family.
- Patient dignity was not always fully respected despite staff efforts to maintain it. Privacy was not facilitated by the layout of the department
- Staff did not always provide emotional support to patients, families and carers to minimise their distress. They sometimes did not make sure patients and those close to them understood their care and treatment.
- The service did not have a consistent process for supporting patients who had been given bad news, if they attended without friends or relatives.

However:

Urgent and emergency services

- Nursing and medical staff were discreet and responsive when caring for patients. Staff followed the policy to keep patient care and treatment confidential. We observed children and seriously ill patients being treated in an understanding, kind and sensitive manner.
- Nursing and medical staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.
- Staff supported patients to make decisions and had access to communication aids or to interpreting skills where necessary.

Is the service responsive?

Inadequate 

Our rating of responsive went down. We rated it as inadequate because:

- The service did not plan or provide care in a way that met the needs of local people and the communities served. Services were not systematically planned to meet local demand. Leaders recognised this and were planning a capacity and demand analysis. The facilities and premises were not appropriate for the services being delivered. Care of children was not kept separate; the resuscitation area did not have enough capacity and mental health facilities were not completely secure
- People could not always access the service when they needed it or receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards. Performance against national standards such as the four-hour target was well below average. The week before we inspected the service 64% of patients were admitted, transferred or discharged within four hours at Lincoln County Hospital, and during our inspection the daily figure varied between 37% and 68%. This was below the trust target of 70.1%. Median total time in A&E was also worse than the national average
- The service at Lincoln County Hospital received 40.8% of the trust's emergency department complaints but 7.5% of compliments. Clinical treatment, waiting times and values and behaviours were the main reasons for complaining.

However,

- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.
- There were arrangements to help patients with communication difficulties such as pictorial guides and access to interpreters
- Within limitations, the service had improved facilities in since our last inspection. There was a small room used as a children's waiting room, a private room for patients who were distressed, and a room on the Rapid Assessment corridor which could be used for patients who were nearing end of life.

Is the service well-led?

Inadequate 

Our rating of well-led went down. We rated it as inadequate because:

- Leaders had not always managed the priorities and issues the service faced, for example the risk of deterioration for patients. There were also some gaps in clinical leadership capacity at hospital level.

Urgent and emergency services

- The Lincoln County Hospital service did not have a comprehensive strategy. There was an urgent care programme but there was no costed strategy at site level which combined quality and safety improvement, workforce planning and training, meeting the Royal College of Emergency Medicine and Royal College of Paediatrics and Child Health standards, and the range of patient's individual needs. Staff were not clear on what the strategy was, other than the need to recruit doctors and nurses.
- Staff did not always feel supported, respected or valued. The service had not performed well for a long time, so staff did not feel proud to work for the organisation, although some worked longer than their contracted hours to ensure patient care.
- Governance processes were in development. Leaders were starting to operate effective governance processes, throughout the service and with partner organisations. This was partially embedded and not all staff had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and teams had not managed performance effectively. Performance monitoring and management systems did not lead to problems being permanently solved. The service lacked processes to check and audit data quality, in particular to monitor whether triage was counted correctly.
- Engagement with staff and patients to inform improvement was limited. Staff were often too busy to survey patients for qualitative feedback, other than the Friends and Family test, and the service did not conduct staff surveys systematically.
- Staff and leaders did not have an in-depth understanding of quality improvement methods or the skills to use them. The service did not have a strong track record of innovation or participation in research.

However:

- New triumvirate leaders at senior level had the skills and knowledge necessary to improve the service. The trust operating model put more emphasis on standardised governance processes. Performance management and clinical governance were starting to strengthen. Leaders were working with external agencies to improve staffing and paediatric skills levels.
- Staff engagement meetings starting to take place to discuss major policy changes and to ensure that staff were aware of key issues such as the Full Capacity Protocol.
- The medicine division had a workforce plan which included the emergency service.

Areas for improvement

We found six areas for improvement. See areas for improvement section above.

Medical care (including older people's care)

Requires improvement ➔➔

Key facts and figures

The trust provides medical care (including older people's care) at three sites: Grantham and District Hospital; Lincoln County Hospital; and Pilgrim Hospital. Services at all sites sit within the division of medicine and are managed through the cardiovascular and specialty medicine clinical business units.

The trust has 546 inpatient medical beds across Lincoln County Hospital and Pilgrim Hospital, with 300 of these beds being located at Lincoln County Hospital.

The trust had 72,242 medical admissions from January to December 2018. Emergency admissions accounted for 33,181 (45.9%), 1,269 admissions (1.8%) were elective, and the remaining 37,792 (52.3%) were day case.

Admissions for the top three medical specialties were:

- General medicine: 31,313 admissions
- Clinical haematology: 7,985 admissions
- Clinical oncology: 7,447 admissions

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

To come to our ratings, during our inspection we:

- Visited all inpatient medical wards, cardiac catheter lab, endoscopy suite and the discharge lounge.
- Spoke with 14 patients and relatives
- Spoke with 47 members of staff representing a broad cross section of clinical specialties and grades and nonclinical roles.
- Reviewed medical records of 24 patients.

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- The service did not always have enough staff to care for patients and keep them safe.
- Managers monitored the effectiveness of the service to make improvements but did not always achieve good outcomes for patients.
- Some key services were not available seven days a week.
- People could not always access the service when they needed it and had wait times above the national average for treatment.
- Leaders had the ability to run the service well, however whilst they understood and managed the priorities and issues the service faced these were not always managed effectively.
- Staff did not always fell respected, supported and valued.

However:

Medical care (including older people's care)

- Most staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well and kept good care records.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it.
- Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback.
- Staff understood the service's vision and values, and how to apply them in their work.
- Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services.

Is the service safe?

Requires improvement 

Our rating of safe stayed the same. We rated it as requires improvement because:

- The service did not have enough nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.
- The service did not have enough medical staff with the right qualifications, skills, training and experience to keep patient's safe from avoidable harm and to provide the right care and treatment.
- The service did not always use systems and processes to safely prescribe, administer, record and store medicines.
- The service mostly made sure all staff completed mandatory training in key skills. However, the number of staff who completed it did not meet trust targets in all training modules.
- The design, maintenance and use of facilities, premises and equipment did not always keep people safe.
- Staff completed and updated risk assessments for each patient and acted to remove or minimise risks. However, staff did not always immediately identify and act upon patients at risk of deterioration.

However:

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Most staff had completed mandatory training on how to recognise and report abuse.
- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

Medical care (including older people's care)

- The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.
- The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

Is the service effective?

Requires improvement 

Our rating of effective went down. We rated it as requires improvement because:

- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and but did not always achieve good outcomes for patients.
- Not all key services were available seven days a week to support timely patient care.

However:

- The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients' subject to the Mental Health Act 1983.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- The service made sure most staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Staff gave patients practical support and advice to lead healthier lives.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Medical care (including older people's care)

- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Is the service responsive?

Requires improvement

Our rating of responsive stayed the same. We rated it as requires improvement because:

- People could not always access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not always in line with national standards.

However:

- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Is the service well-led?

Requires improvement 

Our rating of well-led went down. We rated it as requires improvement because:

- Leaders had the skills and abilities to run the service. However, whilst they understood and managed the priorities and issues the service faced these were not always managed effectively. They were they were not always visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- The trust had effective systems for identifying risks, planning to eliminate or reduce them, however actions to reduce their impact were not always taken. They had some plans to cope with both the expected and unexpected.
- Staff didn't did not always feel respected, supported and valued. However, they were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.
- The trust engaged well with patients, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively. However, some staff felt that there was a lack of engagement from leaders.

However;

- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

Medical care (including older people's care)

- Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.
- All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them.

Outstanding practice

We found two areas of outstanding practice. See outstanding practice section above.

Areas for improvement

We found nine areas for improvement. See areas for improvement section above.

Critical care

Good

Key facts and figures

The trust had 25 critical care beds as reported to NHS England. There were two intensive care units to manage level 2 and level 3 patients at Lincoln County Hospital and Pilgrim Hospital.

The trust had a critical care outreach service which was provided 24 hours a day, seven days a week.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

We inspected Lincoln County Hospital which had a 16 bed adult intensive care unit to manage level two and level three patients.

During our inspection we:

- visited the adult intensive care unit (AICU).
- spoke with two relatives and four patients.
- spoke with members of staff including ward managers, nurses, domestic staff, health care support workers, a physiotherapist, consultants, registrars and junior doctors, a clinical nurse educator, an advanced critical care practitioner, and a Mid Trent critical care network lead.
- looked at five sets of medical and nursing records.
- observed a ward handover, a safety huddle and interactions between patients, relatives and staff.

Summary of this service

Our rating of this service stayed the same. We rated it it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.

Critical care

- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Is the service safe?

Good 

Our rating of safe stayed the same. We rated it as good because:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well.
- Staff completed and updated risk assessments for each patient and took action to remove or minimise risks. Staff identified and quickly acted upon patients at risk of deterioration.
- The service had enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix.
- The service had enough allied health professionals with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.
- The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

However:

- There was not adequate pharmacist cover for the critical care unit at Lincoln Hospital.
- A pharmacist did not always attend the multidisciplinary ward handover meeting each morning.

Critical care

Is the service effective?

Good 

Our rating of effective stayed the same. We rated it as good because:

- The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Most key services were available seven days a week to support timely patient care.
- Staff gave patients practical support and advice to lead healthier lives.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patient's consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

However:

- The service did not provide therapist cover including dietetics, physiotherapists or speech and language therapists seven days a week.
- The service did not provider pharmacy cover seven days a week.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patient's personal, cultural and religious needs.
- Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Critical care

Is the service responsive?

Outstanding ☆ ➔➔

Our rating of responsive stayed the same. We rated it as outstanding because:

- The service planned and provided care in a way that went above and beyond to meet the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care. At our last inspection in 2014, the service operated a single sex protocol for patients, comprising of two separate bays, one area for females and one area for males, with six side rooms. We saw this had been maintained, with minimal breaches for level 1 patients. The service clinical lead was the lead for the Mid Trent Critical Care Network. This ensured the service delivered best practice to meet the needs of the local people.
- The service was extremely inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers. At our last inspection in 2014, the service offered a follow up clinic, of one appointment. We saw this had been extended to meet the needs of more patients, and wider support was offered. The service had also developed enhanced care plans to support vulnerable patients or those with a mental health condition, or a learning disability.
- People could access the service when they needed it and received the right care promptly. The service admitted, treated and discharged patients in line with national standards. The service had not cancelled any operations since before April and cancelled minimal before April. The service recognised an improvement in the number of cancelled operations. At times of increased demand, the service had an additional four beds to support the influx of patients.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service had minimal complaints, with only one at the time of our inspection. The complaint was investigated appropriately, and the complainant was provided with a response in a timely manner. The response included an apology and findings from the investigation.

Is the service well-led?

Good ● ➔➔

Our rating of well-led stayed the same. We rated it as good because:

- Most leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. Most were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.
- Staff mostly felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Critical care

- Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.
- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.
- The service was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.

However:

- A number of staff commented on the number of times they were being moved to support wards in the hospital.

Outstanding practice

We found two areas of outstanding practice. See outstanding practice section above.

Areas for improvement

We found six areas for improvement. See areas for improvement section above.

Maternity

Good

Key facts and figures

The maternity service at Lincoln County Hospital included an antenatal clinic, an antenatal assessment unit, and a maternity ward. The ward (Nettleham) was used for antenatal and postnatal inpatients and) consisted of 31 beds and a further six beds for use by the antenatal assessment unit and or to relieve capacity on the ward. The service provided four beds used as a transitional care area on the ward. The labour ward had ten side rooms, one of which included a birthing pool and they had access to two theatres. The rooms on the labour ward were of varying sizes and two were in use as a midwifery led environment while they awaited renovations being completed to provide an alongside midwifery led unit. There was also a dedicated bereavement room located on Nettleham ward.

Trust wide community midwife teams covered Skegness, Spalding, Grantham, Sleaford, Lincoln, Gainsborough and Boston.

The Early Pregnancy Assessment Unit (EPAU) was located within the gynaecology unit. The EPAU provided early scans and consultations for women experiencing problems in pregnancy between six and 20 weeks gestation.

There were 2695 births at Lincoln County Hospital between July 2018 and May 2019.

We previously inspected maternity jointly with gynaecology therefore we cannot compare our new ratings directly with previous ratings.

During this inspection we:

- Spoke with 29 staff members; including service leads, matrons, midwives, non-registered and administrative staff.
- Spoke with ten women and their relatives using the service.
- Checked 18 pieces of equipment.
- Reviewed eight medical records including CTG tracings.
- Reviewed eight prescription charts.

Summary of this service

We previously inspected maternity jointly with gynaecology therefore we cannot compare our new ratings directly with previous ratings. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.

Maternity

- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However,

- Although the service achieved good outcomes for most patients, some areas required improvement.
- The trust did not routinely audit waiting times to ensure they were in line with national standards.
- The service did not provide a designated midwifery led unit, however they had modified two rooms used as such while awaiting renovation and provision of an alongside midwifery led unit.
- Systems used for identifying risks and planning to eliminate or reduce them were not embedded. The risk register was in a board level format with an overarching title that was not appropriate for clinical risk.

Is the service safe?

Good

We previously inspected maternity jointly with gynaecology therefore we cannot compare our new ratings directly with previous ratings. We rated it as good because:

- The service provided mandatory training in key skills to all staff.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them.
- Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.
- The service had enough midwifery and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave bank staff a full induction.
- The service mostly had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

Maternity

- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.
- The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

Is the service effective?

Good

We previously inspected maternity jointly with gynaecology therefore we cannot compare our new ratings directly with previous ratings. We rated it as good because:

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.
- Staff gave patients enough food and drink to meet their needs and improve their health.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for most patients.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Key services were available seven days a week to support timely patient care. Staff gave patients practical support and advice to lead healthier lives.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

However,

- Although the service achieved good outcomes for most patients, some metrics required improvement.
- Medical staff did not meet the trust target for mental capacity training.

Is the service caring?

Good

Maternity

We previously inspected maternity jointly with gynaecology therefore we cannot compare our new ratings directly with previous ratings. We rated it as good because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Is the service responsive?

Good

We previously inspected maternity jointly with gynaecology therefore we cannot compare our new ratings directly with previous ratings. We rated it as good because:

- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.
- The service was inclusive and took account of most patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

However,

- Although women told us they could access the service when they needed it, the trust did not routinely audit waiting times to ensure they were in line with national standards.
- The trust did not collect data relating to the percentage of women seen by a midwife within 30 minutes and if necessary by a consultant within 60 minutes during labour.

Is the service well-led?

Good

We previously inspected maternity jointly with gynaecology therefore we cannot compare our new ratings directly with previous ratings. We rated it as good because:

- Managers had the right skills and abilities to run a service providing sustainable care.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Maternity

- Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.
- All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them.

However,

- Systems used for identifying risks and planning to eliminate or reduce them were not embedded following the implementation of a new trust operating model.
- The trust was only able to offer scans on four weekly basis to women identified as high risk for 'small for gestational age' (SGA) or fetal growth restriction (FGR). The trust was unable to offer routine scanning to women with BMI of 35 – 39.99. This was not in line with national guidance, however an action plan was in place and a new sonography machine was awaiting installation.

Outstanding practice

We found three areas of outstanding practice. See outstanding practice section above.

Areas for improvement

We found five areas for improvement. See areas for improvement section above.

Services for children and young people

Requires improvement 

Key facts and figures

The trust provides care for children and young people at Lincoln County Hospital and Pilgrim Hospital. Both hospitals provide paediatric services for children from new-born to 16 years of age including day case and emergency services.

There are 24 paediatric inpatient beds on Rainforest Ward and currently 16 beds on Ward 4A. There is also an eight-bedded paediatric day case ward and one intensive care, two high dependency, 12 special care and four transitional care beds.

Lincoln County hospital and Pilgrim hospital were visited as part of the inspection process and each location has a separate evidence appendix and report. Children's and young people's services were run by one management team and are regarded by the trust as one service ('Two sites, one model'). For this reason, it is inevitable there is some duplication contained within the two evidence appendices.

This report relates to children's and young people's service provided at Lincoln County hospital

We inspected the service from 11 to 13 June 2019. As part of the inspection we visited Rainforest ward, Safari ward the neonatal unit, the children's outpatient department, the multi-faith chapel radiology, operating theatres and adult outpatient departments where children are regularly seen.

During the inspection, we spoke with 22 staff of various grades, including ward and theatre managers, nurses, consultants, middle grade doctors, healthcare assistants, nursery nurses and administrative staff. We attended two nursing handovers, two medical handovers and one safety huddle. We interviewed the children's safeguarding lead and the trusts transitional lead

We spoke with 13 children, young people and their family members, observed care and treatment and looked at 11 patient's medical records including some medicines charts. We received comments from people who contacted us to tell us about their experiences, and reviewed performance information about the hospital.

Following a comprehensive inspection in 2016, the trust was required to complete the following actions:

- Ensure nursing Ligature risk assessments had undertaken and ligature cutting equipment was available in all required areas.
- Ensure there were effective system in place to assess, monitor, and mitigate risks to deteriorating patients. Where patients had met the trust's criteria for sepsis screening, all patients must be screened or treated in accordance with national guidance.

Summary of this service

Our rating of this service went down. We rated it as requires improvement because:

- The children's safeguarding lead was not in receipt of regular safeguarding supervision
- Staff were not in receipt of regular group supervision as a member of the safeguarding team who undertook this left the trust in February and their post had only just been replaced at the time of our inspection
- The service did not have enough medical staff to keep children and young people safe, as the medical staff did not match the planned number on all shifts in each department.

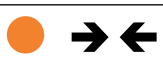
Services for children and young people

- The design of the adult outpatient's department were children regularly attended environment did not always follow national guidance, for example, the outpatient's department clinic waiting area for an x-ray or CT scan had no facilities for children. Staff told us the children would wait with their parents and that sometimes they had to stand as there was not sufficient seating.
- Nursing staffing was on the risk register for Rainforest ward as a red risk and had been for five years Royal College of Nursing (RCN), Paediatric Nurse Standards recommend a ratio of one nurse to four patients over the age of two during the day and at night and a ratio of one nurse to three patients under two years of age day and night. A ratio of one nurse to two patients is recommended for patients requiring high dependency care. The guidance also recommended at least one Band six nurse on every shift. This was achieved on Rainforest ward through the extensive use of bank and agency staff over a prolonged period of time.
- Managers did not ensure staff had access to up to date best practice guidance and carried out very few audits, to assess whether staff complied with national guidance.

However:

- Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service-controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service. There was a medical lead for safeguarding.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Most staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Is the service safe?

Requires improvement 

Our rating of safe stayed the same. We rated it as requires improvement because:

- The children's safeguarding lead was not in receipt of regular safeguarding supervision.
- Staff were not in receipt of regular group supervision as a member of the safeguarding team who undertook this left the trust in February and their post had only just been replaced at the time of our inspection.

Services for children and young people

- The service did not have enough medical staff to keep children and young people safe, as the medical staff did not match the planned number on all shifts in each department.
- Nursing staffing was on the risk register for Rainforest ward as a red risk and had been for five years Rainforest ward reached staffed requirements through the extensive use of bank and agency staff over a prolonged period of time.

However:

- There was a medical lead for safeguarding.
- Staff understood the duty of candour. They were open and transparent, and gave children, young people and their families a full explanation if and when things went wrong.
- We saw ligature risk assessments on all the children's ward and the outpatient clinics we inspected. These were undertaken to identity and mitigate the ligature points where patients might try and hang themselves from. All the children's wards had ligature proof curtain tracks around the patient's bed, that would collapse if any weight was attached to them. Ligature cutters were kept in a compartment in all the resuscitation trollies with a notice and a picture of them on the top of the trolley to both notify and remind staff where they were .
- The service assessed paediatric sepsis using the sepsis six, which is a set of interventions which can be delivered by any healthcare professional and must be implemented within the first hour. Sepsis is a life-threatening condition that arises when the body's response to infection injures its own tissues and organs.
- Rainforest and Safari wards undertook a daily sepsis six audit. At the time of our inspection, data showed that both wards were100% compliant with the sepsis six audit. Staff were given a Recognition and Management of Sepsis in Children and Young People Workbook & Assessment for Children's Inpatient and Children's Assessment Areas.

Is the service effective?

Requires improvement 

Our rating of effective went down. We rated it as requires improvement because:

- Managers did not carry out a comprehensive audit programme and did not always implement the recommendations. For example, quality improvement project on the investigation and management of childhood epilepsy in 2018. One of the recommendations of this project was a need for an Implementation of a well-defined integrated care pathway. However, this pathway was not evident when we undertook our recent inspection.
- Managers did not always share and make sure staff understood information from the audits. There was no identified audit clinical lead for children's and young people's services. This meant that information from audits was not always shared widely with staff.
- Improvement was not always checked and monitored. Sepsis audits were monitored; however, we could not find evidence that there was consistent of monitoring, checking and implementation of action plans from national audits.
- Managers did not always support medical staff to develop through regular, constructive clinical supervision of their work. There was no medical lead for safeguarding. Medical staff told us they did not have regular safeguarding supervision.

However:

- All staff were supported to attend training covering areas such as safeguarding adults and children information governance, medicines management, infection and prevention control and record keeping.

Services for children and young people

- Managers supported staff to develop through yearly, constructive appraisals of their work. All staff we spoke with said they had regular appraisals, annual appraisals give an opportunity for staff and managers to meet, review performance and development opportunities which promotes competence, well-being and capability. All qualified nursing, medical and health care support workers we spoke with confirmed they had received a meaningful appraisal within the past year.
- The service was in the process of working towards accreditation by the UNICEF UK Baby Friendly Initiative.
- Managers did not always support medical staff to develop through regular, constructive clinical supervision of their work. Medical staff told us they did not have regular safeguarding supervision.

Is the service caring?

Good ➔➔

Our rating of caring stayed the same. We rated it as good because:

- We found that at all times staff acted in a compassionate and respectful way towards children, young people and their parents.
- We also observed that staff took time to interact with children, young people, those close to them and treat them with kindness and consideration.
- Staff were knowledgeable about the different personal, cultural, social and religious needs of children, young people and their families and how they may relate to care needs of them.
- Trust staff delivered good emotional support. The parents, we spoke with told us there was good communication and emotional support from staff and any concerns were addressed quickly and appropriately.

Is the service responsive?

Requires improvement ➔

Our rating of responsive went down. We rated it as requires improvement because:

- The environment in the adult outpatient departments where children were frequently seen for example for an x-ray was not suitable for the needs of children. There were no facilities for children. Staff told us the children would wait with their parents and that sometimes they had to stand as there was not sufficient seating.
- During this inspection, we did not see evidence of formal transition plans in place for children and young people
- There was no transition documentation to give parents, however each young person had a booklet named “All about me” which contained various sections concerning the young person, for example mobility, health needs and how I feel.
- Staff did not always make sure children and young people living with mental health problems, learning disabilities and long-term conditions received the necessary care to meet all their needs and there was no provision to flag patients with these needs.

However

Services for children and young people

- Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. Staff were knowledgeable and had a good understanding of the necessities for single sex accommodation and were able to accommodate the mix of age ranges of children and young people attending the children's ward and the day case ward, to enable both privacy and dignity
- Staff could access emergency mental health support 24 hours a day 7 days a week for children and young people with mental health problems and learning disabilities. Staff could call for support from the children's and adolescent mental health team (CAMHS) and, 24 hours a day, seven days a week.
- Anaesthetic room was decorated with child friendly decoration such as cartoons and we observed that general anaesthetics carried out in a very friendly professional manner. We saw two children anesthetised, on each occasion their mother was with child and was involved fully in what was happening.
- Managers ensured that children, young people and families who did not attend appointments were contacted. Staff said they did not have a mobile phone text reminder system, but that this was undertaken by the central booking system. Managers did not routinely contact families themselves to explore reasons for non-attendance.
- The child and adolescent mental health service (CAMHS) crisis response team were present in the emergency department and reviewed patients with a view to preventing admissions. If a child required admission, the CAMHS professionals would review the child on the ward with a view to transferring them to an appropriate environment if required.

Is the service well-led?

Requires improvement 

Our rating of well-led went down. We rated it as requires improvement because:

- Job plans for consultants had not been reviewed since 2017, although we were told a group job plan was being developed and individual job plans were to being reviewed. During this process, leads for clinical audit would be identified and attendance at 70% of clinical governance meetings would be mandatory.
- Clinical governance processes were not fully established and effective. The senior management team explained that the governance framework and meeting structure had been reviewed as part of the new 'two sites one model' approach and some parts were more established than others.
- Although there was an identified clinical audit lead for neonates, there was no clinical audit lead for paediatrics. The trust provided a copy of the planned audits for 2019 to 2020, but there were only six audits planned for children and young people's services across the trust. There were no arrangements in place for paediatric morbidity and mortality meetings.
- The trust had a nominated freedom to speak up guardian (FTSUG) who had been appointed by the senior management team without any staff consultation. Most staff told us they were not confident to speak to the FTSUG and none of the staff we spoke with knew the name of the FTSUG.
- Nurse staffing issues had been on the risk register for five years. However, actions were in place to mitigate risk.

However:

- The service encouraged staff who wanted to progress to apply for The Mary Seacole Local Programme which is a six-month leadership development programme, to develop knowledge and skills in leadership and management. We spoke with two nurses, who said they had been encouraged to apply for this by their ward manager.

Services for children and young people

- The trust had a “Wellbeing wallet” for staff. This has been created after the trusts first managing emotional wellbeing and mental health at work conference. The wellbeing wallet contained information and resources for staff on how to promote a positive emotional wellbeing environment within the trust and where to find more information on how to achieve this.
- Policies and procedures existed on the trust intranet which staff could access easily. For example, escalation policies were in place in the event of fire, water emergencies and computer failure. Staff we spoke with were not aware of these policies.
- Parents and family members were given feedback cards, so they could feedback on their experience whilst attending the hospital.

Areas for improvement

We found five areas for improvement. See areas for improvement section above.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

Please note: Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website www.cqc.org.uk)

This guidance (see goo.gl/Y1dLhz) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Enforcement actions

We took enforcement action because the quality of healthcare required significant improvement.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Section 31 HSCA Urgent procedure for suspension, variation etc.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	S29A Warning Notice: quality of healthcare

Our inspection team

Simon Brown and Michelle Dunna, Inspection Managers led this inspection. Carolyn Jenkinson, Head of Hospital Inspection, and one executive reviewer supported our inspection of well-led for the trust overall.

The combined team (core services and well-led) included two further inspection managers, 13 further inspectors, four of whom were mental health inspectors, one national professional advisor in urgent and emergency care, 21 specialist advisors, two inspection managers, two assistant inspectors and one inspection planner.

Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ. Experts by experience are people who have personal experience of using or caring for people who use health and social care services

United Lincolnshire Hospitals NHS trust

Use of Resources assessment report

Greetwell Road
Lincoln
Lincolnshire
LN2 5QY
Tel: 01522512512
www.ulh.nhs.uk

Date of publication: 17 October 2019

This report describes our judgement of the Use of Resources and our combined rating for quality and resources for the NHS trust.

Ratings

Overall quality rating for this NHS trust	**Requires improvement**
Are services safe?	**Requires improvement**
Are services effective?	**Requires improvement**
Are services caring?	**Good**
Are services responsive?	**Requires improvement**
Are services well-led?	**Requires improvement**

Our overall quality rating combines our five NHS trust-level quality ratings of safe, effective, caring, responsive and well-led. These ratings are based on what we found when we inspected, and other information available to us. You can find information about these ratings in our inspection report for this NHS trust and in the related evidence appendix. (See www.cqc.org.uk/provider/RWD/reports)

Are resources used productively?	**Inadequate**

Combined rating for quality and use of resources	**Requires improvement**

We award the Use of Resources rating based on an assessment carried out by NHS Improvement.

Our combined rating for Quality and Use of Resources summarises the performance of the NHS trust taking into account the quality of services as well as the NHS trust's productivity and sustainability. This rating combines our five NHS trust-level quality ratings of safe, effective, caring, responsive and well-led with the Use of Resources rating.

Use of Resources assessment and rating

NHS Improvement are currently planning to assess all non-specialist acute NHS trusts and foundation NHS trusts for their Use of Resources assessments.

The aim of the assessment is to improve understanding of how productively NHS trusts are using their resources to provide high quality and sustainable care for patients. The assessment includes an analysis of NHS trust performance against a selection of initial metrics, using local intelligence, and other evidence. This analysis is followed by a qualitative assessment by a team from NHS Improvement during a one-day site visit to the NHS trust.

Combined rating for Quality and Use of Resources

Our combined rating for Quality and Use of Resources is awarded by combining our five NHS trust-level quality ratings of safe, effective, caring, responsive and well-led with the Use of Resources rating, using the ratings principles included in our guidance for NHS trusts.

This is the first time that we have awarded a combined rating for Quality and Use of Resources at this NHS trust. The combined rating for Quality and Use of Resources for this NHS trust was Requires Improvement, because:

We rated the use of resources at this NHS trust as Inadequate. Whilst it is recognised the NHS trust is providing services from a number of geographically dispersed sites and has numerous workforce challenges, there still remains scope to improve productivity in its clinical and support services in particular. The NHS trust also continues to operate with a significant deficit and is not meeting its control totals.

United Lincolnshire Hospitals NHS trust

Use of Resources assessment report

Tel: 01522512512
www.ulh.nhs.uk

Date of site visit:
14 June 2019

Date of publication:
17 October 2019

This report describes NHS Improvement's assessment of how effectively this NHS trust uses its resources. It is based on a combination of data on the NHS trust's performance over the previous twelve months, our local intelligence and qualitative evidence collected during a site visit comprised of a series of structured conversations with the NHS trust's leadership team.

The Use of Resources rating for this NHS trust is published by CQC alongside its other NHS trust-level ratings. All six NHS trust-level ratings for the NHS trust's key questions (safe, effective, caring, responsive, well-led, use of resources) are aggregated to yield the NHS trust's combined rating. A summary of the Use of Resources report is also included in CQC's inspection report for this NHS trust.

How effectively is the NHS trust using its resources?	**Inadequate** ●

How we carried out this assessment

The aim of Use of Resources assessments is to understand how effectively providers are using their resources to provide high quality, efficient and sustainable care for patients. The assessment team has, according to the published framework, examined the NHS trust's performance against a set of initial metrics alongside local intelligence from NHS Improvement's day-to-day interactions with the NHS trust, and the NHS trust's own commentary of its performance. The team conducted a dedicated site visit to engage with key staff using agreed key lines of enquiry (KLOEs) and prompts in the areas of clinical services; people; clinical support services; corporate services, procurement, estates and facilities; and finance. All KLOEs, initial metrics and prompts can be found in the Use of Resources assessment framework.

We visited the NHS trust on 14th June 2019 and met the NHS trust's executive team including the chief executive, the chair and relevant senior management responsible for the areas under this assessment's KLOEs.

Findings

Is the NHS trust using its resources productively to maximise patient benefit?	Inadequate ●

We rated the use of resources at this NHS trust as Inadequate. Whilst it is recognised the NHS trust is providing services from a number of geographically dispersed sites and has numerous workforce challenges, there still remains scope to improve productivity in its clinical and support services in particular. The NHS trust also continues to operate with a significant deficit and is not meeting its control totals.

- The NHS trust's overall Cost per Weighted Activity Unit (WAU) at £3,844 is in the highest (worst) quartile for 2017/18, indicating that it delivers activity at a cost higher than most NHS trusts. The NHS trust attributes some of the high cost to the duplication of services due to multisite provision, however there remains a wide range of efficiency opportunities across most areas covered in this assessment.
- The NHS trust has high vacancy rates and is heavily reliant on temporary staffing to deliver safe services. Staff retention is deteriorating and sickness absence rates are high. As a result, workforce costs are high compared to other NHS trusts and pay expenditure exceeds budget with no corresponding overperformance against activity plans.
- Whilst there is some collaboration in provision of imaging and pathology services, the outsourcing and insourcing costs in imaging services are high, mainly due to workforce gaps. Operational and workforce challenges in these areas are impacting the NHS trust's ability to achieve performance standards.
- The NHS trust's performance against the NHS procurement performance metrics indicates scope to improve procurement processes and drive down purchase costs.
- The cost of soft facilities management services is higher than most other NHS trusts, and the NHS trust has accumulated a significant backlog and critical infrastructure risk, which is driving high maintenance spend.
- The NHS trust did not achieve its control total of £54.5million deficit in 2018/19, reporting a worse position of £88.2million deficit, which at 19.7% of turnover, has not improved from the previous year (19.7%). The NHS trust identifies that more than £50 million of this deficit is within its control, however a financial recovery plan is pending completion of other clinical, workforce and support services strategies.
- The NHS trust's financial plan for 2019/20 is control total compliant and it is reporting achievement of the year to date position, however this is with the support of non-recurrent measures.
- Although the levels of missed clinical appointments have reduced, they remain higher than most NHS trusts, and opportunity remains to improve utilisation of non-elective bed capacity, as patients are waiting longer in hospital for their procedures.
- The NHS trust is not meeting any of the constitutional operational standards and its performance is below national median.
- Recognising that the Finance function costs are low, the NHS trust is investing, in this function and wider information management capability, to better support business decisions and finance performance improvement.

However,

- There are areas where the NHS trust compares well, for instance 30-day emergency readmissions, pre-procedure elective bed days and delayed transfers of care, which indicates improved utilisation of elective beds and better discharge processes.
- The NHS trust achieved the nationally identified savings as part of the top ten medicines programme, and it demonstrated using pharmacy staff innovatively, to deliver activity and support patient flow. The NHS trust also demonstrated the use of alternative roles in its workforce model to mitigate some of the workforce challenges.
- The NHS trust has recently undertaken initiatives that demonstrate a structured approach to driving performance and productivity improvements for instance, reconfiguration of beds at one of its sites, which has delivered some improvements in patient flow and care. The NHS trust plans to replicate this at the Lincoln site. The NHS trust also implemented a new divisional management structure to strengthen lines of accountability, and it invested in the human resources function to support better workforce management.

How well is the NHS trust using its resources to provide clinical services that operate as productively as possible and thereby maximise patient benefit?

There is some evidence of a structured approach to making improvements in the NHS trust's clinical services and the NHS trust compares well in some areas, however significant improvement is still required for the NHS trust to achieve national performance levels.

- At the time of the assessment in June 2019, the NHS trust was not meeting most of the constitutional operational performance standards. The NHS trust was meeting the 62-day cancer screening referral standard; however the 62-day Cancer Urgent GP referral performance has been variable with a high of 82% to a low of 61.3% over the past 12 months. Performance against the 4-hr Accident and Emergency target has deteriorated. Referral to Treatment (RTT) Constitutional Standard has not been achieved since June 2016 and Diagnostic Performance since July 2018.
- At 7.2%, the 30-day emergency readmission rate is slightly below the national median for the period January 2019 to March 2019 meaning patients are less likely to require additional medical treatment for the same condition at this NHS trust compared to other providers nationally.
- The NHS trust's reported delayed transfers of care (DTOC) rate is lower than national average of 3.5% and the NHS trust's own internal target of 2.5%. DTOC rates have been on an improving trend, from 5.2% in May 2018 to 2.68%in May 2019. This has been achieved through system working with health and social care partners to improve discharge processes, including system wide electronic demand and capacity monitoring, and the implementation of the NHS Trusted Assessor model for patients discharged to care homes. The NHS trust also has a discharge team working seven days a week.
- The NHS trust successfully reconfigured the Pilgrim Hospital beds and their speciality allocation. The purpose of the reconfiguration was to ensure the site had the appropriate level of medical and surgical beds. It resulted in a new 12-bed orthopaedic ward and a 24-hour Integrated Assessment Centre (IAC), with a 48 bed Acute Medical Short Stay unit and a 54-bed integrated surgical unit. The IAC brings together surgical and medical colleagues, as it is both an Ambulatory Emergency Care and Surgical Admissions unit. It also supports better flow of patients. This work was completed in October 2018.

- The NHS trust commissioned an evaluation of the Pilgrim Hospital reconfiguration, which demonstrated several improvements in the period between October 2018 and March 2019 compared to the period October 2017 to March 2018. These include a 73% overall reduction in medical outliers, 3 % reduction in bed occupancy, 3% improvement of patients being discharged within 0 to 72 hours and a 3% reduction in Length of Stay. The NHS trust are planning to carry out a similar reconfiguration at Lincoln County Hospital in 2019/20.
- For the period January 2019 to March 2019, pre-procedure elective bed days, at 0.12, are the same as the national median, indicating that the number of patients admitted before the day of their surgery is in line with most other NHS trusts. The NHS trust admits patients on the day surgery with exceptions associated with age, pre-identified complexities and distance to hospital.
- Pre-procedure non-elective bed days are on an improving trend, however for the same period at 0.90, they remain above the national median of 0.66 indicating that patients are waiting longer in hospital for their procedures. The NHS trust identified the key specialties contributing to this position as Trauma and Orthopaedics and General Surgery and is addressing this through improving emergency theatre efficiency.
- The Did Not Attend (DNA) rate is on an improving trend, but at 8% remains above the national median for period January 2019 to March 2019. The NHS trust identified that high levels of unnecessary referrals are contributing to high levels of DNAs in specialities such as dermatology, rheumatology, and is working with health system partners to address this. The NHS trust is also improving internal clinic scheduling processes and has implemented an automated telephone and two-way text reminder systems. The NHS trust is also part of the national pilot for virtual clinics with pilots in five specialties.
- The NHS trust has engaged with the Getting It Right First Time (GIRFT) programme and has demonstrated improvements from implementation of recommendations. The changes in Trauma and Orthopaedics resulted in the total incomplete pathway, reducing from 3,391 in August 2018 to 2,731 in May 2019. The backlog of patients waiting over 18 weeks reduced from 604 patients to 451 in the same time. The NHS trust also demonstrated other improvements in Ophthalmology Productivity, Paediatric General Surgery, Laparoscopic Appendectomy.

How effectively is the NHS trust using its workforce to maximise patient benefit and provide high quality care?

The pay cost of delivering activity benchmarks higher than most other acute non-specialist NHS trusts. The NHS trust has high levels of vacancies and is reliant on temporary staff, which is driving the pay bill. Sickness levels are high, staff retention is deteriorating and improvements to the substantive workforce deployment processes are yet to deliver expected benefits. However, there are some examples of where the NHS trust is using new and innovative workforce solutions to mitigate recruitment challenges.

- For 2017/18 the NHS trust had an overall pay cost per WAU of £2,353 compared with the national median of £2,180, placing them in the highest (worst) quartile nationally. This means that it spends more on staff per unit of activity than most NHS trusts. Medical, nursing and AHP costs per WAU are all above the national median, with medical and nursing costs per WAU benchmarking in the highest (worst) quartile and AHP cost per WAU in the second highest cost quartile.
- The NHS trust attributes its performance to several factors including, duplication of services across its sites, and increased dependency on temporary staffing solutions at

premium prices to deliver services. The NHS trust uses bank staff and extra shift payments to cover vacancies, extra session payments to reduce waiting lists and extra duty payments to address reporting backlogs. The NHS trust also indicated that due to the under reporting of activity, the reported WAUs may have been adversely impacted.

- The NHS trust exceeded its agency ceiling as set by NHS Improvement for 2018/19 by 47%, with spend of agency at 10.8% of total pay costs (higher than most other NHS trusts). The NHS trust cited the main driver of agency spend as the increased dependence on temporary staff to cover vacancies and ensure safe nurse staffing levels across the NHS trust, especially over weekends. As a result, the NHS trust still uses services of the more expensive agency firms. The NHS trust is centralising booking of temporary staff and strengthening internal controls on agency use, with long term medical agency staffing contracts signed off by executive.
- Rostering of the nursing workforce is undertaken electronically, and the NHS trust uses an electronic solution to monitor patient acuity. However, the NHS trust indicated that efficiency of the process is adversely impacted by high levels of vacancies and requirement to reallocate staff after rosters have been signed off. E-rostering has recently been rolled out for Allied Health professionals and nurse specialists.
- A nurse staffing skill mix review is undertaken every six months and a governance framework is in place to ensure that the introduction of any new or alternative roles has a full quality impact assessment in line with the National Quality Board and NHS Improvement guidance documents.
- Majority of consultant job plans are historical, with limited correlation to capacity requirements. The NHS trust reviewed its job planning policy and introduced a consistency panel to ensure the approach of agreeing and reviewing job plans, is consistent with local interpretation of national guidance. The ongoing review of job plans is expected to be completed this year, and the NHS trust has procured an electronic job planning solution, which it also plans to implement this year.
- Vacancy rates remain high and above national averages for Nursing and Medical Workforce (17.3% and 20% respectively as at March 2019). The NHS trust is focussing on overseas recruitment especially medical staff for the Emergency Department and has introduced the CESR program to support recruitment of senior medical staff. The specific recruitment initiatives are part of a wider focus on recruitment to all substantive vacancies. The NHS trust also makes use of alternative roles such as advance nurse practitioners to provide resilience in junior staff rotas and deliver outpatients activity.
- The NHS trust is developing the Team Around Patient ‘TAP’ approach to address the high nursing vacancy challenges. This entails use of alternative clinical roles to the traditional registered and unregistered nursing roles as part of the ward staffing, to ensure that care continues to meet patient needs. Pharmacy technicians, physiotherapy assistants, dementia practitioners and nutritional assistants have been introduced into the clinical teams. All proposed changes to ward staffing are quality impact assessed and signed off by the Director of Nursing. However, a continued focus on recruitment is required to increase levels of substantive workforce.
- Staff retention is on a deteriorating trend with a retention rate of 85.1% as at December 2018 (compared to 86.6 in December 2017) and is below (worse than) the national median of 85.6%. Exit interviews are conducted to understand and address the reasons for staff turnover, and interventions in place include; engaging with staff on the future direction of the organisation, working to improve the NHS trust brand, introducing more flexible working and utilising staff who have retired to support and coach junior staff. Work has also been done to create educational and career development opportunities for staff, however implementation is difficult given the high vacancy levels.

- At 4.98% in November 2018, staff sickness absence rates are worse than the national median of 4.35%. To improve this position, the NHS trust has reviewed its sickness absence policy, and has invested in the human resources function to provide more support to managers when addressing sickness absences. Early access to physio and occupational health support is also offered to staff.

How effectively is the NHS trust using its clinical support services to deliver high quality, sustainable services for patients?

The NHS trust is working in collaboration with partners to deliver pathology and radiology services and drive medicines savings. It is making use pharmacy staff to support patient flow and has developed the sustainable approach of using alternative roles in radiology. However, the cost of running imaging services and medicines expenditure remains high.

- The overall cost per test in pathology services benchmarks in the best performing quartile nationally. The NHS trust is part of Path Links Pathology network and the NHS Improvement ME2 network. However, the NHS trust identified that operational challenges exist within the network which are impacting on its performance. This is being addressed through more robust contract management processes, led by key members of the executive.
- Imaging activity is significantly higher than the national average across all modalities. To address this, the NHS trust is conducting a review of activity and has an e-referral process in place, which allows for easier audit of referral for diagnostics. It has also implemented diagnostic bundles in specialities, to address variation in referrals for diagnostic tests. This will contribute to improvements in RTT and cancer pathways.
- Imaging services have high outsourcing and internal pay costs mainly due to the high vacancy levels within the radiologist's workforce. The NHS trust is working to reduce these costs through negotiating lower outsourcing tariffs and increasing capacity through use of remote working facilities (which it has access to given it is part of the EMRAD collaboration).
- The NHS trust is also using advanced practitioners to reduce reliance on medical staff. It compares well nationally in respect to use of reporting radiographers who conduct reporting on plain films, including chest and abdominal x-rays. It also has two radiographers reporting head CTs with a further 5 staff in training. This approach was recognised by the GIRFT team, placing the NHS trust 4th best in the country for this practice. The NHS trust also has three consultant mammographers to provided resilience within its breast screening services.
- The NHS trust demonstrated a sustained improvement in 7-day reporting (from request to report) within radiology since May 2018, which benefits cancer pathways. This was achieved through better booking processes (with some scans undertaken immediately), investment in resource to track reporting progress, and monitoring performance at divisional performance management meetings.
- As part of the Top Ten Medicines programme, the NHS trust is making good progress in delivering on nationally identified saving opportunities, achieving £2.5 million, which is 102% of the savings target for 2017/18. A further £4.5 million has been achieved in 2018/19. The savings are achieved through partnership with commissioners, and the NHS trust benefits from gainshare arrangements for the biosimilar switches.
- 34% of pharmacists actively prescribe medication, which is in line with the national median. Prescribing pharmacists undertake both the prescribing and deprescribing of medications to support safe quality care delivery and reduce waste.

- The amount of pharmacy time spent on clinical activities benchmarks in the best performing quartile. Pharmacy services are open Saturday and Sunday, morning with a business case being submitted to extend these hours. Reconciliation of medicines within 24 hours of admission is just below the national median, and the NHS trust recognises that further improvement can be achieved.
- E-prescribing has been implemented for chemotherapy, however the NHS trust is yet to implement this on a trust wide basis due to capital funding constraints.

How effectively is the NHS trust managing its corporate services, procurement, estates and facilities to maximise productivity to the benefit of patients?

Supplies and Services expenditure is significantly higher than most other NHS trusts, driving a high non-pay cost per WAU. Whilst Human Resources (HR) function costs are low compared with other NHS trusts, capacity is not sufficient to support the required workforce and service productivity improvements. The NHS trust has achieved some improvement in procurement processes, although performance remains lower than most NHS trusts.

- For 2017/18 the NHS trust had an overall non-pay cost per WAU of £1,491, compared with a national median of £1,307 and peer median of £1,331, placing it in the highest (worst) quartile nationally. This indicates opportunities to its spending on supplies and services.
- The Finance function cost is lower than the national median and HR Department is slightly above the national median. The NHS trust invested in the HR function to increase support provided to divisions in managing workforce challenges. The NHS trust is also investing in the finance function to ensure better support of financial improvements, this includes procurement of a new finance system.
- The NHS trust's procurement processes are relatively inefficient. This is reflected in the NHS trust's Procurement Process Efficiency and Price Performance Score of 38.8, which places it in the lowest (worst) quartile. The second highest quartile metrics for the percentage variance for top 100 and top 500 products, and highest quartile % variance from median price and minimum price, also suggest that the NHS trust is not getting the best prices from its procurement operations.
- The NHS trust which hosts the shared procurement service for other NHS organisations in Lincolnshire, has invested in procurement analyst to support with identification of opportunities. The NHS trust has also set-up a clinical product evaluation group to secure clinical engagement in procurement and drive standardisation of clinical products. The NHS trust has recently achieved procurement standards level 1 accreditation and is working towards level 2 which it plans to achieve by March 2020.
- At £302 per square metre in 2017/18, the NHS trust's estates and facilities costs benchmark below the national average. However, the Soft FM Costs benchmark above national average at £134 per m2 and £176 per WAU.
- To reduce Soft FM costs, the NHS trust is currently assessing the benefit of consolidating catering services through implementation of a single processing unit. The NHS trust is also reviewing Laundry and Linen usage at Ward level, with the aim of reducing use.
- The NHS trust metrics show that there may be opportunities to increase activity and space utilisation or reduce overall area of the estate. This can be seen from the Occupied Floor Area m2 per WAU metric at 1.32, placing the NHS trust both above benchmark and peer median. The NHS trust is also showing an underutilised space of

25.9% against a peer median of 1%. The NHS trust indicated that this is partly due to inaccuracies in the internal data underpinning this metric, however, it is currently working on an Estates Strategy to reflect recent clinical strategy changes, which will also address utilisation of space.

- The NHS trust has a significant level of backlog maintenance and critical infrastructure risk and is placed in the highest (worst) quartile for both metrics. The NHS trust has been investing to reduce backlog, and this is reflected in investment to reduce backlog maintenance as a percentage of Total backlog maintenance (%), with the NHS trust invested 13.28% in 2017/18 against a peer median of 6.14%
- Over the last three years, the NHS trust been conducting fire improvement works, which have led to major improvements in fire compartmentation and contributing to a reduction in backlog.

How effectively is the NHS trust managing its financial resources to deliver high quality, sustainable services for patients?

The NHS trust is operating with a significant deficit and did not achieve its control total due to non-achievement of the cost improvement plan and increasing pay costs. The financial plan submitted for 2019/20 is control total complaint, and although the NHS trust is reporting delivery of the year to date plan, there are risks to delivering the full year plan due to slippages against its cost improvement plan and continued pay costs pressures, which the NHS trust recognises.

- For 2018/19 the NHS trust did not accept its control total of £54.5 million deficit. The NHS trust revised its forecast early in 2018/19 to £89.4 million deficit but reported a better position of £88.2 million deficit excluding PSF on a turnover of £447 million (19.7%) at the end of the year.
- A combination of factors contributed to the non-achievement of the plan. The NHS trust did not achieve its planned cost improvement target, and it incurred significant pay cost pressures due to use of temporary staff (at premium rates) to cover vacancies.
- In 2018/19, the NHS trust underperformed against its cost improvement plan, achieving only £18.89 million (3.39% of expenditure) against a plan of £27.6 million plan (5.08% of expenditure). The NHS trust did not have in place the infrastructure required to ensure implementation of initiatives, tracking of benefits and management of delivery risks. This resulted into substantial slippages early in the year, triggering the reforecast. Because of this and other workforce cost pressures, the NHS trust pay expenditure exceeded budget by £17.8 million (5.5%).
- The NHS trust's financial plan for 2019/20 is control total complaint. The NHS trust is planning for a deficit of £70.3 million (14.88% of turnover) before PSF, FRF and MRET and £41.4 million with the funding (8.26% of turnover). Delivery of this plan depends on achieving a £25.6 million efficiency target.
- As at May 2019, the NHS trust is reporting achievement of its year to date plan, however the position has benefited from technical adjustments and the NHS trust has identified risks to achieving its control total. This is due to delays development of schemes to cover the full efficiency target, and slippages in implementation of the schemes that have been developed, such as theatres and premium agency cost reduction. The NHS trust is reporting £16 million of efficiency schemes as developed to the highest level of maturity, and the year to date delivery is £1.12 million against plan of £2.06 million, with the shortfall covered by non-recurrent technical adjustments.
- The NHS trust is strengthening its efficiency delivery infrastructure through implementing a new divisional management structure and reinforcing ownership and accountability of

plan delivery through more robust performance management. The NHS trust has also developed transformation programmes in theatres, outpatients and endoscopy services, where it expects to improve productivity through better utilisation of its facilities and workforce. However, the new divisional structures were still embedding at the time of the assessment.

- The NHS trust has not developed a medium-term plan to return financial balance. This is pending completion of the clinical services strategy and the enabling workforce and support services strategies. However, the NHS trust identifies £30 million of its current deficit as structural and out of its control, because of its current multisite provision of services which would require significant capital investment to address.
- The NHS trust achieved its income plan for 2018/19. It improved its activity capture and income billing processes, which benefited the financial position in the latter part of the year. The NHS trust does not have any material commercial income streams, however it is exploring commercial revenue opportunities and has invested in its car parking payments solution to improve recovery of income.
- Due to its historical deficit position, the NHS trust is reliant on cash support in the interim to consistently meet its financial obligations, make capital investments and maintain its positive cash balance. At the time of the assessment, the total loan balance for both capital and revenue borrowing was £314.7 million and this is expected to increase to £373 million in 2019/20.
- This NHS trust is not meeting the public sector better payment practice code (BPPC) target of 95%. For May 2019, the NHS trust is reporting payment of 70.1% invoices by number and 70.1% invoices by value within 30 days.
- Service line reporting is currently not used by the NHS trust. It recognises the requirement to improve internal financial reporting and is procuring a new finance system to support this.
- For 2018/19, the NHS trust reported expenditure of £3.7 million on external consultancy support. the NHS trust commissioned external consultancies to support the development of workforce and service productivity improvement programmes, including theatre and outpatient facilities utilisation, and improvements in activity capture processes to support better income recovery. The benefit reported, which is mainly against income recovery amounts to £6.4 million

Outstanding practice

None identified

Areas for improvement

We have identified scope for improvement in the following areas:

- The NHS trust should continue working to ensure optimisation of substantive workforce through its workforce deployment solutions,
- The NHS trust should continue working to reduce sickness absences, improve retention rates and reduce dependence on temporary staffing.
- This NHS trust should continue working to achieve further efficiencies from collaborative working with partners in its clinical and support services.
- The NHS trust should reduce the high cost of delivering imaging services and continue working towards improved performance in all areas.
- The NHS trust should continue focusing on building internal capacity and capability to deliver NHS trust wide workforce and service productivity improvements.
- The NHS trust should ensure the improvements that they make in pathways results in improvement in the delivery of constitutional targets. There is a significant amount of work taking place, but delivery remains inconsistent and performance against the national 4-hour A&E target continues to worsen.
- The NHS trust should continue working to ensure improvement in performance against operational standards
- Continuous improvement of procurement process efficiency is still required to achieve competitive prices and drive down cost of purchases.
- The NHS trust should continue addressing the high maintenance backlog and complete its estates strategy.
- The NHS trust should work towards securing the efficiency opportunities within Soft facilities management.

Use of Resources report glossary

Term	Definition
18-week referral to treatment target	According to this national target, over 92% of patients should wait no longer than 18 weeks from GP referral to treatment.
4-hour A&E target	According to this national target, over 95% of patients should spend four hours or less in A&E from arrival to transfer, admission or discharge.
Agency spend	Over reliance on agency staff can significantly increase costs without increasing productivity. Organisations should aim to reduce the proportion of their pay bill spent on agency staff.
Allied health professional (AHP)	The term 'allied health professional' encompasses practitioners from 12 diverse groups, including podiatrists, dietitians, osteopaths, physiotherapists, diagnostic radiographers, and speech and language therapists.
AHP cost per WAU	This is an AHP specific version of the pay cost per WAU metric. This allows NHS trusts to query why their AHP pay is higher or lower than national peers. Consideration should be given to clinical staff mix and clinical staff skill mix when using this metric.
Biosimilar medicine	A biosimilar medicine is a biological medicine which has been shown not to have any clinically meaningful differences from the originator medicine in terms of quality, safety and efficacy.
Cancer 62-day wait target	According to this national target, 85% of patients should begin their first definitive treatment for cancer within 62 days following an urgent GP referral for suspected cancer. The target is 90% for NHS cancer screening service referrals.
Capital service capacity	This metric assesses the degree to which the organisation's generated income covers its financing obligations.
Care hours per patient day (CHPPD)	CHPPD measures the combined number of hours of care provided to a patient over a 24-hour period by both nurses and healthcare support workers. It can be used to identify unwarranted variation in productivity between wards that have similar speciality, length of stay, layout and patient acuity and dependency.
Cost improvement programme (CIP)	CIPs are identified schemes to increase efficiency or reduce expenditure. These can include recurrent (year on year) and non-recurrent (one-off) savings. CIPs are integral to all NHS trusts' financial planning and require good, sustained performance to be achieved.
Control total	Control totals represent the minimum level of financial performance required for the year, against which NHS trust boards, governing bodies and chief executives of NHS trusts are held accountable.
Diagnostic 6-week wait target	According to this national target, at least 99% of patients should wait no longer than 6 weeks for a diagnostic procedure.

Did not attend (DNA) rate	A high level of DNAs indicates a system that might be making unnecessary outpatient appointments or failing to communicate clearly with patients. It also might mean the hospital has made appointments at inappropriate times, eg school closing hour. Patients might not be clear how to rearrange an appointment. Lowering this rate would help the NHS trust save costs on unconfirmed appointments and increase system efficiency.
Distance from financial plan	This metric measures the variance between the NHS trust's annual financial plan and its actual performance. NHS trusts are expected to be on, or ahead, of financial plan, to ensure the sector achieves, or exceeds, its annual forecast. Being behind plan may be the result of poor financial management, poor financial planning or both.
Doctors cost per WAU	This is a doctor specific version of the pay cost per WAU metric. This allows NHS trusts to query why their doctor pay is higher or lower than national peers. Consideration should be given to clinical staff mix and clinical staff skill mix when using this metric.
Delayed transfers of care (DTOC)	A DTOC from acute or non-acute care occurs when a patient is ready to depart from such care is still occupying a bed. This happens for a number of reasons, such as awaiting completion of assessment, public funding, further non-acute NHS care, residential home placement or availability, or care package in own home, or due to patient or family choice.
EBITDA	Earnings Before Interest, Tax, Depreciation and Amortisation divided by total revenue. This is a measurement of an organisation's operating profitability as a percentage of its total revenue.
Emergency readmissions	This metric looks at the number of emergency readmissions within 30 days of the original procedure/stay, and the associated financial opportunity of reducing this number. The percentage of patients readmitted to hospital within 30 days of discharge can be an indicator of the quality of care received during the first admission and how appropriate the original decision made to discharge was.
Electronic staff record (ESR)	ESR is an electronic human resources and payroll database system used by the NHS to manage its staff.
Estates cost per square metre	This metric examines the overall cost-effectiveness of the NHS trust's estates, looking at the cost per square metre. The aim is to reduce property costs relative to those paid by peers over time.
Finance cost per £100 million turnover	This metric shows the annual cost of the finance department for each £100 million of NHS trust turnover. A low value is preferable to a high value but the quality and efficiency of the department's services should also be considered.
Getting It Right First Time (GIRFT) programme	GIRFT is a national programme designed to improve medical care within the NHS by reducing unwarranted variations.
Human Resources (HR)	This metric shows the annual cost of the NHS trust's HR department for each £100 million of NHS trust turnover. A low value is preferable to a high value but

cost per £100 million turnover	the quality and efficiency of the department's services should also be considered.
Income and expenditure (I&E) margin	This metric measures the degree to which an organisation is operating at a surplus or deficit. Operating at a sustained deficit indicates that a provider may not be financially viable or sustainable.
Key line of enquiry (KLOE)	KLOEs are high-level questions around which the Use of Resources assessment framework is based and the lens through which NHS trust performance on Use of Resources should be seen.
Liquidity (days)	This metric measures the days of operating costs held in cash or cash equivalent forms. This reflects the provider's ability to pay staff and suppliers in the immediate term. Providers should maintain a positive number of days of liquidity.
Model Hospital	The Model Hospital is a digital tool designed to help NHS providers improve their productivity and efficiency. It gives NHS trusts information on key performance metrics, from board to ward, advises them on the most efficient allocation of resources and allows them to measure performance against one another using data, benchmarks and good practice to identify what good looks like.
Non-pay cost per WAU	This metric shows the non-staff element of NHS trust cost to produce one WAU across all areas of clinical activity. A lower than average figure is preferable as it suggests the NHS trust spends less per standardised unit of activity than other NHS trusts. This allows NHS trusts to investigate why their non-pay spend is higher or lower than national peers.
Nurses cost per WAU	This is a nurse specific version of the pay cost per WAU metric. This allows NHS trusts to query why their nurse pay is higher or lower than national peers. Consideration should be given to clinical staff mix and clinical staff skill mix when using this metric.
Overall cost per test	The cost per test is the average cost of undertaking one pathology test across all disciplines, taking into account all pay and non-pay cost items. Low value is preferable to a high value but the mix of tests across disciplines and the specialist nature of work undertaken should be considered. This should be done by selecting the appropriate peer group ('Pathology') on the Model Hospital. Other metrics to consider are discipline level cost per test.
Pay cost per WAU	This metric shows the staff element of NHS trust cost to produce one WAU across all areas of clinical activity. A lower than average figure is preferable as it suggests the NHS trust spends less on staff per standardised unit of activity than other NHS trusts. This allows NHS trusts to investigate why their pay is higher or lower than national peers.
Peer group	Peer group is defined by the NHS trust's size according to spend for benchmarking purposes.
Private Finance Initiative (PFI)	PFI is a procurement method which uses private sector investment in order to deliver infrastructure and/or services for the public sector.
Patient-level costs	Patient-level costs are calculated by tracing resources actually used by a patient and associated costs

Pre-procedure elective bed days	This metric looks at the length of stay between admission and an elective procedure being carried out – the aim being to minimise it – and the associated financial productivity opportunity of reducing this. Better performers will have a lower number of bed days.
Pre-procedure non-elective bed days	This metric looks at the length of stay between admission and an emergency procedure being carried out – the aim being to minimise it – and the associated financial productivity opportunity of reducing this. Better performers will have a lower number of bed days.
Procurement Process Efficiency and Price Performance Score	This metric provides an indication of the operational efficiency and price performance of the NHS trust's procurement process. It provides a combined score of 5 individual metrics which assess both engagement with price benchmarking (the process element) and the prices secured for the goods purchased compared to other NHS trusts (the performance element). A high score indicates that the procurement function of the NHS trust is efficient and is performing well in securing the best prices.
Sickness absence	High levels of staff sickness absence can have a negative impact on organisational performance and productivity. Organisations should aim to reduce the number of days lost through sickness absence over time.
Single Oversight Framework (SOF)	The Single Oversight Framework (SOF) sets out how NHS Improvement oversees NHS trusts and NHS foundation NHS trusts, using a consistent approach. It helps NHS Improvement to determine the type and level of support that NHS trusts need to meet the requirements in the Framework.
Service line reporting (SLR)	SLR brings together the income generated by services and the costs associated with providing that service to patients for each operational unit. Management of service lines enables NHS trusts to better understand the combined view of resources, costs and income, and hence profit and loss, by service line or speciality rather than at NHS trust or directorate level.
Supporting Professional Activities (SPA)	Activities that underpin direct clinical care, such as training, medical education, continuing professional development, formal teaching, audit, job planning, appraisal, research, clinical management and local clinical governance activities.
Sustainability and Transformation Fund (STF)	The Sustainability and Transformation Fund provides funding to support and incentivise the sustainable provision of efficient, effective and economic NHS services based on financial and operational performance.
Staff retention rate	This metric considers the stability of the workforce. Some turnover in an organisation is acceptable and healthy, but a high level can have a negative impact on organisational performance (eg through loss of capacity, skills and knowledge). In most circumstances organisations should seek to reduce the percentage of leavers over time.
Top Ten Medicines	Top Ten Medicines, linked with the Medicines Value Programme, sets NHS trusts specific monthly savings targets related to their choice of medicines. This includes the uptake of biosimilar medicines, the use of new generic medicines and choice of product for clinical reasons. These metrics report NHS trusts' %

	achievement against these targets. NHS trusts can assess their success in pursuing these savings (relative to national peers).
Weighted activity unit (WAU)	The weighted activity unit is a measure of activity where one WAU is a unit of hospital activity equivalent to an average elective inpatient stay.

United Lincolnshire Hospitals NHS Trust

Report to:	Trust Board
Title of report:	Quality Governance Committee Assurance Report to Board
Date of meeting:	22nd October 2019
Chairperson:	Liz Libiszewski, Non-Executive Director
Author:	Karen Willey, Deputy Trust Secretary

Purpose	This report summarises the assurances received and key decisions made by the Quality Governance Assurance Committee (QGC). The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board's response. This assurance committee meets monthly and takes scheduled reports from all Trust operational committees according to an established work programme. The Committee worked to the 2019/20 objectives.
	Assurance in respect of SO 1a Issue: Delivering harm free care <u>Source of Assurance: Quality and Safety Oversight Group –</u> The October meeting had been attended by all Divisions with a full agenda that had concentrated on the divisions presenting their issues. The group had been unable to discuss the expert groups in detail and as such discussions would be held to further develop the structure of the meeting to ensure full delivery of the agenda. <u>Source of Assurance: Falls Prevention –</u> The Committee received the report noting that had been the second year of the comprehensive improvement programme. The focus during the past 18 months had resulted in a reduction in falls. A review of the action plan highlighted that a number of actions remain amber however this gave a true reflection of the current position. <u>Source of Assurance: Pressure Ulcers –</u> The Committee noted that there was a Trust wide plan in place however the updated plan had not been attached to the paper. There had been significant work undertaken to reduce pressure ulcers and this had been demonstrated through the reporting. Work had commenced across the system to consider inherited damage and how learning was shared to improve system working. <u>Source of Assurance: Medicines Optimisation Safety Report –</u> The Committee were advised that there had been an upward trend in the number of medication incidents reported however there was a downward trend in relation to incidents causing harm however further work to review the data was requested. Aseptic pharmacy continues to be a concern however the mobile aseptic unit was anticipated to be running by mid-December following the

	commissioning period. The Committee were asked to support the development of the business case for 7 day medicine reconciliation however the Committee were concerned that the 5 day service issues would require resolution prior to 7 day services being considered, including a clear approach to workforce planning across the whole of pharmacy. The Committee reminded the Chief Pharmacist that the Committee's role is not to support business cases. Source of Assurance: QIA. – The Quality Impact Assessment process was becoming more refined and the Committee were presented with 2 QIAs. The Lincoln reconfiguration remained a work in progress and the Committee discussed the introduction of a swing ward and the resizing of wards to support the reconfiguration. The Committee were disappointed that there had not been any baseline measures included within the report and requested sight of the totality of the scheme including the embedding of patient experience and coproduction. The EMAS Rapid Handover demonstrated that the protocol had been developed and risk assessed jointly with the Trust and EMAS. Both organisations had recognised the system risks associated with the rapid handover and mitigation would be in place to ensure that the Trust did not reach level 3. It was anticipated that this would go live on the 4th November. The Committee requested sight of the QIA. Source of Assurance: Incident Management – The Committee received the report noting that the number of incidents was decreasing within normal distribution. The Committee were assured that the number of divisional investigations was being managed and that these were being brought under control. Duty of candour was noted as stable with increased support being put in place to ensure reporting continued to improve. Source of Assurance: Risk Report – The Committee received the risk register noting that there had been no change. The Committee noted that there were a number of risks that were overdue and requested that these were reviewed and updates.
	Assurance in respect of other areas:- Quality Governance Performance report – The Committee received the dashboard noting that some September data had not been populated. The Committee were advised that discussions had taken place to ensure that data was populated for reporting to the Committee. The Committee

	requested that these areas were populated prior to the performance report being submitted to the Board. Completed SI Reports for Never Events – A new process had been put in place which would ensure that the Committee had sight of the completed Serious Incidents/Never Event investigations on the high profile care report. Once approved and submitted to the Commissioners these would be presented to the Committee. Quality and Safety Improvement Plan – The Committee received the plan noting that it was now being updated to reflect the outcome of the recent CQC report. Ward Accreditation, Lancaster – The Committee received the ward accreditation for Lancaster Ward which detailed the position of the ward, issues faced and the detail to support the improvement. The Committee were advised that a critical issue for the ward was staffing and correlated to the discussions held regarding right sizing. The ward were progressing well against the action plan. The Committee noted that they had not had sight of the action plan and this would have been helpful to understand and see progress against the issues. Moving and Handling Report – The Committee had sought clarity on moving and handling from the Finance, Performance and Estates Committee (FPEC). It was clear that FPEC were not assured and that there remained a significant finding against the Trust that had not been discharged. Flu Vaccination Best Practice – The Committee received the completed NHS Improvement/England self-assessment against best practice that had been completed. Actions from the past year had been replicated due to the success of the programme with additional actions being included. The Trust were experiencing challenge currently due to the delays and staged approach to the issuing of vaccinations. The Committee noted that the Board would require sight of the self-assessment and recommended that this be reported to the Board. Internal Audit Medicines Reconciliation action report – The Committee noted the updated action plan and discussed the action relating to the business case for additional personnel, all actions required updating. The Committee requested the support of the Chief Pharmacist to ensure that any actions associated with the CQC report were implemented swiftly. NHS Improvement Observation action plan – The Committee received the action plan requesting that this was received quarterly by the Committee. Actions should be upwardly reported from those groups responsible for delivery.

	The Committee noted that the biggest governance risk was the Medicines Optimisation and Safety Group, there was a degree of urgency to ensure delivery of the actions identified. CQC Report – The committee received a paper outlining the planned approach to managing the findings off the CQC. This included alignment to governance arrangements including the divisions and a clear hold to account through QSOG to QGC. Evidence of outcomes was requested by the Committee and a clear intention that all updates should be subject to internal scrutiny before external reporting. A greater engagement across all of the Executive Team had been proposed which was supported by the committee. The Committee discussed the requirement from the Committee to the Board noting that detailed reporting would continue in light of the findings. The Committee recommended greater detail to be reported to the Board on a regular basis to support accelerated actions and oversight.
Issues where assurance remains outstanding for escalation to the Board	Board are asked to review the new approach to responding to the findings of the CQC and the request for increased board review.
Items referred to other Committees for Assurance	The Committee referred the monitoring of the CQC Use of Resources report to the Finance, Performance and Estates Committee
Committee Review of corporate risk register	The Committee reviewed the risk register noting that there had been no major changes to the document.
Matters identified which Committee recommend are escalated to SRR/BAF	The Committee noted that the Board Assurance Framework had been reviewed since the last meeting. The Committee rated the assurances which were the responsibility for the Committee, both remain Amber, which would be escalated through the Board Assurance Framework
Committee position on assurance of strategic risk areas that align to committee	The Committee considered the reports which it had received which provided assurances against the strategic risks to strategic objectives.
Areas identified to visit in dept walk rounds	No areas identified.

Attendance Summary for rolling 12 month period

Voting Members	N	D	J	F	M	A	M	J	J	A	S	O
Elizabeth Libiszewski Non-Executive Director	X	X	X	X	X	X	X	X	X	A	X	X
Chris Gibson Non-Executive	X	X	X	X	X	A	X	X	A	X	A	X

Agenda Item 12.1

Director												
Alan Lockwood Int Non-Executive Director	X	A	X	A	A							
Michelle Rhodes Director of Nursing	X	X	X	X	X	X	X	X	X	X	D	
Neill Hepburn Medical Director	X	X	X	X	X	X	D	X	X	X	X	X
Victoria Bagshaw Director of Nursing												X

X in attendance
A apologies given
D deputy attended

United Lincolnshire Hospitals NHS Trust

Report to:	Trust Board
Title of report:	Finance, Performance and Estates Committee Assurance Report to Board
Date of meeting:	24 October 2019
Chairperson:	Gill Ponder, Non-Executive Director
Author:	Karen Willey, Deputy Trust Secretary

Purpose	This report summarises the assurances received and key decisions made by the Finance, Performance and Estates Committee (FPEC). The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board's response. This assurance committee meets monthly and takes scheduled reports from all Trust operational committees according to an established work programme.
Assurances received by the Committee	**Lack of Assurance** in respect of SO 2b Providing Efficient and Financially Sustainable Services Issue: Financial Position including Financial Efficiency Programme Reason for lack of assurance: The Committee were advised that at Month 6 the Trust were reporting in line with plan. The reported position is inclusive of the Lincolnshire CCGs support acknowledging the cost pressures the Trust is experiencing driven by the significant levels of NEL activity above plan and the associated impact on the Trust efficiency programme. The system are working together to maximise the financial support from PSF and FRF monies and also to manage and take collective responsibility for patient demand. There is a risk that if unchecked the activity pressures could undermine delivery of the Trust Cost Improvement Programme in the remaining months of the year and ultimately the Control Total, leading to a loss of future cash available to the Trust and the system. The financial plan included repatriation of circa £5.7m of non-elective activity, but there was insufficient bed capacity due to the high level of non-elective demand. Pay remained a key pressure for the Trust reporting at £7.2m above plan. Bank and agency staff pay continued to be adverse to plan, with little improvement in the underlying run rate. The recent move to a new agency staff provider had led to lower rates and should reduce the reliance on high paid agency staff. It was not yet known if the move to an alternative provider would have the desired impact, but there was potential for a reduction in costs of circa £2.5m. A number of Financial Efficiency schemes had still not progressed to financial delivery. Accountability for the delivery of the schemes was

	through PRMs held with the divisions. The Committee remained concerned about the year end outturn forecast, which was a worst case of £87.7m. This was the unmitigated figure, but it included the delivery of the risk adjusted FEP. The Committee raised concerns about CQUIN income, as it had been reported as £250k of non-delivery. The Committee were advised that the lead for CQUIN delivery had confirmed that all CQUINs were on track for full delivery. The Committee were advised that there was no capital borrowing required in December, but were asked to support the request to the Board for revenue borrowing of £5.553m in December 2019. This amount was in line with the financial plan and the Committee recommended approval by the Board. Action requested by the Committee: The Committee asked the Executive Team to provide assurance that the FEP would be delivered by year end.
	Lack of Assurance in respect of SO 2b Providing Efficient and Financially Sustainable Services Issue: Reference Costs Reason for lack of assurance: The Committee raised concerns in relation to the completion of job plans and the activity being carried out by Consultants and SAS Doctors. The Committee were advised that the Executive Team had received a paper regarding job planning and the sign off of job plans. This information would be reported to the Committee to provide further assurance. Action requested by the Committee: The Committee requested that the progress of job planning be reported in order to gain assurance that action was being taken to bring the Trust's costs into line with others.
	Assurance in respect of SO 2b Providing Efficient and Financially Sustainable Services Issue: Financial Strategy The Committee received the Financial Strategy noting that this would need to be reviewed in light of the CQC Use of Resources report that had been published for the Trust. The Committee noted that the Acute Services Review had been omitted from the strategy and would require inclusion. It was noted that the managed equipment service had not been discussed

	in detail but was included in the strategy as this was actively being scoped. The financial impact of a programme to review and replace equipment would require detailed scrutiny. Action requested by the Committee: The Committee requested that consistent delivery of financial plans each year was included in the strategy, along with the other items above.
	Assurance in respect of SO 2b Providing Efficient and Financially Sustainable Services Issue: 2020/2021 Planning The Committee held discussions regarding the 2020/21 planning process proposal, noting concerns that the timescales did not appear to align with the system. It was also noted that the Business Planning Steering Group would require appropriate representation. The Committee supported the proposed planning process, subject to alignment with system timescales
	Lack of Assurance in respect of SO 2b Providing Efficient and Financially Sustainable Services Issue: Estates Update Reason for lack of Assurance: The Committee received the upward report from the Estates Group, noting that the report did not identify those areas that were assured or not assured. However, based on the report the Committee did not raise any concerns. The manual handling report provided a forward plan of work and the Health and Safety Executive and British Safety Council had reviewed the plan and were satisfied with the work to date, describing the programme as an exemplar training system for moving and handling. 150 training sessions had been scheduled to take place each month to ensure compliance. The Committee identified that assurance had still not been received that there were systems in place to provide assurance that managers were exercising their responsibilities to monitor and supervise staff's compliance with safe systems of work after their training. The Committee received the confined spaces report noting the progress against the HSE Improvement and Prohibition Notice for Confined Spaces Working. Evidence of compliance in most areas had been submitted to the HSE, but further evidence was needed to demonstrate compliance with the requirement to provide rescue training. Training would be completed by the end of October and evidence submitted. Concern was raised by the Committee in relation to Fire Safety and the

	cost pressure of £1.5m in relation to security requirements related to lock down which would have to be absorbed within the future maintenance programme. The Committee were assured that progress with the fire safety plans was on track and that the requirements to provide lock down facilities are not expected to affect compliance with the fire enforcement notice requirements. The Committee received the critical infrastructure paper. Positive movement had been seen in the Estates and Facilities Statutory Backlog Maintenance Risk dashboard, but lack of available funding meant that there were still a number of areas where the Trust was non-compliant with all statutory responsibilities, especially in relation to backlog maintenance of mechanical infrastructure. To comply with all planned preventative maintenance requirements would cost, subject to ongoing validation an anticipated£12m per annum. The Trust was currently investing £4m per annum. The Committee received the Progress Housing update, noting progress with the actions agreed by the Committee. Action requested by the Committee: The Committee requested a review of the red risks relating to mechanical critical infrastructure, identifying the risk to the organisation of enforcement notices.
	Lack of assurance in respect of SO1 Providing Consistently Safe, Responsive, High Quality Care Issue: Pilgrim Hospital Urgent Care Project The Committee were advised that a full business case would be required in order to access the funding awarded for the expansion of the Resuscitation Area and Urgent Treatment Centre at Pilgrim. The Committee did not approve the paper for onward submission to NHS England/Improvement for the consultancy fees. A conversation would be required with NHS England/Improvement to understand the process for accessing funds to support the initial building design consultancy work required to start the project. Action requested by the Committee: The Committee requested clarification of the process to access funding at each stage of the project.
	Assurance in respect of SO1 Providing Consistently Safe, Responsive, High Quality Care Issue: EU Exit The Committee received the EU Exit update, noting that the contingency planning had utilised the national proforma of risk. The overall level of risk remained high, with the main risk for the Trust being medicine supply, but

	national contingency plans were in place.
	Assurance in respect of SO1 Providing Consistently Safe, Responsive, High Quality Care Issue: Winter Planning The Committee received the Winter Plan, noting that the Trust would not open additional beds or create additional capacity during the Winter period. The plan had been developed on schemes that were known to have worked and were currently having a positive impact. The plan had been discussed with both regional and national teams, who had supported the approach being taken by the Trust. The Committee noted that if bed capacity was not increased there could be a risk of longer waits for access to beds. The plan factored in the increased demand factor and the bed deficit described was the peak deficit. The Trust ambition was to achieve 92% occupancy which included the maximising of Grantham for elective work. The plan would be updated and re-issued once the local Council plans were included. The Committee received and endorsed the plan.
	Lack of assurance in respect of SO1 Providing Consistently Safe, Responsive, High Quality Care Issue: Urgent and Emergency Care Improvement Programme and Referral to Treatment Reason for lack of Assurance: The Committee were advised that the Trust were the 7th most improved organisation in the country and that a circa 7% improvement in Urgent Care had been seen, but trajectory had still not been achieved. September had been a positive month and had shown expected improvements, but the Committee were advised that there had already been a significant deterioration during October. This had resulted in an increase in bed occupancy. Referral to treatment and 52 week performance had not been as positive as planned. The Trust had managed to keep 52 week breaches to 3 reported during August and 1 in September. However, this was a zero tolerance indicator and dialogue had taken place with NHS England/Improvement to mitigate the risks moving forward. Action requested by the Committee: The Committee requested an update on the impact of the improvement activities underway.
	Lack of Assurance in respect of SO1 Providing Consistently Safe, Responsive, High Quality Care

	Issue: Delivery of Cancer Performance Reason for lack of Assurance: The Committee were advised that the Trust had achieved 3 of the 9 cancer standards during August, comparable to national performance. There had been a deterioration of the 62 day performance, but the Trust had improved the 62 and 104 day backlogs. This enabled an opportunity for improved performance in future months. Action requested by the Committee: The Committee requested further details of the revised improvement action plan.
	<u>Assurance in respect of other areas:</u> <u>Committee Dashboard:</u> The Committee received the dashboard, noting that there remained gaps in the data reported. The Committee requested that the data was fully populated in future reports, but understood that the current month's data may not be available at the time of report production. <u>Risk Deep Dive – Quality of the Hospital Environment:</u> The Committee received the risk deep dive relating to the quality of the hospital environment, noting that in order for improvements to be seen investment was required. A proposal for a PLACE Care Environment steering group was being developed within the Trust in order to support the required improvements. Working groups would be established and the reporting metrics would be included within the Estates updates to the Committee. The Committee requested a clear plan, with key milestones, to enable assurance to be obtained. <u>Board Assurance Framework:</u> The Committee undertook a thorough review of the content of the Board Assurance Framework identifying a number of updates required and confirming the assurance ratings. The framework would be updated following discussions and presented to the November Board. <u>Internal Audit:</u> The Committee received the Data Quality Diagnostics internal audit report and requested that regular updates were presented to the Committee on progress with completion of the identified actions.
Issues where assurance remains outstanding for escalation to the Board	None

Items referred to other Committees for Assurance	The Committee requested that the Workforce, Organisational Development and Transformation Committee continued to monitor the Time To Hire update provided to the Committee in order to demonstrate the impact of actions on improving the filling of substantive vacancies that would lead to a reduction in the cost of temporary staff.
Committee Review of corporate risk register	The Committee received the corporate risk register and noted that there had been no material change to the corporate risk profile or very high and high risks.
Matters identified which Committee recommend are escalated to SRR/BAF	The Committee was assured that the SRR/BAF was reflective of the key risks in respect of the strategic objectives of the organisation. Assurances received were noted and updates would be made to the BAF to reflect discussions.
Committee position on assurance of strategic risk areas that align to committee	As above
Areas identified to visit in dept walk rounds	None

Attendance Summary for rolling 12 month period

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

X in attendance A apologies given D deputy attended

Agenda Item 13.2

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

Title:	**EU Exit Contingency Planning Report**

Responsible Director: Mark Brassington, Chief Operating Officer

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

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

The Report is provided to the Committee for:

Decision		Discussion	✓
Assurance	✓	Information	✓

Summary/Key Points:

- The UK Government is putting contingency plans in place at a national level, in the event that the UK leaves the EU in 2019 without a deal in place
- Plans for the UK to leave the EU on 31st October 2019 have now been delayed; at the time of reporting, a flexible extension has been agreed in principle by the EU until 31st January 2020, which means that the UK may leave earlier than that date if all necessary arrangements are in place
- The Trust has set up an EU Exit Contingency Planning Group, chaired by the Chief Operating Officer as Senior Responsible Officer (SRO), to oversee contingency planning arrangements and compliance with national and regional requirements
- Included with this report is an updated risk register for EU Exit; the overall level of risk remains High due to the degree of uncertainty with regard to the scale of possible impact
- The highest risk areas for the Trust remain as follows:
    - **medicines supply** (due to reliance on supply for the EU and the scale of potential impact) – a national Memorandum of Understanding has been developed to support transfer of medicines between providers if needed;
    - **medical devices and consumables** (due to reliance on supply from the EU of single use consumables and spare parts for devices in Cardiology and Radiology);
    - **workforce** (due to the range of ways in which the workforce may be affected, with an emerging concern that DBS check for a European national maybe subject to a long delay);
    - **finance** (capacity to deal with a potential increase in overseas visitor screening and billing/payment processing

Agenda Item 13.2

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

1. Purpose of Report

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

2. Background

2.1 Plans for the UK to leave the EU on 31st October 2019 have now been delayed; at the time of reporting, a flexible extension has been agreed in principle by the EU until 31st January 2020, which means that the UK may leave earlier than that date if all necessary arrangements are in place

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

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

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

2.5 A National Response Centre and 7 Regional Centres have been set up, with a daily SitRep process in place from Monday 21st October. It is anticipated that any potential impact is likely to occur 6-8 weeks after EU Exit.

3. Recommendations

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

4. ULHT contingency planning

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

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

- Medicines supply (due to reliance on supply for the EU and the scale of potential impact) – a national Memorandum of Understanding has been developed to support transfer of medicines between providers if needed;
- Medical devices and consumables (due to reliance on supply from the EU of single use consumables and spare parts for devices in Cardiology and Radiology);
- Workforce (due to the range of ways in which the workforce may be affected, with an emerging concern that DBS check for a European national maybe subject to a long delay) – a Memorandum of Understanding has been agreed for staff sharing within Lincolnshire
- Finance (capacity to deal with a potential increase in overseas visitor screening and billing/payment processing)

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

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

- Potential for issues with traffic in the north of the county towards Scunthorpe due to Operation Wellington (the multi-agency response to possible delays at the Humber Ports) which may impact on the supply chain; escalation arrangements are being discussed with Northern Lincolnshire & Goole NHS Foundation Trust (NLAG)

4.5 A copy of the latest letter from the Chief Commercial Officer of the DHSC is attached for information as **Appendix II**.

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

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

Appendix I - EU Exit Risk (October 2019)

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

Department of Health & Social Care

Steve Oldfield
Chief Commercial Officer
Second Floor South, 39 Victoria Street, SW1H 0EU

By email
8th October 2019

Dear Colleagues,

I am writing to update you on the Government's contingency planning to get ready for Brexit on 31 October 2019, and to provide more operational details of several elements of these plans:

- NAO Report: *"Exiting the EU: supplying the health and social care sectors"*
- Government-secured freight capacity
- Department of Health and Social Care's Express Freight Service procurement
- How to register for the Government freight contingency measures – all recipients of this letter should register
- Trader readiness and additional measures to support industry

On 26th June, I wrote to you to inform you of our multi-layered approach to support the continued supply of medicines and medical products, one element of which was to support supplier rerouting through two freight procurements. Ministers and the Department recognise, and are extremely grateful for, the work that suppliers of medicines and medical products and sponsors of clinical trials and clinical investigations have continued to do since 26th June and would like to thank you once again for your collaboration and efforts.

The Department continues to work alongside our stakeholders including industry, Royal Colleges, charities, patient groups and the NHS. This includes the Devolved Administrations (DAs), (DHSC and the DAs have jointly formed a 'Supply Forum', which meets fortnightly to focus on information sharing at a senior level relating to the continuity of supply of medicines and medical products), Crown Dependencies and Gibraltar.

NAO Report

I would like to welcome the recent report from the National Audit Office (NAO) into the Department's preparations in the event that the UK leaves the EU without a deal. I am pleased that the NAO recognised the enormous amount of work already done by the Department, and our industry partners, in preparation for leaving the EU. To supplement this, government and industry continue to work together to enhance our knowledge of supplier readiness and needs.

We firmly believe our preparations and multi-layered approach remain necessary to support the continued supply of medicines and medical products if the UK leaves the EU without a deal. Our latest data collection exercise and supplier assurance process show that:

- 96% of medicines suppliers within scope of the programme have responded;
- this represents 98% of the market;
- 82% of products within scope have a 6-week stockpile in place;

These numbers are constantly rising and will do so until 31st October, providing an ever-clearer picture and even greater levels of assurance.

Government-secured freight capacity

Further to my letter of 26th June and the possibility of significant disruption at the short Strait for up to six months, the Government is procuring additional freight capacity away from terminals and ports forecast to have the most disruption. This will be available as an alternative supply route for companies moving all priority goods into the UK including medicines and medical products which have been prioritised for use of the Government-secured freight capacity.

The Government is securing capacity from freight operators and these will be sold at market rates to suppliers of 'Category 1' goods. The Call Off mini-competitions to secure capacity from the freight capacity framework began on 20th September and the Department for Transport (DfT) intends to award contracts in mid-October. At this point DfT will announce the routes and terminals available. The process for securing capacity will be similar to last time. Access to the Government-secured freight capacity will be via tickets; there will be no 'turn up and go' access. Tickets will be available for purchase after the Call Off contracts have been awarded

If you wish to access the Government-secured freight capacity you will need to register. Details of how to register are included below.

Express Freight Service procurement

The DHSC is, in addition, seeking to procure an 'express freight service' to provide access to an end-to-end solution able to deliver small consignments on a 24-hour basis and a two-to-four-day pallet delivery service. This is designed to be used only if suppliers' own contingency measures encounter difficulties or there is an urgent need for specific medicines or medical products. The bid response window for this procurement has now closed and we are currently reviewing the bids. Again, we are looking to award the contract(s) in early October subject to the relevant approvals.

To enable products to be channelled through this logistics route at short notice, it is necessary that we have received and verified a range of information from suppliers, by means of an Express Freight Service registration process. Registration does not constitute a commercial agreement and does not commit the supplier to use this contingency or provide any guarantee that the DHSC will grant access to this contingency arrangement.

While we recognise that you may have full confidence in your own contingency measures and may feel that you would not need to call on this arrangement, **we encourage all suppliers to register as an important element of their preparedness arrangements** so that products can be moved quickly and efficiently in the event that this additional contingency needs to be deployed.

How to register for the Government Secured Freight Capacity and Express Freight Service

Suppliers will need to register online to be eligible for access to both the Government-secured freight capacity and Express Freight Service, regardless of whether they registered last time. Previous registrations for Government secured freight options were carried out on a different registration system and to streamline the process during this registration period we are using the same system for access to both the Government-secured freight capacity and the Express Freight Service contingency measures. Suppliers should complete the relevant form at https://ship.mixmove.io/registerfreightservice. Please note the following guidance:

- We recommend that the form is completed by colleagues working on the supply chain.
- Suppliers should aim to register by the **16th October** to allow good time for processing
- Following successful registration, an access code will be provided to you within 2 working days

- The access code will enable the purchase of freight capacity from the week commencing mid-October. For the Government secured freight capacity, you will also need to instruct your hauliers to complete the Haulier Registration process.
- Further guidance will be distributed in mid-October with further information on the process for accessing capacity on to the Government-secured capacity and Express Freight Service.
- Registration does not constitute a commercial agreement to purchase the capacity, but it will form the basis of the Department's future contact with suppliers and their logistics providers about the ticketing process.
- If you do not believe you will require, or are unsure, whether you will require use of the Government-secured capacity, please continue with registration and provide comments to indicate this during the registration process.
- If you choose to not respond it will not preclude you from later registering for the freight capacity, although we encourage you to respond early as this will assist the Department in ongoing contingency planning.
- The Department will be holding a webinar to provide practical support on how to register. Further details on how to join will follow.

Please be assured that any data provided will be handled in confidence and is protected in law through the General Data Protection Regulation (GDPR), the Data Protection Act 2018 (DPA 2018) and the Law Enforcement Directive. Information provided in the registration process will be held securely on behalf of DHSC by its appointed agents and used only for the purpose of enabling shipments via the Government-secured freight capacity and Express Freight Service.

Trader readiness and additional measures to support industry

The Department's multi-layered approach includes an ask of companies to be trader ready – ready for new customs and border arrangements that will come into place from Day One, if the UK leaves without a deal. To support industry further in their preparations, we are announcing that, following engagement and feedback with trade associations, suppliers and distributors, we will establish a dedicated trader readiness unit to support the health and social care sector. With this important step the Department re-affirms its support for industry, provides practical guidance to logistics providers and enhances the level of assurance we can provide the NHS and patients ahead of 31st October. The contact email address for the team is: BeTraderReady@dhsc.gov.uk.

These teams of specialists will be able to provide up-to-date advice and practical guidance on the steps they need to take to be ready for new customs and border arrangements from day one, if the UK leaves the EU without a deal. These teams will be working closely with both HMRC and the Border Delivery Group to ensure advice and guidance provided is grounded in the latest planning assumptions and the latest advice for traders.

The Department is committed to working closely with industry, through trade bodies and representatives, so that our contingency plans work effectively for patients and care providers across the UK, and that we can be as prepared as possible in advance of Brexit.

In the meantime, should you have any questions, please contact the workstream relevant for your sector directly at one of the following email addresses:

- Medicines: medicinescontingencyplanning@dhsc.gov.uk
- Medical Devices and Clinical Consumables: mdcc-contingencyplanning@dhsc.gov.uk
- Clinical Trials: ctcontingencyplanning@dhsc.gov.uk
- Vaccines and Countermeasures: Immunisation-MB@dhsc.gov.uk
- Blood and Transplants: transplants@dhsc.gov.uk

- Non-Clinical Goods and Services: contractreview@dhsc.gov.uk

I urge all suppliers to give full consideration to the contingency measures set out in this letter and take the necessary steps to ensure your organisation is registered through the system outlined above. Thank you in advance for your continued cooperation with this important work.

Yours faithfully,

Steve Oldfield
Chief Commercial Officer

United Lincolnshire Hospitals NHS Trust

To:	Trust Board
From:	Simon Evans, Director of Operations
Date:	5 November 2019
Healthcare standard	Urgent Care Constitutional Standards

Title:	ULHT Winter Plan – Version 2.8

Author/Responsible Director: Michelle Harris, Deputy Director of Operations – Urgent Care/Simon Evans, Director of Operations / Mark Brassington, Chief Operating Officer

Purpose of the report: To provide Trust Board with the ULHT proposed Winter Plan.

The report is provided to the Board for:

Decision		Discussion	X
Assurance	X	Information	

Summary/key points:

- The Winter Plan details the processes and systems in place or in development to assure our ability and capability to respond to winter pressures, keep our patients safe and respond to the well-being of our staff.
- This plan does not currently include the Lincolnshire County Council seasonal schemes. The next iteration of the plan will include these.
- The Plan details Urgent and Elective care provision across the three acute sites
- The Plan aligns to the recently published System Wide winter plan intentions
- The Plan contains scheme level details and performance impact
- The Plan has considered the impact of staff well-being and resilience
- The plan describes in particular the arrangements over the Festive Period.
- This Plan is draft and is incomplete without the full details of System wide support structures, therefore at this time, offers only limited assurance.

Recommendations:

- Trust Board are asked to note the completion of this winter plan substantially complete and with mitigation for known demands.
- Trust Board are asked to note specifically the gaps currently identified (sign off of LCC seasonal demand schemes)

Strategic risk register - Management of emergency demand (corporate) (4175)	**Performance KPIs year to date** All Urgent and Elective Care metrics 'Zero Wait' indicators

Resource implications (eg Financial, HR) – Multiple divisional implications with

engagement from divisional areas in improvement schemes.
Assurance implications – Assurance is required for implementation of a winter plan programme at system level. Urgent and Emergency Care Delivery Board system plan has been signed off.
Patient and Public Involvement (PPI) implications – Communications plans associated at Trust and System level detail the engagement of public and staff required for the success of this plan. In particular the impact of patient choice during peak demands on acute hospital services.
Equality impact – No equality impact identified
Information exempt from disclosure – No
Requirement for further review? Yes

NHS
United Lincolnshire Hospitals
NHS Trust

United Lincolnshire Hospital NHS Trust

Draft Winter Plan 2019/20

V2.8

16/10/2019

Contents

Introduction

The Trust wide Winter Plan sets out the organisations arrangements for the winter period. The plan sits as part of the wider Lincolnshire system plan and as such may reference other provider plans (such as LCHS) where there are dependencies.

Winter is not an emergency or considered an unusual event, but recognised as a period of increased pressure due to demand both in the clinical acuity of the patients and the capacity demands on resources within the trust. In addition, the winter period often brings with it untoward events such as widespread infectious diseases including Norovirus and there is the risk of the onset of the unusual such as pandemic flu. Each year, all sites experience increased pressure in patient flow. The Winter Plan prepares the organisation with support from the Health and Care Community in Lincolnshire.

The Objectives of the plan are:-

- To keep our patients safe at all costs through one of the most challenging times of the year
- To ensure both the well-being and resilience of our staff to enable sustained high quality care delivery not at personal cost
- To focus on admission avoidance schemes and Same Day Emergency Care pathways
- To create the capacity to meet increased demand through 'right sizing' our core bed base
- To link the Trust Winter Plan to the Lincolnshire System Resilience Plan
- To robustly performance manage the Trust and system to maintain quality, activity, safety and experience for patients and staff

Much of this plan echoes the Urgent Care improvement plan currently being implemented throughout Q3-Q4 as part of the Urgent Care Delivery Plan.

These objectives are underpinned by 8 key themes:

- Pre-hospital
- Emergency Department
- SDEC/Ambulatory Care
- Inpatient Flow
- Elective Care Planning
- Discharge & Long Length of Stay
- Community
- Staff Wellbeing and Resilience

1. Context

In August and September 2019 it became very clear that assumptions in anticipated demand had been shown to be a significantly under-estimated. Up to 11% increase in medical emergency admissions versus other emergency (e.g. Trauma, Paediatric etc.) presented a significant challenge on the bed base, as well as a risk on the urgent care pathway with exit block for A&Es. In addition to this, certain assumptions about discharge (including DTOC) have been made that have an increased risk based on actual rates experienced, especially at Lincoln County.

The Plan describes extensive work undertaken, and continuing to be developed across the system to bridge the significant demand versus capacity gap. Particularly the inpatient bed provision at Lincoln hospital which has the greatest deficit of all the acute sites.

This plan will follow the patients' journey in describing actions to be taken through winter and will identify key success factors that will ensure our objectives are delivered. The plan will also consider pre hospital processes that aim to avoid admissions within the urgent care pathway.

A&E Trajectory

A performance trajectory for the 4 hour standard for 2019/20 assumes improvements in process, staffing, physical capacity and aligns with anticipated demand changes over the winter period. The failure to deploy a winter plan before December 2019, has led to much of the September and October period performance being significantly below plan.

Type 1 Trajectory											
Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
	70%	72%	73%	75%	77%	79%	80%	80%	82%	82%	82%	82%

Bed Occupancy Approach

Bed usage fluctuates between around 828 and 941 beds across the organisation with escalation Q1 & Q2 (2019/20). Based on previous year by 804 and 986 beds respectively for the same time period.

		Grantham	Lincoln	Pilgrim	Total
Q1 & Q2 2019-20	Min	45	460	261	828
	Max	96	528	346	941
Q1 & Q2 2018-19	Min	49	422	282	804
	Max	112	518	365	986
2018-19 Overall	Min	49	407	251	732
	Max	112	534	365	986

Forecast demand has been modelled based on anticipated adult bed requirement throughout 2019/20. At a Trust-level the model forecasts a bed shortfall of 120 beds at peak demand based on use of actual levels of experienced admissions, LoS and experience following the Pilgrim Adult bed reconfiguration (Against *core* bed capacity).

Whilst at an aggregated level the pressure is seasonal, the model is forecasting the bed-base to be insufficient throughout 2019/20.

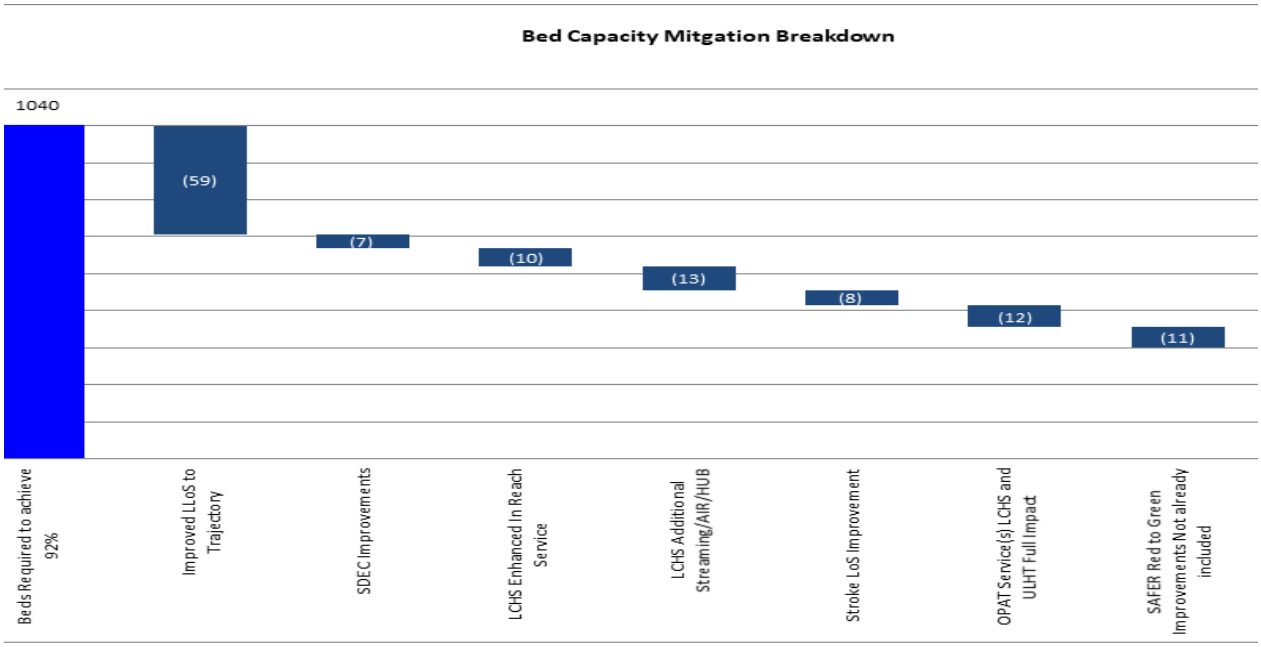
The planned reconfiguration of adult bed allocation at Lincoln County will be particularly pertinent over winter months. In year, experience of bed occupancy has indicated the model to be correct and as determined, throughout summer months, bed occupancy has consistently exceeded the 92% standard set to maintain flow. In the latter parts of August and September 2019, work was undertaken to explore an extended winter system support plan that closed this deficit in order to deliver 92%.

Winter 2019/20 plans expect an increase in bed capacity as a system of c36 - 45 beds. It is anticipated that additional Community beds will be available and staffed from within. Further detail is outlined in section 3.

United Lincolnshire Hospitals NHS Trust

2. Capacity and Demand

The following waterfall chart details the peak bed deficit challenge facing the Trust this year and the schemes in development to mitigate. Overall the Trust requires 1040 inpatient beds to meet peak demand over winter at a level to deliver good urgent care flow. (92% occupancy)



Below outlines the internal improvement schemes that assist in 'closing the gap'. The benefits of these schemes equate to 61 beds. The remaining gap of 59 beds fall must be covered through the System wide schemes that both cover admission avoidance and an 'at pace' release of acute capacity for our 'Medically Fit' for Discharge cohort of patients.

Scheme	Benefit in Beds
Long length of stay patient reduction (the Intensive Support Team supported) LLoS Programme	(59)
SDEC Improvements	(7)
LCHS Enhanced In Reach Service	(10)
LCHS Additional Streaming/AIR/HUB	(13)
Stroke LoS Improvement	(8)
OPAT Service(s) LCHS and ULHT Full Impact	(12)
SAFER Red to Green Improvements Not already included	(11)

Profiling of Elective Activity

The elective activity programme across all divisions has been profiled to account for increased emergency demand from November to 31st March 2020. This profiling will allow the agreed contract to be delivered as planned. Measures are being put in place to avoid medical outliers occupying surgical beds (swing ward) thus reducing the risk to the delivery of contract. In addition, through the reconfiguration at Lincoln the day case facility (SAL) will be protected. Grantham will continue to

deliver a full elective programme throughout Q4, in addition to the transfer of further elective activity from Lincoln.

Emergency Care Capacity

It has been demonstrated following the reconfiguration of the Pilgrim site to realign and right size medical assessment and in patient capacity has dramatically reduced the number of patients cared for outside of the medical bed base. As a result forecast occupancy for Pilgrim Hospital does not include any hospital specific schemes and instead will see the system contribution as detailed in the waterfall chart above. Building on the success of Pilgrim Hospital reconfiguration and following extensive analysis, there is planned a reconfiguration of the Lincoln site. It is anticipated that this will reduce the number of outliers in surgical inpatient beds and afford a better patient experience and a decreased length of stay. From mid-December additional capacity will be created to support emergency care flow as part of the reconfiguration of the Lincoln site.

Christmas & New Year

Elective care programming the week prior to Christmas will incorporate scheduling procedures with longer LOS for the early part of the week, and reducing routine inpatient elective activity by approximately 50% on 21st - 24th December in order to assist with the aim of achieving 80% bed occupancy on Christmas Eve.
Christmas Eve falls on a Tuesday, and low discharges are generally experienced on Tuesday's. It is unlikely that additional staff other than the normal roster will work the 24th. The planning of discharges from Friday the 20th will need to be maximised. This will include additional medical, nursing and pharmacy staffing to ensure patients are ready to go as well as securing increased capacity from transport providers to ensure that demand is matched at this important time.
We anticipate increased pressure on the system and are therefore planning additional support to start from the Thursday 27th – to ease flow and prepare the organisation for the New Year period.

3. Reconfiguration of the LCH Site

The reallocation and reconfiguration of wards at LCH will take place during Q3 and Q4 of 2019/20. The reconfiguration will address the following requirements;

- Appropriate sized assessment units for all urgent care patients to improve patient experience, urgent care flow and performance
- Short stay facilities to manage the majority of patients with 72 hours
- Appropriate sized elective area to protect elective activity and deliver against the GIRFT recommendations
- Co-location of medical same day emergency care unit with ED
- Right sized areas for Specialities
- Creation of flexible capacity (swing ward) to absorb the known increase in demand which will promote organisational resilience whilst maintaining the delivery of safe care to patients. It will also support the protection of ring-fenced beds ie, NIV and Stroke
- Protect and reduce the reliance on the elective bed base therefore reducing the risk of 'on the day cancellation' and the maintenance of elective surgical pathways

4. Enablers– Reinforcing Good Practice

The winter plan considers a set of key enabler schemes that aim to drive quality patient care and experience. They are as follows:

SAFER Patient Flow Bundle –The bundle relates to a series of common sense practises to improve flow in the hospital such as earlier senior review, clear planning for discharge, early flow out of assessment wards to help clear A&E and early discharge. The delivery of SAFER has greatly improved over the last 12 months however two significant areas of improvement will be incorporated into both the urgent care improvement plan and this winter plan.

- Board rounds at weekends – is an area of weakness currently within the trust. The combination of increased medical cover at weekend together with this operating process is anticipated to greatly improve the ratio of weekday and weekend discharges

- Pull from base wards from admissions by 10:00 am is another area of weakness that will be implemented in preparation for winter. The target of pulling a patient for each ward by 10:00 will be incorporated into each wards accreditation and safety checklists. Displayed on every ward it will be a key measure of flow and safety across the trust

- Out of hours reviews and discharges

- *Increased substantive nursing, medical and managerial teams in post*- Will be in place across Q3 into Q4 building on capacity and delivery improvement plans created earlier in the year. These teams will likely decrease the number of agency nurses and doctors in each of the ED departments at PHB and LCH with a possible small increase in substantive staff. Additional managerial posts will be substantive team members and will help strengthen the grip and control of the urgent care pathway throughout the winter months. *(Funded)*

The following schemes have been identified for winter resilience.

- *Enhanced Discharge Lounge Team* – Comprised of Pharmacy Technicians and Porters to facilitate flow of patients throughout the organisation. Proposal being completed.

- *Ambulance Handover* - The Trust works closely with EMAS to improve handover times and the impact that ED overcrowding and pressure can have on released ambulance crews in a timely way. A recently proposed escalation process has been agreed with EMAS regarding >60 mins to 90 mins handover delays. We are currently working through the risk share impact. The use of Rapid Assessment and Initial Triage (RAT) across the EDs has greatly improved handover times over the past year 12 months. This process is still maturing and will continue to improve. 24 hour RAT and PHP is now routine at both LCH and PHB. A series of change cycles (PDSA) are in train and will seek to deliver a sustained improvement across the winter months.

5. Management of Leave and Senior Support throughout the Festive Period including On Call arrangements (BAU)

The management of leave throughout holiday periods will be set against minimum number of staff on duty, together with maximum level of leave allowed. Study leave will pause over the B/H period 14 days.

This will be monitored by the Divisional Management Teams under the direction of the Divisional Managing Director and a review and oversight meeting will be held in early December to go through all rotas for inpatient and emergency services across all three sites. The Deputy Chief Nurse (Operations) and Deputy Director of Operations – Urgent Care will lead this and where necessary make amendments to leave, requesting further changes where necessary.

Management teams will also be subject to a holiday period leave review and a rota of Divisional Managers will be been prepared and authorised to ensure that each Division has Senior Management cover and Senior Nursing Leadership available each day during working days, and that throughout the entire period. Site Duty Manager, Silver (Senior Managers, General Managers and Lead Nurses) and Gold (Directors on call) are all covered.

Throughout the period from Friday 20th December through till the 12th January all office days for managers will be devoted to supporting the Operational Site needs and the Silver and Gold command structure. All identified personnel will devote time to supporting each area with their winter plan and where necessary directly manage departments or support wards.

Below is Silver and Gold cover for this period:-

Date	Gold	Silver
20th December	David Cleave	Ian Fulloway
21st December	Roz Howie	*Vacant* – **To be covered by recently appointed Silvers*
22nd December	Martin Rayson	Lisa Vickers
23rd December	Paul Boocock	Rebecca Elsom
24th December	Penny Snowden	Tracey Wall
25th December	Neill Hepburn	Jamie Hodgkins
26th December	Neill Hepburn	Michelle Harris
27th December	Paul Matthew	Jennie Negus
28th December	David Cleave	Debrah Bates
29th December	Victoria Bagshaw	Catherine Capon
30th December	Simon Hallion	Damian Carter
31st December	Simon Evans	Linda Keddy
1st January 2020	Roz Howie	*Vacant* – **To be covered by recently appointed Silvers*
2nd January	Mark Brassington	Katy Mooney
3rd January	Karl Ratcliffe	Beverley Bolton
4th January	David Cleave	Ian Fulloway
5th January	Paul Boocock	Lisa Vickers
6th January	Mark Lacey	Catherine Capon
7th January	Yavenushca Lalloo	Damian Carter
8th January	Paul Matthew	Rebecca Elsom
9th January	Martin Rayson	Debrah Bates
10th January	Victoria Bagshaw	Ian Fulloway
11th January	Mark Brassington	Chloe Scruton
12th January	Yavenushca Lalloo	Andrew Prydderch

6. Site Capacity Overview and Scrutiny

Throughout the winter period, as with any other time, operational flow through the sites will be managed by the Operations Centres. Standardising working methods between the sites, accepting some variance due to size and services provided is known. The Capacity, Performance and Flow meetings will act as the 'guardian' of managing pressures and will also act as the vehicle for rectification actions and site stabilisation.

Capacity and Performance Meetings (Bed Meetings) times have already been standardised throughout the day so that situation reporting is constant and Trust wide real time meetings are in place via VC. These meetings occur at 08.30hrs, 12.00hrs and 15.30hrs. Chairmanship is dependent on the Site/Trust level of escalation.

The sites continue to operate a Bronze (Operational), Silver (Tactical) and Gold (Strategic) structure out of hours and during emergency situations. During the winter period an Operational Matron of the day will work alongside the Operational Lead Nurse, Capacity and Flow in providing additional clinical support as needed. Twilight Clinical Sisters and Bed Managers will also work at both Pilgrim and Lincoln sites. Silver and Gold roles for working days will be carried out by Deputy Director of Operations, Urgent Care /Operational Lead Nurse, Capacity and Flow for Silver and Director of Operations/COO for Gold. Out of hours cover will remain as a rota of Senior Managers and Directors on call. Details are contained within the 'Clinical Operational Flow Policy'.

7. Inclement Weather

The local resilience forum (LRF) produce a multi-agency weather plan and ULHT has a Snow and Adverse Weather plan that includes advice for staff on preparedness, adverse weather warnings and actions for different levels of escalation. The trust also benefits from the Lincolnshire 4x4 response scheme (www.ln4x4r.org.uk) that can assist in getting staff and resources around the county. Full details are contained with the 'Snow and Adverse Weather Policy'.

8. Communications Plan

The communication plan for 19/20 is a system wide plan. This contains key messages for the public and across the organisation to promote "choose well messages" and for staff around areas such as SAFER. Ways of communicating the status of the organisation across the organisation will be improved. This is documented within the Lincolnshire System Winter Communications Plan 2019/20. The plan builds upon previous plans and aims to co-ordinate the communication work already happening across Lincolnshire into a single source of reference for all stakeholders. Many current messages are based on National guidance from NHSE and focus on empowering and engaging people with self-care, staying well and choosing the right service at the right time for their health care needs. Full details are contained within the 'Lincolnshire System Communications Plan'.

9. IP&C

Norovirus can have a major impact on the capacity of the site and its ability to deal with additional pressure. Increased demand will be managed with a cohesive communications plan and the sites operating outbreak meetings in line with the policy. The Infectious Outbreak / Incident Policy including Major Outbreak will be followed and invoked throughout this winter.

The medical admissions ward has a door system that can support the compartmentalisation of the ward in the event of infectious outbreak. This would reduce the likelihood of spread and enable the ward to remain open for longer.

During Flu season Clinical staff who are likely to undertake an **aerosol generating procedure would need to wear a Fit Tested FFP3 mask. Masks have to be fit tested at least annually. The model the trust uses for achieving fit testing is the "train the trainer" approach and the IPC assistants will provide this service. Staff who fall into the above category will need to be fit tested before the beginning of November.

10. Influenza

The Trust has a flu plan that has been agreed at Trust Board. Historically the Trust complies well against vaccination and is rated in the top decile nationally. The trust was ranked 5th in the country 2019/20

The plan describes a robust approach to be delivered in conjunction with the ULHT Flu Charter. Vaccinations have commenced in October. Incentives and a wider media campaign are in the plan which is built on best practice taken from other Trusts and national guidance. Within the plan, specific reference is made to appropriate cohorting and the use of testing, confirmed diagnosis cohorting and impact on intensive care capacity.

In 2018/19 the Trust achieved 84% and it is planned to achieve a greater percentage compliance this year.

Full details are contained within the Trust's 'Outline Flu Programme'.

11. Winter Plan – Scheme Level Detail and Assurance

The winter plan describes interventions to the whole patient pathway that will lead to an improved experience for patients and staff as well as improved control of performance during the Winter season. Where appropriate the performance impact of these schemes is being developed to be shared in a subsequent version of this plan.

Pre-Hospital			
	Action	Action Required	Progress /Assurance
1	Simplification of the pathways available to ambulance crews	CCG and EMAS to review 38 alternative pathway options	SRG to confirm completion date and pathway decisions and monitor impact
2	Reduce high intensity users by 30%	To develop individual care pathways to avoid re-attendances	Complete audit of high intensity users undertaken. Task and finish established to identify a minimum of 10 individual care pathways for our

			highest intensity users
3	All care homes to have direct access to CAS as part of integrated urgent care development	The role out of a direct line for identified care homes in Lincolnshire through to the CAS service with the aim to admission avoid	CAS for care homes is now included in the core integrated urgent care (IUC) contract with a structured roll out to all care homes by 1st December 2019
4	Introduction of the mental health helpline for patients with access to the crisis team if required	To confirm a mental health helpline for patients is in place and evidence of improved patient outcome	SRG to confirm completion date and monitor impact
5	Continuation of the Physician Response Unit	To confirm the 2nd physician response unit has been commissioned	Ambulance handover delay group to confirm and monitor impact
6	2 x falls response cars funded until June 2020	To confirm vehicles commissioned and are providing an active response	Ambulance handover delay group to confirm and monitor impact
7	CAHMS – Process for managing patients at ULHT	To confirm the process for managing CAHMS patients at ULHT	SRG to confirm completion date and monitor impact
8	Mental Health Act Assessment – Process for managing safely in ED	LPFT to ensure adequate staffing and rapid response is made available to ED to help manage this cohort of patients`	SRG to confirm completion date and monitor impact
9	Rapid response – support for people to keep them at home and prevent admissions	Awaiting intentions from LCC	SRG to confirm completion date and monitor impact
Emergency Departments			
10	Frailty service in place to support patients home rather than admission	To ensure rapid start dates for recently recruited posts achieve early impact	All appointees will be in place by mid December 2019
11	GP streaming capacity during the winter holidays to be optimal	Confirmation from LCHS that correct levels of capacity are in place for this service over this period	SRG to confirm completion date and monitor impact
12	Increase flow and inpatient bed availability increasing exit block (reduced capacity)	Completion of Lincoln reconfiguration	Final sign off achieved 17th October 2019. Scheme completion planned for December 2019
13	Reduce demand on EDs through	Compliance against recently	UEC Steering Group to

	bypassing of ED and straight to (SDEC)ambulatory/assessment units	implemented pathways and ensure there is a push/pull model co-ordinated by the ACPs	monitor compliance
14	Reduce demand on EDs through increased streaming of patients to other services; internally within the hospitals, newly built primary care service areas, and externally to community based services	Ensure all pathways are clearly defined to signpost patients to the correct treatment option	UEC Steering Group to monitor compliance
15	Improve ambulance turnaround time including zero tolerance for >59 mins	Implement PHP role at Lincoln and roll out HALO role. Ensure all staff are aware of their responsibility for safe and timely handover	Ambulance handover delay group to confirm and monitor impact
16	Improved Senior ED Clinician presence 24/7 via rota management and additional recruitment	Rota demand and capacity needs to be finalised following the 'perfect rota week' and in time for December	UEC Steering Group to monitor compliance
17	Increased capacity through greater number of medical staff in each of the two main EDs at LCH and PHB – Utilising the model of specialty (medicine, surgery and T&O) doctors working within the teams directly (excluding Hospital @ Night)	Short term rescue of A&E Policy (STRAP) process to be reviewed.	Deputy Director of Operations for Urgent Care has commenced the review. Review to be completed by mid November and presented to Urgent Care Steering Group
18	Protection of Minors pathway with dedicated staff and ACPs	Ensure all daily staff rotas have in place staff allocated to support and manage the Minors stream and dedicated space provision is in place	This is now in place and managed/monitored by the Divisional Team. Escalation of deviation from agreed process is via Director of Operations/Deputy Director of Operations
Same Day Emergency Care (SDEC)			
19	The trust has ambulatory care units at LCH, PHB and GDH. LCH AEC moved in 2019 to an area that could not be used for inpatient beds, thus protecting the facility from	The reconfiguration will support the new and revised pathways. These require communication, education and embedding.	Low risk chest pain pathway now in place. UEC Steering Group to monitor compliance

	becoming surge capacity overnight. This improvement together with the pathway of direct GP referrals reduces the burden on both ED and the admission units.		
20	The implementation of IAC at PHB in late 2018 provided a 24/7 multi-speciality assessment unit, which is also supported by SDEC provision.	Pathways require revision and communication, education and embedding.	UEC Steering Group to monitor compliance
21	The combined effect of IAC/AEC improvements at PHB will positively impact on exit block, as well as reduction of overall ED attends.	The number of patients referred to and accessing this stream to be reported daily in the Capacity Performance meetings	UEC Steering Group to monitor compliance
In-patient Schemes			
22	Red2Green has been completely redesigned. A new approach to electronic reporting (WebV) is being rolled out across all three acute sites.	Trust wide communication and engagement events to be completed leading up to launch day for Red2Green on 4th November.	UEC Steering Group to monitor compliance and implementation timescales
23	Patients to be discharged within 24 hours of PDD	All Clinical teams to ensure clear discharge plans in place against agreed PDD	UEC Steering Group will monitor compliance with clinical leadership from the Medical Director
24	Roll-out of criteria led discharge (CLD) across the hospital	This is currently being rolled out across medicine and surgery using the exemplar ward model. Roll out plan and timescales to extend this to the whole hospital to be confirmed	UEC Steering Group to monitor compliance
25	10x10 to be in place routinely on all sites	Matrons to ensure all wards consistently have at least 1 patient leaving the ward before 10am	Monitored as part of SAFER. Challenged and monitored by CPM midday and 3.30hrs. Confirm and challenge on system wide call.
Elective Care Planning			
26	Starting with Orthopaedic patients and building on the Getting it Right First Time (GiRFT) opportunities of	Implementation of the GIRFT recommendations	Impact to be monitored through PRM meetings with

	LOS efficiency bed reductions are expected on each of PHB and LCH hospital sites.		the Divisions
27	Enhanced recovery after surgery (ERAS) across specialties.	Identified groups of patients with variation between 1.8 days LOS and 5.4 LOS are priorities and have excellent clinical buy in to pathway improvements.	Impact to be monitored through PRM meetings with Divisions
28	Profile of Elective Activity	Elective activity has been profiled to take account of reduced working days (bank holidays) and surgical capacity after conversion of the swing ward. The swing ward will support a reduction in on the day cancellations and traditionally seen through winter.	Impact to be monitored through PRM meetings with Divisions
29	During January, the Division of Surgery will not schedule any routine inpatient surgery at PHB and LCH hospitals however they will continue to book cancer, urgent and day case surgery. Louth and Grantham Hospitals will continue to offer full operating schedules throughout the holiday period. Surgical activity will return to standard levels from the beginning of March 2020.	An Elective care production plan for winter is in development for sign off at PRM	Impact to be monitored through PRM meetings with Divisions
Discharge and Long Length of Stay			
30	DTOC reduction to 3.0%	The Trust traditionally performs well against DTOC. Partnership support is key to achieving this. Performance for 19/20 is better than 18/19.	UEC Delivery Board to monitor
31	Effective decision making for patients (safe care) from combined system partner collaboration #longstayreviews	Continued improvement is being seen in Long length of stay work. Sustainability plan to be developed.	UEC Steering Group and UEC Delivery Board to monitor compliance

32	Patient have a clear and agreed reason for admission to bed based care – Home First	Clear criteria to be communicated across the Trust	UEC Delivery Board to monitor compliance
33	Acute and transitional care to have clear pathways of care with milestones and accountabilities	Clear criteria to be communicated across the Trust	UEC Delivery Board to monitor compliance
34	Effective use of the discharge lounges as a norm and not by exception	Communication to all wards about the use of and criteria for discharge lounges.	Monitored through daily CAP meetings and through UEC Steering Group workstream 5
35	Discharge hub brining all the services together from community services and social care focussing medically fit for discharge	Implementation of the Integrated Discharge processes/hub to be agreed and communicated	SRG to monitor
36	No patients MFD beyond 72 hours in an acute bed	Internal delays to be identified and remedied through Red to Green. System partners to ensure that patients are pulled out of the hospital without delay	SRG to monitor
Community			
37	Introduction of 3 new specialist neighbourhood practitioners to work in the community in the East of the County.	Confirmation date to be supplied to the acute Trust when this is active	SRG to monitor
38	Introduction of 2 anticipatory care nurses	Confirmation date to be supplied to the acute Trust when this is active	SRG to monitor
39	Development of 'self funder' process	Self Funder process to be developed in collaboration with the acute trust and communicated widely	SRG to monitor
40	Strengthen patient transport services	Acute processes for booking transport to be reinforced. Gaps in service provision to be acted upon by commissioner to prevent unnecessary delays during winter	UEC Delivery Board
41	Trust Assessor model to be fully implemented	Not all care homes accept referrals from Trusted	UEC Steering Group to monitor through

		Assessors. This creates re-work and lost patient time. Agreement should be reached that Trust Assessor assessments are final and where training and education is required to meet a required standard this should be provided	workstream 5 and SRG to monitor for assurance
42	Additional Beds – Additional sub-acute beds will be created including beds that can be used for Discharge to Assess. The Discharge to assess scheme is designed to remove delays whilst awaiting assessment, and the potential to overprescribe patients rehab/support packages, whilst still in an acute environment. These beds will be across the county, in a combination of nursing and community beds.	Identify discharge to assess beds and access criteria. Criteria to be developed so that it is flexible to meet the changing demands on the acute service without blocking community provision	SRG to monitor
43	Support at Home (HART) – an admission avoidance scheme to support patients in their own home. This service also supports discharge of patients with a planned date of package of care commencement. This ability to "bridge" package of care enables a more rapid discharge and reduction in LOS. This service is led by LCHS.	Details of winter provision to be shared across the system	SRG to monitor
Staff wellbeing and Resilience			
44	Personal resilience training to be developed and rolled out to staff in preparation for winter	Packages to be developed and training to commence during December	UEC Steering Group to monitor with progress reports to UEC Delivery Board
45	Access to senior leaders within divisions and Trust made clear and accessible	Currently in development with Divisions. For communication during December	UEC Steering Group
46	Site safety workshops to support competency development for on call management teams	Packages to be developed and training to commence during December	UEC Steering Group to monitor with progress reports to UEC Delivery Board

47	Recognising the signs of burnout at all levels, how to seek help and how to provide help	To be included as part of the training around personal resilience	UEC Steering Group to monitor with progress reports to UEC Delivery Board

12. Governance

A robust and integrated governance structure for the winter period will be established. A fortnightly Winter Planning Group, comprising relevant services, will be responsible for the operational delivery of the plan. An Integrated Winter Planning Board, chaired by Director of Operations, who has operational responsibility for, will oversee delivery and effective implementation of the Winter Plan. The plan will be reviewed and a confirmation of assurance with be by both the Acute Trust Board and partner agencies through appropriate governance processes.

Locally the plan will be delivered under the operational management of the DDO for Urgent care.

Escalation processes will be as described in the Clinical Operational Flow Policy, this will continue to be developed over the coming months.

13. Risk Management

The delivery of the system winter plan is essential in order to provide good quality care for the people of Lincolnshire.

If the plan is not delivered, there is the potential for:

- Non-compliance with national standards with significant risk to patients
- Prolonged adverse publicity
- Prolonged disruption to one or more divisions
- Extended service closure
- Multiple complaints
- Unsafe staffing levels in some areas for > 5day

Without effective planning, both within the ULHT and the system resulting in additional services, changes in process and increased resource it is somewhat likely that this situation will occur (between 50% -80% chance). This means that the risk of plan not being delivered has a risk score of 16 and as such will be added to the corporate risk register.

The ULHT plan will be monitored weekly against a performance trajectory. This will provide assurance that schemes and initiatives being put in place will lead to achievement of the 4 hour standard by increasing capacity through reduced admissions, timely discharge, reduced LOS and maintenance of efficient bed occupancy levels.

The major risk factor to the delivery of the ULHT schemes is that vacancies and new posts will not be filled although some progress is being made. This would result in reduced capacity and capability to meet the winter planning assumptions. Currently are being developed to source additional staff, through the use of long term bank and agency and recruitment to fixed term post. The plans to mitigate this risk will be monitored through the Divisional Performances Framework, reporting into Trust Management Group (TMG).

The ability to meet the system demands depends very much on the system's ability to mobilise the plan. This delivery of the system plan and associated risks will be managed through the Operational and System Resilience Meetings which will report in the Urgent Care Delivery Board.

14. Summary

Winter 2019/20 will undoubtedly see increase demand for patient services throughout Lincolnshire. Occupancy levels are predicted to drop from November.

Bed occupancy will continue to be monitored over winter with close collaboration with system partners. Metrics such as Medically Fit for Discharge, Delayed Transfers of Care, Admission numbers and overall discharges will be used to track progress and intervene where they be a may need for further escalation to succeed.

Report to:	Trust Board
Title of report:	Workforce, OD and Transformation Committee Assurance Report to Board
Date of meeting:	30th September 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 Revised People Strategy** **SO Ref: SO3a** **Source of Assurance:** The Committee undertook a review of the People Strategy noting that this continued to develop. A work programme is in place however clearer data would be required in order to track the outputs. The strategy would be presented to the Executive Team to ensure that the objectives provided challenge.
	Assurance in regard to Workforce KPI Report **SO Ref: SO3a** **Source of Assurance**: The Committee received the key performance indicators noting the improved quality of the statistics which would be reviewed by the Committee and continuous improvement considered. The Committee noted the pipeline for recruitment that was in place and actions to enhance numbers were being implemented. Overseas medics however take time to commence in post. The Committee were not assured that the timescales and numbers of recruits would significantly impact on the current year financial position due to the length of lead times for new staff.
	Lack of Assurance in regard to Financial Efficiency Programme **SO Ref: SO3a** **Reason for lack of assurance:** The Committee received the Financial Efficiency Programme update noting that there had been a sound review to risk rate the FPE, however some areas remained that required review in the near future. The Committee were not assured that the Trust will achieve the annual FEP relating to workforce and risk remained in the current risk adjusted forecast.

	The FEP relating to recruitment improvement had shown that more permanent staff were being employed however the vacancy rate had worsened due to the budget/establishment rising from 7703 to 7742. The Committee were not assured that the recruitment actions would meet the required number whilst the establishment continued to increase. The recruitment improvement programme milestone had shown 50% complete, 36% overdue and 3% not yet started. The medical capacity and activity management FEP has been significantly reduced due to further delays and concerns reported previously. The Committee were not assured that the position would improve in the current year. The improvement programme milestones had shown 30% complete and 70% overdue. The Committee could not be assured that the agency spend reduction would achieve the overall lowering of agency costs due to the increased numbers of agency staff being employed. The programme milestones review had shown 66% complete, 28% on track and 6% overdue which provided assurance that the reduction on the price paid for planned number of agency staff are on track for delivery.
	Assurance in regard to Retention Deep Dive **SO Ref: SO3a** **Source of Assurance:** The Committee were assured form the review that initiatives have started over the past few months. Evidence of success had been shown in some areas. However it was too soon for the Committee to be fully assured until further evidence of the impact of individual initiatives is provided towards the end of the year.
	Lack of assurance in regard to International Recruitment Partner **SO Ref: SO3a** **Reason for lack of Assurance**: The Committee were not currently assured regarding the proposal for the international recruitment partner. The Committee requested further clarity of the risk and responsibility for the Trust in order to inform the Board.
	Assurance in regard to Nurse Establishment Review **SO Ref: SO3a** **Source of Assurance**: The Committee received the Nurse Establishment Review noting some concern that the previous recommendations had not been fully implemented. The Committee were advised that some recommendations were now being actioned. The Committee would receive the next review at the December Committee.

	Assurance in regard to Policy Review – Embracing Just Culture **SO Ref: SO3a** **Source of Assurance:** The Committee were assured that the review based on the Mersey Care approach has commenced and that work was ongoing to adapt the Trust's core policies. The Committee were concern that this would not be completed quickly enough to satisfy the regulators within reasonable timescales.
	Assurance in regard to National Staff Survey Preparation **SO Ref: SO3a** **Source of Assurance:** The Committee were assured that preparation are in hand to try and improve the involvement and uptake by staff of the survey and divisional support would be put in place.
	Assurance in regard to Medical Engagement **SO Ref: SO3a** **Source of Assurance:** The Committee received the Medical Engagement report noting that an action plan has been developed and commenced. A further review would be required on the progress of delivery in January 2020. The Committee were advised that dedicated resource was now in place. The main concern for medical staff remained the rotas for junior doctors as well as more transparency of the Excellence Awards. A development programme/offer is being developed as well as QSIR training being offered.
	Assurance in regard to Equality, Diversity and Inclusion Annual Report **SO Ref: SO3a** **Source of Assurance:** The Committee received a suite of annual reports noting that the reporting requirements had been dealt with. The Committee recommend to the Board the publication of the reports and to note the declining areas of the assessment along with the actions in place to support improvement of the position going forward. RES - Areas under our local control show improvement RES - Areas under National Control show decline which is reflected across the NHS in general
	Assurance in regard to Guardians Quarterly Report **SO Ref: SO3a** **Source of Assurance:** The Committee received the quarterly report noting that there had been some forward movement but there was still a long way to go. The Committee were not fully assured that the issue have been resolved.

	Assurance in regard respect of other areas: **Board Assurance Framework** The Board Assurance Framework was presented to the Committee who agreed that the current assurance ratings remain **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
Issues where assurance remains outstanding for escalation to the Board	None
Items referred to other Committees for Assurance	No areas identified
Committee Review of corporate risk register	None
Matters identified which Committee recommend are escalated to SRR/BAF	None
Committee position on assurance of strategic risk areas that align to committee	No further areas identified.
Areas identified to visit in ward walk rounds	No areas identified

Attendance Summary for rolling 12 month period

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

Agenda Item 14.2

NHS
United Lincolnshire Hospitals
NHS Trust

To:	**Trust Board**
From:	Victoria Bagshaw, Director of Nursing
Date:	25 November 2019
Healthcare standard	

Title:	Healthcare Worker Flu Vaccination

Author: Victoria Bagshaw

Responsible Director: Victoria Bagshaw, Director of Nursing

Purpose of the Report: Inform Trust Board of the instructions to Trusts against the national flu vaccination campaign.

The Report is provided to the Board for:

Decision		Discussion	
Assurance		Information	x

Summary/Key Points:

The Trust annual vaccination plan is led through the occupational health team and over the last years has been very successful, achieving 87.8% in 2018/19 which was ranked best regional position and nationally in the top five. The 2019/20 vaccination plan builds on what has worked well in previous years and will place an additional focus on those clinical teams and areas of the workforce where the vaccination rates were lower by addressing specific fears and myths held by these individuals and teams.

The Director of Nursing has set a stretch target for 2019/20 of achieving 90% flu vaccination of frontline staff against the nationally requirement of 80%.

The paper details the Trusts self-assessment against the NHSEI best practice checklist for Flu vaccination during the winter period of 2019/20.

Recommendations: For Trust Board to endorse the actions identified against the checklist	
Strategic Risk Register	**Performance KPIs year to date**
Resource Implications (eg Financial, HR)	
Assurance Implications	
Patient and Public Involvement (PPI) Implications	
Equality Impact -	
Information exempt from Disclosure -	
Requirement for further review?	

United Lincolnshire Hospitals NHS Trust Healthcare worker flu vaccination best practice management checklist.
For public assurance via trust boards by December 2019-2020

A	Committed leadership (number in brackets relates to references listed below the table)	Trust self-assessment
A1	Board record commitment to achieving the ambition of 100% of front line healthcare workers being vaccinated, and for any healthcare worker who decides on the balance of evidence and personal circumstance against getting the vaccine should anonymously mark their reason for doing so.	The Trust has indicated that we aim for 100% of frontline Health care workers and we are working towards this. We have not and are not intending to ask formally in writing staff there reason for not having the flu vaccine and recording it. The reason is this counterproductive and alienates staff and puts them off having the vaccine, even when we state it is anonymous they feel this is undue pressure. OH do record this information when they refuse we ask them why and record it informally and we have that information
A2	Trust has ordered and provided the quadrivalent (QIV) flu vaccine for healthcare workers	The Trust has QIV vaccine in place and aTIV for employees 65 years and over and Cell grown egg free vaccines.
A3	Board receive an evaluation of the flu programme 2018/19, including data, successes, challenges and lessons learnt	Last year the Trust achieved 87.8% and a brief outline of what went well has informed this year's flu plan
A4	Agree on a board champion for flu campaign	Chief Nurse, HR &OD.
A5	All board members receive flu vaccination and publicise this	Planned for SLF on September the 27th of September, some members of the executive team have already been vaccinated and publicised.
A6	Flu team formed with representatives from all directorates, staff groups and trade union representatives	Not in place, tried on numerus occasions to put in place and over the past 5 years attendance has been very poor. Directorates respond when asked to action support for campaign. Small group of OH and communications in place progress fed up through SEG and ICP committee.
A7	Flu team to meet regularly from September 2019	OH and communications meet regularly to direct flu campaign. Monthly reports are taken to SEG and IPC
B	**Communications plan**	
B1	Rationale for the flu vaccination programme and facts to	Trust flu letter and flu charter in place signed by senior leaders and

	be published – sponsored by senior clinical leaders and trades unions	trades unions
B2	Drop in clinics and mobile vaccination schedule to be published electronically, on social media and on paper	These are regularly published on Face Book
B3	Board and senior managers having their vaccinations to be publicised	Planned for SLF on the 27th of September
B4	Flu vaccination programme and access to vaccination on induction programmes	Yes all Trust induction sessions have a flu vaccinator booked to be in attendance
B5	Programme to be publicised on screensavers, posters and social media	Communications have a programme in place.
B6	Weekly feedback on percentage uptake for directorates, teams and professional groups	The system for reporting is by Trust and staff group for inform/DH For Trust it will be: Site, Staff group, Directorate, and where possible ward/department.
C	**Flexible accessibility**	
C1	Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered	There are forty peer – peer vaccinators in the Trust spread across all sites and a number of bank staff trained to provide out of ours drop in and ward visits.
C2	Schedule for easy access drop in clinics agreed	Agreed and in place published on intranet
C3	Schedule for 24 hour mobile vaccinations to be agreed	Team of peer to peer vaccinators in and bank staff in place
D	**Incentives**	
D1	Board to agree on incentives and how to publicise this	We do not use incentives as we feel these detract from the main reason for vaccination and demean its importance or vaccination rates have increased since we stopped using incentives. We Use the Protect yourself,
D2	Success to be celebrated weekly	Published weekly through communications in Jab ‘O’ Metter format

Stephen Kelly
Occupational Health.

United Lincolnshire Hospitals NHS Trust

To:	Trust Board
From:	Jayne Warner
Date:	5 November 2019
Essential Standards:	

Title:	Freedom To Speak Up Quarterly Report Jul - Sept 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

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 Sept 2019

Reporting Period	July 2019 – Sept 2019
Number of issues raised	7 (2 Lincoln, 3 Pilgrim 1 Louth, 1 Grantham)
Number of issues raised anonymously	1
Number of issues raised with element of Patient Safety	1
Number of issues raised with elements of Bullying/ harassment	7
Did reporter describe having suffered detriment from speaking up	0
Staff Groups referrals came from	2 Nursing 3 Admin and Clerical 1 Doctors 1 Allied Health
Feedback Obtained	0

Whistleblowing Notifications

During Quarter 2 of 2019/20 (July to Sept 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 2

- Relationship issues between teams and managers which remain unresolved
- Concerns about colleagues behaviours within teams

Freedom to Speak Up Guardian

National Update

The National Guardian's Office have published two case reviews during 2019/20. Trusts are expected to use the findings from the reviews to identify where the findings of this review apply to their own circumstances and take appropriate action to apply the learning described. When making this decision, other trusts should refer to the report's findings, rather than the actions of the trust in response. The reviews published in June and Sept 2019 are attached for Board information as appendix 1 to this report. The Guardian has agreed with the Chair that the

findings from the review will be considered by the Guardian, learning identified and resultant action shared with the Workforce and OD Committee in November.

In September 2019 the National Guardian's Office updated its guidance for Boards. This is attached as Appendix 2 to this report. The aim has been to simplify the guidance from the previous version and reduce the level of duplication. The Workforce and OD Committee were tasked with reviewing the action plans identified from the previous guidance and reviewed this most recently at their meeting in May. The Guardian will support the Executive Lead to complete an assessment against the new guidance and update the action plans accordingly.

In October 2019 the National Guardian's Office published the FTSU Index Report. This triangulated data from 4 questions within the staff survey and CQC ratings for Trusts to create a speaking up index. The Trust has recognised it has significant work to do to support a culture within the organisation where staff feel safe to speak up and where concerns raised by staff are listened to. The Index report is attached as Appendix 3.

Local Update

The Final report from the CQC made a number of comments on relation to speaking up in the Trust and these will be considered as part of the revised action plan from the Board guidance.

The Guardian continues to have quarterly 1:1 meetings with the Chief Executive.

The Trust has launched the new network of FTSU Champions. There are now 12 identified Champions across 3 sites and from a range of staff groups. Further communication of the role of the champions is being completed. All Champions will be attending national training which will be provided for them in Lincolnshire.

The National Guardian announced that October 2019 would be national FTSU Month and the Guardian has worked with Communications to share the speaking up message with staff. The Guardian held Freedom to Speak Up drop in clinics on all 4 sites. These were published through Trust communications and the closed staff facebook page. Whilst turnout was low staff did react on social media to the posts supporting the idea and confirming that they hadn't known previously about the Guardian being available to staff.

One of the staff who did make contact over the 4 days posted the following to the staff facebook page

"I would recommend anyone with any issues or concerns that haven't been resolved to have a chat with Jayne Warner. She really does support in finding answers. A really useful and underutilised resource for staff"

The Communications team have supported the Guardian in developing a FTSU video guide which will be shared through the Trust social media channels and on the intranet.

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.

National Guardian
Freedom to Speak Up

A summary of speaking up learning and actions in response

September 2019

Contents

Summary:

1. The National Guardian's Office (NGO) reviewed the handling of two speaking up cases referred to it by workers from Northwest Ambulance Service NHS Trust ('the trust',) as the workers' referral information indicated that the trust's response to their speaking up had not been in accordance with good practice.

2. The office decided to review the cases referred to it because of the potential important learning that could be obtained.

3. The NGO visited the trust to gather information for its review in January and February 2019. It then held discussions with the trust about aspects of that information, before returning in May 2019 with colleagues from NHS Improvement[1] to discuss the provisional findings of the review with trust leaders and to agree actions in response.

4. The trust supported the review process by providing all requested information and by participating fully in the engagement process to discuss the review's findings.

5. As part of the review, NGO staff interviewed the workers who had referred their cases to the office and those in the trust responsible for responding to the matters they had originally raised. In addition, we met with senior leaders responsible for the trust's speaking up arrangements. The review also looked at relevant speaking up policies and procedures and how the trust had implemented the Freedom to Speak Up Guardian role.

6. At the time of the review the Trust had two full time Freedom to Speak Up Guardians, supported by a number of champions across the Trust, a lead Executive Director and a lead Non-Executive Director of Speaking Up. There were a range of policies and procedures in place to support the speaking up culture and evidence of both training and effective Board reporting.

7. The review found areas where the trust's response to the issues raised by the workers could be improved, including in relation to providing feedback on the progress of the trust's investigation into their concerns.

8. The review also found that there was lack of clarity among workers about the scope of the Freedom to Speak Up Guardian role and what matters they could support workers to raise.

9. In response to the potential lack of clarity, the NGO recommended that the trust developed a single policy to describe the available support and procedures in relation to speaking up.

[1] From 1st April 2019 NHS England and NHS Improvement are working together as a single organisation; see - https://improvement.nhs.uk/

10. A central feature of the review was an engagement process, involving the NGO, the trust's leaders and NHS Improvement, to discuss the review's findings and agree actions in response to its findings.

11. The review's findings and agreed actions are set out in a table below. Additional information from the NGO about the role of Freedom to Speak Up Guardians is also set out in Annex A.

The National Guardian's Office case review engagement process

12. The NGO trialled the engagement process described at paragraph 10 above as part of its revision of how it responds to the case review referrals it receives. Information on the NGO's revised case review process will be available on its webpages later in 2019.

13. The principal objective of the engagement process was to work in partnership with the referrers, the trust and NHS Improvement to ensure that a helpful outcome was achieved, which provided learning for the trust and the rest of the system.

Acknowledgements and thanks

14. We would like to thank the following individuals and organisations for their help and assistance in the completion of the report:

- Trust workers who have shared their experiences of speaking up in the organisation
- The trust's Freedom to Speak Up Guardians
- The leaders of the trust
- NHS Improvement

Findings and agreed actions

15. A summary of the review's findings is set out below, with the trust's actions in response to those findings. Additional information is provided in Annex A in relation to the findings in part 1.

16. In addition to those actions, the National Guardian's Office will also be revising its guidance on the recording of Guardians' cases, following issues raised during the review about the confidentiality of such records and access to them.

17. NHS Improvement will oversee the delivery of the trust's agreed actions and provide updates to the NGO as to the progress of their implementation.

18. Consistent with other NGO review reports, the office expects other NHS trusts to identify where the findings of this review apply to their own circumstances and take appropriate action to apply the learning described. For clarity, when making this decision, other trusts should refer to the report's findings, rather than the actions of the trust in response, as they apply to that trust's particular circumstances in this case.

What will happen next

19. The National Guardian's Office will continue to provide ongoing support to the trust, through its training and guidance for those delivering Freedom to Speak Up in the organisation.

Review findings and comments	Actions in response to findings
1. Speaking up policies The trust had two policies covering speaking up: (i) 'Raising Concerns at Work (Whistle Blowing) Policy and Procedure', based on the Public Interest Disclosure Act.[2] (ii) 'Freedom to Speak Up Policy', based on the 'Raising Concerns Policy for the NHS' produced by NHS Improvement.[3] The trust had developed the second policy as part of improvement work to respond to staff who raise issues. The purpose of a speaking up policy is to set out how workers can speak up and the support they can expect when they do so. Such policies include options for workers about who they can speak up to, including their line manager, supervisor, Freedom to Speak Up Guardian or others. They should be written in a way that is accessible, easily understood, and that encourages workers to speak up. The existence of multiple policies in the trust does not promote these objectives. The policies seen in the review included a focus on The Public Interest Disclosure Act. This has only limited relevance to speaking up culture and, therefore, this emphasis does not add to the clarity of the policies.	**The trust's actions in response are:** 1.1 Merge the two policies based around the current 'Freedom to Speak Up Policy' in relation to all matters raised by its workers. 1.2 Revise its Freedom to Speak Up Policy to reflect the content of the updated national policy, once NHS Improvement has completed its revision of the policy. 1.3 Advise all its workers of any revisions made to its policies which support its workers to speak up.

[2] https://www.legislation.gov.uk/ukpga/1998/23/contents
[3] https://improvement.nhs.uk/documents/27/whistleblowing_policy_final.pdf

A review by NHS Improvement of the national speaking up policy is expected to take place later in 2020. In addition, the NGO has produced a policy review framework to help organisations ensure that their speaking up policies clearly set out how their workers can speak up, to who and the support they will receive. This framework will be available soon on the NGO's webpages. We acknowledge the trust's recent attempts to identify learning from the speaking up cases at the centre of the NGO review and to improve processes to support speaking up.	
2. The scope of support from Freedom to Speak Up Guardians There was a lack of clarity regarding the scope of the role of the Freedom to Speak Up Guardians in the trust and whether there were certain types of issues that it was not within the Guardian's remit to support workers to raise. The remit of Freedom to Speak Up Guardians, as set out in guidance from the National Guardian's Office[4], is to provide support for workers to speak up, regardless of the type of matter involved. Further information about the scope of the Guardian role is set out in Annex A below. In response the trust told our review that they acknowledge that there had been a lack of clarity about the arrangements for managing cases raised through FTSU which are then investigated through HR processes, but it has always supported FTSU as a route to raise any type of concern.	**The trust action in response is:** 2.1 The trust's new speaking up policy will make it clear that all workers can seek support from the trust Freedom to Speak Up Guardian about any issue. 2.2 FTSU awareness has been delivered through mandatory training and is included at induction, and the Trust will continue to look for positive opportunities to train and promote FTSU.

[4] https://www.cqc.org.uk/sites/default/files/20180213_ngo_freedom_to_speak_up_guardian_jd_march2018_v5.pdf

The trust also said it had identified learning from recent speaking up cases and had developed agreed protocols for ensuring that cases raised through the Freedom to Speak Up Guardian continue to be supported by them, regardless of the process through which the investigation was managed. Changes have already been made to the disciplinary policy and associated standard letters, to ensure that the right of access to the FTSU guardian is clear and other policies will be reviewed.	
3. Thanking workers for speaking up Two trust workers, who spoke up about serious issues concerning staff safety, reported that they had not been thanked for speaking up. The trust view on this point was different but acknowledged the workers' perceptions on the matter. This was not managed as well as it could have been in accordance with good practice, or the Freedom to Speak Up policy for the NHS.	**The trust action in response is:** 3.1 The trust's new speaking up policy will include a reference to thanking all workers who speak up. 3.2 The trust is continuing to train managers in investigation training to address this issue.
4. The independence of investigators into speaking up matters An investigation into the issues raised by the two workers was undertaken by an individual who both workers regarded as potentially conflicted and therefore not suitably independent.	**The trust's actions in response are:** The trust will review its relevant policies in relation to investigations to ensure that – 4.1 they take proper and reasonable account of workers' objections relating to the perceived independence of investigators, and that a clear rationale for any decisions regarding investigators is given to workers in response to such objections.

The trust told our review that it was aware of the potential conflict of interest. It explained it had assessed the risk associated with this and determined that it was not a conflict. This decision was made in line with its policies. It added that its investigation processes include an independent, senior review which looks at the quality of investigation, the outcome and recommendations and provides an extra layer of scrutiny and assurance as to fairness and objectivity. However, trust leaders acknowledged it could have done more to address the workers' concerns. The National Guardian's Office, in a previous case review report,[5] has recommended that the Department of Health and Social Care commissions guidance on investigations for NHS trusts. This should include guidance on selecting suitably independent investigators. The national speaking up policy for the NHS makes clear that investigations into matters raised by workers should be conducted by a 'suitably independent' person. Published guidance on conducting investigations from the Advisory, Conciliation and Arbitration Service[6] (ACAS) emphasises the need for processes to be conducted in 'fair' and 'reasonable' manner. It states that the perceptions of bias 'should be avoided wherever possible.'	4.2 they provide more transparency about the way in which the trust will manage potential conflicts of interest relating to investigations.

[5] https://www.cqc.org.uk/sites/default/files/20180620_ngo_derbyshirecommunityhealthservices_nhsft-case_review_speaking_up_processes_policies_culture.pdf

[6] https://www.acas.org.uk/media/4483/Conducting-workplaceinvestigations/pdf/Conducting_Workplace_Investigations.pdf

It also sets out questions to be considered when choosing an investigator, which include considering whether the appointment would raise any concerns regarding conflicts of interest. ACAS provides training based on that guidance. Training for investigations specifically into clinical practice is also available from NHS Resolution.[7]	
5. Timeliness and handling of investigations In respect of the above investigation, the workers concerned felt they received insufficient feedback during the investigation, including as to its progress and how long it might take. The workers received formal feedback on the outcome of the investigation six months after first speaking up. The workers concerned were not told under which policy or procedure the trust was investigating their concerns. There was also evidence that staff involved in the investigation were unclear about this. The national speaking up policy for the NHS makes clear that workers should be kept updated with the progress of investigations.	**The trust's actions in response are:** 5.1 Ensure its revised speaking up policy includes the commitment to investigations being completed within reasonable timescales and for workers to be kept regularly informed of progress, particularly in circumstances where timescales become extended. 5.2 Continue the work it has commenced to improve tracking of HR-related investigations and that this is used proactively to provide oversight of investigation process. 5.3 Ensure that workers who speak up are clear on the policies under which their complaints are being investigated. 5.4 Review the trusts own protocols setting out the working arrangements between FTSUGs and HR to ensure that these principles are embedded.

[7] https://resolution.nhs.uk/ppa-training/

The trust's disciplinary processes already include a commitment to delivering investigations within a reasonable timeframe, taking account of the complexity of the case and its oversight and visibility of this is being improved through the implementation of a new HR case management system.	
6. Perceived attitudes towards female workers Some who spoke to our review expressed the belief that there were examples of poor attitudes demonstrated towards female workers who spoke up. In response, the trust provided evidence to demonstrate that it took the issue of equality, diversity and inclusion seriously and that, overall, its staff survey results show an improving picture in respect of the experience of women in the workplace.	**The trust will continue its work to improve the experience of women in the workplace, including:** 6.1 delivering 'women into leadership' programmes, that support the progression for women leaders in operational roles. 6.2 drawing up a gender action plan focused on improving the gender pay gap and the experience of women in the workplace. 6.3 rolling-out a range of training including Dignity at Work Training, Managing Healthy Workplace training, the Trusts 'BE Think Do' leadership training and a new course designed to tackle the issues of inappropriate banter in the workplace. 6.4 creating a joint management and staff side working group reviewing the trust's approach to tackling conflict in the workplace. 6.5 rolling-out bespoke leadership and management training within the service line where these workers worked to help enable the management team to support employees effectively. 6.6 utilizing a range of support interventions as part of its Health and Wellbeing Strategy.

	The Trust is also intending to implement a Working Towards an Outstanding Culture survey/audit. The work will be carried out and analysed by an independent organisation who are leaders in this field. The work will be designed through engagement with staff and will aim to focus on the cultural and leadership changes required to improved employee experience and well-being.
7. Mediation Following the investigation process described above, the trust offered mediation to the workers involved in the investigation. The trust explained that they did this entirely in accordance with their policies and procedures and that the process was entirely voluntary. The workers whose speaking up had triggered the investigation said that they did not want mediation. A staff member involved in the handling of the matter of mediation commented that the trust could have better communicated the proposed use of mediation to the workers concerned.	**The trust's actions in response are:** 7.1 Taking appropriate steps to ensure that managers and HR staff are up to date with existing guidance on explaining the value of mediation to workers.
8. Freedom to Speak Up and 'advocacy' The trust had appointed 12 volunteer FTSU 'champions' to support the work of the trust FTSU Guardians. They were described by some of the staff we spoke to as 'advocates.' It was clarified that the champions did not act as advocates or representatives for workers.	**The trust's actions in response are:** 8.1 The trust will ensure that the role of 'champion' is properly reflected in the policy review referred to in point 1 above. 8.2 The trust will also engage with the existing champions to ensure that their roles and responsibilities are clear, especially when individuals hold more than one voluntary role which may create conflict or create

Other than the name, the job roles' description was consistent with the function of champions and ambassadors as seen in other trusts. Concern was also expressed in some parts of the organisation that individuals with responsibility for supporting speaking up in the trust acted, at times, more as an 'advocate' for workers, where they appeared to take the side of a member of staff. The NGO is clear in its training[8] and published guidance[9] that those with responsibility for supporting workers to speak up must act impartially, ensuring that they 'remain objective and unbiased.' Where individuals responsible for supporting speaking up act or are perceived as acting as advocates for the views of individuals, they risk undermining the purpose and integrity of their speaking up position. At the same time, where those responsible for supporting workers to speak up do so in accordance with published training and guidance, in a robust and impartial way, trusts must ensure that they respond effectively to this support in accordance with good practice. The NGO will offer additional support to those with a speaking up role in the trust to address these matters.	confusion for those workers seeking support, such as peer supporter roles.

[8] https://www.cqc.org.uk/sites/default/files/20180419_ngo_education_training_guide.pdf
[9] https://www.cqc.org.uk/sites/default/files/20180213_ngo_freedom_to_speak_up_guardian_jd_march2018_v5.pdf

Annex A:

The scope of the role of Freedom to Speak Up Guardians

The purpose of the Freedom to Speak Up Guardian role is set out in a job description, issued by the National Guardian's Office, issued in March 2018,[10] which states:

Freedom to Speak Up Guardians help:

- Protect patient safety and the quality of care
- Improve the experience of workers
- Promote learning and improvement

By ensuring that:

- Workers are supported to speak up
- Barriers to speaking up are addressed
- A positive speaking up culture is fostered
- Issues raised are used as opportunities for learning and improvement

As implied by this summary, the range of issues that a Freedom to Speak Up Guardian can support a worker to raise is not restricted to any particular type and instead covers a wide range of matters, including, but not limited to:

- concerns about unsafe clinical practice
- staffing and resource levels
- cultural concerns
- bullying and harassment
- training and improvement ideas
- personal employment issues
- dignity at work issues

The NGO has observed in its case reviews that a barrier to speaking up has been created where workers are told by their employer that the matters they wish to speak up about are not within the scope of the Guardian to support.[11]

Many of the matters a Guardian can support a worker to raise will carry their own set of policies and procedures. In such circumstances, the Guardian can help a worker explore the best way to speak up under those processes, including helping them to understand their rights and obligations under that policy.

As stated in the job description, Guardians also promote learning and improvement within their organisation, helping to ensure that lessons learned from the issues raised by workers are actioned appropriately to deliver lasting improvement.

[10] https://www.cqc.org.uk/sites/default/files/20180213_ngo_freedom_to_speak_up_guardian_jd_march2018_v5.pdf

[11] https://www.cqc.org.uk/sites/default/files/201801107-Nottinghamshire%20Healthcare%20NHS%20Foundation%20Trust%20A%20review%20of%20the%20handling%20of%20speaking%20up%20cases.pdf

The job description also makes it clear that Freedom to Speak Up Guardians should act '*independently, impartially and objectively*.' They should therefore neither act, nor be seen to act, as either the representative of an individual worker, or for an organisation, but instead be an independent arbiter for their organisation's speaking up processes, helping to lead cultural change and improvement.

National Guardian
Freedom to Speak Up

A case review of speaking up processes, policies and culture

June 2019

Contents

Executive summary

The National Guardian's Office (NGO) has conducted a review of the speaking up processes, policies and culture at Brighton and Sussex University Hospitals NHS Trust (BSUH). The office undertook this review in response to information it had received from some current and former trust workers that suggested there was not a positive speaking up culture in the trust, particularly in relation to issues raised by black, Asian and minority ethnic (BME) members of staff.

As well as looking at the issues raised in their referral, the review also looked for evidence of improvements to the trust's speaking up culture that the trust leadership said it had made.

As with all our case reviews, our purpose was to identify learning and improvement and to highlight good practice and innovation.

The trust fully supported the review and provided all necessary information for its completion.

The review found evidence that the trust was in the process of making improvements to its speaking up culture and that its leaders were focussed on the importance of positive working cultures in the delivery of high-quality patient care.

Examples of actions to improve the organisation's culture included the use of weekly 'improvement huddles', where all staff in a service were encouraged to speak up about issues where they worked and actions to address them were then agreed by the team members.

Many of the workers we spoke to commented that there had been an improvement in the working culture of the trust since a new leadership team, which also runs a neighbouring NHS trust, started work in April 2017. The staff survey for 2018, published during our review, reflected significant improvements from the previous year's survey in how trust workers viewed the organisation's working culture.

Care Quality Commission (CQC) inspectors also found considerable improvements in the working culture of the organisation when they inspected the trust in 2018.

Our review has commended good speaking up practice, where this was identified and has made 6 recommendations on how the trust can build on the improvements it has begun. The review also makes one recommendation for the National Guardian's Office.

The optimism expressed by many trust workers to our review about cultural improvements was often cautious. The changes were described as 'fragile' and 'green shoots' and there was clear concern that the new trust leaders might leave before the changes they have instigated are complete.

Some workers and former workers told our review that historic issues relating to discrimination in the organisation still remained.

Our findings can be summarised as follows:

- The majority of the 78 workers we spoke with expressed the view that the working culture in the organisation had improved since the new leadership team had taken over responsibility for the trust in April 2017
- The 'Patient First' programme provided a framework for workers of all levels in the services where it was run to speak up about issues and resolve those matters collectively
- The trust leadership was taking active steps to address historic issues about discrimination in the organisation, including engaging with and putting events on for staff group representatives. The trust was also receiving ongoing support from NHS England's Workforce Race Equality Standard (WRES) implementation team
- The trust had implemented a new governance process to ensure that medium-level and serious clinical incidents reported by workers were robustly managed and monitored, with clear mechanisms to share learning with individuals
- The trust had implemented the role of Freedom to Speak Up Guardian in accordance with guidance issued by the National Guardian's Office
- The trust NHS staff survey and comprehensive CQC inspection, both taking place in 2018, identified clear improvements in the trust's speaking up culture
- Workers and former workers reported that discrimination was a problem in the trust and that more work needed to be done to address this issue
- Workers expressed concern that the cultural changes in the trust still had some way to go and these could be lost if the new leadership team did not remain in position long enough to complete their work

Acknowledgements and thanks

The completion of our review has been made possible only because of the support and contributions from the following individuals and organisations:

- Trust workers and former trust workers who have shared their experiences of speaking up in the organisation
- The leaders of the trust
- The trust's Freedom to Speak Up Guardian
- NHS Improvement
- NHS England Workforce Race Equality Standard Implementation Team
- Care Quality Commission

Introduction

The National Guardian's Office

The National Guardian's Office (NGO) provides leadership, support and guidance on speaking up in the NHS, and was set up in response to recommendations made in Sir Robert Francis' 'Freedom to Speak Up' review, published in 2015[1].

The review set out 20 principles and actions to enable NHS workers to speak up freely at work, without fear of detriment, and to ensure that that their concerns are responded to appropriately. These principles are designed to create a safer and more effective service for everyone.

The office began its work in April 2016. Its remit is to provide support, training and guidance for a network of Freedom to Speak Up Guardians across the NHS, whose function is to provide independent support for workers to raise issues in the workplace. The office also undertakes reviews of the speaking up arrangements in NHS trusts, including how individual cases have been handled, where it receives evidence that good practice may not have been followed.

The NGO is an independent, non-statutory body funded by NHS Improvement, NHS England and the Care Quality Commission.

More information about the work of the National Guardian's Office is available here.

Case reviews by the NGO

As part of its work the NGO reviews how an NHS trust has supported its workers to speak up, where it receives evidence that this support may not have met with good practice.

The standards of good practice against which the NGO assess the actions of trusts are found in a variety of sources, including the Francis Freedom to Speak Up review and the speaking up guidance for trust boards, published jointly by NHS Improvement and the National Guardian's Office in May 2018 [2].

The purpose of our reviews is to listen to individuals' experiences of speaking up, whether they have raised matters, or have been responsible for responding to them, to identify learning and improvement for the benefit of their trust, as well as the wider system. We make recommendations for all bodies with a responsibility for supporting a positive speaking up culture in NHS trusts, including regulators and government.

To promote this shared learning, the guidance for boards described above expects all trusts adopt, where appropriate, the recommendations for improvement identified in each NGO speaking up review.

[1] http://freedomtospeakup.org.uk/wp-content/uploads/2014/07/F2SU_web.pdf

[2] https://improvement.nhs.uk/documents/2468/Freedom_to_speak_up_guidance_May2018.pdf

The NGO operates independently. The NGO works closely with the regulators that fund it and shares the findings of its case reviews with them to help ensure NHS trusts receive all appropriate support to improve their speaking up culture, processes and policies.

Care Quality Commission inspectors review evidence relating to speaking up cultures and arrangements as part of their assessment of how well a trust is led.

Why we conducted a case review at Brighton and Sussex University Hospitals NHS Trust

In December 2017 the NGO received a referral collectively from a group of current and former black and minority ethnic (BME) trust workers. Their referral information suggested that the trust had historically not always responded to instances of BME workers speaking up in accordance with good practice, or the policies and procedures of the organisation.

The matters described in the referral related to recent and historic issues of alleged discrimination. Having decided these matters were suitable for review, we notified the trust leadership of our decision in early 2018.

The leadership responded to our decision by asking us to delay our review. It explained that one of its key priorities agreed with NHS Improvement was to address cultural improvement in the organisation and it wanted time to begin this work before we reviewed the organisation's speaking up culture.

The workers and former workers who had originally referred their concerns to the NGO did not want a review to be delayed. After considering all viewpoints, to avoid delaying improvement work and to have an opportunity to view the improvements the trust intended to make, the NGO agreed to delay its review until the start date requested by the trust of November 2018.

How we conducted our review

We visited the two principal trust sites; Royal Sussex County Hospital in Brighton and the Princess Royal Hospital in Haywards Heath.

In total we met with 78 members of staff, including clinicians, managers and ancillary staff, as well as the trust chief executive officer (CEO), board members and the Freedom to Speak Up Guardian and Trust Ambassadors.

We held a total of seven forums to encourage as many workers as possible to tell us about their experiences of speaking up in the trust, to gain an insight into the culture, to identify examples of good practice and to understand where we could support the trust to improve.

Forums were held for BME staff members, for lesbian, gay, bisexual and transgender (LGBT) workers, and for staff with disabilities.

The case review team also met separately with a group of BME workers and past workers (the 'BME action group') whose referral concerning alleged discrimination in the trust had first triggered our case review.

As well as meeting with staff, we reviewed a range of documents relating to speaking up in the trust, including trust policies, procedures, strategies, and staff surveys. Workers were able to contact the review team directly and meet with them away from the trust, if they wished.

We asked other bodies to share what they knew about the trust's support for speaking up, including the Care Quality Commission and NHS Improvement.

Where we found issues we immediately raised them with the trust to allow them to address them as quickly as possible.

We worked jointly with the trust to undertake the review, including collaborating on joint communications. We want to thank the trust for its positive and supportive response to the review process at every stage.

The structure of this report

Firstly, we set out information in relation to speaking up and equality and diversity in the organisation, focussing on the issues relating to BME matters and alleged, historic discrimination in the trust.

It also includes the response from the trust's leaders to those concerns raised, the views of other workers and external bodies about equality and diversity in the trust, relevant data and a review of trust actions since April 2017 to address these matters.

We then give our findings and recommendations relating to speaking up and equality and diversity in the trust.

Secondly, we look at wider aspects of the trust's speaking up culture, focussing on whether there was evidence of improvement and set out our findings and recommendations accordingly.

Where we found evidence of good speaking up practice and innovation we have commended this. Where we have identified areas for improvement we have made recommendations about how this should happen.

Recommendations and actions

We have made recommendations for the trust about how it can improve the support it provides its workers to speak up.

Each of our recommendations carries a time frame by which we expect them to be implemented. NHS Improvement will ask the trust's leaders to provide them with a plan, within 28 days of the publication of this report, summarising the actions they intend to take to implement our recommendations.

The NGO will ask NHS Improvement to provide it with a similar plan, within the same time frame, relating to the recommendation we have made for it.

In all cases, we expect the actions to implement our recommendations to include measures to determine their effectiveness.

Representatives from NHS Improvement will meet with the trust and the NGO at regular intervals to review the implementation of their respective action plans.

About the trust

Brighton and Sussex University Hospitals Trust is an acute teaching hospital trust working across two main sites, Royal Sussex County Hospital in Brighton and the Princess Royal Hospital in Haywards Heath. The Royal Sussex site includes the Royal Alexander Children's Hospital and the Sussex Eye Hospital.

The trust provides services to a local population of approximately 540,000 people. These comprise district general hospital services, in and around the Brighton and Hove, Mid Sussex and the western part of East Sussex and more specialised and tertiary services for patients across Sussex and the south east of England.

The trust employs approximately 8,500 workers.

Brighton and Sussex University Hospitals Trust has been in receipt of substantial management support from Western Sussex Hospitals NHS Foundation Trust (WSHT) since April 2017 as part of an agreement arranged by NHS Improvement (NHSI) between NHSI, Brighton and Sussex University Hospitals Trust and WSHT. Under the agreement and further to appointments made by NHSI, the trust's board is mainly made up of WSHT board members.

Currently, the arrangements put in place under the agreement are due to end in March 2020.

Published information about speaking up in the trust

NHS England annual Staff Survey[3]

All NHS trusts are required to participate in the NHS England staff survey. Its purpose is to collect staff views about working in their NHS organisation to help trusts improve working conditions for staff and patient care.

4,739 staff took part in the survey, which represented a response rate of 59%, an increase of 3 percentage points from the survey the previous year. This compared with an average response rate to the 2018 survey in acute NHS hospital trusts of 44%.

Several questions in the survey asked workers for their views about different aspects of the trust's speaking up culture. The results for these questions in the 2018 survey showed an improvement compared with those from the previous year's survey. We have set this information out in section B below, in table four.

We also look at further results from the survey in relation to equality and diversity. This can be found in section A below, in tables one and three.

[3] http://www.nhsstaffsurveys.com/Page/1064/Latest-Results/2018-Results/

Care Quality Commission (CQC) Inspection

Inspectors assess a trust's speaking up culture in relation to how well the organisation is governed, as well as how safe it is. They consider evidence relating to how the trust supports its workers to speak up and how it responds to, and learns from, the issues they raise.

Inspectors from the CQC last undertook a comprehensive inspection of the services in the trust in September 2018. They published their report in January 2019.[4] Previously, they had inspected all the trust's services in April 2016.[5]

In their 2016 report inspectors were critical of the trust's working culture. They stated that 'the trust must develop and implement a people strategy that leads to cultural change. This must address the current persistence of bullying and harassment, inequality of opportunity afforded for all staff, but notably those who have protected characteristics…'

In that inspection the CQC gave a rating of 'inadequate' for how well the trust's services were and the same rating for how 'safe' they were. They also rated the trust overall as 'inadequate'.

After the 2016 inspection the trust was placed in 'quality special measures.' The trust was also placed in financial special measures by NHS Improvement in October 2016. Special measures[6] apply when NHS trusts and foundation trusts have serious problems and there are concerns that the existing leadership cannot make the necessary improvements without support.

The trust exited financial special measures in July 2017, because of its improved control environment and management of resources.

In their 2018 inspection the CQC rated how 'well led' the trust's services were as 'good' and gave them the same rating for 'safe.'[7] They gave the trust an overall rating of 'good'. Following this inspection, the trust exited quality special measures, because of the improvements it had made in the delivery of care.

These significantly improved ratings were reflected in inspectors' comments in their 2018 inspection report about the trust's working culture. They observed that 'without exception, all staff we spoke with on inspection and engagement talked about a [significant improvement] in culture across the whole trust.'

We note that the BME Network Action Group, whose concerns about the trust's speaking up culture are set out below, expressed their strong disagreement with the CQC's findings about working culture as part of their 2018 inspection. The group provided the CQC with a written submission of its views during the inspection.

[4] https://www.cqc.org.uk/sites/default/files/new_reports/AAAH5824.pdf
[5] https://www.cqc.org.uk/sites/default/files/new_reports/AAAF5032.pdf
[6] https://improvement.nhs.uk/resources/special-measures-guide-nhs-trusts-and-foundation-trusts/
[7] https://www.cqc.org.uk/sites/default/files/new_reports/AAAH5824.pdf

Our review

A. Speaking up and equality and diversity in the trust

This first section looks at the issues raised by members of the BME action group and the trust's response to them. It then reviews how the trust has addressed wider equality and diversity issues in the organisation.

A1. Issues about speaking up raised by some current and former black and minority ethnic (BME) workers (the BME Network Action Group)

A1. 1 Background

As described above, a group of BME current and former workers collectively referred concerns to the NGO about the speaking up culture, as they believed it affected BME staff in the trust. The group belonged to a body called the 'BME Network Action Group'.

The group's members previously belonged to the formal 'BME network' in the trust, a recognised network of staff representatives within the organisation whose purpose was to provide a forum and a voice for BME Network members within the organisation.

The trust informed us that they decided to no longer recognise the network in 2018, because of its view of the approach and behaviours adopted by the group.

Following a meeting with the Chair, Chief Executive Officer and Chief Workforce and Organisational Development Officer in 2018 to discuss working together the BME Action Group wrote to the Chief Executive Office stating they had 'no confidence' in the chief executive officer of the trust.

In the same year the network's members formally declared that they had 'no confidence' in the chief executive officer of the trust.

Some of its members formed the 'BME Network Action Group' to act on behalf of the members of the former network, while others joined the new Workforce Race Equality Standard working group in the trust.

The action group gave its consent for the NGO to discuss their speaking up concerns with the trust.

A1. 2 BME Network Action Group's speaking up concerns

The action group described to the NGO a series of examples, dating back to 2014, of how they believed the organisation had historically failed to respond to BME workers speaking up and had demonstrated a 'discriminatory attitude' towards BME staff members.

The group said that such discrimination had the effect of 'raising some specific patient safety concerns in a number of departments.'

Included in the action group's concerns were allegations that BME workers had been historically 'punished and victimised', as well as 'sacked' for speaking up. It also alleged that a restructuring of one of the services in the trust in 2016 had led to BME workers being 'removed' and 'replaced with white staff'. As described below, the trust, in response to these allegations said they were untrue.

The group said that in 2017 it had sought support to speak up about these matters from individuals in the trust responsible for helping workers to do so but believed that those they met with did not understand issues from a BME worker's perspective.

The group said that they had asked to speak up about their concerns to the new trust leadership after its appointment in April 2017, but that they only succeeded in obtaining a meeting with them in March 2018. The group told our review that they were very unhappy with the response they received at that meeting, which they said was unsupportive of their views and did not recognise their experiences of discrimination.

The trust informed us that they ceased engaging with the BME network later in 2018. Trust leaders gave us their view on why this had happened. They said they had done this after concluding that, despite trying to engage with BME Network Members, including inviting an external facilitator to help improve working arrangements with BME Network members, the members made it clear that they did not wish to engage in the new ways of working.

BME Network members stated that they wanted the Trust to continue to adopt the previous "Race Equality Strategy Framework" that had been in place in 2016.

In contrast, the trust leaders said it was necessary to find 'a new way of working' to address equality and diversity issues in the Trust because 'the previous approach and strategies to addressing culture and equality issues in the trust had not worked effectively'. They said these failings were evidenced by 'the 2016 CQC inspection report and 2016 staff survey results …', but that the BME network 'were not prepared to accept' new ways of working.

The BME Network Action Group told our review that this decision meant, in their view, that BME workers in the trust no longer had a voice.

The group's members told our review that they wanted the trust to reverse its decision to exclude the group, reinstating it as the official BME network.

Many members of the action group felt strongly that the new trust leadership had not delivered any positive cultural change in the organisation, in terms of BME issues.

A1. 3 The trust's response to issues raised by BME Network Action Group

We raised the matters described above to the leaders of the trust. In doing so we acknowledged that they could only comment on the handling of those speaking up issues raised since their appointment in April 2017.

In response to allegations of discrimination, bullying and victimisation of BME workers the trust's leaders said they understood that, historically, a poor working culture had existed in the organisation, including the bullying and harassment of workers in minority groups. They highlighted that the trust's culture, particularly in relation to staff belonging to minority groups had been criticised in an inspection report from the Care Quality Commission in 2016.[8]

The leaders said they had agreed with NHS Improvement that tackling these issues would be one of their five key objectives following their appointment.

The leaders added that 'the trust has now adopted a new approach to race equality which is showing improvements for BME staff.' It gave examples to our review of these improvements, which are described in section A4, below.

With regards to allegations relating to the restructuring of a service that was discriminatory in its effects, the leaders said that while the matter pre-dated their appointment, 'no BME staff lost their jobs to non-BME workers' and one BME staff member took voluntary redundancy. It also said that the previous leadership of the trust had undertaken an equality impact assessment before the restructuring process began. The impact assessment was not examined as part of this review.

The trust leaders said that although they no longer recognised the previous BME network, this did not mean, in their view, that BME workers did not have a voice in the organisation. They said that all BME workers were welcome to join the new Workforce and Race Equality Standard (WRES) working group in the trust, which acted as a forum for all staff to contribute to BME matters, including providing views and input relating to policies and training.

With regards to reinstating the former BME network, the trust leaders said that they believed their new approach to equality issues in the trust was working, as evidenced by a more recent staff survey and CQC inspection report and therefore 'it would not be appropriate to go back to an old way of working.'

A1. 4 Identifying obstacles to speaking up

Because of the concerns expressed by those in the BME Network Action Group and other workers that discrimination, against a variety of minority groups, still took place in the trust, we asked its leaders what steps it had taken to identify whether such groups faced obstacles to speaking up.

In response, the trust said that it monitored the existence of such potential obstacles through a variety of routes. Firstly, through its evaluation of the staff survey; secondly through its engagement with minority workers via the networks and action groups; thirdly through conferences, such as the WRES conference in 2017 and the LGBT conference in 2018; and fourthly through social media, where the trust was 'cross-tweeting' with groups such as the LGBT social media group to optimise its presence.

The trust also highlighted that the Freedom to Speak Up Guardian attended staff-group network meetings, in their role as a leader of culture change, to understand potential barriers to speaking up faced by workers. The Guardian then set out plans and ideas to address such barriers in their reports to the trust leadership.

[8] https://www.cqc.org.uk/sites/default/files/new_reports/AAAF5032.pdf

A2. The views of other trust workers about equality and diversity

We also asked other trust workers, of all levels, for their views and experiences of equality and diversity issues in the organisation. 16 workers referred to historic difficulties relating to discrimination in the organisation, which included prejudice against BME workers and other minorities, including Jewish and lesbian, gay, transgender and bisexual (LGBT) staff.

One senior staff member commented that, historically, 'race issues have been ignored', while another, very senior leader observed about the recent history of the trust that there were 'real, historic issues [regarding race] that needed to be addressed.'

Another worker described historic 'racial tensions' that had existed in the trust and that the organisation's previous leaders had not successfully resolved these.

All 16 commented positively, if cautiously, that things were beginning to improve in terms of equality and diversity in the trust. One staff member observed 'we are on the right track, but we are just at the beginning.' However, many observed that discrimination against workers from minority groups was still common and that the organisation had much more to do to end this.

A3. The views of external organisations about equality and diversity in the trust

The trust's new leaders asked for help in addressing equality and diversity issues from NHS England's Workforce and Race Equality Standard (WRES) Implementation Team. The role of the team is, where requested, to provide help and guidance to NHS services to improve the support they give their BME workforce.

The effectiveness of the support that organisations provide to their BME workers is measured by a range of data, known as 'WRES data' that is discussed further, below. Some of these measures are taken from the NHS staff survey. More information about workforce race equality standards are available via this link.

The team described the support provided to the organisation, including guidance for its board members and workshops on addressing BME issues and commented to our review that the trust leadership 'was doing a really good job' in addressing historic equality and diversity issues in the organisation.

Inspecting the trust in 2018, Care Quality Commission inspectors reported an improvement from their inspection two year's earlier on how staff felt about equality and diversity issues, commenting that 'staff [we spoke to] felt equality and diversity were promoted in their everyday work.' Inspectors also reported that: *'*Staff told us that although they had not always felt supported in the past since the new executive team had arrived they now felt confident that they could raise any concerns about staff behaviours towards them…'

For balance, the BME Network Action Group told our review that the CQC report's findings did not reflect their views.

A4. The trust's actions to address diversity and equality issues

We looked at what actions the new trust board had taken to address equality and diversity issues. As mentioned above, the organisation's new leaders had agreed with NHS Improvement that addressing such matters would be one of their key priorities.

We learned from the NHS England Workforce and Race Equality Standard (WRES) team that the trust's senior leaders had contacted them shortly after their appointment in April 2017 to seek guidance and support on improving the working culture for minority ethnic staff. The request led to considerable help from the team.

This included a number of meetings with the trust board to provide assistance and insight on addressing workforce inequality, workshops and training for senior managers on race issues, support for development of the trust's workforce equality action plan, and assistance in setting up a conference in 2018 for trust workers to discuss BME and equality issues.

The conference was attended by over 200 members of staff and led to three workstreams focussing on equality and diversity in relation to communication, recruitment and education. These workstreams are led by the trust chief executive officer and they provide the trust's board with a regular update on their actions as part of the Leadership, Culture and Workforce Programme.

The conference also provided input to the trust's WRES action plan for 2018-2021. All trusts must produce an annual WRES report, in accordance with their contractual obligations to NHS England, stating how they will address race and equality issues among their workforce and meet standards of race equality set by the regulator.

Guidance from NHS England[9] states that the workforce race equality standard is intended to 'provide a blueprint of what "good" looks like, and through the sharing of replicable good practice on how "good" may be achieved and sustained.'

We therefore looked at trust data from the NHS staff survey relating to those standards, which is set out in the next section below.

The trust's WRES action plan included measures to address racial discrimination in the workplace, to reduce the number of BME staff subject to formal HR processes and increase the representation of BME workers across all Agenda for Change pay bands in the organisation. The need to address these issues in the trust is highlighted in table 2, below.

In addition to working with the NHS England WRES Implementation team the trust leadership also, at the time of our review, signed a collaboration agreement with the British Association of Physicians of Indian Origin (BAPIO) to work together on race equality issues. The signing of the agreement took place during a conference entitled 'Improving Patient Safety by Promoting Equality and Inclusion'. As part of the agreement, the association undertook to provide the trust with support in recruitment, training and the resolution of conflicts relating to race equality.

To continue to address equality issues relating to lesbian, gay, bisexual and transgender (LGBT) staff, in February 2019 the trust held its first LGBT inclusion conference[10], attended by over 300

[9] https://www.england.nhs.uk/wp-content/uploads/2017/03/wres-technical-guidance-2018.pdf
[10] https://www.bsuh.nhs.uk/wp-content/uploads/sites/5/2016/09/LGBT-2019-conference-programme.pdf

workers. Its purpose was to discuss LGBT issues in the organisation and how trust staff and its leaders could work together to address them. Included in the conference was an action planning workshop that produced more than 235 ideas about LGBT support and inclusion from staff, which, at the time of writing of this report, have formed part of the trust's LGBT action plan for 2019-2020.

During our review the trust also set up a disability network, in response to workers who asked for this to be put in place. At the time of the writing of this report the network's terms of reference were not yet in place, but we understood its purpose would be to provide a voice for disabled workers to speak up about issues in the trust and to feed into discussions on policies and future plans for the organisation.

The trust provided evidence that the views of minority staff groups fed into the work of the organisation. For example, the human resources and employment policy forum, of which the WRES working group, LGBT network and, more recently the new disability network are members, had reviewed over 20 trust policies, to ensure they properly addressed issues of equality and diversity in the organisation.

In response to analysis of the NHS staff surveys in 2017 and 2018, which highlighted a decline in the numbers of individuals working in facilities and estates who were completing the survey, the trust provided support for staff from this group to speak up, including from the Freedom to Speak Guardian.

Aware that many workers from this group are from overseas, the trust also provided literacy support for those who asked for this assistance.

Equality and diversity training was mandatory for all trust staff.

A5. Data about equality and diversity in the trust

We first set out data relating to the Workforce Race Equality Standard (WRES). This is because, as mentioned above, they are a key indicator of 'what good looks like' in an organisation. We have separated these into those WRES indicators taken from the trust staff survey, followed by those taken from the trust's workforce information.

The 'variance' column in the table below compares the 2018 results with those in 2017. Where the variance is marked in green this shows an improvement from the previous year.

A5. 1 WRES indicators from the NHS staff survey

Table 1

Question	Ethnicity	2016 survey result	2017 survey result	2018 survey result	Variance between '17 – '18	National average 2018
Percentage of staff experiencing, harassment, bullying, or abuse from patients, relatives or public in the past 12 months	White	31%	37%	31%	-6%	28%
	BME	34%	39%	35%	-4%	30%
Percentage of staff experiencing harassment, bullying or abuse from staff in past 12 months	White	32%	30%	26%	-4%	26%
	BME	37%	30%	30%	No change	29%
Percentage of staff believing that the organisation provides opportunities for career progression or promotion	White	82%	85%	88%	-3%	87%
	BME	64%	72%	72%	No change	72%
Percentage of staff experiencing discrimination at work from their manager, team leader or other colleagues the last 12 months	White	8%	8%	7%	-1%	7%
	BME	21%	18%	15%	-3%	15%

A5. 2 WRES indicators from the trust workforce information

As well workers' perceptions from the staff survey to measure race equality, NHS England define five additional indicators of race equality from an organisation's workforce data that, again, compare relative data between white and BME staff.

Below are the summaries for these indicators, obtained from the trust's 2018 WRES report, comparing data from 2017 and 2018. The quotes indicated are taken from that report. Those in green indicate an improvement and those in red a worsening:

Table 2

WRES Indicator	Comparison of 2017 to 2018 results
The numbers of staff working in each of the organisation's pay bands	There was increase in BME representation at some medium and very senior positions, but decreased representation at other bands, including non-consultant grades and other medical positions
The relative likelihood of staff being appointed from shortlisting across all posts	"It would appear whilst there was a steady balancing of outcomes over earlier reports, there now appears to be more of a disproportionate appointment of white candidates."
The relative likelihood of staff entering a formal disciplinary process	The data shows that BME staff continue to be more likely to enter a formal disciplinary process and this gap widened between 2017 and 2018
The relative likelihood of staff accessing non-mandatory training and continual professional development	The results showed that there was an improvement in the relative likelihood of BME staff accessing non-mandatory training, as compared with white staff
The ethnicity of board members	The proportion of non-white board members increased from 2017-2018

A5. 3 Other results from the NHS staff survey relating to equality and diversity and speaking up

Beginning with the 2018 survey, the national results were grouped into 10 new themes, one of which is 'equality, diversity and inclusion'. An overall score for this theme combines results from survey questions about workers' perceptions relating to equal opportunities and discrimination.

The trust's score for this new theme was 8.9, compared with a national average of 9.1. (The lowest score nationally was 8.1 and the highest was 9.6.)

We also looked at questions in the staff survey that relate to speaking up, whether about improvement and change, or the reporting of incidents. Because issues relating to discrimination were central to our referral we also looked at the ethnicity of those answering the survey questions and compared the answers given by BME workers between 2017 and 2018 to help identify whether they felt more confident about speaking up.

We set out the overall answers for these survey questions in table 4 below.

Improvements in BME results are indicated in green and worse results in red:

Table 3

NHS Staff Question	Ethnicity	2016 survey result	2017 survey result	2018 survey result
I am able to make suggestions to improve the work of my team/department	White	72.5%	73.3%	75.9%
	BME	67.4%	71.2%	74.3%
I am involved in deciding on changes introduced that affect my area/team/department	White	50.7%	49.3%	53.7%
	BME	49.0%	52.0%	55.9%
The team I work in often meets to discuss the team's effectiveness	White	48.3%	50.3%	56.5%
	BME	53.1%	58.5%	64.0%
My immediate manager asks for my opinion before making decisions that affect my work	White	49.8%	51.3%	54.9
	BME	56.8%	58.6%	61.9%
I would feel secure raising concerns about unsafe clinical practice	White	67.4%	66.0%	70.2%
	BME	66.9%	70.3%	71.6%
I am confident that my organisation would address my concern	White	45.4%	45.4%	54.0%
	BME	51.7%	56.4%	57.9%
If you were concerned about unsafe clinical practice would you know how to report it?	White	93.2%	92.6%	93.7%
	BME	92.5%	95.1%	95.1%

My organisation encourages us to report errors, near misses or incidents	White	80.1%	82.0%	86.5%
	BME	82.4%	86.1%	85.8%
My organisation treats staff who are involved in an error, near miss or incident fairly	White	48.8%	48.1%	60.0%
	BME	59.9%	60.4%	66.1%
When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again	White	58.0%	58.8%	66.9%
	BME	63.4%	70.3%	73.7%
We are given feedback about changes made in response to reported errors, near misses and incidents	White	50.7%	50.4%	58.3%
	BME	57.2%	64.3%	68.3%
The last time you experienced bullying or abuse at work did you or a colleague report it?	White	39.3%	41.1%	44.1%
	BME	50.0%	54.4%	50.3%

A6. Trust monitoring of staff engagement

As well as using the staff survey to inform its work on equality and diversity, the new trust board conducted monthly staff surveys to monitor staff engagement and track the effect of its cultural improvements. The results from this survey were then reviewed by the leadership, culture and workforce programme, which set objectives and milestones to address the necessary cultural improvements highlighted by the survey.

Currently, this survey does not enable responses to be analysed according to protected characteristics. Given the state of change in which the trust is regarding diversity and equality, the trust may consider changes to this survey to enable comparisons to be made according to protected characteristics.

A7. Our findings and recommendations

It was clear that the new trust leadership, in accordance with its agreement with NHS Improvement, had made addressing historical equality issues in the organisation a priority.

With regards to ethnicity, this was reflected in the support that the new board sought from NHS England and the ongoing work it has done with its WRES Implementation Team, in particular to produce and deliver its race equality action plan, mentioned above.

The data relating to how the trust was meeting NHS England's race equality standard, (see tables one and two above,) also showed that these actions were beginning to have a positive effect, with the majority of the indicators showing an improvement, including in workers' perceptions about race equality.

To embed these improvements the trust was working closely with its WRES action group, and at the time of our review had just started working with the British Association of Physicians of Indian origin (BAPIO).

Where the WRES data indicated that improvements in the treatment of BME staff were still required, actions to address these issues were set out in the trust WRES action plan. The trust had received continued support from the WRES Implementation Team at NHS England in putting this plan together.

The new leadership's commitment to addressing equality issues was also demonstrated in its engagement and collaboration with LGBT workers in the trust. We also note that the trust's willingness to work with its LGBT workers triggered a significantly positive response from its workforce, not only in the numbers wanting to attend its recent conference, but also in the number of ideas and suggestions from workers it produced.

We also observe that the trust leaders' efforts to make these changes occurred at the same time as facing significant challenges in delivering care and financial management. Because of improvement in these areas, the 'special measures' support provided by NHS Improvement ended (see page 9 above.)

The survey results in table three show the improved experiences of BME workers in relation to speaking up. Out of the 12 survey questions highlighted, the results for nine were better in 2018 as compared with 2017, with two being worse.

While it is clear that the trust's leaders are not complacent, we do reflect that workers and former workers in the trust, including members of the BME network action group, believe that racial discrimination continues to exist in the organisation.

We also note that the trust has not put in place a network for BME workers to replace the one it ceased to recognise in 2018. The trust leadership told our review that it would keep this situation under review, but that it was confident that the new WRES action group provided a supportive and effective forum for BME staff to speak up.

It is not the function of this review to comment upon whether any historic allegations are true. But we do conclude that the organisation should continue to strive to engage with all its workers and ensure that all are free to speak up, especially those who have expressed concern that discrimination remains in the trust.

The small number of results highlighted in red in tables two 2 and three 3 respectively, are an indication that there is still some work for the trust to do to address issues of race inequality.

In concluding our findings on these matters, firstly we commend and endorse the actions taken by the organisation to improve the speaking up culture in respect of minority staffing groups.

Secondly, specifically in relation to BME issues, while we do not make a recommendation about instituting a new BME network, as the trust is receiving close support from the WRES implementation team on such matters, we do suggest that it keeps a watching brief on this issue, given the feelings expressed by some staff about the continued existence of racial discrimination in the organisation.

Thirdly, we observe that, while the trust undertook some additional surveys of its staff to measure cultural change, (see A6 above) these did not identify the ethnicity, or other protected characteristics, of the workers responding to them and therefore potentially missed an opportunity to learn more about those workers' views of their working culture. The trust should therefore consider adapting any future such surveys so that comparisons in engagement levels can be made according to protected characteristics.

Lastly, we do make one recommendation for ourselves in relation to the concern expressed by the BME Network Action Group that those to whom they spoke up in the trust did not understand issues from a BME worker's perspective (see paragraph A1.2.)

It is the responsibility of the NGO to provide speaking up training and training guidance that is supportive of workers' needs. Our current National Foundation training stresses the importance of identifying and supporting the needs of workers from vulnerable groups.

The term "vulnerable groups" is defined to include a potentially broad range of workers including students and trainees, agency and shift workers as well as workers with protected characteristics. However, we will review our training material to ensure that it includes clear messages about the need for Freedom to Speak Up Guardians to consider vulnerable groups in their organisation in the widest sense as well as specifically referencing the importance of considering the needs of BME workers.

Recommendation 1

Within 3 months the National Guardian's Office will take steps to ensure that the speaking up training it delivers and planned national guidance, specifically references the needs of BME workers as a 'vulnerable group' alongside wider considerations of other groups of workers who may encounter particular barriers to speaking up.

B. Overall speaking up culture in the trust

B1. Introduction

As described above, we not only looked at issues of ethnicity and diversity during our review, but also the overall speaking up culture in the trust and the steps its leaders had taken to improve it.

This was because we had previously delayed commencing our review to give the new trust board time to make cultural changes and we therefore wanted to review these actions and the effect they have made.

We have commended those examples of innovation that we found and made recommendations where we have identified that support for workers to speak up can be improved.

B2. Speaking up data

B2. 1 NHS Staff Survey

As shown in table 3 above, the NHS staff survey asks workers for the views on a range of questions related to speaking up culture.

We have divided these questions and their responses into those that relate to speaking up about improvement and change and those that concern speaking up about incidents and concerns.

This is an important distinction. Speaking up culture is not just about whether workers are free to raise matters relating to actual harm to workers or patients, or the risk of it happening. For speaking up to be business as usual, workers should be encouraged to speak up about improvement and change where they work.

The table below shows the results for the latest survey in the trust in 2018, compared with the results in 2017 and the national average from acute trusts. All these results improved and are highlighted in green:

Table 4

NHS Staff Survey Question	Trust 2017 survey result	Trust 2018 survey result	National average in 2018
Speaking up and responding to views about improvement and change			
I am able to make suggestions to improve the work of my team/department	72.1%	75.3%	74.5%
I am involved in deciding on changes introduced that affect my area/team/department	49%	53.5%	52.6%
The team I work in often meets to discuss the team's effectiveness	51.5%	57.2%	58.6%
Senior managers act on staff feedback	22.6%	33.1%	32.4%
My immediate manager asks for my opinion before making decisions that affect my work	52.1%	55.8%	54.1%
Speaking up about and responding to unsafe practices, errors and incidents			
I would feel secure raising concerns about unsafe clinical practice	65.4%	69.4%	69.2%
I am confident that my organisation would address my concern	46.2%	54.4%	56.8%
If you were concerned about unsafe clinical practice would you know how to report it?	92.4%	93.5%	94.2%
My organisation encourages us to report errors, near misses or incidents	81.8%	86%	88%
My organisation treats staff who are involved in an error, near miss or incident fairly	49.4%	60.7%	58.5%
When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again	59.6%	67.7%	69.9%
We are given feedback about changes made in response to reported errors, near misses and incidents	51.5%	59.5%	58.9%
The last time you experienced bullying or abuse at work did you or a colleague report it?	42.7%	45.1%	44.2%

The last time you saw an error, near miss or incident that could have hurt staff or patients/service users, did you or a colleague report it?	93.8%	95%	95%

Another important indicator of the working culture in a trust, as measured by the NHS staff survey, is the 'staff engagement score'. This is calculated by combining the survey results relating to staff levels of motivation and satisfaction, workers' perception of their involvement in the organisation and their willingness to be an advocate for it.

The engagement score in trust had improved from 6.5 in the 2017 survey, to 6.9 in the 2018 survey. The national average for acute trusts in 2018 was 7.0.

B3. Published data about cases raised to the trust's Freedom to Speak Up Guardians

The National Guardian's Office asks Freedom to Speak Up Guardians in all trusts and foundation trusts for information on Freedom to Speak Up cases raised with them.[11] The office publishes the majority of this data. In line with the expectations of the office, the trust Guardian included this data in regular reports in person on speaking up culture to the trust board. The FTSU Guardian also seeks feedback from workers who they have supported to speak up and, where possible, collects demographic information on the workers who have spoken up.

This data is not intended to reflect the full picture of speaking up in a trust. There are many routes for workers to raise matters, whether through incident reporting mechanisms, via their line manager or educational supervisor, or directly to an executive or non-executive director amongst others. However, there may be occasions where none of these routes are suitable and a worker seeks an alternative route.

[11] https://www.cqc.org.uk/national-guardians-office/content/speaking-data

The most up-to-date results at the time of writing of this report, for the period between April 2017 – December 2018, are below:

Table 5

	Total cases raised	Raised anonymously	Element of patient safety	Element of bullying and harassment	Staff report suffering detriment for speaking up
2017-2018					
April - June	15	1	9	7	2
July – Sept.	15	1	11	10	0
Oct. – Dec.	12	0	5	8	0
2018					
Jan. - March	9	0	3	1	0
April - June	14	0	7	2	0
July – Sept.	13	1	6	6	0
Oct. – Dec.	15	0	5	4	3

B4. Staff views on the trust culture

During our review we met with 78 workers, either in face-to-face interviews, or in forums where we met groups of workers together. We were able to ask most of these workers for their personal views on the speaking up culture in the trust, including on whether they believed it had changed since the appointment of the new trust board in April 2017.

The majority of those who expressed a view (approximately 35 workers) were generally positive about how the culture of the organisation had changed. One commented that there was a new focus on improving the speaking up culture, which also had the effect of 'putting patients first'. Another worker described the trust as 'moving in the right direction.'

Several workers spoke positively of the 'patient first' system for supporting workers to raise issues and collectively resolve them in the services where they worked. There is more about this process below.

There were also many compliments for the role of the trust Freedom to Speak Up Guardian and the additional support it provided for workers to raise matters. One commented: 'I feel confident to speak up now because I know there is someone there to support me.'

Another explained that they had experienced bullying and threatening behaviour from a colleague and 'was on the verge of going off sick, but once they contacted the Guardian meetings with HR were arranged that led to the resolution of the matter and an apology from their colleague'.

However, five workers we spoke to either expressed some confusion about the role's purpose or had never heard of it before. Two commented that they thought the Guardian was only there to support medical staff about patient safety issues.

More information is provided in this report about the role of the Freedom to Speak Up Guardian in section C below.

Not all workers comments were positive. Three expressed the view that the service where they worked was 'very 'cliquey', with a culture of 'favouritism and cronyism'. Another, who worked with many staff members across the organisation, said that there were ongoing issues with the 'culture of individual managers [who consistently fail] to set a good example when handling speaking up'. One worker, who asked to remain anonymous, commented that whenever their colleagues spoke up they 'were shouted and sworn at'.

A common concern expressed to our review, from workers of all levels in the organisation, was the cultural improvements were far from complete and that the leaders in place since April 2017 would leave before this was done. One worker observed that the new construction programme at the site 'was a symbol of hope', but if the leaders left 'the improvement in morale would be lost'. Another commented that a previous lack of leadership stability in the organisation 'in the past few years was incredibly de-motivating' and that further leadership turnover would have the same effect.

Workers also identified that in addition to 'fragile' improvements staff were also currently working under great pressure, particularly because of the shortage of resources in the organisation and this in turn put the working culture under stress.

We asked all workers we met about what more they thought the organisation could do to improve the speaking up culture. A common response was that workers needed more training to have 'difficult conversations' with each other, both from the point of view of speaking up about matters likely to cause disagreement and in respect of how those matters should be handled, especially by line managers.

One senior trust worker, observing that those in supervisory roles needed more support to better handle speaking up issues commented '… there has been a gap in training and skills development in the organisation'.

We make more observations about training in section C below.

B5. Actions to improve the speaking up culture

B5. 1 Patient First Programme

Trust leaders cited their most significant improvement action was the 'Patient First Programme'. This is described as "a long-term approach to transforming hospital services for the better, through improving, re-designing, standardising and empowering." The programme was first rolled out at Western Sussex Hospitals NHS Foundation trust before that trust formed a partnership with Brighton and Sussex University Hospitals trust (in April 2017).

The Western Sussex website[12] states the programme is 'based on proven improvement methodologies, most notably the principles of 'kaizen' (or 'continuous improvement') and the 'lean approach' to management developed by the Toyota Motor Company and adapted successfully for use in healthcare by organisations such as the Virginia Mason Medical Center and Thedacare.'

[12] https://www.westernsussexhospitals.nhs.uk/your-trust/performance/patient-first/

The principal element in the programme which supported workers to speak up was 'improvement huddles.' These were meetings comprising of any workers or patients who wished to attend with the purpose of raising and discussing issues, of any nature or size, to find solutions and identify improvements.

The team responsible for delivering the programme to different services in the organisation also had a role in sharing the learning from the different huddles across the trust. In addition, teams were invited to share their respective learning by attending regular 'lunch and learn sessions'.

During our review, we attended an improvement huddle on a ward in one of the trust's services where the programme had been rolled out. All 11 staff members attending the huddle spoke positively about them. They explained the huddles took place three times a week and were attended by workers from all parts of their service and of all levels of seniority.

At each meeting workers spoke up about and discussed subjects on the 'improvement huddle board' that both workers and patients in the service were free to post. Matters raised were divided into different categories, including 'quick wins' 'improvement ideas' and 'work in progress'.

Where able, individuals raising matters were encouraged to put their name to the matter they had posted and to lead on its resolution, though the managers present noted that this was not always practical. An example was given of an improvement outcome from a recent huddle on the ward. An issue was raised by a worker concerning violence and aggression from patients. The improvements put in place led to policy and procedural changes and a reduction in incidents.

Away from the ward we visited we asked other trust workers about the effect on speaking up of the improvement huddles. Responses were generally positive. We also noted that one staff member was keen for the programme to be extended to their service. The trust had a timetable to roll it out to further parts of the organisation.

B5. 2 Governance oversight of incidents

The trust leadership had implemented new governance processes to help deliver more effective responses to low, moderate and severe clinical incidents reported by workers. Those incidents categorized as 'moderate' or 'severe' were monitored by a group of senior trust managers, to ensure the services where they were raised properly responded to them, as well as identifying appropriately independent people to conduct any investigations.

Monthly meetings of senior trust staff also took place as part of these processes to oversee the outcomes of investigations and to identify learning from them. Learning was then shared at team level, including at multi-disciplinary team meetings. Mechanisms were also in place to ensure that the individual workers who reported the incidents received feedback, including an email sent to the worker concerned, detailing the findings and lessons learned, once the investigation into the matter was complete.

B5. 3 Speaking up policy

To support its workers to speak up the trust had a policy entitled 'Freedom to speak up: raising concerns (whistleblowing) policy and procedure'. The new leadership issued a revised speaking up policy in March 2018 based on national guidance from NHS Improvement[13], as part of its cultural improvement work. Our colleagues at NHS Improvement commented on the trust's policy as follows:

- **General comments**

'Overall, the tone and language is good, with really helpful and practical info in the appendices – particularly the flow chart and tips for managers. The policy gets to the point of things fairly quickly.'

- **Suggestions to improve language and terminology**

  - Remove the comment *"whistleblowing has been the subject of much adverse attention"* as this could potentially dissuade workers from speaking up
  - References to speaking up *"in good faith"* and *"in the public interest"* are references to the Public Interest Disclosure Act, but such references are 'unhelpful and are best avoided.'
  - The message *"Seen Something – Say Something"* – is 'really good'. Can it 'be highlighted even more prominently?'
  - The reference to *"hate crime"* should be removed as 'staff cannot be expected to know what the definition of that is and only the police can investigate crime'
  - An explanation of the difference between confidentiality and anonymity 'could be helpful'
  - The policy should include contact details for individuals referred to in the policy 'as and when they are mentioned'
  - The policy implies that there will be circumstances where it's inappropriate for a worker to speak up to an outside body, 'but this is not helpful, since staff can do this if they choose.'
  - The policy refers to staff accessing *"independent advice"*, without explaining where this could come from
  - The policy does not explain the difference between an informal review, an internal enquiry and a formal investigation
  - The undertaking in the policy that workers who speak up will receive an agreed summary of the issues raised is 'good'
  - The wording of the policy suggests that the trust Freedom to Speak Up Guardian only presents their reports about the culture and the cases they have supported to a committee of the board, rather than in person to the full board. This should be changed to reflect the fact that the trust Guardian does present their reports in person to the full
  - board, as required by guidance from NHS Improvement[14], in addition to the board quality and risk committee

[13] https://improvement.nhs.uk/documents/2468/Freedom_to_speak_up_guidance_May2018.pdf

B5. 4 Speaking up self-assessment tool

As part of its guidance on speaking up for trust boards NHS Improvement provides a self-review tool[15] to 'enable boards to carry out in-depth reviews of leadership and governance arrangements in relation to FTSU and identify areas to develop and improve.'

At the time of our review the trust had recently completed a self-assessment that highlighted several improvements it needed to make to its speaking up arrangements. The board had set out actions to achieve these improvements. These actions included:

- Regular meetings between the trust Freedom to Speak Up Guardian, HR staff and managers responsible for overseeing the handling of reported serious incidents to ensure workers raising issues were properly supported and to identify issues, challenges and improvements in supporting speaking up
- Analysis of the results of the 2018 staff survey in the trust (published at the time of our review) to identify opportunities for learning and improvement
- Strengthen the messages in 'Patient First' training so it describes 'a clear expectation that all staff have a role in speaking up to enable continuous improvement'
- Build management skills in crucial/difficult conversations to grow confidence in managing and dealing with issues of any type as they arise

B5. 5 Gap analysis of previous NGO case review recommendations

In line with guidance for boards on speaking up produced by NHS Improvement and the NGO, trusts should undertake gap analysis of recommendations made in previous published reviews. At the time of writing, we have made over 80 recommendations to improve support for workers to speak up, most aimed at NHS trusts and foundation trusts.

During our review we saw that the trust had undertaken quite detailed analysis of our recommendations and had identified some areas where it needed to take action to implement our findings but had not yet made any plans to undertake those actions.

B5. 6 Obtaining data about speaking up culture using exit interviews

Trust leaders we spoke to said they were considering using exit interviews with staff leaving the organisation to obtain potentially valuable insights about workers' views on the trust's speaking up culture. All workers leaving the trust were offered an exit interview.

In common with exit interviews used in other NHS trusts, (as well as other sectors) workers leaving the organisation were able to provide information about their experiences about working in the trust by completing a questionnaire. Workers could also request a face-to-face interview with a member of organisation's HR team to provide this feedback. In some areas of the Trust where there were retention issues face-to-face interviews were offered to all workers.

The trust used information gathered from its exit interviews to inform the work of one its cultural workstreams, which reported to the board on cultural issues and how the organisation should address them.

[15] https://improvement.nhs.uk/resources/freedom-speak-guidance-nhs-trust-and-nhs-foundation-trust-boards/

A senior leader said that the trust was considering adding questions to the questionnaire to gain additional insights into workers' views into the speaking up culture and any obstacles to speaking up they believe they faced to help contribute to this cultural improvement work.

In the 12 months prior to our review 42% of workers leaving the organisation took part in an exit interview.

B6. Our findings and recommendations

There was clear evidence that the speaking up culture of the trust was improving.

Firstly, this was evident from the 2018 NHS staff survey, which showed positive changes in responses from workers, compared to the 2017 survey. For example, there was a 4-percentage point improvement in how secure workers felt raising concerns about unsafe clinical practice, an 8-percentage point improvement in the numbers reporting receiving feedback about concerns raised and an 11-percentage point increase in those saying they would be treated 'fairly' for speaking up about such matters (see table 4 above.)

Secondly, a large proportion of the total number of workers who expressed a view on the culture of the organisation said that it was beginning to improve, and many cited the actions of the new trust board, since their appointment in April 2017, as the primary cause for those positive changes.

Thirdly, the Care Quality Commission's evaluation of the trust's culture in its 2018 inspection report, which mentions the role of the Guardian, (though without describing the speaking up culture in detail) referred to a wholly improved working culture from its previous inspection in 2016.

There was anxiety among many workers we spoke to, at all levels across the trust, that the new trust leaders might leave the organisation before the improvements they had started were completed. Adding to this anxiety was uncertainty about what would happen once the management agreement finished in April 2020.

We therefore recommend that once NHS Improvement reaches a decision with the two trusts and any relevant stakeholders regarding the future leadership of the organisation, to mitigate the anxiety that we found during our review, this decision is communicated to all trust workers without undue delay.

Recommendation 2

As soon as is practicable, following the decision regarding the future leadership of the organisation, the trust should inform its workforce of that decision.

We saw evidence that workers were positive about the Patient First programme and saw it as an opportunity to speak up to deliver change, about a myriad of issues, big or small.

We observe that such open forums may not always be the appropriate place for workers to speak up about all issues, for example those relating to the conduct of their colleagues. On its own, this programme also cannot provide a solution to all the barriers to speaking up that an organisation may need to tackle, but instead can form part of an integrated and holistic solution to such issues.

The governance framework around responding to medium and serious clinical incidents reported by workers, included clear oversight to ensure prompt and independent investigation of those incidents. It also described processes to provide feedback and learning about actions taken in response to incident reports to specific staff groups, as well to the individuals who reported them. Providing feedback to workers who speak up is an important element in positive working cultures.

As discussed, the trust had implemented a new speaking up policy to reflect the principles and values set out in the standard policy for the NHS. The review of the trust's policy by NHS Improvement was largely positive and we recommend to the trust that it makes the amendments they have set out above.

As the trust has already identified in its gap analysis of our case review recommendations for Nottinghamshire Healthcare NHS trust[16] the need to alert staff to potential policy changes, we do not make an additional recommendation in this regard.

Recommendation 3

Within 12 months the trust should revise its speaking up policy, to ensure it is in line with the amendments required by NHS Improvement quoted in this report.

As set-out in the joint NGO and NHS Improvement guidance on speaking up for boards, the trust had undertaken gap analysis of our previous case review recommendations but had not taken steps to implement the completed analysis. We therefore recommend that the trust completes this work.

Recommendation 4

Within 6 months the trust should take all appropriate steps to implement the actions identified in its gap analysis of National Guardian Office case review recommendations.

We commend the trust's plans to use its exit interviews as a source of additional information about what workers leaving the organisation feel about its speaking up culture. This data will not only potentially provide valuable insight into workers' views, in addition to staff surveys, but revising the exit interview at this point will also provide a helpful baseline from which the trust can measure the effect of its cultural improvement work.

[16] https://www.cqc.org.uk/sites/default/files/201801107-Nottinghamshire%20Healthcare%20NHS%20Foundation%20Trust%20A%20review%20of%20the%20handling%20of%20speaking%20up%20cases.pdf

C.Supporting good practice

C1. Introduction

In this section we set out information about how the trust was specifically supporting good practice in speaking up and our findings and recommendations in relation to that work.

C2. Freedom to Speak Up Guardian

As required by its contract[17] with NHS England, the trust had appointed a Freedom to Speak Up Guardian to support workers to raise matters. In accordance with guidance from the National Guardian's Office[18], (that is included in the principles described below,) the trust provided protected time to the Guardian to perform their role.

As indicated by table five, since their appointment the Guardian was providing support to workers who were speaking up about a variety of issues.

C2. 1 Good practice we found – based on the principles from the 2017 Freedom to Speak Up Guardian Survey

We identified examples of good speaking up practice relating to how the trust had implemented the role of the trust Freedom to Speak Up Guardian, based on the principles we set out in our survey of Guardians in 2017.

- **Fairness -** the Freedom to Speak Up Guardian in the trust was appointed following a fair and open recruitment process, which included advertising the post externally

- **Conflict** – the Guardian did not have any conflicts of interest in respect of their role

- **Reach**– in the absence of the Guardian, and to provide an alternative route to speaking up, workers were able to seek support from the Guardian in the neighbouring NHS trust that had formed a partnership with Brighton and Sussex.

  At the time of our review the trust had also begun developing a network of cultural ambassadors. Their role included modelling behaviours that representing the values of the organisation. They could also signpost workers wishing to speak up to sources of support. Ambassadors were appointed from across different teams and levels of the trust, following nomination by their colleagues in recognition of their work. They were recognised as demonstrating their ability to role model the values of the organisation.

[17] https://www.england.nhs.uk/wp-content/uploads/2019/03/7-SF-GCs-1920.pdf
[18] https://www.cqc.org.uk/sites/default/files/20170915_Freedom_to_Speak_Up_Guardian_Survey_2017.pdf

- **Communication**– there was a communications strategy to communicate the role of the Guardian across the organisation, including:
    - via the trust internal communication system
    - for new workers on induction
    - in weekly staff bulletins
    - through speaking engagements given by the Guardian to a variety of staff groups
    - posters advertising the role across the organisation

  At the time of our review the Guardian was also undertaking a 'roadshow' to visit all services across the widely dispersed trust to meet workers and describe the purpose of their role.

- **Partnership** – the Guardian attended regular meetings of different parts of the organisation to help develop working partnerships with key staffing groups involved in cultural change, including diversity networks, colleagues from the trust's HR department and the 'leading change' working group to discuss how the organisation should respond to the results from the staff survey.

  At the time of our review the Guardian was also planning to attend further such regular meetings with the Guardian of Safe Working Hours and the new disability network.

- **Leadership** - The Guardian had access to all trust leaders, including regular meetings with, and direct supervision from, the trust chief executive officer

- **Openness** – The Freedom to Speak Up Guardian reported regularly to the trust board, as well as executive committees of the board, on their work, providing information on the numbers and types of cases they were supporting workers to raise and the themes arising.

  Their reports also included analyses of the data on those cases and recommendations for action for the board in response to that analysis. The reports' content was in accordance with guidance from NHS Improvement

- **Feedback -** the Guardian sought feedback from all individuals they had supported to speak up regarding their performance, to help them identify learning and improvement

- **Time** – the trust provided the Guardian with 2.5 days per week of protected time for them to perform their Guardian role.

  At the time of our review the trust was looking at whether to increase this allocation. Its leaders said they would consider a range of factors before reaching a decision, including the current workload of the Guardian, the number of cases raised with them and the overall needs of the workforce

C3. Having 'difficult conversations'

As described earlier in this report (see paragraph B4,) many workers told our review that an area for potential improvement in the speaking up culture of the trust was improving the ability of staff, particularly those in managerial and supervisory roles, to conduct and respond to 'difficult conversations'. This can be a key challenge in responding to speaking up effectively, particularly where messages are given that do not want to be heard.

The trust was aware of the potential need to provide training in this area and at the time of our review a meeting between senior trust managers to consider whether such training might be provided was held. At the time of writing of this report the trust told us that in this meeting 'there was a positive appetite to take forward [these ideas and] next steps are being prepared.'

C4. Our findings and recommendations

The role of the Guardian was implemented in accordance with the principles set out above, which included communicating the role using a variety of channels, including those directed at reaching vulnerable workers. However, as noted above (see paragraph B4) some workers were either ignorant of the role, or misunderstood its purpose, believing it to only support workers to speak up about clinical or patient safety concerns, whereas the role of Guardians is to support workers to speak up about any matters that are important to them.

The 'roadshow' mentioned above, to help raise awareness about the Guardian is something we commend, particularly given the dispersed geographical nature of the trust and the confusion that appears to exist around the role, albeit among a small minority of those we spoke to. Nevertheless, given the vital function played by the Guardian in any trust's culture, we recommend that, following the completion of the roadshow, the trust also takes appropriate steps to test the awareness and understanding of its workers about the role.

Recommendation 5

Within 6 months of the completion of its roadshow to promote the existence and purpose of its Freedom to Speak Up Guardian across its workforce, the trust takes appropriate steps to measure the effectiveness of its communications strategy relating to the role.

Recommendation 6

Within 12 months the trust completes the work it identifies as necessary to help ensure that workers, in particular those responsible for responding to speaking up matters, have the appropriate skills to handle difficult conversations.

The development of the cultural ambassador role, described above, was a further example of the actions being taken by the trust to improve the working culture in the organisation.

It was clear that that trust sought to appoint a diverse range of ambassadors including from different parts and levels of the organisation, although there was no information on how the ambassador programme would take account of the demographics of the organisation.

From our 2018 Freedom to Speak Up Guardian survey[19] we have recommended that trusts consider the demographics of their workers when appointing guardians and champions. An element of the ambassador role, as described by trust, reflects that of champions in other organisations, namely to promote positive cultural values and to signpost workers to sources of support to resolve issues.

Given the issues already identified in this report concerning equality and diversity this is an opportunity for the trust to ensure that there is appropriate representation of ambassadors that will meet the needs of the entire workforce.

Recommendation 7

Within 6 months the trust should take reasonable steps to ensure that its network of cultural ambassadors reflects the diversity of the workforce that it supports.

What will happen next

An action plan from the trust to implement our recommendations

Following publication of this report, NHS Improvement, which is the regulator in England for NHS trusts and foundation trusts, will ask the trust to produce an action plan to implement our recommendations, within the timescales we have set.

It is the NGO's expectation that NHS Improvement will ask trusts to publish their action plans. Once the trust puts their plan into effect NHS Improvement will monitor the trust's implementation of that action plan and will provide the NGO with updates regarding its progress.

Where there is evidence that the trust has not taken effective actions to implement our recommendations we will expect NHS Improvement, as well as Care Quality Commission inspectors, to take appropriate steps to address this.

Our response to individual contributors to our review

The National Guardian's Office will contact those individuals who have spoken up to our review, thanking them and providing feedback to them on how their experiences have been reflected in this report. We will also ask them for feedback on their experience of how we have conducted this review.

In addition, we will contact staff who spoke to us individually during the review to confirm whether they have subsequently experienced any detriment for speaking up. Where they tell us this has

[19] https://www.cqc.org.uk/sites/default/files/20181101_ngo_survey2018.pdf

taken place we will refer any such cases to the trust and, if necessary, regulators to take appropriate action.

Other NHS trusts' responsibilities to implement our recommendations

As described on page four of this report, we expect all other NHS trust boards in England, in accordance with the guidance we have co-produced for them in collaboration with NHS Improvement, to implement this report's recommendations in their own services, where it is appropriate to do so.

Feedback to help improve our case review process

To help us improve our process we welcome feedback from all readers of this report. Please send your comments to: casereviews@nationalguardianoffice.org.uk

Annex – summary of recommendations

The recommendations arising from the case review are listed below.

They are grouped according to when we recommend the work is completed by the body in question to implement each recommendation.

Recommendations to be completed within three months

Recommendation 1

Within 3 months the National Guardian's Office will take steps to ensure that the speaking up training it delivers and planned national guidance, specifically references the needs of BME workers as a 'vulnerable group' alongside wider considerations of other groups of workers who may encounter particular barriers to speaking up.

Recommendation 4

Within 3 months the trust should take all appropriate steps to implement the actions identified in its gap analysis of National Guardian Office case review recommendations.

Recommendations to be completed within six months

Recommendation 5

Within 6 months of the completion of its roadshow to promote the existence and purpose of its Freedom to Speak Up Guardian across its workforce, the trust takes appropriate steps to measure the effectiveness of its communications strategy relating to the role.

Recommendation 7

Within 6 months the trust should take reasonable steps to ensure that its network of cultural ambassadors reflects the diversity of the workforce that it supports.

Recommendations to be completed within twelve months

Recommendation 6

Within 12 months the trust completes the work it identifies as necessary to help ensure that workers, in particular those responsible for responding to speaking up matters, have the appropriate skills to handle difficult conversations.

Recommendation 3

Within 12 months the trust should revise its speaking up policy, to ensure it is in line with the amendments required by NHS Improvement quoted in this report.

To be completed as soon as it is practicable

Recommendation 2

As soon as is practicable, following the decision regarding the future leadership of the organisation, the trust should inform its workforce of that decision.

National Guardian
Freedom to Speak Up

NHS

Guidance for boards on Freedom to Speak Up in NHS trusts and NHS foundation trusts

July 2019

NHS England and NHS Improvement

Contents

Introduction

Effective speaking up arrangements help to protect patients and improve the experience of workers. We know the main reasons workers do not speak up are because they fear they might be victimised or because they do not believe anything will change.

Since we first launched this guidance the NHS has published its interim People Plan, setting out its vision for people who work for the NHS to enable them to deliver the best care possible. Ensuring that everyone feels they have a voice, control and influence is at the forefront of the plan.

This guide supports boards to create that culture; one where workers feel safe and able to speak up about anything that gets in the way of delivering safe, high quality care or affects their experience in the workplace. This includes matters related to patient safety, the quality of care, and cultures of bullying and harassment. To support this, managers need to feel comfortable having their decisions and authority challenged: speaking up should be embraced. Speaking up, and the matters that speaking up highlights, should be welcomed and seen as opportunities to learn and improve.

We have aimed this guide at senior leaders because it is the behaviour of executives and non executives (which is then reinforced by managers) that has the biggest impact on organisational culture. How an executive director (or a manager) handles a matter raised by a worker is a strong indicator of a trust's speaking up culture and how well led it is.

Meeting the expectations set out in this guide will help a board create a culture responsive to feedback from workers and focused on learning and improving the quality of patient care and the experience of workers. Our expectations are accompanied by a self-review tool. Regular and in-depth reviews of leadership and governance arrangements in relation to Freedom to Speak Up (FTSU) will help boards to identify areas for further development.

The Care Quality Commission assesses a trust's speaking up culture under Key Line of Enquiry (KLOE) 3 as part of the well-led domain of inspection. This guide forms part of the resource pack given to inspectors ahead of well-led inspections.

Completing the self-review tool and developing an improvement action plan will help trusts to reflect on their current speaking up culture as part of their overall strategy and create a coherent narrative for their patients, workforce and oversight bodies. Details of the support available to do this are on page 10.

About this guide

This guide has been produced jointly by NHS Improvement and the National Guardian's Office, with input from a group of executives and non-executive directors (which included chief executives and chairs), FTSU Guardians and leading academics in culture and leadership.

The guide sets out our expectations, details individual responsibilities and includes supplementary resources.

We expect the executive lead for FTSU to use the guide to help the board reflect on its current position and the improvement needed to meet our expectations. Ideally the board should repeat this self-reflection exercise at least every two years.

It is not appropriate for the FTSU Guardian to lead this work as the focus is on the behaviour of executives and the board as a whole. But obtaining the FTSU Guardian's views would be a useful way of testing the board's perception of itself.

The improvement work the board does as a result of reflecting on our expectations is best placed within a wider programme of work to improve culture. This programme should include a focus on creating a culture of compassionate and inclusive leadership; the creation of meaningful values that all workers buy into; tackling bullying and harassment; improving staff retention; reducing excessive workloads; ensuring people feel in control and autonomous, and building powerful and effective teams.

The good practice highlighted here is not a checklist: a mechanical 'tick box' approach to each item is not likely to lead to better culture. Equally, focusing on process and procedure at the expense of honestly reflecting on how you respond when someone speaks up will not improve the way the board leads the cultural improvement agenda. The attitude of the board to the review process and the connections it makes between speaking up and improved patient safety and staff experience are much more important.

We will review this guide in 2021. In the meantime, please provide any feedback to nhsi.ftsulearning@nhs.net

Our expectations

Behave in a way that encourages workers to speak up

All executive directors have a responsibility for creating a safe culture and an environment in which workers are able to highlight problems and make suggestions for improvement. FTSU is a fundamental part of that. They also understand that an organisational or department culture of bullying and harassment or one that is not welcoming of new ideas or different perspectives may prevent workers from speaking up which could put patients at risk, affect many aspects of their staff's working lives, and reduce the likelihood that improvements of all kinds can be made.

Executive directors understand the impact their behaviour can have on a trust's culture and therefore how important it is that they reflect on whether their behaviour may inhibit or encourage someone speaking up. To this end executive directors:

- are able to articulate both the importance of workers feeling able to speak up and the trust's own vision to achieve this
- speak up, listen and constructively challenge one another during board meetings
- are visible and approachable and welcome approaches from workers
- have insight into how their power could silence truth
- thank workers who speak up
- demonstrate that they have heard when workers speak up by providing feedback
- seek feedback from peers and workers and reflect on how effectively they demonstrate the trust's values and behaviours
- accept challenging feedback constructively, publicly acknowledge mistakes and make improvements.

Executive directors could test how their behaviour is perceived with direct and incidental feedback from staff surveys; pulse surveys; social media comments; reverse mentoring, 360º feedback and appraisals.

Demonstrate commitment

The board demonstrates its commitment to creating an open and honest culture where workers feel safe to speak up by:

- having named executive and non-executive leads responsible for speaking up, who can demonstrate that they are clear about their role and responsibility and can evidence the contribution they have made to leading the improvement of the trust's speaking up culture. **Section 1 of the supplementary information pack** sets out the responsibilities of the executive and non-executive lead

- including speaking up and other related cultural issues in its board development programme

- having a sustained and ongoing focus on the reduction of bullying, harassment and incivility

- sending out clear and repeated messages that it will not tolerate the victimisation of workers who have spoken up and taking action should this occur with these messages echoed in relevant policies and training. The executive lead for FTSU is responsible for gaining assurance that the experience of workers who speak up is a positive one

- investing in sustained and continuous leadership development

- having a well-resourced FTSU Guardian and champion model. **Section 2 of the supplementary information pack** sets out suggestions of how to assess your FTSU Guardian's capability and capacity

- supporting the creation of an effective communication and engagement strategy that encourages and enables workers to speak up and promotes changes made as a result of speaking up. **Section 3 of the supplementary information pack** sets out suggestions of how to evaluate the effectiveness of your communication strategy

- inviting workers who speak up to present their experiences in person to the board.

Have a strategy to improve your FTSU culture

Boards have a clear vision for the speaking up culture in their trust that links the importance of encouraging workers to speak up with patient safety, staff experience and continuous improvement. The vision is supported by a strategy that has been developed by the executive lead for FTSU; this sits under the trust's overarching strategy and supports the delivery of other relevant strategies.

The board discusses and agrees the strategy and is provided with regular updates. The executive lead for FTSU reviews the FTSU strategy annually, including how it fits with the overall trust strategy, using a range of qualitative and quantitative measures, to assess what has been achieved and what hasn't; what the barriers have been and how they will be overcome; and whether the right indicators are being used to measure success.

It doesn't matter whether the strategy document is called a plan or a strategy; as long as the executive lead has well-thought-out goals that are measurable and have been signed off by the board. **Section 4 of the supplementary information pack** sets out suggestions for what should be in your strategy and provides a checklist to help with the evaluation of your strategy.

Support your FTSU Guardian

Boards demonstrate their commitment to creating a positive speaking up culture by having a well-resourced FTSU Guardian, supported by an appropriate local network of 'champions' if needed. FTSU Guardians need access to enough ringfenced time and other resources to enable them to meet the needs of workers in your organisation. See **Section 2 of the supplementary information pack.**

The executive lead and the non-executive lead, along with the chief executive and chair meet regularly with the FTSU Guardian and provide appropriate advice and support. The FTSU Guardian has ready access to senior leaders and others to enable them to escalate urgent matters rapidly (preserving confidence as appropriate). **Section1 of the supplementary information pack** sets out the individual responsibilities of relevant executives.

Relevant executive directors ensure the FTSU Guardian has ready access to applicable sources of data and other information to enable them to triangulate speaking up issues and proactively identify patterns, trends, and potential areas of concerns. **Section 5 of the supplementary information pack** sets out the kind of data and other information you could triangulate.

Finally, executive directors encourage and enable their FTSU Guardian to develop bilateral relationships with regulators, inspectors, and other FTSU Guardians, and attend regional network meetings, National Guardian conferences, training and other related events.

Be assured your FTSU culture is healthy and effective

The board needs to be assured that workers will speak up about things that get in the way of providing safe and effective care and that will improve the experience of workers. **Section 6 of the supplementary information pack** sets out the different elements that the board should consider seeking assurance for.

Boards may need further assurance when there have been significant changes, where changes are planned, or there have been negative experiences such as:

- before a significant change such as a merger or service change
- when an investigation has identified a team or department has been poorly led or a culture of bullying has developed
- when there has been a service failing
- following a Care Quality Commission (CQC) inspection where there has been a change in rating

It is the executive lead's responsibility to ensure that the board receives a range of assurance and regular updates in relation to the FTSU strategy.

An important piece of assurance is the report provided in person by the FTSU Guardian, at least every six months and **Section 7 of the supplementary information pack** sets out the kind of information the board should expect to be in the FTSU Guardian's report. To be clear this should not be the only assurance the board receives.

Another important piece of assurance is an audit report of the trust's speaking up policy. The trust's speaking up arrangements must be based on an up-to-date speaking up policy that reflects the minimum standards set out by NHS Improvement and should be audited at least every two years. **Section 8 of the supplementary information pack** sets out what a comprehensive audit should cover. The audit report should not focus solely on FTSU Guardian activity but on the effectiveness of all the speaking up channels as well as the whole speaking up culture.

If the board is not assured its workers feel confident and safe to speak up, it should consider getting external support to understand what is driving that fear.

Be open and transparent with external stakeholders

A healthy speaking up culture is created by boards that are open and transparent and see speaking up as an opportunity to learn. Executives routinely discuss challenges and opportunities presented by the matters raised via speaking up with commissioners, CQC, NHS Improvement and their local quality surveillance groups. The board welcomes engagement with, and feedback from, the National Guardian and her staff.

The board regularly discusses progress against the FTSU strategy and (respecting the confidentiality of individuals) themes and issues arising from speaking up (across all the trust's speaking up channels) at the public board. The trust's annual report contains high level, anonymised data relating to speaking up, as well as information on actions the trust is taking to support a positive speaking up culture.

To enable learning and improvement, executive directors discuss learning from speaking up reviews, audits and complex cases among their peer networks. To support this learning, ideally, reviews and audits are shared on the trust's website.

The executive lead for FTSU requests external improvement support when required.

Conclusion

Meeting the expectations in this guide will help boards to send the message that ideas, concerns, feedback, whistleblowing and complaints are all seen as opportunities to stop and reflect on whether something could be done differently.

Valuing workers' opinions and acting on them, publicising the good that comes from speaking up, and making clear and unequivocal statements that you will not tolerate staff being victimised for speaking up, will all encourage workers to use their voice for the benefit of patients and their colleagues.

We have provided useful resources as supplementary information to this guide but if having completed your review you would like further support to improve aspects of your FTSU arrangements, please get in touch with:

- nhsi.ftsulearning@nhs.net for the following support to the executive lead:
  - review FTSU policy, strategy or action plans and provide feedback to bring them in line with national policy or recognised best practice
  - design and facilitate workshops to develop board understanding of speaking up and behaviour that encourages or inhibits it
  - host online surveys and facilitate focus groups with workers to identify issues, causes and solutions
  - facilitate an assessment of your trust's FTSU arrangements against national guidance and support the executive lead to build a FTSU improvement action plan
- enquiries@nationalguardianoffice.org.uk who will arrange for support for the FTSU Guardian in relation to their role.

NHS England and NHS Improvement
133-155 Waterloo Road
London
SE1 8UG

0300 123 2257
enquiries@improvement.nhs.uk
improvement.nhs.uk

@NHSImprovement

National Guardian's Office
151 Buckingham Palace Road
London
SW1W 9SZ

0300 067 9000
enquiries@nationalguardianoffice.org.uk
cqc.org.uk/national-guardians-office/content/national-guardians-office

@NatGuardianFTSU

This publication can be made available in a number of other formats on request.

July 2019 Publications code: CG 44/19

Publishing Approval Reference 000787

National Guardian
Freedom to Speak Up

Freedom to Speak Up Index Report 2019

Contents

Foreword by Simon Stevens

Speaking out when you see something going wrong at work takes courage no matter what your job. When you work in the NHS – as a nurse, doctor, physio or in any other role – it can sometimes also feel a lonely and daunting experience. That is why we are determined to ensure we do everything possible to support those who make their voices heard on behalf of patients.

Freedom to speak up guardians can be a very powerful presence to ensure that NHS organisations – their management and boards – listen to concerns. NHS England is tripling funding and we now have 500 guardians in place across the country.

In the past, however, not every NHS organisation has done enough to make staff feel that they can speak out. That is why last year I asked the National Guardian to help measure how free nurses, doctors and other staff felt to raise concerns at different organisations.

Twelve months on there is encouraging progress in making NHS organisations more open and transparent. Our staff are world-class but if we want to help them to deliver the improvements in care and treatment set out in the NHS Long Term Plan we need to show them the same duty of care, compassion and empathy that we provide our patients.

A porter, nurse or consultant surgeon who speaks up is an invaluable part of any NHS organisation – they do so because they want the very best for their patients and their colleagues. And trusts that allow staff to speak out about issues are likely to deliver better outcomes for patients and will have happier staff.

The Freedom to Speak Up Index helps trusts understand how their staff perceive the speaking up culture. Trusts can compare their scores to others, buddy up with those that have received higher index scores and promote learning and good practice.

Already the index is having a significant impact, with 180 trusts (82%) having made progress in making it easier for staff to speak out since 2015, with London Ambulance improving its rating by 18%. This means more staff than ever before feel secure raising concerns if they see something unsafe and feel confident that if they were to make a mistake, they would be treated fairly by their trust.

But a more open and transparent working culture will not just mean happier staff, it will also mean happier patients too. Evidence consistently shows that a positive speaking up culture leads to better CQC ratings, and ultimately better care for our patients. And this is what drives over a million people to go to work for the NHS every day. It is everyone’s responsibility to speak up when they see something that doesn’t look right – and now more than ever, staff are doing exactly that.

Foreword by Dr Henrietta Hughes

Everyone needs to be valued and listened to and feel fairly treated at work. Nowhere is this more important than in health when it can be a matter of life or death. A positive environment and a supportive culture are key elements of the People Plan[1]. We have shown that a positive speaking up culture is often associated with higher performing organisations. Workers are the eyes and ears of an organisation and they should be listened to when considering patient safety and experience. The best leaders understand how important this is. These leaders create an inclusive speaking up culture where everyone's insight and expertise is valued, and all workers are empowered to speak up and contribute to improvements in patient care.

Culture is a term which can be interpreted in different ways. To some it might seem vague and difficult to pin down. Some organisations want their culture to change but do not know where to start or how to change. In our Freedom to Speak Up Guardian Surveys, we showed that guardians in organisations rated Outstanding by the Care Quality Commission were more positive in their perceptions of the speaking up culture[2]. To ensure speaking up becomes business as usual, the voices of other workers must also be involved. We have therefore created a single measure from four questions from the 2018 NHS Staff Survey[3].

This new Freedom to Speak Up Index, brought together by my office and NHS England, identifies the view of the staff on the speaking up culture in NHS Trusts and Foundation Trusts (FTs). For trust boards to be able to use a measure to learn more about their own Freedom to Speak Up culture, as experienced by their workforce, is an opportunity for improvement. This is not a perfect tool, as it is based on a sample of staff and there are additional limitations as students, volunteers and others are not included.

When it comes to establishing effective speaking up cultures, the highest scoring NHS trusts and Foundation Trusts featured in this report have shared their experience for the rest of the health system to learn from. They have had meaningful conversations with their workers, embraced opportunities to improve, followed guidance from my office and developed innovative ways to create and sustain a positive speaking up culture for their workforce.

The average FTSU Index score nationally has increased since 2015 and I am optimistic that this will continue to improve but not complacent about the organisations in which there is significant room for improvement. I call on leaders and Freedom to Speak Up Guardians in NHS trusts and FTs to use the index as a new measure for assessing the speaking up culture in their organisation. The insights of the organisations featured in this report will help you find comparable organisations with whom you can buddy up and learn from the best in the NHS. I encourage commissioners and

[1] https://www.longtermplan.nhs.uk/publication/interim-nhs-people-plan/

[2] https://www.cqc.org.uk/sites/default/files/20171115_ngo_annualreport201617.pdf

[3] https://www.nhsstaffsurveys.com/Page/1056/Home/NHS-Staff-Survey-2018/

regulators to use the FTSU Index to ask providers about their speaking up arrangements and to encourage improvement.

Introduction

The Interim People Plan aims to 'to grow the NHS's workforce, support and develop NHS leaders and make our NHS the best place to work'. The plan says that in addition to recruiting extra staff, much more needs to be done to improve staff retention and transform ways of working. Secretary of State Matt Hancock MP has said that 'we need …. a more supportive culture to make that plan a reality'[4]. A positive speaking up environment where workers feel valued and listened to is fundamental to developing a supportive culture.

The events at Mid Staffs[5] and Gosport War Memorial Hospital[6] serve as reminders of the harm that can occur to patients when this type of culture does not exist. Following the publication of the Francis Freedom to Speak Up Review in 2015[7] Trusts and Foundation Trusts in England have appointed Freedom to Speak Up Guardians[8]. The network has now grown to over 1000 guardians, champions and ambassadors in NHS trusts and FTs, independent sector providers, national bodies and primary care organisations. Thousands of cases have been brought to Freedom to Speak Up Guardians since April 2017[9].

The National Guardian's Office has previously published survey reports that indicate that a positive speaking up culture is associated with higher performing organisations as rated by CQC. The annual NHS staff survey contains several questions that serve as helpful indicators of the speaking up culture. Working with NHS England, the National Guardian's Office has brought four questions together into a 'Freedom to Speak Up (FTSU) index'. This is to enable trusts to see at a glance how their FTSU culture compares with others. This will promote the sharing of good practice and enable trusts that are struggling, to 'buddy up' with those that have recorded higher index scores.

The results throughout are based on the results of the 2018 NHS annual staff survey. Where percentage point improvement is recorded, this is based on the overall changes recorded between 2015 and 2018.

Nationally the median FTSU score has improved since 2015. Some trusts have seen a rapid improvement in their FTSU index score and in others there has been a reduction in the score. We have included case studies from the best performing trusts of each type and those that have made the most significant improvement. These case studies detail the changes that trusts have made to engage with their workforce and develop a positive speaking up culture and the impact that this has made.

[4] https://www.england.nhs.uk/2019/06/more-staff-not-enough-nhs-must-also-be-best-place-to-work-says-new-nhs-people-plan/

[5] https://www.bbc.co.uk/news/health-21244190

[6] https://www.bbc.co.uk/news/topics/cx2pw2r8yp9t/gosport-hospital-deaths

[7] http://freedomtospeakup.org.uk/the-report/

[8] https://www.cqc.org.uk/sites/default/files/20180213_ngo_freedom_to_speak_up_guardian_jd_march2018_v5.pdf

[9] https://www.cqc.org.uk/sites/default/files/CCS119_CCS0718215408-001_NGO%20Annual%20Report%202018_WEB_Accessible-2.pdf

The Freedom to Speak Up Index for each trust and the CQC ratings for Overall and Well Led are included in Annex 1. The information is taken from the CQC website[10] and the annual NHS Staff Survey at the time of publication.

Survey questions and FTSU Index

The FTSU index was calculated as the mean average of responses to four questions from the NHS Annual Staff Survey.

The survey questions that have been used to make up the FTSU index are:

- % of staff responded "agreeing" or "strongly agreeing" that their organisation treats staff who are involved in an error, near miss or incident fairly (question 17a)
- % of staff responded "agreeing" or "strongly agreeing" that their organisation encourages them to report errors, near misses or incidents (question 17b)
- % of staff responded "agreeing" or "strongly agreeing" that if they were concerned about unsafe clinical practice, they would know how to report it (question 18a)
- % of staff responded "agreeing" or "strongly agreeing" that they would feel secure raising concerns about unsafe clinical practice (question 18b)

[10] https://www.cqc.org.uk/


Disability is
not a choice –
your attitude is

Summary of results

Overall, the national median FTSU index has increased since 2015, and this pattern is reflected for all trust types:

	FTSU index			
Trust type	2015	2016	2017	2018
National	75%	77%	77%	78%
Acute Specialist Trusts	79%	79%	79%	81%
Acute Trusts	75%	76%	76%	77%
Ambulance Trusts	66%	69%	69%	74%
Combined Acute and Community Trusts	76%	77%	77%	78%
Combined Mental Health / Learning Disability and Community Trusts	78%	77%	79%	80%
Community Trusts	79%	80%	81%	83%
Mental Health / Learning Disability Trusts	74%	76%	77%	79%

The following represent the trusts with the highest FTSU index result for 2018, broken down by trust type:

Trust type	Trust	FTSU index value 2018
Community	Cambridgeshire Community Services NHS Trust	87%
Combined mental health / learning disability and community trust	Solent NHS Trust	86%
Acute Specialist	Liverpool Heart and Chest Hospital NHS Foundation Trust	86%
Acute	The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	84%
Combined acute and community	Gateshead Health NHS Foundation Trust	83%
Combined mental health / learning disability	Surrey and Borders Partnership NHS Foundation Trust	81%
Combined mental health / learning disability	Northumberland, Tyne and Wear NHS Foundation Trust	81%
Combined mental health / learning disability	Tees, Esk and Wear Valleys NHS Foundation Trust	81%
Combined mental health / learning disability	Tavistock and Portman NHS Foundation Trust	81%
Ambulance	Isle of Wight NHS Trust (ambulance sector)	79%

Cambridgeshire Community Services NHS Trust: Visible leadership in action

"Our transparent and open culture has been built up over a number of years and during that time we have developed a style across the organisation that puts our people first. We have a long standing systematic 'back to the floor' programme in place that our senior leaders prioritise each month and this visibility and approach is positively received by our staff. Additionally, it is in the DNA of the organisation for all our leaders to be out and about every week, talking and listening to staff in an informal and low-key way. We have lots of examples through these visits of our staff sharing concerns and issues and feeling very comfortable and confident to speak up.
We support our managers to be leaders and have embedded compassionate leadership into our internal development programmes and our appraisal systems and processes.

'*it is in the DNA of the organisation for all our leaders to be out and about every week, talking and listening to staff in an informal and low-key way. We have lots of examples through these visits of our staff sharing concerns and issues and feeling very comfortable and confident to speak up*'.

'We support our managers to be leaders and have embedded compassionate leadership into our internal development programmes and our appraisal systems and processes'.

We developed our values with our staff over 8 years ago and we continually check that they remain valid today through talking with our staff. Our values and agreed set of behaviours are embedded in all that we do, and we spend time and energy on making sure we encourage people to speak up if they are concerned about anything. How our staff speak up is entirely up to them, there is never a wrong way. We are explicit at induction about them never worrying about telling the wrong person the most important thing if they are concerned about anything is to tell someone! They can raise concerns informally or formally and we work with them directly to agree how they wish their concern to be handled.

They can speak with their line manager; another member of their team; contact our Freedom to Speak Up Guardian or one of our Freedom to Speak Up Champions; link with our full-time staff side chair; speak with one of our Cultural Ambassadors or share directly with our Chief Executive or another member of our Executive team and we have lots of examples of when our staff have done this. We always provide feedback to individuals who raise concerns so that they are assured and confident that their issue/s have been dealt with. We also deal with concerns anonymously if requested to do so - the most important thing for us is that the concern is being heard and acted upon.

'..through the results our staff have fed back that they feel secure in raising concerns; that they are confident that we would deal with these and that they feel engaged and valued'.

We are very proud of our annual national staff survey results and have seen year on year improvements. We focus on a small number of improvement areas each year rather than everything and through the results our staff have fed back that they feel secure in raising concerns; that they are confident that we would deal with these and that they feel engaged and valued. We continue to make further improvements to ensure that we are an excellent employer and one of the NHS Best Places to Work."

'We are explicit at induction about them never worrying about telling the wrong person the most important thing if they are concerned about anything is to tell someone!'

Liverpool Heart and Chest Hospital NHS FT: Learning and Sharing to create an open and safe culture

Freedom to Speak Up Guardian Helen Turner with Mr Sanjay Ghotkar and the FTSU Charter

"Liverpool Heart and Chest Hospital is committed to FTSU and its principles, patient safety and staff experience are at the heart of everything we do. Our Board of Directors takes an active interest in concerns raised by staff, the process in which these are dealt with and supports an ethos of learning and sharing. The Trust's approach to FTSU is summed up by the Chief Executive's 3-point pledge which is widely communicated:

Please Speak Up – when you do:

I will listen
I will investigate, and if you let me know who you are you will receive feedback
I will keep you safe

A quarterly 'Freedom to Speak Up Summit' is chaired by the Director of Corporate Affairs /Executive Lead for FTSU and attended by the Chief Executive, Medical Director, Director of Nursing, Director of Workforce, Deputy Director of Nursing, Freedom to Speak up Guardian and Deputy Freedom to Speak up Guardian. The commitment of the Trust towards empowering staff to speak up, keeping both patients and staff safe is demonstrated by the membership of the group.
The purpose of the summit is to review the quarter's speak ups and triangulate data from staff experience and patient safety looking for trends, themes and any areas that maybe hotspots in order that any action can be identified and swiftly taken.

'The Trust is constantly innovating to ensure patient safety, the data produced for the summit includes the usual serious incidents, never events, incident reporting but also data from the daily trust wide safety huddle convened in the Chief Executive's office where current issues are raised and escalated immediately'.

Patient Safety

The Trust is constantly innovating to ensure patient safety, the data produced for the summit includes serious incidents, never events and incident reporting but also data from the daily trust wide safety huddle convened in the Chief Executive's office where current issues are raised and escalated immediately. Other data shared at the summit include HALT an innovation that was introduced at the Trust in 2015.

HALT is an acronym that stands for
Have you seen this?
Ask – did you hear my concern?
Let them know it is a patient safety issue
Tell them to **STOP** until it is agreed it is safe to continue

HALT empowers all staff no matter what grade and whether clinical or not to use the HALT process if they see a potential patient or staff safety incident. HALT has not only prevented 92 safety incidents to date, since its inception but has broken down hierarchical barriers that have traditionally existed in healthcare.
A monthly Learning and Sharing Forum brings together senior leaders, including ward and departmental managers to cascade learning, share examples and promote an open and safe culture.

HALT is an acronym that stands for
***H**ave you seen this?*
***A**sk – did you hear my concern?*
***L**et them know it is a patient safety issue*
***T**ell them to **STOP** until it is agreed it is safe to continue*

Staff Experience

'The "grass is greener" is an initiative which encourages staff who are leaving or thinking about leaving the Trust to understand their reasons and look at what we could do to reduce turnover and improve staff safety and experience'

Workforce data is shared at the summit including an HR relations report, which includes the number of bullying and harassment, grievances/ET claims, disciplinaries, suspensions etc. Also, innovations such as 'grass is greener' data is shared and discussed. The 'grass is greener' is an initiative which encourages staff who are leaving or thinking about leaving the Trust to understand their reasons and look at what we could do to reduce turnover and improve staff safety and experience.

Freedom to Speak Up Guardian

The Freedom to Speak Up Guardian (FTSUG) reports to the membership not just on concerns raised and action taken but also on national guidance and any actions the Trust needs to take to ensure best practice, this means benchmarking against case reviews, information from the latest NGO guidance and reporting on pertinent issues from the regional network groups and the national conference.

Learning from Freedom to Speak Up

Feedback from our staff has revealed that at times managers and those with supervisory roles have felt vulnerable about staff speaking up against them, sometimes as a result of unpopular management decision. In response to this we have worked with staff to develop an 'FTSU Charter' setting out clearly what can be expected both when you speak up and when you are spoken up about.

'we have worked with staff to develop an 'FTSU Charter' setting out clearly what can be expected both when you speak up and when you are spoken up about'.

The focus on FTSU and Board level membership of the summit means that the Trust is proactive and not just reactive in dealing with matters of patient and staff safety and is constantly pushing the agenda forward through innovation."

Tees Esk and Wear Valleys NHS Foundation Trust: Speaking Up drives improvement

Freedom to Speak Up Guardian Dewi Williams

"We are using the principles identified within the 2017 Freedom to Speak Up Guardians survey as a framework for the description of how Tees, Esk and Wear Valleys NHS Foundation Trust has sought to make Freedom to Speak Up arrangements business as usual."

- **FAIRNESS.** The Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) Freedom to Speak Up Guardian (FTSUG) Dewi Williams, was appointed in October 2016 following interview as part of a post retirement redeployment process. He currently works 18 ½ hours a week, and this is his sole employment.

- **REACH AND DIVERSITY.** We have a developing network of 'Dignity at work champions,' who support the FTSUG and who will be key to the success of our new Bullying and Harassment Resolution Procedure. We currently have 16 champions but hope to have around 40 by the end of the year. It is intended that they are present within each of the TEWV geographical localities and will be representative of protected characteristic groups. We also have a deputy FTSUG working one day a week, Barry Speak, who is a psychologist and works in a staff wellbeing service.

'We have a monthly awareness raising message attached to our electronic staff newsletter which communicates key messages and reminds staff about where they can get support with Speaking Up'.

- **COMMUNICATION.** We have a monthly awareness raising message attached to our electronic staff newsletter which communicates key messages and reminds staff about where they can get support with Speaking Up. The FTSUG also has an intranet page where staff can get contact details, see the policy, and get downloadable posters.

- **PARTNERSHIP.** We have developed a monthly in-house support forum. Staff from a range of staff wellbeing services get together to share intelligence, debrief, and support each other in what could otherwise be very isolated and challenging roles. Part of the FTSUG role is to meet as many people as possible to raise awareness. The FTSUG conducts regular staff training in all our sites. The opportunity is taken to conduct informal meetings with teams in those sites.

- **LEADERSHIP.** Board of Directors and Executive Management Team members undertake a series of planned visits each month to individual wards and departments throughout the Trust to engage directly with staff about service and workplace issues, including speaking up. The FTSUG meets at least bi-monthly with the chief executive and the director of human resources. He also meets regularly with many other senior managers as part of the role. He meets at least twice yearly with the executive and non-executive directors with responsibility for Speaking Up. They also deliver twice yearly board reports. Demonstrating board commitment to Speaking Up can be seen by our [staff] video which shares directors' values, beliefs, and commitment to ensuring that staff can feel safe to come forward.

'Board of Directors and Executive Management Team members undertake a series of planned visits each month to individual wards and departments throughout the Trust to engage directly with staff about service and workplace issues, including speaking up'

- **FEEDBACK.** At the conclusion of cases the FTSUG has asked two questions; would you do it again, and did you experience any detriment? Whilst getting many complimentary replies, the specific questions have been sporadic. We will be addressing this issue as part of an upcoming process review day. In addition to approaching their line manager, the Dignity at Work Champions and the FTSUG all TEWV staff can raise concerns electronically and anonymously, should they choose to do so. Each of these concerns are published within the TEWV e-bulletin along with the responses that are agreed by the Executive Management Team under the heading of 'You said, we did.'

In addition to approaching their line manager, the Dignity at Work Champions and the FTSUG all TEWV staff can raise concerns electronically and anonymously, should they choose to do so. Each of these concerns are published within the TEWV e-bulletin along with the responses that are agreed by the Executive Management Team under the heading of 'You said, we did.'

- **PROACTIVE AND REACTIVE ROLE. We are constantly reviewing how we are doing and improving practice.** We are to hold an event with some of those who have experience of conducting whistleblowing investigations, and some who have experienced being investigated, to look for opportunities to standardise and improve the experience for all involved. Initially the FTSUG role was predominantly reactive. However, are using our Staff 'Friends and Family' results to identify teams that may benefit from proactive support awareness raising, and training.
-
- **ATTENDING SUPPORT NETWORKS.** On appointment the FTSUG attended the initial training provided by the National Guardian's Office and has since attended updates delivered within the regional network. To date the FTSUG has been to three national conferences, and regularly attends the very useful and supportive regional meetings.

- **DATA MANAGEMENT.** We have a confidential data storage system. It has benefitted from being audited. Currently we only log issues raised with the FTSUG and we know that many more issues are raised with line managers and are successfully handled. However, we do not know exactly how many, and therefore are not able to quantify, or benefit from the potential shared learning. We aspire to developing an acceptable data gathering approach that will help us develop a library of experience from which we can share more learning."

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust: Reach and visibility to engage staff

Freedom to Speak Up Guardian Helen Martin with Tom Beaumont, Sally Papworth and Catherine Bishop

"In 2013 The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust faced a number of significant challenges, including a poor CQC rating. A programme of improvement and culture change was introduced by our Board. Within this journey we heard staff in our cultural audit say that they wanted to feel safer in raising concerns, so we developed our culture of safety.

'we heard staff in our cultural audit say that they wanted to feel safer in raising concerns, so we developed our culture of safety'.

A major part of this was the creation of our first Freedom to Speak Up Guardian (FTSUG) post. The Trust took guidance from the National Guardian Office (NGO) conference to ensure that the role was ring-fenced to meet its full requirements and that networking with national and local colleagues was encouraged to help develop and evolve the role.

'The Trust took guidance from the National Guardian Office (NGO) conference to ensure that the role was ring-fenced to meet its full requirements and that networking with national and local colleagues was encouraged to help develop and evolve the role'.

We used feedback from our cultural audit to shape our own [framework]. Staff wanted easy access, more face-to-face interactions and visibility irrespective of ethnicity or background. Our Guardian devised a clear policy around speaking up, supported by a communications strategy.

Our guardian attended team meetings, delivered presentations including to trust induction, facilitated focus groups, as well as deployed our highly successful (and decorated) roaming trolley. The trolley rounds of our wards were often accompanied by our diversity team or one of our executives, demonstrating that we wanted to hear the voices of all our staff and as part of our Board commitment. Our Board developed a public statement of commitment and benchmarked our progress within interactive Board development session. They also receive regular feedback from our Guardian and support her wellbeing through supervision.

'The trolley rounds of our wards were often accompanied by our diversity team or one of our executives, demonstrating that we wanted to hear the voices of all our staff and as part of our Board commitment'.

The Trust built on our local and trust governance structure, with a renewed focus on learning from errors. This was underpinned with new incident reporting forms which encourage sharing and learning of good practice from errors as well as raising improvement ideas and issues. Both have made significant impacts to the reporting culture of RBCH.

Helen Martin, the Trust's Freedom to Speak Up Guardian, said: 'The key to all our work has been listening to our staff to develop a culture of safety and feedback. Raising concerns is something that should routinely be done and as part of an ongoing conversation. We continue to evolve our model and feel that we are in the best position to support our staff in our future organisation change.'

'..new incident reporting forms which encourage sharing and learning of good practice from errors as well as raising improvement ideas and issues. Both have made significant impacts to the reporting culture of RBCH'.

Our guardian has now expanded the role to a team of six ambassadors across a variety of professional backgrounds which has made speaking up more accessible. Helen is now also working across Royal Bournemouth and Poole hospitals, as our two trusts move towards merger. This ensures staff have access to FTSU teams while undergoing significant organisational changes.

Six years on and RBCH is seeing the benefits of the Trust-wide programme of improvement, including national leaders for safety culture and staff engagement. Helen Martin added, 'We are proud to see that RBCH is recognised as having the highest index score for 2018 for acute trusts further demonstrating the success of our cultural journey over the last six years'."

The ‘Roaming Trolley’ at Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust

Increase and decrease in the FTSU index by individual trust

The table below shows the percentage point increase and decrease in FTSU Index value during the period 2015 – 2018 for 220 trusts.

Of these 220 trusts:

- 180 recorded an overall increase 2015 - 2018 in FTSU index (82%)
- 40 recorded an overall decrease 2015 – 2018 in FTSU index (18%)
- The highest overall increase was recorded by London Ambulance Service NHS Trust (18 percentage points)
- The greatest overall decrease was recorded by Wrightington, Wigan and Leigh NHS Foundation Trust (-4 percentage points)

Trusts with greatest overall increase in FTSU index

Trust	2015	2018	2015 - 18
London Ambulance Service NHS Trust	57	75	**18**
Isle of Wight NHS Trust (ambulance sector)	62	79	**17**
North East Ambulance Service NHS Foundation Trust	64	76	**12**
East Sussex Healthcare NHS Trust	66	78	**12**
South East Coast Ambulance Service NHS Foundation Trust	64	74	**10**
The Royal Orthopaedic Hospital NHS Foundation Trust	73	82	**9**
Sherwood Forest Hospitals NHS Foundation Trust	70	79	**9**
Isle of Wight NHS Trust (mental health sector)	69	77	**8**
Gloucestershire Care Services NHS Trust	74	82	**8**
Lincolnshire Partnership NHS Foundation Trust	72	80	**8**

Trusts with greatest overall decrease in FTSU index

Trust	2015	2018	2015 - 18
Great Western Hospitals NHS Foundation Trust	81	79	**-2**
Salisbury NHS Foundation Trust	82	80	**-2**
East and North Hertfordshire NHS Trust	75	73	**-2**
The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust	74	72	**-2**
King's College Hospital NHS Foundation Trust	77	75	**-2**
Great Ormond Street Hospital for Children NHS Foundation Trust	80	78	**-2**
James Paget University Hospitals NHS Foundation Trust	79	76	**-3**
Wrightington, Wigan and Leigh NHS Foundation Trust	81	77	**-4**

London Ambulance Service: 100 Voices Case Study

At London Ambulance Service NHS Trust (LAS), a paramedic spoke up to the Freedom to Speak Up Guardian, Katy Crichton, about a number of matters. The issues reported to Katy ranged from challenging behaviours to service-wide problems, such as a lack of training for new staff and inadequate capacity to deal with call volumes.

'I have seen significant changes in my place of work. It is a much more pleasant place to be. People are listened to and actions have been taken'

The paramedic told Katy, "I had sat in the office for several weeks worrying if I should speak to a colleague, a manager or a friend outside work. Occasionally, I would convince myself that I was exaggerating the state of affairs. Feeling isolated, I decided to contact the LAS guardian.

"My brief email prompted a very quick reply back from the guardian. We met a few days later in a coffee shop away from work and I already felt I was going to be taken seriously."

Katy escalated the matters and, with the involvement of the leadership team, including the Chief Executive, an action plan was established. After a couple of months, a review of the issues revealed that the actions had not gone far enough, and further measures were put in place, taking into account advice from the paramedic who spoke up.

'Listening to staff and learning from them is hugely important'

The paramedic said, "I have seen significant changes in my place of work. It is a much more pleasant place to be. People are listened to and actions have been taken."

As a result of the issues raised, the trust increased staffing levels in some areas, developed a new operational structure for the service, invested in additional training for staff, and monitored calls through a regular audit. Feedback from commissioners reported positive changes to the service and outcomes for patients.

Katy said, "We are very grateful that the paramedic felt able to come forward. By speaking up they have improved the working environment for themselves and for our patients.

"Listening to staff and learning from them is hugely important. It was particularly gratifying that the leadership team continued to listen, even after they had drawn up an action plan, and modified it based on further feedback. The ongoing experiences of the paramedic who spoke up really helped to address the problems in a comprehensive way."

'an email to the Guardian changed a lot, making the trust a better place to work and providing safer care for our patients'

The paramedic remarked when reflecting on their experience of speaking up, "One thing is for sure – an email to the guardian changed a lot, making the trust a better place to work and providing safer care for our patients."

Surrey and Borders Partnership NHS Foundation Trust: Joy at work

Freedom to Speak Up Guardian Lynn Richardson with Roopavathay Krishnan

"Surrey and Borders Partnership NHS Foundation Trust appointed its Freedom to Speak Up Guardian (FTSUG) through open competition in October 2016. The FTSUG came into post from April 2017 and since then has worked with the senior leadership and staff teams as part of our work to further develop the culture within our Trust.
SABP is a mental health and learning disability Trust with many sites spread across Surrey and North East Hampshire.

We have always aspired to be a diverse and inclusive Trust; one of our first activities when we were formed in 2005, led by our Chief Executive and Chair, was to coproduce our Vision and Values through a series of conversations with people who use our services, carers and families, other stakeholders and our staff. Our Values have guided us, as our "compass", and formed the foundations for our aspirations ever since. Building upon them we have placed great importance on our staff's

'one of our first activities when we were formed in 2005, led by our Chief Executive and Chair, was to coproduce our Vision and Values through a series of conversations with people who use our services, carers and families, other stakeholders and our staff. Our Values have guided us, as our "compass", and formed the foundations for our aspirations ever since'.

responses through the national staff survey and working closely with our Staff Networks to develop our practice as part of staff engagement.
Once our FTSUG was in post, we began to gain a rich intelligence through our quarterly Speaking Up reports. These enabled the senior leadership team to begin thinking about building upon Speaking Up, as part of our quality improvement approach, to build a workforce where our employees enjoy coming to work, are encouraged to develop their skills and by so doing, create a compassionate, caring culture for the people who use our services.

'Our Senior Leadership team undertook a programme of staff consultations with our workforce in the summer of 2018 in order to understand what gave our employees 'Joy At Work' but also where we needed to do better to improve their working experience'.

Our Senior Leadership team undertook a programme of staff consultations with our workforce in the summer of 2018 in order to understand what gave our employees 'Joy At Work' but also where we needed to do better to improve their working experience. We took away actions such as improved information technology needs and the re-introduction of water coolers. The important part of this exercise was for the voice of our staff to be heard by our senior leaders and this has been built upon since then. For example, we used to organise our own programme of Board and Governor "walkaround" visits with a checklist of things to look out for in our services. Since really listening to our staff, we now ask our teams to invite us to their service and encourage them to show us the things they are really proud of.

'we now ask our teams to invite us to their service e.g. to showcase for us the things they are proud of, rather than them feeling that we are checking up on them'

We also really wanted to welcome our new recruits into the organisation effectively and instil our belief in a speaking up culture. We changed our induction programme to make it shorter, based on feedback, and since our FTSUG has been speaking at that programme, we have had some excellent intelligence from our new staff on things we can improve upon. Our staff gain confidence by meeting our Guardian in person, either through induction or at team meetings/formal training events and we are pleased with our achievements to date in the first two years of our Raising Concerns approach.

'Our staff gain confidence by meeting our Guardian in person, either through induction or at team meetings/formal training events and we are pleased with our achievements to date in the first two years of our Raising Concerns approach'.

Conclusions and next steps

Listening to the voice of workers is fundamental to improving patient safety and experience and improving the working lives of our colleagues. At a time when the NHS workforce is under extreme pressure and trusts are seeking to recruit and retain staff the annual NHS Staff survey can provide vital insights into the experience of workers.

In our previous publications we have shown that the perceptions of Freedom to Speak Up Guardians are linked with the performance of organisations as shown by their overall CQC rating. Freedom to Speak Up is inspected as part of the CQC Well Led Domain. For trust Boards to be able to use information to learn more about their own Freedom to Speak Up culture, as experienced by their workforce, is an opportunity for improvement. This may help to open a new conversation with their workforce, as many of the trusts featured in this report have done, developing their own innovations, borrowing the innovations identified here or buddying with similar trusts with higher FTSU index scores.

For commissioners and regulators, this is potentially a lead indicator which can be viewed together with other information about safety, workforce and culture. The system needs to offer support, guidance and expertise to organisations where the workforce has indicated that there is room for improvement in the speaking up culture.

Not all organisations in the health service ask their workforce the same questions as in the NHS staff survey, therefore we have not been able to use the FTSU Index for primary care organisations, independent sector providers and national bodies who have Freedom to Speak Up Guardians. For these organisations, there are insights to learn from this report, in terms of leadership behaviours and listening to the ideas and concerns from the workforce. Similar survey questions could potentially be devised to develop a FTSU Index for national bodies and others. We will continue to track the progress of NHS trusts and Foundation Trusts as they develop positive speaking up cultures for their workforce. In this way we work towards speaking up being business as usual.

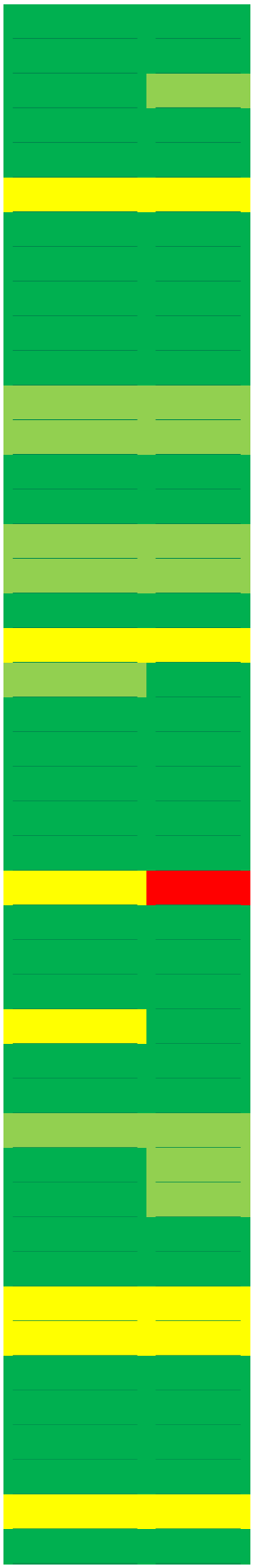
Annex 1

FTSU Index including CQC Overall and Well Led Ratings

Outstanding
Good
Requires improvement
Inadequate

FTSU index	Name of trust	CQC Overall	Well Led
87%	Cambridgeshire Community Services NHS Trust		
86%	Solent NHS Trust		
86%	Liverpool Heart and Chest Hospital NHS Foundation Trust		
85%	Hounslow and Richmond Community Healthcare NHS Trust		
85%	Northamptonshire Healthcare NHS Foundation Trust		
84%	Leeds Community Healthcare NHS Trust		
84%	The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust		
84%	The Royal Marsden NHS Foundation Trust		
84%	Lincolnshire Community Health Services NHS Trust		
83%	The Christie NHS Foundation Trust		
83%	Hertfordshire Community NHS Trust		
83%	Sussex Community NHS Foundation Trust		
83%	Gateshead Health NHS Foundation Trust		
83%	Royal Brompton and Harefield NHS Foundation Trust		
83%	Moorfields Eye Hospital NHS Foundation Trust		
83%	Derbyshire Community Health Services NHS Foundation Trust		
83%	Norfolk Community Health and Care NHS Trust		
83%	Shropshire Community Health NHS Trust		
82%	The Royal Orthopaedic Hospital NHS Foundation Trust		
82%	Wirral Community NHS Foundation Trust		
82%	Surrey and Sussex Healthcare NHS Trust		
82%	Frimley Health NHS Foundation Trust		
82%	Guy's and St Thomas' NHS Foundation Trust		
82%	Northern Devon Healthcare NHS Trust		
82%	Gloucestershire Care Services NHS Trust		
82%	The Clatterbridge Cancer Centre NHS Foundation Trust		
82%	Cambridgeshire and Peterborough NHS Foundation Trust		
82%	Berkshire Healthcare NHS Foundation Trust		
82%	Northumbria Healthcare NHS Foundation Trust		
82%	Cumbria Partnership NHS Foundation Trust		

82%	Harrogate and District NHS Foundation Trust
81%	Kent Community Health NHS Foundation Trust
81%	Cambridge University Hospitals NHS Foundation Trust
81%	The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS FT
81%	South Warwickshire NHS Foundation Trust
81%	Airedale NHS Foundation Trust
81%	City Hospitals Sunderland NHS Foundation Trust
81%	Worcestershire Health and Care NHS Trust
81%	Tavistock and Portman NHS Foundation Trust
81%	East Lancashire Hospitals NHS Trust
81%	Surrey and Borders Partnership NHS Foundation Trust
81%	Kingston Hospital NHS Foundation Trust
81%	St Helens and Knowsley Teaching Hospitals NHS Trust
81%	University Hospital Southampton NHS Foundation Trust
81%	North Tees and Hartlepool NHS Foundation Trust
81%	The Newcastle upon Tyne Hospitals NHS Foundation Trust
81%	Northumberland, Tyne and Wear NHS Foundation Trust
81%	Royal Devon and Exeter NHS Foundation Trust
81%	Pennine Care NHS Foundation Trust
81%	West Suffolk NHS Foundation Trust
81%	Somerset Partnership NHS Foundation Trust
81%	Royal Surrey County Hospital NHS Foundation Trust
81%	North East London NHS Foundation Trust
81%	Midlands Partnership NHS Foundation Trust
81%	Tees, Esk and Wear Valleys NHS Foundation Trust
80%	Leicestershire Partnership NHS Trust
80%	Oxford Health NHS Foundation Trust
80%	Salisbury NHS Foundation Trust
80%	Dorset HealthCare University NHS Foundation Trust
80%	University Hospitals Coventry and Warwickshire NHS Trust
80%	Cheshire and Wirral Partnership NHS Foundation Trust
80%	Dudley and Walsall Mental Health Partnership NHS Trust
80%	Hertfordshire Partnership University NHS Foundation Trust
80%	Lincolnshire Partnership NHS Foundation Trust
80%	Mersey Care NHS Foundation Trust
80%	Central London Community Healthcare NHS Trust
80%	Oxleas NHS Foundation Trust
80%	North West Anglia NHS Foundation Trust
80%	University Hospitals Plymouth NHS Trust
80%	2gether NHS Foundation Trust
80%	Sheffield Children's NHS Foundation Trust
80%	Nottingham University Hospitals NHS Trust
80%	Tameside and Glossop Integrated Care NHS Foundation Trust
80%	Southern Health NHS Foundation Trust
80%	Queen Victoria Hospital NHS Foundation Trust



80%	East London NHS Foundation Trust
80%	East Cheshire NHS Trust
80%	Royal Papworth Hospital NHS Foundation Trust
79%	University Hospitals Bristol NHS Foundation Trust
79%	Poole Hospital NHS Foundation Trust
79%	South West Yorkshire Partnership NHS Foundation Trust
79%	Luton and Dunstable University Hospital NHS Foundation Trust
79%	Mid Cheshire Hospitals NHS Foundation Trust
79%	Sandwell and West Birmingham Hospitals NHS Trust
79%	Leeds Teaching Hospitals NHS Trust
79%	Isle of Wight NHS Trust (ambulance sector)
79%	North West Boroughs Healthcare NHS Foundation Trust
79%	Royal Berkshire NHS Foundation Trust
79%	North Staffordshire Combined Healthcare NHS Trust
79%	Central and North West London NHS Foundation Trust
79%	Great Western Hospitals NHS Foundation Trust
79%	Sherwood Forest Hospitals NHS Foundation Trust
79%	Chelsea and Westminster Hospital NHS Foundation Trust
79%	Cornwall Partnership NHS Foundation Trust
79%	Blackpool Teaching Hospitals NHS Foundation Trust
79%	Royal National Orthopaedic Hospital NHS Trust
79%	Leeds and York Partnership NHS Foundation Trust
79%	Sheffield Teaching Hospitals NHS Foundation Trust
79%	University Hospitals of Morecambe Bay NHS Foundation Trust
79%	Bolton NHS Foundation Trust
79%	Portsmouth Hospitals NHS Trust
79%	Bradford District Care NHS Foundation Trust
79%	Calderdale and Huddersfield NHS Foundation Trust
79%	The Walton Centre NHS Foundation Trust
79%	Homerton University Hospital NHS Foundation Trust
79%	West Hertfordshire Hospitals NHS Trust
79%	Gloucestershire Hospitals NHS Foundation Trust
79%	Devon Partnership NHS Trust
79%	Camden and Islington NHS Foundation Trust
79%	Sussex Partnership NHS Foundation Trust
79%	Yeovil District Hospital NHS Foundation Trust
79%	Bridgewater Community Healthcare NHS Foundation Trust
78%	Manchester University NHS Foundation Trust
78%	Buckinghamshire Healthcare NHS Trust
78%	Lancashire Teaching Hospitals NHS Foundation Trust
78%	Barnsley Hospital NHS Foundation Trust
78%	Wye Valley NHS Trust
78%	The Princess Alexandra Hospital NHS Trust
78%	Birmingham Community Healthcare NHS Foundation Trust
78%	West London NHS Trust

78%	Hull and East Yorkshire Hospitals NHS Trust
78%	Kettering General Hospital NHS Foundation Trust
78%	Alder Hey Children's NHS Foundation Trust
78%	Kent and Medway NHS and Social Care Partnership Trust
78%	Milton Keynes University Hospital NHS Foundation Trust
78%	Southend University Hospital NHS Foundation Trust
78%	Torbay and South Devon NHS Foundation Trust
78%	University College London Hospitals NHS Foundation Trust
78%	Greater Manchester Mental Health NHS Foundation Trust
78%	East Sussex Healthcare NHS Trust
78%	Bradford Teaching Hospitals NHS Foundation Trust
78%	Great Ormond Street Hospital for Children NHS Foundation Trust
78%	University Hospitals of Derby and Burton NHS Foundation Trust
78%	South Tyneside NHS Foundation Trust
78%	Birmingham Women's and Children's NHS Foundation Trust
78%	Warrington and Halton Hospitals NHS Foundation Trust
78%	Essex Partnership University NHS Foundation Trust
78%	Taunton and Somerset NHS Foundation Trust
78%	Dartford and Gravesham NHS Trust
78%	Northampton General Hospital NHS Trust
78%	Coventry and Warwickshire Partnership NHS Trust
78%	Barnet, Enfield and Haringey Mental Health NHS Trust
77%	Western Sussex Hospitals NHS Foundation Trust
77%	Rotherham Doncaster and South Humber NHS Foundation Trust
77%	Bedford Hospital NHS Trust
77%	Ashford and St Peter's Hospitals NHS Foundation Trust
77%	Stockport NHS Foundation Trust
77%	Brighton and Sussex University Hospitals NHS Trust
77%	The Royal Liverpool and Broadgreen University Hospitals NHS Trust
77%	Barts Health NHS Trust
77%	Nottinghamshire Healthcare NHS Foundation Trust
77%	East Suffolk and North Essex NHS Foundation Trust
77%	Hampshire Hospitals NHS Foundation Trust
77%	Mid Essex Hospital Services NHS Trust
77%	George Eliot Hospital NHS Trust
77%	Lancashire Care NHS Foundation Trust
77%	Isle of Wight NHS Trust (mental health sector)
77%	Wrightington, Wigan and Leigh NHS Foundation Trust
77%	Lewisham and Greenwich NHS Trust
77%	Basildon and Thurrock University Hospitals NHS Foundation Trust
77%	Imperial College Healthcare NHS Trust
77%	Walsall Healthcare NHS Trust
77%	Chesterfield Royal Hospital NHS Foundation Trust
77%	Dorset County Hospital NHS Foundation Trust
77%	Royal Free London NHS Foundation Trust

77%	Oxford University Hospitals NHS Foundation Trust
77%	Derbyshire Healthcare NHS Foundation Trust
77%	Humber Teaching NHS Foundation Trust
77%	The Royal Wolverhampton NHS Trust
76%	South Central Ambulance Service NHS Foundation Trust
76%	Salford Royal NHS Foundation Trust
76%	South London and Maudsley NHS Foundation Trust
76%	The Rotherham NHS Foundation Trust
76%	York Teaching Hospital NHS Foundation Trust
76%	The Hillingdon Hospitals NHS Foundation Trust
76%	North East Ambulance Service NHS Foundation Trust
76%	Sheffield Health and Social Care NHS Foundation Trust
76%	London North West University Healthcare NHS Trust
76%	Avon and Wiltshire Mental Health Partnership NHS Trust
76%	Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust
76%	Isle of Wight NHS Trust (community sector)
76%	Black Country Partnership NHS Foundation Trust
76%	University Hospitals of Leicester NHS Trust
76%	James Paget University Hospitals NHS Foundation Trust
76%	Whittington Health NHS Trust
76%	Liverpool Women's NHS Foundation Trust
76%	Birmingham and Solihull Mental Health NHS Foundation Trust
76%	South West London And St George's Mental Health NHS Trust
76%	Barking, Havering And Redbridge University Hospitals NHS Trust
75%	Countess of Chester Hospital NHS Foundation Trust
75%	North Bristol NHS Trust
75%	Croydon Health Services NHS Trust
75%	Mid Yorkshire Hospitals NHS Trust
75%	King's College Hospital NHS Foundation Trust
75%	University Hospitals Birmingham NHS Foundation Trust
75%	Royal United Hospitals Bath NHS Foundation Trust
75%	County Durham and Darlington NHS Foundation Trust
75%	Maidstone and Tunbridge Wells NHS Trust
75%	Aintree University Hospital NHS Foundation Trust
75%	The Dudley Group NHS Foundation Trust
75%	Royal Cornwall Hospitals NHS Trust
75%	Norfolk and Norwich University Hospitals NHS Foundation Trust
75%	Weston Area Health NHS Trust
75%	Norfolk and Suffolk NHS Foundation Trust
75%	Epsom and St Helier University Hospitals NHS Trust
75%	London Ambulance Service NHS Trust
75%	Pennine Acute Hospitals NHS Trust
75%	East Kent Hospitals University NHS Foundation Trust
74%	North Middlesex University Hospital NHS Trust
74%	St George's University Hospitals NHS Foundation Trust

74%	South East Coast Ambulance Service NHS Foundation Trust	
74%	University Hospitals of North Midlands NHS Trust	
74%	Worcestershire Acute Hospitals NHS Trust	
74%	West Midlands Ambulance Service NHS Foundation Trust	
74%	Northern Lincolnshire and Goole NHS Foundation Trust	
74%	North West Ambulance Service NHS Trust	
73%	Wirral University Teaching Hospital NHS Foundation Trust	
73%	Isle of Wight NHS Trust (acute sector)	
73%	South Tees Hospitals NHS Foundation Trust	
73%	East and North Hertfordshire NHS Trust	
73%	Southport and Ormskirk Hospital NHS Trust	
72%	United Lincolnshire Hospitals NHS Trust	
72%	The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust	
72%	Medway NHS Foundation Trust	
72%	South Western Ambulance Service NHS Foundation Trust	
71%	North Cumbria University Hospitals NHS Trust	
71%	Yorkshire Ambulance Service NHS Trust	
70%	The Shrewsbury and Telford Hospital NHS Trust	
70%	East of England Ambulance Service NHS Trust	
68%	East Midlands Ambulance Service NHS Trust	

Please note, CQC ratings as at date of publication 08.10.2019
If any information in this report is inaccurate, please contact enquiries@nationalguardianoffice.org.uk so it can be updated

Acknowledgements

We would like to thank everyone who has helped with the preparation of the Freedom to Speak Up Index and this report. This includes all the trusts featured, the survey team at NHS England and current and previous members of the team at the National Guardian's Office

Agenda Item 14.4

LINCOLNSHIRE DIVERSITY AND INCLUSION EVENT
RACE EQUALITY
Tuesday, 15 October 2019 at 9.00 am - 4.00 pm
The Showroom, Tritton Road, Lincoln, Lincolnshire, LN6 7QY

Initial Briefing for the Trust Board

Background:

October is Black History Month in the United Kingdom and is a celebration of the contributions of Black, Asian and Minority Ethnic people in British society.

This event was the fourth annual NHS Lincolnshire Race Equality conference and hosted by ULHT. The conference was planned by the local NHS Equality, Diversity and Inclusion Leads, with active contributions from the BAME Staff Networks. The conference was chaired by Elaine Baylis, Chair at LCHS and ULHT.

Conference agenda and content:

The conference agenda and content comprised of the following key elements:

- ✓ A celebration of Black, Asian and Minority Ethnic History
- ✓ The NHS – 'A Model Employer' – Race Equality (Workforce Race Equality Standard - WRES)
- ✓ Reflections on a journey with equality in the British Medical Association
- ✓ Exploring the role of race equality champions and allies
- ✓ A cultural celebration, led by members of our BAME Networks
- ✓ Introduction to the new NHS Equality Delivery System
- ✓ Personal stories from BAME people living and working in Lincolnshire
- ✓ Sharing 'big ideas' for improvement

Key points from the primary speakers:

The NHS – 'A Model Employer' – Race Equality (Workforce Race Equality Standard)
Yvonne Coghill, Director – WRES Implementation Team, NHS England

- Race equality remains a challenge in the UK, with BAME people experiencing a poorer experience than white people.
- In employment – BAME staff have poorer experiences and opportunities in the workplace (this is confirmed locally in ULHT's WRES data).
- Exploration of the impact of racism on the lived experience of BAME people.
- NHS England WRES Team launched 'A model employer' to improve race equality in NHS leadership.
- ULHT Model Employer aspirations to develop a representative workforce over the term of the NHS Long Term Plan presented to the conference.
- Ultimate aim: A fair experience for all.

Agenda Item 14.4
'So what.....? Making the link – EDS and related tools', Gaynor Walker, Senior EHI Programme Manager, Midlands Region – East of England Region, Equality and Health Inequalities Unit, Nursing Directorate, NHS England and NHS Improvement

- Introduction to the new, revised Equality Delivery System (version 3).
- Overview of the primary NHS Equality and Inclusion frameworks.
- Focus on strengthened leadership domain in EDS, requiring leaders and board members to evidence their personal commitment and contribution to the equality and inclusion agenda of their organisation.
- Shift of responsibility for delivery of equality related action plans to those delivering the service (not just the ED&I Lead).
- Requirement for stronger and more varied evidence (opportunity for innovation).
- Requirement for system-wide alignment and collaboration of the EDS.

Cultural celebration and Personal stories from BAME people living and working in Lincolnshire.

The cultural celebration was led by members of the BAME Staff Networks and provided an inspiring and at times humorous insight into the wealth of cultural diversity. By contrast, the honesty and authenticity of the lived experience of NHS colleagues from the BAME Staff Networks provided a moving and emotional insight into real life lived experience in Lincolnshire and our NHS.

Group work – our 'One big idea':

The group work from the morning and afternoon sessions, culminated in the groups sharing their 'one big idea'. A selection is provided below:

- Getting boards to listen more directly to the BAME networks
- Positive action in the recruitment process
- Breaking silence at team level
- Offering actual progression
- Understand 2028 aspirations – start today
- NELFT – learning into action – networking better
- Replicate something like rainbow badges – visibility
- Engage with BAME student midwives
- Challenge people safely culture
- Not being neutral – using stories positively
- Middle managers to be 'encouraged' to attend such events – accountability.

Feedback from the delegates:

The event delegates were offered the opportunity to complete an evaluation, here is a sample of the feedback received:

Agenda Item 14.4

“The conference far exceeded my expectations and I would like to thank the organisers and contributors. All service leads need to attend as well. I honestly feel that I have learnt so very much about how people feel.”

“Particularly powerful were the personal stories, very emotional and thought provoking. “

“A bit disappointed in the number of participants/attendees considering it is 3 NHS Trusts this conference involves.”

“Thank you for putting on such a powerful and thought provoking conference.”

“More circulation of event to ground level staff.”

“Consider alternative ways of promoting the conference to attract middle level managers.”

Conclusion and next steps:

In summary, we can look back at a successful and inspiring conference. One of the senior leaders present at the conference noted that the NHS in Lincolnshire’s maturity around race equality continues to improve. However, it is noted that the NHS in Lincolnshire needs to continue to develop and demonstrate its commitment to race equality.

The Equality, Diversity and Inclusion Leads will in coming weeks produce a full conference report and work with their BAME staff networks and senior leaders to develop meaningful actions as a direct result of this event.

Tim Couchman, Equality, Diversity and Inclusion Lead
October 2019

Excellence in rural healthcare

NHS
United Lincolnshire Hospitals
NHS Trust

To:	The Trust Board
From:	Tim Couchman, Equality, Diversity and Inclusion Lead
Date:	28th October 2019
Healthcare standard	NHS England Workforce Race Equality Standard.

Title:	Lincolnshire NHS Race Equality Conference, 15th October 2019 - Briefing

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

Purpose of the report:

To provide the Trust Board with an initial briefing following the successful Lincolnshire NHS Race Equality Conference, hosted by the Trust, on 15th October 2019 in Black History Month.

The report is provided to the Board for:

Decision		Discussion	X
Assurance		Information	X

Summary/key points:

- 4th Annual Lincolnshire NHS Race Equality Conference, hosted by ULHT.
- >65 delegates attended from across NHS Lincolnshire organisations.
- A celebration of the contribution of Black, Asian and Minority Ethnic (BAME) people to the NHS in Lincolnshire.
- Inspiring presentations from national, regional and local speakers.
- A cultural celebration and 'collage of experience' led by members of BAME staff networks from the county.
- Workshop focus on raising the profile of BAME visible leaders and allies.
- Groups worked up their 'one big idea' to improve race equality in the NHS in Lincolnshire.

Recommendations: It is recommended that the Trust Board receives, supports and approves this initial briefing.
Equality impact: Race is one of the protected characteristics of the Equality Act 2010 and the NHS Lincolnshire Race Equality Conference has a positive impact on raising awareness and improving race equality.

To:	Trust Board
From:	Paul Matthew, Director of Finance & Digital
Date:	5th November 2019
Healthcare standard	All healthcare standard domains

Title:	Integrated Performance Report for September 2019

Author/Responsible Director: Paul Matthew, Director of Finance & Digital

Purpose of the report:
To update the Board on the performance of the Trust for the period 30th September 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
October 2019

EXECUTIVE SUMMARY

Quality

HSMR (June 2018-May 2019) is 89.18 and is below expected limits, the lowest reported HSMR for the Trust.
SHMI (May 2018-April 2019) is 109.82 and is in band 2 within expected limits.

1052 patient incidents were reported in September, which is below the 2019 monthly average but not statistically significant. This level of reporting was reflected across all hospital sites.
Patient accidents / falls remains the highest volume incident category in 2019; followed by Medication incidents and Diagnostic processes. No particular incident type is showing an unexplained trend in recent months.

The Trust declared 12 Serious Incidents in August 2019, which is in line with the monthly average for 2019 so far (and compared with an average of 18 per month in 2018). There were 28 Serious Incident investigations open at the end of August. No SIs have been overdue their deadline to the CCG in the last 7 months.
3 Never Events have been declared this financial year so far; 5 in 2019.

Duty of Candour (in person notification) compliance in August 2019 was 86% (3 non-compliant incidents) with written notification at 86% (3 non-compliant incidents).
This was the first month in a year where the Trust did not achieve a compliance level of 90% or more.
A suite of dashboard reports has also now been created to provide divisional and Clinical Governance managers with live status information for all notifiable incidents and this continues to be closely monitored through the Risk & Incident Team.

Operational Performance

Zero waiting indicators showed substantial improvements across nearly all areas. September 4 hour standard performance indicated the strongest performance for 13 months, although did not meet the standard. The A&E 4 hour standard shows the 7th best improvement of all Trusts nationally over the last 12 month period. Ambulance handovers waiting >59 minutes improved back to below average levels but did not show improvement to trajectory. Ambulance conveyances reduced for the first time in 3 months although not back to trajectory.
There were a number of positive improvements within the urgent care programme in long length of stay, triage and streaming patients to primary care, all which showed improved levels and contributed to the overall 4 hour standard improvement across EDs This improvement was a considerable achievement despite above plan, above 2018/19 level attendances and emergency admissions.

September saw the final series of workshops for Lincoln Big Change reconfiguration scheme that sits alongside the 5 other urgent care improvement streams covering all aspects of the urgent care pathway. The first move commenced successfully in the month, although delays have occurred due to capital works required that were not anticipated. Delivery of the full programme is still anticipated for December.

Zero waiting indicators in planned care showed overall RTT incomplete pathway waiting lists have reduced slightly but is not in line with trajectory or improvement plans. Risk of failure to deliver trajectory is high with the large volume of pathways that must be treated being a key concern together with ongoing administration validation issues.

Overall performance against the RTT incomplete 18 week standard deteriorated in September at 82.64% of patient pathways waiting less than 18 weeks for treatment. This was a 0.57% decrease from August.
In August there were 3 patients waiting for more than 52 weeks for their treatment. This exceeds the 0 tolerance trajectory disappointingly reflects the risk carried regarding data quality and training on RTT and patient pathway monitoring. Each of the patient pathways had been incorrectly recorded. All patients were treated subsequently in September 2019.

The planned care improvements on data quality and pathway management continue with a focus on intensive training in September. This scheme will support the sustained performance of RTT 18 week standard, and will help alleviate errors in pathway management that contribute to 52 week wait patient pathways. In addition to internal improvement activities the Trust is requesting continued support from the NHSi Intensive Support Team who have provided access to training and specialist advice in recent months.

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

Zero waiting indicators in Cancer Services showed our 62 Day Cancer performance in August dropped in relation to our performance in July, and was below the national percentage which was 78.5%. Regionally our performance places us below all the other trusts, with UHL achieving 71.7% and NUH who achieved 80.2%.

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

The Trust continues to be in the top 15 of the largest providers of cancer treatments in the UK with August showing that the Trust has moved up from 14th to 10th largest number of treatments.

Our 62+ backlog has resolutely remained well above the target of 40 (107 as of 10/10/19). A trajectory to regain this by the New Year is being completed, with the Divisions adding the narrative on how this will be accomplished and identifying risks to achievement, for Director sign-off before being shared with NHSI. This will be monitored and managed by both our internal Cancer Delivery & Recovery meeting and the external NHSI Cancer Improvement Meeting. A recent internal review of the national rules, including discussions with neighbouring Cancer Centres, has clarified the process around non-cancer diagnosed patients being discharged back to GP care and this will allow quicker and easier pathway completion for this cohort of patients and support the reductions the Divisions are making.

The 104+ backlog is reliant on the work to reduce the 62+ backlog, thereby limiting the number of patients approaching this higher level. The main themes currently contributing to patients reaching day 104 are capacity

(OPA, theatres, pathology, diagnostics), admin (delay in letters or tests not requested promptly), patient fitness and patient choice to delay appointments and tertiary diagnostics and treatments. This last cohort are being reviewed and taken forward by one of the new Cancer Improvement Managers in discussions with the tertiary trusts.

The 14 day standard (2ww Suspect) deteriorated in August although September is showing five tumour sites above the national standard of 93%. To better support the Divisions in managing this standard a new dashboard has been rolled out giving them sight of the patients waiting to be booked, available capacity for the next 6 weeks, tumour site referral trends for the past 18 weeks and in-month performance to-date.

Finance

YTD financial performance is £27,079k deficit, or £27k favourable to the planned £27,106k deficit.

Income is £5,454 to plan YTD. Excluding the £961k adverse movement to plan in relation to pass through, income is £6,415k favourable to plan YTD. However, the income position includes income from backlog and repatriation of £3,156k, delivery of which is yet to be validated, and is a risk to the Trust. The income position also includes £5,900k of transitional support.

Expenditure is £5,595k adverse to plan YTD: pay is £7,252k adverse to plan and non-pay is £1,657k favourable to plan.

The YTD pay position includes £1,021k of non-recurrent technical FEP, without which Pay would be £8,273k adverse to plan. The £7,252k adverse pay movement YTD is driven by higher than planned expenditure on temporary staffing: while substantive pay is £692k favourable to plan, bank pay is £1,755k adverse to plan and agency pay is £6,191k adverse to plan. The pay position is driven by lower than planned FEP savings delivery in relation to workforce schemes and temporary staffing pressures in relation to Medical and Nursing Staffing. Staffing pressures are most acute in the Medicine Division.

The in-month pay position includes arrears for national Medical & Dental pay award back-dated to April. The YTD impact of the pay award is roughly £400k higher than provided for, of which half has been offset by additional funding the Trust has received.

Excluding the £961k favourable variance in relation to pass through, non-pay is £694k favourable to plan. However, the non-pay position includes £1,493k of non-recurrent technical savings delivery, without which non-pay would be £799k adverse to plan, and the reasons for this adverse movement to plan are being reviewed. Some variation to plan would, though, be expected in Non Pay given the higher than planned levels of Non Elective volumes.

Overall, FEP savings of £6,887k have been delivered YTD, or £1,856k less than savings of £8,743k planned YTD. Excluding non-recurrent technical savings delivery of £2,531k, FEP savings delivery is £4,387k adverse to plan YTD.

The most likely unmitigated forecast is a deficit of £79.2m excluding PSF, FRF and MRET or £8,826k adverse to plan. This forecast is inclusive of £20.2m of FEP savings or £5.4m less than planned.

Workforce

The adverse variance between planned and actual pay costs YTD increased further in September, which continues to be driven by continued higher than planned agency costs exceeding substantive staff savings, with the actual savings on substantive pay cost reducing further in September.

The total agency, medical and nursing agency run rate reduced significantly (- £450K) in month.

The overall vacancy rate improved significantly again (-0.6%) in August with improvement in Medical, Nursing and AHP rates, with continued recruitment improvement and a strong Newly Qualified Nursing 2019 intake.

Overall turnover also significantly improved in August (- 1.0%)

Sickness absence (rolling twelve months) remained static at 4.9% and the Non – Medical Appraisal Rate dipped by 0.5%.

The number of unresolved employee relations cases remained static at 50 maintaining the improved position in August.

Paul Matthew
Director of Finance & Digital
October 2019

PERFORMANCE OVERVIEW

True North	KPI	CQC Domain	2021 Objective	Responsible Director	In month Target	Jul-19	Aug-19	Sep-19	YTD		Latest Month Pass/Fail	Trend Variation	Kitemark
Harm Free Care	Clostridioides difficile position	Safe	Our Patients	Victoria Bagshaw	9	3	6	9	31		P		
	MRSA bacteraemia	Safe	Our Patients	Victoria Bagshaw	0	0	0	0	0		P		
	MSSA bacteraemia cases counts and 12-month rolling rates of hospital-onset, using trust per 1000 bed days formula	Safe	Our Patients	Victoria Bagshaw	TBC	0.06	0.03	0.21	0.07				
	E. coli bacteraemia cases counts and 12-month rolling rates, per 1000 bed days formula	Safe	Our Patients	Victoria Bagshaw	TBC	0.16	0	0.21	0.25				
	Never Events	Safe	Our Patients	Neill Hepburn	0	0	1	0	3		P		Reviewed: 12.06.19 Data available at: Specialty level; Timeliness; Completeness; Validation; Process
	New Harm Free Care	Safe	Our Patients	Victoria Bagshaw	99%	99.20%	98.80%		98.84%		F		Reviewed: 12.06.19 Data available at: Specialty level; Timeliness; Completeness; Validation; Process
	Pressure Ulcers category 3	Safe	Our Patients	Victoria Bagshaw	4.3	3	2	1	20		P		
	Pressure Ulcers category 4	Safe	Our Patients	Victoria Bagshaw	1.3	0	4	0	4		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	Victoria Bagshaw	80%	84.10%	86.40%		81.70%		P		
	Stroke - Swallowing assessment < 4hrs	Caring	Our Patients	Victoria Bagshaw	80%	79.10%	73.20%		76.26%		F		
	Stroke - Scanned < 1 hrs	Caring	Our Patients	Victoria Bagshaw	50%	52.90%	46.30%		55.30%		F		
	Stroke - Scanned < 12 hrs	Caring	Our Patients	Victoria Bagshaw	100%	98.90%	97.60%		98.20%		F		
	Stroke - Admitted to Stroke Unit < 4 hrs	Caring	Our Patients	Victoria Bagshaw	90%	65.50%	59.80%		64.04%		F		
	Stroke - Patient death in Stroke	Caring	Our Patients	Victoria Bagshaw	17%	3.70%	7.40%		8.82%		P		
	Summary Hospital Mortality Indicator (SHMI) (rolling year data 6 month time lag)	Effective	Our Patients	Neill Hepburn	100	110.67	109.91	109.82	110.43		F		
	Hospital Standardised Mortality Ratio - HSMR (rolling year data 3 month time lag)	Effective	Our Patients	Neill Hepburn	100	89.41	89.18		90.64		P	L	

PERFORMANCE OVERVIEW

True North	KPI	CQC Domain	2021 Objective	Responsible Director	In month Target	Jul-19	Aug-19	Sep-19	YTD		Latest Month Pass/Fail	Trend Variation	Kitemark
Harm Free Care	Sepsis screening (bundle) compliance for inpatients (adult)	Caring	Our Patients	Victoria Bagshaw	90%	92.00%	96.00%	94.00%	89.00%		P	H	
	Sepsis screening (bundle) compliance for inpatients (child)	Safe	Our Patients	Victoria Bagshaw	90%	100.00%	100.00%	100.00%	95.00%		P		
	IVAB within 1 hour for sepsis for inpatients (adult)	Safe	Our Patients	Victoria Bagshaw	90%	81.80%	95.20%	87.50%	79.97%		F		
	IVAB within 1 hour for sepsis for inpatients (child)	Safe	Our Patients	Victoria Bagshaw	90%	20.00%	50.00%	100.00%	53.33%		P		
	Sepsis screening (bundle) compliance in A&E (adult)	Safe	Our Patients	Victoria Bagshaw	90%	88.00%	98.00%	100.00%	90.00%		P	A	
	Sepsis screening (bundle) compliance in A&E (child)	Safe	Our Patients	Victoria Bagshaw	90%	70.00%	40.00%	90.00%	68.33%		P		
	IVAB within 1 hour for sepsis in A&E (adult)	Safe	Our Patients	Victoria Bagshaw	90%	100.00%	95.80%	97.10%	95.70%		P	A	
	IVAB within 1 hour for sepsis in A&E (child)	Safe	Our Patients	Victoria Bagshaw	90%	0.00%	N/A	N/A	25.00%				
	Rate of stillbirth per 1000 births	Safe	Our Patients	Victoria Bagshaw	4.2%	2.69%	2.93%	2.95%	3.01%		P	B	
	Number of Serious Incidents (including never events) reported on StEIS	Safe	Our Patients	Neill Hepburn	14	14	9	12	72		P	B	Timeliness, Completeness, Validation, Process
	Catheter Associated Urinary Tract Infection	Safe	Our Patients	Victoria Bagshaw	1	0	0	1	1		P		
	Falls per 1000 bed days resulting in moderate, severe harm & death	Safe	Our Patients	Victoria Bagshaw	0.19	0.13	0.06	0.17	0.13		P		Timeliness, Completeness, Validation, Process
	Reported medication incidents per 1000 occupied bed days	Safe	Our Patients	Neill Hepburn	4	9.06	6.54	5.46	6.84		F		
	Medication incidents reported as causing harm (low /moderate /severe / death)	Safe	Our Patients	Neill Hepburn	10%	12.5%	13.5%	13.20%	11.08%		F		
	Potential under reporting of patient safety incidents / Reported incidents (all harms) per 1,000 bed days	Safe	Our Patients	Neill Hepburn	TBC	11.46			7.41				
	Patient Safety Alert compliance (number open beyond deadline)	Safe	Our Patients	Neill Hepburn	0	1	1	1	6		F		
	National Clinical audit participation rate	Effective	Our Patients	Neill Hepburn	98%	95.35%	91.11%	91.11%	93.94%		F		
	7 day Services Clinical Standard 2 (all patients have a Consultant review within 14 hours of admission)	Effective	Our Patients	Neill Hepburn	90%	Not Collected	Not Collected	61.00%	61.00%		F		
	7 day Services Clinical Standard 8 (ongoing review)	Effective	Our Patients	Neill Hepburn	90%	Not Collected	Not Collected	83.00%	83.00%		F		
	Venous Thromboembolism (VTE) Risk Assessment	Safe	Our Patients	Victoria Bagshaw	95%	97.53%	97.16%	96.98%	96.93%		P		
	eDD issued	Effective	Our Patients	Neill Hepburn	95%	94.50%	93.0%	93.60%	91.72%		F		

PERFORMANCE OVERVIEW

True North	KPI	CQC Domain	2021 Objective	Responsible Director	In month Target	Jul-19	Aug-19	Sep-19	YTD	YTD Trajectory	Latest Month Pass/Fail	Trend Variation	Kitemark
Modern and Progressive Workforce	Overall percentage of completed mandatory training	Safe	Our People	Martin Rayson	95%	92.16%	91.16%	90.26%	91.63%		F		
	Number of Vacancies	Well-Led	Our People	Martin Rayson	12%	15.22%	14.94%	15.30%	14.81%		F		
	Sickness Absence	Well-Led	Our People	Martin Rayson	4.5%	4.82%	4.87%	4.87%	4.81%		F		
	Staff Turnover	Well-Led	Our People	Martin Rayson	6%	11.79%	11.88%	10.92%	10.76%		F		
	Staff Appraisals	Well-Led	Our People	Martin Rayson	90%	76.00%	76.00%	75.85%	74.33%		F		
True North	KPI	CQC Domain	2021 Objective	Responsible Director	£'000	£'000	£'000	£'000	£'000	£'000			
Sustainable Services	Surplus / Deficit	Well-Led	Our Services	Paul Matthew	-£3,203	-£2,808	-£5,136	£31	-£22,925	-£22,784	P	H	
	Income	Well-Led	Our Services	Paul Matthew	£41,238	£43,614	£41,112	£47,349	£253,656	£248,201	P	A	
	Expenditure	Well-Led	Our Services	Paul Matthew	-£44,441	-£46,422	-£46,248	-£47,318	-£276,581	-£270,985	F		
	Efficiency Delivery	Well-Led	Our Services	Paul Matthew	£1,869	£1,557	£940	£992	£6,887	£8,743	F		
	Capital Delivery Program	Well-Led	Our Services	Paul Matthew	£2,877	£3,135	£1,751	£1,669	£12,227	£11,240	F		
	Agency Spend	Well-Led	Our Services	Paul Matthew	-£2,514	-£4,027	-£4,147	-£3,699	-£23,154	-£16,963	F	A	

PERFORMANCE OVERVIEW

True North	KPI	CQC Domain	2021 Objective	Responsible Director	In month Target	Jul-19	Aug-19	Sep-19	YTD	Latest Month Pass/Fail	Trend Variation	Kitemark
Valuing Patients Time	Friends & Family Test Inpatient (Response Rate)	Caring	Our Patients	Martin Rayson	26%	27.72%	28.09%		29.00%	P	A	
	Friends & Family Test Inpatient (Recommend)	Caring	Our Patients	Martin Rayson	97%	89.83%	86.82%		89.47%	F		
	Friends & Family Test Emergency Care (Response Rate)	Caring	Our Patients	Martin Rayson	19%	25.42%	26.23%		24.33%	P		
	Friends & Family Test Emergency Care (Recommend)	Caring	Our Patients	Martin Rayson	87%	79.33%	81.95%		80.65%	F		
	Friends & Family Test Maternity (Response Rate)	Caring	Our Patients	Martin Rayson	23%	23.71%	12.72%		15.69%	F		
	Friends & Family Test Maternity (Recommend)	Caring	Our Patients	Martin Rayson	97%	100.00%	96.08%		98.9%	F		
	Friends & Family Test Outpatients (Response Rate)	Caring	Our Patients	Martin Rayson	14%	11.49%	11.16%		10.57%	F		
	Friends & Family Test Outpatients (Recommend)	Caring	Our Patients	Martin Rayson	94%	93.82%	92.42%		93.26%	F		
	Mixed Sex Accommodation breaches	Caring	Our Patients	Victoria Bagshaw	0	0	0	0	0	P		Timeliness, Completeness, Validation, Process
	No of Complaints received	Caring	Our Patients	Martin Rayson	70	64	58		302	P		Timeliness, Completeness, Validation, Process
	No of Pals	Caring	Our Patients	Martin Rayson		499	474		2349			Timeliness, Completeness, Validation, Process
	% Triage Data Not Recorded	Effective	Our Patients	Mark Brassington	0%	5.16%	3.77%	1.76%	2.92%	F		
	Duty of Candour compliance - Verbal	Responsive	Our Patients	Neill Hepburn	100%	96.00%	86.00%		94.00%	F	A	
	Duty of Candour compliance - Written	Responsive	Our Patients	Neill Hepburn	100%	82.00%	86.00%		85.40%	F	A	

PERFORMANCE OVERVIEW

True North	KPI	CQC Domain	2021 Objective	Responsible Director	In month Target	Jul-19	Aug-19	Sep-19	YTD	YTD Trajectory	Latest Month Pass/Fail	Trend Variation	Kitemark
Zero Waiting	4hrs or less in A&E Dept	Responsive	Our Services	Mark Brassington	79.0%	67.05%	69.24%	73.07%	69.40%	74.35%	F		
	12+ Trolley waits	Responsive	Our Services	Mark Brassington	0	0	0	0	0	0	P		
	%Triage Achieved under 15 mins	Responsive	Our Services	Mark Brassington	81.0%	69.49%	75.27%	82.39%	79.23%	77.75%	P		
	52 Week Waiters	Responsive	Our Services	Mark Brassington	0	1	3		7	0	F		
	18 week incompletes	Responsive	Our Services	Mark Brassington	84%	83.20%	82.64%		83.53%	83.77%	F		
	Waiting List Size	Responsive	Our Services	Mark Brassington	36,718	40,457	39,853				F	H	
	62 day classic	Responsive	Our Services	Mark Brassington	82%	73.42%	65.60%		72.19%	78.09%	F		
	2 week wait suspect	Responsive	Our Services	Mark Brassington	93%	85.70%	78.70%		81.20%	93.00%	F		
	2 week wait breast symptomatic	Responsive	Our Services	Mark Brassington	93%	85.52%	62.37%		80.40%	93.00%	F		
	31 day first treatment	Responsive	Our Services	Mark Brassington	96%	96.50%	96.08%		96.97%	96.00%	P		
	31 day subsequent drug treatments	Responsive	Our Services	Mark Brassington	98%	100.00%	98.25%		98.74%	98.00%	P		
	31 day subsequent surgery treatments	Responsive	Our Services	Mark Brassington	94%	95.00%	96.15%		94.58%	94.00%	P		
	31 day subsequent radiotherapy treatments	Responsive	Our Services	Mark Brassington	94%	92.31%	88.31%		93.46%	94.00%	F		
	62 day screening	Responsive	Our Services	Mark Brassington	90%	82.10%	86.57%		90.19%	90.00%	F		

PERFORMANCE OVERVIEW

True North	KPI	CQC Domain	2021 Objective	Responsible Director	In month Target	Jul-19	Aug-19	Sep-19	YTD	YTD Trajectory	Latest Month Pass/Fail	Trend Variation	Kitemark
Zero Waiting	62 day consultant upgrade	Responsive	Our Services	Mark Brassington	85%	81.69%	80.13%		83.30%	85.00%	F		
	diagnostics achieved	Responsive	Our Services	Mark Brassington	99.0%	94.53%	94.15%	96.59%	95.85%	98.94%	F		
	Cancelled Operations on the day (non clinical)	Responsive	Our Services	Mark Brassington	0.8%	3.30%	2.10%	1.84%	2.11%		F	B	
	Not treated within 28 days. (Breach)	Responsive	Our Services	Mark Brassington	5%	1.88%	6.35%	0.00%	4.79%		P		
	#NOF 48 hrs	Responsive	Our Services	Mark Brassington	90%	86.90%	90.36%	91.43%	90.46%		P		
	#NOF 36 hrs	Responsive	Our Services	Mark Brassington		82.14%	81.93%	82.86%	83.11%				
	EMAS Conveyances Delayed >59 mins	Responsive	Our Services	Mark Brassington	0	809	563	516	585		F		
	104+ Day Waiters	Responsive	Our Services	Mark Brassington	5	18	13	14	91		F		
	Average LoS - Elective (not including Daycase)	Effective	Our Services	Mark Brassington	2.80	3.08	2.52	2.57	2.63		P		
	Average LoS - Non Elective	Effective	Our Services	Mark Brassington	4.50	4.19	4.33	4.36	4.35		P		
	Delayed Transfers of Care	Effective	Our Services	Mark Brassington	3.5%	3.03%	3.32%		2.94%		P		
	Partial Booking Waiting List	Effective	Our Services	Mark Brassington	4524	9111	10705	10504	9178		F	H	
	Outpatients seen within 15 minutes of appointment	Effective	Our Services	Mark Brassington	50.5%	34.8%	35.1%	33.7%	35.22%		F	A	
	% discharged within 24hrs of PDD	Effective	Our Services	Mark Brassington	45.0%	59.0%	59.2%	48.8%	56.13%		F		

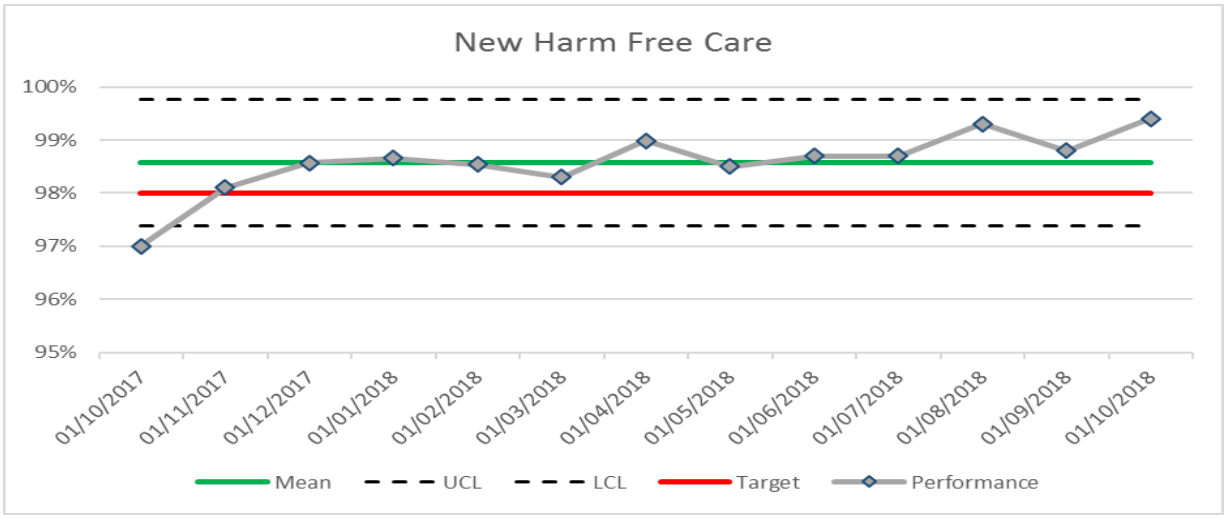
STATISTICAL PROCESS CONTROL CHARTS

Statistical Process Control (SPC) charts are an analytical tool that plot data over time. They help us understand variation which guides us to make appropriate decisions.

SPC charts look like a traditional run chart but consist of:

- A line graph showing the data across a time series. The data can be in months, weeks, or days- but it is always best to ensure there are at least 15 data points in order to ensure the accurate identification of patterns, trends, anomalies (causes for concern) and random variations.
- A horizontal line showing the Mean. This is the sum of the outcomes, divided by the amount of values. This is used in determining if there is a statistically significant trend or pattern.
- Two horizontal lines either side of the Mean- called the upper and lower control limits. Any data points on the line graph outside these limits, are 'extreme values' and is not within the expected 'normal variation'.
- A horizontal line showing the Target. In order for this target to be achievable, it should sit within the control limits. Any target set that is not within the control limits will not be reached without dramatic changes to the process involved in reaching the outcomes.

An example chart is below:



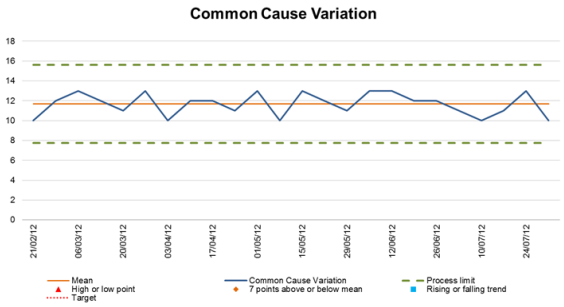
Normal variations in performance across time can occur randomly- without a direct cause, and should not be treated as a concern, or a sign of improvement, and is unlikely to require investigation unless one of the patterns defined below applies.

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

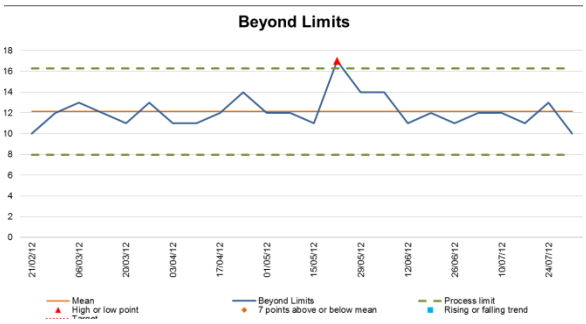
- Normal variation – (common cause) fluctuations in data points that sit between the upper and lower control limits
- Extreme values – (special cause) any value on the line graph that falls outside of the control limits. These are very unlikely to occur and where they do, it is likely a reason or handful of reasons outside the control of the process behind the extreme value
- A trend – may be identified where there are 7 consecutive points in either a patter that could be; a downward trend, an upward trend, or a string of data points that are all above, or all below the mean. A trend would indicate that there has been a change in process resulting in a change in outcome

Icons are used throughout this report either complementing or as a substitute for SPC charts. The guidance below describes each icon:

Normal Variation

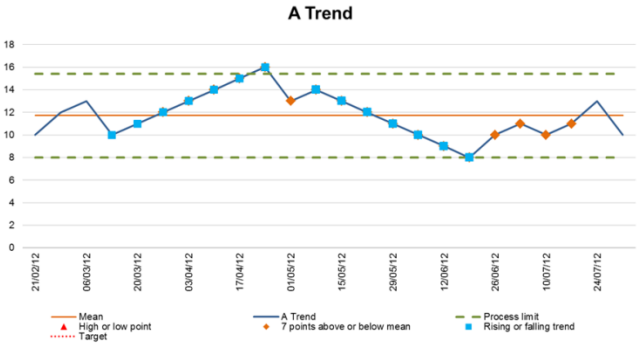


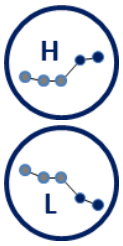
Extreme Values



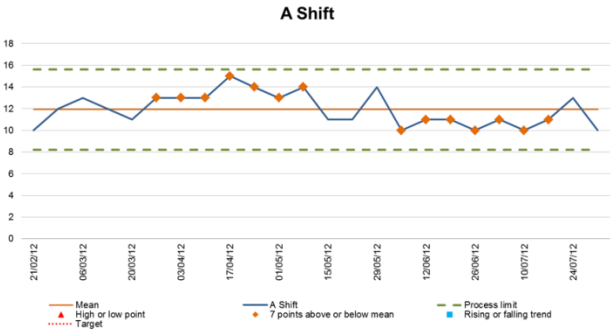
There is no Icon for this scenario.

A Trend (upward or downward)





A Trend (a run above or below the mean)



Where a target has been met consistently

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

Where a target has been missed consistently

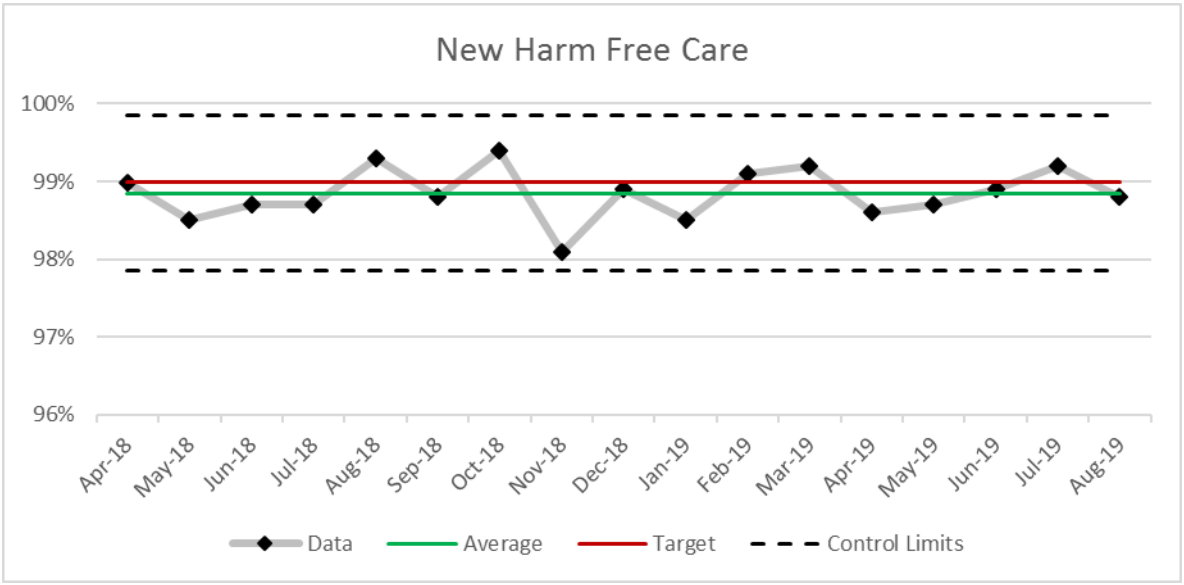
Where the target has been missed for at least 3 of the most recent data points in a row, or in a string of 7 of the most recent data points, at least 5 out of the 7 data points have missed.

HARM FREE CARE – NEW HARM FREE CARE

Executive Lead: Victoria Bagshaw

CQC Domain: Safe

2021 Objective: Our Patients



The national average for New Harm Free Care is 97.8% and the Trust achieved 98.8% in August 2019. The Trust has consistently been above the national average since December 2017. The Trust has a Harm Free Care Group which is chaired by the Chief Nurse which reviews the key harms incorporated within the New Harm Free Care metrics – Pressure Ulcers, Venous Thrombus Embolism (VTE), Catheter Associated Urinary Tract Infection (CAUTI) and Falls. The Trust has not had a new CAUTI since March 2019 and has been regularly been below the national average for new pressure ulcers, falls with harm within the last 72 hours and for new VTE.

HARM FREE CARE - MORTALITY

Executive Lead: Neill Hepburn

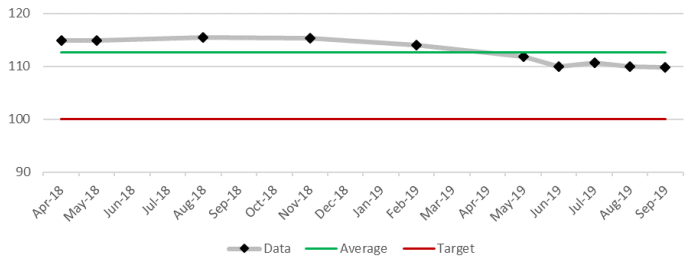
CQC Domain: Safe

2021 Objective: Our Patients

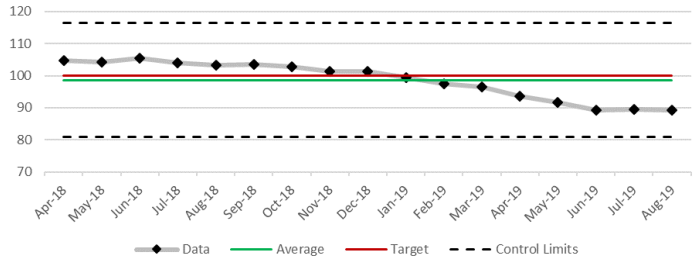
SHMI

HSMR

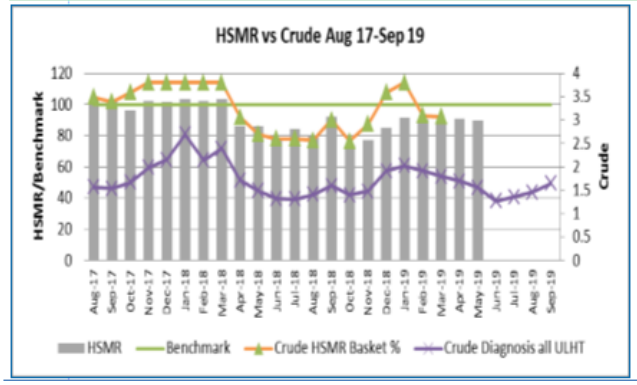
Summary Hospital Mortality Indicator (SHMI) (rolling year data 6 month time lag)

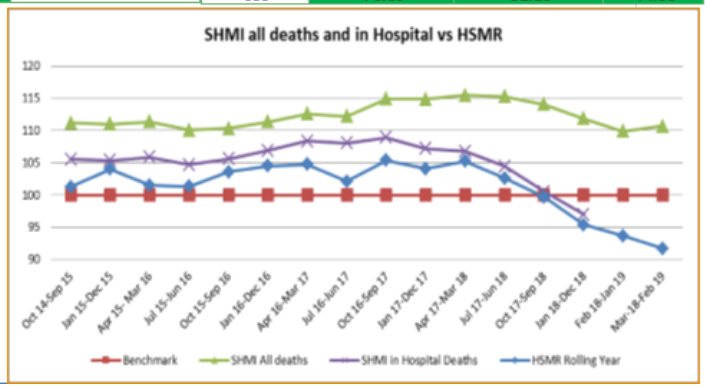


Hospital Standardised Mortality Ratio - HSMR rolling yeay 3 month time lag



Trust/ Site	ULHT HSMR Jun 18-May 19 12 month	ULHT HSMR Apr 19-May 19 FYTD	ULHT HSMR May 19	ULHT SHMI May 18-Apr 19	Trust Crude Mortality Internal source Oct 18-Sep 19	Division	ULHT HSMR Jun 18-May 19 12 month	ULHT HSMR Apr 19-May 19 FYTD	ULHT HSMR May 19
Trust	89.18	90.74	89.96	109.82	1.63%	Medicine	83.98	88.38	88.97
LCH	101.84	111.64	112.32	113.82	1.70%	Surgery	127.26	116.32	118.95
PHB	83.53	75.39	72.86	112.34	1.81%	F/H	143.26	122.59	0.00
GDH	50.60	54.40	48.65	79.51	0.69%	CSS	70.09	61.10	44.96





Performance Overview

Hospital Standardised Mortality Ratio – HSMR

ULHT's HSMR is below expected limits at 89.18 this is the lowest recorded Trusts HSMR. All sites are within expected limits. Both Pilgrim and Grantham are below expected limits. HSMR has now been reported by divisions, where HSMR is high but not alerting is due to small numbers and high confidence intervals. **HSMR analysis has been excluded from this month's report due to a delay in the Dr Foster Upload.**

Alerts: The Trust is alerting for 'Other Perinatal Conditions', there is an action plan to address the improvements required. A mortality process is currently being ratified by Family Health.

There are no site alerts currently; COPD was previously alerting and an action plan is being developed utilizing the National Audit Results.

Summary-level Hospital Mortality Index-SHMI

ULHT are in Band 2 within expected limits with a score of 109.82, which shows a slight decrease from the previous reporting period. SHMI includes both death in-hospital and within 30 days of discharge. The data is reflective up to April 2019.

No current alerting diagnosis

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:

- Medical Examiner business case was approved to function as a 5 day service at the Boston and Lincoln site with a satellite to Grantham.
- Once the Medical Examiner model has expanded and they are screening all deaths the Mortality Review Assurance Group (MoRAG) will be disbanded and the Mortality Assurance Learning and Strategy Group (MorALS Group) the group will be focusing on themes from Medical Examiner referrals, mortality in-depth review outcomes, strategy to deliver the learning from deaths policy, Lincolnshire Mortality Collaborative Themes and themes highlighted within the Division.
- COPD and CAP bundles are currently being audited. Results and recommendations will be presented at the pneumonia group.
- COPD and bronchiectasis improvement plan is currently being developed which will be presented at Patient Safety Group.
- The Community have various work streams they are undertaking to ensure out of hospital patients receive appropriate end of life care which include; End of life audits in care homes, end of life training, multidisciplinary approach to advance care planning and anticipatory prescribing and Project Echo.
- Lincolnshire health and care community have launched; Home First Prioritisation. An initiative aimed to focus on frail and over 75's out of hospital and close to their homes. Neighbourhood team have work streams in; advanced care planning in care homes, Complex Case Managers, Short term overnight carer intervention, practice Care Coordinator and Triage Practitioner.
- The Mortality Summit will become a Lincolnshire Learning Mortality Forum.
- The CCG have developed Enhanced Health in Care Home work programme in line with National care elements.
- The Importance of coding workshop was held at Pilgrim Hospital on the 27th September 2019. The Clinical Governance team have received good feedback from the session. The next session is due to be held in Lincoln on the 3rd December 2019.

Crude Mortality

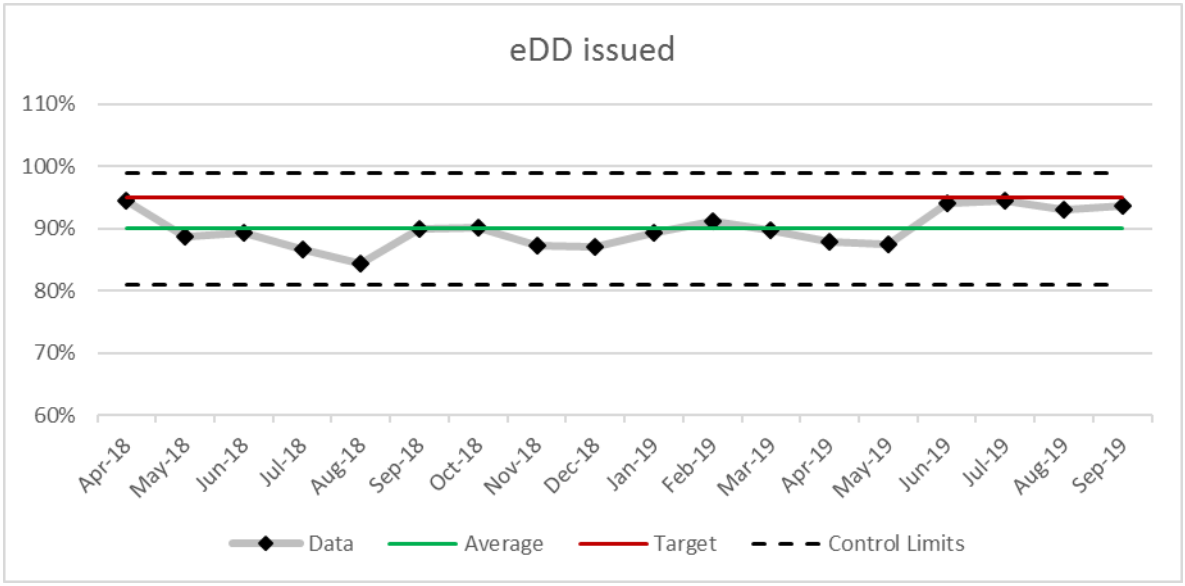
The crude mortality has increased in September 2019 to 1.65%. In rolling year October 18-September 19 crude has remained the same at 1.63%.

HARM FREE CARE – eDD ISSUED

Executive Lead: Neill Hepburn

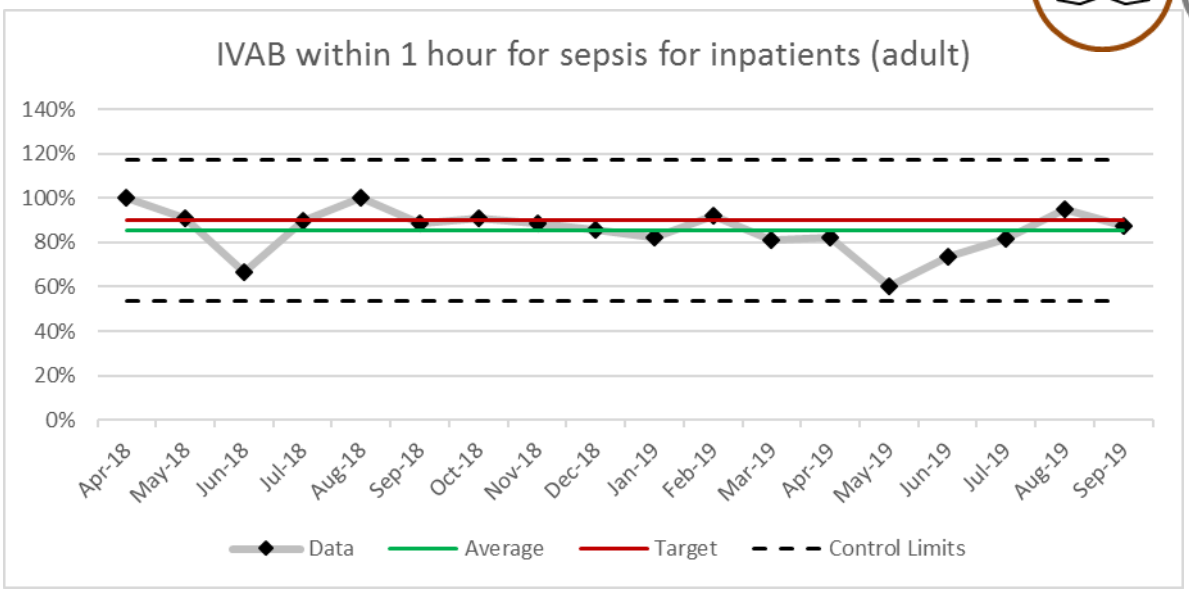
CQC Domain: Effective

2021 Objective: Our Patients



The Trust for September is at 93.6% of eDDs being sent within 24 hours of a patients discharge. The compliance has dropped over the last 2 months where it was 94.5% in July sent within 24 hours. A potential reason for this drop could be the intake of new junior doctors. The Clinical Governance Team are targeting the wards where the compliance has dropped. The Clinical Governance Team are also in discussion with the Paediatric team to streamline their eDD template.

HARM FREE CARE – SEPSIS INTRAVENOUS ANTIBIOTICS



Challenges/Successes- Intraveneous Antibiotic administration

The performance for this month for both A&E and inpatients in Adult patients has shown an improvement following the decline in previous months. Inpatient paediatrics antibiotic compliance shows a decline, the data sample continues to be small numbers which has a substantial effect on the percentages. From the beginning of July we have moved towards validating 100% of the data and this should stop the variances being so marked from month to month. The policies for all aspects of sepsis are now out for agreement and final sign off this is hoped that this will strengthen the clinical pathways and support decision making particularly around paediatrics.

Actions in place to recover- Intraveneous Antibiotic administration:

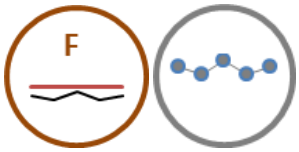
It is again in discussion with the paediatric medical lead to consider an 'unsure' option as an addition to the sepsis screening process as many children require time and additional tests prior to further invasive procedures and a sepsis diagnosis. This will be followed up through the governance structure. From completing harm reviews no harm came to the children who received IV abx outside the hour of increased their increased observations.

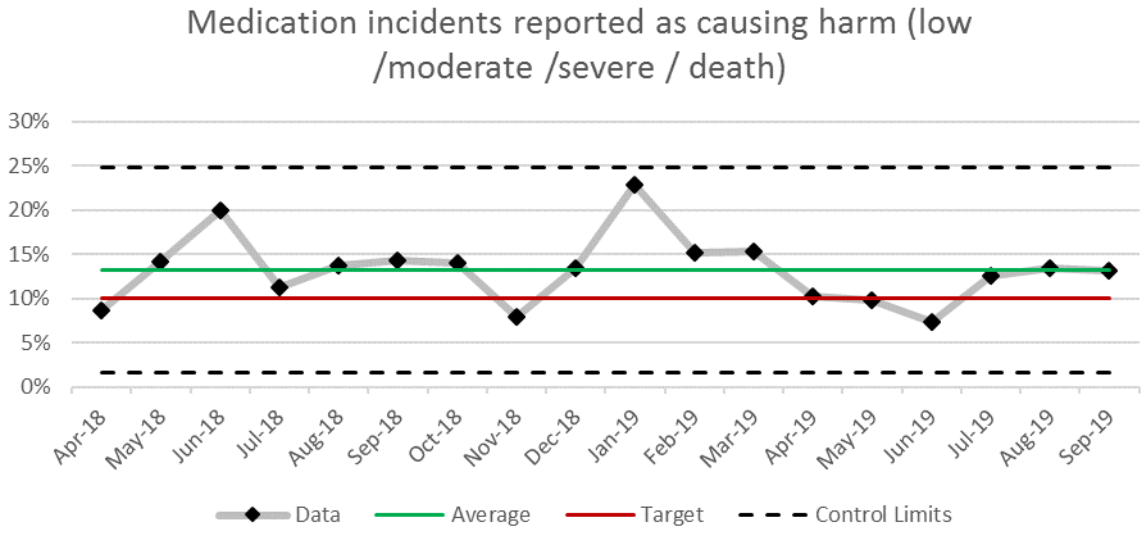
HARM FREE CARE – MEDICATION INCIDENTS CAUSING HARM

Executive Lead: Neill Hepburn

CQC Domain: Safe

2021 Objective: Our Patients





Challenges/Successes –

In September there were 159 medication related incidents reported via Datix.

For September the medication incident reporting rate for the Trust per 1000 bed days was 5.46. The rate is expressed as total number of medication incidents reported divided by the number of bed days in the Trust, multiplied by 1000 bed days.

The national average as displayed by Model Hospital (from data taken from NRLS, National Reporting and Learning Service) is 4.0 and the peer average is 3.4 – this figure was last updated in November 2018.

Of the 159 medication incidents reported:

- 1.9% were rated as either Moderate Harm, Severe Harm or Death (calculated as medication incidents reported as causing Moderate Harm, Severe Harm or death x 100 – (3/159x100).
- 13.2% were rated as causing some level of harm (calculated as medication incidents reported as causing some level of harm or death x 100 – (21/159x100).
- The national average of medication incidents reported as causing harm or death is 10.6% and the peer average is 14%.

Action plan to reduce harm and reduce omitted and delayed medicines

Within the Quality and Safety Improvement Plan - QS08 Medicines Management are improvement goals that ULHT will work towards to improve overall quality and safety around medicines across the organisation. The key milestone that is relevant to this report is 'Reducing harm through the culture of safety and learning from medication related adverse events'.

To support this key mile stone there are miles stones and actions to achieve them:

1. Develop a monthly data report demonstrating the medication incident trends
- This report will be highlighting the trends and patterns within medication incidents submitted via Datix. This report can be developed further to provide the information required by each Division and speciality.

2. Review of medication incident investigation and review process and develop SOP
- With the support of the Risk Team we will review the process of investigation for medication incidents and ensure it links in and supports the SI policy. An SOP will be developed and shared with medical and nursing teams so that all medication related incidents are addressed appropriately.

3. Staff to do a written reflection of any medication incidence they are involved in and with their line manager agree lessons learnt and training needs.
- With the Heads of Nursing and the quality matrons we will develop a pathway to support staff and identify any training needs.

4. Define high risk/critical medication and develop SOP for obtaining medication in and out of hours
- The Guideline for Reducing Harm from Omitted and Delayed Medicines will be reviewed and updated will include a comprehensive guide to obtaining medicines in and out of hours.

5. Raise awareness of site duty manager and on-call pharmacist
- As part of the review of the Guideline for Reducing Harm from Omitted and Delayed Medicines we will include information on how to utilise the site duty manager and the on-call pharmacist.

6. Educate staff that there is more than one prescription chart in use and prescription chart should move with patient if transferred
- A piece of work needs to be done alongside the nursing teams to educate staff around the potential numbers of inpatient chart and the different types of specialist charts we have within the organisation.

Further actions to be taken

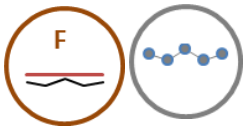
- In addition to these actions within the Quality and Safety Improvement Plan we have updated the Prescribing and Medicines Optimisation and Safety webpages and made them more engaging and user friendly. Within the new design we have a page dedicated to sharing learning from medication incidents and informing staff of themes and trends. There are also strategies to help combat medication related incidents.
- We have created a Facebook account to link in with the ULHT Together account and share information via that forum. This will then help to us to capture as many of ULHT staff as possible and ensure that learning reaches as far as possible.
- A specialist forum is to be set up. This forum will give opportunity to discuss medication incidents, look at the themes and trends, and allow staff to share good practice and ideas from different areas. Medicine Management Link Nurse and junior grade doctors will be given the opportunity to attend.
- To address the prescribing issues in the outpatient department individual prescribers are now being identified and are being informed directly about the error made.
- The speciality pharmacists are linking into the speciality governance meetings and are sharing their bespoke reports. From these reports actions can be discussed to support reducing harm from medication incidents.
- The four Divisions are asked to support the actions required to improve prescribing within their area and to address key issues highlighted within this report to reduce harm from medication incidents.

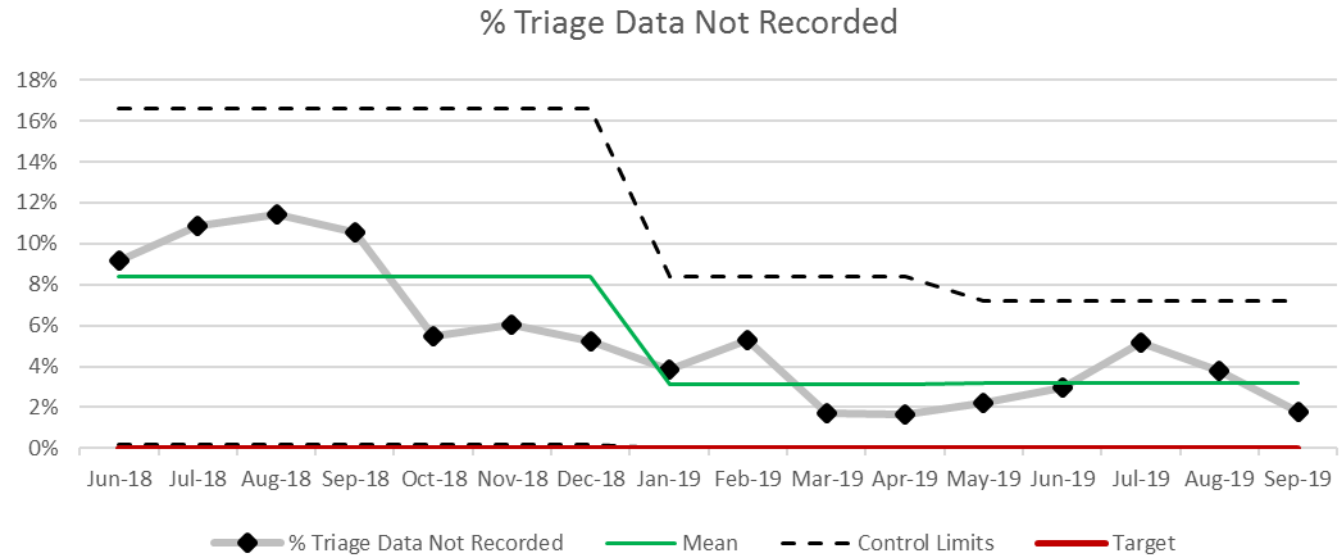
VALUING PATIENTS TIME – % TRIAGE DATA NOT RECORDED

Executive Lead: Mark Brassington

CQC Domain: Effective

2021 Objective: Our Patients





Challenges/Successes

An improving position was demonstrated in September by 2.01%. Now reporting 1.76%

Achievement against this metric is still dependent upon having a fully trained and compliant staffing rota as well as the individual compliance of staff. Daily monitoring in place.

Higher levels of agency usage and temporary non-substantive staff have an impact on being able to consistently achieve higher levels of performance against this target.

Alternative systems have been developed at PHB where agency usage is at its highest and the impact on triage is at the greatest. The use of a triage coordinator role ensures that this important process is delivered consistently and a greater compliance has been demonstrated.

Additional support from divisional managerial teams is in place each day and ensures all staff are accurately recording triage times. Robust departmental leadership is crucial to maintaining focus on this.

Actions in place to recover:

The newly appointed Urgent and Emergency Care Lead Nurse (Secondment) will ensure compliance is reached and maintained

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

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

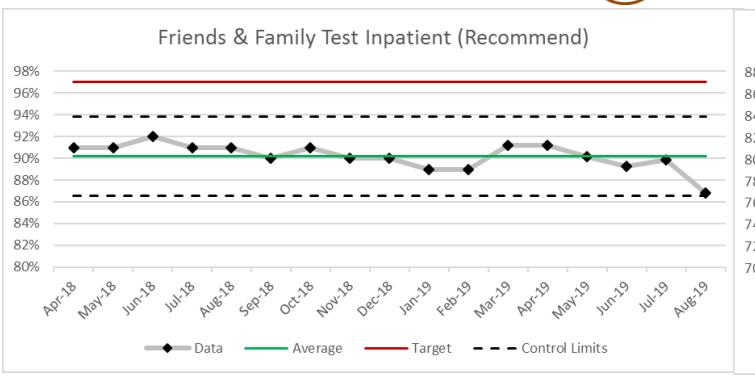
The new printing device installed and issues with the location of the photocopier should rectify the bottleneck within the process and this is being monitored.

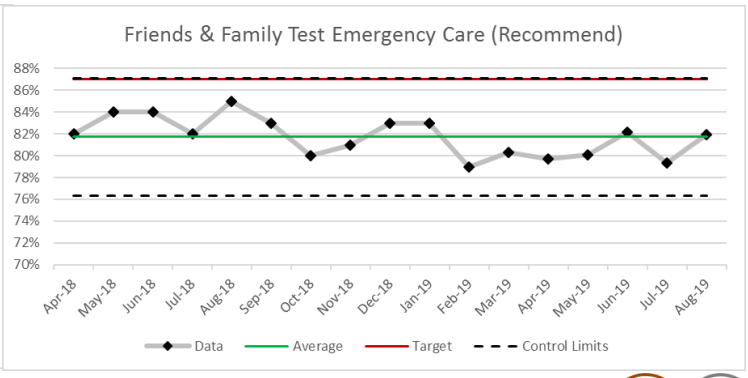
VALUING PATIENTS TIME – FRIENDS AND FAMILY RECOMMEND RATES

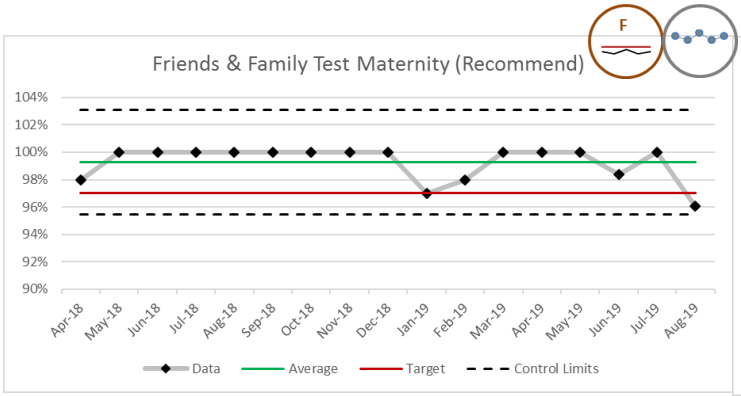
Executive Lead: Martin Rayson

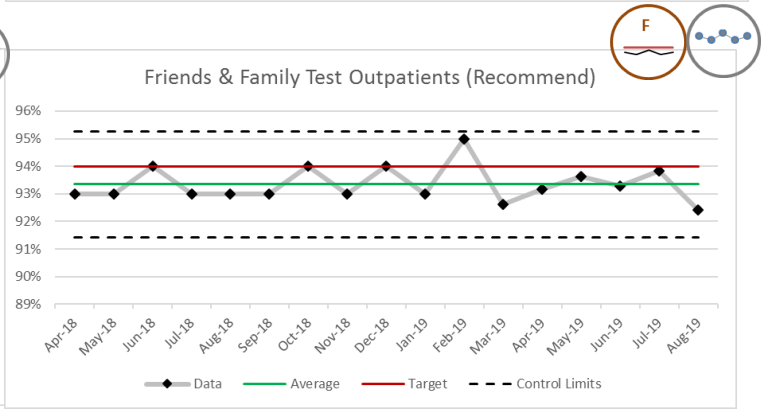
CQC Domain: Caring

2021 Objective: Our Patients









Challenges/Successes

- Inpatients has seen a 3% decrease in % FFT recommends and a 2% increase in % non recommends in August
- Other FFT streams have remained static since April 2019
- Overall 90% of patients would recommend and 5% of patients would not recommend. This was based on 7,255 ratings and 5,619 comments with 76% of comments received being positive, 6% neutral and 18% negative. Top 3 positive themes from FFT comments were Staff attitude, waiting times and implementation of care

Actions in place to recover:

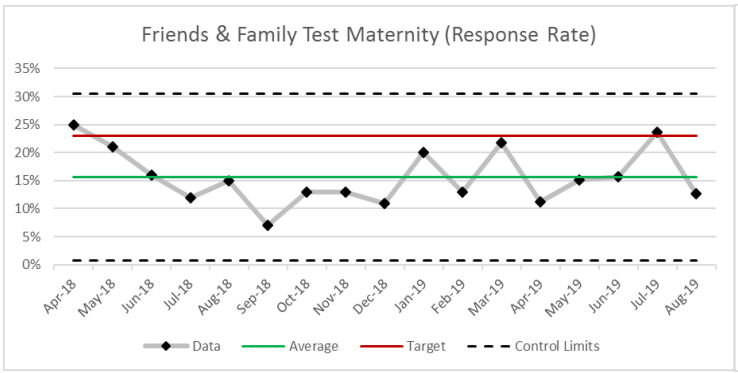
- Meetings scheduled during October with divisional clinical leads to secure patient experience engagement and actions
- FABChange19 programme of activities in place to showcase and promote champion roles
- Communication First training under review and new proposal to come to PX group in November that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

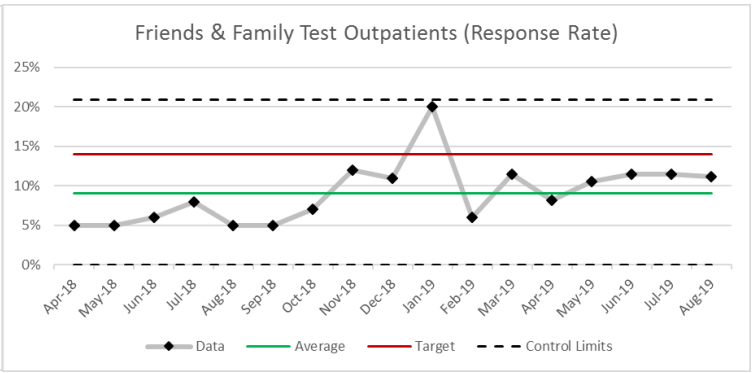
VALUING PATIENTS TIME – FRIENDS AND FAMILY RESPONSE RATES

Executive Lead: Martin Rayson

CQC Domain: Caring

2021 Objective: Our Patients



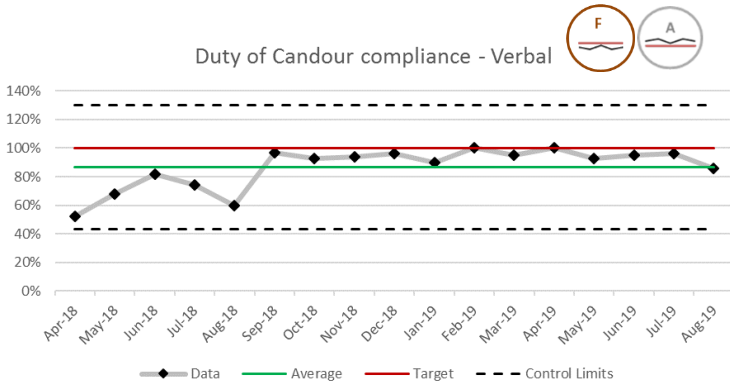


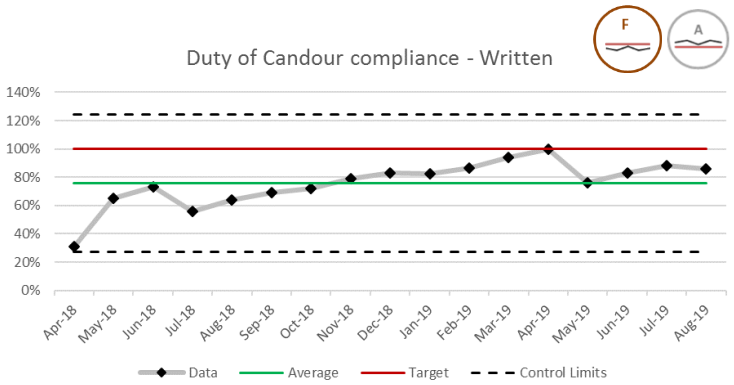
VALUING PATIENTS TIME – DUTY OF CANDOUR

Executive Lead: Neill Hepburn

CQC Domain: Safe

2021 Objective: Our Patients





Challenges/Successes

- Duty of Candour (in person notification) compliance in August 2019 was 86% (3 non-compliant incidents)
- This was the first month in a year where the Trust did not achieve a compliance level of 90% or more
- Written follow-up compliance in August 2019 was 86% (3 non-compliant incidents)

Actions in place to recover:

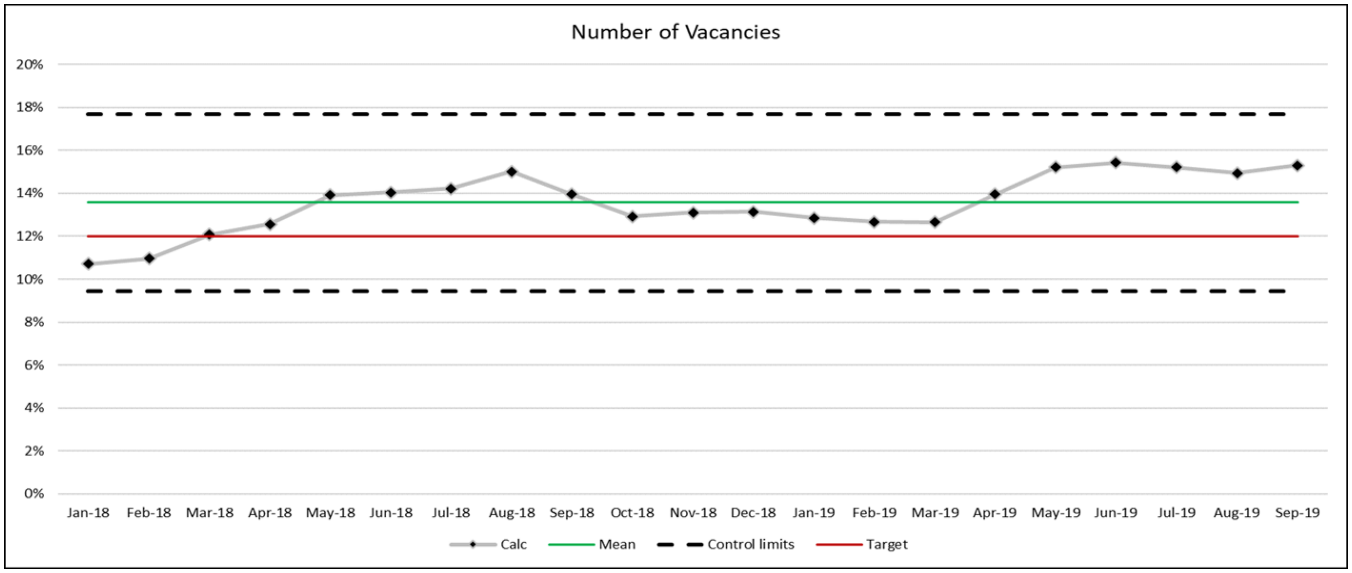
- Additional guidance has been added to the Datix system to support managers in accurately recording Duty of Candour compliance; these changes went live at the end of July
- A suite of dashboard reports has also now been created to provide divisional and Clinical Governance managers with live status information for all notifiable incidents
- A review of compliance over the last 6 months is to be presented to the Patient Safety Group in October

MODERN AND PROGRESSIVE WORKFORCE – VACANCY RATES

Executive Lead: Martin Rayson

CQC Domain: Safe

2021 Objective: Our People

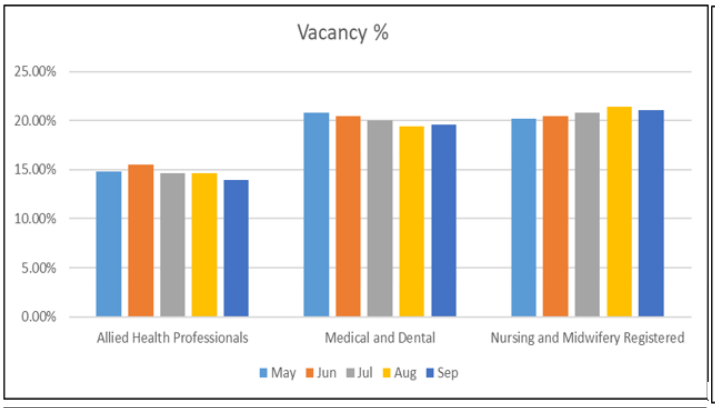


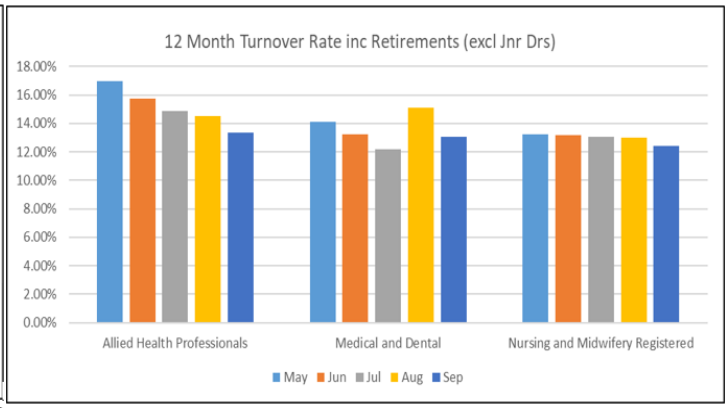
Challenges/Successes

Overall Trust Vacancy Rate further improved to 14.3% from 14.9% in August 19.

Weekly recruitment and exit tracking continues. There was a total of 21.4 fte of consultant and Speciality Doctors starts in July and August with 20.4 fte of leavers. 104 fte of new registered nurses started in July and Augusts with 39 fte of leavers significantly improving vacancy rate.

Overall Turnover reduced again in August by 1%, with improvement in medical, Nursing and AHP rates. However, the rates remain above national and regional benchmarks slowing the improvement in vacancy rate from recruitment.





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

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

Vacancy rate for nursing staffing is overstated due to NQNs Starts in September not processed at reporting point

Medical Vacancy Rate

Plan for every post is being used and has been further developed, as a tool to deliver recruitment strategy and agency reduction. There are examples of how it is being used across the Divisions. For example, Family Health strategy is to recruit Locum Consultants as soon as vacancy occurs with AAC panel dates planned in the following 12 months.

CSS have identified that full review of medical establishment against capacity and demand needs to be undertaken. Several NHS Locums are in the pipeline. Further details of "hot spot" Medical Vacancy Rates are provided in the following table:

Division	Team	Vacancy FTE	Vacancy %
Clinical Support Services	Radiology Consultants	6.7	40%
	Pilgrim Clin Haematology IP	3.0	75%
	Lincoln Clin Haematology IP	2.1	22%
Family Health	Lincoln Paediatrics IP	7.0	24%
	Pilgrim Paediatrics IP	4.7	24%
	Pilgrim Breast Surgery IP	2.0	47%
Medicine	Lincoln Elderly Care IP	12.2	50%
	Lincoln Acute Medicine	4.8	49%
	A&E Attenders Lincoln	12.7	33%
	Grantham Cardiology IP	4.0	57%
Surgery	Lincoln ENT IP	4.7	44%
	Pilgrim Urology IP	4.0	44%
	Lincoln Max Facial Surgery IP	6.6	48%

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

Nursing Vacancy Rate

The nursing vacancy rate significantly reduced to 17.8% but high vacancy rates remain on a number or wards and higher risk clinical areas. Further details of "hot spot" Nurse Vacancy rates are provided in the following table:

Division	Team	Vacancy FTE	Vacancy %
CSS	Clinical Support Pan Trust Mgmt	5.0	71%
	Waddington Unit	4.7	19%
	Ward 7A Chemo Suite	6.7	43%
Medicine	Pilgrim AMSS	18.2	53%
	Pilgrim Stroke Unit	14.6	51%
	A&E Pilgrim	30.4	50%
	Ward 6A	11.9	51%
	Ward 7B	9.6	42%
	Ward 1	8.2	43%
Surgery	Bevan Ward	9.9	67%
	Ward 5B	8.8	40%
	Ward 9A	8.7	40%
	Ward 2	9.9	45%
	Lincoln Main Theatres	15.6	24%
Family Health	Nettleham Ward	16.4	71%
	Bardney Ward	29.2	67%
	Rainforest Ward	13.5	42%

AHPs Vacancy Rate

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

Division	Team	Vacancy FTE	Vacancy %
CSS	Pilgrim Physiotherapy	12.5	39%
	Pilgrim Occupational Therapy	4.0	22%

Actions in place to recover

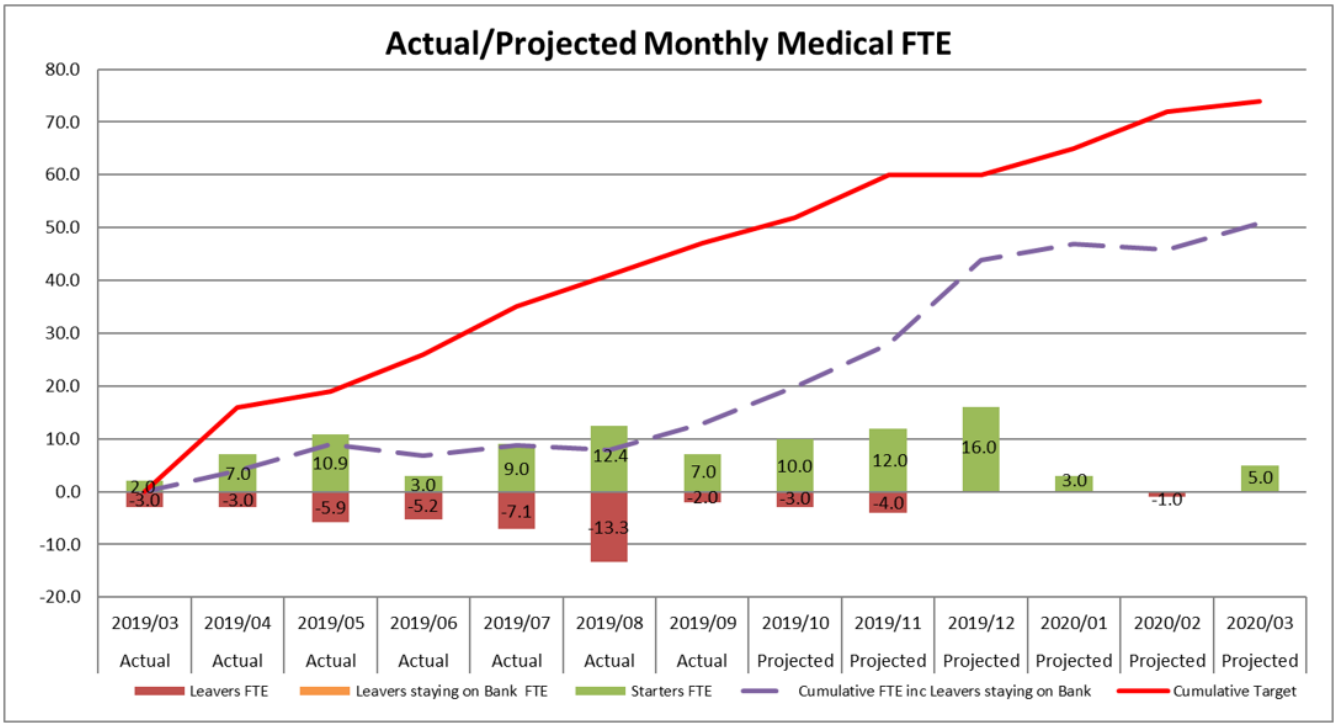
Medical and Dental

Continued strong pipeline into Q3.

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

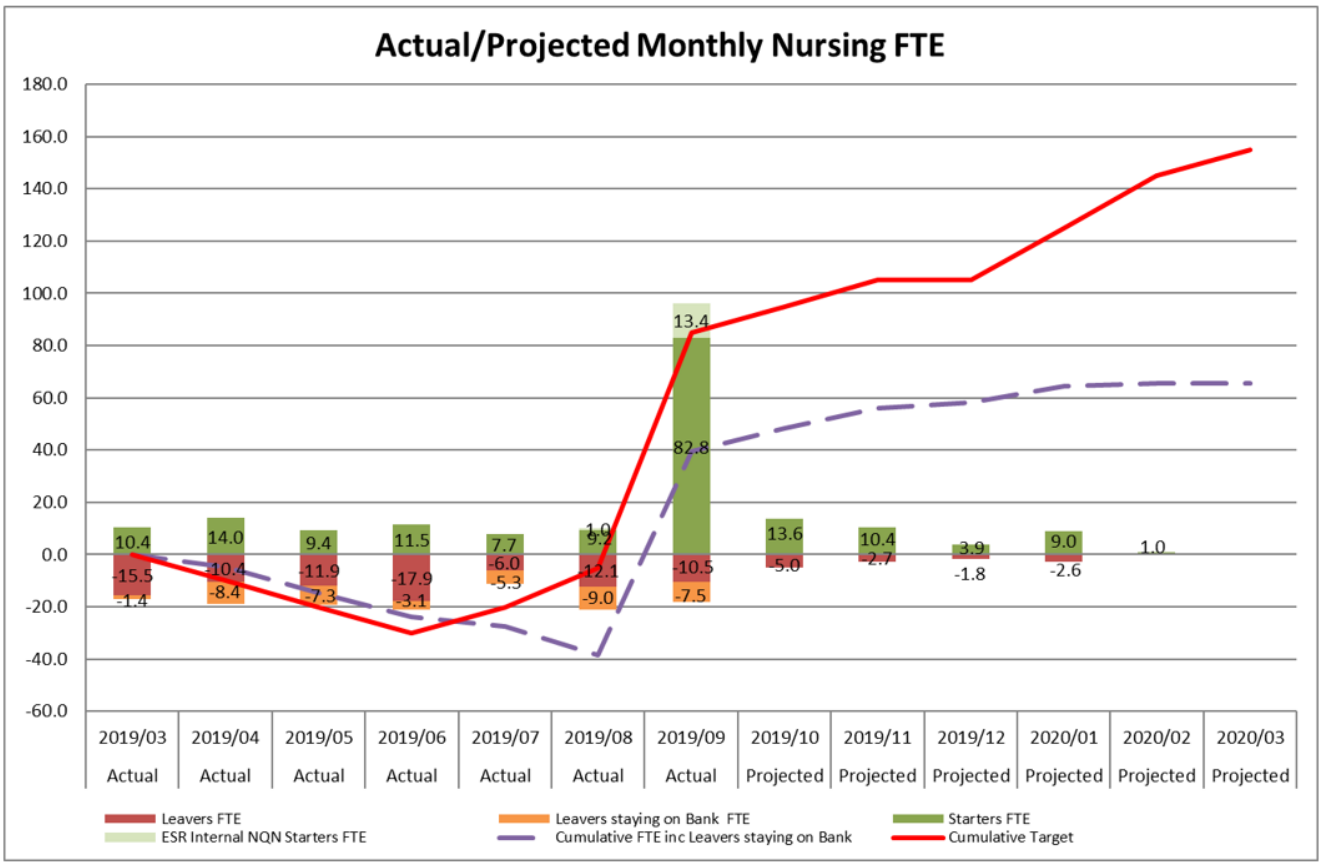
New international strategic partner contract approved and will now be mobilised with initial focus on all fragile services.

Increased focus on medical engagement to reduce turnover.



Graph as at 30 September 2019

Nursing – Strong NQN intake as planned



Graph as at 30 September 19

International strategic partner agency contract approved and will now be mobilised.

Information on high vacancy areas and wards using block nursing agency will be used to inform TMP supported domestic campaigns to take place w/c 14th October.

AHP recruitment campaign continues with good response.

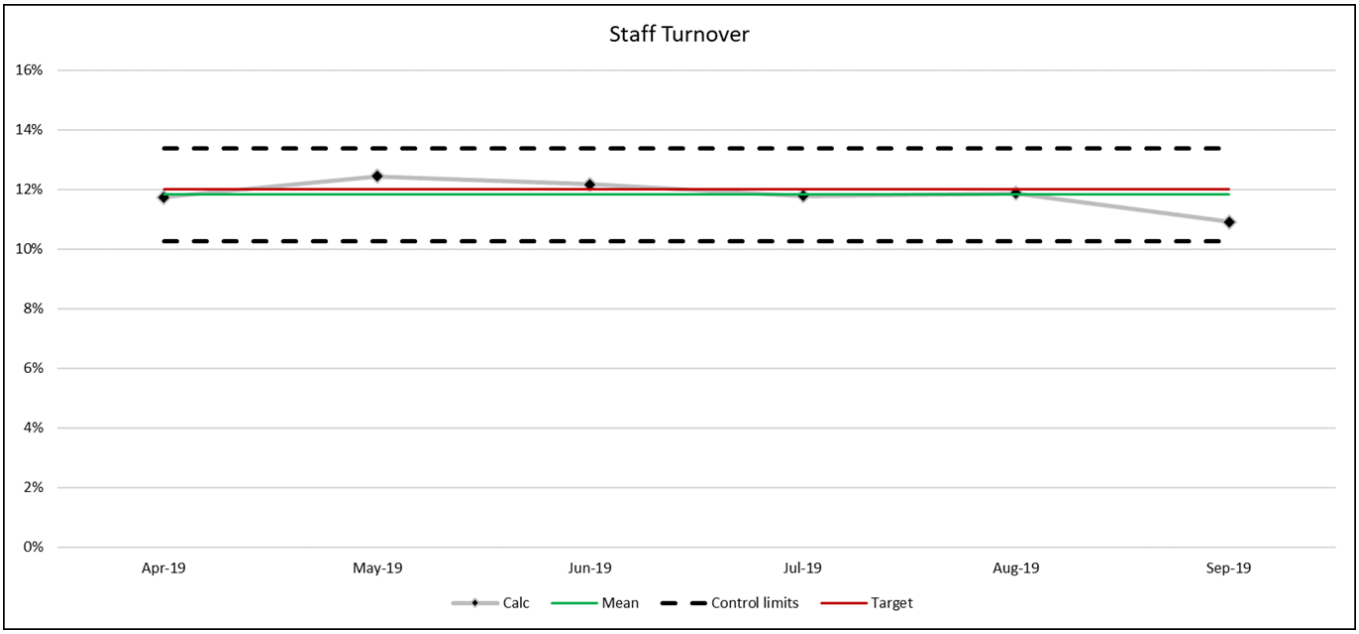
The Trust is also engaging with the National NHSE/I retention team to support continued work and focus on retention

MODERN AND PROGRESSIVE WORKFORCE – VOLUNTARY TURNOVER

Executive Lead: Martin Rayson

CQC Domain: Well-Led

2021 Objective: Our People



Challenges/Successes

- Exit Report: The (July – Sep) leavers report shows that there has been a dip in the number of staff who have completed an exit survey. This has dropped to 16% from the last quarter. This is somewhat disappointing. Lack of development opportunities and lack of work life balance continues to rank high on the list of reasons why staff leave.
- The Bus Station event that took place during the week of the 16th of September was a massive success. The team was able to directly connect with over 700 members of staff across Lincoln, Grantham, Pilgrim and Louth.

Actions in place to recover

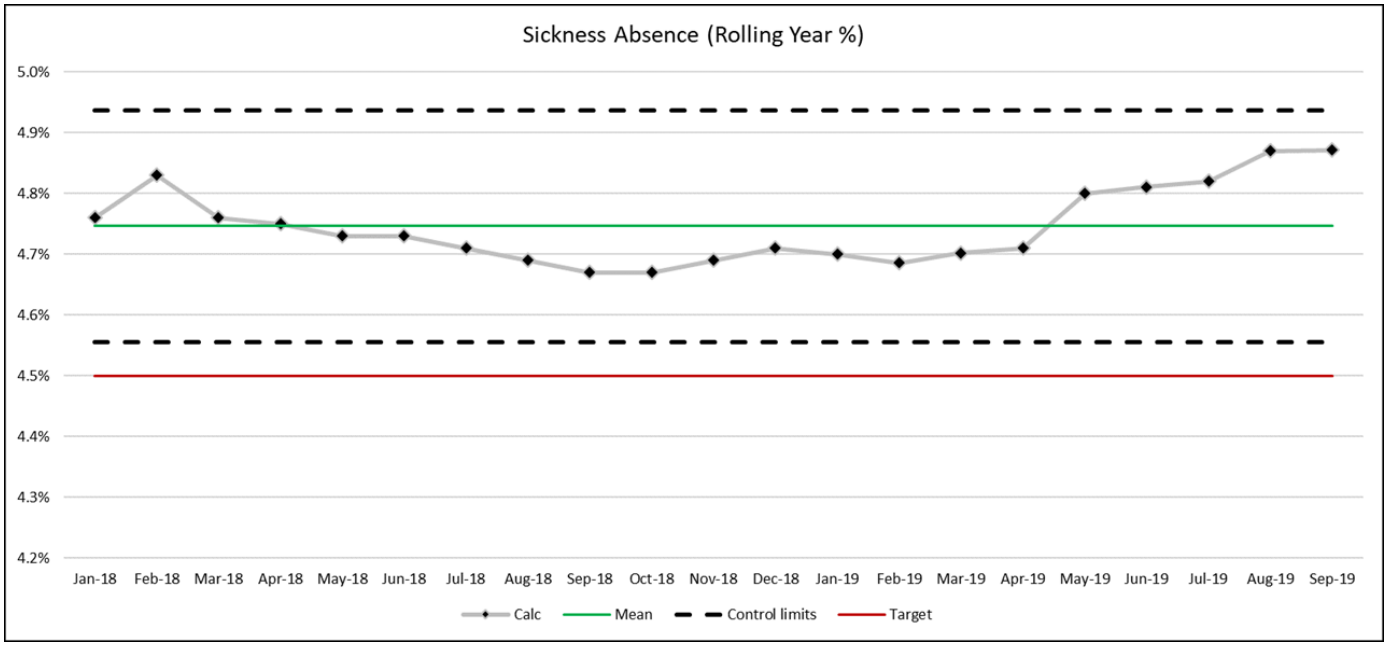
Improving the response rate of exit surveys - we will be working with the HR Business Partners to try and increase the number of people accessing the survey so that we can get meaningful data.
Internal Transfer: To address the issue of 'lack of development', an internal transfer policy has been created. Through this policy, we hope to encourage staff to move across wards and sites allowing them to explore multiple areas and develop skills within the Trust.
Flexible working - There is also some action underway on enhancing staff awareness about flexible working opportunities available within the Trust.

MODERN AND PROGRESSIVE WORKFORCE – SICKNESS ABSENCE

Executive Lead: Martin Rayson

CQC Domain: Well-Led

2021 Objective: Our People

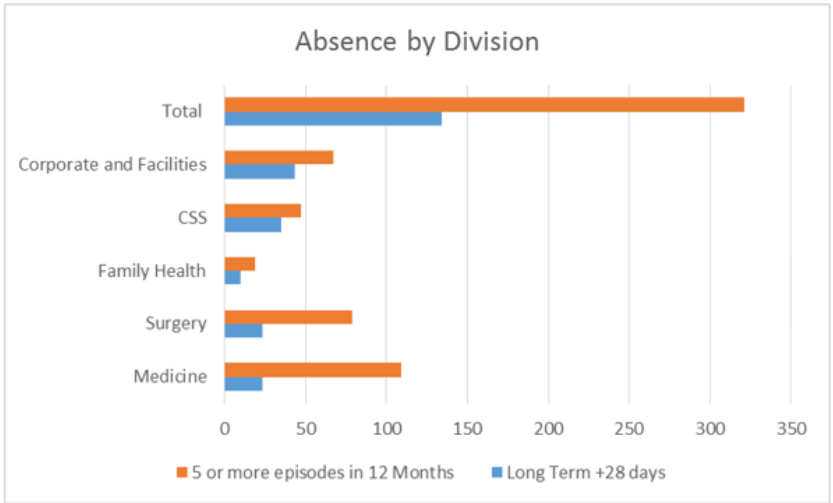


Challenges/Successes

The rolling 12 month average remains at 4.9%. We are concerned about the growth in sickness in the period May to September, when sickness traditionally declines. We have a longer-term plan to address absence, linked to the use of the Empactis system. In the short-term, it is the combination of HR, OH and managers working together that will put us in the best place to reverse the current upward trend.

The tables below shows the monthly sickness cases that are being managed, by Division:

Absence cases	Medicine	Surgery	Family Health	CSS	Corporate and Facilities	Total
Long Term +28 days	36	28	24	34	65	187
5 or more episodes in 12 Months	97	67	21	51	65	301



Absence data is reported to the Divisions on a monthly basis by the ER Advisors, this highlights areas of focus and concerns. The ER Advisors are working with the Divisions and SHRBP's to work on trajectories for future sickness reporting. The table below shows the reduction/ increase in cases by Division

Absence cases	Medicine	Surgery	Family Health	CSS	Corporate and Facilities
Long Term +28 days	13	5	14	-1	22
5 or more episodes in 12 Months	-12	-12	2	4	-2

Actions in place to recover

Full review of all training packages is ongoing to support managers with the attendance management training, however bespoke absent management training continues to be given to Managers by the ER Advisors on an as-hoc basis, Band 6 ICU Lincoln Staff have received training in September.

Vacancies that are currently on hold are being monitored to support permanent redeployment opportunities becoming available at the earliest opportunity to support staff returning to work.

Template letters have been created and awaiting sense check and approval.

A review of all special leave has taken place to understand why and where it is being used.

Project manager has been identified to implementation of the Empactis Attendance Platform, the next step will be build project group to be chaired by Martin Rayson.

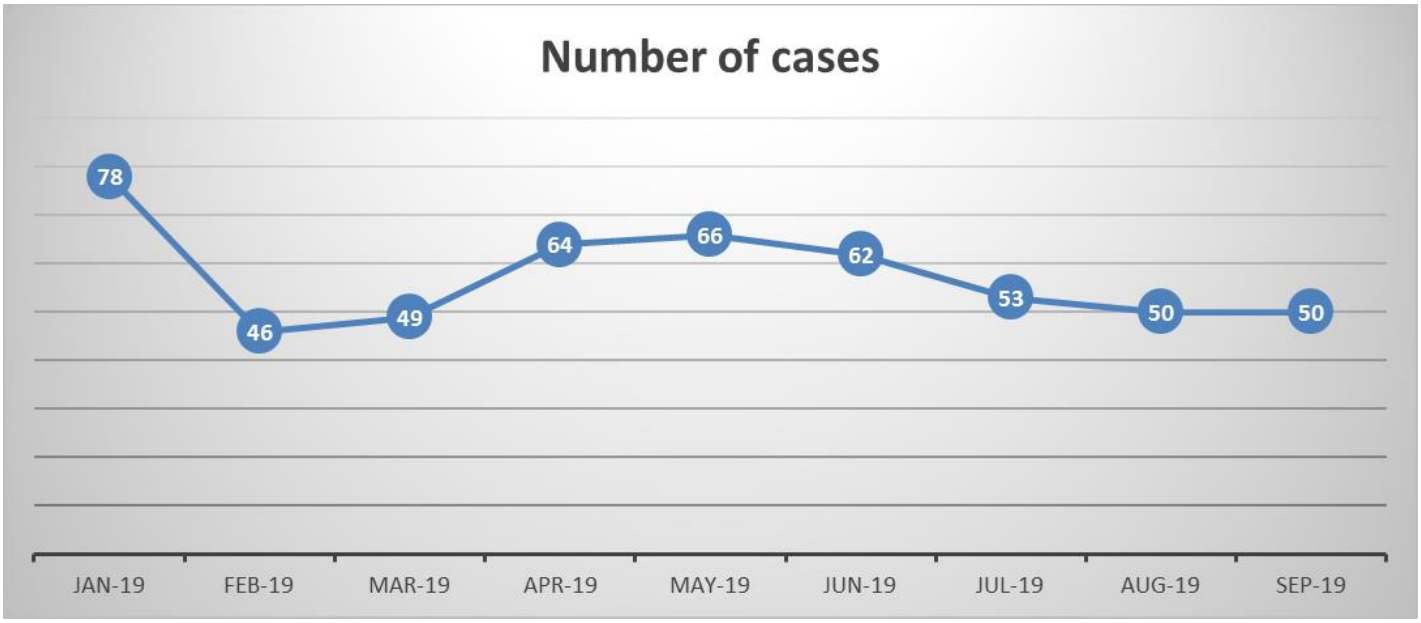
ER Advisors to formulate Sickness action plans within their Divisions. The number of people on long-term sickness absence is increasing and the focus will be on having individual plans to tackle this pattern of sickness.

MODERN AND PROGRESSIVE WORKFORCE – Employee Relations

Executive Lead: Martin Rayson

CQC Domain: Well-Led

2021 Objective: Our People



Employee Relations Cases:

There are 50 open cases in September compared with 50 cases in August.

There are currently 8 cases proceeding to hearings for October covering:

- Appeals x 3
- Grievance x 3
- Disciplinary x 1
- Capability Ill Health x 1

In September we have had 4 hearings cancelled 1x Grievance and 1x disciplinary & two appeals.

Actions in place to recover

We have received 4 SAR requests in September and need to review the process to manage these with the Information Governance Team, as they are a significant drain on our resources.

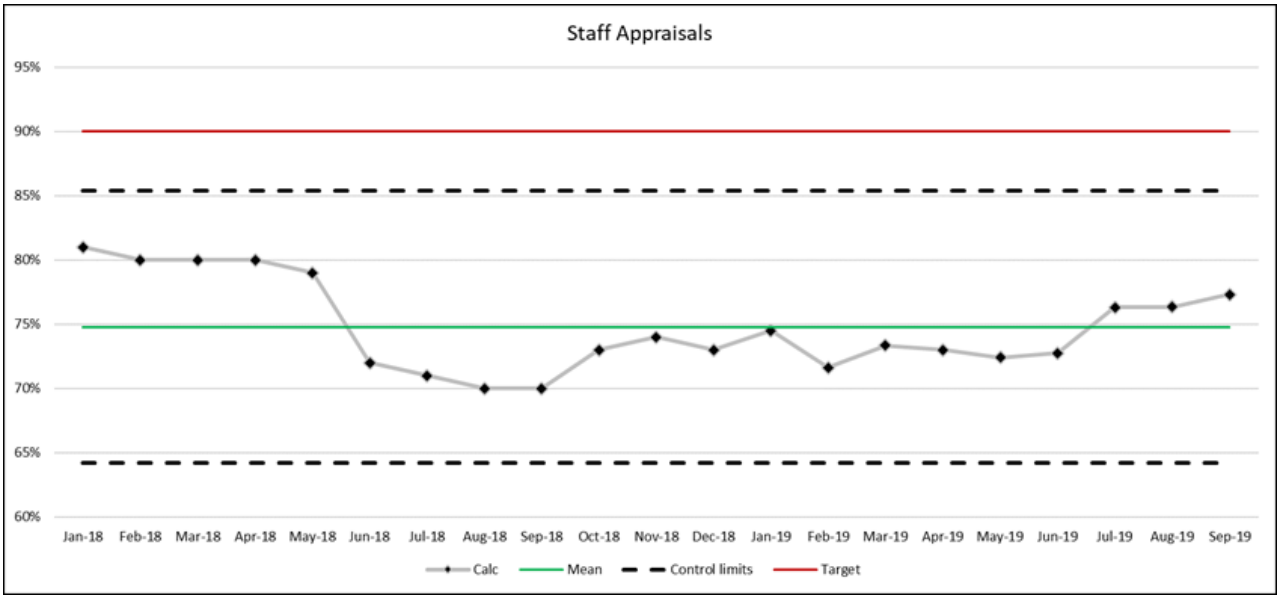
We are continuing to review our key workforce policies against the “Just Culture” framework.
We continue to support Managers in their role as “Commissioning Manager” in terms of adhering to timescales for investigations and a working group is being set up to consider how we can improve process and timescales.

MODERN AND PROGRESSIVE WORKFORCE – APPRAISALS

Executive Lead: Martin Rayson

CQC Domain: Well-Led

2021 Objective: Our People



Challenges/Successes

Overall Trust performance continues to be well below the current target; however, the percentage completed is increasing.

Actions in place to recover

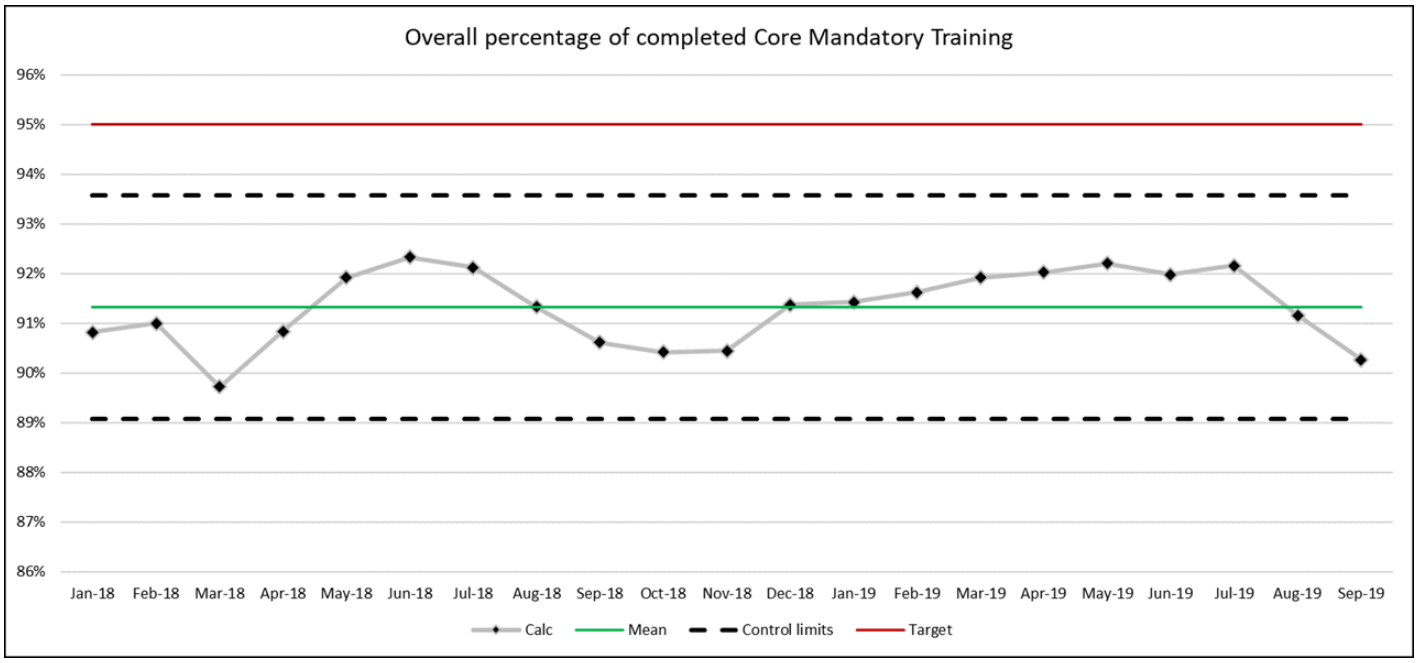
- Appraisee and appraiser training widely available across all sites
- SHRBPs working with Divisional teams to improve position

MODERN AND PROGRESSIVE WORKFORCE – CORE LEARNING

Executive Lead: Martin Rayson

CQC Domain: Well-Led

2021 Objective: Our People



Challenges/Successes

Core learning is showing a consistent pattern of over 90% compliance, although there has been a decline in the last two months, which we will watch.

Data from Lincolnshire Partnership Foundation Trust (LPFT) and Lincolnshire Community Health Services (LCHS) show that their compliance rates are in the same overall range.

Actions in place to recover

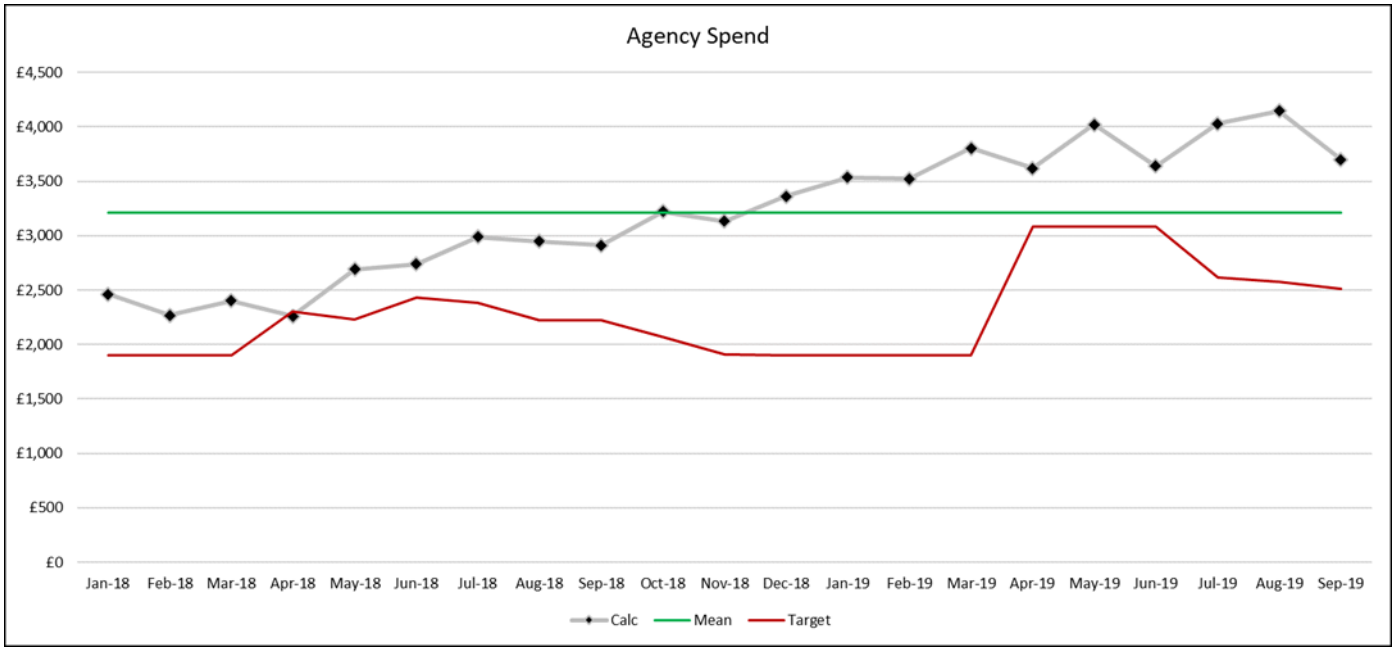
Discussions are ongoing within the STP to consider the possible benefits of establishing a Shared Service with other Trusts in the Lincolnshire Healthcare community and the potential of this to increase Core Learning compliance even further. In addition, HR Business Partners are working actively with senior managers to continue to improve compliance.

SUSTAINABLE SERVICES – AGENCY SPEND

Executive Lead: Martin Rayson

CQC Domain: Well-Led

2021 Objective: Our People



Challenges/Successes

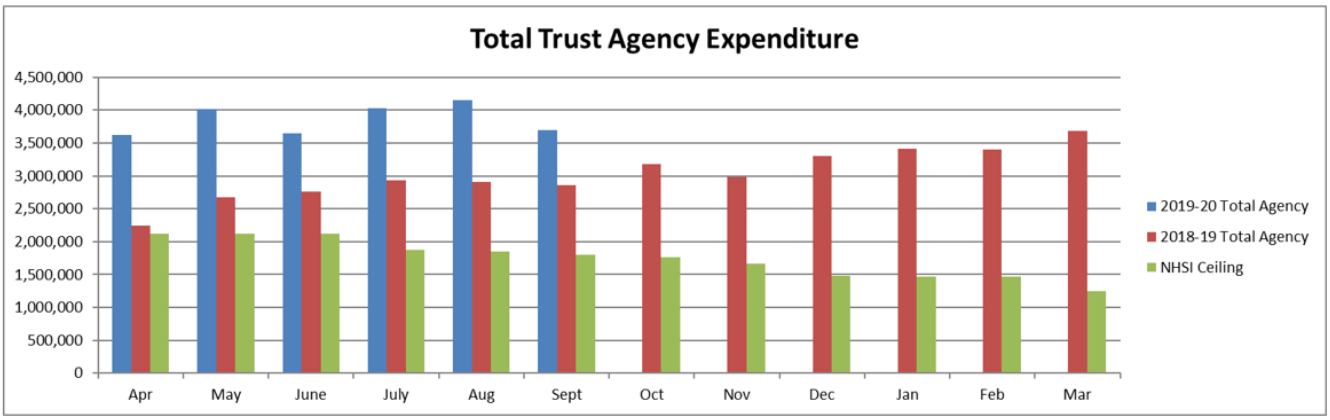
In September (M06), Year to Date (YTD) planned pay costs deteriorated to 4.2% adverse to plan [an underlying position of 4.7% adverse to plan excluding releases] and an improved 71.8% (-1.5%) of income, although 1.3% higher than plan. The adverse variance to plan for both bank and agency increased YTD with a corresponding decrease in the savings for substantive staff.

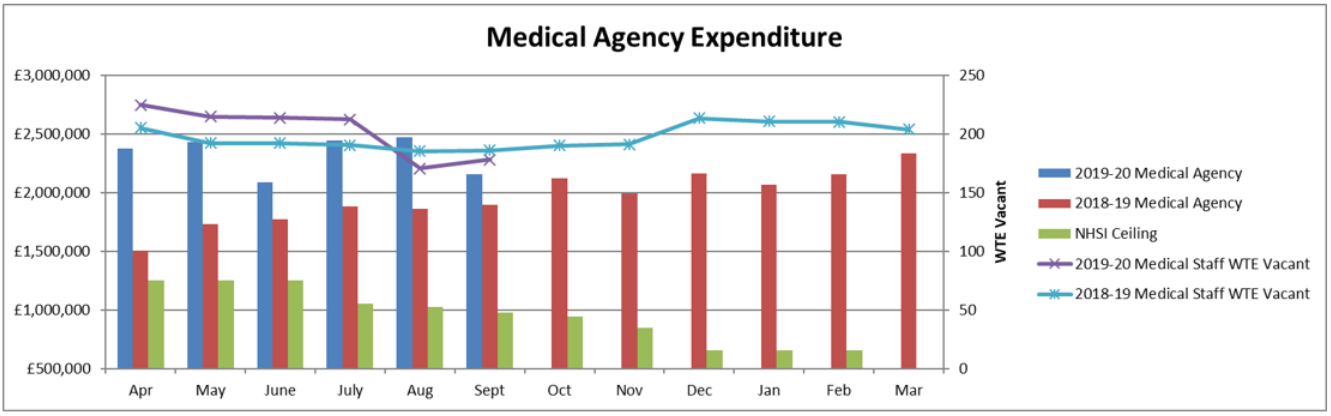
The adverse variance to plan remains driven by the higher premium cost of agency staffing and under delivery of workforce FEP.

The monthly run rate for total agency spend decreased significantly (- £448K) from Month 5 to Month 6 to £3.6M, but a similar reduction was built into plan so continues to exceed that planned by 36% (+1.0%)

Continued good progress against the delivery plan of the medical central agency team (see below for details) and a series of division medical agency review meetings were held. Medical Agency pay costs decreased in September (- £313K). This is inclusive of investment in trial of a redesigned rota in ED at a cost of £70K.

Nursing Agency costs reduced significantly (- £250 K, 15%) in September. Tier 6 (off – framework) use reduced and one of the largest suppliers of agency staffing has agreed price reductions from 18th October.





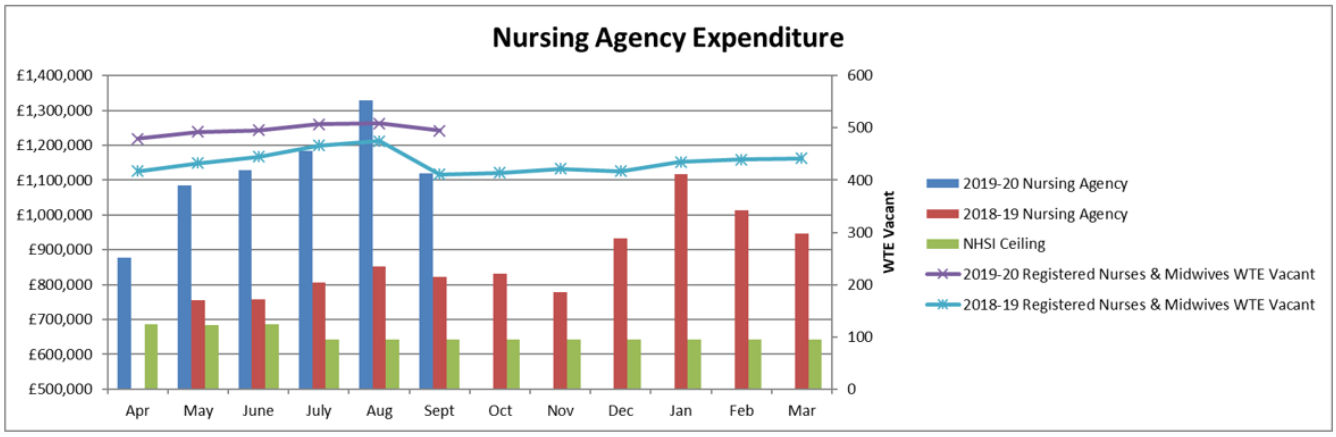
Medical Agency pay costs decreased in September (- £313K). This is inclusive of investment in trial of a redesigned rota in ED at a cost of £70K so the underlying monthly run rate reduced by c. £400K. £ per vacant fte decreased from £14,484 to £12,128.

This is a little lower than should have been expected from the vacancy rate improvement at Trainee Level. This is likely because whilst requested shifts were down at 3,534 from 3,905 in August, agency booked hours were up at 24,831 from 24, 699 in August with the fill rate for requested shifts in September increasing to 99.1% compared to 97.9% in August. September prices remained broadly static partly due speciality mix.

Positive work on commissions control continued in September with a further £11,888 savings. In the last 12 months, there has been a total saving of £148K against commissions Holt tendered as part of the contract, demonstrating additional controls on rates.

A further £10,357 has been saved on breaks, above and beyond break policy, for the month of September. This takes the total for the last 12 months to £91,103.

DE savings for the month of August were at £363,800 taking the last 12 months total to £4.21M. The DE efficiency was at 92.8% (+0.2%) with only 201 (-- 14) shifts being VAT applicable. AHP DE savings are at a total of £62,210 with £10,200 being saved in September.



Nursing Agency costs reduced significantly (- £250 K, 15%) in September and Tier 6 (off – framework) use also reduced. There will be a vacancy rate improvement from September as a consequence of NQN starts but this is not fully reflected in the data yet due to processing stage at the point of data reporting. Agency spend is not expected to reduce from this group of staff until late October/Early November due to initial work plans for this group of newly qualifying staff.

Whilst Nursing Agency cost reduced, fill rate increased to 95% at Lincoln with that increase being covered by agency staffing.

LINCOLN Date	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Contracted staff percentage	76%	71%	71%	73%	72%	69%	67%	66%	66%
Total temp percentage	20%	24%	23%	22%	22%	25%	26%	27%	29%
Bank percentage	11%	13%	14%	12%	11%	12%	12%	12%	12%
Agency percentage	9%	11%	9%	10%	11%	14%	14%	15%	17%
Total bank requests	540	657	665	606	640	711	749	781	762
Total percentage staffing against required	96%	95%	94%	95%	94%	94%	94%	92%	95%
Total percentage staffing without agency	87%	84%	85%	85%	83%	81%	79%	77%	78%

BOSTON Date	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Contracted staff Percentage	58%	57%	59%	59%	58%	58%	60%	57%	59%
Total temp percentage	38%	37%	38%	36%	38%	38%	38%	39%	37%
Bank percentage	11%	11%	12%	12%	11%	10%	10%	11%	10%
Agency percentage	27%	27%	26%	24%	27%	28%	28%	28%	27%
Total bank requests	679	704	664	667	686	685	665	712	678
Total percentage staffing against required	96%	95%	97%	96%	96%	97%	97%	96%	96%
Total percentage staffing without agency	69%	68%	71%	71%	69%	68%	69%	68%	69%

Scientific and AHP agency costs increased from £148K in August to £180K in August.
Other Agency costs increased from £196K to £249K per month and is largely from investment in transformation and FEP programmes.

Actions in place to recover

The primary action to reduce agency costs is to still to reduce vacancy rates through substantive recruitment (See Vacancy Rates Section).

Medical Agency

Continued targeted removal of Medical Umbrella companies.

Continued focus on total fill rate.

Continued Divisional Medical Agency Review Meetings and follow up actions.

Further improvements to triangulation with vacancies and divisional 'plans for every post'

Careful monitoring of projected October Week 4 (half term) agency requests.

The Trust is exploring a technology solution (Patchwork) to increase medical bank working which has interoperability with Allocate.

Nursing

- Continued introduction of tier 3.5 framework agencies to further reduce reliance on off frame work agency use;
- Enhanced nursing bank rate pilot, focused on high cost agency areas – September 19;
- Full review of rostering practice for Nursing including payments of breaks and management of annual leave – September 2019 and
- Longer term temporary nursing staffing plans to be developed to avoid higher premiums of shorter lead time requests.
- Planned commitment to remove Thornbury supply in the next rostering period (October 7th)
- Planned rate reduction of Tier supplier – 18th October

STT and Other

Full analysis of STT and other agency September increases to determined actions to reduce spend.

SUSTAINABLE SERVICES – INCOME & EXPENDITURE

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

Income & Expenditure Summary 2019/20

2019/20	Current Month			Year to Date			Plan		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
Income	41,238	47,349	6,111	248,201	253,655	5,454	501,616	480,437	(21,179)
Expenditure	(44,441)	(47,321)	(2,880)	(270,985)	(276,580)	(5,595)	(533,922)	(543,553)	(9,631)
EBITDA	(3,203)	28	3,231	(22,784)	(22,925)	(141)	(32,306)	(63,117)	(30,811)
Net Finance costs	(749)	(760)	(11)	(4,329)	(4,269)	60	(9,106)	(8,815)	291
Surplus/(Deficit)	(3,952)	(732)	3,220	(27,113)	(27,194)	(81)	(41,412)	(71,931)	(30,519)
Technical adjustments	2	19	17	7	115	108	14	230	216
Surplus/(Deficit)	(3,950)	(713)	3,237	(27,106)	(27,079)	27	(41,398)	(71,701)	(30,303)
EBITDA % Income	(7.8%)	0.1%	7.8%	(9.2%)	(9.0%)	0.1%	(6.4%)	(13.1%)	(6.7%)
CIPs	1,869	992	(877)	8,743	6,887	(1,856)	25,610	20,200	(5,410)

Income is £5,454k favourable to plan YTD. Excluding the £961k adverse movement to plan in relation to Passthrough, Income is £6,415k favourable to plan YTD. However, the income position includes income from backlog and repatriation of £3,156k, delivery of which is yet to be validated and is a risk to the Trust. The income position also includes £5,900k of transitional support.

Expenditure is £5,595k adverse to plan YTD. Excluding the £961k favourable movement to plan in relation to Passthrough, Expenditure is £6,556k adverse to plan YTD, and the overall Expenditure position is heavily impacted by the £7,252k adverse movement to plan in Pay.

The £7,252k adverse Pay movement YTD is driven by higher than planned expenditure on temporary staffing: while substantive Pay is £692k favourable to plan, Bank Pay is £1,755k adverse to plan and Agency Pay is £6,191k adverse to plan. The Pay position has been adversely impacted by both lower than planned FEP savings delivery in relation to workforce schemes and temporary staffing pressures in relation to Medical and Nursing Staffing. Staffing pressures are most acute in the Medicine Division and the Division has been placed into enhanced support in order to improve performance.

The in-month pay position includes arrears for national Medical & Dental pay award back-dated to April. The YTD impact of the pay award is roughly £400k higher than provided for, of which half has been offset by additional funding the Trust has received.

Excluding the £961k favourable variance in relation to Passthrough, Non Pay is £695k favourable to plan. However, the Non Pay position includes £1,493k of non-recurrent technical savings delivery, without which Non Pay would be £798k adverse to plan and the reasons for this adverse movement to plan are being reviewed.

Overall, CIP savings of £6,887k have been delivered YTD or £1,856k less than savings of £8,743k planned YTD. Excluding non-recurrent technical savings delivery of £2,531k, CIP savings delivery is £4,387k adverse to plan YTD.

The most likely unmitigated forecast is a deficit of £79.2m excluding PSF, FRF and MRET or £8,826k adverse to plan. This forecast is inclusive of £20.2m of FEP savings or £5.4m less than planned.

SUSTAINABLE SERVICES – INCOME & EXPENDITURE RUN RATE

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

Income & Expenditure Run Rate 2019/20

2019/20	By Month / Quarter				In Month			Year to date			Full Year		
	Actual Qtr 1 £'000	Actual M4 £'000	Actual M5 £'000	Actual M6 £'000	Plan September £'000	Actuals September £'000	Variance September £'000	Plan September £'000	Actuals September £'000	Variance September £'000	Plan Full Year £'000	Unmitigated Most Likely Forecast Full Year £'000	Required Mitigation Full Year £'000
Income													
Clinical income	96,836	34,422	32,741	38,209	32,283	38,209	5,926	195,722	202,208	6,486	389,070	392,147	3,077
Pass through income	11,962	4,455	3,745	4,228	4,224	4,228	4	25,351	24,390	(961)	50,710	48,390	(2,321)
Total Patient related income	**108,798**	**38,877**	**36,486**	**42,436**	**36,507**	**42,436**	**5,929**	**221,073**	**226,597**	**5,524**	**439,780**	**440,536**	**756**
PSF, FRF and MRET funding	4,705	1,989	1,989	1,990	1,990	1,990	0	10,673	10,673	0	28,928	7,450	(21,478)
Other Income	8,078	2,748	2,636	2,923	2,741	2,923	182	16,455	16,385	(70)	32,908	32,450	(458)
Total Other operating income	**12,783**	**4,737**	**4,625**	**4,913**	**4,731**	**4,913**	**182**	**27,128**	**27,058**	**(70)**	**61,836**	**39,900**	**(21,936)**
Total Income	**121,581**	**43,614**	**41,111**	**47,349**	**41,238**	**47,349**	**6,111**	**248,201**	**253,655**	**5,454**	**501,616**	**480,437**	**(21,179)**
Expenditure													
Pay	(89,930)	(30,551)	(30,758)	(30,999)	(28,607)	(30,999)	(2,392)	(174,986)	(182,238)	(7,252)	(342,620)	(355,203)	(12,583)
Pass through non pay	(11,962)	(4,455)	(3,745)	(4,228)	(4,224)	(4,228)	(4)	(25,351)	(24,390)	961	(50,710)	(48,390)	2,321
Other Non pay	(34,701)	(11,416)	(11,741)	(12,095)	(11,610)	(12,095)	(485)	(70,648)	(69,953)	695	(140,592)	(139,961)	631
Total Expenditure	**(136,593)**	**(46,422)**	**(46,244)**	**(47,321)**	**(44,441)**	**(47,321)**	**(2,880)**	**(270,985)**	**(276,580)**	**(5,595)**	**(533,922)**	**(543,553)**	**(9,631)**
Interest receivable	39	12	10	9	3	9	6	18	70	52	36	146	110
Finance costs	(2,069)	(747)	(771)	(772)	(752)	(772)	(20)	(4,347)	(4,359)	(12)	(9,142)	(9,252)	(110)
Profit on disposal of assets	12	2	3	3	0	3	3	0	20	20	0	291	291
I&E - Deficit	**(17,030)**	**(3,541)**	**(5,891)**	**(732)**	**(3,952)**	**(732)**	**3,220**	**(27,113)**	**(27,194)**	**(81)**	**(41,412)**	**(71,931)**	**(30,519)**
Impairments/Revaluations Adjustment	0	0	0	0	0	0	0	0	0	0	0	0	0
Donated/Govern't grant Asset Adjustment	58	19	19	19	2	19	17	7	115	108	14	230	216
Adjusted Surplus/(Deficit)	**(16,972)**	**(3,522)**	**(5,872)**	**(713)**	**(3,950)**	**(713)**	**3,237**	**(27,106)**	**(27,079)**	**27**	**(41,398)**	**(71,701)**	**(30,303)**
Adjusted Surplus/(Deficit) ex PSF, FRF & MRET	**(21,677)**	**(5,511)**	**(7,861)**	**(2,703)**	**(5,940)**	**(2,703)**	**3,237**	**(37,779)**	**(37,752)**	**27**	**(70,326)**	**(79,151)**	**(8,825)**
Total Trust (including passthrough)													
Adjustments to derive underlying deficit													
FSM Loan Interest	2,030	735	761	763							9,106	9,106	(0)
External Support	1,675	75	75	75							1,900	1,900	0
Profit on Disposals	(12)	(2)	(3)	(3)							(250)	(250)	0
Technical Adjustments	(1,581)	(950)	0	0							(500)	(2,531)	(2,031)
Transitional Support	0	0	0	(5,900)							0	(5,900)	(5,900)
Underlying Surplus/(Deficit)	**(14,860)**	**(3,664)**	**(5,039)**	**(5,778)**							**(31,142)**	**(69,376)**	**(38,234)**

As at the end of September, the Trust position is a deficit of £29,079k or £27k favourable to plan, including a favourable movement to plan of £3,237k in September.

The adverse movement to plan YTD in Expenditure of £5,595k has largely been offset by a favourable movement in Income of £5,454k which includes transitional support of £5,900k.

The unmitigated most likely forecast is a deficit of £79,151k or £8,825k adverse to plan. Including PSF, FRF and MRET, the forecast is £30,303k adverse to plan because failure to achieve the financial plan in the second, third and final quarter of 2019/20 would result in the loss of £21,478k of PSF and FRF funding. Actions are therefore required to mitigate the £8,825k adverse movement to plan in order to achieve the PSF and FRF funding.

.

SUSTAINABLE SERVICES – NHS PATIENT CARE INCOME & ACTIVITY

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

NHS Patient Care Income & Activity 2019/20

2019/20 Clinical Income Summary: YTD Month 06

	Activity: In-Month				Income: In-Month				Activity: Year-To-Date				Income: Year-To-Date			
	2018/19 Actual September Activity	2019/20 Plan September Activity	2019/20 Actual September Activity	Variance September Activity	2018/19 Actual September £'000	2019/20 Plan September £'000	2019/20 Actual September £'000	Variance September £'000	2018/19 Actual September Activity	2019/20 Plan September Activity	2019/20 Actual September Activity	Variance September Activity	2018/19 Actual September £'000	2019/20 Plan September £'000	2019/20 Actual September £'000	Variance September £'000
Activity:																
Accident & Emergency	12,034	11,801	12,556	755	1,752	2,006	2,164	158	75,805	71,992	75,196	3,204	10,974	12,236	12,896	660
Daycases	4,907	5,373	4,852	(521)	2,587	2,864	2,610	(254)	32,382	32,492	32,174	(318)	16,749	17,318	17,477	159
Elective Spells	674	771	708	(63)	1,677	2,128	1,976	(152)	4,508	4,663	4,435	(228)	11,423	12,867	12,808	(59)
Non Elective Spells	5,755	5,952	6,025	73	9,897	11,125	12,420	1,296	35,159	36,216	37,544	1,328	61,879	67,640	77,638	9,998
Elective Excess Bed Days	126	117	52	(65)	29	32	15	(17)	767	703	618	(85)	190	191	166	(25)
Non Elective Excess Bed Days	1,754	1,645	1,497	(148)	414	431	235	(196)	9,680	9,868	7,414	(2,454)	2,327	2,586	1,830	(755)
Outpatient Firsts	23,331	24,538	23,653	(886)	3,158	3,516	3,378	(138)	147,439	148,385	144,999	(3,386)	19,614	21,260	20,712	(548)
Outpatient Follow Ups	29,900	31,841	30,696	(1,145)	2,551	2,953	2,808	(145)	191,822	192,562	187,578	(4,984)	16,264	17,861	17,250	(611)
Outpatient Non Face To Face	1,818	2,090	2,337	247	40	137	154	17	12,448	12,573	15,469	2,896	272	821	994	173
Outpatient Virtual	0	0	0	0	0	0	0	0	0	0	78	78	0	0	2	2
Outpatient Advice & Guidance	0	279	445	166	0	8	11	3	0	1,675	2,771	1,096	0	51	69	18
Critical Care	1,164	1,630	1,514	(116)	864	1,551	1,392	(160)	8,915	9,782	8,838	(944)	6,923	9,309	8,296	(1,013)
Maternity	1,008	1,028	946	(82)	797	895	876	(19)	6,052	6,165	5,700	(465)	5,033	5,370	5,277	(93)
Non PbR				0	3,723	3,096	3,078	(18)				0	22,713	18,512	18,737	225
Block	0	0	0	0	0	237	237	0	0	0	0	0	0	1,424	1,424	0
Shadow Monitoring	0	1,395	1,407	12	0	0	0	0	0	8,370	8,341	(29)	0	0	0	0
Repatriation						467	467	0						2,850	2,850	0
Backlog						48	48	0						306	306	0
Work in Progress:						0	(521)	(521)						0	(622)	(622)
Sub total without passthrough					**27,489**	**31,494**	**31,348**	**(146)**					**174,361**	**190,601**	**198,109**	**7,508**
CQUIN					563	361	369	8					3,564	2,189	2,292	103
Fines						0	(75)	(75)						0	(448)	(448)
Fines Reinvested						0	31	31						0	189	189
Bring Lincolnshire CCG Contract to Plan						0	(160)	(160)						0	(7,813)	(7,813)
APA (calculated at quarterly billing)						0	44	44						0	854	854
Prior Year								0								0
Maternity Prepayment								0								0
Total (Non Passthrough)					**28,052**	**31,855**	**31,558**	**(297)**					**177,925**	**192,790**	**193,183**	**393**
Non-recurrent Transitional Support						0	5,900	5,900						0	5,900	5,900
Total (Non Passthrough including transitional support)					**28,052**	**31,855**	**37,458**	**5,603**					**177,925**	**192,790**	**199,083**	**6,293**
Passthrough					3,214	4,224	4,157	(67)					23,654	25,351	24,390	(961)
Total (Inc Passthrough)					**31,266**	**36,079**	**41,615**	**5,536**					**201,579**	**218,141**	**223,473**	**5,332**

SUSTAINABLE SERVICES – NHS PATIENT CARE INCOME & ACTIVITY

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

Headline
Contract income year to date of £223m is £5m (2.4%) favourable to plan. Excluding £1.0m adverse variance on pass-through, contract income year to date is £6m favourable to plan.

Key variances by POD below excluding pass-through

- Non Elective Spells are favourable to plan by £10m (14.7%) – Medicine accounts for £9m of the over-performance. Activity is above plan by 1,328 (3.7%) and the Trust has seen 2,385 more patients for the same time period in 2018/19.
- Outpatients are £1m adverse to plan - Medicine and Surgery account for 84% of the adverse movement to plan. Activity is 4,300 adverse to plan in 2019/20
- Critical Care is £1m adverse to plan – with this variance driven by Adult Critical Care. Activity is 944 adverse to plan in 2019/20 and 77 down on the same time period in 2018/19.
- A&E attendances are £0.7m favourable to plan. Activity in 2019/20 is above planned levels by 3,204 attendances, however this is 609 less than the same time period in 2018/19.

Key variances by Commissioner

- Lincolnshire CCGs are £0.9m favourable to plan excluding the £5.9m non-recurrent transitional support funding. This is driven by the NEL APA adjustment.
- Non Lincolnshire commissioners are £461k adverse to plan driven by:
- Fines of £260k, predominantly due to 2ww breast symptomatic and suspect cancer.
- Screening is £217k adverse to plan, of which bowel scope is £232k, diabetic retinopathy is £90k, offset by a favourable variance of £104k in Breast Screening.

Risks

- Lincolnshire CCGs are querying the level of NEL financial over-performance for both volume (activity) and price (casemix). Specifically these queries are in relation to Frailty Unit, Discharge (from A&E) and Paediatric Assessment Unit.
- Delivery of the backlog and repatriation activity levels. The Trust assumes £2.3m backlog and £5.7m repatriation. Backlog is presentationally split; where there are plans these are split at specialty/POD for 2019/20 with £0.6m unidentified at present. No plans have been identified and agreed with commissioners for repatriation. The current risk around repatriation and unidentified backlog is £3.2m in the year-to-date position.
- A&E over performance – the plan assumed a greater impact in relation to primary care streaming and commissioner demand management schemes than is currently being delivered.
- PLCV challenges – It has been identified that prior approval is not being received for all procedures currently and there is a risk in the year-to-date position of c£0.4m, in particular tonsillectomy's and hernias. This is not transacted through the current contract arrangements.

SUSTAINABLE SERVICES – NHS PATIENT CARE INCOME & ACTIVITY RUN RATE

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

Income & Activity Run Rate - Activity 2019/20

	Activity Units: By Month / Quarter				In Month				Year to date			
Activity	Actual Qtr 1	Actual M4	Actual M5	Actual M6	Plan September Activity	Actual September Activity	Variance September Activity	% Variance	Plan September Activity	Actual September Activity	Variance September Activity	% Variance
Accident & Emergency	36,746	13,263	12,631	12,556	11,801	12,556	755	6.4%	71,992	75,196	3,204	4.5%
Daycases	16,353	5,697	5,272	4,852	5,373	4,852	(521)	(9.7%)	32,492	32,174	(318)	(1.0%)
Elective Spells	2,148	790	789	708	771	708	(63)	(8.2%)	4,663	4,435	(228)	(4.9%)
Non Elective Spells	18,545	6,688	6,286	6,025	5,952	6,025	73	1.2%	36,216	37,544	1,328	3.7%
Elective Excess Bed Days	264	168	134	52	117	52	(65)	(55.6%)	703	618	(85)	(12.1%)
Non Elective Excess Bed Days	3,393	1,162	1,362	1,497	1,645	1,497	(148)	(9.0%)	9,868	7,414	(2,454)	(24.9%)
Outpatient Firsts	72,243	26,549	22,554	23,653	24,538	23,653	(886)	(3.6%)	148,385	144,999	(3,386)	(2.3%)
Outpatient Follow Ups	93,236	34,292	29,353	30,696	31,841	30,696	(1,145)	(3.6%)	192,562	187,578	(4,984)	(2.6%)
Outpatient Non Face To Face	7,825	2,792	2,515	2,337	2,090	2,337	247	11.8%	12,573	15,469	2,896	23.0%
Outpatient Virtual	-	1	77	-	-	-	0		-	78	78	
Outpatient Advice & Guidance	1,334	529	463	445	279	445	166	59.3%	1,675	2,771	1,096	65.4%

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

Whilst A&E activity is lower for the first six months of 2019/20 when compared to 2018/19, this is primarily due to a change in plan in relation to assumed levels of increased activity transferring to Primary Care Streaming (i.e. a planned change between years).

A&E and Non-Elective activity levels are being raised formally with Lincolnshire CCGs given their impact upon the Trust's ability to manage flow and bed resources and their overall impact on the Trust's financial position. As a note of caution, CCGs are also querying back to ULHT the level of NEL activity and income recording that is currently being shown as they believe they are incorrect. Those discussions are continuing around Discharge Lounge, PAU and Frailty activity.

Non Elective activity is 3.7% up against plan YTD in relation to activity and c15% in relation to income. This Non Elective over performance is mainly within the Medicine Division and further details are being shared with the Division.

SUSTAINABLE SERVICES – NHS PATIENT CARE INCOME & ACTIVITY RUN RATE £

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

Income & Activity Run Rate - £ 2019/20

	By Month / Quarter							In Month			Year to date		
	Actual M1 £'000	Actual M2 £'000	Actual M3 £'000	Actual Qtr 1 £'000	Actual M4 £'000	Actual M5 £'000	Actual M6 £'000	Plan September £'000	Actual September £'000	Variance September £'000	Plan September £'000	Actual September £'000	Variance September £'000
Accident & Emergency	2,039	2,167	2,060	6,267	2,284	2,181	2,164	2,006	2,164	158	12,236	12,896	660
Daycases	2,898	3,144	2,902	8,944	3,128	2,795	2,610	2,864	2,610	(254)	17,318	17,477	159
Elective Spells	1,963	2,295	2,082	6,340	2,195	2,297	1,976	2,128	1,976	(152)	12,867	12,808	(59)
Non Elective Spells	12,689	13,551	12,453	38,693	13,723	12,802	12,420	11,125	12,420	1,296	67,640	77,638	9,998
Elective Excess Bed Days	17	29	25	71	47	33	15	32	15	(17)	191	166	(25)
Non Elective Excess Bed Days	274	326	318	918	318	360	235	431	235	(196)	2,586	1,830	(755)
Outpatient Firsts	3,478	3,509	3,350	10,337	3,804	3,194	3,378	3,516	3,378	(138)	21,260	20,712	(548)
Outpatient Follow Ups	2,874	2,950	2,770	8,594	3,157	2,690	2,808	2,953	2,808	(145)	17,861	17,250	(611)
Outpatient Non Face To Face	172	168	163	503	178	159	154	137	154	17	821	994	173
Outpatient Virtual	0	0	0	0	0	2	0	0	0	0	0	2	2
Outpatient Advice & Guidance	9	11	13	33	13	12	11	8	11	3	51	69	18
Critical Care	1,381	1,167	1,608	4,155	1,106	1,643	1,392	1,551	1,392	(160)	9,309	8,296	(1,013)
Maternity	898	829	901	2,628	929	844	876	895	876	(19)	5,370	5,277	(93)
Non PbR	3,012	3,316	2,915	9,243	3,329	3,086	3,078	3,096	3,078	(18)	18,512	18,737	225
Block	237	237	237	712	237	237	237	237	237	0	1,424	1,424	0
Repatriation	467	483	467	1,417	483	483	467	467	467	0	2,850	2,850	0
Backlog	48	54	48	150	54	54	48	48	48	0	306	306	0
Work in Progress	(220)	(392)	571	(41)	(360)	300	(521)	0	(521)	(521)	0	(622)	(622)
Sub total without passthrough	**32,237**	**33,846**	**32,883**	**98,966**	**34,625**	**33,171**	**31,348**	**31,494**	**31,348**	**(146)**	**190,601**	**198,109**	**7,508**
CQUIN	375	395	373	1,143	405	376	369	361	369	8	2,189	2,292	103
Fines	(20)	(22)	(186)	(227)	(60)	(87)	(75)	0	(75)	(75)	0	(448)	(448)
Fines Reinvested	16	17	61	94	18	45	31	0	31	31	0	189	189
Bring Lincolnshire CCG Contract to Plan	(1,619)	(1,347)	(1,872)	(4,837)	(1,729)	(1,087)	(160)	0	(160)	(160)	0	(7,813)	(7,813)
APA (calculated at quarterly billing)	124	206	54	384	531	(105)	44	0	44	44	0	854	854
Total (Non Passthrough)	**31,113**	**33,097**	**31,313**	**95,523**	**33,789**	**32,313**	**31,558**	**31,855**	**31,558**	(297)	**192,790**	**193,183**	**393**
Non-recurrent Transitional Support	0	0	0	0	0	0	5,900	0	5,900	5,900	0	5,900	5,900
Total (Non Passthrough)	**31,113**	**33,097**	**31,313**	**95,523**	**33,789**	**32,313**	**37,458**	**31,855**	**37,458**	5,603	**192,790**	**199,083**	**6,293**
Passthrough	4,101	4,174	3,958	12,233	4,197	3,802	4,157	4,224	4,157	(67)	25,351	24,390	(961)
Total (Inc Passthrough)	**35,214**	**37,271**	**35,271**	**107,756**	**37,987**	**36,115**	**41,615**	**36,079**	**41,615**	**5,536**	**218,141**	**223,473**	**5,332**

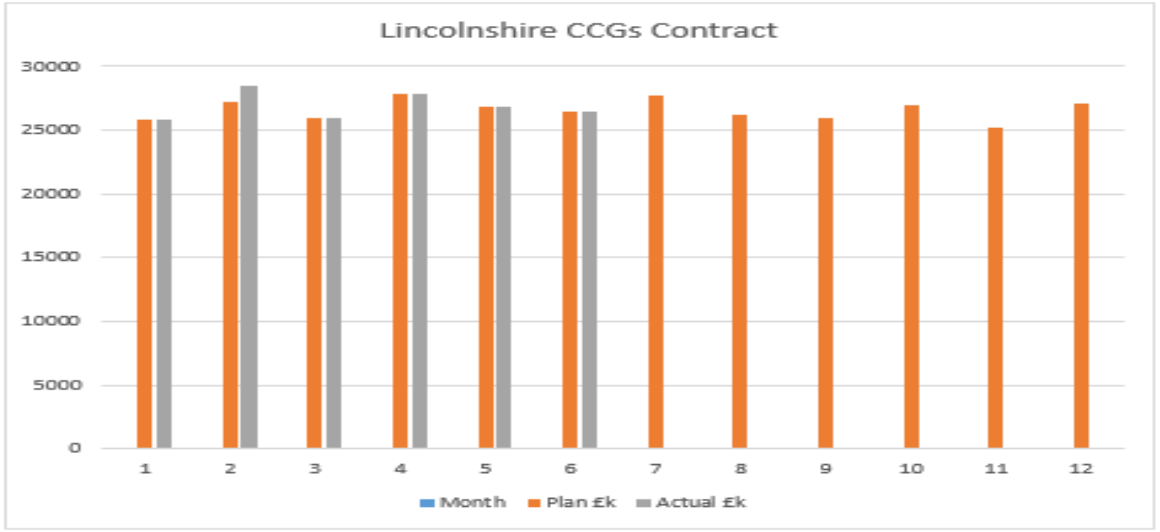
SUSTAINABLE SERVICES – NHS PATIENT CARE INCOME 2019/20

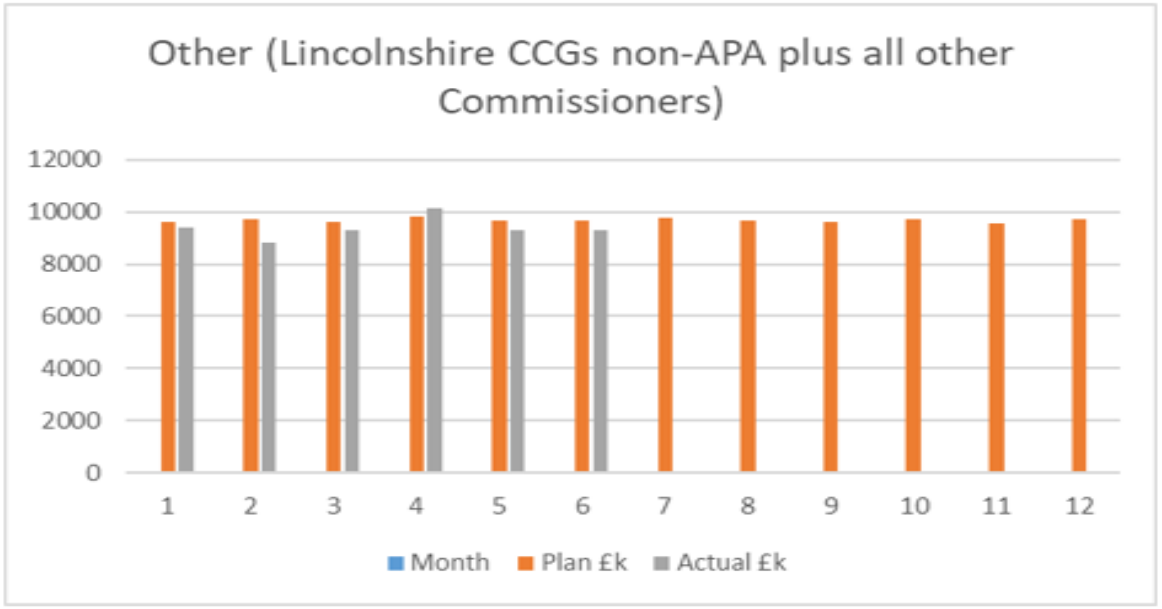
Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

NHS Patient Care Income 2019/20 - Lincolnshire CCGs and 'Other' performance





SUSTAINABLE SERVICES – PAY SUMMARY

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

Pay Summary 2019/20

2019/20 Pay Summary: YTD Month 06	By Month / Quarter				Pay: In-Month				Pay: Year-To-Date			
Staff Groups	Actual Qtr 1 £'000	Actual M4 £'000	Actual M5 £'000	Actual M6 £'000	2018/19 Actual September £'000	2019/20 Plan September £'000	2019/20 Actual September £'000	Variance September £'000	2018/19 Actual September £'000	2019/20 Plan September £'000	2019/20 Actual September £'000	Variance September £'000
Substantive:												
Registered Nursing, Midwifery and Health visiting staff	21,589	7,082	7,158	7,149	7,092	7,190	7,149	41	41,650	43,306	42,978	328
Health Care Scientists and Scientific, Therapeutic and Technical staff	8,251	2,739	2,737	2,766	2,607	2,602	2,766	(164)	15,129	15,700	16,493	(793)
Support to clinical staff	14,800	4,895	4,869	5,117	5,092	4,780	5,117	(337)	27,677	28,875	29,681	(806)
Medical and Dental Staff	19,093	6,855	6,871	7,230	6,554	6,784	7,230	(446)	39,213	41,138	40,049	1,089
Non-Medical - Non-Clinical Staff	8,256	2,730	2,872	3,118	2,691	2,911	3,118	(207)	15,309	17,566	16,976	590
Apprentice levy	347	86	113	117	113	106	117	(11)	635	641	663	(22)
Capitalised staff	(45)	(16)	(15)	(230)	(171)	0	(230)	230	(325)	0	(306)	306
Total Substantive costs	**72,291**	**24,372**	**24,605**	**25,267**	**23,978**	**24,373**	**25,267**	**(894)**	**139,287**	**147,226**	**146,534**	**692**
Bank:												
Registered Nursing, Midwifery and Health visiting staff	1,523	496	506	524	461	473	524	(51)	2,865	2,830	3,050	(220)
Health Care Scientists and Scientific, Therapeutic and Technical staff	131	48	44	44	40	47	44	3	254	268	266	2
Support to clinical staff	1,144	404	466	402	497	373	402	(29)	2,300	2,230	2,416	(186)
Medical and Dental Staff	2,846	1,004	796	958	930	650	958	(308)	4,998	4,407	5,604	(1,197)
Non-Medical - Non-Clinical Staff	715	199	199	103	236	177	103	74	1,216	1,062	1,216	(154)
Total Bank costs	**6,358**	**2,150**	**2,012**	**2,031**	**2,164**	**1,720**	**2,031**	**(311)**	**11,632**	**10,797**	**12,552**	**(1,755)**
Agency:												
Registered Nursing, Midwifery and Health visiting staff	3,086	1,185	1,329	1,118	851	876	1,118	(242)	4,474	5,430	6,717	(1,287)
Health Care Scientists and Scientific, Therapeutic and Technical staff	500	155	149	180	145	131	180	(49)	835	807	984	(177)
Support to clinical staff	6	0	0	0	1	17	0	17	14	81	7	74
Medical and Dental Staff	6,901	2,442	2,473	2,160	1,863	1,344	2,160	(816)	10,647	9,319	13,976	(4,657)
Non-Medical - Non-Clinical Staff	787	245	196	241	88	146	241	(95)	571	1,326	1,470	(144)
Total Agency costs	**11,281**	**4,027**	**4,147**	**3,699**	**2,948**	**2,514**	**3,699**	**(1,185)**	**16,542**	**16,963**	**23,154**	**(6,191)**
Total Pay	**89,930**	**30,549**	**30,763**	**30,997**	**29,090**	**28,607**	**30,997**	**(2,390)**	**167,461**	**174,986**	**182,240**	**(7,254)**

Pay year to date is £7,252k adverse to plan including an adverse movement to plan of £2,392k in September, despite the release of £1,021k of non-recurrent technical savings in prior months.

The adverse movement to plan in Pay includes two key movements: £692k favourable movement against substantive staffing and £7,944k adverse movement on temporary staffing.

Whilst the above table shows that Substantive Pay is £692k favourable to plan, this includes £993k of one-off technical benefit. Excluding the impact the one-off cost of £920k in April of the Agenda for Change pay award and the one-off technical benefits of £993k, Substantive Pay was broadly flat in the first quarter at £24.0m per month, but increased to £24.3m and £24.4m in July and August respectively. The in-month pay position includes arrears for national Medical & Dental pay award back-dated to April. The YTD impact of the pay award is roughly £400k higher than provided for, of which half has been offset by additional funding the Trust has received.

The above table shows that:

1) The adverse movement to plan on temporary staffing comprises of an adverse movement to plan of £1,755k on Bank Pay and £6,191k on Agency Pay.
2) Medical & Dental Pay accounts for £4,765k (66%) and Nursing & Midwifery accounts for £1,178k (16%) of the overall adverse movement to plan.

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

SUSTAINABLE SERVICES – NON PAY SUMMARY

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

Non Pay Summary 2019/20

2019/20 Non Pay Summary: YTD Month 06

	By Month / Quarter				Non Pay: In-Month				Non Pay: Year-To-Date			
Non Pay	Actual Qtr 1 £'000	Actual M4 £'000	Actual M5 £'000	Actual M6 £'000	2018/19 Actual September £'000	2019/20 Plan September £'000	2019/20 Actual September £'000	Variance September £'000	2018/19 Actual September £'000	2019/20 Plan September £'000	2019/20 Actual September £'000	Variance September £'000
Ambulance Services	469	166	169	165	176	169	165	4	674	1,018	969	49
Clinical Supplies & Services	14,984	5,702	5,112	5,177	4,720	5,182	5,177	5	30,147	31,088	30,975	113
Drugs	913	(446)	278	447	513	440	447	(7)	2,985	2,638	1,192	1,446
Pass through	11,962	4,455	3,745	4,228	3,194	4,224	4,228	(4)	23,584	25,351	24,390	961
Establishment Expenditure	1,606	674	561	819	539	528	819	(291)	3,300	3,168	3,660	(492)
General Supplies & Services	2,841	889	661	785	1,010	489	785	(296)	6,118	3,933	5,176	(1,243)
Other	898	184	293	235	133	328	235	93	1,231	1,956	1,610	346
Premises & Fixed Plant	4,524	1,429	1,842	1,647	951	1,633	1,647	(14)	8,040	9,801	9,442	359
Clinical Negligence	5,222	1,741	1,741	1,741	1,775	1,741	1,741	0	10,647	10,446	10,445	1
Capital charges	3,244	1,077	1,084	1,081	944	1,100	1,081	19	5,776	6,600	6,486	114
Total Non Pay	**46,663**	**15,871**	**15,486**	**16,324**	**13,955**	**15,834**	**16,324**	**(490)**	**92,502**	**95,999**	**94,344**	**1,655**

Non Pay expenditure of £94,344k is £1,655k favourable to plan.

Excluding £961k favourable variance on Pass-through, Non Pay is £694k favourable to plan. However, the Non Pay position includes £1,493k of non-recurrent technical savings delivery, without which Non Pay would be £799k adverse to plan, and the reasons for this adverse movement to plan are being reviewed.

Some variation to plan would, though, be expected in Non Pay given the higher than planned levels of Non Elective volumes.

SUSTAINABLE SERVICES – COST IMPROVEMENT PROGRAMME (CIP) SUMMARY

Executive Lead:

Paul Matthew

CQC Domain:

Well-Led

2021 Objective:

Our Services

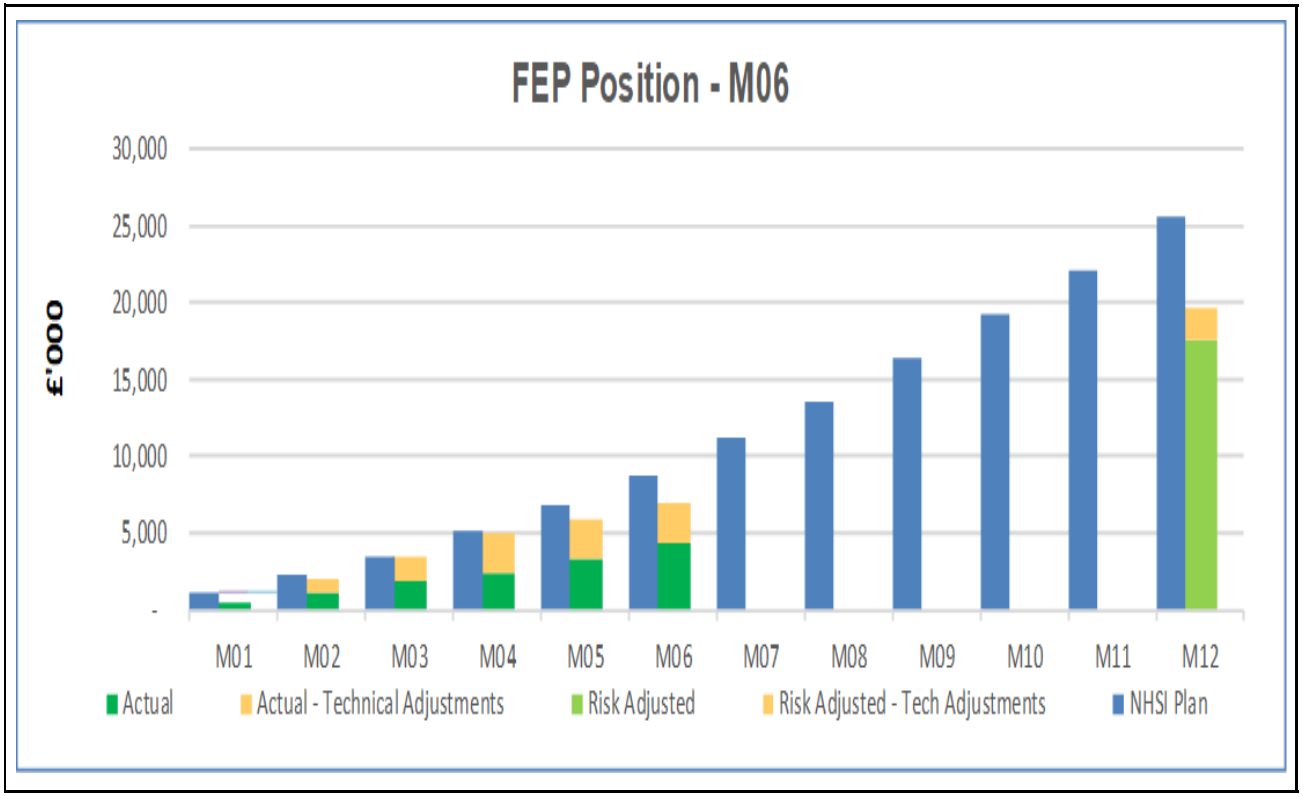
M06

	In Month: 2019/20			YTD: 2019/20			
	Plan September £'000	Actual September £'000	Variance September £'000	Plan September £'000	Actual September £'000	Variance September £'000	RAG
CIP	1,869	992	(877)	8,743	6,887	(1,856)	

Finance Position

YTD ACTUAL	£'000	FORECAST	£'000
Recurrent	4,356	Recurrent	17,419
Non Recurrent	2,531	Non Recurrent	2,781
TOTAL	**6,887**	**TOTAL**	**20,200**

Financial Commentary - Month 06 Position



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

CIP savings delivery of £992k is reported in September; compared to planned CIP savings delivery of £1,869k, savings delivery in September is £877k adverse to plan.

YTD CIP savings delivery of £6,887k to the end of September is £1,856k adverse to planned CIP savings delivery of £8,743k.

However, the YTD CIP position is supported by delivery of £2,531k of non-recurrent Technical CIP savings. This non-recurrent CIP savings delivery comprises of £1,022k of Technical Savings in relation to Pay, £1,493k in relation to Non Pay and £16k in relation to Income.

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

SUSTAINABLE SERVICES – STATEMENT OF FINANCIAL POSITION

	Year end		Year to date			Monthly Actual 2019/20				Forecast Outturn		
	Plan	Actual	Plan	Actual	Variance	Actual	Actual	Actual	Actual	Actual	Plan	Variance
	31 March 2019		30 September 2019			Qtr 1	31-Jul	31-Aug	30-Sep		31 March 2020	
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Non-current assets												
Intangible assets	5,488	6,341	4,827	5,484	(657)	5,907	5,766	5,625	5,484	4,639	4,637	2
Property, plant and equipment: **on-SoFP** IFRIC 12 assets	22,495	27,654	27,156	27,446	(290)	27,550	27,515	27,481	27,446	27,238	26,954	284
Property, plant and equipment: other	213,599	181,095	210,509	187,899	22,610	184,058	186,292	187,134	187,899	202,923	224,849	(21,926)
Trade and other receivables: due from non-NHS/DHSC group bodies	1,828	1,560	1,600	1,561	39	1,537	1,558	1,586	1,561	1,600	1,600	0
Total non-current assets	**243,410**	**216,650**	**244,092**	**222,390**	**21,702**	**219,052**	**221,131**	**221,826**	**222,390**	**236,400**	**258,040**	**(21,640)**
Current assets												
Inventories	6,799	7,440	7,350	7,484	(134)	7,317	7,449	7,961	7,484	7,350	7,350	0
Trade and other receivables: due from NHS and DHSC group bodies	17,664	15,203	23,053	25,931	(2,878)	16,170	19,002	20,023	25,931	26,845	26,845	0
Trade and other receivables: Due from non-NHS/DHSC group bodies	4,848	6,833	7,956	15,671	(7,715)	15,803	16,544	17,839	15,671	7,912	7,912	0
Assets held for sale and assets in disposal groups	0	660	510	660	(150)	660	660	660	660	0	510	(510)
Cash and cash equivalents: GBS/NLF	6,143	7,376	990	3,423	(2,433)	1,206	1,645	1,818	3,423	5,447	4,214	1,233
Cash and cash equivalents: commercial / in hand / other	10	10	10	10	0	10	10	10	10	10	10	0
Total current assets	**35,464**	**37,522**	**39,869**	**53,179**	**(13,310)**	**41,166**	**45,310**	**48,311**	**53,179**	**47,564**	**46,841**	**723**
Current liabilities												
Trade and other payables: capital	(4,723)	(10,791)	(4,217)	(6,831)	2,614	(7,990)	(8,790)	(7,581)	(6,831)	(6,344)	(4,466)	(1,878)
Trade and other payables: non-capital	(38,039)	(40,622)	(37,490)	(41,788)	4,298	(47,043)	(47,082)	(47,352)	(41,788)	(39,001)	(41,096)	2,095
Borrowings	(77,359)	(114,339)	(50,209)	(122,404)	72,195	(124,423)	(106,008)	(106,008)	(122,404)	(197,586)	(197,289)	(297)
Provisions	(735)	(608)	(565)	(608)	43	(608)	(608)	(608)	(608)	(565)	(565)	0
Other liabilities: deferred income	(2,707)	(2,869)	(1,200)	(1,871)	671	(1,110)	(1,634)	(1,487)	(1,871)	(1,200)	(1,200)	0
Other liabilities: other	(503)	(503)	(503)	(503)	0	(503)	(503)	(503)	(503)	(503)	(503)	0
Total current liabilities	**(124,066)**	**(169,732)**	**(94,184)**	**(174,005)**	**79,821**	**(181,677)**	**(164,625)**	**(163,539)**	**(174,005)**	**(245,199)**	**(245,119)**	**(80)**
Net Current liabilities	**(88,602)**	**(132,210)**	**(54,315)**	**(120,826)**	**66,511**	**(140,511)**	**(119,315)**	**(115,228)**	**(120,826)**	**(197,635)**	**(198,278)**	**643**
Total assets less current liabilities	**154,808**	**84,440**	**189,777**	**101,564**	**88,213**	**78,541**	**101,816**	**106,598**	**101,564**	**38,765**	**59,762**	**(20,997)**
Non-current liabilities												
Borrowings	(228,888)	(188,196)	(298,707)	(232,940)	(65,767)	(199,326)	(226,484)	(237,202)	(232,940)	(178,309)	(178,440)	131
Provisions	(2,911)	(2,863)	(2,932)	(2,689)	(243)	(2,989)	(2,689)	(2,689)	(2,689)	(2,825)	(2,782)	(43)
Other liabilities: other	(13,081)	(13,081)	(12,829)	(12,830)	1	(12,956)	(12,914)	(12,872)	(12,830)	(12,578)	(12,578)	0
Total non-current liabilities	**(244,880)**	**(204,140)**	**(314,468)**	**(248,459)**	**(66,009)**	**(215,271)**	**(242,087)**	**(252,763)**	**(248,459)**	**(193,712)**	**(193,800)**	**88**
Total net assets employed	**(90,072)**	**(119,700)**	**(124,691)**	**(146,895)**	**22,204**	**(136,730)**	**(140,271)**	**(146,165)**	**(146,895)**	**(154,947)**	**(134,038)**	**(20,909)**
Financed by												
Public dividend capital	257,563	260,042	260,366	260,042	324	260,042	260,042	260,042	260,042	266,293	265,318	975
Revaluation reserve	34,455	32,159	35,311	31,707	3,604	31,933	31,858	31,782	31,707	31,255	34,951	(3,696)
Other reserves	190	190	190	190	0	190	190	190	190	190	190	0
Income and expenditure reserve	(382,280)	(412,091)	(420,558)	(438,834)	18,276	(428,895)	(432,361)	(438,179)	(438,834)	(452,685)	(434,497)	(18,188)
Total taxpayers' and others' equity	**(90,072)**	**(119,700)**	**(124,691)**	**(146,895)**	**22,204**	**(136,730)**	**(140,271)**	**(146,165)**	**(146,895)**	**(154,947)**	**(134,038)**	**(20,909)**

BORROWINGS	Year end		Year to date			Monthly Actual 2019/20				Forecast Outturn		
Current	31 March 2019		30 September 2019			Qtr 1	31-Jul-19	31-Aug-19	30-Sep-19		31 March 2020	
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Borrowings: DHSC capital loans	2,429	1,889	2,562	2,701	(139)	1,828	2,570	2,570	2,701	2,900	2,636	264
Borrowings: DHSC working capital / revenue support loans	74,930	112,450	44,773	117,357	(72,584)	120,859	101,935	101,304	117,357	191,520	191,521	(1)
Accrued interest on DHSC loans	0		2,412	2,346	66	1,736	1,503	2,134	2,346	2,703	2,670	33
Borrowings: other (non-DHSC)	0	0	462	0	462	0	0	0	0	463	462	1
Total current borrowings	**77,359**	**114,339**	**50,209**	**122,404**	**(72,195)**	**124,423**	**106,008**	**106,008**	**122,404**	**197,586**	**197,289**	**297**
Non-current												
Borrowings: DHSC capital loans	33,343	24,283	30,325	34,179	(3,854)	25,005	25,863	28,026	34,179	32,629	32,746	(117)
Borrowings: DHSC working capital / revenue support loans	195,545	163,913	268,104	198,761	69,343	174,321	200,621	209,177	198,761	142,674	142,687	(13)
Borrowings: other (non-DHSC)	0	0	278	0	278	0	0	0	0	3,006	3,007	(1)
Total non-current borrowings	**228,888**	**188,196**	**298,707**	**232,940**	**65,767**	**199,326**	**226,484**	**237,203**	**232,940**	**178,309**	**178,440**	**(131)**

The Year to date and forecast balance sheets are broadly in line with plan with the following main exceptions:

- Property plant and equipment: the 2019/20 plan was constructed prior to the results of the 31 March 2019 revaluation being completed. This resulted in an increase in asset valuation of circa £32m; the offset to this can be seen within the revaluation and Income & Expenditure Reserves.

- Borrowings: the split between debt due to be repaid within and after one year was incorrect at plan. In total however this is accurate.

- Trade / Non NHS Receivables: the levels at 30 September are significantly increased against plan due to a rise in the levels of Non-NHS Accrued income versus plan. The reasons for this are being investigated and where appropriate corrective action will be taken.

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

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

SUSTAINABLE SERVICES – CASH REPORT

Executive Lead: Paul Matthew

Cash Report 2019/20 Month 06

CQC Domain: Well-Led

2021 Objective: Our Services

	In Month Actual September			Year to date September			Year End Forecast		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
Operating Surplus	(3,203)	(5,135)	(1,932)	(22,784)	(22,926)	(142)	(32,306)	(32,591)	(285)
Depreciation	1,100	1,084	(16)	6,600	6,486	(114)	13,200	13,200	0
Other Non Cash I&E Items	(17)	0	17	(107)	0	107	(214)	(120)	94
Movement in Working Capital	(3,630)	(2,776)	854	(13,409)	(19,694)	(6,285)	(13,680)	(16,465)	(2,785)
Provisions	0	0	0	69	(183)	(252)	(81)	(81)	0
Cashflow from Operations	**(5,750)**	**(6,827)**	(1,077)	**(29,631)**	**(36,317)**	(6,686)	**(33,081)**	**(36,057)**	(2,976)
Interest received	3	10	7	18	70	52	36	140	104
Capital Expenditure	(2,529)	(2,960)	(431)	(18,073)	(16,187)	1,886	(38,312)	(37,239)	1,073
Cash receipt from asset sales	150	3	(147)	150	22	(128)	150	682	532
Cash from / (used in) investing activities	**(2,376)**	**(2,947)**	**(571)**	**(17,905)**	**(16,095)**	**1,810**	**(38,126)**	**(36,417)**	**1,709**
PDC Received	108	0	(108)	324	0	(324)	5,276	6,251	975
Interest on Loans, PFI and leases	(559)	(140)	419	(3,874)	(3,966)	(92)	(8,486)	(8,327)	159
Drawdown on debt - Revenue	5,637	7,925	2,288	38,478	41,718	3,240	59,809	59,795	(14)
Drawdown on debt - Capital	2,940	3,155	215	8,700	11,700	3,000	15,400	15,400	0
Repayment of debt	0	(993)	(993)	(1,245)	(993)	252	(2,721)	(2,574)	147
Cashflow from financing	**8,126**	**9,947**	**1,821**	**42,383**	**48,459**	**6,076**	**69,278**	**70,545**	**1,267**
Net Cash Inflow / (Outflow)	**0**	**173**	**173**	**(5,153)**	**(3,953)**	**1,200**	**(1,929)**	**(1,929)**	**0**
Opening cash balance	1,000	1,655	655	6,153	7,386	1,233	6,153	7,386	1,233
Closing Cash balance	**1,000**	**1,828**	**828**	**1,000**	**3,433**	**2,433**	**4,224**	**5,457**	**1,233**

SUSTAINABLE SERVICES – CASH REPORT continued

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

Year to date:
The cash balance of £3.4m at 30 September reflects a number of factors, of which the most significant are:
- the reduction in capital creditors from the year end high of £10.8m to £6.8m;
- the operating deficit (£27.2m) against plan
- Drawdown of Capital and Revenue loans being higher than plan
- Working Capital being flexed as necessary to manage payments in line with income receipt and borrowings

Despite the current deficit, the impact on the ability to pay suppliers has to date been limited due to the high levels of capital creditors. Capital cash is supporting the overall cash position by circa £12.1m at September 2019.

Borrowing:
Revenue and capital cash loans drawn between April - September 2019 equate to £41.7m / £11.7m respectively; taking the total revenue and capital borrowings (excluding accrued interest) at 30 September to £355.4m. As a consequence borrowing costs for 2019/20 are anticipated to be £9.1m in I&E terms, and in cash terms £8.8m.
The September capital drawing of £6.3m took the total borrowings since February 2018 against the Fire Safety Capital Scheme to £38.2m. The original business case agreed with NHSI set external support at £39.9m. NHSI have requested the business case be refreshed before signing off the final £1.7m.

Timing differences between income / expenditure being recorded within revenue and the receipt / payment of cash, alongside the year to date deficit and reduction in capital creditors indicate that the Trust will experience severe cashflow issues without further intervention or support between Nov - Dec 2019. To assist mitigation against these, the Lincolnshire CCGs have agreed to make an additional cash payment in October to support the year to date deficit.
In addition the Trust has submitted a business case to access an exceptional working capital loan of £7.3m in November.

Forecast:
The cash forecast is in line with plan. The capital creditors are forecast to reduce from £10.8m in March 2019 to £4.3m in March 2020

The cash forecast assumes capital borrowing of £11.7m and revenue borrowing in 2019/20 at £59.8m (£41.4m: 2019/20 deficit support; plus £9.6m 2018/19 deficit support and £8.8m PSF and FRF).

SUSTAINABLE SERVICES – CAPITAL REPORT

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

Funding available 2019/20

The Trust has capital resources of c£32m for 2019/20 including ring-fenced funding e.g. Fire, Medical School and LED Lighting.

The Trust has very limited discretionary capital resources available, totalling c£9m - the discretionary capital available has been reduced due to the requirement to pay the fire loan. This leaves limited resources available to prioritise against Medical Device replacement, IT infrastructure and replacement, Estates Backlog and Service and Digital Developments.

The year-to-date spend incurred amounts to c£12m against a planned spend of c£11m, details below:

Facilities; Minimal spend at M6 of £357k. Majority of spend incurred links to Anti-barricading improvements, £185k. 2nd IT room at Pilgrim, £26k. Lincoln Heating where CQC had raised an issue following an incident with a patient, £22k. Pilgrim Kitchen Floor, £31k. Corridor Flooring, £18k. Endoscopy, £14k. Regular meetings are taking place to ensure planned spend levels are accurate, and risks identified early - currently the roof improvement scheme is incurring significantly higher costs than was planned and the allocation has risen from £13k to £140k as part of the re-prioritisation work and the current forcast is closer to £250k but not confirmed.

Fire; Expenditure on fire related schemes continues to progress at pace. Costs incurred at the end of September amounted to c£10m (spend in month was c£1.2m). Fire Works package 1 at LCH is £3.0m, package 2 is £1.9m, Emergency Lighting at LCH is £0.5m. Package 1 at Pilgrim amounts to £1.5m. Work continues with the QS to ensure robust mechanisms are in place for capturing financial information and projections. Cash flow forecasts are also being managed.

Medical Devices; Spend year-to-date is £0.5m. The equipment replaced this year has been; Radiology Ultrasound machine £66k, Theatre Tables £177k, Surgical Diathermy £114k, Theatre lights £106k and Field Analyser £38k. Due to the levels of emergency equipment replacement required there has been further reprioritisation of allocations involving Divisions - this has removed the £100k allocation for phaco-emulsifiers and enabled the Field Analyser, YAG Laser and Ultrasound for LCH A&E to be purchased instead.

IT; Spend to date of £0.8m. Key spend areas are as follows - E-Health-record costs of £246k, Windows 7 to 10 £131k, E-prescribing £122k, Cyber Security £104k, PC replacement £98k, Wifi spend linked to HSLI deferred monies amounting to £63k and Digital Dictation £60k. Forecasts of each are currently being progressed as there may be potential in 2 key schemes for slippage or actual reduction in spend anticipated, those being E-prescribing and Robot.

Updated Phased Plan profile

A revised capital programme has been agreed following the national requirement to deliver within an STP control total. Subsequently, following the Prime Minister's increased funding support across the country, NHSI have stated that all providers revert back to the original plans submitted however Lincolnshire have requested a preference to continue as an STP.

External Funding update

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

SUSTAINABLE SERVICES – CAPITAL REPORT continued

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

Year to date	Plan	Actual	Variance
	£'000	£'000	£'000
Capital Balance	**11,240**	**12,226**	(986)

Year End Forecast	Plan	Actual	Variance
	£'000	£'000	£'000
Capital Balance	**32,132**	**32,132**	**0**

Year to date	Plan	Actual	Variance
	£'000	£'000	£'000
Medical Equipment replacement	775	501	274
Estates - Fire	5,900	10,368	(4,468)
ICT	820	836	(16)
Estates - Backlog	708	357	351
Service developments	3,037	165	2,872
Total	**11,240**	**12,226**	(986)

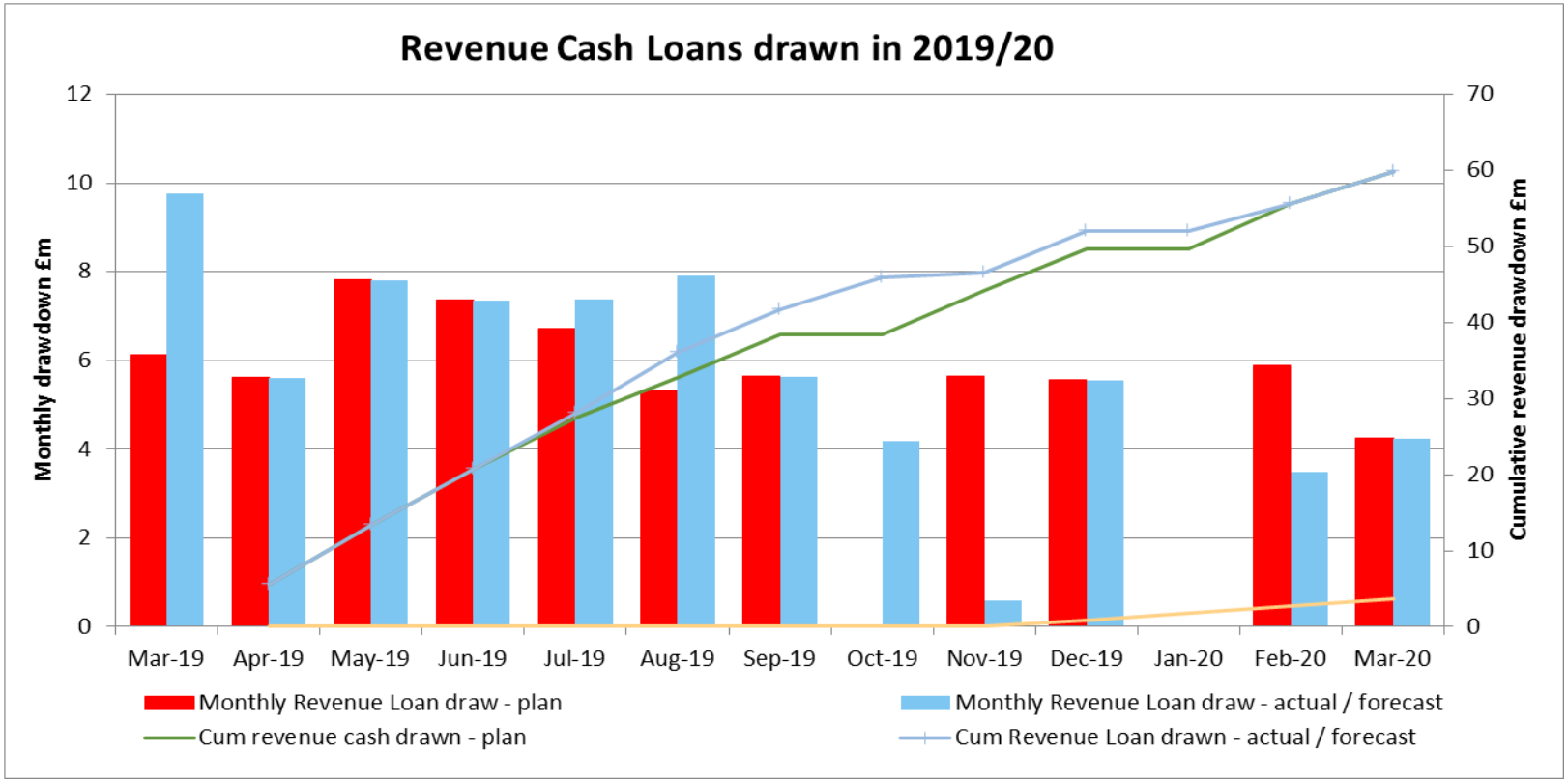
Year End Forecast	Plan	Actual	Variance
	£'000	£'000	£'000
Medical Equipment replacement	1,697	1,697	0
Estates - Fire	13,470	13,470	0
ICT	4,242	4,242	0
Estates - Backlog	2,852	2,852	0
Service developments	9,871	9,871	0
Total	**32,132**	**32,132**	**0**

SUSTAINABLE SERVICES – NEW BORROWING

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services



Borrowing
The Trust has drawn cash loans of £53.4m during the six months to September 2019, this is split £41.7m revenue support and £11.7m capital. This includes £9.6m deficit support relating to 2018/19.

Revenue
The forecast deficit for 2019-20 is £41.4m in line with the financial plan. Revenue borrowings are planned to be £59.8m (Deficit support 19/20: £41.4m, 18/19: £9.6m and PSF / FRF: £8.8m). The impact of I&E pressures upon the Trust ability to pay suppliers has to date been largely been mitigated by capital cash, available due to the high level of capital creditors brought forward from 2018/19. A significant proportion of these are expected to be cleared during October / November which will crystalise the underlying revenue working capital pressures.
The Trust borrowing for November of £7.9m includes deficit support / PSF adjustment in line with plan plus £7.3m exceptional working capital to support this. The latter is not reflected in the graph above and is subject to NHSI approval.

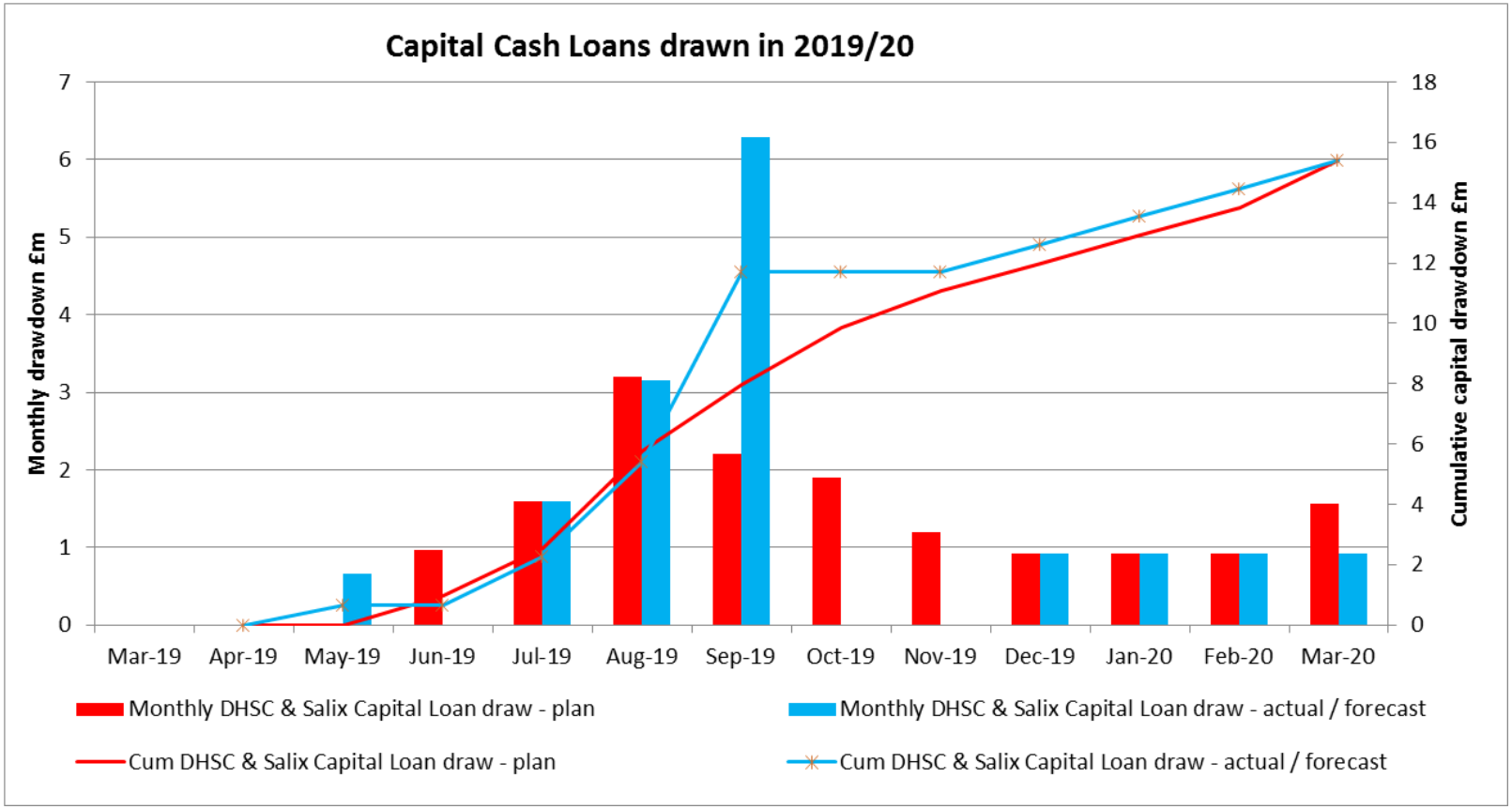
In accordance with Trust Standing Financial Instructions and in line with the draft 2019/20 financial plan, the Board is requested to approve revenue borrowing of £5.553m in December 2019.

SUSTAINABLE SERVICES – NEW BORROWING

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services



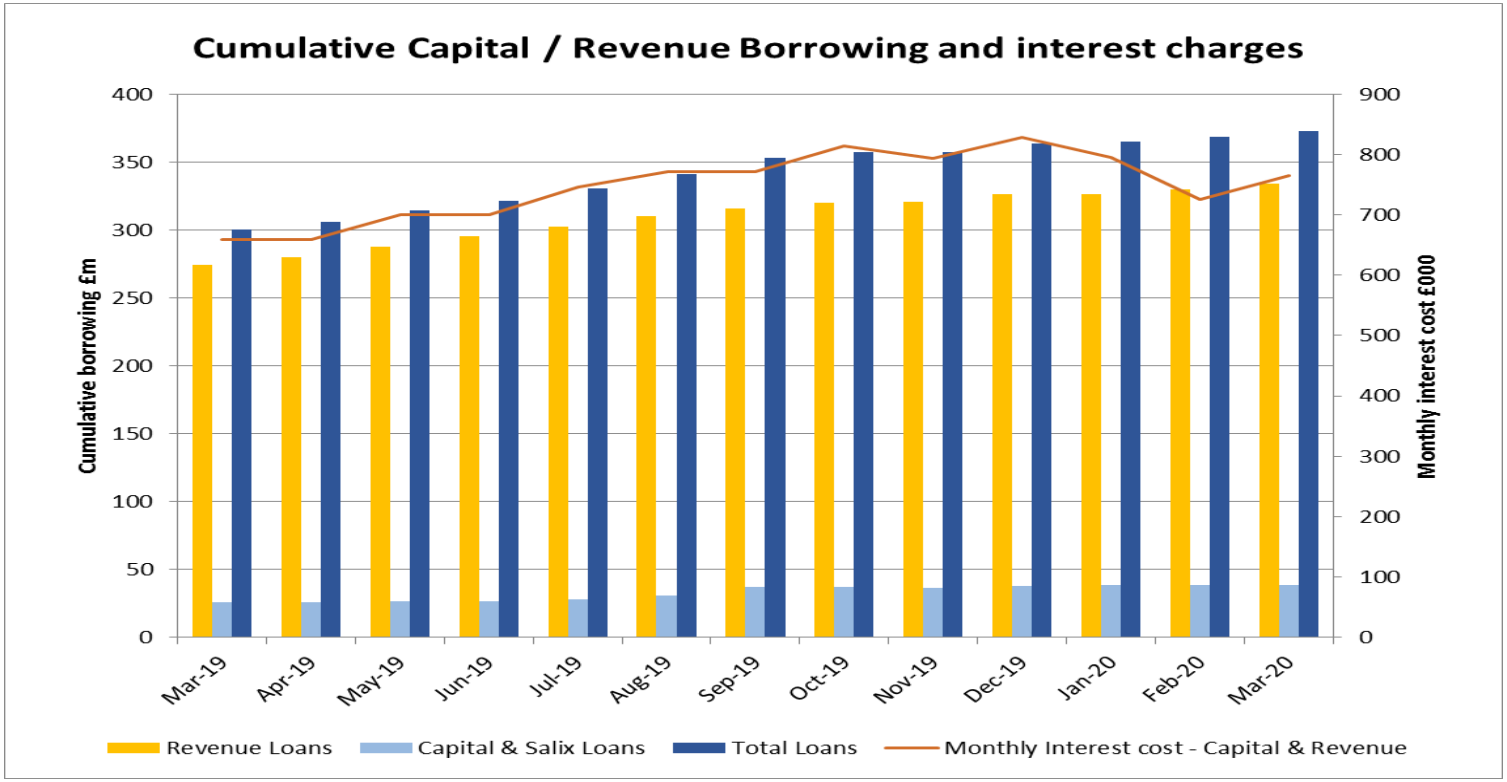
Capital Borrowing
A series of capital loans totalling £28.7m were agreed with DHSC in relation to the Fire Safety Capital scheme. Against this £17m was drawn prior to 2019/20. The balance of £11.7m has subsequently been drawn over the first 6 months of 2019/20.
A further loan of £3.0m funded through the SALIX Energy Efficiency Loan Scheme is expected to be drawn from December 2019.

SUSTAINABLE SERVICES – CUMULATIVE BORROWING

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services



Borrowings and Interest
At 30 September 2019 total 'repayable' borrowings (excluding accrued interest) were £353m, capital (£36.9m) and revenue (£316.1m).
Existing loans are held at a variety of interest rates, Capital 1.1% (£8.9m) & 1.37% (£28.0m), Revenue 1.5% (£155.3m), 3.5% (£117.4m) & 6.0% (£43.4m).

In 2018/19 a revenue loan of £35.6m due to be repaid in November 2018 was extended by DHSC, no revised repayment date or interest rate has been advised. For the purposes of the above analysis the interest charge has been assumed at 3.5%.
A further £74.9m of revenue loans are due to be repaid between November 2019 - March 2020. No details regarding extensions have been received to date.

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

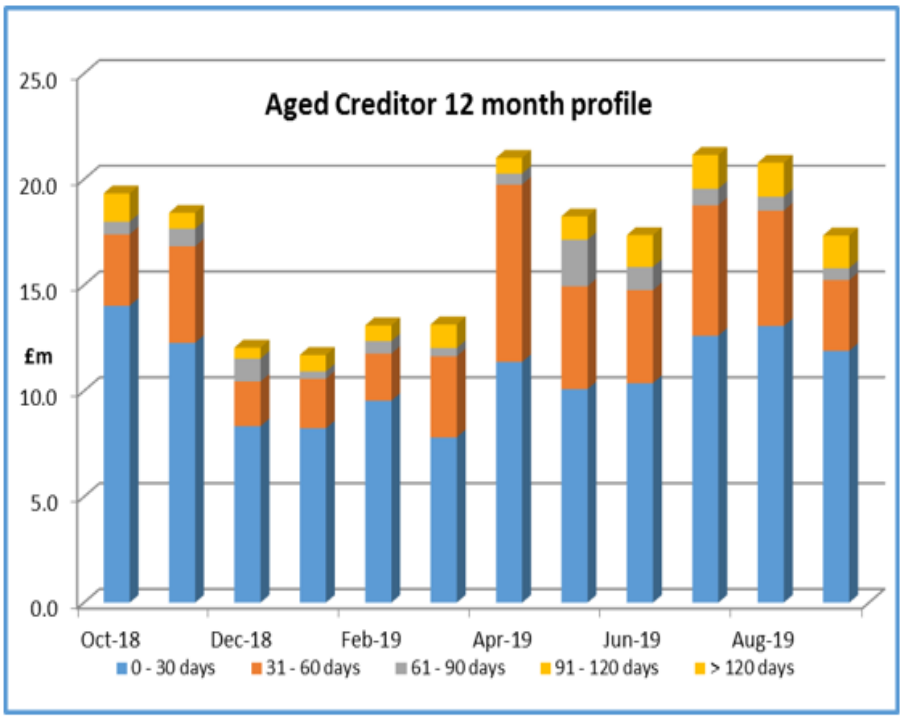
Associated interest costs for 2019/20 are £9.1m (Revenue £8.7m / Capital £0.4m).
Changes in accounting standards from 2018/19 have meant that any accrued interest (September 19 - £2.3m) is now reported as part of overall borrowings on the Statement of Financial Position.

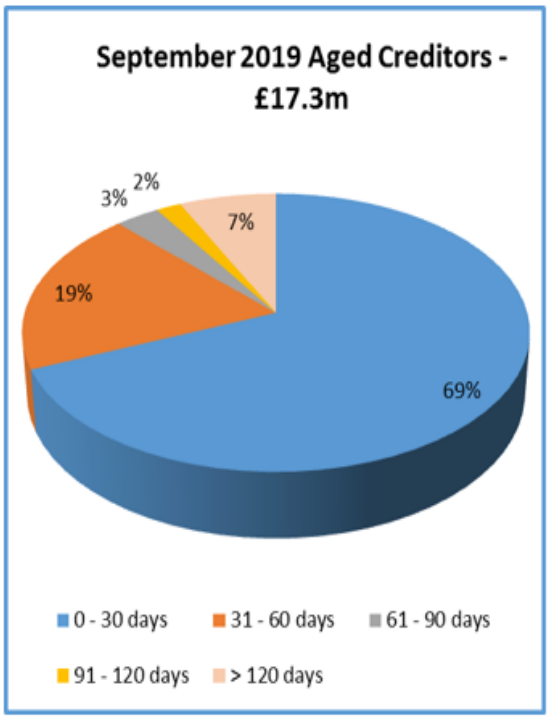
SUSTAINABLE SERVICES – CREDITOR PAYMENTS

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services





Creditors
Total Creditors were £17.3m at 30 September 2019, of which; £5.4m were over 30 days (£1.5m > 90 days).
Focusing further upon those invoices over 30 days; £1.7m had been authorised and was ready to pay at 30 September, a further £2.3m (61%) relates to ten suppliers where there are specific queries and which the payments team are working to resolve with the supplier and purchasing departments. The remaining £1.4m is spread across 340 suppliers and circa 1200 invoices.

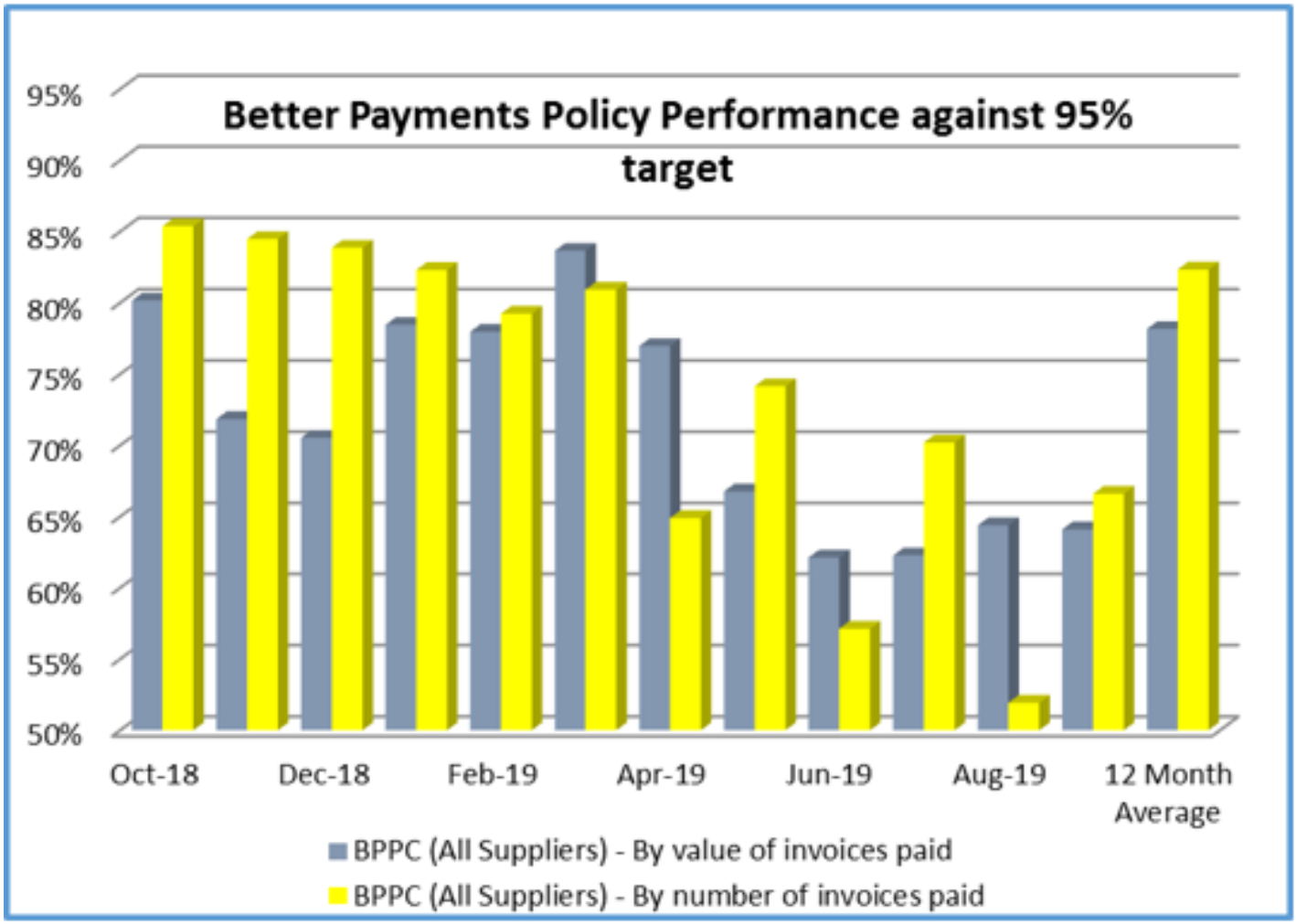
Performance
Performance against BPPC has declined from 2018/19 levels, principally due to the cash position of the Trust. It has been necessary to carefully manage outgoings often at the expense of BPPC to ensure sufficient reserves have been maintained to cover month end payroll costs and other potential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

SUSTAINABLE SERVICES – BETTER PAYMENTS

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services



BPPC

The Better Payment Practice Code (BPPC) requires the Trust to aim to pay all valid invoices by the due date or within 30 days (whichever is the latter).

The 12 month rolling and August 2019 performance are shown in the following table.

	NHS		Non-NHS	
	By volume Number	By Value £000s	By volume Number	By Value £000s
Total bills paid in the year	1308	22,603	63,463	101,801
Total bills paid within target	741	19,106	40,693	62,300
% of bills paid within target YTD	**56.65%**	**84.53%**	**64.12%**	**61.20%**
% of bills paid within September 2019	**48.27%**	**66.36%**	**67.08%**	**63.54%**

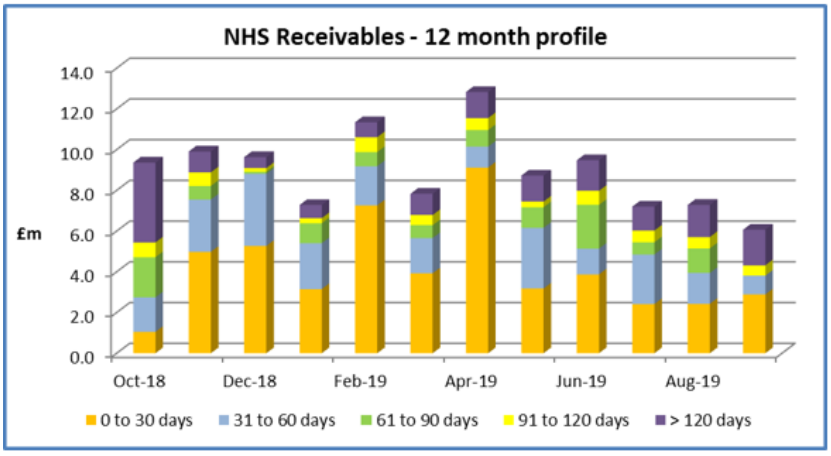
SUSTAINABLE SERVICES – NHS RECEIVABLES

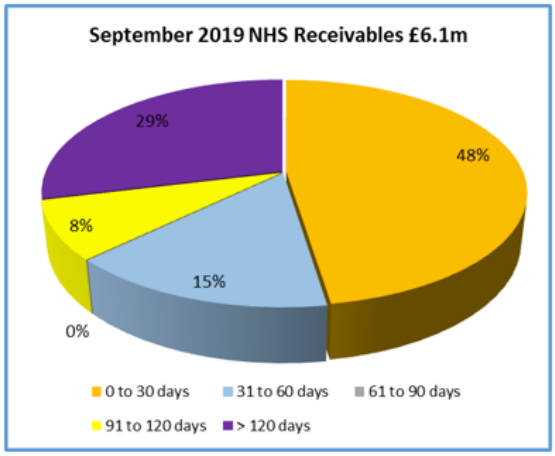
Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

NHS Receivables





	Totals outstanding debt £'000						
	0 - 30 days	31 - 60 days	61 - 90 days	91 - 120 days	120 + days	Grand Total	90+ days
CCGs - Lincolnshire	1,314	220	171	131	306	**2,142**	437
CCGs - Other	595	178	(58)	75	250	**1,040**	325
Trusts - Lincolnshire	505	30	16	15	103	**669**	118
Trusts - Other	407	273	271	378	672	**2,001**	1,050
Other NHS	64	223	(800)	308	421	**216**	729
Total	**2,885**	**924**	**-400**	**907**	**1,752**	**6,068**	**2,659**

The tables above show the level of Non-NHS debt over the last 12 months alongside the aged split at 30 September 2019.
Overall levels of debt are at the lowest point for over 12 months. Much of this can be attributed to the 'without prejuduce' agreement between ULHT and the four Lincolnshire CCGs, LPFT and LCHS to make invoice payments 'on account' to assist ULH cash liquidity.

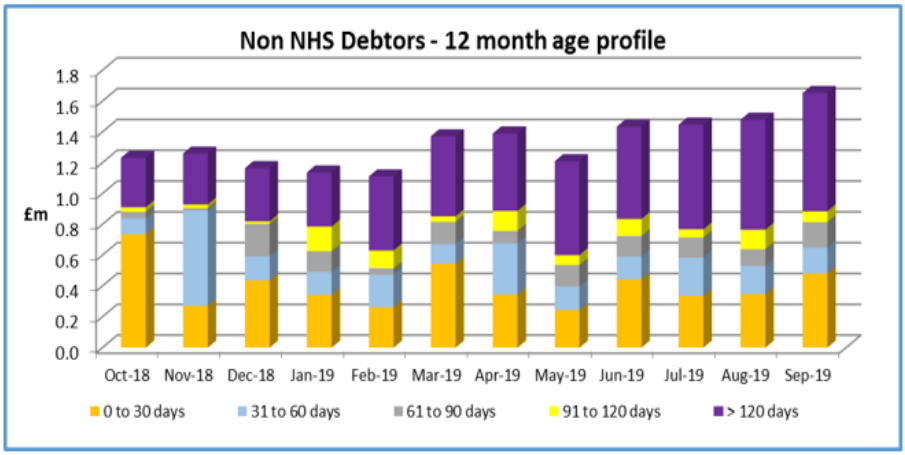
The principal area of concern at present is the level of debt outstanding with Nottingham University Hospitals (£1.5m) and Leicester Hospitals (£0.3m), the majority of which is over 30 days. At the time of writing, £0.7m of this had been cleared, with the balance escalated.

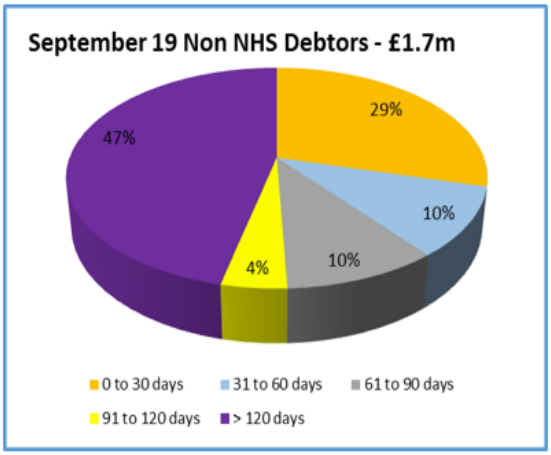
SUSTAINABLE SERVICES – NON NHS RECEIVABLES

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services





	Totals outstanding debt £'000						
Description	0 - 30 days	31 - 60 days	61 - 90 days	91 - 120 days	120 + days	Grand Total	90+ days
Overseas Visitors	17	16	39	0	150	222	150
Debt Collection - Overseas	0	0	0	0	129	129	129
NHS Non English	45	30	10	0	8	93	9
Misc	410	86	113	57	384	1,049	440
Salary Overpayments	0	16	5	12	37	69	48
Private Patients	0	0	0	0	0	-	0
Debt Collection - General	0	0	0	0	24	24	24
Agreed Installment Plans	11	19	0	1	35	65	36
Grand Total	482	167	166	70	767	1,652	837

The tables above show the level of Non-NHS debt over the last 12 months alongside the aged split at 30 September 2019.

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

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

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

SUSTAINABLE SERVICES – EXTERNAL FINANCIAL LIMIT & CAPITAL RESOURCE LIMITS

Executive Lead: Paul Matthew

CQC Domain: Well-Led

2021 Objective: Our Services

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

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

Trusts are not permitted to exceed the CRL.

Position as at 30 September 2019

External Financing Limit Target (EFL)	Forecast £000s
Anticipated EFL at Plan	**79,693**
Opening EFL allocated to Trust	
April 19 Plan movement in cash balances	**1,929**
Capital element of Finance leases - repayments	**0**
Initial EFL	**1,929**
Confirmed / actioned adjustments	
2018/19 additional deficit financing	9,552
Interim revenue support loan: deficit financing	28,797
PSF temporary loan financing	3,369
Fire safety - Loan	11,700
Fire safety loan repayments	(993)
PDC received: E- Health Records	977
Current Notified EFL	**55,331**
Anticipated adjustments	
Interim revenue support loan: deficit financing	12,601
PSF temporary loan financing	5,476
Fire safety loan repayments	(1,350)
Salix Loan Financing	3,700
Salix Loan repayment	(231)
PDC received: Medical School	1,500
PDC received: LED Lighting	2,800
PDC received: E- Health Records	0
PDC received: STP support LCHS / LPT	974
Anticipated EFL	**80,801**

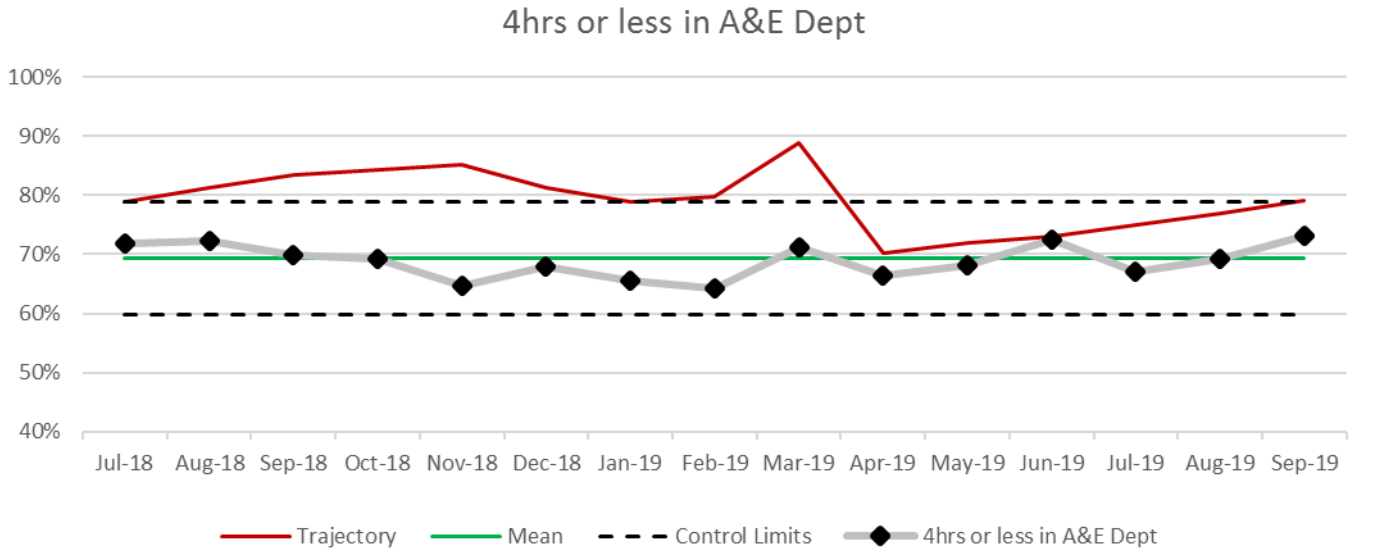
Performance against Capital Resource Limit (CRL) Target	Forecast £000s
Anticipated CRL at Plan	**31,155**
Opening CRL allocated to Trust	
Depreciation	**13,200**
Fire safety loan repayments	**(2,490)**
Salix Loan repayment	**(231)**
Initial CRL	**10,479**
Confirmed / actioned adjustments	
Fire safety - Loan	11,700
Fire safety loan repayments	
PDC received: E- Health Records	977
Current Notified CRL	**23,156**
Anticipated adjustments	
Fire safety loan repayments	
Salix Loan Financing	3,700
Salix Loan repayment	0
PDC received: Medical School	1,500
PDC received: LED Lighting	2,800
PDC received: E- Health Records	0
PDC received: STP support LCHS / LPT	974
Current Anticipated CRL	**32,130**
Forecast Capital expenditure	**32,402**
Less Capital funded via Charitable Donations	**(120)**
Less Net book value of disposed assets	**(152)**
Charge against CRL	**32,130**
(Over) / Under shoot against CRL target	**0**

ZERO WAITING – A&E 4 HOUR WAIT

Executive Lead: Mark Brassington

CQC Domain: Responsive

2021 Objective: Our Services



Challenges/Successes

- A&E overall outturn for August, Type 1 and primary care streaming delivered 73.07% against a trajectory of 79%, a variance of -5.93% and was a 3.83% performance improvement on August performance of 69.24%.
- The system has set a target of 20% of all ED attendances at LCH and PHB to be primary care streamed. For September, PBH delivered 20.2% a -0.9% performance deterioration compared with August. LCH delivered 19.3%, a -0.3% performance deterioration compared with August.
- A&E attendances in September were 15,039, compared to 13,574 in September 2018 - Type 1 & 3 numbers and represent an 9.75% increase. Non-elective demand has experienced a marginal decrease of 9 (3315 September vs 3324 August).
- Nursing and Medical staffing levels for inpatient wards and the emergency department continue to be an area of concern. The fragility of medical staffing will improve towards the end of Q3 2019/20 beginning of Q4 2019/20 as we start to see newly appointed doctors come into post. Recruitment plans against start dates are monitored weekly.
- The weekly long stay meetings at LCH and PHB continue to deliver within trajectory with performance in September for LCH at 71.5 against a trajectory of 102, PHB performance at 23.5 against a trajectory of 48 and GDH performance at 5.5 against a trajectory of 11.
- Total ULHT bed occupancy for September was 88.70% compared with 89.99% in September. LCH and PHB continue to experience the greatest operational occupancy and flow pressures.

Actions in place to recover:

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

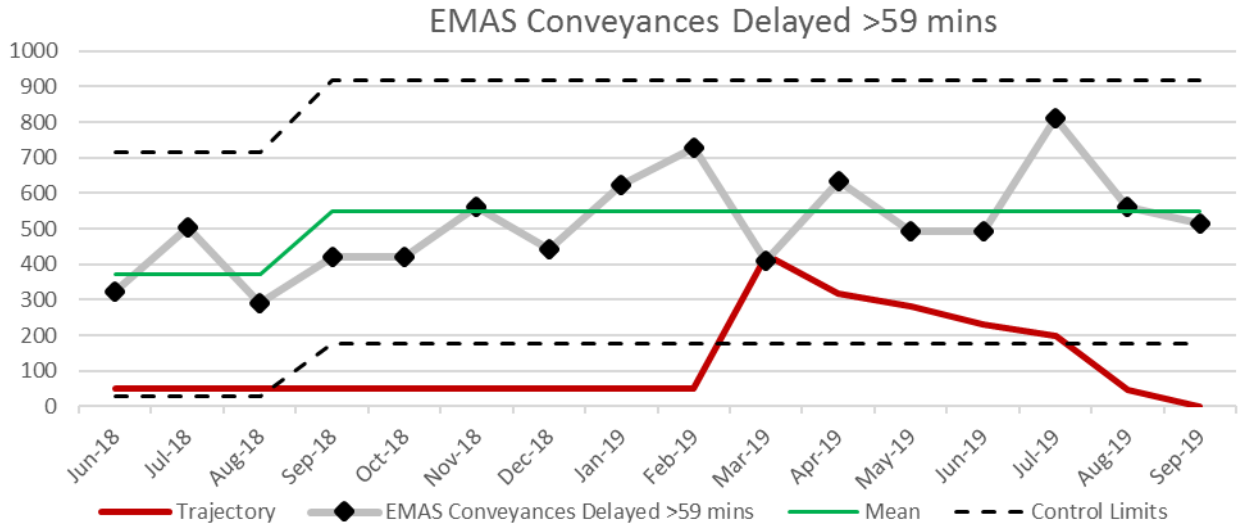
- Reduction of ambulance conveyances through alternative pathways targeting out of area first and increased use of the Clinical Assessment Service;
- Increasing the numbers of patients seen through primary care streaming; protecting the minors stream and focussing on delivering 4 hours through this stream;
- Long stay Tuesday and Wednesday at LCH and PHB to further reduce stranded patient numbers;
- Criteria led discharge;
- Increasing the numbers of patients who are seen and treated through a Same Day Emergency Care (SDEC) pathway;
- Red to Green has been rolled out across the organisation and delays are being actively managed. Board Rounds are also under scrutiny with increased focus around the SAFER patient bundle. #ReadySteadyFlow

ZERO WAITING – AMBULANCE HANDOVER

Executive Lead: Mark Brassington

CQC Domain: Responsive

2021 Objective: Our Services



Challenges/Successes

- Handover delays >59 mins experienced a further improvement in September but still missed the agreed trajectory. 513 exceeding 59 mins compared with 563 in August. PHB have seen an improvement in handover delays >59 mins. All 3 acute sites experiences a reduction in conveyance in September, however, overall conveyance remains above plan (478 for September) The trajectory for September was 0, which exceeded the trajectory by 513.

- Same Day Emergency Care (SDEC) pathways have been implemented in AEC and SAU at LCH. Gains are being realised in terms of ambulance handover times but not consistently.

Actions in place to recover

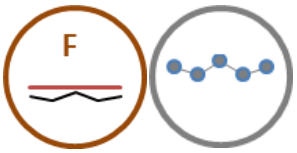
- New pathways at PHB rolled out to enable GP direct admissions bypassing ED.
- Rapid Access and Treatment (RAT) models are being reviewed at both LCH and PHB hospital sites in particular the staffing models for RAT, competency and processing of patients. An example of this would be at PHB where an additional HCA has added to the team in July. Throughout august and September indications is that this is having a positive impact on turnaround times.
- This is a key performance indicator within the newly formatted Capacity and Flow Meetings. The route cause for any delay is discussed and mitigation actions are formulated in response.
- Site Duty Managers (SDMs) track and monitor every conveyance to ED greater than 15 minutes and record actions taken and report to the Deputy Director of Operations, Urgent Care
- Daily calls remain in place to review trends and activity spikes to inform the Emergency Department and maximise readiness to receive.

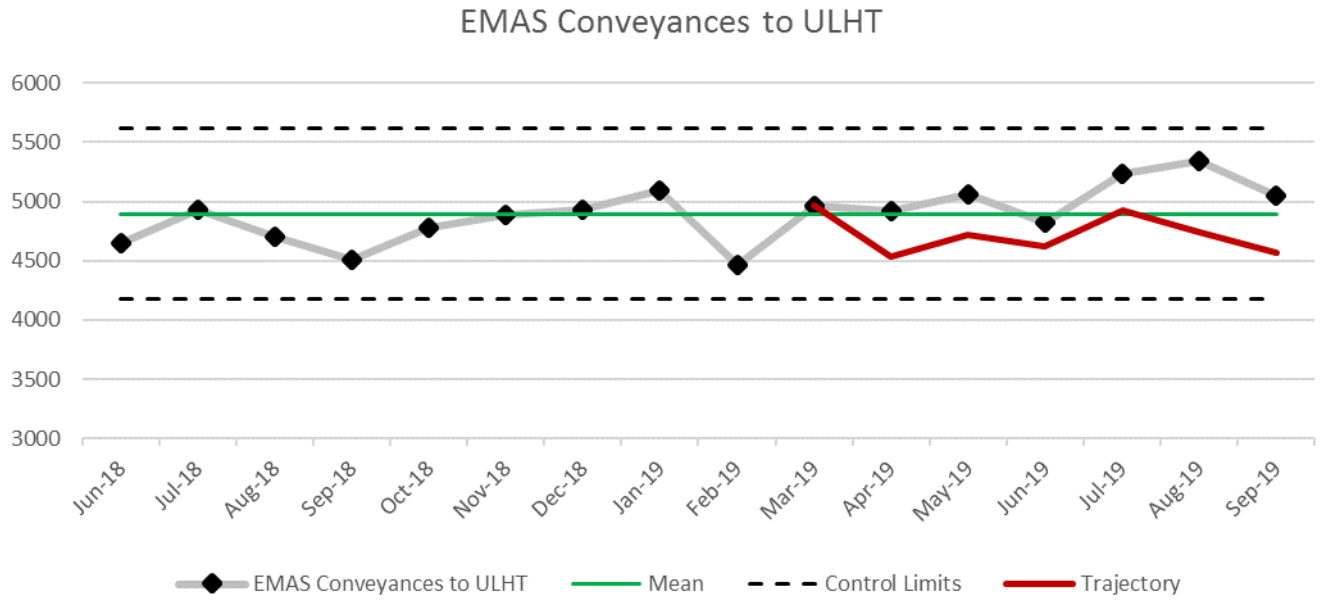
ZERO WAITING – AMBULANCE CONVEYANCES

Executive Lead: Mark Brassington

CQC Domain: Responsive

2021 Objective: Our Services





Challenges/Successes

- There was an overall decrease in ambulance conveyance through September (5049) with 298 fewer ambulances than in August (5347). However, this was still 478 conveyances above plan for September.
- At hospital site level, LCH received 50 less than August; PBH received 222 less ambulances than August and GDH received 26 less ambulances than August.
- Alternative pathways to avoid conveyance have still not been fully realised to deliver the percentage reduction anticipated.
- 38 pathways remain under review for conveyance with no demonstrable output as yet.

Actions in place to recover

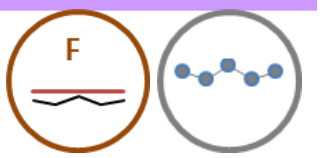
- This is a key metric within the Capacity and performance meetings held x 3 daily and has individual accountability to ensure delivery. This is overseen by the Deputy Director of Operations, Urgent Care.
- Work remains ongoing with System Partners in applying a more intelligent demand response tool to support compliance with agreed handover recovery trajectory. This is a standard agenda item on the System Wide/Regulator Call conducted daily and the monthly Ambulance handover delay meeting chaired by NHSi
- ULHT Representative and EMAS ROM / DOM control continue to apply a daily review of pressure on the departments, County profile against demand, destination of demand and attempts manage that demand. Daily intelligence is now shared routinely as to the forecast spikes in demand and this is being applied to the Emergency Department response capability.
- Conveyance numbers continue to be monitored through the Ambulance Handover Group which is chaired by NHSi
- Appropriate conveyance monitoring is in place within EMAS with oversight by Deputy Director of Operations – Urgent Care and Daily System Call. 38 alternative conveyance pathways are being reviewed.

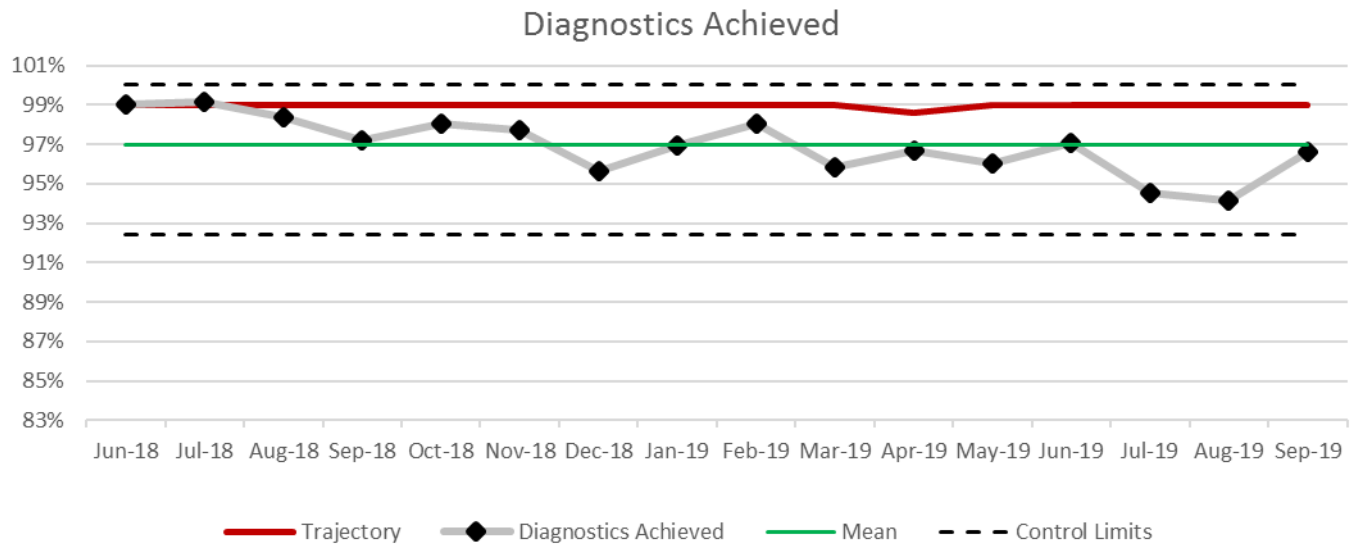
ZERO WAITING - DIAGNOSTICS

Executive Lead: Mark Brassington

CQC Domain: Responsive

2021 Objective: Our Services





Challenges/Successes

Performance has shown improvement for September at 96.59%.

Trajectory is not being met and a recovery trajectory has been developed to return to the national standard.

	September	October	November	December	January	February
Forecast Percentage	96%	97%	97.70%	98%	98.40%	99%
Actual Percentage						
Forecast Breaches	276	183	151	128	114	65
Actual breaches						

The trajectory has been based on August's return although the predicted numbers are calculated going forward the waiting list will alter each month so the percentage may vary slightly depending on the current waiting list.

Main causes Septemmbers performance include:

Cardiology lack of capacity due to illness, Urodynamics lack of staff due to sickness and sudden retirement. Neuropysiology illness in the outsourcing team caused clinics to be cancelled.

Actions in place to recover

Cardiology

- Physiology vacancy recruitment continues. Following posts identified and recruited to:
- 1wte Band 7 – successful candidate accepted and checks being worked on
- 1wte Band 4 – successful candidate appointed and checks being worked

- 1.8wte Band 2 – currently at shortlisting stage
- Echo referral grading policy for inpatients awaiting CEC approval. Once approved, will reduce inpatient work and inpatient echoes converting to outpatients on discharge, potentially reducing referral demand.
- Long term sickness at Pilgrim site reducing, operator returning to work on a phased return basis with view to full return from October.
- Discussions ongoing with Paediatrics re. recharges and potential joint use of lists / kit to reduce net overall wait for echocardiography

Cardiac are forecasting 37 October month end breaches but additional capacity is being looked at and should reduce to 20 TOES by October month end.

Urodynamics

- one clinic a week is being carried out by the staff member who undertakes the Neurophysiological procedures a maximum of 6 patients a week, this has caused a drop in capacity in neurophysiology
- Additional clinics will run on the 7th,21st,28th November seeing 12 additional patients and a further 2 more additional in December reducing the backlog by 20 patients these clinics are being provided by urology
- Radiology are observing a clinic to see what needs to be undertaken before they start their training. It is estimated that this training should be complete in 5 months' time.
- All patients are being validated so see if any other test could be performed or do they still require investigation.
- Recovery to 1% will be within 5 months February backlog should reduce each month from November.

Urodynamics have forecast 92 breaches for October.

Neurophysiology

- Band 7 post has been recruited to but was an internal candidate
- Band 6 post going out to advert to fill the now vacant band 6 post.
- Outsourcing company back to full establishment so backlog can be dealt with going forward
- When Urodynamics has recovered and vacant post in neurophysiology is filled position will be recovered.
- 5 months to full recovery, February backlog should be dealt with but outsourcing from November

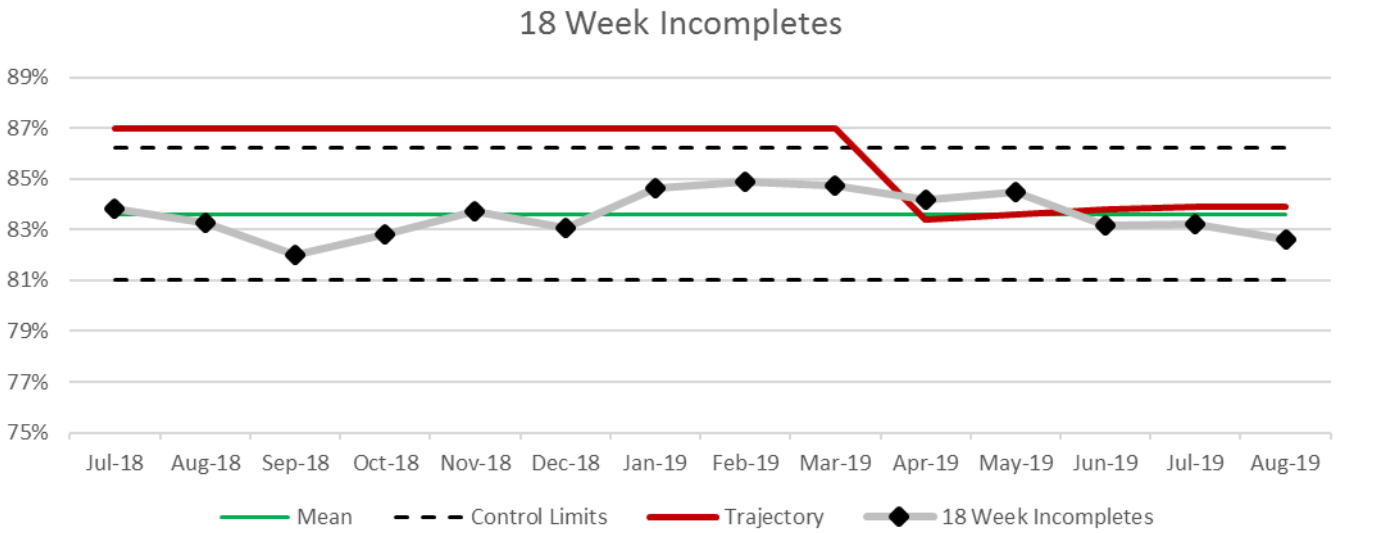
Neurophysiology have Forecast 30 month end breaches for October a drop in performance was due to outsourcing capacity suffering illness so clinics were cancelled in October

ZERO WAITING - RTT 18 WEEKS INCOMPLETES

Executive Lead: Mark Brassington

CQC Domain: Responsive

2021 Objective: Our Services



Challenges/Successes

RTT performance is currently below trajectory and standard.

August saw RTT performance of 82.64%, a decrease of 0.57% on July.

Specialities with the lowest performance against the RTT standard continue to be; Neurology (42.84%), General Medicine (66.11%) and Maxillo-Facial Surgery (71.31%) Each have recovery plans in place all but Maxillo-Facial Surgery are demonstrating small but positive improvements.

Community Paediatrics has shown the worst decline in performance at 8.41% lower than July and Paediatric Cardiology has improved by 6.81%.

Although Neurology performance remains weak, significant improvements have been made and for the first time since the service reopened over 18 week waiting list size is reducing. This has resulted in total incompletes reducing by 13% between July and August. 193 patients in real terms.

Actions in place to recover:

Additional capacity and focus in ENT has kept performance stable into August.

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

A cohort of Maxillo-Facial patients are being identified to commence outsourcing to an external provider.

Validation software has been procured to ensure standardisation of process across Trust. Although full rollout will not be completed until March 2020.

Alignment with system elective improvement plans. These are converting into actions to support trajectories in some specialties.

The targeted specialty specific recovery plan in Neurology is a significant shared priority with CCGs which has included an external provider taking via IPT, a cohort of patients between 25 – 40 weeks waiting. This piece of work is now finished, with approx. 74 patients being returned to ULHT to be appointed. The GP with Special

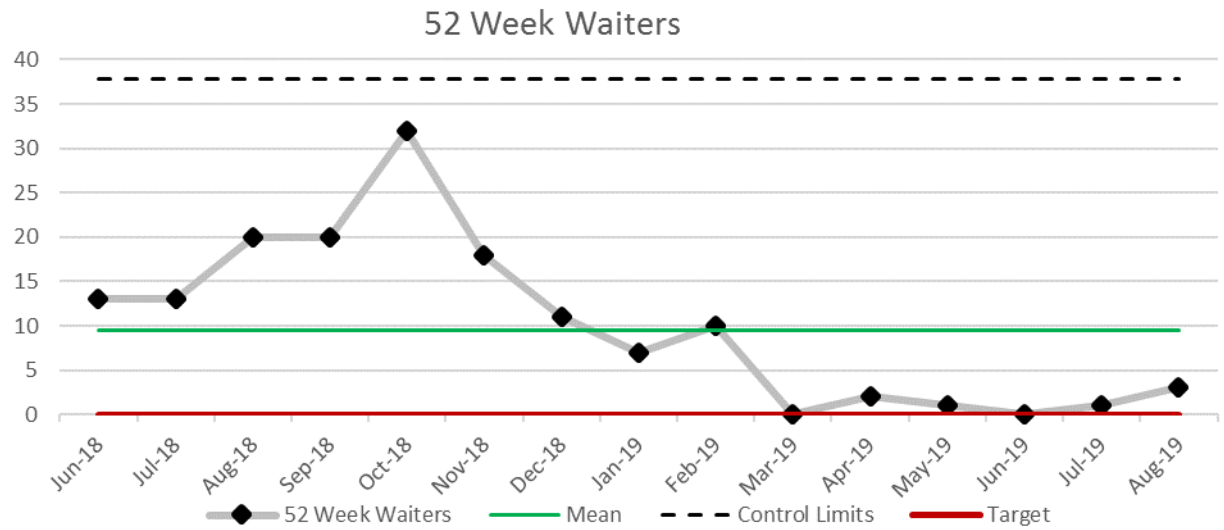
Interest (GPwSI) clinics are now set up and running. Revised pathways out of hospital and suspension of referral access are being reviewed.

ZERO WAITING - RTT 52 WEEK WAITERS

Executive Lead: Mark Brassington

CQC Domain: Responsive

2021 Objective: Our Services



Challenges/Successes

August 52 week performance – 3 patients were waiting longer than 52 weeks at the end of August. This is a detrimental position from July when 1 was confirmed.

- The end of August position was reported as 3 incomplete 52 week waiters.

In order to prevent deterioration in 52 week wait patient numbers, all patients are escalated at 45 weeks and above. This performance metric is being used as lead indicator for reducing 52 week wait risk

Validation and administrative error remains a key risk to the delivery of 52 week standard and was the root cause of the 3 August 52 week breaches.

Although training controls are now in place for new staff and rollout out to existing users is ongoing, there is a ongoing risk of data quality from the last 52+ weeks which cannot be 100% mitigated until 2020.

July to August showed an increase of 25 patients waiting over 40 weeks, with Gynaecology and Urology showing the largest increase.

The Trust are also planning to reduce overall waiting times to 26 weeks. With monitoring/challenge of this target being tracked through the RTT Recovery and Delivery meeting. From July to August there was an increase of 105 patients with Gastroenterology having the largest increase of 104 and General Surgery 65 patients. The biggest reduction (122) was seen in Neurology

Actions in place to recover:

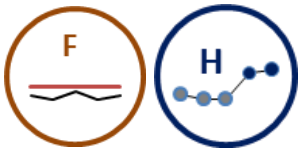
- Continued operation of weekly oversight via RTT PTL meeting and senior review of over 45 week patients.
- OMF has backlogs in dental extractions and skin. A mid-grade doctor left the Trust in July, however the division now have an agency doctor whilst advertising for a substantive replacement.
- Validation tracking software has been procured and will be rolled out, first wave of the roll out is expected to be complete during October.
- An in house RTT training programme has also been developed with competency and compliance monitoring to ensure that administrative errors reduce. This commenced 29 July and is anticipated to complete by 31 October 2019.

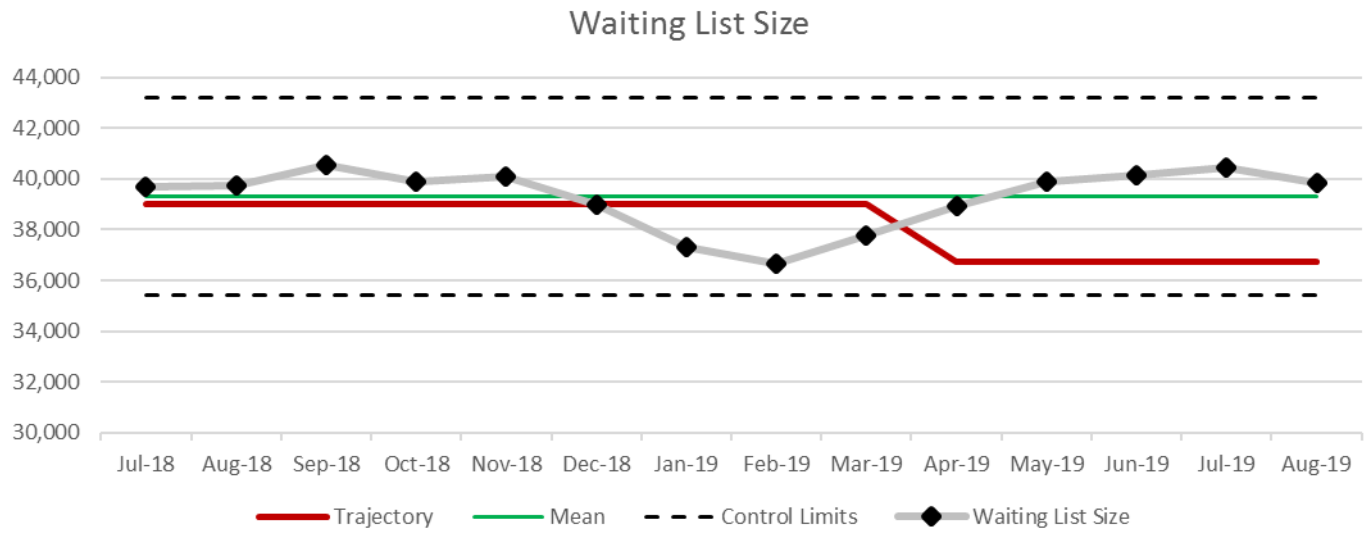
ZERO WAITING – WAITING LIST SIZE

Executive Lead: Mark Brassington

CQC Domain: Responsive

2021 Objective: Our Services





Challenges/Successes

Overall waiting list size has improved, with August total waiting list decreasing by 604 to 39,853.

The incompletes position for August 19 is now approx. 703 less than it was in 2018. After 6 consecutive months of negative effect (more new pathways than removed), August is the first month (more pathways removed than created), to show improvement, despite having 632 fewer clock stops than average.

The top three specialties showing an increase in total incomplete waiting list size from July are:

- Gastroenterology - 115
- Dermatology - 85
- Breast Surgery - 80

Actions in place to recover

Continued analysis of incomplete waiting list to determine reason for growth. In depth analysis of cause and contributory factors such as clock starts, stops and data entry; each service now has a tailored recover plan that reflects one of three main causes:

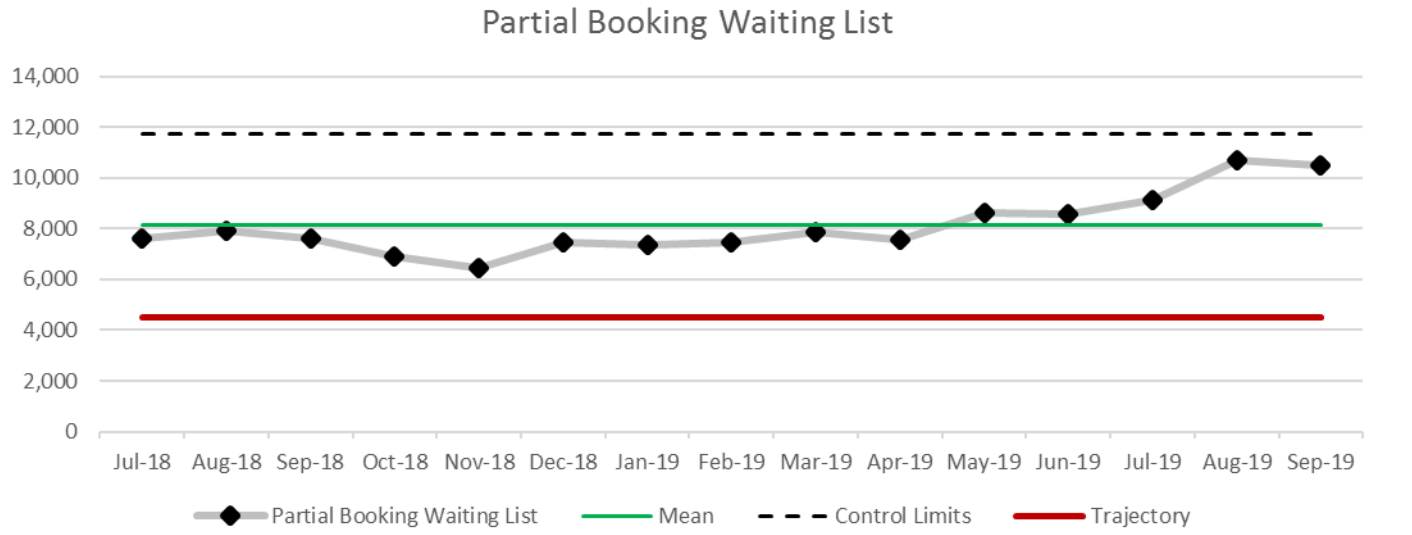
- Growth in referrals – with strategies to reduce this either internally through reduction in consultant to consultant, or externally working with CCG and the planned care improvement programme
- Mismatch of demand and capacity, or short term reduction in capacity through lack of workforce – with appropriate alternatives to attempting locums or existing models of staffing services which may have failed previous. For example the use of virtual clinics, nurse led clinics or non face to face and telephone clinics in key areas.
- Lack of appropriate validation and completion of administrative activities to remove from waiting list – with a targeted release of vacancy hold where staffing is insufficient to complete all tasks, alongside targeted improvement in processes and the flexible use of teams across sites.

ZERO WAITING – PARTIAL BOOKING WAITING LIST

Executive Lead: Mark Brassington

CQC Domain: Responsive

2021 Objective: Our Services



Challenges/Successes

Backlog recovery plans are being revisited as original plans have not had the desired effect.

Slight reduction in PBWL numbers from previous month, however still higher than pre August and significantly higher than trajectory.

More emphasis has been placed on validating patients on the PBWL, especially those patients that are significantly overdue.

Overall Outpatient Capacity and attendances has reduced YTD.

Other challenges for the PBWL backlog recovery plans are

- the availability of locums,
- the extra costs incurred to provide extra capacity,
- providing nursing and space for the extra capacity requested in the right areas,
- balancing priorities due to focus on 2WW patients in Trust
- Reduction in attendances overall up to M6

Actions in place to recover:

All Divisions have been requested to update their backlog recovery plans and submit a revised plan with a trajectory that will be adhered to.

Agreed to be monitored going forward by the Chief Operating Officer as part of delivering productive services group to ensure delivery of plans

The Outpatient 642 process to be re-introduced to challenge all short notice cancellations and support adhoc sessions required.

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

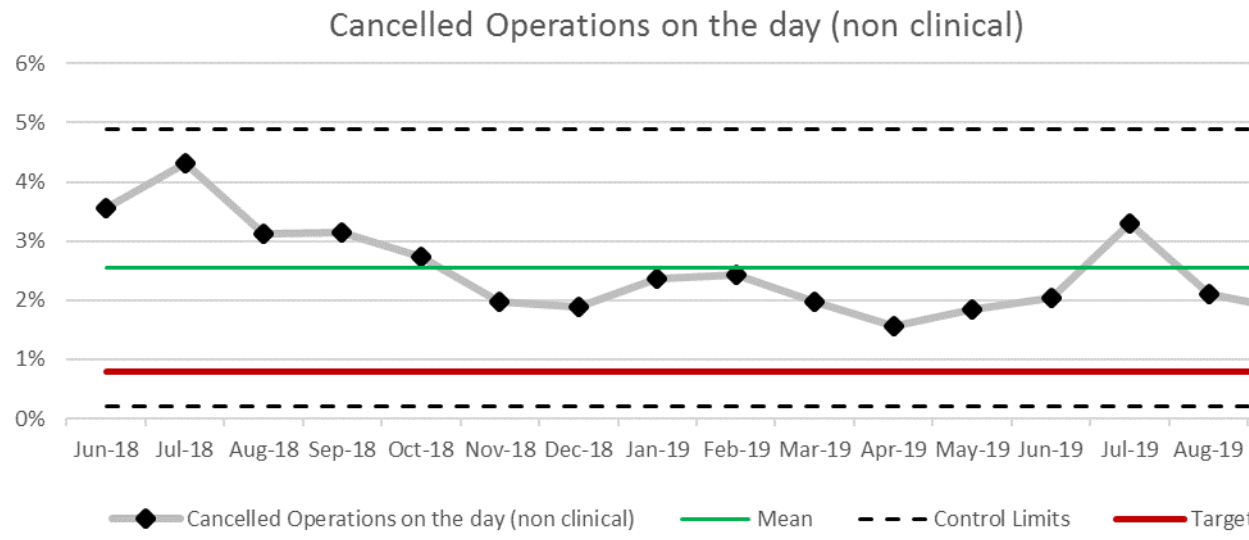
The Divisions will be accountable to the action plans, the main themes are Validation, Alternative patient pathways, Outsourcing and Locums

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

Executive Lead: Mark Brassington

CQC Domain: Responsive

2021 Objective: Our Services



Challenges/Successes

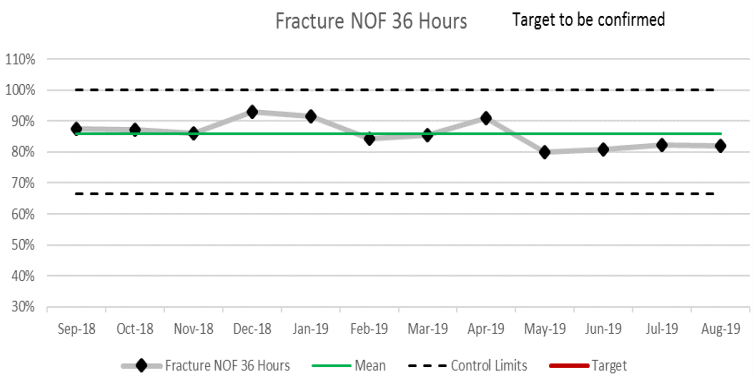
Actions in place to recover:

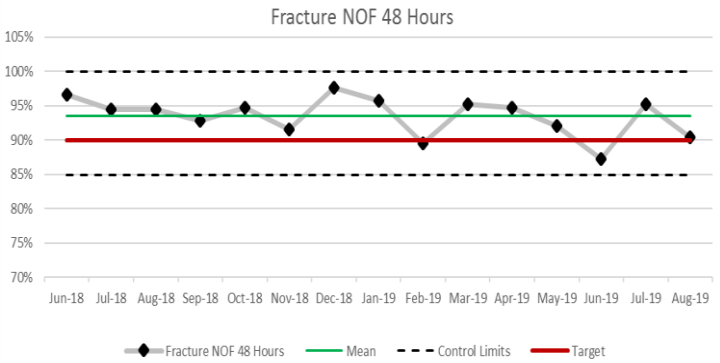
ZERO WAITING – FRACTURE NECK OF FEMUR BPT

Executive Lead: Mark Brassington

CQC Domain: Responsive

2021 Objective: Our Services





Challenges/Successes

Performance for time to theatre within 48 hours is starting to improve and was achieved in Aug 19
Performance for time to theatre within 36 hours continues to fluctuate.
Performance has been challenged by lack of consistency in process so when the #NOF lead is on leave at PHB, there is a lack of focus on #NOF performance. There is no #NOF lead at LCH.
Issues in Aug for time to theatre within 36 hours relates to issues with patients being optimised/fit for surgery. Patients have breached both targets due to fitness for surgery which has caused a delay in them being added to the trauma list
X-ray availability issues i.e. only one C Arm available between both Orthopaedic elective and Trauma theatre, this causes delays on the list which means patients are often cancelled/delayed due to lack of theatre time
There seems to be a discrepancy in the recording of #NOF and what is reported i.e. patients treated conservatively for #NOF should not be excluded from the time to theatre reported performance
Inefficiencies in trauma theatres leads to delays in treatment and patients being cancelled from the end of the lists

Actions in Place to Recover

LCH –

- #NOF lead to be recruited update 9/9/19 job plan with the royal college for approval
  Update 16/10/19 job plan approved by royal college, awaiting advertisement
- #NOF theatres to be allocated in place of specialty trauma lists update 9/9/19 theatres to be adapted from OCT 19 (this will not impact elective capacity)
  Update 16/10/19 specialist lists have been allocated

PHB –

- Current #NOF lead to become Trustwide #NOF lead so best practice at PHB is shared across the sites update 9/9/19 lead to commence Trustwide responsibilities once LCH #NOF lead is recruited
  Update 16/10/19 job plan approved by royal college and on TRAC, awaiting advertisement
- Sustainable processes to be put in place as current performance improvement relies on #NOF lead (people rather than process) update 9/9/19 #NOF lead, Clinical Lead and Deputy GM to meet 17/9/19 to discuss and come up with an improvement plan
  Update 16/10/19 action plan formulated and approved, now to be put in place

Trustwide -

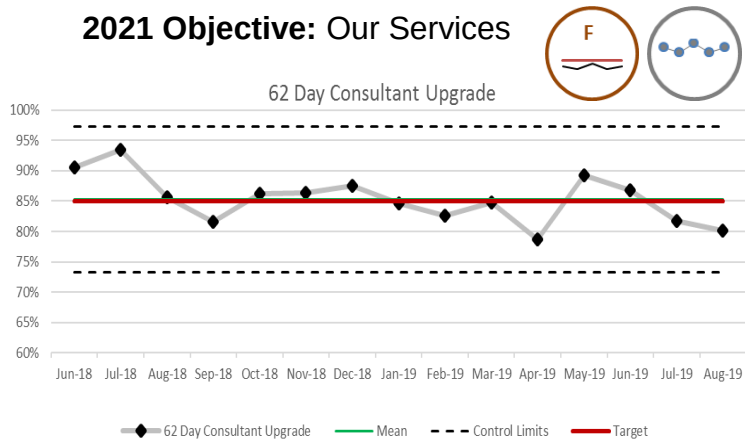
- Trauma coordinator vacancies at both LCH and PHB have now been recruited into so this will improve co-ordination of patients on the trauma lists – Update 16/10/19 completed
- Audit to be carried out on June and July #NOF patients to understand breach themes and create an action plan to reduce breaches update 9/9/19 #NOF lead at PHB to undertake audit w/c 9/9/19 Update 16/10/19 action plan formulated based on audit and approved, now to be put in place
- Discussion to be held with the GIRFT team to understand the target for time to theatre within 36 hours. This is cannot be 100% and cannot be due to the nature of the patients, some will not be fit for surgery and others will not require surgery update 9/9/19 Deputy General Manager to contact GIRFT national team for advice
  Update 16/10/19 still awaiting advice. Deputy GM chased 16/10/19
- Review of NHFD data and reporting of performance update 9/9/19 Orthopaedics Clinical Lead, #NOF lead, Deputy General Manager and Head Of Information to review
  Update 16/10/19 review to be undertaken Nov 19
- Orthopaedic Consultants and Anaesthetic Consultants to discuss how to optimise patients and ensure early investigations so to reduce the wait time in being ready for surgery update 9/9/19 Orthopaedics Clinical Lead and Anaesthetic Clinical Lead to meet in Sept 19 to discuss
  Update 16/10/19 Leads have met and are discussing plans moving forward to tie in with the GIRFT peri-operative plans and meetings
- Anaesthetic trauma lead to take responsibility for ensuring anaesthetists are supported to reduce cancellation of patients and protocols are put in place update 9/9/19 Orthopaedics Clinical Lead and Anaesthetic Clinical Lead to meet in Sept 19 to discuss
  Update 16/10/19 Leads have met and are discussing plans moving forward to tie in with the GIRFT peri-operative plans and meetings
- Review the possibility of anaesthetists specialising in trauma with the aim of reducing anaesthetic time, therefore, increasing the efficiency of the trauma theatre lists update 9/9/19 Orthopaedics Clinical Lead and Anaesthetic Clinical Lead to meet in Sept 19 to discuss
  Update 16/10/19 Discussions are ongoing with specialty leads and Surgery Clinical Director to identify if this is a possibility
- Orthopaedic ACP's to be trained in how to optimise #NOF patients for surgery, currently undertaken by F2's which is not a permanent workforce update 9/9/19 #NOF lead, Clinical Lead, Lead Nurse and Deputy GM to meet 17/9/19 to discuss and plan how this role will work for the ACP's
  Update 16/10/19 still under review and to be worked up once #NOF leads commence in post
- Optimise 'golden patient' night before to ensure theatre starts on time the next day update 9/9/19 this has been started and is ongoing
  Update 16/10/19 ongoing
- There is currently no review of trauma/emergency theatre efficiency. Efficiency of trauma theatre to be reviewed and performance target to be set update 9/9/19 efficiency to be reviewed by TACC Business Manager September 2019
  Update 16/10/19 Ongoing as part of theatre efficiency project
- Review of Consultant on-call rota with the aim of a team of 2 Consultants undertaking the on-call and trauma commitments for a full week. This will decrease the possibility of patients not being fully optimised due to daily change of trauma surgeon update 9/9/19 meeting held with Consultants 4/9/19 to discuss proposal and final decision to be agreed on 4/10/19
  Update 16/10/19 New rota to be implemented January 2020
- Discussion to be held with Diagnostic Services about x-ray support in theatre update 9/9/19 TACC Business Manager and Deputy General Manager to discuss with Radiology Manager in September 2019
  Update 16/10/19 discussions held and booking of x-ray managed by Theatre co-ordinator

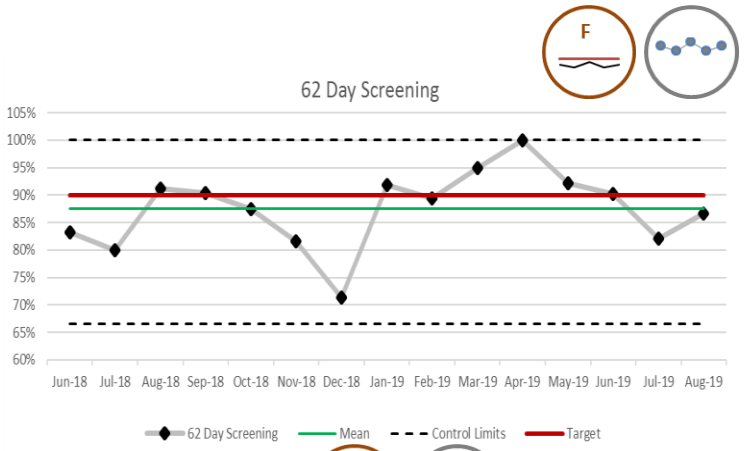
ZERO WAITING – CANCER 62 DAY

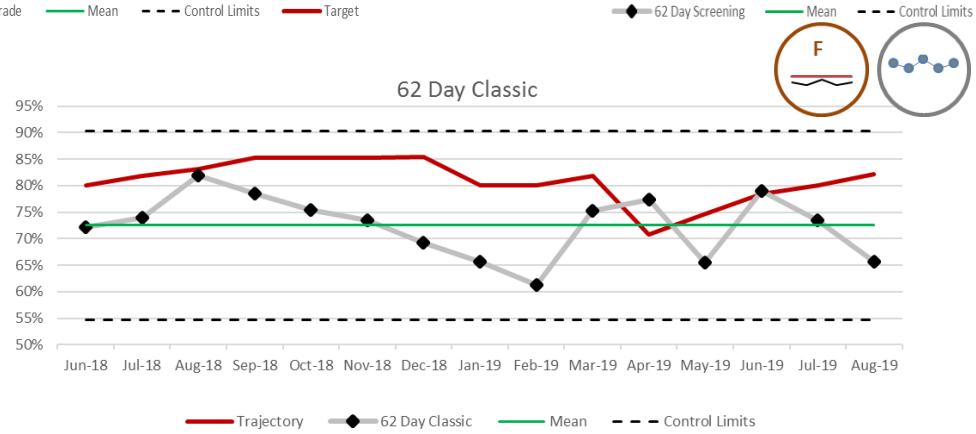
Executive Lead: Mark Brassington

CQC Domain: Responsive

2021 Objective: Our Services







The 62 Day Classic standard under-performed against the trajectory of 82.2%, with only Urology performing against their agreed trajectory though Haematology and Skin finished close to their targets.

Early indications are that our September 62 Day Classic performance will be more successful than August, with anticipated performance being circa 75% (trajectory 82.5%).

The number of Trust patients waiting over 104 days has been decreasing. The number of Trust patients waiting over 62 days has been gradually increasing since the end of August and there is now an increased focus on getting this figure down, particularly for those patients only awaiting an FDS letter (confirmation that they do not have cancer).

A daily report is issued to the Divisions, highlighting the volumes in their areas with the report allowing immediate drill-down to patient-level detail.

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

- Faster Diagnosis Standard (FDS) +62 Day patients (diagnosed & undiagnosed) – 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). A recent internal review of the national rules, including discussions with neighbouring Cancer Centres,

  has clarified the process around non-cancer diagnosed patients being discharged back to GP care and this will allow quicker and easier pathway completion for this cohort of patients.

- Colorectal – From April 2019 this tumour site has had difficulty in achieving its 62 Day performance. Colorectal did not meet their agreed trajectory in April, May and June for number of treatments or breaches contained within the treated volume. In July and August they have met their trajectory for number of treatments but significantly exceeded the number of breaches.

- Gynaecology – Through April, to August 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 July for number of treatments or breaches contained within the treated volume and in August they did not meet their agreed trajectory for number of treatments and significantly exceeded the number of breaches.

- Pathology – Path Links have been unable to recruit sufficient staff to cover their core service demand, particularly visible on Gynaecology and Urology pathways where less than 5% of samples are being reported within 7 days. Local operational relations with the Path Links team are positive but the organisational relationships are less so and impacted by the absence of a signed contract, with clear KPIs, escalation and penalties. Path Links are hosted by NLAG and ULHT representatives are seeking active contract negotiations. NHSI are also to engage in discussions about regional provision of pathology services, including the Path Links service – an input that should assist ULHT in better engaging NLAG. We routinely review cancer patient turn-around times for pathology.

- Tertiary Diagnostics and Treatments - A number of tumour sites are continuing to experience delays in securing timely diagnostics and/or treatments from the tertiary cancer centres (predominately Nottingham) and this is now being supported by one of the East Midlands Cancer Alliance funded Cancer Improvement Managers.

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

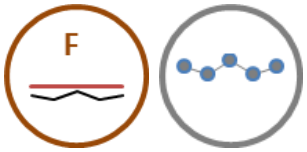
- MDT Organisation – There are a number of tumour sites which are operating hospital site specific MDTs. The rationale for the continuation of such arrangements needs to be reviewed in the context of national guidance for MDTs, the ULHT commitment to Trust-wide working and the pressures in supporting services to attend or support MDTs (particular pressures in pathology, radiology and oncology). Recognising the commitment in MDTs to site working, the direction of wider reviews is likely to need direction from the Medical Director/Trust Cancer Lead.

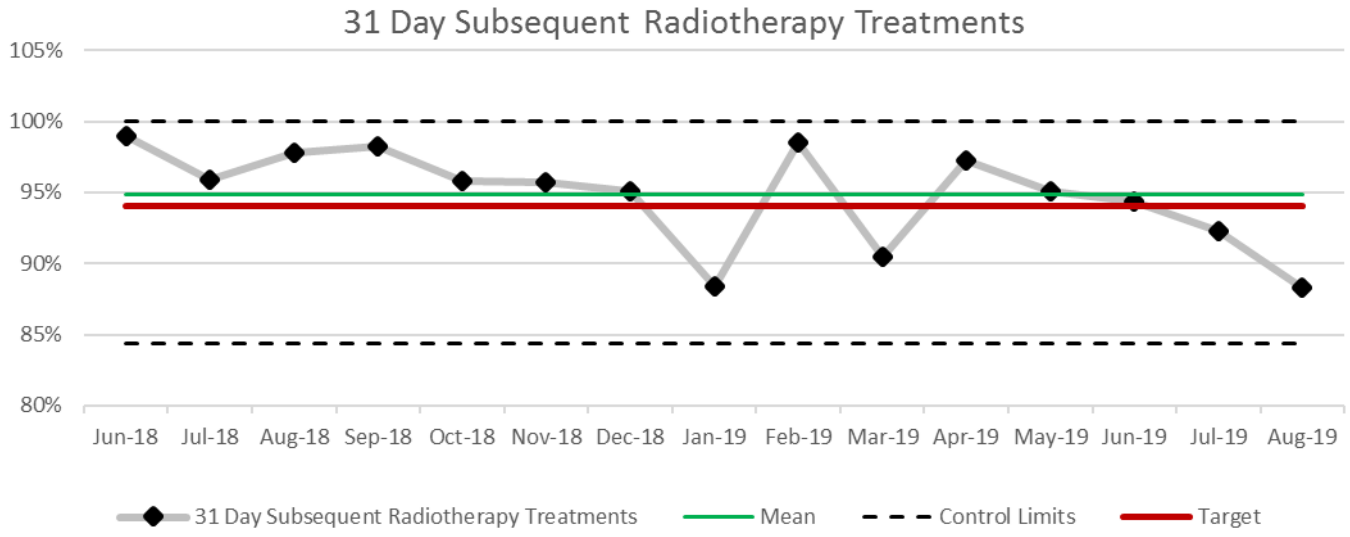
ZERO WAITING – CANCER 31 DAY

Executive Lead: Mark Brassington

CQC Domain: Responsive

2021 Objective: Our Services





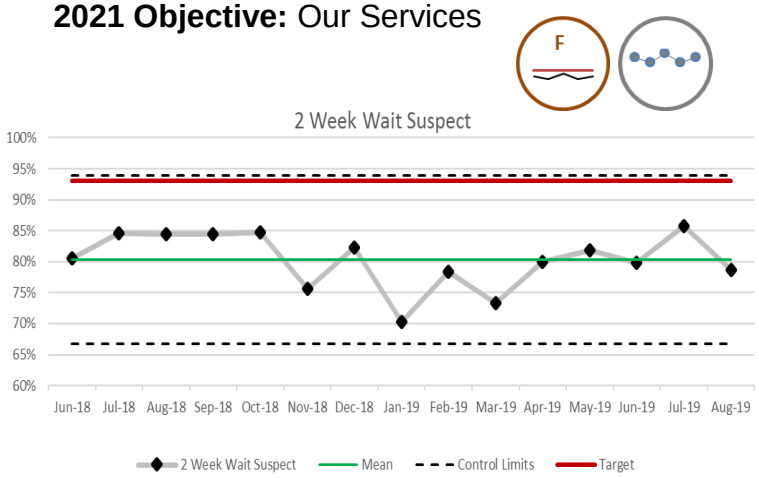
31 Day standards – The Trust achieved three of the four 31 Day standards in August, failing the Subsequent Radiotherapy due to a surge in patient numbers, together with one of the LINAC machines breaking down (this carried over from July).

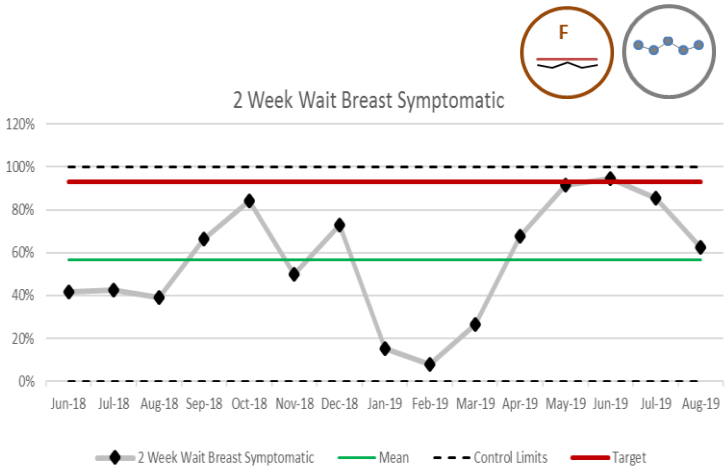
ZERO WAITING – CANCER 2 WEEK WAIT

Executive Lead: Mark Brassington

CQC Domain: Responsive

2021 Objective: Our Services





14 Day standards – Four tumour sites met the 14 Day standard in August (Lung, Haematology, Brain and Upper GI) up on just two meeting it in July, with Urology, Head & Neck and Sarcoma all being above 90%.

The Trust has set an internal standard for a 7 Day Horizon of 60%. This standard is continuing to prove to be difficult to achieve however the ambition is to have all tumour sites, with the exception of Gynaecology, accomplishing this by December 2019 in preparation for implementation of the 28 Day faster Diagnosis Standard (shadow monitoring 19/20). The Cancer Centre are supporting the Divisions, working collaboratively with Access, Booking and Choice with a new dashboard for 2ww First Appointments has been rolled out to the Divisions. September's forecast tumour site performance is as below:

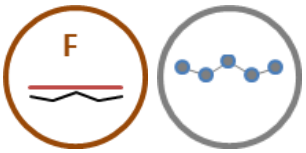
7 Day internal target = 60% 14 Day national standard = 93%	Total	< 7 Day Prfrmnce %	< 14 Day Prfrmnce %
Brain/CNS	10	60.0	**100.0**
Breast	299	**0.7**	**43.8**
Breast Symptomatic	150	**0.7**	**36.7**
Colorectal	468	**55.1**	**90.2**
Gynaecology	174	**19.0**	**84.5**
Haematology	7	71.4	**100.0**
Head & Neck	251	**58.2**	**96.4**
Lung	60	60.0	**100.0**
Sarcoma	16	**43.8**	**81.3**
Skin	547	**14.3**	**72.4**
Upper GI	164	62.2	**95.1**
Urology	270	**35.6**	**85.6**
Totals (excl Breast Sympto)	2266	**33.9**	***80.1***

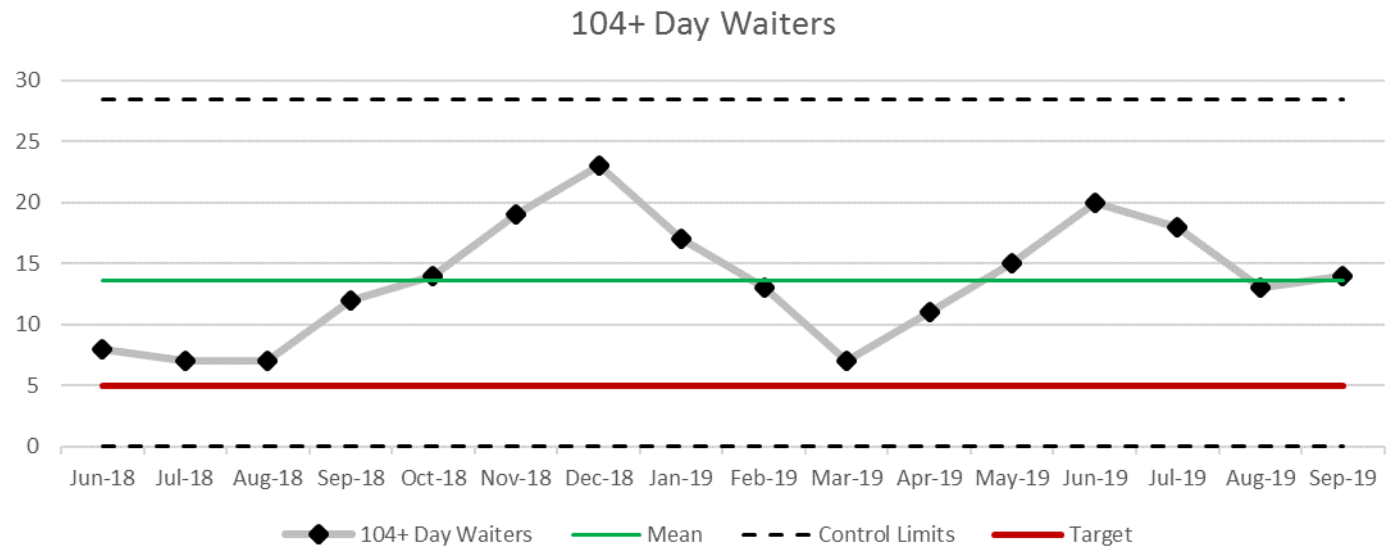
ZERO WAITING – 104+ DAY WAITERS

Executive Lead: Mark Brassington

CQC Domain: Responsive

2021 Objective: Our Services

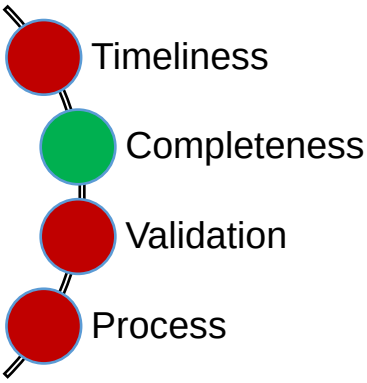




The number of Trust patients waiting over 104 days has been decreasing. The number of Trust patients waiting over 62 days has been gradually increasing since the end of August and there is now an increased focus on getting this figure down, particularly for those patients only awaiting an FDS letter (confirmation that they do not have cancer).
A daily report is issued to the Divisions, highlighting the volumes in their areas with the report allowing immediate drill-down to patient-level detail. The 104+ patients are first to be discussed during the twice weekly Trust-wide Cancer Call, chaired by the CSS Divisional Managing Director.

APPENDIX A – KITEMARK

Reviewed:
1st April 2018
Data available at: Specialty level



Domain	Sufficient	Insufficient
Timeliness	Where data is available daily for an indicator, up-to-date data can be produced, reviewed and reported upon the next day. Where data is only available monthly, up-to-date data can be produced, reviewed and reported upon within one month. Where the data is only available quarterly, up-to-date data can be produced, reviewed and reported upon within three months.	Where data is available daily for an indicator, there is a data lag of more than one day. Where data is only available monthly, there is a data lag of more than one month. Where data is only available quarterly, there is a data lag of more than one quarter.
Completeness	Fewer than 3% blank or invalid fields in expected data set. This standard applies unless a different standard is explicitly stated for a KPI within commissioner contracts or through national requirements.	More than 3% blank or invalid fields in expected data set
Validation	The Trust has agreed upon procedures in place for the validation of data for the KPI. A sufficient amount of the data, proportionate to the risk, has been validated to ensure data is: - Accurate - In compliance with relevant rules and definitions for the KPI	Either: - No validation has taken place; or - An insufficient amount of data has been validated as determined by the KPI owner, or - Validation has found that the KPI is not accurate or does not comply with relevant rules and definitions
Process	There is a documented process to detail the following core information: - The numerator and denominator of the indicator - The process for data capture - The process for validation and data cleansing - Performance monitoring	There is no documented process. The process is fragmented/inconsistent across the services

NHS
United Lincolnshire Hospitals
NHS Trust

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

Title:	**Corporate Risk Report**

Responsible Director: Dr Neill Hepburn, Medical Director

Author: Paul White, Risk Manager

Purpose of the Report:
The purpose of this report is to enable the Trust Board to:

- Review the management of corporate risks within the Trust and the extent of risk exposure at this time
- Evaluate the effectiveness of the Trust's risk management processes

The Report is provided to the Committee for:

Decision		Discussion	✓
Assurance		Information	✓

Summary/Key Points:

- The highest rated corporate risks remain the same as last month: financial sustainability; workforce capacity, capability and morale; and the vulnerability of aseptic pharmacy services;
- 45% of corporate risks are currently rated Very high or High risk (compared with 42% last month); this is due to the consolidation of risk register entries rather than a material change in risk exposure
- There is one additional High risk on operational (business unit) risk registers since last month – availability of equipment in Theatres & Critical Care CBU

Recommendations
That the Trust Board considers the content of the report and advises if any further action is required.

Strategic Risk Register Corporate risks that are considered to be of strategic significance are referenced within the Board Assurance Framework (BAF).	**Performance KPIs year to date** Performance in reviewing risk in accordance with the Risk Management Policy is reported regularly to the Audit Committee.

Assurance Implications
This report enables the Trust Board to review the effectiveness of risk management processes so that it can be assured regarding current risk control strategies and the extent of risk exposure at this time.

Patient and Public Involvement (PPI) Implications The effectiveness of the Trust's risk and corporate governance arrangements is reported through the Annual Governance Statement (AGS) and is included in the opinion of both internal and external audit. As such, it may influence the degree of confidence that patients and members of the public have in the Trust.
Equality Impact The Trust's Risk Management Policy has been assessed for equality impact and no issues were identified.
Information exempt from Disclosure – No
Requirement for further review? No

1. Purpose of the Report

1.1 The purpose of this report is to enable the Trust Board to:

- Review the management of corporate risks within the Trust and the extent of risk exposure at this time
- Evaluate the effectiveness of the Trust's risk management processes

2. Recommendations

2.1 That the Trust Board considers the content of the report and advises if any further action is required.

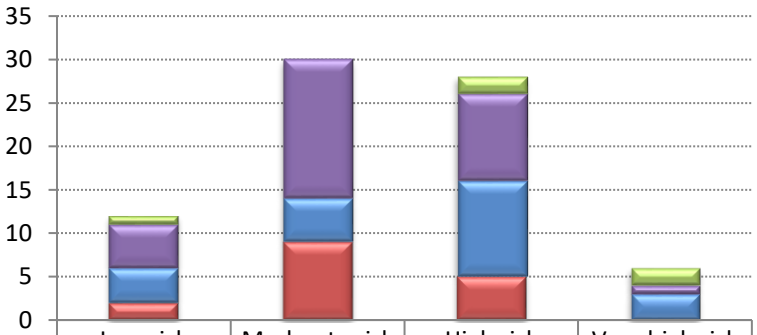
3. Reasons for Recommendations

3.1 The Trust Board has overall accountability for the management of risk within the organisation.

4. Summary of Key Points

Corporate Risk Profile

4.1 **Chart 1** shows the number of corporate risks by current (residual) risk rating:



	Low risk	Moderate risk	High risk	Very high risk
Finances	1	0	2	2
Reputation / compliance	5	16	10	1
Service disruption	4	5	11	3
Harm (physical or psychological)	2	9	5	0

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

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

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

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

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

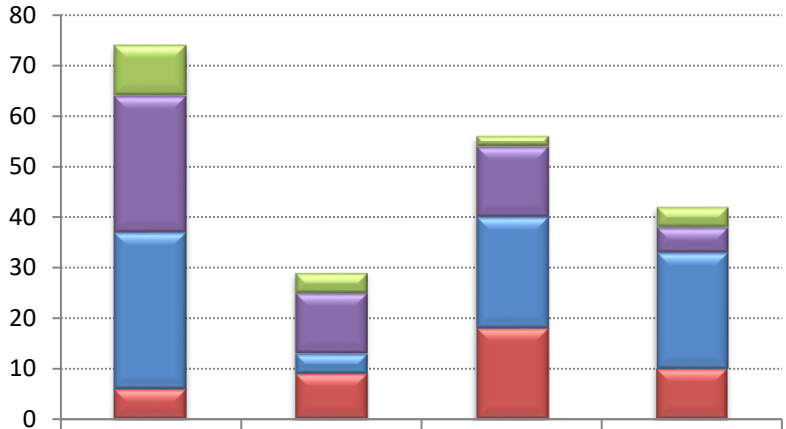
ID	Title	Division	Risk Type	Rating (current)	Risk level (current)
4155	Safety of research project participants (corporate)	Corporate	Harm (physical or psychological)	4	Low risk

4.3 45% of corporate risks are currently rated as Very high or High (compared with 42% last month). This percentage change is due to the review and consolidation of several risk register items. There has been no material change in significant risk exposure since the previous report.

4.4 A report showing details of all corporate risks recorded on the Corporate Risk Register with a current (residual) risk rating of High or Very high (a score of 12 or more), along with planned mitigating actions is included as **Appendix I**.

Operational Risk Profile

4.5 **Chart 2** shows the number of operational (divisional business unit) risks by current (residual) risk rating:



	Very low risk	Low risk	Moderate risk	High risk
Finances	10	4	2	4
Reputation / compliance	27	12	14	5
Service disruption	31	4	22	23
Harm (physical or psychological)	6	9	18	10

4.6 21% of operational risks are currently rated as High, compared with 20% last month. This is due to the risk relating to equipment availability in Theatres & Critical Care CBU increasing in rating from Moderate to High in order to be consistent with several component specialty risks currently recorded. A summary of those operational risks with a current rating of High risk is included as **Appendix II**.

Risk management process

4.7 Each corporate risk has an Executive lead, with overall responsibility for its management; and a Risk lead responsible for reviewing and updating the risk

register. The majority are also assigned to a lead management group for regular scrutiny. All are aligned with the appropriate assurance committee of the Trust Board.

4.8 Risks are defined according to the type of consequence that would be experienced should they materialise, with a severity scale of 1 to 5 using the following definitions:

- Harm (physical or psychological) – this may be to patients (as a result of issues with care); to members of staff, or to visitors (arising from health & safety issues) and covers a range from minor injuries through to multiple fatalities
- Service disruption – which ranges from the implementation of local business continuity plans up to critical and major incidents
- Reputation / compliance – which covers the potential for individual complaints up to a fundamental loss of confidence amongst commissioners; regulators; and the government (many risks of this nature relate to compliance with national standards, regulations and contractual obligations)
- Finances – which is based on the budgetary impact, from minimal cost increases to jeopardising financial sustainability

4.9 Within each corporate risk register entry there may be several risk factors associated with identified gaps in the risk control framework. These are individually assessed and prioritised by way of a 'Component risk rating', which is shown on the attached report.

4.10 The Risk Scoring Guide, which is used to assess all risks recorded on the Trust's corporate an operational risk registers, is attached for reference as **Appendix III**.

4.11 Operational risk registers are also in place for every Clinical Business Unit (CBU) and corporate department. The provision of management information to divisional and business unit management teams is progressing, along with additional support and training provided by the central Risk Team within Clinical Governance, in order to facilitate more regular and routine review of operational risks and improve the level of analysis that can be done to identify areas of significant concern. Oversight of risk management at divisional level is already included with the Performance Review Meeting (PRM) process.

Appendix I - Very high High Corporate Risks (November 2019)

ID	Title & description	Executive / divisional lead	Risk Type	Risk level (inherent)	Controls in place	Risk level (current)	Lead assurance committee	Risk level (acceptable)	Next review date	Weakness/Gap in Control	Component risk rating	Specialty	Planned actions	Action due date	Progress
4175	**Management of emergency demand (corporate)** If the volume of emergency demand significantly exceeds the ability of the Trust to manage it; Caused by an unexpected surge in demand, operational management issues within other healthcare providers or a reduction in capacity and capability within ULHT; It could result in a significant, prolonged adverse impact on the quality and productivity of services across multiple directorate and / or sites affecting a large number of patients and the achievement of national NHS access standards.	Brassington, Mr Mark	Service disruption	Very high risk	ULHT operational demand management policies & procedures. Operational performance management framework & regular reporting / monitoring at divisional and corporate levels. Monthly performance report to Trust Board. Urgent and Emergency Care Board (UECB) delivery plan. Lincolnshire Sustainability & Transformation Partnership (STP) and Plan. Horizon scanning processes.	Very high risk (20)	Finance, Performance & Estates Committee	Moderate risk	31/10/2019	• Comprehensive and effective triage • Improve time to RAT • Reduce ambulance handover delay • Improve time to 1st assessment • Effective GP Streaming • Improve non-admitted pathway compliance • Delivery of an ambulatory care model • Implementation of frailty model • Reconfiguration • Redesign the site management and bed meeting model • SAFER implementation • Effective discharge by 1000 • Reduce number of stranded and super stranded patients • Implementation of Red to Green • Implementation of Full Capacity Protocol (FCP) • Implementation of criteria led discharge	Very high risk (20-25)	Operations	Urgent and Emergency Care Programme work streams: QS04 Pilgrim EC1A Lincoln EC1B Grantham EC2 Assessment Function EC3 Site Function EC4 Inpatient Ward Function EC5 Discharge and Partnerships	31/03/2020	Project updates for each of the five work streams are brought to Recovery Steering Group meetings which take place fortnightly. The recovery steering group has now been extended to include partners, stakeholders and regulators.
4382	**Delivery of the Financial Recovery Programme (corporate)** If the Trust becomes unable to delivery key elements of the Financial Recovery Plan within the current financial year; Caused by issues with the design or implementation of planned cost reduction initiatives; It could result in a material adverse impact on the ability to achieve the annual control total and reduce the scale of the financial deficit.	Matthew, Paul	Finances	Very high risk	Financial strategy. Financial recovery planning process. Financial Recovery Plan governance & monitoring arrangements. Directorate performance & accountability framework. Financial management information. Financial Special Measures (since September 2017). Financial Turnaround Group (FTG) oversight. Programme Management Office & dedicated Programme Manager.	Very high risk (20)	Finance, Performance & Estates Committee	Moderate risk	31/10/2019	Identified schemes for 2019/20 cover the level of efficiency required (£25.6m). If assumptions are inaccurate; or if there are capacity & capability issues with delivery; it may result in failure to deliver these schemes.	Very high risk (20-25)	Finance	Finance PMO team working with divisions to manage planned schemes and identify mitigating schemes. Additional external resource to be brought in to support delivery.	31/03/2020	
4383	**Substantial unplanned expenditure or financial penalties (corporate)** If the Trust incurs substantial unplanned expenditure or financial penalties within the current financial year; Caused by issues with budget planning, budgetary controls, compliance with standards or unforeseen events; It could result in a material adverse impact on the ability to achieve the annual control total and reduce the scale of the financial deficit.	Matthew, Paul	Finances	Very high risk	Financial strategy. Annual budget setting process. Capital investment planning process. Capital investment programme delivery & monitoring arrangements. Monthly financial management & monitoring arrangements. Contract governance and monitoring arrangements. Directorate performance & accountability framework. Key financial controls. Financial management information.	Very high risk (20)	Finance, Performance & Estates Committee	Moderate risk	31/10/2019	Continued reliance upon a large number of temporary agency and locum staff to maintain the safety and continuity of clinical services across the Trust, at substantially increased cost.	Very high risk (20-25)	Finance	Financial Recovery Plan schemes: recruitment improvement; medical job planning; agency cost reduction; workforce alignment.	31/03/2020	
										Interest rate may increase if the Trust deviates adversely from plan in the financial year. Non-delivery of plan would also mean the Trust won't have access to FRF; PSF; and MRET (valued at £29m).	Very high risk (20-25)	Finance	Delivery of the Financial Recovery Programme; maintaining grip & control on expenditure; use of PRM process to hold divisions to account and develop mitigating schemes where needed.	31/12/2018	
										The Trust is at risk of being removed from the National Windows 10 licensing arrangement with a potential liability of up to £1.5m. NHSDigital will make a final decision in March 2020 depending on the overall state of the NHS estate in England. The recent announcement by Microsoft that they will continue to provide extended support for Windows 7 until January 2021 does not provide any reason to delay your migration to Windows 10. Currently licensed organisations have been granted free licensing on the basis of agreeing to fully utilise the Windows 10 licences provided. As per Clause 2.11 of your Service Agreement, licences may be revoked if they are not fully utilised. This decision will be taken in March 2020, the annual review point at which we must decide which organisations continue to be part of the national agreement with Microsoft. Any organisation who has licences revoked will also cease to qualify for the free extended support for Windows 7, since this free extended support is only available by being part of the NHS national agreement. Therefore by delaying Windows 10 local organisations will not only risk losing the free Windows 10 licences but will also need to pay for their own extended support for their Windows 7 estate. The cost of replacing free National licences and purchasing extended support is currently £205 per user (inc. VAT) x all users in your estate - £1m for an NHS organisation with 5,000 users. Please ensure that you calculate and include this risk on your corporate risk register if you are not planning to have completed your Windows 10 migration by March 2020.	Moderate risk (8-10)	Information & Communications Technology	The Trust to continue to work closely with NHS Digital keeping them appraised of our situation. The ICT Department has a plan to continue the rollout of Windows 10 upgrading the devices that can be upgraded and by rolling out the correct version to the VDI environment, this will continue to increase the numbers of devices that are using the national licensing agreement. The ICT Department working with finance continue to explore ways and means of accessing external capital resource and this continues to be top priority pending any capital allocation to ICT in 19/20 and beyond.	31/03/2020	Risk has been discussed within ICT and with Paul Matthew, it has also been escalated as a system issue to the STP via IMTEG. Current capital position is unhelpful and unsupportive of a resolution. ICT working with Finance colleagues to explore options and review potential for emergency capital bids.
4083	**Workforce engagement, morale & productivity (corporate)** If the Trust were to lose the engagement of a substantial proportion of its workforce; Caused by issues with low morale, lack of job satisfaction or uncertainty about the future; It could result in a substantial, widespread and prolonged reduction in productivity across multiple services affecting a large number of patients and staff.	Rayson, Martin	Reputation / compliance	Very high risk	Staff Charter & Personal Responsibility Framework Staff engagement strategies & plans. Internal communications platforms (intranet; bulletins; forums). Staff survey process and response planning. People management & appraisal policies, processes, systems (e.g. ESR) training & monitoring. Core learning programmes. Leadership development and succession planning processes. Management of change policies, guidelines, support and training. Partnership agreement with staff side representatives. Occupational health & wellbeing arrangements for staff.	Very high risk (20)		Low risk	30/11/2019	Impact of the cost reduction programme & organisational change on staff morale. The national staff survey results for 2017 shows that the impact of the Trust going into special measures for both quality and finance is being felt by staff. Morale has declined significantly, pride in working for ULHT has gone down and staff feel that decisions are taken on the basis of finance, rather than patient experience and safety and to the detriment of staff (e.g. increase in car parking charges & controls over travel and training). There is significant cynicism amongst staff, which will not be resolved until they see action alongside the words.	Very high risk (20-25)	Human Resources	Shaping a response to the staff survey results which will inform the revised People Strategy and the 2021 Programme. One of the key themes will be creating a strategic narrative which gives hope for the future and addresses the issue that quality and money are not incompatible. Improvement methodology work provides means for staff to make efficiency and patient experience improvements. FAB programme will emphasise what is possible. Directorates will be tasked with also addressing staff survey issues at a local level. The actions proposed provide the mitigation, but we have to recognise that this remains a tough environment in which to drive up morale. Staff survey predated launch of 2021, but there is a need to tackle vacancy gaps as well.	31/03/2020	Actions have been taken since the 2018 staff survey results against some the biggest themes emerging. Each Division has been asked to work to address the issues identified in their survey results. The Engagement Bus will be visiting each site in September. This will be accompanied by a "you said, we did" campaign. The next staff survey will be open in October 2019 and results will be available in early 2020. Review once the next set of staff survey results are available.
										Relationships with staff side representatives are challenged by the scale of organisational change required and the extent to which staff side wish to protect the status quo. There are disagreements amongst staff side representatives and not all meetings have taken place as scheduled.	Moderate risk (8-10)	Human Resources	Reviewing the current recognition agreement to modernise it and ensure it is fit for purpose. It is based on the Sandwell model and seeks to ensure proper debate, without giving staff side the capacity to prevent us moving beyond the status quo. Intention is to write to staff side to propose a further partnership meeting. Formal consultation around the new recognition agreement will begin shortly.	31/03/2020	Vote of no confidence in the Board by staff side in November 2018. Outstanding issues have been resolved, except there is a need for a facilitated discussion on future partnership working. The review of the recognition agreement has been on hold. We will resurrect this and elements of this will be controversial.
4362	**Workforce capacity & capability (recruitment, retention & skills)** If there is a significant reduction in workforce capacity or capability across the Trust; Caused by issues with the recruitment and retention of sufficient numbers of staff with the required skills and experience; It could result in sustained disruption to the quality and continuity of multiple services across directorates and may lead to extended, unplanned closure of one or more services which has a major impact on the wider healthcare system.	Rayson, Martin	Service disruption	Very high risk	Overall ULHT People Strategy & Workforce Operational Plan. Workforce planning processes & workforce information management. Medical staff recruitment framework & associated policies, training & guidance. Medical staff appraisals / validation processes. National audit & benchmarking data on the medical workforce. Nursing staff recruitment framework & associated policies, training & guidance. Allied Healthcare Professionals (AHPs) staff recruitment framework & associated policies, training & guidance. Non-clinical staff recruitment framework & associated policies, training & guidance. Bank, locum & agency staffing arrangements. Rota management systems & processes. People management policies, training & guidance.	Very high risk (20)	Workforce, Organisational Development & Transformation Committee	Moderate risk	30/11/2019	Substantial challenge to recruiting and retaining sufficient numbers of Registered Nurses (RNs) to maintain safely the full range of services across the Trust.	Very high risk (20-25)	Human Resources	Focus on nursing staff engagement & structuring development pathways; use of apprenticeship framework to provide a way in to a career in nursing; exploration of new staffing models, including nursing associates; continuing to bid for SafeCare live funding.	31/03/2020	Nursing offer in place. Strategy for recruiting nurses in place, involving international and national recruitment, alongside maximising NQNs and trainee nurse associates. Review again at end of financial year.
										High vacancy rates for consultants & middle grade doctors throughout the Trust.	Very high risk (20-25)	Human Resources	Focus on medical staff engagement & structuring development pathways. Utilisation of alternative workforce models to reduce reliance on medical staff.	31/03/2020	Plan for every medical post in place. Good progress on recruitment (to plan) in QTR 1 and good pipeline in QTR 2. Working with two agency partners. Review again at end of financial year.
										A significant proportion of the current clinical workforce are approaching the age at which they could retire, which may increase skills gaps and vacancy rates.	High risk (12-16)	Human Resources	Workforce plans to identify the potential risk due to the age profile in more detail, by year and service area; People Strategy includes mitigating actions; using HEE funding to bring additional capacity into OD in order to make progress on this project.	31/12/2019	Retention plan in place - aiming for 1-2% reduction in attrition in 2019/20. Review again at end of calendar year.

Appendix I - Very high High Corporate Risks (November 2019)

ID	Title & description	Executive / divisional lead	Risk Type	Risk level (inherent)	Controls in place	Risk level (current)	Lead assurance committee	Risk level (acceptable)	Next review date	Weakness/Gap in Control	Component risk rating	Specialty	Planned actions	Action due date	Progress
					- Local management policies, training & guidance. Core learning programme & training provision. Leadership development programme.					The Trust is dependent on Deanery positions to cover staffing gaps with medical trainees; shortages in the medical recruitment team will impact on the next rotation if not resolved.	High risk (12-16)	Human Resources	Education Director action plan to address the issues raised.	31/12/2019	Higher number of junior doctors in August rotation. Actions to improve juniors experience identified. Review again at end of calendar year.
										NHSI propose the introduction of 2 further measures to reduce agency spend in non-clinical areas: - a restriction on the use of off-framework agency workers to fill non-clinical and unregistered clinical shifts (to use of on-framework agencies only) - A restriction on the use of admin and estates agency workers to bank or substantive / fixed term only (with exemptions for special projects and shortage specialties)	High risk (12-16)	Human Resources	Review of proposals and potential impact, to identify any required action.	31/12/2019	Action plan in place to reduce agency spend. Central medical agency team operating and impact is being felt. However agency spend is not reducing as expected. Further action being taken, particularly around nursing agency spend. Review again at end of calendar year.
4405	**Critical infrastructure failure disrupting aseptic pharmacy services (corporate)** If there is a critical failure of the infrastructure that supports aseptic pharmacy services within the Trust; Caused by issues with the age and condition of the facilities and the impact of managing increasing levels of demand; It could result in unplanned suspension of services which would have a significant and prolonged impact on a large number of patients, services, and other service providers.	Hepburn, Dr Neill	Service disruption	Very high risk	Aseptic pharmacy services facility at LCH and PHB. Quality Assurance of Aseptic Pharmacy Services (QAAPS). Aseptic pharmacy lead. Estates & Facilities Planned Preventative Maintenance programme & responsive repairs process. Medicines management policies, guidance, systems and supporting documentation. Medicines Safety Committee & sub-group governance structure. Datix incident reporting & investigation processes. Regular monitoring of the capacity, performance and antimicrobial contamination of the Pilgrim Pharmacy ASU (includes pressure differentials monitoring in rooms and isolators and microbial growth plates). Business continuity plans for ASU require patients to be treated outside of the Trust in the event of service disruption.	Very high risk (20)		Low risk	31/10/2019	The Pilgrim ASU facility is18 years old, is operating at capacity and the availability of external supplies is both erratic and inconsistent. In addition, cancer care in the Trust is increasing by 10% annually and demand for aseptic preparations is predicted to outstrip current levels of availability by the end of 2020.	Very high risk (20-25)	Pharmacy	Development of a sustainable infrastructure plan for aseptic pharmacy services.	31/12/2020	Full Business Case being prepared for Trust Board in October 2019, containing proposals for a new aseptic unit; preferred option is a joint venture partnership through the STP.
										Repeated incidents of water leaks into one of the PHB aseptic rooms (tray washing room) from an upstairs toilet. If this happens and water reaches the main clean room it could result in closure of the aseptic unit for recommissioning and therefore inability to provide an aseptic service for the Trust for several months.	Very high risk (20-25)	Pharmacy	With Estates, to identify the reasons for the ongoing leaks and provide a permanent resolution to the problem; if a permanent resolution is not possible, to explore a way to identify the leaks at an early stage to minimise the risks (detection alarms are in other areas of the aseptic unit, so can this be applied to all other areas). To arrange cultures and chemical assay of the water. To request an assessment from Bernie Sanders, East Midlands Regional Quality Assurance to advise on	31/10/2019	Temporary closure of the aseptic unit at PHB - implementing BCP until assurance is received that the contamination is safely managed.
3520	**Compliance with fire safety regulations & standards (corporate)** If the Trust is found to be systemically non-compliant with fire safety regulations and standards; Caused by issues with the design or consistent application of required policies and procedures; It could result in regulatory action and sanctions which damages the reputation of the Trust and could lead to adverse publicity, with the potential for financial penalties and disruption to services.	Boocock, Paul	Reputation / compliance	Very high risk	Fire Safety Group. Fire Policy. Estates risk governance & compliance monitoring process. Health & Safety Committee & site-based H&S committees. Personal Emergency Evacuation Plans (PEEPs). Incident reporting and investigation proces & system (Datix). Planned Preventative Maintenance (PPM) / testing. Fire Risk Assessments. Fire safety training (Core Learning, annual) Capital investment planning & implementation processes.	High risk (16)		Low risk	31/10/2019	The Fire Alarm System at LCH requires additional new work to ensure continued compliance with current standards. The Maternity Wing has a partially compliant alarm system in need of upgrading to current standards (Any works to the Fire alarm system within the Maternity Wing are constrained by the presence of asbestos. This applies to maintenance works and any upgrade works). Detection Zones plans are also referenced as a reason for the inadequate Fire Detection System under Article 13(1) (a) & 13 (2) of the Fire Enforcement noticed served 14th June 2017. Following the installation of the additional fire compartmentation within the east wing roof voids and corridors a review of the fire alarm system is required to ensure compliance.	High risk (12-16)	Estates	The Fire Alarm System at LCH is maintained by a specialist contractor and directly employed labour force. The system in some areas has been upgraded as part of services developments e.g. HDU & ICU and as part of previously funded upgrade. Programme of refurbishment and re-provision on a phased basis to install a 'loop' for the site and linking in modern equipment is underway.	31/12/2019	Phases 1, 2 and 3 complete. Phases 4 is underway and as part of these works; and to improve auditability and compliance with DDA, additional sounders and beakers are being installed. Phase 5 (Mat Wing) The Fire Alarm systems on 1st and 6th floor have been replaced, works are currently on-going to replace the Fire Alarm system within all lift lobby areas and within the 3rd floor ward area.
										Fire Doors, Fire/Smoke Dampers and Fire Compartment Barriers above ceilings in Pilgrim, Lincoln and Grantham require improvements to ensure compliant fire protection of patient and staff areas in accordance with statutory standards. See Fire Strategy surveys for areas affected. As referenced under article 8 in the Fire Enforcement Notices. Numerous sets of fire doors in poor condition due to wear and tear and damage where the fire resisting qualities have been reduced or negated.	High risk (12-16)	Estates	Fire Strategy Plans and surveys identify where compartmentation is required. Fire compartmentation works costs are detailed within the capital plan. Fire Doors will be addressed as part of the Fire Action Plan from the enforcement notices received for Lincoln and Pilgrim. Fire Doors requiring replacement to be replaced with new certified fire doors. PPM inspections and ad hoc repairs to fire doors in response to serious damage, etc.	31/12/2019	The work packages for the remedial works are taking place subject to availability of sufficient capital funding.
										Adherence to fire safety policy, procedures, strategic approach to active and passive fire safety measures and evacuation strategy. Adherence to Fire Safety training arrangements which include recording, analysis of training needs, personal development systems in place for all staff inclusive of permanent, temporary, agency and or bank staff. 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.	High risk (12-16)	Estates	Specific actions in relation to fire safety training & evacuation: 1. staff identified and managers informed to ensure staff attend 2. Evacuation drills to be implemented and tested. 3. New Fire safety training packages being introduced. 4. persons requiring PEEP and procedures tested during evacuation drills. 5. discussions with HR to identify an appropriate procedure to identify and inform staff outside of compliance dates, with managers cc into correspondence to ensure urgent attendance. 6. Fire safety trainer to discuss with ESR team about information required for PDR and H & S team for reporting against core modules to ensure compliance.	31/03/2020	New mandatory staff fire safety awareness module introduced.
3688	**Quality of the hospital environment (corporate)** If the Trust is unable to maintain a hospital environment and facilities that meet the expectations of patients, staff and visitors and the requirements of services across all of its sites; Caused by the condition of the estate and facilities and issues with maintenance and development; It could result in widespread dissatisfaction which leads to significant, long term damage to the reputation of the Trust and may lead to commissioner or regulatory intervention.	Boocock, Paul	Reputation / compliance	Very high risk	Estates Infrastructure and Environment Committee (EIEC). Patient Experience Committee. NHS Premises Assurance Model (PAM) Patient-led Assessment of the Care Environment (PLACE) survey & response plans. Robust defect reporting system which prioritises critical issues within available resources. Cleanliness audit system that integrates with the Estates helpdesk. Estates capital investment process and programme.	High risk (16)		Moderate risk	31/10/2019	Reduced standards if painting & decorating of clinical areas on all sites are not completed. (Identified through PLACE annual inspection).	High risk (12-16)	Estates	Require a programme to improve standard of hospital environments, via painting & decorating of clinical areas.	31/12/2019	Funding and resource to be allocated.
										Floor Coverings across the Trust - Many areas are 45 years old, looks tired and is damaged in areas. Frequently fails environment and PLACE audits. Sub Floor is also damaged in some cases. High risk areas include Maternity at Lincoln, Tower Block at Grantham, Theatre Corridors at Pilgrim.	High risk (12-16)	Estates	Ad hoc repairs to flooring carried out across the Trust. Funding required for comprehensive programme.	31/12/2019	
										LCH & GDH: Lack of resources to carry out external decoration. High level areas in the East Wing are difficult and costly to access due to requirement to erect scaffolding. Deterioration of paint finish to wooden windows and door fascias and soffits leaving timber exposed to weather. Will lead to deterioration of timber window frames and their failure with associated costs. Physical appearance very poor. Fails annually on PLACE scores.	Moderate risk (8-10)	Estates	Repairs to external decoration at LCH & GDH undertaken based on available labour, accessibility. Monitor the situation and carry out ad hoc repairs where situation dictates. Funding required for a rolling programme of external decoration, window replacement and facias.	31/12/2019	
										LCH: Patient bed space curtain track systems within patient areas are obsolete; sufficient hooks to hang the curtains satisfactorily are not available; not all curtain tracking is ligature safe; inadequately hung curtains can affect patient dignity as reported on PLACE.	Moderate risk (8-10)	Estates	Existing curtain hooks at LCH are "spaced out" to increased distances to allow curtains to hang. Funding required to replace the obsolete curtain rail systems.	31/12/2019	

Appendix I - Very high High Corporate Risks (November 2019)

ID	Title & description	Executive / divisional lead	Risk Type	Risk level (inherent)	Controls in place	Risk level (current)	Lead assurance committee	Risk level (acceptable)	Next review date	Weakness/Gap in Control	Component risk rating	Specialty	Planned actions	Action due date	Progress
4384	**Substantial unplanned income reduction or missed opportunities (corporate)** If the Trust experiences a substantial unplanned reduction in its income or missed opportunities to generate income within the current financial year; Caused by issues with financial planning, an unexpected reduction in demand or loss of market share; It could result in a material adverse impact on the ability to achieve the annual control total and reduce the scale of the financial deficit.	Matthew, Paul	Finances	Very high risk	Financial strategy. Contract governance and monitoring arrangements. Annual budget setting & monthly management process. Monthly financial management & monitoring arrangements. Key financial controls. Financial management information.	High risk (16)		Moderate risk	31/10/2019	Clinical coding & data quality issues impacting on income.	High risk (12-16)	Information Services	Iqvia engaged to review Trust data on a monthly basis; strengthening of clinical coding practice.	31/03/2020	
										Operational ownership of income at directorate level.	High risk (12-16)	Finance	Strengthening of management of activity and income plans at speciality level through the divisional PRM process.	31/10/2019	
										Commissioners have a combined shortfall to contract of c£8m. This could result in a number of schemes that will impact the Trust.	High risk (12-16)	Finance	Agreed contractually that the impact of income reduction for these schemes will be on a net neutral basis for the Trust; monitored and managed through the Finance & Contracting Group.	31/03/2020	
										Activity levels increase above the plan where the Trust remains under tolerance, no additional income is received; where above tolerance only a percentage of tariff is received.	High risk (12-16)	Finance	Internal control via PRM process for monitoring and agreeing any necessary actions to manage demand; & via Finance & Contracting Group for the system to manage demand.	31/03/2020	
										Up to £8m at risk through non-delivery of backlog improvements and repatriated activity.	High risk (12-16)	Finance	System to develop robust plans and internal productivity gains to ensure there is sufficient capacity to deliver the activity; where the planned level of activity can't be achieved to secure income, the associated costs will need to be removed.	31/03/2020	

Appendix I - Very high High Corporate Risks (November 2019)

ID	Title & description	Executive / divisional lead	Risk Type	Risk level (inherent)	Controls in place	Risk level (current)	Lead assurance committee	Risk level (acceptable)	Next review date	Weakness/Gap in Control	Component risk rating	Specialty	Planned actions	Action due date	Progress
3951	**Compliance with regulations & standards for aseptic pharmacy services (corporate)** If the Trust is found by a regulator to be systemically non-compliance with regulations & standards for aseptic pharmacy services; Caused by fundamental issues with the design or application of local policies and procedures, or the quality of the facility; It could result in regulatory intervention that forces immediate closure of the facility and suspension of services, impacting on a large number of patients, services and other service providers.	Hepburn, Dr Neill	Reputation / compliance	Very high risk	Aseptic pharmacy services facility at LCH and PHB. Quality Assurance of Aseptic Pharmacy Services (QAAPS). Aseptic pharmacy lead. Medicines management policies, guidance, systems and supporting documentation. Medicines Safety Committee & sub-group governance structure. Datix incident reporting & investigation processes. Regular monitoring of the capacity, performance and antimicrobial contamination of the Pilgrim Pharmacy ASU (includes pressure differentials monitoring in rooms and isolators and microbial growth plates).	High risk (16)		Low risk	31/10/2019	Pilgrim Hospital ASU does not comply with national and EU standards: • the Air Handling Unit is aging, • air changes are below the recommended levels for the clean rooms, • risk of leak from water pipes located above the unit. Leaks have occurred in the past, • there is limited capacity for the preparation of TPNs. Only one positive pressure isolator and no room space for the addition of a second isolator, • there are inadequate workflows of materials, finished products, personnel and waste due to current layout of the unit.	High risk (12-16)	Pharmacy	Proposals for a sustainable aseptic services facility to support compliance with QAAPS requirements.	31/12/2020	Business Case in development, to be presented to Trust Board in October 2019.
										Aseptic preparation services must have adequate resources to ensure compliance with the defined national standards as described in Quality Assurance of Aseptic Pharmacy Services (QAAPS). Aseptic preparation time has increased due to changes in aseptic services standards (addition of an extra disinfection stage and use of a sporicidal agent with an increased contact disinfection time).	High risk (12-16)	Pharmacy	Additional staffing capacity with appropriate skill mix required to provide a service that complies with QAAPS standards. CSS Division to identify resources for additional staff required.	31/03/2020	Business case developed for additional staffing capacity. Phase 1 staffing has helped but has not brought us to a capacity below 80%. Phase 2 staffing will take us below 80% capacity.
4497	**Contamination of aseptic products (corporate)** If the products supplied by the Trust's aseptic pharmacy services were to become contaminated; Caused by issues with hygiene standards at the production facility, or user error; It could result in significant harm and potentially the death of multiple patients.	Hepburn, Dr Neill	Harm (physical or psychological)	Very high risk	Aseptic pharmacy services facility at LCH and PHB. Quality Assurance of Aseptic Pharmacy Services (QAAPS) regulatory stndards. Aseptic pharmacy lead. QAAPS states that aseptic capacity should not exceed 80%. Medicines management policies, guidance, systems and supporting documentation. Medicines Safety Committee & sub-group governance structure. Datix incident reporting & investigation processes. Regular monitoring of the capacity, performance and antimicrobial contamination of the Pilgrim Pharmacy ASU (includes pressure differentials monitoring in rooms and isolators and microbial growth plates).	High risk (15)		Low risk	31/10/2019	Due to the current state of the infrastructure in Lincoln, and the potential risk of contamination, the Lincoln Pharmacy ASU is not fit for purpose.	High risk (12-16)	Pharmacy	Closure of the Lincoln Pharmacy ASU to avoid the risk.	28/02/2018	Lincoln Pharmacy ASU has been closed.
										Most aseptic processes are operator dependant. This means that when overcapacity there is an increased risk of calculation errors or producing contaminated products. Whilst air pressure monitoring will highlight the risk of contamination it does not give information on the actual risk. Microbial plates take 2 weeks to provide results, therefore any potentially contaminated products cannot be identified until after they have been issued and administered to patients. This is because the aseptic unit operates under Section 10 exemption from the Medicines Act and is not licensed. There is therefore no batch manufacturing and no associated quality control of batch manufactured products which would otherwise enable microbiological and chemical stability testing to take place.	High risk (12-16)	Pharmacy	Additional staffing capacity with appropriate skill mix required to provide a safe service and achieve capacity levels of under 80%. CSS Division to identify resources for additional staff required.	31/03/2020	Business case developed for additional staffing capacity. Phase 1 staffing has helped but has not brought us to a capacity below 80%. Phase 2 staffing will take us below 80% capacity. Frequent activation of BCP paces additional workload strain on staff, which further increases the associated risks. This is only sustainable for a short period of time.
										The current condition of the aseptic facility at Pilgrim Hospital is inadequate, which increases the risk of contamination: • the Air Handling Unit is aging, • air changes are below the recommended levels for the clean rooms, • risk of leak from water pipes located above the unit. Leaks have occurred in the past, • there is limited capacity for the preparation of TPNs. Only one positive pressure isolator and no room space for the addition of a second isolator, • there are inadequate workflows of materials, finished products, personnel and waste due to current layout of the unit.	High risk (12-16)	Pharmacy	Implementation of a sustainable and fit for purpose aseptic services facility at Pilgrim Hospital.	31/12/2019	Business Case in development, to be presented to Trust Board in October 2019.
4300	**Availability of medical devices & equipment (corporate)** If the Trust's is unable to maintain the availability of essential medical devices and equipment; Caused by issues with capital and / or revenue planning, procurement and delivery processes or the availability of sufficient funding and resources; It could result in widespread disruption to clinical services across one or more divisions, reducing productivity and impacting on the experience of multiple patients.	Hepburn, Dr Neill	Service disruption	Very high risk	Capital and revenue planning processes. Procurement, delivery and contract management processes. Medical Device Group operational oversight. Medical device & equipment inventory. Clinical Engineering Services and Estates & Facilities equipment maintenance programmes & repairs capability. Business continuity / contingency plans for reduced availability of devices & equipment. CAS Alerts processes for managing device safety issues. Datix incident reporting & management processes for incidents.	High risk (12)		Low risk	31/12/2019	Trust-wide issues with the availability of suitable equipment (e.g. beds / trolleys; wheelchairs; weighing scales; blood pressure cuffs) and appropriate policies, procedures & pathways supported by training for the safe care of bariatric patients.	High risk (12-16)	Corporate Nursing	To review and update where necessary policies, procedures and relevant pathways to improve the safety of care for bariatric patients across existing policy areas, including: moving & handling policy; Theatres - procedures on trolleys / tables; observation policy (e.g. right size cuff to take blood pressure); A&E; outpatients.	31/12/2019	Working group set up, involving corporate nursing, health & safety & risk, to identify required improvements.
										Lack of a centralised database for all medical devices; some records are held locally.	High risk (12-16)	Clinical Engineering	To deliver a Trust centralised medical equipment management database(which includes asset register, re-active and proactive maintenance planning, service history, etc.)	30/11/2019	MDSG has agreed on MEMS as the centralised medical equipment management database. Divisional engagement is underway.
										Current contractual arrangements for bed frames and mattresses (with ARJO) have expired and continue on a 6 month rolling basis; the current contract model may not represent the best value for money. Bed management processes lack corporate oversight and effective control.	High risk (12-16)	Clinical Engineering	Appointment of a dedicated project manager to coordinate development of a revised bed / mattress operational model and contract review. Option to work collaboratively with LCHS and LPFT.	31/12/2019	BC developed and approved in principle by CRIG
4081	**Quality of patient experience (corporate)** If multiple patients across a range of the Trust's services have a poor quality experience; Caused by issues with workforce culture or significant process inefficiencies and delays; It could result in widespread dissatisfaction and a high volume of complaints that leads to a loss of public, commissioner and regulator confidence.	Rayson, Martin	Reputation / compliance	Very high risk	Patient Experience Strategy and Workplan; Patient experience metrics and reporting (FFT, Care Opinion, PALS & Complaints, Healthwatch data, compliments); Patient Experience training (leadership development programmes).	High risk (12)		Low risk	31/12/2019	Staff engagement & ownership of patient experience feedback, staff morale and staff shortages; lack of pride or hope in working at ULHT translated as low energy and passion; communication features highly as a negative indicator within feedback; staff lacking awareness of the 'impact of self'; staff do not feel valued; workload and demand gives little time to provide the care to the standard aspired to leaving staff disappointed and dissatisfied.	High risk (12-16)	Human Resources	Deliver against Patient Experience workplan; provide service and divisional level patient experience reports that are useful, timely and meaningful, secure a FAB Experience champion in every directorate; promote & spread Academy of FAB NHS Stuff to highlight FAB patient experience quality projects and achievements - spreading celebration and enthusiasm to rebuild motivation and hope and passion; determine links between staff and patient experience and drill down to team level to support improvements and interventions; provide data that delivers confidence that this is what staff and patients are saying about their experience within that service - and then support that service to design and deliver improvements.	30/09/2019	

Appendix I - Very high High Corporate Risks (November 2019)

ID	Title & description	Executive / divisional lead	Risk Type	Risk level (inherent)	Controls in place	Risk level (current)	Lead assurance committee	Risk level (acceptable)	Next review date	Weakness/Gap in Control	Component risk rating	Specialty	Planned actions	Action due date	Progress
4142	**Safe delivery of patient care (corporate)** If there are multiple patient incidents throughout the Trust; Caused by fundamental issues with the safe and consistent application of clinical policies, procedures, guidelines or pathways; It could result in significant harm caused to a large number of patients.	Hepburn, Dr Neill	Harm (physical or psychological)	Very high risk	Clinical policies, procedures, guidelines, pathways & supporting documentation. Clinical governance arrangements at corporate level - Quality & Safety Oversight Group (QSOG) / Patient Safety Group (PSG) & sub-groups: - Harm Reduction Group - Radiation Protection Group - Deteriorating Patient Group - Medical Devices Group - Hospital Transfusion Group - Nutrition Group Divisional Clinical Cabinets & CBU / specialty governance arrangements. Clinical staff recruitment, induction, mandatory training, registration & re-validation processes. Risk & incident management policies & procedures / Datix system. Quality & safety improvement planning process & plans. Defined safe staffing levels. Ward accreditation programme & data monitoring / review processes (including Safety Thermometer). Quality Matron team and specialist nurses (Tissue Viability; Frailty; Sepsis).	High risk (12)		Low risk	30/11/2019	Inconsistent identification of & response to deteriorating patients, including sepsis screening & intervention.	High risk (12-16)	Corporate Nursing	Design & introduce refined policies and processes for the identification of & response to deteriorating patients.	30/09/2019	Regular progress reporting through Quality & Safety Implementation Group (QSIG).
										Inconsistent levels of compliance with the Trust's Local Safety Standards for Invasive Procedures (LocSSIPs), particularly outside of the operating theatre environment, which increases the likelihood of a Never Event occurring.	Moderate risk (8-10)	Quality & Compliance	Conduct an initial review of compliance with LocSSIPs to identify areas for improvement.	31/10/2019	
										Development of the WebV system for handover has been delayed due to lack of dedicated project manager; potential adoption of the Nervecentre system is not possible until 2021. Presently there is no Trustwide handover IT system in place.	High risk (12-16)	Information & Communications Technology	Development of the WebV system for handover process Trustwide. Requires a business case for investment and project management with the supplier.	31/03/2020	Associate Director of ICT to be invited to PSG in August to discuss project management options.
										Inconsistent application of clinical pathways and guidelines for pneumonia, leading to increased mortality risk.	Moderate risk (8-10)		Pneumonia Task & Finish Group to oversee completion of CQUINS Action Plan.	31/03/2020	Business case in development for audit function.
4145	**Compliance with safeguarding regulations & standards (corporate)** If the Trust is found to be systemically non-compliant with safeguarding regulations and standards; Caused by fundamental issues with the design or application of local policies and procedures; It could result in the imposition of sanctions by the Care Quality Commission (CQC), NHS Improvement or local Clinical Commissioning Groups (CCGs) including warning or prohibition notices and financial penalties.	Bagshaw, Victoria	Reputation / compliance	Very high risk	Safeguarding policies, guidance, systems and supporting documentation. Chaperone policy supported by guidance, posters and training. Mandatory safeguarding training (role-based) as part of Core Learning; accountability through performance reviews and Ward Accreditation. Safeguarding Group & sub-group governance structure. Specialist advice & support from the Safeguarding team. Datix incident reporting & investigation processes. Safeguarding compliance monitoring / auditing.	High risk (12)		Low risk	30/11/2019	Inconsistent compliance with Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLs) and Trust safeguarding policy requirements (e.g. Failure to recognise the need to assess capacity & make a DoLS application) picked up by regular audits.	Moderate risk (8-10)	Safeguarding	Increase visibility of the Safeguarding team who are providing advice, support and supervision to staff to bridge theory practice gap; Monthly audits to monitor progress which are reported through operational group and committee; Benchmarking data being explored.	30/11/2019	Lead professional for MCA reports that although MCA audits continue to show areas of concern they are showing a significant increase in knowledge and compliance. This is supported by CCG and CQC feedback. There remains some cases where there is clear evidence of lack of compliance with policy for example SI investigation. Monitoring will continue through audit and review of incidents, complaints and concerns. On this basis risk reduced to moderate.
										Not yet consistently achieving 90% compliance with safeguarding training requirements.	Moderate risk (8-10)	Safeguarding	Confirm that safeguarding training completion continues to be included in performance framework with compliance reviewed and managers held to account through operational performance management reviews; individual accountability to be managed through appraisal process.	30/11/2019	9/8/19 Training compliance is consistently not achieving the 90% trajectory. Monitoring and reporting of this will continue through Safeguarding Group.
										Capacity within the Safeguarding team affecting the ability to fulfil all statutory responsibilities of their roles (e.g. Domestic Homicide and Serious Case Reviews) and deliver proactive support to front-line staff.	High risk (12-16)	Safeguarding	Areas for more efficient working to be identified and improvements implemented; progress work to develop an integrated Safeguarding model for Lincolnshire that will deliver optimum benefits for Safeguarding across the county and ultimately deliver improved safeguarding outcomes for adults, children and young people in receipt of an holistic service: minimal duplication and gaps in provision (including transitions); greater innovation as future need is better anticipated; smooth patient hand-over and movement across organisational boundaries; urgent advice available via the Local Authority.	30/11/2019	Different models of working being explored. 9/8/19 -Additional temporary support is in place to support work required from the team. Will require a sustainable plan to meet the recommendations with in the Intercollegiate staffing guidance.
4146	**Effectiveness of safeguarding practice (corporate)** If there is a significant, widespread deterioration in the effectiveness of safeguarding practice across the Trust; Caused by fundamental issues with the design or application of local policies and protocols; It could result in multiple incidents of significant, avoidable harm affecting vulnerable people in the care of one or more directorates.	Bagshaw, Victoria	Harm (physical or psychological)	Very high risk	Safeguarding policies, guidance, systems and supporting documentation. Mandatory safeguarding training (role-based) as part of Core Learning. Safeguarding Committee & sub-group governance structure. Specialist advice & support from the Safeguarding team. Datix incident reporting & investigation processes. Safeguarding compliance monitoring / auditing. Learning Disability Mortality Review process (LeDeR). Safeguarding Statements of Intent (covering access to services by children, young people & adults as well as modern slavery & human trafficking).	High risk (12)		Low risk	30/11/2019	Agitated patients may receive inappropriate sedation, restraint, chemical restraint or rapid tranquilisation; policies are now in place and training is in the process of being rolled out across the Trust. Audit of the use of chemical sedation is raising concerns that the Trust policy is not consistently being adhered to: choice of drug; dose; route of administration.	High risk (12-16)	Safeguarding	Develop & roll out clinical holding training for identified staff Trust-wide. Introduce debrief process. Identify trends and themes through incidents reported on Datix. Monitor training compliance rates. Introduce audit of 5 security incidents per month from September 2018. Review of chemical sedation pathway.	30/11/2019	9/8/19 Clinical Holding Level 4 training (2 day) compliance at 69% from staff identified as requiring training as virtue of their role would be responders to urgent assistance calls. In addition staff from other roles such as portering/security ,safeguarding and training have attended. 67% of identified staff have attended the level one day training. Further training dates are available and training needs analysis being refreshed to reflect staff changes and to establish if any further courses require commissioning. Outstanding staff will be monitored on an individual basis to prioritise booking and completion. Learning events/debrief process provide scrutiny(in place of audit of 5 security incidents per month).Safeguarding team are alerted to datix incidents from security or involving vulnerable patients. Monthly chemical sedation audits continue to be undertaken by Safeguarding team and show improvements in compliance.Process in place for clinical areas to escalate to Matron when chemical restraint has been used to allow for review of episode of care. Rapid Tranquilisation policy has been reviewed and incorporates new pathways to support staff. Currently in consultation process prior to submission to CESG. Local training package on use of chemical restraint in development by Safeguarding Lead, delivery will be supported by the Clinical Education team.
										The Trust has no agreed pathway for referring clinicians, both internal and external, for patients with significant learning disabilities and challenging behaviours and no pathway to achieve a General Anaesthetic for procedures such as blood tests/ MRI, etc. This can lead to sub-optimal care and delays in diagnosis or treatment.	High risk (12-16)	Safeguarding	Development of an appropriate pathway for patients with learning disabilities: Plans currently made on an individual basis however this results in delays; task and finish group to scope extent of issues and to progress pathway development.	30/11/2019	Draft pathway developed and under consultation. 9/8/19 Plan for key stakeholders to meet to agree pathway prior to submission to CESG for approval.
										There is no mandatory, core learning or core learning plus formal training programme provision within the Trust for: 1. Mental Health - awareness; responsibilities in relation to administering the Mental Health Act, ligature risk 2. Learning disability - awareness, care in hospital and reasonable adjustments 3. Autism - - awareness, care in hospital and reasonable adjustments	Moderate risk (8-10)	Safeguarding	1. Liaise with training and development department to resubmit applications for core learning. 2. Liaise with clinical education department to determine numbers and reach of HEE funded programme. 3. Refresh training needs analysis to incorporate Autism developments. 4. Ensure reflected within MHLD&A Strategy and associated work-plan.	30/11/2019	Mental Health Awareness Core learning training developed and available from 1st July 2019. As of 25th July 2019 49.66% of required staff had completed it. Compliance and impact will be monitored through MHLDA group. Update reports received by Safeguarding Group.

Appendix I - Very high High Corporate Risks (November 2019)

ID	Title & description	Executive / divisional lead	Risk Type	Risk level (inherent)	Controls in place	Risk level (current)	Lead assurance committee	Risk level (acceptable)	Next review date	Weakness/Gap in Control	Component risk rating	Specialty	Planned actions	Action 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.	High risk (12-16)	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.	31/03/2020	Action plan to be reassigned to appropriate lead once in post.

Appendix I - Very high High Corporate Risks (November 2019)

ID	Title & description	Executive / divisional lead	Risk Type	Risk level (inherent)	Controls in place	Risk level (current)	Lead assurance committee	Risk level (acceptable)	Next review date	Weakness/Gap in Control	Component risk rating	Specialty	Planned actions	Action due date	Progress
4156	**Safe management of medicines (corporate)** If there are multiple, widespread failings in the safe management of medicines across the Trust; Caused by issues with the design or application of medicines safety policies and procedures; It could result in multiple incidents of significant, avoidable harm to patients in the care of one or more directorates.	Costello, Colin	Harm (physical or psychological)	Very high risk	Medicine safety policies & procedures. Medicine management governance arrangements (including audit & performance monitoring). Medicine safety training & education programmes. Pharmacy support and advice service. Pharmacy facilities & specialist equipment. Incident reporting and investigation systems & processes (Datix).	High risk (12)		Low risk	30/11/2019	The Trust currently uses a manual prescribing process across all sites, which is vulnerable to human error that increases the potential for delayed or omitted dosages; moving of charts from wards; and medicines not being ordered as required.	High risk (12-16)	Pharmacy	Planned introduction of an electronic prescribing system across the Trust, to eliminate some of the risks associated with manual prescribing.	31/03/2020	
										Pharmacy is not sufficiently involved in the discharge process or medicines reconciliation, which increases the potential for communication failure with primary care leading to patients receiving the wrong continuation medication from their GPs.	High risk (12-16)	Pharmacy	Routine monitoring of compliance with electronic discharge (eDD) policy. Request for funding to support additional pharmacy resources for involvement in discharge medicine supply.	31/03/2019	
										The Trust routinely stores medicines & IV fluids on wards in excess of 25 degrees (& in some areas above 30 degrees). This is worse in summer months. These drugs may not be safe or effective for use.	High risk (12-16)	Pharmacy	Introduction of electronic temperature monitoring systems for all drug storage areas to enable central monitoring. Capital investment required. Contingency ward monitoring of temperatures & escalation of issues.	31/12/2019	
										Inappropriate storage of refrigerated medicinal products (fridges constantly going above 8 degrees) due to lack of fridge(s) space. Periods of time where storage requirements are compromised has the potential to affect the stability of the products and therefore could have impact on patient treatment.	Very high risk (20-25)	Pharmacy	Temperatures of refrigerated medicinal products to be monitored continuously. Additional fridges required in order to ensure appropriate storage and product quality and comply with standards. Business case to request additional funding for fridges completed and approved. Fridges being purchased.	31/03/2019	
										Inadequate and unsecure storage and stock accountability of medical gas cylinders at all sites. Modifications required to meet standards and improve security.	Moderate risk (8-10)	Pharmacy	Risk regarding unsecure storage and stock accountability of medical gas cylinders at all sites to be assessed with local security management specialist; recommendations will include new lighting to storage buildings, surveillance cameras, effective alarm system and new doors to replace weak hinges and stronger locks.	30/06/2019	
4157	**Compliance with medicines management regulations & standards (corporate)** If the Trust is found to be systemically non-compliant with medicines management regulations and standards; Caused by fundamental issues with the design or application of local policies and procedures; It could result in the imposition of sanctions by regulators such as the Care Quality Commission (CQC), NHS Improvement and the Medicines and Healthcare products Regulatory Agency (MHRA) or local Clinical Commissioning Groups (CCGs) including warning or prohibition notices and financial penalties.	Costello, Colin	Reputation / compliance	Very high risk	Medicines management policies, guidance, systems and supporting documentation. Medicines Safety Committee & sub-group governance structure. Mandatory medicines management training as part of Core Learning for clinical staff. Specialist advice & support from the Pharmacy team. Datix incident reporting & investigation processes. Root cause analysis of serious medications incidents. Pharmacy compliance monitoring / auditing.	High risk (12)		Low risk	30/11/2019	The Trust currently uses a manual prescribing process across all sites, which is inefficient and presents challenges to auditing and compliance monitoring.	High risk (12-16)	Pharmacy	Planned introduction of an auditable electronic prescribing system across the Trust.	31/03/2020	
										Compliance with Falsified Medicines Directive (FMD) legislation (Directive 2011/62/EU) is mandatory from February 2019, aiming to provide assurance to patients that the medicines they are supplied are not counterfeit or 'Falsified Medicines' that might contain ingredients, including active ingredients, which are not of a pharmaceutical grade or incorrect strength or indeed may contain no active ingredient. Falsified medicines are considered a major threat to public health with seizures by regulators increasing annually across the globe. We do not currently have a plan in place to ensure that we will comply with this legislation, and be able to robustly provide the necessary assurance to patients.	High risk (12-16)	Pharmacy	The FMD legislation requires that a system be established to enable all pharmaceuticals to be tracked through the supply chain, from manufacturer, via wholesalers, to pharmacy and to end user, and will be facilitated through the use of 2D barcode scanning technology. The Trust will work regionally with wholesalers and pharmacy computer system providers. Funding for new equipment is likely to be needed.	30/06/2019	
										Administration of medication by pharmacy technicians including oral, intravenous, NG and PEG - legislation, governance and training issues. The Medicines Regulations 2012 specified that parenteral products can be legally administered by persons acting under the instruction of a legally valid appropriate prescriber (as shown in Regulation 214). Pharmacy technicians could also adopt this role in clinical areas in the Trust. However, his practice has not been approved and accepted by the Trust and is not embedded into the Medicines Management policy.	High risk (12-16)	Pharmacy	To define the process for administration of medicines by pharmacy technicians and their supervision and training. To embed the process in the Medicines Management Policy.	30/09/2019	
										There is not full assurance that the new pharmacy technician roles and practices are acceptable in terms of professionally registered practice and that professional codes of practice are being correctly adhered to.	High risk (12-16)	Pharmacy	To establish the professional supervision and development of the new roles. To take advice from the General Pharmaceutical Council (GPhC) and NHSI to ensure the new roles are covered by the relevant professional codes of practice.	30/09/2019	
4041	**Safe and responsive delivery of Non-Invasive Ventilation (NIV)** If there are delays in the identification or treatment of patients requiring or receiving Non-Invasive Ventilation (NIV) within the Trust; Caused by issues with staffing capacity or capability, equipment availability, bed availability, the design or application of systems and processes; It could result in severe, permanent harm or the death one or more patients.	Bagshaw, Victoria	Harm (physical or psychological)	Very high risk	Guidelines and Care Pathway for commencing Non-invasive Ventilation (NIV) in the non-ITU setting. Governance arrangements within Medicine Division. National & local audits of compliance with best practice guidelines. NIV Quality & Safety Improvement Group established with membership from Respiratory teams from all 3 sites. Carlton-Coleby Ward (LCH) is established for 4 NIV beds, with 6 NIV machines (4 installed 2009; 1 in 2011; 1 in 2018). Ward 7B (PHB) is established for 2 NIV beds, with 4 NIV machines (2 installed in 2007; 1 in 2017; 1 in 2018). Additional NIV machine available in Clinical Engineering if needed. Acute Care Unit at GDH is established for 3 NIV beds. Escalation process in place. Authorisation to increase staffing capacity through the use of Bank, overtime and agency. Oxygen saturation monitoring in place and cardiac monitoring can be accessed via the Outreach Team if any concerns re potential 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)		Low risk	31/12/2019	1. Treatment may not commence within 1 hour of decision to treat if NIV bed unavailable on the ward or if insufficient nurse capacity. 2. NIV may be the ceiling of care which would deem a patient not suitable for admission to an ICU bed; if a patient were then admitted to ICU it may be unsuitable for the patient and would be in breach of Critical Care Network agreed policies. 3. Supply of Bank and Agency staff with NIV competencies is limited and may involve use of Tier 4 agencies. 4. Recruitment of nurses with required skills to vacancies on Ward 7B (PHB). 5. Inconsistent adherence to the NIV Care Pathway.	High risk (12-16)	Respiratory Medicine	1. SOP to be developed for commencement of NIV in Emergency Departments. 2. Escalation Process for Ward Based NIV Capacity developed. 3. Capacity & demand being reviewed with the aim of increasing established, trained staff levels. 4. On-going competency training in place for all nurses. 5. NIV to review audit results and agree appropriate action.	31/03/2020	Action plan kept under regular review by the NIV Group, which meets quarterly. Next meeting September 2019.

Appendix I - Very high High Corporate Risks (November 2019)

ID	Title & description	Executive / divisional lead	Risk Type	Risk level (inherent)	Controls in place	Risk level (current)	Lead assurance committee	Risk level (acceptable)	Next review date	Weakness/Gap in Control	Component risk rating	Specialty	Planned actions	Action due date	Progress
4423	**Working in partnership with the wider system (corporate)** If the Trust fails to work effectively in partnership with the wider system, including other healthcare providers and commissioners; Caused by issues with the planning process, the availability of sufficient resources or the effectiveness of partnership governance arrangements; It could result in significant disruption to the provision and sustainability of multiple services that has a long term impact on the experience and quality of care for a large number of patients.	Hepburn, Neill	Service disruption	Very high risk	Sustainability & Transformation Partnership (STP), including ULHT; LCHS' LPFT; & others. STP partnership governance arrangements. STP planning & delivery mechanisms. Lincolnshire Coordinating Board (including chairs of each partner organisation).	High risk (12)		Low risk	30/09/2019	Failure to work effectively in partnership may result in some ULHT services having demand that exceeds capacity; failure to work with other providers and CCGs may also result in the viability of ULHT services being jeopardised. Failure to progress on taking forward the Acute Services Review may result in some existing fragile services failing, or some services becoming fragile.	High risk (12-16)		Re-assessment of strategic risk and development of appropriate mitigations.	31/03/2020	Continued engagement with the STP delivery process through established governance arrangements.
4437	**Critical failure of the water supply (corporate)** If there is a critical failure of the water supply to one or more of the Trust's hospital sites; Caused by the age and condition of water pipes, or a major incident which damages the infrastructure; It could result in significant, prolonged disruption to multiple services throughout the site, impacting on the experience and care of a large number of patients and the productivity of a large number of staff.	Boocock, Paul	Service disruption	Very high risk	Estates Investment & Environment Group oversight. Water Safety Group operational governance. Capital & revenue prioritisation & investment procedures. Planned Preventative Maintenance (PPM) programme. Management of critical infrastructure risk (CIR) and backlog maintenance quantification. Appointed Authorising Engineer (Water). Emergency & business continuity plans for infrastructure failure / evacuation / relocation.	High risk (12)		Low risk	31/10/2019	Pilgrim Hospital is served by only one incoming water main. This is in very poor condition and has burst on several occasions causing loss of supply to the site.	High risk (12-16)	Estates	Regular inspection, automatic meter reading and telemetry for the incoming water main at Pilgrim Hospital. Install additional supply to provide resilience.	31/12/2019	Scheme of work and design currently being produced.
4385	**Compliance with financial regulations, standards & contractual obligations (corporate)** If the Trust is found to be systemically non-compliant with financial regulations & standards & or is unable to meet its contractual payment obligations; Caused by issues with the design or application of financial and contract management policies and procedures, or the availability of sufficient cash to meet payment obligations; It could result in regulatory action and sanctions or legal action which damages the reputation of the Trust amongst key stakeholders and may lead to sustained adverse local and / or social media coverage.	Matthew, Paul	Reputation / compliance	Very high risk	Financial governance & compliance monitoring arrangements. Trust Board approval of borrowing. Scheme of delegation & authority limits. Financial management policies, procedures, systems & training. Working capital strategy; prioritisation of payroll & critical supplier payments and escalation through Trust Board to NHSI. Cash forecasting and reconciliation processes. Contingency fund balance. Self-assessment & management processes for statutory & regulatory requirements. Annual internal audit plan. External audit annual report.	High risk (12)		Low risk	31/10/2019	The Trust has a financial deficit and is therefore not able to meet its statutory obligation to break even.	High risk (12-16)	Finance	In Financial Special Measures; agreed Financial Recovery Plan to return the Trust to a sustainable footing ove ther medium term.	31/03/2024	
3689	**Compliance with asbestos management regulations & standards (corporate)** If the Trust is found to be systemically non-compliant with asbestos management regulations and standards; Caused by issues with the design or consistent application of required policies and procedures; It could result in regulatory action and sanctions which damages the reputation of the Trust and could lead to adverse publicity, with the potential for financial penalties and disruption to services.	Boocock, Paul	Reputation / compliance	Very high risk	Estates Infrastructure and Environment Committee (EIEC). Trust Asbestos Core Working Group. Asbestos Awareness training for managers and operatives (Estates staff and contractors). Specialist contractor appointed to advise Trust on specific Asbestos management issues across sites. Site Survey data available on Micad. Third Party Contractor induction for both capital schemes and day to day maintenance. Annual Facefit training for specialist PPE equipment. Occupational Health reviews, lung function test. Specialist surveys prior to making any physical change to built-in environment. Air monitoring of specific areas to give assurance that controls in place are adequate. Risk Prioritised Estates Capital Programme. Restricted access where known asbestos containing materials (ACMs) exist (permit to work system).	High risk (12)		Low risk	31/10/2019	Asbestos Policy is overdue for review.	High risk (12-16)	Estates	Asbestos Policy to be reviewed, updated and approved by Estates Environment & Investment Committee.	31/10/2019	
										Asbestos Management Plan still to be fully developed.	High risk (12-16)	Estates	Complete development & begin implementation of Asbestos Management Plan.	31/10/2019	
										Availability of sufficient capital funding to remove Asbestos; or other higher risk competing priorities depleting capital resources.	High risk (12-16)	Estates	Involvement with Trust Capital prioritisation process to make case for Estates backlog maintenance to cover costs associated with the Asbestos Management Plan.	31/10/2019	
										Appointed Person not yet in place; Asbestos Management Structure to be agreed.	Moderate risk (8-10)	Estates	Agree Appointed Person & structure for Asbestos management.	31/10/2019	
										Continuity of contractors appointment requires resourcing and managing; verification of contractors training required.	High risk (12-16)	Estates	Review of asbestos contractors appointment & verification of training.	31/10/2019	
										No Access areas still to be surveyed for asbestos.	Moderate risk (8-10)	Estates	Asbestos re-Inspection Programme to be completed (including 'no access' areas.	31/10/2019	
										Potentially inaccurate survey data due to restricted access to areas.	Moderate risk (8-10)	Estates	Periodic review of site survey data to ensure current and up to date; Micad to go live with the Asbestos Module.	31/10/2019	
3690	**Compliance with water safety regulations & standards (corporate)** If the Trust is found to be systemically non-compliant with water safety regulations and standards; Caused by issues with the design or consistent application of required policies and procedures; It could result in regulatory action and sanctions which damages the reputation of the Trust and could lead to adverse publicity, with the potential for financial penalties and disruption to services.	Boocock, Paul	Reputation / compliance	Very high risk	Estates Infrastructure and Environment Committee (EIEC). Estates risk governance & compliance monitoring process. Trust Water Safety Group. Oversight by Infection Prevention & Control Committee (monthly report submitted by the AE). Water safety policies, procedures & training. Duty Holder, Responsible person, Site Deputy responsible persons and competent persons in place. Appointed Authorising Engineer (Water). Chlorine Dioxide Injection water treatment. Planned maintenance regime in place including written scheme of works. Site based Risk Assessments informing the Water Safety Group Management process. Water sampling, temperature monitoring and flushing undertaken; remedial actions taken in response to positive samples.	High risk (12)		Low risk	31/10/2019	Unable to comply fully with ACOP and Trust Policies for legionella monitoring due to competing priorities.	Moderate risk (8-10)	Estates	Appoint additional staff or contractor in lieu of staff to carry out work. Further actions required (subject to funding): water systems drawings are required for all sites (CAD); review and issue a Trustwide tender document for the monitoring work; to appoint a responsible person; to form a Trustwide Legionella group to consist of Facilities, Infection Prevention and Control Consultant and Nurses (sub group of Infection Prevention and Control Committee?)	31/12/2019	Legionella monitoring carried out by direct labour as far as possible with competing priorities.
										13 waste disposal units do not incorporate a 'Type A Air Gap' on the water supply inlet and therefore as they are classed as 'CAT 5 Fluid' they do not comply with the 'Water Regulations' which is a statutory regulation.	High risk (12-16)	Estates	The non-compliant units to be replaced with those which comply with the Water Regulations. Obtain costs for the supply and installation of compliant units and prepare a business case for replacement.	31/12/2019	A 'Double Check' valve has been fitted to waste disposal units to non-compliant provide a higher level of protection after discussion with Anglian Water's 'Regulations Inspector' as an 'interim measure'.
										Lack of compliance with ACOP L8 and HTM standards in respect of water schematics for the hot and cold water systems could impact on the Trust's ability to demonstrate compliance with statutory standards and potentially place service users at risk of poor water safety.	High risk (12-16)	Estates	Water flushing as per agreed IP&C Standard Operating Procedure. Surveys undertaken at Lincoln County, Pilgrim Hospital and at Grantham surveys are on-going.	31/10/2019	Funding required for replacement TMVs, sinks and hand basins. Schematics produced by surveyors have not been quality assessed and have not been stitched into Estates and Facilities master CAD models. Some funding has been identified from Facilities CIP.

Appendix I - Very high High Corporate Risks (November 2019)

ID	Title & description	Executive / divisional lead	Risk Type	Risk level (inherent)	Controls in place	Risk level (current)	Lead assurance committee	Risk level (acceptable)	Next review date	Weakness/Gap in Control	Component risk rating	Specialty	Planned actions	Action due date	Progress
										Although routine checks are undertaken, the water tanks at LCH do not comply with the Water Regulations	Moderate risk (8-10)	Estates	Replacement of non-compliant water tanks at LCH.	31/12/2019	Capital funding required.
										Trustwide Water Systems - Chlorine Dioxide Dosing System. Scotmas inform that some of the monitors are now obsolete and require replacing. BMS is now linked to Lincoln.	Moderate risk (8-10)	Estates	Specification tender for the renewal of maintenance contract. Costs are to be obtained for Pilgrim and Grantham. If it fails, Scotmas will set new controllers.	31/10/2019	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.	Moderate risk (8-10)	Estates	Completion of new water main. Automatic monitors in place. Capital investment required to mitigate this risk.	31/12/2019	Delayed completion of new water main which is required before we can gain access to complete the work required.
										The Water Safety Statutory Improvement Programme (directed by site risk assessments) may not complete on time; ongoing upgrade to sanitary ware, WHB's, Showers etc. to comply with ACOP L8 and HTMs.	Moderate risk (8-10)	Estates	Completion of the Water Safety Statutory Improvement Programme. Stringent Water sampling and flushing programs in place.	31/12/2019	Funding required to complete the programme.

Appendix I - Very high High Corporate Risks (November 2019)

ID	Title & description	Executive / divisional lead	Risk Type	Risk level (inherent)	Controls in place	Risk level (current)	Lead assurance committee	Risk level (acceptable)	Next review date	Weakness/Gap in Control	Component risk rating	Specialty	Planned actions	Action due date	Progress
3720	**Critical failure of the electrical infrastructure (corporate)** If the Trust experiences a critical failure of its electrical infrastructure; Caused by issues with the age and condition of essential equipment and the availability of resources required to maintain it; It could result in significant disruption to multiple services across directorates, impacting on productivity and the experience of a large number of patients.	Boocock, Paul	Service disruption	Very high risk	Estates Infrastructure and Environment Committee (EIEC). Estates Strategy. Estates capital investment programme. Estates revenue investment programme. Management of critical infrastructure risk (CIR) and backlog maintenance quantification. Planned Preventative Maintenance (PPM) / testing. Emergency & business continuity plans for infrastructure failure / evacuation / relocation. Authorising engineers for water, ventilation and medical gas pipeline systems appointed. Statutory insurance inspections carried out by the Trusts appointed insurance company. Compliance monitoring - NHS PAM / MiCAD systems. Compliance monitoring of 3rd party premises.	High risk (12)		Low risk	31/10/2019	Potential for Electrical Infrastructure Breakdowns at LCH due to poor condition of distribution systems.	High risk (12-16)	Estates	Regular Inspection & Essential repairs are carried out as necessary. Funding required to upgrade Infrastructure.	31/12/2019	Estimated cost £50k +vat.
										Electrical Infrastructure at Pilgrim Hospital is in poor condition and needs significant investment to eliminate backlog maintenance, reduce maintenance costs, maintain capacity of the estate to deliver clinical activity.	High risk (12-16)	Estates	Regular inspection & urgent repairs as required. Identify backlog maintenance funding and capital funding. Allocate funding through the Facilities Capital allocations.	31/12/2019	
										Potential for failure of Electrical Infrastructure at GDH resulting in service interruption, fire and closure of clinical services. The site has an aging electrical infrastructure and some of the switchgear is obsolete and in need of replacing. It does not comply with current IET wiring regulations (BS7671). 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	High risk (12-16)	Estates	Capital investment required to upgrade electrical infrastructure at GDH.	31/12/2019	Capital funding applied for.
4176	**Management of demand for planned care (corporate)** If demand for planned care (elective, outpatient and diagnostic services) significantly exceeds the ability of the Trust to manage it; Caused by an unexpected surge in demand, operational management issues within other healthcare providers or a reduction in capacity and capability within ULHT; It could result in a significant, prolonged adverse impact on the quality and productivity of services across multiple directorate and / or sites affecting a large number of patients and the achievement of national NHS access standards.	Brassington, Mr Mark	Service disruption	Very high risk	Divisional capacity management processes. Corporate assurance processes including weekly PTL & fortnightly recovery & delivery meetings. Specialty recovery plans. System-wide planned care group driving reduced referrals into secondary care. Annual capacity & demand planning process. Productive services work-streams including: outpatients; theatres; endoscopy.	High risk (12)		Low risk	31/10/2019	Too much inappropriate activity defaults to ULHT. Sustainability of a number of specialties due to workforce constraints. Availability of physical assets & resources (e.g. diagnostic equipment; outpatient space; inpatient beds). ASR / STP not agreed / progressing at required pace (left shift of activity).	High risk (12-16)	Operations	System-wide planned care group setting up referral facilitation service & 100 day improvement programme, amongst other projects. Local mitigations in place including locum workforce; recruitment & retention premium; altering the model of working. Capital plan for estate development, space utilisation and medical equipment.	31/03/2020	Progression of 2021 Strategy. Engagement in local Acute Services Review (ASR) & Sustainability & Transformation Partnership (STP).
4368	**Management of demand for outpatient appointments (corporate)** If the Trust's Outpatient Services are unable consistently to manage the level of demand for appointments; Caused by issues with the design or application of demand management systems and processes; It could result in a significant reduction in the quality and continuity of outpatient services across multiple directorates and failure to achieve NHS constitutional standards, affecting a large number of patients.	Rinaldi, Dr Ciro	Service disruption	Very high risk	Governance & performance management arrangements. Outpatient Improvement Group. Clinical policies, guidelines and pathways. Staff recruitment, induction & training policies & programmes. Access management policies, guidelines & staff training. Medway patient administration system. Self-assessment & performance management processes for national requirements. Patient Tracking List (PTL) validation & management processes. Approval policy for clinic cancellation with less than 6 weeks notice (Deputy Director level). Weekly PTL meetings. Incident reporting and management systems and processes (Datix).	High risk (12)		Low risk	30/11/2019	Potential for failure to meet national targets of 52 weeks for clinic waiting times due to patients not appearing on PTL & Business Units occasionally lacking visibility of long waiting patients.	High risk (12-16)	Operations	Information Support team to develop further reports to minimise number of patients not been visible in PTL.	31/12/2019	Requested further information from performance team to understand discussions at PTL meetings. Information are producing an extra report for all 40week+ patients regardless of RTT status for validation, also further DQ checks have been completed on specific cohorts of patients to improve DQ.
										Capacity to record e-outcomes onto Medway in a timely manner; Consultants not taking ownership of completing e-outcomes. May lead to Missing Outcomes not being completed & consequent delayed treatment.	Moderate risk (8-10)	Operations	Short term solution to offer overtime to reduce the number of patients outstanding in the report to within 48hours. Business case to be investigated and written to allow e-outcomes to update Medway with the outcomes.	31/12/2019	Missing Outcomes transposing of outcomes is currently about 10 days behind on LCH site. Overtime being offered to reduce timeframes. All other sites being completed within 2 working days. Increase in number of outcomes not being completed by clinicians, this is being highlighted to DMD's for action. Business case for API links agreed by CRIG, delays in implementation occurring due to upgrades by 3rd parties need to happen first. Further update due [illegible]
										Capacity gaps within individual specialities, and with outpatients from a staffing / estates perspective increase the potential for appointment delays due to issues with the management of overdue new referrals; Appointment Slot Issues (ASIs); and the Partial Booking Waiting List (PBWL) for management of Overdue follow-ups.	High risk (12-16)	Operations	Clinical Directorates to provide trajectories for recovery plans - monitored at fortnightly RTT Recovery and Delivery Groups. Detailed plans at speciality level. C&A manually drawing down referrals from ASI list.	30/11/2019	CBU Recovery plans submitted to the performance team and they are tracking performance against trajectory. Performance being monitored at Delivering Productive Services Group.
										Overdue new appointments may be incorrectly added / unvalidated on the Open Referrals worklist . The New Booking team identify 'other' new patient referrals added to the Open Referral worklist by other parties in BU's. As the New Booking Team did not make the entry they are unable to validate the referral.	High risk (12-16)	Operations	The Trust was required to be fully compliant with an electronic booking system with a target set by NHSI of June 2018.	31/12/2019	The Trust is fully compliant with the NHSI requirement to be receiving GP requests to first consultant led appointment by eRS. It is those referrals that do not fit the specific criteria of the NHSI scheme that could lead to un-validated patients on the open referral worklist. Further work required with information support and the booking team to ensure all patients are identified and validated.
4179	**Major cyber security attack (corporate)** If the Trust is subject to a major cyber security attack that breaches its network defences; Caused by the exploitation of an existing vulnerability or the emergence of a new type of threat; It could result in loss prolonged, widespread loss of access to ICT systems throughout the Trust which disrupts multiple services and affects a large number of patients and staff.	Humber, Michael	Service disruption	Very high risk	ICT network security arrangements. Network performance monitoring. Cyber security alerts from NHS Digital (CareCerts) ICT hardware & software upgrade programme. NHS Data Security Protection Requirements (DSPR). Corporate and local business continuity plans for loss of access to ICT systems. Mandatory major incident training for all staff (part of Core Learning). Installation of Site based Firewalls with full Traffic inspection enabled.	High risk (12)		Low risk	31/12/2019	A structured framework approach to cyber security would provide more reliable assurance that existing measures are effective and support any necessary improvement work.	Moderate risk (8-10)	Information & Communications Technology	The Trust is working towards compliance with standards in the NHSD DSPT as updated in 2019	31/03/2020	The DPST was updated nationally to include the requirements of Cyber Essentials and other national requirement's. The Trust is working towards meeting this for march 2020 return.
										Availability of sufficient funds to support required hardware & software upgrades & deliver the digital strategy, with increasing scale of threat which may leave the network vulnerable to attack.	High risk (12-16)	Information & Communications Technology	Prioritisation of available capital and revenue resources to essential cyber security projects through the business case approval process.	31/03/2020	For financial year 19/20 no Trust capital has currently been provided to any Business as Usual schemes. Affecting the ability to continue in delivery schemes Move forward with in plan schemes Delays will affect the strategy as attack vectors and methods are constantly evolving
										Digital business continuity & recovery plans are in place but need to be updated with learning from the 'Wannacry' incident (May 2017) and routinely tested.	Moderate risk (8-10)	Information & Communications Technology	Digital business continuity & recovery plans to be updated & tested at STP level. ICT plan to engage an independent security consultant to advise on any further action required.	31/12/2019	The BCP and Disaster plan has been updated A test of the plan is scheduled for the 31st July 2019, to desktop test the current plan.
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;	Hepburn, Dr Neill	Reputation / compliance	Very high risk	Clinical governance arrangements in place at corporate level: Quality & Safety Oversight Group (QSOG) / Clinical Effectiveness Group. Clinical policies, guidelines and best practice management processes.	High risk (12)		Low risk	30/11/2019	Infrastructure is in place for divisional management of clinical policies; guidelines; best practice and clinical audit. Issues with time allocation within job plans for divisional leads to deliver against requirements.	High risk (12-16)	Quality & Compliance	Development & implementation of regular divisional reports to provide a comprehensive overview of clinical effectiveness.	31/03/2020	Report template in development.

Appendix I - Very high High Corporate Risks (November 2019)

ID	Title & description	Executive / divisional lead	Risk Type	Risk level (inherent)	Controls in place	Risk level (current)	Lead assurance committee	Risk level (acceptable)	Next review date	Weakness/Gap in Control	Component risk rating	Specialty	Planned actions	Action due date	Progress
	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.				National clinical audit programme management processes. Local clinical audit programme management processes.					Oversight of clinical effectiveness is not current part of the divisional Performance Review Meeting (PRM) process.	Moderate risk (8-10)	Quality & Compliance	Integration of routine oversight of clinical effectiveness as part of the divisional Performance Review Meeting (PRM) process through the introduction of appropriate KPIs.	31/03/2020	
										Insufficient staffing resources within the established Clinical Effectiveness central support team.	High risk (12-16)	Quality & Compliance	Restructure of the Clinical Governance directorate to increase and redesign establishment to provide an appropriate level of support to divisions.	31/12/2019	
4467	**Impact of a 'no deal' EU Exit scenario (corporate)** If the UK leaves the European Union without a deal in place; Caused by failure to agree terms; It could result in prolonged, widespread disruption to the health and social care sector that has a significant adverse impact on the continuity of services provided by the Trust.	Brassington, Mr Mark	Service disruption	Very high risk	COO appointed as Senior Responsible Office (SRO) for EU Exit preparations. UK Government guidance on: - the regulation of medicines; medical devices; and clinical trials - ensuring blood and blood products are safe - quality and safety of organs; tissues; and cells UK Government contingency plans for continued supply of: - medical devices and clinical consumables - medicines (6 weeks supply), including prioritised freight capacity and arrangements for air freight of medicines with short shelf-lives NHS Supply Chain systems & processes ULHT Business Continuity Policy & service-specific contingency plans ULHT EU Exit Planning Group: - local risk assessment, covering: potential demand increase; supply of medicines, medical devices & clinical consumables; supply of non-clinical goods & services; EU workforce; reciprocal healthcare; research & clinical trials; data sharing & security.	High risk (12)		Low risk	31/12/2019	The supply of medicines & vaccines may be disrupted in the event of a 'no deal' EU Exit.	High risk (12-16)	Pharmacy	Completion of all required actions in respect of medicines and vaccines, as detailed in the national EU Exit guidance. Specific instruction not to stockpile medicines or to prescribe extra medicines.	31/12/2019	Current Pharmacy stock holding of around 27 days. Local protocol for management of short supply medicines. Most significant residual risk concerns high-cost drugs that cannot readily be switched to an alternative. Supply chain heavily reliant on national arrangements. MoU in place to support transfer of medicines between providers if needed.
										The supply of medical devices & clinical consumables may be disrupted in the event of a 'no deal' EU Exit. Some parts for diagnostic machines used in Radiology & Cardiology (Cath Lab imaging systems; MRI compatible monitors – two out of support monitors, two MRIs) are obtained from Germany, which may lead to delays in fulfilling orders. There are BC plans in place, including back-up machines and some spare parts held, but not all possibilities can be covered. Availability of single-use consumable accessories for medical devices that are used constantly across the trust is also of concern.	Moderate risk (8-10)	Finance	Completion of all actions in respect of medical devices & clinical consumables, as detailed in the national EU Exit guidance.	31/12/2019	Supply chain heavily reliant on national arrangements. Local supplier risk assessment complete. Monitoring for further developments. National arrangements extended to cover additional high risk suppliers based on organisational risk assessments. Concern that we do not have assurance about plans to manage the traffic impact of Immingham being opened up to increase port capacity – to be escalated through SCG to the Dept of Transport/Highways Agency.
										The supply of non-clinical goods and services may be disrupted in the event of a 'no deal' EU Exit. There are some concerns regarding the supply of food, as 30% comes from the EU and import delays would affect perishable goods.	Low risk (4-6)	Finance	Completion of all required actions in respect of non-clinical goods and services, as detailed in the national EU Exit guidance. The DHSC has issued updated guidance on supply of food, advising a common sense approach in the event of short-term shortages.	31/12/2019	Supply chain heavily reliant on national arrangements. Local supplier risk assessment complete. Monitoring for further developments. National arrangements extended to cover additional high risk suppliers based on organisational risk assessments.
										The supply of workforce may be disrupted in the event of a 'no deal' EU Exit. Concern emerging that under a 'no deal' scenario a DBS check for a European national maybe subject to a long delay.	Moderate risk (8-10)	Human Resources	Completion of all required actions in respect of the workforce, as detailed in the national EU Exit guidance.	31/12/2019	General message regarding settlement scheme & registration sent out. Approx 300 affected staff. Concern that DBS check for a European national maybe subject to a long delay. Memorandum of Understanding has been agreed for staff sharing within Lincolnshire.
										Existing arrangements in relation to reciprocal healthcare may be disrupted in the event of a 'no deal' EU Exit.	Low risk (4-6)	Finance	Completion of all required actions in respect of reciprocal healthcare, as detailed in the national EU Exit guidance.	31/12/2019	Concern over staffing capacity to deal with a potential increase in overseas visitor screening and billing/payment processing.
										Existing arrangements in relation to Research & Clinical Trials may be disrupted in the event of a 'no deal' EU Exit.	Low risk (4-6)	Research and Development	Completion of all required actions in respect of Research & Clinical Trials, as detailed in the national EU Exit guidance.	31/12/2019	All sponsors are UK-based and actively working to ensure continuity of drug supply. ULHT is not a sponsor for any of the 38 current trials. Some trial drugs come from the EU. Current trials to be risk assessed against threat from a 'no deal' scenario.
										Existing arrangements for data sharing, processing & access may be disrupted in the event of a 'no deal' EU Exit.	Moderate risk (8-10)	Information & Communications Technology	Completion of all required actions in respect of data sharing, processing & access, as detailed in the national EU Exit guidance. Instruction to follow advice from The Department for Digital, Culture, Media and Sport and the ICO and to complete the annual Data Security and Protection Toolkit assessment as early as possible.	31/12/2019	Local risk assessment carried out did not identify any significant data sharing implications.
										Existing arrangements for the recording of costs may not cover all aspects of preparing for and responding to a 'no deal' EU Exit.	Low risk (4-6)	Finance	Completion of all required actions in respect of finance (recording of costs), as detailed in the national EU Exit guidance.	31/12/2019	Processes in place to record costs associated with Brexit planning. Agreed to include all related costs, included opportunity costs (staff time).
										Existing arrangements for communications may not cover all aspects of preparing for and responding to a 'no deal' EU Exit.	Moderate risk (8-10)	Communications & Engagement	Completion of all required actions in respect of communications, as detailed in the national EU Exit guidance.	31/12/2019	Use of traditional and social media channels to provide up to date information to staff and patients; managed in conjunction with Local Health Resilience Partnership (LHRP) communications teams and into the Local Resilience Forum (LRF).
4082	**Workforce planning process (corporate)** If there is a fundamental failure in the Trust's workforce planning process; Caused by issues with the design or application of the process, the availability of accurate workforce information or the capability to utilise it; It could result in significant, prolonged disruption to multiple services across directorates and potential unplanned closure of one or more services.	Rayson, Martin	Service disruption	Very high risk	Workforce strategy & improvement plans. Workforce planning processes. Workforce management information. Recruitment framework & associated policies, training & guidance. Rota management systems & processes. Bank, locum & agency temporary staffing arrangements. Operational governance arrangements.	High risk (12)		Moderate risk	30/11/2019	Capacity within the business to support the process and recognition of its priority is an inhibiting factor, which is less within the direct control of HR.	Very high risk (20-25)	Human Resources	KPMG are providing additional capacity and capability. Created temporary team to take forward work aligned to CSR. Business partners to be appointed. Skill-building planned at STP level, where we also have continued support from WSP. Escalation to FRG if necessary.	31/03/2020	Greater capacity has been created in the HR team (business partners and enhanced workforce information function) to support workforce planning. New business planning process being put in place for 20/21 and workforce planning will be an integral part of that. The Clinical Services Review process is in place and includes a workforce planning element. Workforce planning is also taking place at a system level. Further review at the end of the business planning process.
3503	**Sustainable paediatric services at Pilgrim Hospital, Boston (Children & YP CBU)** If the Trust is unable to maintain the full range of paediatric services at Pilgrim Hospital, Boston; Caused by issues with the recruitment or retention of sufficient numbers of staff with the required skills and experience; it could result in extended, unplanned closure of the service or significant elements of it, impacting on the care and experience of a large number of patients and on the provision of interdependent services across the region.	Joachim, Suganthi	Service disruption	Very high risk	Workforce planning systems & processes. Workforce management information. Recruitment framework & associated policies, training & guidance. Rota management systems & processes. Bank, locum & agency temporary staffing arrangements. Operational governance arrangements for paediatric services. Project Manager appointed to coordinate review & development of future service model.	High risk (12)		Low risk	30/11/2019	Issues with recruiting and retaining sufficient numbers of middle grade doctors to safely maintain paediatric services at PHB.	High risk (12-16)	Paediatric Medicine	Interim paediatrics service model in place; dependent upon locum staffing and therefore vulnerable and not cost effective or sustainable.	30/03/2020	
										Concerns about limited supervisory resource for trainee doctors at PHB could result in withdrawal of trainees by HEE.	High risk (12-16)	Paediatric Medicine	Interim arrangements in place to provide sufficient supervision in order to maintain supply of trainee doctors. Sustainable position is dependent upon agreement and resourcing of long-term service model.	31/03/2020	
										Long term service model not yet agreed; until this is agreed and in place the service remains vulnerable to staffing and demand management issues. Current demand is lower than expected (for reasons unknown).	High risk (12-16)	Paediatric Medicine	Development of sustainable long-term model for paediatrics at PHB, through the STP.	31/03/2020	

Appendix II - High Operational Risk Summary (November 2019)

ID	Title	Division	Risk Type	Rating (current)	Risk level (current)
4305	Exceeding annual budget (Specialty Medicine CBU)	Medicine	Finances	16	High risk
4311	Access to essential areas of the estate (Specialty Medicine CBU)	Medicine	Service disruption	16	High risk
4317	Exceeding annual budget (Cardiovascular CBU)	Medicine	Finances	16	High risk
4324	Access to essential areas of the estate (Cardiovascular CBU)	Medicine	Service disruption	16	High risk
4331	Exceeding annual budget (Urgent & Emergency Care CBU)	Medicine	Finances	16	High risk
4170	Workforce capacity & capability (Pharmacy)	Clinical Support Services	Service disruption	15	High risk
4297	Workforce capacity & capability (Therapies & Rehabilitation)	Clinical Support Services	Service disruption	15	High risk
4302	Workforce capacity & capability (Specialty Medicine CBU)	Medicine	Service disruption	15	High risk
4303	Safety & effectiveness of patient care (Specialty Medicine CBU)	Medicine	Harm (physical or psychological)	15	High risk
4320	Workforce capacity & capability (Cardiovascular CBU)	Medicine	Service disruption	15	High risk
4328	Quality of patient experience (Urgent & Emergency Care CBU)	Medicine	Reputation / compliance	15	High risk
4330	Workforce capacity & capability (Urgent & Emergency Care CBU)	Medicine	Service disruption	15	High risk
4334	Access to essential areas of the estate (Urgent & Emergency Care CBU)	Medicine	Service disruption	15	High risk
4340	Workforce capacity & capability (Cancer Services CBU)	Clinical Support Services	Service disruption	15	High risk
4115	Workforce capacity & capability (TACC CBU)	Surgery	Service disruption	12	High risk
4116	Availability of essential equipment & supplies (TACC CBU)	Surgery	Service disruption	12	High risk
4120	Delayed patient discharge or transfer of care (TACC CBU)	Surgery	Harm (physical or psychological)	12	High risk
4168	Availability of essential equipment & supplies (Pharmacy)	Clinical Support Services	Service disruption	12	High risk
4169	Availability of essential information (Pharmacy)	Clinical Support Services	Service disruption	12	High risk
4190	Safety & effectiveness of patient care (Surgery CBU)	Surgery	Harm (physical or psychological)	12	High risk
4191	Availability of essential equipment (Surgery CBU)	Surgery	Service disruption	12	High risk
4195	Delayed patient discharge or transfer of care (Surgery CBU)	Surgery	Reputation / compliance	12	High risk
4196	Workforce capacity & capability (Surgery CBU)	Surgery	Service disruption	12	High risk
4214	Workforce capacity & capability (T&O and Ophthalmology CBU)	Surgery	Service disruption	12	High risk
4262	Availability of essential equipment & supplies (T&O and Ophthalmology CBU)	Surgery	Service disruption	12	High risk
4304	Health, safety & security of staff, patients and visitors (Specialty Medicine CBU)	Medicine	Harm (physical or psychological)	12	High risk
4315	Delayed patient diagnosis or treatment (Cardiovascular CBU)	Medicine	Harm (physical or psychological)	12	High risk
4327	Delayed patient diagnosis or treatment (Urgent & Emergency Care CBU)	Medicine	Harm (physical or psychological)	12	High risk
4329	Safety & effectiveness of patient care (Urgent & Emergency Care CBU)	Medicine	Harm (physical or psychological)	12	High risk
4333	Delayed patient discharge or transfer of care (Urgent & Emergency Care CBU)	Medicine	Reputation / compliance	12	High risk
4372	Compliance with regulations & standards (Outpatient Services)	Clinical Support Services	Reputation / compliance	12	High risk
4373	Availability of essential information (Outpatient Services)	Clinical Support Services	Service disruption	12	High risk
4408	Safety & effectiveness of patient care (Children & Young Persons CBU)	Family Health	Harm (physical or psychological)	12	High risk
4409	Health, safety & security of staff, patients and visitors (Children & Young Persons CBU)	Family Health	Harm (physical or psychological)	12	High risk
4410	Compliance with regulations & standards (Children & Young Persons CBU)	Family Health	Reputation / compliance	12	High risk

Appendix II - High Operational Risk Summary (November 2019)

ID	Title	Division	Risk Type	Rating (current)	Risk level (current)
4420	Workforce capacity & capability (Children & Young Persons CBU)	Family Health	Service disruption	12	High risk
4425	Workforce capacity & capability (Diagnostics CBU)	Clinical Support Services	Service disruption	12	High risk
4426	Availability of essential equipment & supplies (Diagnostics CBU)	Clinical Support Services	Service disruption	12	High risk
4435	Access to essential areas of the estate (Diagnostics CBU)	Clinical Support Services	Service disruption	12	High risk
4456	Exceeding annual budget (Women's Health & Breast Services CBU)	Family Health	Finances	12	High risk
4460	Workforce capacity & capability (Women's Health & Breast Services CBU)	Family Health	Service disruption	12	High risk
4461	Safety & effectiveness of patient care (Women's Health & Breast Services CBU)	Family Health	Harm (physical or psychological)	12	High risk

NHS
United Lincolnshire Hospitals
NHS Trust

Risk Management Policy Appendix I: Risk Scoring Guide

To be used when assessing risks that are recorded on the Trust risk register (Datix).

	Severity score & descriptor (with examples)				
Risk type	**1 Very low**	**2 Low**	**3 Medium**	**4 High**	**5 Very high**
Harm (physical or psychological)	Low level of harm affecting a small number of patients, staff or visitors within a single location.	Low level of harm affecting a large number of patients, staff or visitors within a single location.	Significant but not permanent harm affecting multiple patients, staff or visitors within a single business unit.	Significant long-term or permanent harm affecting multiple patients, staff or visitors within one or more business units.	Significant long-term or permanent harm affecting a large number of patients, staff or visitors throughout the Trust.
Service disruption	Manageable, temporary disruption to peripheral aspects of service provision affecting one or more services.	Noticeable, temporary disruption to essential aspects of service provision reducing the efficiency & effectiveness of one or more services.	Temporary, unplanned service closure affecting one or more services or significant disruption to efficiency & effectiveness across multiple services.	Extended, unplanned service closure affecting one or more services; prolonged disruption to services across multiple business units / sites.	Indefinite, unplanned general hospital or site closure.
Compliance & reputation	Limited impact on public, commissioner or regulator confidence. e.g.: Small number of individual complaints / concerns received.	Noticeable, short term reduction in public, commissioner and / or regulator confidence. e.g.: Recommendations for improvement for one or more services; concerns expressed in local / social media; multiple complaints received.	Significant, short term reduction in public, commissioner and / or regulator confidence. e.g.: Improvement / warning notice for one or more services; independent review; adverse local / social media coverage; multiple serious complaints received.	Significant, long-term reduction in public, commissioner and / or regulator confidence. e.g.: Special Measures; prohibition notice for one or more services; prosecution; sustained adverse national / social media coverage.	Fundamental loss of public, commissioner and / or regulator confidence. e.g.: Suspension of CQC Registration; Parliamentary intervention; vitriolic national / social media coverage.
Finances	Some adverse financial impact (unplanned cost / reduced income / loss) but not sufficient to affect the ability of the service / department to operate within its annual budget.	Noticeable adverse financial impact (unplanned cost / reduced income / loss) affecting the ability of one or more services / departments to operate within their annual budget.	Significant adverse financial impact (unplanned cost / reduced income / loss) affecting the ability of one or more business units to operate within their annual budget.	Significant adverse financial impact (unplanned cost / reduced income / loss) affecting the ability of the organisation to achieve its annual financial control total.	Significant aggregated financial impact (unplanned cost / reduced income / loss) affecting the long-term financial sustainability of the organisation.

Likelihood score & descriptor (with examples)				
1 Extremely unlikely	**2 Quite unlikely**	**3 Reasonably likely**	**4 Quite likely**	**5 Extremely likely**
Unlikely to happen except in very rare circumstances. Less than 1 chance in 1,000 (< 0.1% probability). No gaps in control. Well managed.	Unlikely to happen except in specific circumstances. Between 1 chance in 1,000 & 1 in 100 (0.1 - 1% probability). Some gaps in control; no substantial threats identified.	Likely to happen in a relatively small number of circumstances. Between 1 chance in 100 & 1 in 10 (1- 10% probability). Evidence of potential threats with some gaps in control.	Likely to happen in many but not the majority of circumstances. Between 1 chance in 10 & 1 in 2 (10 - 50% probability). Evidence of substantial threats with some gaps in control.	More likely to happen than not. Greater than 1 chance in 2 (>50% probability). Evidence of substantial threats with significant gaps in control.

Risk scoring matrix						
Severity	**5**	5	10	15	20	25
	4	4	8	12	16	20
	3	3	6	9	12	15
	2	2	4	6	8	10
	1	1	2	3	4	5
		1	**2**	**3**	**4**	**5**
		Likelihood				

Risk rating	**Very low** (1-3)	**Low** (4-6)	**Moderate** (8-10)	**High** (12-16)	**Very high** (20-25)

Item 17.2

United Lincolnshire Hospitals NHS Trust

To:	Trust Board
From:	Karen Willey, Deputy Trust Secretary
Date:	5th November 2019
Essential Standards:	

Title:	Board Assurance Framework (BAF) 2019/20

Author/Responsible Director: Karen Willey, Deputy Trust Secretary/Jayne Warner, Trust Secretary

Purpose of the Report:

To present the 2019/20 Board Assurance Framework

The Report is provided to the Board for:

Decision		Discussion	X
Assurance		Information	X

Summary/Key Points:

The 2019/20 BAF has been presented to the Board Committees during October with the exception of Workforce, Organisational Development and Transformation Committee as this meetings bi-monthly. A thorough review of the content of the framework has been undertaken following the discussions at the Board on 1 October. The updates have not resulted in a change to the assurance ratings.

Direction of Travel of Assurance Ratings:

RAG Rating	September 2019	October 2019	Direction
Red	6	6	→
Amber	1	1	→
Green	0	0	→

The BAF will continue to be updated through the Executive Directors before being presented to Committee meetings for discussion and further update where required, monthly updates will be received by the Trust Board.

Recommendations:

The Trust Board are asked to:

- Note the updates within the Board Assurance Framework and confirm the assurance ratings provided by the Committees
- Consider the identified gaps in assurance and advise/identify reports to be presented to the Board or Committees which would support the closure of the assurance gaps

Strategic Risk Register	**Performance KPIs year to date**
Links to the risk register are included within the BAF and will be updated as risks are identified	Appropriate KPIs relevant to the ambitions will be identified within the BAF

Resource Implications (eg Financial, HR) N/A

Assurance Implications Assurance on delivery of Trust ambitions is provided within the BAF

Patient and Public Involvement (PPI) Implications N/A

Equality Impact N/A

Information exempt from Disclosure No

Requirement for further review? Monthly review through Committees and Trust Board

Board Assurance Framework (BAF) 2019/20 - October 2019

Ambition	Board Committee	Enabling Strategy	
Our Patients: Providing consistently safe, responsive, high quality care	Quality Governance Committee	Quality Strategy	Research Strategy
Our Services: Providing efficient and financially sustainable services	Finance, Performance and Estates Committee	Financial Strategy Estates Strategy	Digital Strategy Environmental Strategy
Our People: Providing services by staff who demonstrate our values and behaviours	Workforce, OD and Transformation Committee	People Strategy Equality Diversity and Inclusion Strategy Communications and Engagement Strategy	
Our Partners: Providing seamless integrated care with our partners	Finance, Performance and Estates Committee		

Ref	Objective	Metric	Exec Lead	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Control Gaps	How identified control gaps are being managed	Source of assurance	Assurance Gaps - where are we not getting effective evidence	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating
SO1	**Providing consistently safe, responsive, high quality care**													
1a	Deliver harm free care	Mortality - HSMR within control limits	Medical Director	Coding incomplete/inaccurate Non delivery of the Trust Mortality Reduction Strategy Not working in Partnership across the health care system Inability to control/manage emergency demand	Corporate Risk ID 4138 - Mortality rates (Moderate)	CQC Safe	Dr Foster - investigations into Dr Foster alerts HSMR and SHMI National Benchmarking Reports National audit - secondary control ReSPECT Quality Account Priority 3 Learning from deaths and patient safety incidents	Consistent delivery of ReSPECT Inability to control/manage emergency demand System wide partnership working: - preventing admission - provision of appropriate and timely discharge - reviewing deaths	Comprehensive ReSPECT roll out programme, system wide multi-professional education and audit Urgent Care Board Lincolnshire Mortality Learning Network	Triangulation of lessons learned, incidents, coroners, claims and complaints National audit reports Mortality Reduction Plan Regular reporting on learning from deaths. Reviews of alerting diagnosis/conditions, including independent reviews IPR Routine quarterly focussed assurance reports to Quality Governance Committee	System wide partnership reports	System wide mortality group System Improvement Board	Quality Governance Committee	A
		Harm Free Care - Safety Thermometer 99%	Director of Nursing	Unreliable or inaccurate data Failure to deliver against action plans in place for key harms Inconsistency in quality reporting from new Divisions.	Corporate Risk ID 4142 - Safety of patient care (Moderate)	CQC Safe	QSIP Plan Harm Free Action Plans in all areas Ward Accreditation Programme National benchmarking Integrated Performance Report Quality Strategy Patient Experience Plan Inclusion Strategy QSOG reports Quality Account priorities 1 ,2 & 4 Hygiene Code	Lack of capacity to deliver Inclusion of actions from CQC visit within QSIP plan Not available in all areas Data Quality Quality Strategy not approved Metric not finalised Sharing and learning not at desired level	Bi weekly meetings Harm Free care Steering Group QSIP Programme Patient experience annual plan as part of Quality Strategy Meeting to finalise metrics Infection Prevention and Control Group	Integrated Performance Report Patient Experience Dashboard and codesign of pathways with patients Quality and Safety Improvement Plan Clinical Audit Programme Ward Accreditation results Harm Free Care Group Medicines Management exception report Safeguarding exception report Infection Prevention	Quality Strategy not approved Harm Review data quality - Process has been significantly reviewed fits with committee work programme. To remain as gap for time being QSOG still in development New Trust Operating Model still embedding. Patient Experience and links to Quality Strategy and how articulated in BAF	Director of Nursing and Medical Director to further develop Quality Strategy Identification of relevant groups ownership of Harm Review policy and process	Quality Governance Committee	

Ref	Objective	Metric	Exec Lead	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Control Gaps	How identified control gaps are being managed	Source of assurance	Assurance Gaps - where are we not getting effective evidence	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating
							Internal Audit: Data quality of KPIs - Q4 Compliance with legislation - Q2			Infection Prevention Control exception report Equality and Diversity Patient report Inclusion strategy				
1b	Valuing our patients' time	% patients seen at appointment time (within 15 minutes of appointment time)	Chief Operating Officer	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 post TOM implementation	Monthly Delivering Productive Services report PRM FPEC	Impact of actions being taken via PRM	Focussed PRM discussions	Finance, Performance and Estates Committee	R
SO2	Providing efficient and financially sustainable services													
2a	Have 'zero waits' to access our services	% patients discharged within 24 hours of PDD	Chief Operating Officer	Systems unable to capture and report data Unreliable or inaccurate data Poor engagement with setting PDD Internal systems not efficient to support timely discharge	Corporate risk ID 4176 - Planned care demand (High)	CQC Effective	Urgent and Emergency Care Improvement Programme - workstream 4, Ward Processes and 5, Discharge and Partnerships Daily review and overview by operational services Delivering Productive Services Group	Specialty Governance Data Quality Issues	Data Quality workstream PRMs probing gaps in speciality control and assigning actions to close Roll out of the TOM in line with the governance framework	Urgent and Emergency Care Improvement Programme update IPR	Reporting shows legitimate amendments made to dates of predicted discharge generate an artificially positive position at times.	A new process is in place that prohibits changes to PDD for all but clinical reasons. Plan changes are being monitored and this gap is expected to be fully mitigated by December 2019	Finance, Performance and Estates Committee	R
2b	Ensure that our services are sustainable on a long-term basis i.e. here to stay	Delivery of Financial Plan £70.3m deficit	Director of Finance and 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	Corporate risk ID 4382 - Delivery of FRP (Very high) Corporate risk ID 4384 - Income reduction (High) Corporate risk ID 4383 - Unplanned expenditure (Very	CQC Well Led CQC Use of Resources	Financial Turnaround Group (FTG) oversight of FRP Vacancy control process Centralised agency team Financial Strategy and Annual Financial Plan Performance Management Framework Delivery of output of Clinical Service Review programme System wide savings plan Internal Audit: Finance efficiency programme - Q2 Performance Management and reporting - Q3	Reliance on temporary staff to maintain services, at increased cost Operational ownership and delivery of efficiency schemes, workforce reduction in particular Clinical coding & data quality issues Operational ownership of income at directorate level Lack of control over local demand reduction initiatives	Recruitment & retention initiatives to reduce reliance on temporary staff Income improvement plan for each directorate Engagement with commissioners through system wide contract management framework Improved reporting in to divisions System savings plan and delivery group Performance review process refresh through new operating model	Monthly Finance Report to Trust Board including capital and contracting FSM meetings with NHSI Scrutiny and challenge through Finance, Performance and Estates Committee Internal Performance Review Meetings Internal Audit work reports IPR System Wide NHSE&I Performance and Escalation Meeting	Impact of recruitment and reduction in temporary staff Structures and systems in place however the Trust have a lack of control over expenditure Model Hospital Benchmarking CQC Use if resources	Report on recruitment and temporary staffin impact PRM Meeting outcomes, dashboard to be developed to be presented to Finance, Performance and Estates Committee Delivery of Financial Efficiency plans	Finance, Performance and Estates Committee	R

United Lincolnshire Hospitals NHS Trust

Ref	Objective	Metric	Exec Lead	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Control Gaps	How identified control gaps are being managed	Source of assurance	Assurance Gaps - where are we not getting effective evidence	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating
				[illegible] levels over and above repatriation and fails to secure all income due from commissioners	high)		[illegible] Education Funding - Q1							

Ref	Objective	Metric	Exec Lead	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Control Gaps	How identified control gaps are being managed	Source of assurance	Assurance Gaps - where are we not getting effective evidence	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating
		% of services rated as 'delivering' *Note: 2019/20 is baseline year. % not in place, working through baseline in draft, scrutiny and road testing criteria and application, scheme of delivery and devolution* *Baseline analysis of how to manage classification of service performance - 3 levels*	Director of Finance and 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	
SO3	**Providing services by staff who demonstrate our values and behaviours**													
3a	Have a modern and progressive workforce	Vacancy fill rate	Director of HR&OD	Inability to recruit and retain a suitably skilled workforce to meet demand resulting in unplanned and indefinite closure of multiple services across the Trust Failing to reduce high vacancy rates of consultants, doctors and registered nurses Reliance on deanery positions to cover staffing gaps Significant proportion of workforce approaching retirement age Inadequate workforce planning process	Corporate risk ID 4362 - Workforce capacity & capability (Very high) Corporate risk ID 4082 - Workforce planning (High)		People Strategy and Annual Workforce Plan Recruitment and retention strategies People management policies & procedures Vacancy controls Agency cost reduction plan Access to workforce business intelligence Core learning & leadership development programmes <u>Internal Audit:</u> Temporary Staffing Recruitment - Q3	Impact of Brexit on staff from EU countries Capacity within the business to support the process Shortage of sufficient numbers of staff in key areas, impacting on vulnerable services and potential risk to maintain safe services Talent management + succession planning arrangements Age profile of the clinical workforce Accuracy of all workforce information	Focus on nursing & medical staff engagement & development to reduce attrition Review approach to recruitment to deliver at greater pace and scale Communication & engagement with EU staff & their managers Development of sustainable service model + new roles Talent Academy to develop new entry and development pathways NHSI Retention Project Review of age profile & People Strategy to mitigate impact	People Strategy Additional resourcing support Staff survey results Data on effective application of people management policies Absence management arrangements in Trust GMC Surveys Data quality work	Medical capacity planning Delivery of People Strategy Workforce planning	Reviewing progress with Trust Management Group Completion of more detailed action plans Agreement of revised People Strategy and workforce plans	Workforce, OD and Transformation Committee	**R**
3b	Work as one team	Recommend as a place to work in staff survey 46% (↑ of 5%) Recommend as a place to receive care in staff survey 53% (↑ of 5%)	Director of HR&OD	A fundamental loss of workforce engagement which could result in a culture of low morale and motivation that impacts on the quality & safety of services throughout the Trust and permanently damages its reputation	Corporate risk ID 4083 - Workforce engagem ent (High)		Freedom To Speak Up Guardian role Staff engagement strategies & plans (including staff surveys) Focus on drivers of engagement: -Engagement of staff in 5-Year Strategy -Opportunities for staff voice to be heard -Work on staff charter and values -Leadership and management development Staff charter and vision and values People management policies, systems, processes & training Management of organisational change policies & procedures Inclusion strategy Quality Account Priority 2 <u>Internal Audit:</u> Policy compliance - Q2 Mandatory training - Q2	Consistent quality of local leadership and management Staff engagement and belief in 5-year strategy as means of bringing improvement 2018 Staff Survey suggest gap between individuals and Trust around belief that patient care is most important	Localised divisional action plans in response to staff survey results Reviewing the current recognition agreement to modernise it and ensure it is fit for purpose Leadership and management development programmes Revamp of communications around 5-year strategy and direction of travel Trust-wide response to staff survey results to inform revised People Strategy	CQC report Workforce Committee KPIs including vacancy rates, appraisals, turnover, core learning, agency usage Pulse survey Staff Survey Quarterly FTSU Guardian report to Board Staffside representative feedback Report on application of people policies - Sickness absence, disciplines, grievances TB FTSU Self Assessment IA Review Public Sector Equality Duty	Guardians of Safe Working Divisional management teams, completing engagement work with staff Bullying and harassment scores are a concern, particularly for BAME staff Lack of evidence of improvement in scores around quality and consistency of leadership	Development of alternative to deliver Guardians of Safe Working responsibilities FTSU champions Review Divisional management teams through PRMs Project underway to understand causes of scores on bullying and harassment - initial survey and focus groups to gather intelligence - actions to follow Review of approach to leadership development, with additional actions to follow e.g. coaching, 360 appraisal and middle manager forum	Workforce, OD and Transformation Committee	**R**

United Lincolnshire Hospitals NHS Trust

Ref	Objective	Metric	Exec Lead	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Control Gaps	How identified control gaps are being managed	Source of assurance	Assurance Gaps - where are we not getting effective evidence	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating
SO4	**Providing seamless integrated care with our partners**													
4a	Make sure that the care given to our patients is seamless between ULHT and other service providers through better service integration	% reduction in face to face contacts in Outpatients 5% (Responsibility for the metric delivery sits with the Chief Operating Officer)	Chief Executive Officer	Lack of robust system plan Lack of/insufficient system capacity Poor engagement with primary/community care Demand Unaffordable Poor system working No single system plan	Corporate risk ID 4368 - Outpatient demand (High)	CQC Caring CQC Responsive CQC Well Led	1st line Activity monitoring Activity plan Contract Improvement project System plan delivery System Performance Report to SET STP/SET/LCB infrastructure ASR Single system plan ICC development programme 2nd line: ICS Development 3rd line: NHS ICS Maturity Index Internal Audit: STP Governance - Q2	ASR - capital limitation System delivery method not yet mature	ASR being refreshed for resubmission System wide SROs appointed and delivery framework being established	LCB Oversight SET CEO Updates at Board Healthy Conversation	System wide partnership reports not routinely shared	System SRO to share reports. Allocation of responsibility and resource to ULHT individual for delivery of workstream	Finance, Performance and Estates Committee	R

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

The BAF management process

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

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

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

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

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

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

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

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

United Lincolnshire Hospitals NHS Trust

Report to:	Trust Board
Title of report:	Audit Committee Report to Trust Board
Date of meeting:	14th October 2019
Status:	For Discussion
Chairperson:	Mrs Sarah Dunnett, Non-Executive Director
Author:	Mrs Jayne Warner, Trust Secretary

Purpose	To provide the Board of United Lincolnshire Hospitals NHS Trust with a formal report of the work of the Audit Committee since its last meeting, the assurances that have been received and validated, and those that are missing along with the actions to address them.
Background	This Committee meets at least quarterly and takes scheduled reports from the Trust's Internal and External Audit Providers, Counter Fraud Service, Finance Director and other parties in accordance with an established work programme.
Business undertaken	**Internal Audit** The Committee received the Internal Audit progress report. Despite finalisation of only one audit to date the Committee received assurances from Grant Thornton the Trust internal audit provider, that the internal audit plan for 2019/20 remained on track to deliver the full year programme by 31st March 2020. The Internal Auditors alerted the Committee to delays which had been experienced in the Estates Governance review. The Committee noted the delay recognising issues with both Internal Audit and the Trust but acknowledged that these concerns had not been escalated by the Internal Auditors with the Trust. It was agreed that future concerns should be promptly escalated with the relevant Director and Trust Secretary. The Committee considered a request to postpone the recruitment audit to quarter 4, reflecting a changing scope around the People Strategy which is still under review. Given the workforce challenges the Trust faces the Committee did not approve the delay. The Committee agreed that the scope should be focussed on recruitment and commence in quarter 3. The Committee agreed that some of the audit contingency time should be focussed on Pharmacy and Medicines Management, recognised concerns raised in a recent governance and external audit report.

	The Committee questioned when audit planning for 2020/21 would commence. The Committee were assured that the planning process for 2020/21 would commence early and it was agreed that a first draft plan would be provided for the January 2020 Committee meeting. The Board would be engaged in the planning process throughout December 2019.
	Outstanding Audit Recommendations The Committee reviewed the revised action plan and completion dates for prior year outstanding internal audit recommendations. The Committee were not assured on implementation of actions relating to job planning and medical devices. The Committee agreed that the concerns relating to this area needed to be escalated to Board in a report to include why the matters had not been addressed and timetabled actions to be taken to implement.
	Counter Fraud The Committee received the LCFS progress report and were assured on overall delivery of the counter fraud plan for 2019/20. However the Committee noted the increasing number of investigations being undertaken and the impact on the counter fraud resource. The Committee were satisfied that this was being considered by the Director of Finance and Digital.
	External Audit The Committee received the progress report from External Audit. The Committee were alerted to imminent changes within the PwC practice which would mean a focussed external audit service. The Trust were advised that audit costs were likely to rise for 2019/20 and PwC were in discussion with the Director of Finance and Digital with revised costs being submitted for approval to the Committee in January 2020. It was anticipated the PwC team for the 2019/20 accounts audit would remain the same. **ISA 260 Audit Recommendations** The Committee received an update on actions taken to address the recommendations from the financial accounting statement and quality account audits. The Committee were assured on actions in respect of the financial accounting standards but asked for a further progress check on the quality account recommendations and action to be

	brought to the Committee in January 2020. These issues would also be referred to Quality Governance Committee and Finance, Performance and Estates Committee for consideration in October 2019.
	IFRS16 Leases The Committee were advised of the requirement for the Trust to implement IFRS 16 Leases in readiness for 1 April 2020 and the potential implications and associated workload/plan for implementation. The Committee asked for the matter to be referred to Executive Team and to be kept on the forward agenda as a standard item. The Committee would be seeking assurances from the Director of Finance and Digital on preparation and readiness status.
	Policy Management The Committee were not assured and challenged the lack of progress since the previous meeting in respect of clinical and non-clinical policy management. The Committee heard that progress was reliant on development of a system which would allow policies to be adequately controlled. Whilst the Committee acknowledged that this was a contributing factor the Committee agreed that the risk to the Trust needed to be adequately reflected in the risk register and should be escalated to the Trust Board for consideration.
	Scheme of Delegation The Committee had expected to receive an update to the Trust's Scheme of Delegation. The revision of this had been paused so that it could be considered alongside the development of the Trust scheme of devolution for the TOM structure. The Committee expressed concern that there was still not clarity on the authority delegated to the new divisional structure and asked for clarity on how this was being resolved. This would need to be completed urgently and escalated to the Board. had
Issues where assurance remains outstanding for escalation to the Board	**NHSI Undertakings** The Committee reviewed on behalf of the Board the updated assurance document of compliance with the NHSI undertakings. The Committee remained concerned that the Trust could not adequately evidence assurance that it was complying with the undertakings and delivering the required results. The Committee also believed that the report would need to be revised on receipt of the final report from the Care Quality Commission. The Committee agreed that this needed to be a whole Board discussion and could not be resolved without full Board consideration. The Committee suggested that discussion take place at Board development/private board. Trust Secretary would discuss with Chair and CEO. **STP Governance:** The Committee was not able to assure itself in respect of risks relating to the STP. The Committee noted that this issue

	was not unique to the Trust and would continue to be raised through the Non Exec and Lay Members Forum. The Committee noted a pan STP internal audit was in progress, the item would remain on the action log and work programme for the Committee.
Items referred from other Committees and Board	The Committee noted the action from Trust Board to consider governance issues raised in the NHSI Board and Committee observations including specific issues raised in relation to the Medicines Optimisation Group. The Committee agreed to consider the actions at its January meeting when assurance would be sought from each of the Committee Chairs that action had been implemented.
Committee Review of Risk Management	The Committee received the risk management update which included performance against KPIs and internal audit recommendations. The Committee noted the noted that the report was embryonic, reflecting the implementation of the new risk management strategy. In future the Committee requested that quarterly reports included profiling of risks by division showing where risk had been reduced/mitigated and how the use of the risk register was being embedded within the divisions.
Matters identified which Committee recommend are escalated to SRR/BAF	The Committee received the Board Assurance Framework which had been updated through all of the Assurance Committees during September and seen by the Board at its meeting in October. The Committee noted the comments from the Committee Chairs in respect of the Committee consideration of the BAF and were satisfied that the framework was effective and still representative of the risks to the organisation. The Committee acknowledged that work on review for 2020/21 was planned.

NHS
United Lincolnshire Hospitals
NHS Trust

To:	**Trust Board**
From:	Paul Matthew, Director of Finance and Digital
Date:	5th November 2019
Healthcare standard	

Title:	Finance Strategy

Author/Responsible Director: Paul Matthew, Director of Finance and Digital

Purpose of the Report: To provide Trust Board with sight of the proposed Finance Strategy for approval.

The Report is provided to the Board for:

Decision	√	Discussion	√
Assurance		Information	

Summary/Key Points:

The strategy describes the Trust approach in becoming financially sustainable whereby being financial secure will allow the Trust to be able to invest, at the most appropriate time, in the delivery of our Clinical Strategy, other supporting strategies, emerging technology and new ways of working to provide excellent services.

The strategy describes the goals in which will be worked towards:-

Goal 1: Ensuring our services deliver value for money

Goal 2: Earned autonomy for Clinical Divisions

Goal 3: Supporting a sustainable healthcare system

Recommendations:
For the Trust Board to note the contents and approve the Finance Strategy

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

Resource Implications (eg Financial, HR)	
Assurance Implications	
Patient and Public Involvement (PPI) Implications	
Equality Impact	
Information exempt from Disclosure	
Requirement for further review?	

Excellence in rural healthcare

NHS
United Lincolnshire Hospitals
NHS Trust

Our Finance Enabling Strategy 2019 to 2024

Using Our Resources Wisely

Introduction

The purpose of this strategy ('why' this strategy has been formed) is to describe the approach the Trust will take forward in becoming financially sustainable. Being financially secure will allow us to be able to invest, at the most appropriate time, in the delivery of our Clinical Strategy for our core services (based on patient need), the other supporting strategies, emerging technology and new ways of working to provide excellent services.

2019/20 is the first full year of the new Trust Operating Model (TOM) following the consolidation of 15 divisions and the Trust will continue to work with all of our people to deliver our Trusts visions, values, ambitions and priorities.

To achieve our goal of financial sustainability, we must firstly work hard to be as efficient and productive as we can. We know the Trust benchmarks unfavourably against its peers as evidenced in Model Hospital (A national digital tool which benchmarks hospitals in order to identify and realise opportunities to deliver the best practice care in the most efficient way.)

Our back office services, including the Finance function, are in the best quartile in terms of value for money. However, our recent CQC rating of Inadequate for Use of Resources shows that there is more to do to use our resources and assets productively and efficiently.

The financial challenge within the NHS both from an income and expenditure viewpoint as well as capital is now well known. Most acute provider Trusts in the NHS are reporting an overspend against their control totals. (Annual financial targets that must be achieved to unlock access to national funding and other financial benefits for example Provider Sustainability Funding PSF).

The system cannot therefore, currently be described as 'sustainable' when one looks at the growth in waiting lists and waiting times, as well as substantial deficits in some parts of the system, offset by surpluses elsewhere. Financial sustainability therefore cannot be looked at in isolation and it is intrinsically linked to challenges in population health, workforce and system planning across the STP, region and the wider NHS and public sector.

More than this, achieving financial sustainability is not simply about balancing the books. Financial security impacts the way that the organisation behaves, how quickly it can respond to changes and how much flexibility we can have in investing and driving innovation.

The Provider Sustainability Fund (PSF) and Financial Recovery Fund (FRF) payments have helped most Trusts improve their reported financial performance but often encourage short-term gains over long-term sustainability. More progress is needed and the recent long-term plan for the NHS is committed to longer-term stable growth in funding for NHS England which is a positive development.

However, given the endemic nature of the financial position across the NHS, we must act differently in order to achieve the potential benefits of financial independence. This alone will not resolve inconsistencies in the current funding flows in the NHS. We therefore, also need to work with national and local systems partners to integrate our services so that we can better manage demand, control cost and ultimately invest and direct resources appropriately and where this is needed most.

The Trust worked with Lincolnshire STP partners in the production of the Acute Service Review (ASR), which was focused on improving access to high quality care for patients in a more efficient way.

One of the main outcomes of achieving our overall goal to be financially sustainable is that in doing so will enable us to invest in our significant equipment and estate needs and improve our use of resources rating.

ULHT has an ageing estate and dated IT kit and medical equipment, placing significant demands on the Trusts limited internally generated capital resources. Unless the Trust generates surpluses or is supported by the national capital funding regime, it will not have the cash to invest in new clinical or IT equipment or to improve its building infrastructure.

The Trust and as part of the Lincolnshire STP has proactively pursued accessing additional national capital funding, bidding against a wide range of schemes with varied success.

In order to mitigate the historic lack of capital funding, the Trust is actively scoping the potential for a Management Equipment Services (MES) for high value items of equipment such as MRI and CT scanners, which the Trust pays for through revenue in the form of a unitary charge payment.

The Trust will continue to explore alternate and innovative sources of capital such as MES agreements, Grants and Charitable Donations and agreements with Commercial, Local Authority and STP Partners. In addition to working with and challenging regulators to provide further capital resources.

In the context of the current NHS financial regime, our goal to achieve financial sustainability is extremely challenging but our goals are straight forward. Getting this right ensures we are able to match clinical resources to clinical need and by investing our resources wisely, we can ensure we are fit for the future.

Our financial performance is the shared responsibility of all employees working in the Trust. We want to ensure this strategy links to clear goals that everyone can understand and influence regardless of hierarchical structures and so we have limited them to three. Each section includes ‘what’ we will do to achieve these

Goal 1: Ensuring our services deliver value for money

Goal 2: Earned autonomy for Clinical Divisions

Goal 3: Supporting a sustainable healthcare system

Paul Matthew, Director of Finance and Digital

Goal 1: Ensuring our services deliver value for money

One of the principle benefits driving the recent implementation of the TOM was to secure financial stability for the Trust through sharing best clinical practice, embedding of back office services in the Clinical Services and having the ability to attract clinical staff to work in an organisation with increased opportunities both for the individual and the Trust.

Being in deficit, some might assume the Trust is inherently wasteful. In fact, compared to other NHS Trusts, we fare much better than average in certain areas compared to a number of metrics. The Trust has been commended for its GIRFT work by National teams in Trauma and Orthopaedics which has improved the quality of care of the Trust by reducing unwarranted variation. But, we acknowledge there is much we can improve upon as was demonstrated through our use of resources score.

The Finance team will continue via the nominated Model Hospital Ambassador to influence the development of the Model Hospital and improve the quality of Trust information mandated by the Regulator for example reference costs used in the Model Hospital.

In doing so, we can help demonstrate that for all the services we provide, we deliver value for money. To achieve this, we have to have robust processes and systems in place to control cost decisions and evidence reductions in waste and improvements in productivity and efficiency.

Within 5 years, we want to:

- Have a financial system that produces patient level costing so that operational departments can make informed and timely decisions on a regular basis which do not have a detrimental impact on our patients.
- Have continually reviewed each of our services to ensure financial viability and sustainability.
- Understand how we benchmark clinically and financially against other providers, and internally across sites and clinicians.
- Ensure best value for money from our corporate overhead.

To achieve this, we will:

- Develop our patient level costing model in line with NHSI guidance which will allow peer group and national benchmarking through Model Hospital.
- Analyse the financial difficulties in our service provision and share these with our commissioners. This transparency will allow us to develop robust improvement plans for all stakeholders.

- Actively seek to resolve issues with our Commissioners and to agree mutually beneficial actions which will improve the whole health economy we serve without detriment to any one of our partners.
- Support delivery of the agreed outcomes of the ASR
- Develop robust demand and capacity models for each of our services which will allow easier contract modelling whilst maintaining clinical quality.
- Produce detailed PLICs analysis by service and down to clinician.
- Use the best technology within the Finance function to ensure our financial processes are lean and reporting robust.
- Use GS1 technology to eliminate paper-based ordering and requisitioning.
- Maximise the use of scanning our consumable stock and minimise stock levels and improve patient safety by utilising 'track and trace' technology.
- Support the Trust to review and streamline services and adopt Lean Principles to provide our staff with the tools to improve outcomes for our patients.

Goal 2: Earned autonomy for clinical divisions

Today, given the level of the financial burden on the Trust, key decisions which require financial investment are taken through strict decision making channels. Operating in this way whilst controlling costs, can be deemed as bureaucratic, time consuming and stifle innovation and dynamic decision making.

Controlling cost is, however, very different to having systems in place to control cost decisions. The latter is aimed at supporting and empowering staff (through robust governance processes and accountability) to make decisions on behalf of their clinical divisions. Upon implementing the new Trust Operating Model (TOM), the Trust reconfigured its clinical divisional structure to ensure the management and governance of our services is organised in a logical way and staff are responsible for groups of services which are in synergy. Devolved decision making was a fundamental tenet of the Trust Operating Model and we aspire to seeing it run throughout our organisation to our clinical divisions and the management structures therein.

A change in behaviour Trust-wide could ultimately ensure teams self-regulate and therefore, plan more effectively and sustainably but it will also need them to recognise the responsibility which goes with this autonomy.

Within 5 years, we want to:

- Enhance training to all non-financial staff to ensure clear understanding of the constraints of the financial environment in which we operate and the financial consequences of their actions.
- Equip clinical and non-clinical leaders with more appropriate information to make informed decisions.

- Put clinical divisions at the centre of decisions making to support agility and responsiveness to changing patient needs.
- Ensure our clinical divisions fully understand their contribution margins at speciality level and own the full costs they are incurring.

To achieve this, we will:

- Enhance the accountability framework understood across the Trust.
- Develop the Trust Devolution policy to empower decision makers.
- Develop a training programme for all staff to understand the drivers of finance information.
- Utilise the current process for revenue and capital investment decisions and criteria for approval with robust post implementation review.
- Provide regular contribution reporting at speciality level.
- Provide a service line reporting model which show full costs including overheads that services are incurring.

Goal 3: Supporting a sustainable healthcare system

It is recognised that through effective partnership working across health and social care we can achieve far more for the population we service than our best efforts alone. The NHS Long Term Plan sets out a clear expectation that Integrated Care Systems (ICS) will be central in the delivery of the plan and that individual statutory organisations will take on greater collaborative responsibilities. We have already seen the Lincolnshire CCGs and Provider Trusts come together with the ambition to drive operational and clinical improvements through the aligned incentive contract.

ULHT is the largest healthcare provider in the Lincolnshire (STP). We therefore have a significant responsibility to not only participate, but drive forward the transformational change needed to truly integrate the provision of health and care services across our region in order to improve the health and well-being of our population. This includes deploying the resources and assets we have in the most effective and valuable way to prevent people from becoming ill where this is avoidable. In doing this, we will be able to work towards resolving system risks around quality, finance and personnel through effective partnership working and optimising partnership assets and resources and deliver the outcomes of the ASR.

There are a number of challenges which affect this ambition. For example, having a shared vision with our partners in Lincolnshire, where the vision to enable change may benefit the system, but could be detrimental to an individual organisation (which can translate to financial risk). Also, trust and transparency is required in an NHS culture which has been built over the last two decades on competition rather than collaboration. A final example is moving organisational attitudes and behaviours towards collective accountability. Although a system control total may be a

mechanism to achieve this, today's language of commissioner QIPPs and Trust CIPs does not acknowledge that in many cases. For schemes to be successful, we require collaboration between providers and commissioners putting patients at the heart of the decision making process.

In addition, in order to eliminate the current situation where community mental health and local authority services are dis-incentivised to take additional patients due to block contract payment agreements, a mechanism to move resources around the system to incentivise providers to provide appropriate care to individual patients needs to be developed. This would build upon and take further the ethos established by the Lincolnshire AIC.

In 5 years, we want to:

- Have a collective decision making model which plans and commissions care for our entire population underpinned by a model of shared accountability for system quality and financial performance.
- Have a solid partnership across health, local authorities and third sector providers and commissioners, in order to improve population health by tackling the causes of illness and the wider determinants of health.
- Have adopted a shared approach to transformation of services through the use of the Improvement Practice across the ICS.
- Be involved in the decision making process to determine the future payment mechanisms to care providers.
- Develop efficiency schemes jointly with system partners, with savings based on cost rather than income (to mitigate the impact of financial loss and cost removal).

To achieve this, we will:

- Work with system partners to develop a risk and gain share agreement for joint STP schemes.
- Work with partners to maximise the capital resources in Lincolnshire to deliver clinical improvements and deliver the ASR and modern patient services.
- Commit to maximising overhead recovery (to support more local cost release at full cost).
- Continue to share information on an open and transparent basis to engender trust accepting the need to comply with procurement laws and regulations
- Sufficiently resource in terms of time and personnel, input into the clinical leadership and management required to drive forward transformational change.
- Review our services to ensure that we are providing affordable and efficient services to the specification required by the healthcare systems in which we operate.

Delivery Plan

To support the implementation of the strategy a working group will be established drawing upon a number of disciplines and chaired by the Deputy Director of Finance. By February 2020 we will form a Delivery Plan which will specify the resources required, key milestones and where the risks to implementing this strategy will be assessed, quantified and mitigated.

United Lincolnshire Hospitals NHS Trust

TRUST BOARD FORWARD PLANNER

[2019/20]

	May 19	June 19	July 19	Aug 19	Sept 19	Oct 19	Nov 19	Dec 19	Feb 20	Mar 20	Apr 20
Standing Items											
Chief Executive Horizon Scan	X	X	X	X	X	X	X	X	X	X	X
Patient/ Staff Story	X	X	X	X	X	X	X	X	X	X	X
Integrated Performance Report	X	X	X	X	X	X	X	X	X	X	X
Board Assurance Framework	X	X	X	X	X	X	X	X	X	X	X
Declaration of Interests	X	X	X	X	X	X	X	X	X	X	X
Governance											
Audit Committee Report	X	X		X			X		X		
Strategic Objectives for 2019/2020									X		
BAF Sign off for 2019/20	X									X	
Annual Accounts, Annual Report and AGS Sign Off	X										
Quality Account	X										
Corporate Risk Register	X	X	X	X	X	X	X	X	X	X	X
NHSI Board Observation Actions						X			X		
SO 1. Providing Consistently Safe, Responsive, High Quality Care											
Quality Governance Committee Assurance and Risk Report	X	X	X	X	X	X	X	X	X	X	X
Quality and Safety Improvement Plan	X	X	X	X	X	X	X	X	X	X	X
Safer Staffing Report		X					X				
Safeguarding Annual Report			X								
Annual Report from DIPC				X							
Innovation Update	X	X	X	X	X	X	X	X	X	X	X
SO 2 Providing Efficient and Financially Sustainable Services											

Finance, Performance and Estates Committee Assurance and Risk Report	X	X	X	X	X	X	X	X	X	X	X
Financial Plan and Budgets										X	
Clinical Strategy Update					X					X	
Operational Plan Update					X		X		X		
Emergency Planning Annual Self Assessment					X						
SO 3 Providing Services by Staff Who Demonstrate our Values and Behaviours											
Workforce, OD and Transformation Committee Assurance and Risk Report	X			X		X			X		X
Staff Survey Results											X
Freedom to Speak Up Report	X			X			X			X	
Report from Guardian of Safe Working		X			X					X	
Equality and Diversity Strategy		X									
5 Year Strategy	X			X			X		X		X
SO 4 Providing Seamless Integrated Care with our Partners											

NHS
United Lincolnshire Hospitals
NHS Trust

To:	**Trust Board**
From:	Anna Richards
Date:	5 November 2019
Healthcare standard	

Title:	Innovation Report

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

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

The Report is provided to the Board for:

Decision		Discussion	
Assurance		Information	√

Summary/Key Points:

ULHT staff were invited to 'climb on board' a double decker bus with a difference in September, when the ULHT bus station visited all four hospital sites. The bus engaged directly with 700 staff across the sites where visitors were able to explore the bus and talk to staff and colleagues from different wards and departments across the Trust.

Recommendations:

For Trust Board to note the Innovation report.

Strategic Risk Register	**Performance KPIs year to date**
Resource Implications (eg Financial, HR)	
Assurance Implications	
Patient and Public Involvement (PPI) Implications	
Equality Impact	
Information exempt from Disclosure	
Requirement for further review?	

Agenda Item 20

Staff got ‘on board’ at the #ULHTBusStation

ULHT staff were invited to ‘climb on board’ a double-decker bus with a difference in September, when the Bus Station visited all four hospital sites.

The Trust wide event was staged by the organisational development team as way of promoting the range of benefits, development opportunities and career progression initiatives for prospective and current ULHT staff.

This was a response to feedback received from the national NHS Staff Survey and elsewhere that staff were unaware of the health and wellbeing support and career development opportunities available.

Visitors were able to explore a fully fitted out bus and chat to staff and colleagues from a host of different wards and departments across the Trust, including occupational health, organisational development, clinical education, human resources and the Lincolnshire Talent Academy.

The bus packed up its wares each afternoon and drove to a different site every day, kicking off and finishing proceedings at Lincoln County Hospital, visiting Grantham, Pilgrim and Louth hospitals en-route.

Over the popular weeklong event, which took place from Monday 16 September to Friday 20 September, the bus engaged directly with 700 staff across the four main hospital sites.

Saumya Hebbar, Organisational Development Lead at ULHT, said the event was a great opportunity for staff to come and find out about what’s on offer for them at the Trust.

“We’ve got so many benefits and initiatives for staff to enjoy, but not everyone knows about them,” said Saumya.

“The Bus Station was a way of showcasing them all under one, moveable, roof and we made sure it visited all of our hospital sites over the week to see as many of our staff as we could.

“The bus was also a place where we could listen to staff and find out what more we can do to help them do the best job they can.”

In addition to being staffed by colleagues from various ULHT departments, the Bus Station also included representation from Lincolnshire Police, who were on hand to talk about bike safety, staff from cosmetic company Lush, who gave hand massages and bath bomb making workshops, as well as fitness sessions and free tea, coffee, soft drinks and biscuits.

Agenda Item 20