Bundle Trust Board Meeting in Public Session 3 November 2020

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

1 Introduction, Welcome and Chair's Opening Remarks
Chair

2 10:15 - Public Questions
Chair

3 Apologies for Absence
Chair

4 Declarations of Interest
Chair

5.1 10:30 - Minutes of the meeting held on 6 October 2020
Chair
Item 5.1 Public Board Minutes October 2020v1.docx

5.2 10:35 - Matters arising from the previous meeting/action log
Chair
Item 5.2 Public Action log October 2020.docx

6 10:40 - Chief Executive Horizon Scan Including STP
Chief Executive
Item 6 Chief Executive's Report, 031120.docx

7 BREAK

8 Strategic Objective 1 To Deliver high quality, safe and responsive patient services, shaped by best practice and our communities

8.1 10:55 - Assurance and Risk Report from the Quality Governance Committee
Chair of QGC
Item 8.1 QGC Upward report October 2020.doc

8.2 11:05 - Patient Safety and Incident Management Report
Director of Nursing
Item 8.2 TB - Incident Management Report - including Never Events & other Serious Incidents - November 2020.docx

8.3 11:15 - Safe Staffing Report
Director of Nursing
Item 8.3 Safer Nurse Staffing Sept 2020.docx

8.4 11:25 - Infection Prevention and Control Annual Report
Director of Nursing
Item 8.4 Board-Report-IPC Annual Report October 2020.docx
Item 8.4 Infection Prevention and Control Annual report 2019-20.docx

8.5 11:30 - Complaints Annual Report
Director of Nursing
Item 8.5 Complaints Front page.docx
Item 8.5 Complaints Annual Report.pptx

9 Strategic Objective 2 To enable our people to lead, work differently and to feel valued, motivated and proud to work at ULHT

9.1 11:35 - Assurance and Risk Report from the People and Organisational Development Committee
Chair of P&ODC
Item 9.1 POD - Upward Report - October 2020v1.doc

9.2 11:45 - Freedom to Speak Up Quarterly Update
Freedom to Speak Up Guardian
Item 9.2 FTSU Update.docx

10	Strategic Objective 3 To ensure that services are sustainable, supported by technology and delivered from an improved estate
10.1	11:50 - Assurance and Risk Report from the Finance, Performance and Estates Committee *Chair of FPEC* Item 10.1 FPEC Upward Report October 2020 v 2.docx
10.2	12:00 - Phase 3 plan - return to non Covid Health Services *Chief Operating Officer* Item 10.2 ULHT_Summary Phase 3 Accelerating Return to Non Covid Health Services v4.docx
10.3	12:20 - Patient and Visitor Car Parking *Director of Finance and Digital* Item 10.3 Car Parking Report Oct 20.docx
11	Strategic Objective 4 To implement integrated models of care with our partners to improve Lincolnshire's health and wellbeing
11.1	12:30 - Research and Innovation Strategy *Medical Director* Item 11.1 Research and Innovation Strategy final V1.0.docx Item 11.1 ULHT_Research Innovation_Strategy_2021_2024_DRAFT v1.3.pdf
12	12:40 - Integrated Performance Report *Director of Finance and Digital* Item 12 Integrated Performance Report - Trust Board.docx
13	Risk and Assurance
13.1	12:45 - Risk Management Report *Director of Nursing* Item 13.1 TB - Strategic Risk Report - October 2020.pdf
13.2	12:50 - Board Assurance Framework *Trust Secretary* Item 13.2 BAF 2020-21 Front Cover November 2020.docx Item 13.2 BAF 2020-2021 v22.10.2020.xlsx
13.3	12:55 - Audit Committee Upward Report *Chair of Audit Committee* Item 13.3 Audit Committee Upward Report.docx Item 13.3 Item Audit and Risk Committee TOR 121020.docx
13.4	13:05 - CQC Update *Director of Nursing* Item 13.4 2020-10-20 CQC Must Do Should Do Front Sheet.docx Item 13.4 2020-10-20 CQC Must Do Should Do Actions V10 FINAL.pdf
14	Board Forward Planner *Trust Secretary - For Information* Item 14 Board Forward Planner 2020 v 3.doc
15	Any Other Notified Items of Urgent Business
16	The next meeting will be held on Tuesday 1 December 2020

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

Minutes of the Trust Board Meeting

Held on 6 October 2020

Via MS Teams Live Stream

Present

Voting Members:
Mrs Elaine Baylis, Chair
Mrs Sarah Dunnett, Non-Executive Director
Dr Karen Dunderdale, Director of Nursing
Mrs Gill Ponder, Non-Executive Director
Mr Andrew Morgan, Chief Executive
Dr Neill Hepburn, Medical Director
Mr Mark Brassington, Director of Improvement and Integration/Deputy Chief Executive
Mrs Liz Libiszewski, Non-Executive Director
Mr Paul Matthew, Director of Finance and Digital
Dr Chris Gibson, Non-Executive Director

Non-Voting Members:
Mr Martin Rayson, Director of People &OD
Mr Simon Evans, Chief Operating Officer

In attendance:
Mrs Jayne Warner, Trust Secretary
Mrs Karen Willey, Deputy Trust Secretary (Minutes)
Mrs Anna Richards, Associate Director of Communications
Ms Cathy Geddes, Improvement Director, NHSE/I
Dr Maria Prior, Healthwatch Representative
Mrs Clare Frank, Project Manager (Item 7)

Apologies
Mr Geoff Hayward, Non-Executive Director

1317/20 **Item 1 Introduction**

The Chair welcomed Board members and members of the public who had joined the live stream to the meeting.

In line with guidance on Covid-19 the Board continue to hold meetings open to the public through the use of MS Teams live. In line with policy, papers had been published on the Trust website a week ahead of the meeting and the public able to submit questions in the usual manner.

1318/20 The Chair moved to questions from members of the public.

Item 2 Public Questions

Q1 from Jody Clark

Since the 29th June, Grantham Hospital has become the Green Site. This unpopular decision locally, has had some benefits.

2500 patients received timely treatment for a life threatening illness. None of us would begrudge that.

It is just unfortunate that out of a potential 79% activity, only 48% was utilised. Especially considering 67% of patients transferred from Grantham UTC to an alternative A&E at Lincoln or Pilgrim, were admitted in July and 63% in August! Showing the need for the return of our inpatient facilities and the unfair disadvantage given to Grantham Residents.

This does not include the 4500 outpatient appointments that can still be seen locally at the Health Clinic and Gonerby Road Health Centre, nor does it include the fracture clinic or orthodontics outpatients that our residents are still travelling for.

It is only fair to mention the issues patients face in getting to the Grantham Green site for treatment, from across the county. It is a difficult county for us all to get around. With Coronavirus being with us for the foreseeable, we need our local services back, so we don't have to travel to higher risk areas.

It is unnerving to read the aims set out in the paper, as although your "reviewing" ongoing need for the Green Site, it also states to recommend intentions for ongoing evaluation and next quarterly review! As if the decision is already made?

So with all this in mind, I would like to ask, do you honestly think continuing with the Green site considering the higher impact this is having across the county but on Grantham residents predominantly, is the right thing to do?

The Chief Operating Officer responded:

The paper presented was not prejudged and is being presented to the Board as the quarterly review. The recommendations contained within the report set out a perspective and would be debated as part of the review.

Whilst the question picks up the detail of transfers and percentages of these there is also the need to consider the full breadth of the report including safety and infection prevention and control. These are all included within the report.

The detail of the report will be discussed in further detail on the agenda.

Q2 from Councillor Ray Wootten

Does the board agree with the comment made by the CCG at their AGM that they do not have a plan B for the future of Grantham A&E and that their preferred option is also your preferred option, an Urgent Treatment Centre.

The Chief Executive responded:

Several times over recent months the point has been communicated that any consultation in relation to Grantham A&E would be led by the Clinical Commissioning Group (CCG) and not the Trust. The Trust would of course participate but statutorily the consultation would be led by NHS Lincolnshire CCG. There has been no consultation document issued and therefore the CCG has not published any options that would form part of a consultation.

Any consultation would have to be carried out in accordance with Cabinet Office principles around fair and open consultation and this would clearly need to be conducted in line with case and common law.

In 2019 the Healthy Conversation was held which was a comprehensive engagement event with the population. A number of senior clinicians expressed that an emerging option they would support would be for a 24/7 urgent treatment centre at Grantham. For accuracy, it was phrased as an emerging option, not a preferred option.

Irrespective of any options within a CCG consultation document the Chief Executive would expect the CCG to give conscientious consideration to the outcome of any consultation undertaken, including any alternative proposals put forward. In reaching any decision there would be the need for an explanation as to the reason for choosing an option and why.

1319/20 **Item 3 Apologies for Absence**

Apologies were received from Mr Geoff Hayward, Non-Executive Director

1320/20 **Item 4 Declarations of Interest**

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

1321/20 **Item 5.1 Minutes of the meeting held on 1 September 2020 for accuracy**

The minutes of the meeting held on 1 September 2020 were agreed as a true and accurate record subject to the following amendments.

Ms Cathy Geddes, Improvement Director, NHSE/I to be recorded as in attendance and not a voting member of the Board.

1166/20 should read fire works not fireworks

1248/20 should read EU Exit not Brexit

1322/20 **Item 5.2 Matters arising from the previous meeting/action log**

1641/19 – NHSE/I observations – A full update would be expected in due course following review at the October Audit Committee

077/20 – Assurance and Risk Report Quality Governance Committee – The draft report from internal audit was awaited in relation to the review of the Trust Operating Model and Governance. Once received this would be reported through the Committees and to Trust Board.

343/20 – Staff survey results – A task and finish group had been set up to review reported levels of violence. The group would consider a number of issues to ensure appropriate follow up of reported incidents and how greater protection could be offered to staff. The task and finish group would report progress against the actions to the People and Organisational Development Committee – Action Closed

1323/20 **Item 6 Chief Executive Horizon Scan including STP**

The Chief Executive presented the report to the Board noting that there were four interlocking pieces of work for which focus was being provided, these were the recovery work to return to normal levels of activity, winter pressures, upsurge in Covid-19 cases and the end of the EU Exit transition period.

System Issues

1324/20 The Chief Executive noted that the national alert level had increased to level 4 of 5 whilst the NHS Incident alert level was at 3 of 4. This recognised that activity needed to take place a regional level.

1325/20 The system had been developing recovery plans for Phase 3 and taking in to account if Covid-19 reached a certain level this would impact on the recovery plans. Guidance for the second half of the year and the financial regime had now been announced. Funding was being provided at a system level and colleagues were working together to understand the implication and possible impact to the system and Phase 3.

1326/20 A system review meeting had taken place on 9th September, this had been a positive discussion. There had been good progress made and it was recognised that there was a joined up leadership team. There were however a number of issues and challenges which remained that needed to be worked through.

1327/20 The Chief Executive noted that plans were being developed for the system to move to an Integrated Care System as of April 2021. The key issue focused on the leadership arrangements that were required including the Partnership Board, Chair and Executive Lead arrangements in addition to the operating systems in place at neighbourhood level.

1328/20 The system were still awaiting the outcome of the pre-business case for the Acute Services Review.

Trust Specific Issues

1329/20 The Chief Executive reflected on the excellent news regarding the capital that had been secured for the development of Lincoln Accident and Emergency and noted that this was considered to be the first phase of the development. It was expected that confirmation would be received next year for additional funding to finalise the developments in addition to funding for Electronic Medicines and Administration.

1330/20 Conversations were being held with staff in relation to the Integrated Improvement Plan and positive feedback had been received. There was an ambition for staff to take up the invitation to transform the organisation.

1331/20 The Chief Executive advised that Board that he had been out presenting staff awards for 2020, this could not be done in the usual manner so the Chief Executive and Deputy Chief Executive had been surprising individual winners with their awards, this had been well received.

1332/20 The staff flu vaccination campaign had commenced and there had been a number of staff appreciation weeks being held, the most recent for estates and facilities staff.

1333/20 The Chief Executive was pleased to announce that the national recruitment process for the Director of Nursing role had concluded and following final interviews, Dr Karen Dunderdale had been appointed substantively to the role.

1334/20 The Chair noted that the report indicated significant assurance and invited Board members to endorse the content. There was a need to recognise the large volumes of work required for national, regional and system plans in addition to the Trusts own plans being put in place.

1335/20 In addition to this the Trust continued to restore services and plan for winter, a second surge of Covid-19 and the EU Exit. In terms of the operating context the Board needed to be mindful of this. There was a need to ensure there was capacity in the Trust and to ensure the health and wellbeing of colleagues, including Executive Directors so that they could continue to discharge their leadership functions.

1336/20 The Chair was pleased that regional colleagues were recognising the work taking place in Lincolnshire, not only from an operational perspective but also lobbying for capital. The Chair thanked those who had made the case for capital requirements.

1337/20 The Chair was delighted that Dr Dunderdale had chosen to apply and had been successful in the recruitment process to the Trust and felt that this was a good appointment for the Trust.

The Trust Board:

- **Noted the update and significant assurance provided**

1338/20 **Item 6.1 Green Site Quarterly Review**

The Chair advised Board members that the paper received followed on from the 11th June decision for the temporary green site and provided the agreed quarterly review.

1339/20 The Chief Operating Officer presented the paper to the Board noting that that paper included considerations from the number of domains including patient safety, patient and staff experiences and the principles that had been set out in the original case.

1340/20 Part of the criteria for reviewing and putting forward recommendations to the Board had been to review the original case put forward on 11th June and assess this against the principles set out.

1341/20 There had been changes since the implementation of the green site in Covid-19 presentations and emergency demand. Some of the recommendations reflected that demand had changed, as had some of the original ambitions. These had been reflected in the subsidiary recommendations at the end of the report.

1342/20 When conducting the review against the set criteria the Trust found that, the principles had been upheld and delivery had been achieved on the intended areas. Services were put in place that restored cancer services and operating had been restored to all patients in Lincolnshire, predominantly at Grantham Hospital. Chemotherapy services had also been restored and the Trust had maintained a level of protection against Covid-19 and other infectious diseases, no patients had contracted Covid-19 at Grantham Hospital.

1343/20 It was recognised that there were areas that required strengthening in the model and amendments had been made to reflect both staff and patient feedback. There had been an increase in the number of services being offered in the Grantham area over and above the original model described. This had included more outpatient services at the Gonerby Road site and diagnostic and outpatient services had increased in both breadth and number of patients able to access services.

1344/20 The Trust recognised that there remained areas for improvement, some of these would need to be addressed regardless of the decision made by the Board. These had been described in the secondary recommendations.

1345/20 The primary recommendation was for the green site to continue as proposed, noting a number of areas recommended to be strengthened in the future and as part of the original governance.

1346/20 The secondary recommendations described were over and above the primary recommendation made to the Board.

1347/20 Mrs Dunnett sought further information on three areas of the report including the emergency department at Lincoln and Pilgrim. An increase in attendances and admission from people with a Grantham postcode had been seen and Mrs Dunnett asked if there was a theme to the type of cases coming forward.

1348/20 Secondly Mrs Dunnett asked how quality and safety metrics were being collected alongside nurse sensitive indictors, had there been an increase in serious incidents. Thirdly Mrs Dunnett was pleased to see engagement with staff and patients being undertaken and asked how this would move forward over the coming months.

1349/20 The Chief Operating Officer explained that the increase in numbers of attendances was being seen in all areas, whilst there had been an increase in patients from the Grantham area accessing Lincoln and Pilgrim, there had been a significant increase overall.

1350/20 Before the model was put in place there had been a 66% reduction in patients accessing emergency care, part of the model was to restore urgent care services to pre-Covid-19 levels and restore confidence. The increase in patients proportionately accessing Lincoln and Pilgrim was expected and had been included in the original model. A large proportion would have been admitted due to patient transfers that would ordinarily have been seen.

1351/20 The themes for attendance were broad and themes for transfer from Grantham to Lincoln and Pilgrim were those conditions for which a subsequent admission would be expected. Many of the patients transferred in this period would have would have transferred prior to Covid-19 due to the range of services at Lincoln and Pilgrim.

1352/20 The Director of Nursing noted that there had not been any areas of concern raised through the Trusts incident management system or serious incidents. A number of incidents were reported each month and the severity of harm was in line nationally with acute hospitals. A specific piece of work was being conducted around the nurse sensitive indicators and as yet there had been no flags raised. Quality Metric Review meetings would commence in November across all sites on a monthly basis, initially reviewing the past 2 months of data.

1353/20 Dr Prior sought clarification on ophthalmology due to the increase in waiting lists. There had been indications from the people in the community of cancelled operations and also within the report there had been narrative to suggest increasing trends however Dr Prior felt the data did not support the interpretation. This was specifically in relation to surgical procedures, theatre data by speciality and first outpatient appointments.

1354/20 The Chief Operating Officer noted that ophthalmology was predominantly a low risk service and throughout phase 1 and 2 the majority of services had stopped across the county. As such this would feature heavily in the phase 3 recovery plan for services to be put back in place. The recovery phase started in August and therefore this was only partially reflected in the report. Ophthalmic services had commenced in significant numbers and Louth Hospital was being used to ensure social distance could be adhered to for those patients not prepared to or able to go through Covid-19 testing. It was noted that access to Louth Hospital was not straightforward, consideration was being given to service delivery from Gonerby Road or the Health Clinic in Grantham to increase outpatient capacity.

1355/20 Recently there had been an increase in cancellations. In the period between wave 1 and recent weeks there had been an increase in patients not completely adhering to isolation and social distancing. As such cancellations were made to protect the level of infection prevention and control. There had also been instances where testing capacity had not been timely and due to increased pressure and this had led to testing not being available before attendance at the green site.

1356/20 A smaller portion of cancellations had also been due to list overruns and the time required to decontaminate between procedures, this was however a minority. Cancellations compared to the last year, and proportionately adjusted, had improved on the previous year. The Grantham model offered protection from cancellation and would provide a strong position if the Board agreed to continue the model.

1357/20 The data presented in the report through Statistical Process Control (SPC) charts format had been to show elements of trend. This had been running across a significant period of time where it was not always easy to describe the overall impact in an SPC chart across a 3 month period. The narrative had attempted to describe the overall behaviour however it was noted that the increase in trend was genuine and an increasing position had been seen from the early moments of the model being put in place. A plateau however had started to be seen and the recommendations in the paper strengthen the model and increase this moving forward.

1358/20 Dr Prior noted that the information received about cancellations had been in relation to staff shortages and patients self-isolating with families were being told within 48 hours of the operation that it had been cancelled, this was in particular reference to orthopaedics.

1359/20 The Chief Operating Officer noted that this had occurred on one occasion where there had not been the level of staff required for the theatre that day. This was an isolated case and treated seriously, actions had been taken to ensure that this did not reoccur.

1360/20 Dr Gibson noted that the driving force behind the decision had been the impact for cancer patients and the significant deaths that could occur. Dr Gibson commended the Trust on the significant increases and impact on cancer patients.

1361/20 Dr Gibson noted that the data had shown a larger number of attendances at the urgent treatment centre (UTC) than previously attended the restricted hours A&E and asked if the attendances reflected out of hours attendances at the UTC.

1362/20 Secondly, Dr Gibson asked what the intentions were to enrich the measurement of patient experience not only for those at Grantham but to patients attending other care settings. There was a need to consider those patients that had been displaced.

1363/20 The Chief Operating Officer stated that that Trust did not run the UTC at Grantham, however worked closely with Lincolnshire Community Health Services NHS Trust (LCHS) who would hold the data. As such a response would need to be sought from LCHS.

1364/20 Comment was passed however that the increase was not proportionate to the increase in hours and there had not been significant volumes of arrival between midnight to 6am. Whilst this did accommodate for some of the increase it did not necessarily explain the increase over and above pre-Covid-19 levels. The Chief Operating Officer caveated the response to note that much of the modelling that had been undertaken was not following previous years behaviour within UTCs due to patients not necessarily accessing services and then requiring different levels of care.

1365/20 Patient experience, recognised in the report, had been a limitation. Whilst there had been a bespoke set of questionnaires for patients accessing Grantham services it was not easy to identify those patients accessing services elsewhere. There was a survey in place that covered patients and staff across all sites. Further work would be required to identify those patients who had accessed Grantham services in the past and were now attending elsewhere.

1366/20 Mrs Libiszewski asked if the long term health impact on the population, of the decision made around the reaction and treatment of Covid-19, was being considered by Public Health and the CCG. Particularly where there were continued delays to diagnostics and patients' not attending screening and GP practices. This may not be specific to the Trust as an acute provider but to the system.

1367/20 Secondly, Mrs Libiszewski asked if the movement to the emergency departments had been due to the skill set of the UTC and if these patients were expected normal presentations or outside of the normal presentation for a UTC. This could explain those referred to Lincoln but then not admitted. Mrs Libiszewski noted that as a member of the Board at LCHS the question would also be asked there.

1368/20 Thirdly, the table that described the types of patient being seen, refers to level 1 critical care medicine. This did not explain if these patients were expected to need that level of care or if it was needed due to what had happened to them during surgery. There was a need to understand the position to ensure that the case selection was appropriate for the level of care that could be delivered.

1369/20 Mrs Libiszewski also noted the need for comprehensive patient experience information that would enable the Trust to understand how patients were receiving care across Lincolnshire and the impact on the totality of patients moving across the county. There appeared to be more patients moving from Lincoln and Boston than were moving from Grantham. The totality of the impact on the Lincolnshire population of the green model would need to be seen to ensure this was meeting the needs of the patient.

1370/20 The Chief Operating Officer noted that work in phase 3 would be undertaken as a directive from NHS England on the review of long term health impacts with a focus on health inequalities. The CCG and system response would actively discuss the issues and impacts and this was being reviewed. It was clear that there was also activity taking place both in the NHS and across other professional groups to consider the impact of decisions made. Further publications would be expected from these groups to be distilled in to the systems' interpretation of what may have been done differently to other regions. It was expected that this work would take some time.

1371/20 The presentations to the UTC outside of normal presentations would need to be discussed. The model put in place had prescribed protocols and processes that were consistent with all other UTCs and therefore it would be unlikely for the UTC to expand the range of patient presentation characteristics because there was an increase in acute staff within this. The caveat to this is that a Same Day Emergency Care (SDEC) unit had continued to be delivered alongside the UTC and combined with that there may not be something picked up directly at the UTC but may be transferred internally to SDEC, this was led by ULHT physicians. This could account of some of the figures but should be explored further.

1372/20 In regards to the level 1 facility and lower level critical care, these patients were expected. There had been higher numbers anticipated and this reflected the precautions that had been taken and caution around having patients requiring higher dependency or critical care, there have been more caution that intended.

1373/20 There had not been significant transfers due to the need for critical care, this was positive. Going forward it was expected that this figure would marginally increase if the model continued.

1374/20 Comprehensive patient experience is needed and there are greater volumes of patients transferring Grantham rather than other way. A system would need to be developed to seek patient feedback across all sights in order to designate what service was being accessed to

understand the impact. Some of the qualitative data had been useful but was not at the volume required.

1375/20 The Chief Executive asked if capacity was being fully utilised at Grantham and if not what more could be done. Secondly, there was the need for the NHS to set aside dedicated capacity for planned operations, particularly as Covid-19 increases. If Grantham was reverted back to what it was prior to the decision on 11th June, what impact would that have on planned operations that could be carried out.

1376/20 The Chief Operating Officer noted that currently the theatres, throughout the first quarter, were being utilised to the highest levels ever recorded. However, the case selection of those operated on at Grantham meant that bed capacity was not being fully utilised. The original model made a recommendation to consider some bed capacity as a rehabilitation unit for green pathways. This was being considered and subject to the decision by the Board, would be something that would continue to be explored and put in place for winter, phase 3 and a potential second wave.

1377/20 In addition, there was a need to consider reconfiguration of the theatres, previously discussed had been weekend operating. This had not been put in place across all theatres but if this was to continue this would need to be done in the later months of the year. Consideration would also need to be given to extending and adding more theatres to fully utilise beds.

1378/20 Regarding capacity, if the Trust reverted the green site back the question would be how could green pathways be operated when there were known or query Covid-19 positive patients. The likelihood would be a significant increase in the level of risk to patients being operated on due to the mixed environment. Should there be an instance where a patient contracted Covid-19 operating would need to stop with possible closure of a service to conduct a deep clean. This would result in a loss of circa 30-40% each time this occurred and the risk of operating at Lincoln and Pilgrim combined was 10-15% should there be a positive case on either green pathway on those sites.

1379/20 The Chair noted the potential go live date for rehabilitation beds as the 1st November and asked if this would be achievable.

1380/20 The Chair sought a view from the Medical Director on how the arrangements at the green site had been felt to be working.

1381/20 The Medical Director noted that Covid-19 had brought a fundamental difference to the Trust and presented both a problem and opportunity. The green site had enabled clinicians to offer treatments required by patients and elective surgery that had improved the quality of life for patients.

1382/20 It had been a journey for clinical teams the protocols that had been put in place worked well. Teams had been able to upskill appropriately and this had enabled clinicians to maintain skill sets.

1383/20 The Trust had been able to offer training to Junior Doctors at the green site and from the perspective of the Medical Director this had made a big difference in providing care in a timely and appropriate way. There was learning but this continued to be a positive way in which to deal with the temporary issues of delivering services during a pandemic.

1384/20 The Director of People and Organisational Development offered a view on staff engagement nothing that dialogue with both staff and Staff Side had been positive. Executive Directors had conducted visits to both the green site and staff on other sites in the Grantham area.

Staff had recognised the impact the changes had made to patients and the positive benefits and staff were supportive of the actions taken.

1385/20 Staff had identified areas that could be improved both in terms of patients experience and the way in which the Trust operates in relation to staff and patients. These had included issues around the use of infection prevention and control and the extent to which there could be ongoing dialogue with staff that was more consistent.

1386/20 There was a need to recognise the impact of the model on a broad range of staff including those redeployed to and off the Grantham site. The Trust wanted to ensure that there was an opportunity for staff deployed away from Grantham to provide feedback on their experiences. Some of the recommendations within the report were important to ensure ongoing dialogue and improve staff engagement and experience of working in the new model.

1387/20 The Chair noted that there had been a good review of the paper and questions from Board members. The Chair noted that the Chief Operating Officer had confirmed that the Trust were on track for 16 rehabilitation beds from 1st November.

1388/20 The Chair summarised the discussions and drew the Boards attention to the recommendations within the paper. The criteria set in June that would result in halting the model and reverting, in the last three months, had not been met. The national context had been described and the model introduced at Grantham was a model that was being promoted by NHS England/Improvement.

1389/20 The Trust Board had debated the primary recommendation made to the Board for the continuation of the temporary service changes.

1390/20 The subsequent recommendations were considered by the Board noting that there were a number of site specific recommendations and three corporate recommendations.

1391/20 The Chair thanked the Chief Operating Officer and Executive colleagues for the work undertaken to establish the green site.

1392/20 The Trust Board:

- **Received the report noting the significant assurance**
- **Approved the primary recommendation - to approve the continuation of the temporary service changes enacted in June as a consequence of establishing the Grantham Green site model. The timescale for this continuation to last for the duration of Covid-19 to at least 31 March 2021. This timescale to be subject to a system wide review of the full next quarters activity available in early January 21 for the Trust Board's consideration in February 21.**
- **Approved the 9 secondary recommendations**
    - **Consider strengthening the Operational Management Capacity to provide oversight to the delivery of the Green site model at Grantham, to last for the duration of Covid-19. This capacity to ensure the establishment of a comprehensive performance management framework so that ongoing evaluation and routine reporting of the impact of these arrangements may be made. This to include**
        - **routine triangulation of Grantham surgical activity data pertaining to patient activity, theatre and bed utilisation to identify opportunities for further improvement of operational performance and update original modelled activity projections within the context of overall Trust activity.**
        - **revised OP attendance targets for Grantham**

- **an audit of IPC standards on the Grantham site, against the IPC BAF**

- **Consider establishing a Grantham Green site working group with clear terms of reference to undertake a review the existing Clinical Model with a view to further optimising capacity at Grantham and formally refresh the activity modelling, activity targets and QIAs & EIAs previously undertaken. This to include modelling of intended rehabilitation services to be present on the Grantham site from 1st November identifies clear activity and performance targets, the monitoring of which may be included in the ongoing Grantham wide evaluation and next formal review and as part of the Trusts overall performance reporting.**
- **Invite the endoscopy working group to remodel endoscopy activity trust wide in anticipation of easing of IPC requirements, translating this to explicit targets for Grantham going forward, including the potential for establishing 12hr sessions. This information to enable a routine monthly evaluation of performance to be reported on as part of the Trusts overall performance reporting.**
- **Invite the chemotherapy management team to remodel chemotherapy activity based upon the transfer of all patients onto the Grantham site. This information to enable a routine monthly evaluation of performance to be accurately and consistently reported on as part of the Trusts overall performance reporting.**
- **Consider the identification of a single individual taking responsibility for standardising, coordinating and reporting on surgical performance of the Trust as a whole, this to include overall surgical performance at Grantham.**
- **Formally establish with LCHS a collaborative framework for comprehensively evaluating the impact to patients and staff following the closure of Grantham A&E, findings to shared monthly with all stakeholders and as part of the next formal quarterly review of the Grantham Green model.**
- **Consider ways of establishing a dialogue with all staff currently working at Grantham, those visiting Grantham and those transferred from the Grantham site, to ensure all experiences and suggestions inform learning and ongoing strengthening of the temporary model.**
- **Ensure any future need to redeploy staff is based upon clear corporate criteria relating to skills and need, to promote fairness and equality.**
- **Consider inviting STP colleagues to support the trust develop an explicit framework for establishing and sustaining effective engagement with staff to strengthen communication across the trust.**

1393/20 **Item 7 Patient/Staff Story**

1394/20 The Director of Nursing introduced the patient story to the Board noting that this provided patient feedback from the rapid introduction of video consultation during the beginning of the year. The story reflected the experiences of both staff and patients. The Director of Nursing thanked Clare Frank - Project Manager for joining the Board to answer specific questions following the story.

1395/20 The patient story was played for Board members and detailed the aim of introducing video consultation for patients. It was recognised that outpatient services were difficult for many

people to attend and did not always meet the needed of patients, leading to high rates of non-attendance.

1396/20 The introduction of non-face to face outpatient appointments aimed to reduce the footfall within outpatient departments by 30% in line with the NHS Long Term Plan, improve patient experience, reduce the Trust's carbon footprint and provide an opportunity to redesign delivery of current outpatient services.

1397/20 The Trust had in place an Attend Anywhere licence that delivered video consultations until March 2021. To date over 4000 patients had used video consultations and 900 had responded to the feedback survey, with 68% of respondents stating that it had been more convenient.

1398/20 The feedback received had been positive from both patients and staff however it was noted that a number of staff had found video consultation more stressful than holding a face to face clinic.

1399/20 The Trust planned to continue using video consultations and for these to become the default modality wherever clinically appropriate. Following the rapid introduction of video consultation there had been key learning identified.

1400/20 The Chair felt that both the clinical and patient feedback demonstrated that there was a need to try different ways of working as these were convenient and easy to use.

1401/20 The Medical Director noted that as video consultations commenced he was cynical about how these would work. However there had been significant learning and for a good proportion of patients there had been a good experience and many patients had asked for a follow up in this manner. There were limits to being able to examine patients and to understand the environment in which they were in during a consultation. The Medical Director noted that this had been a great development, particularly for such a rural county.

1402/20 The Chief Executive noted that Phase 3 guidance stated that where an outpatient appointment was clinically necessary the national benchmark was for at least 25% of these to be conducted by video or telephone, including 60% of all follow up appointments to be held in this way. The new way of working will be virtual and the Chief Executive asked if the public were aware of the aspiration for the NHS. This was something that required focus and when discussing recovery there should be clarity that this was about considering new models and pathways, not just putting back what was in place before.

1403/20 Discussions were ongoing with the CCG and also promotion with GP practices in relation to video consultations.

1404/20 Areas were being identified where there was a lack of broadband and consideration being given to potential alternative provision for patients.

1405/20 The Chair confirmed that the Board would continue to support the use of video consultations.

1406/20 The Director of Improvement and Integration noted that both video consultation and outpatient improvements were part of the Integrated Improvement Plan pre-Covid-19. Covid-19 had enabled the acceleration of what the Trust were trying to achieve and increased the scale of achievement in the financial year. The Trust had taken the opportunity to increase the scale across all sites and specialities.

1407/20 The ambition for the Trust was to exceed the national expectation and it was felt that this would be achievable. This would need to be progressed with staff, the public and other organisations.

1408/20 The Director of Improvement and Integration thanked the team for the work undertaken in a challenging and anxious time and for the rapid transformation of outpatients. Video consultation hubs were now in place and there was now the need to consider how notes were transferred across the sites and how consultations were captured and supported. This was very different to traditional care and there had been a need to review policies and procedures. A large amount of work had been undertaken to reach this position and it was positive that this had been so well received by patients and staff.

1409/20 The Director of Finance and Digital noted that there had been a significant amount of digital work undertaken and this had been one of the biggest things undertaken in the short amount of time for the Trust. The Director of Finance and Digital noted thanks to the team for the support to make this work.

1410/20 It was noted that Attend Anywhere had been funded nationally until March 2021 at which point future contracts would revert to the Trust. This was currently being reviewed to ensure that the system used to deliver the service provided a good experience for both patient and staff users. The use of Attend Anywhere had also supported staff to work from home during the pandemic.

1411/20 The moving of notes around the Trust reinforced the need to continue on the journey to achieve E-Health records and the Trust were progressing this. As the county was so rural there would be a need to consider innovative approaches to ensure this worked for Lincolnshire.

1412/20 The Chair noted the comments made by Board members asking how staff who were not confident with technology were supported and what was being considered to support patients who did not have access to technology.

1413/20 The Board were advised that staff had been sent a guide to using the technology and a training package was being developed by the Education Department. Clinicians were also offered an opportunity to conduct a practice session and for someone to sit with them during the first live clinic.

1414/20 For patients who did not have access to technology the Trust were considering the use of video conferencing hubs in local health centres and alternative locations.

1415/20 The Chair noted that the presentation and endorsed the comments made by the Executives. This was a fantastic pieces of work that had moved the Trust to delivering a technology solution at considerable volumes. The change in behaviour and culture could not be underestimated.

1416/20 The Trust Board:

- **Received the patient story**

Item 7.1 BREAK
Item 8 Objective 1 To Deliver high quality, safe and responsive patient services, shaped by best practice and our communities

1417/20 **Item 8.1 Assurance and Risk Report Quality Governance Committee**

The Chair of the Quality Governance Committee, Mrs Libiszewski provided the assurances received by the Committee at the 22nd September 2020 meeting.

1418/20 Mrs Libiszewski noted the lack of assurance received in respect of objective 1a however the Committee were heartened to see an improved level of detail in the reporting of Never Event actions.

1419/20 There was significant work happening across the Patient Safety Group to review the risk register and particularly the completed actions to ensure the risk register was kept up to date.

1420/20 A training need had been identified within the divisions in relation to management of the risk registers and training was due to take place.

1421/20 The Committee had asked to receive an update on the safety culture work being undertaken in the organisation.

1422/20 The Committee noted that there was significant work happening with regard to safeguarding training packages to enable the Trust to deliver training virtually rather than face to face. The Safeguarding Annual Report had been received by the Board but scrutinised by the Committee.

1423/20 The Committee noted that there had been a non-clinical outbreak of Covid-19 amongst staff, this had been handled appropriately.

1424/20 The Clinical Effectiveness Group had reported on the national lung cancer audit and the Committee noted that the Trust fell below the national standard. Further work was being undertaken in the group and a further report would follow in due course. It was noted that the group had reviewed the First Do No Harm report and this again would be received by the Committee at a future meeting.

1425/20 Concern was noted by the Committee in relation to IR(ME)R licenses and an issue identified by the Patient safety Group. This had be quickly rectified and the Radiation Group were reviewing the issue to ensure that this did not occur again.

1426/20 Several reports were received by the Committee relating to patient experience however these were not of a sufficient quality to provide assurance, these would be re-presented to the Committee in due course.

1427/20 The first of the divisional attendances had taken place and these had now been scheduled for all divisions. The Family Health Division had provided the Committee with an update on the Paediatric Assessment Model as delegated by the Board. The model was now fully embedded with further refinement within the improved model, there had been significant engagement with the public.

1428/20 The Maternity Clinical Negligence Scheme for Trusts (CNST) would be reinvigorated nationally following Covid-19 and a pause, a significant review of the work would be undertaken by the Committee however Mrs Libiszewski recommended to the Board that consideration should be given to a workshop for Board members to familiarise themselves with the agenda.

1429/20 The maternity dashboard was received and significant action was being taken across a number of indicators. An update was received on the Healthcare Safety Investigation Branch (HSIB) work and the reports were awaited.

1430/20 An update was provided to the Committee in relation to the recent inquest and the division were due to meet with the Director of Nursing and Medical Director to discuss specific issues.

1431/20 The Committee requested that the Clinical Governance Review was received back at the October Committee as sufficient time had not been afforded for due diligence. Following this the Committee would advise the Board if there were any actions that required consideration.

1432/20 The Committee received the position against the NHS England/Improvement review of the Committee and whilst all actions had been completed the Committee would embed these in to the terms of reference and work programme of the Committee.

1433/20 Mrs Dunnett supported the recommendation, as the Maternity Champion, for consideration of a workshop to be held in relation to CNST.

Action – Trust Secretary, 3 November 2020

The Trust Board:

- **Received the assurance report**

1434/20 **Item 8.2 Patient Safety Incident Management Report**

The Director of Nursing presented the report to the Board highlighting that this was a summary of the detailed report received by the Quality Governance Committee.

1435/20 There was now a clearer view of the number of open incidents and those completed within 4 weeks as per the key performance indicator (KPI). As previously reported to the Board the reported demonstrated that the current approach for incidents required strengthening.

1436/20 During August there had been 17 serious incidents reported and as previously described to the Board 1 Never Event had occurred, the detail of this had been delivered to the Quality Governance Committee in September.

1437/20 An improving position was being seen in relation to open actions associated with Never Events. The Board were asked to note that 78% of incidents resulted in no harm, 20% in low harm and 2% with moderate, sever harm or death. This was in line with national average however the Trust aspired to learn from these.

1438/20 The Patient Safety Group were picking up a number of recommendations from the report and would take action to improve.

1439/20 Dr Gibson commended the detailed analysis of the root cause of Never Events noting that this had provided and understanding and a number of helpful actions going forward.

1440/20 Mrs Ponder asked if there was a plan in place to deal with overdue investigations as considerable progress had previously been made on reducing the backlog and how the Trust would improve the dissemination of learning from investigations.

1441/20 The Director of Nursing noted that in relation to overdue investigations, month on month overdue investigations were picked up. Specific work was underway with the division in order to address the backlog, some actions were process related and others were about needing to close actions in a timely manner.

1442/20 There were a number of real actions associated with incidents and there were being worked through with the divisions with support being provided by the Clinical Governance Team. A number of actions were now coming through and being completed.

1443/20 KPIs were being developed in order to have a clear dashboard in place that provided an oversight of the number of actions, those overdue or those coming on as a result of incident reports. This would be seen on a weekly basis and reported to the Quality Governance Committee.

1444/20 The Director of Nursing stated that in relation to the dissemination of learning, if there were a number of overdue actions this would raise the questions of the learning culture within the organisation. This would feed in to the safety culture work being led by the Medical Director.

1445/20 The Board were advised that there were some immediate actions that could be taken as good practice including newsletters, immediate safety alerts and being clear at the point of the incident that immediate action was taken.

1446/20 The Chair noted that there was a degree of rigour that had been applied and the Board had received moderate assurance.

The Trust Board:

- **Received the report noting the moderate assurance**

1447/20 **Item 8.3 CQC Update**

1448/20 The Director of Nursing presented the report to the Board noting that it was important for the Board to be updated on the Truss communications plan in relation to an impending CQC inspection.

1449/20 The Director of Nursing noted that this was not about preparing for an inspection but being ready for an inspection, the Trust should be delivering the same care day in day out with every day being a CQC day.

1450/20 The Board were advised that a number of confirm and challenge sessions had been undertaken with the divisions with all but one completed. These had been held with Executive colleagues to support the divisions in demonstrating their position against previous inspection actions. Positive progress had been seen from divisions and support provided from the triumvirates.

1451/20 The communications plan was presented along with a leaflet to support staff who may not have previously experienced a CQC inspection and also for those that had. The leaflet would allow staff to understand what an inspection was about and the expectation of the CQC when they arrive in the organisation.

1452/20 The plan and leaflet had been endorsed by the Executive Directors and the Board were asked to endorse the documents ahead of sharing across the organisation.

1453/20 The Chair and other Board members noted how well thought out the document was and commended colleagues who had pulled this together.

1454/20 Mrs Dunnett asked how the Non-Executive Directors may be able to, in the future, provide support with preparation for inspections.

1455/20 Dr Gibson asked if there was a need to supplement the information for those staff who were in non-ward settings as this was clinically focused.

1456/20 Mrs Ponder noted that the role of middle and junior managers as leaders and their role in leading teams to be prepared, was not clear within the document. The Director of Nursing

noted that there had been a number of conversations regarding middle and junior managers and reflected that this would be further clarified within the communications plan.

1457/20 The Chief Executive echoed the comments made regarding the quality of the paper and agreed with the remarks from the Director of Nursing that this was not about rehearsing for an inspection. The Chief Executive was keen that staff felt able to share achievements, opportunities as well as the challenges that were faced in an open, transparent and confident manner. The Trust were keen that staff could reflect the work that staff were undertaking along with the values of the organisation.

1458/20 The Chair agreed with the comments made by the Chief Executive noting that there was a desire to move to a culture approach that celebrated what was done well whilst recognising areas for improvement.

The Trust Board:

- **Received the report noting the significant assurance**
- **Endorsed the communications plan**

Item 8.4 Safeguarding Annual Report

1459/20 The Director of Nursing presented the annual safeguarding report to the Board noting this was the report for 2019/20. The report provided the Board with the level of assurance required to meet its statutory responsibility in relation to safeguarding.

1460/20 The Trust now had a strategic lead in place for safeguarding who would produce the 2020/21 report during quarter one of next year for onward reporting to the Board. The current report had been reviewed in detail be the Quality Governance Committee and was presented to the Board for final approval.

The Trust Board:

- **Received the report**
- **Approved the Safeguarding Annual Report**

1461/20 **Item 8.5 Establishment Review**

1462/20 The Director of Nursing presented the establishment review to the Board noting that these had been undertaken during August for all inpatient ward areas for two reasons. To assure the Director of Nursing on the appropriateness of ward establishments and to consider if these were still appropriate given the impact of Covid-19.

1463/20 A number of areas were not included within the review and work would be undertaken across the emergency departments. Birth Rate Plus was being commissioned in order that a review of maternity establishments could be undertaken. There was also a need to look at the paediatric model based on the changes that were being made.

1464/20 An establishment review for theatres had been conducted last year and approved, this would be reviewed towards the end of the year to determine if this remained appropriate.

1465/20 Through the review MEAU on the Lincoln site was reviewed and currently operates at a 50 bed base, this had previously been budgeted at 40. Through the work undertaken a review and establishment for 50 beds had been funded at no additional cost to the organisation.

1466/20 The Intensive Care Unit (ICU) at Lincoln was commissioned for 10 level 2 beds and 6 level 3 beds, in order to provide flexibility in the unit at Lincoln. The level of occupancy at the unit meant that a number of ICU staff had been moved to support the wider site, this was appropriate, but a consequence to doing this was that the education and knowledge base of critical care nursing staff reduced. Some of the budget apportioned back would provide flexibility to support education and training and to develop a points based system for how the funded beds were staffed across the critical care unit.

1467/20 There had been a clear methodology used for the review that was objective and evidence based. Wards undertook work to bring evidence to the review meetings and in doing so this ensured that the Trust continued with long days and long nights but shorter shifts were built in to support the flexible working policy.

1468/20 Leave arrangements were built in to the establishment and headroom of 22.5% in line with safer staffing nationally.

1469/20 Supernumerary and supervisory time for Band 7 Ward Sisters had been built in to the establishment and equates to a significant amount of the registered nursing that the Trust would be looking to remove overall from the establishment. This would provide 56 whole time equivalent of registered nursing movement against healthcare assistant movement within the establishment. This move was predominantly associated with the shift to a 60/40 split of supernumerary and supervisory time and stated the attitude to clinical leadership at ward level and was in line with the ward leaders national handbook.

1470/20 The Board were advised that there was now a nursing workforce plan in place and that this was in line with the Chief Nursing Officer for England's' call for action across the NHS to extend the number of registered nurses and healthcare assistants.

1471/20 The costs and variation had been included within the report and this would deliver a subtotal of circa £1.1m saving of which £500k would be reinvested in to Lincoln ICU. This would provide an overall saving of £534k.

1472/20 A number of actions, once the establishment was approved, would be taken to implement templates and ghost rosters had already been undertaken from November, this would set the Trust up well for the winter and festive period. A skill mix review would be undertaken in 6 months.

1473/20 The output from the review provided a baseline and supported the nursing workforce transformation programme which could now be implemented with a degree of robustness and clarity of process and control, particularly around the temporary workforce usage and spend.

1474/20 The Director of Nursing advised that, with the finance team, the impact of any ward inefficiencies that had been identified were being worked through and collectively with the Director of Finance and Digital and Chief Operating Officer offered the paper to the Board for approval of the new establishments.

1475/20 The Chair noted that the report provide clarity of the intention to achieve and the methodology that had been applied, alongside the outcome. The Chair thanked the Executives for the work that had been undertaken.

1476/20 The Director of Finance and Digital advised that the work undertaken in relation to efficiencies was something that had not previously been carried out. It had been possible to identify drivers of the cost base that differed for the Trust if the estate and rural nature of the county did not impact how the establishments were configured.

1477/20 Further work was being carried out that should enable the Trust to identify the cost of operating in the model and build in to the long term why the cost of operating is so much for United Lincolnshire Hospitals NHS Trust.

1478/20 Mrs Libiszewski noted that the Board were required to receive assurances on the workforce safeguards report and this required a review of all staff to ensure the right numbers were in place. The review conducted was in relation to nursing and Mrs Libiszewski asked if other elements of the workforce would be reviewed, both clinical and non-clinical.

1479/20 The Director of Nursing noted that there was a desire to work through a review for all staff and the review conducted provided a positive start for the largest element of the workforce which had been supported by an evidence base. It would be the right thing to do particularly in relation to clinical nurse specialists.

1480/20 The Director of Improvement and Integration noted that this had been the most transparent methodology with regard to identifying the nursing establishment, clarity was sought in relation to the impact on the core bed stock given the changes described to bed bases.

1481/20 The Chief Operating Officer noted that there were advantages and disadvantages of establishing core bed capacity. Overall the impact of the review would be minus 14 beds however included would be the establishment of additional beds. As part of planning for Phase 3 and winter these figures had been used. There were also escalation beds that had not been counted within the core capacity in order that these could be used to flex.

1482/20 The Director of Nursing noted that if had been clear that the modelling needed to be objective and transparent and stand up to scrutiny. All quality impact assessments had been reviewed to support this and with the methodology in place this had been straight forward.

1483/20 The Chief Executive sought assurance that ward leaders have been involved and support the outcome.

1484/20 The Director of Nursing advised that ward leaders were involved in the process and supplied the data and evidence to the review the establishments. There had been an open dialogue with ward leaders and agreement from all involved with the outcome of the establishment reviews and these were supported.

1485/20 Ongoing review of staffing was taking place through twice daily staffing reviews and quality metric review meetings with a number of triggers in place, this would alert to an establishment that may not be appropriate or if there had been a case mix or acuity change. At this point a review would be undertaken of the establishment.

1486/20 The Medical Director reflected on the point raised about establishment reviews being applied more widely. There was no clear national guidance or methodology in place for clinical service reviews to ensure efficient and effective staffing. The Get It Right First Time programme could be used to support this however this would not resolve all issues. National methodology would support the Trust in order to be able to undertake wider reviews.

1487/20 The Director of People and Organisational Development noted that there had been a discussion at the Trust Leadership Team about the issue of having a methodology in place for transforming the medical workforce and ensure capacity was right sized for the services the Trust would like to deliver.

1488/20 A task and finish group had been established to identify a methodology for reviewing services and the intent was to identify clear strategies going forward for the use of alternative roles

such as Physician Associates.

The Chair noted that the nursing aspect was only part of the establishment for the Trust and there was a need to provide focus to other areas.

The Trust Board:

- **Received the report noting the significant assurance**
- **Approved the establishment**

Item 9 Objective 2 To enable our people to lead, work differently and to feel valued, motivated and proud to work at ULHT

1489/20 **Item 9.1 Assurance and Risk Report People and Organisational Development Committee**

The Deputy Chair of the People and Organisational Development Committee, Mrs Dunnett provided the assurances received by the Committee at the 16th September 2020 meeting.

1490/20 Mrs Dunnett noted that an update had been received by the Committee in relation to progress towards the Medical School and University Hospital Teaching Trust status and advised that the Committee were yet to be assured on completeness and progress of the plans presented. As a result of the lack of assurance the Committee had revised the assurance rating from Amber to Red.

1491/20 The Board were advised that there was a significant amount of work being undertaken however this was not being seen by the Committee. The Committee had requested sight of an overarching plan that detailed the timescales and asked that quarterly reports were provided in order that assurance could be provided to the Board.

1492/20 The Medical Director noted that the reduction of the assurance rating was valid and the progress that had been made now offered clarity on the exact nature of the task. This was the commencement of a journey and remained an aspiration however the precise metrics had remained unclear. The paper received by the Committee had been able to offer a criteria providing a clearer and better defined goal.

1493/20 The Medical Director advised that the Research Strategy was due to be received by the Board in November and this would be a key element of progress towards the objective.

1494/20 The Chair noted within the report the action requested by the Committee in relation to the bullying update and endorsed the action requested by the Committee to understand the effectiveness of the programme.

The Trust Board:

- **Received the assurance report**

Item 10 Objective 3 To ensure that service are sustainable, supported by technology and delivered from an improved estate

1495/20 **Item 10.1 Assurance and Risk Report from the Finance, Performance and Estates Committee**

The Chair of the Finance, Performance and Estates Committee, Mrs Ponder provided the assurances received by the Committee at the 24th September 2020 meeting.

1496/20 Mrs Ponder noted that there was some planned investment through the capital programme which would alleviate some of the historical issues faced in relation to water flushing.

1497/20 The fire programme had experienced some delays largely due to Covid-19 however work was underway to rectify the position. A Fire Authorising Engineer had been appointed to help deliver compliance with fire safety.

1498/20 The Trust had continued to break even at Month 5 and the Committee had been advised by the Digital Hospital Group that it continued to mitigate server risks using network segregation. The Board were advised that this was a national issue that NHS Digital were seeking a solution to.

1499/20 The Committee had received assurance that should a second wave of Covid-19 be experienced that this would not have a major impact on capital programmes as ward activity was unlikely to be affected.

1500/20 The Director of Finance and Digital advised that the server patching was in relation to suppliers of systems and not Trust owned devices or servers. NHS Digital were attempting to resolve the issues due to this being a national concern.

The Trust Board:

- **Received the assurance report**

Item 11 Objective 4 To implement integrated models of care with our partners to improve Lincolnshire's health and wellbeing

1501/20 **Item 11.1 CQC Lincolnshire System Provider Collaboration Review**

The Chair noted that the item was received by the Board for information and was a system review that considered the Sustainability and Transformation Partnership (STP) and focused on how organisations had worked collaboratively in light of the Covid-19 pandemic.

1502/20 It was noted that the review had been positive with the highest effective collaboration between organisations across the Lincolnshire STP footprint. There were some areas to provide focus to which had been identified by the system and a number of actions were in train.

The Trust Board

- **Received the report**

1503/20 **Item 11.2 System Wide Social Marketing Campaign**

Due to technical difficulties the Director of Communications and Engagement, Lincolnshire NHS was unable to join the meeting. This item was taken at the end of the Board agenda.

1504/20 The Chief Executive presented the social marketing campaign to the Board noting that this had been at the Chief Executives' forum and had flowed from the Covid-19 experiences about how the system worked with the population to sustain some of the positive behaviour changes that had been seen.

1505/20 There were 5 positive behaviours that the system were suggesting would be the focus of a social marketing campaign, these being; looking after yourself, eating healthy food and getting advice, visits a pharmacist before a GP, maintaining routine appointments, asking for a telephone or video appointment and calling or visiting 111 online before attending an urgent treatment centre of A&E.

1506/20 The Board were receiving the marketing campaign to ensure they were informed of this and to seek any observations on the campaign ahead of this being progressed.

1507/20 The Board were advised that a number of groups and settings across the system had been engaged in the development of the campaign and it was noted that there was support for engaging with the population around behavioural change.

1508/20 The Chair noted that members of the Board had provided comments that would be fed back to the Director of Communications and Engagement.

1509/20 Dr Prior noted that the campaign metrics indicated a 5% increase on pre-Covid-19 level of outpatient telemedicine appointments and noted that given the 436% increase during Covid-19 this did not appear to be ambitious.

1510/20 The Chief Executive noted that the metrics had been developed on the understanding that some services may not revert back to pre-Covid-19 delivery models. As time had gone on, particularly since some of the campaign had been written, general practice and the hospital sector had agreed to continue with the telemedicine approach. It was noted however that the campaign was encompassing across all system partners and there was a desire for this to be ambitious.

1511/20 The Board noted that the metrics were yet to be finalised and that these would be linked with improvement work across the system.

1512/20 Dr Gibson asked if this was supported by Primary Care and it was noted that the campaign had been developed across the Clinical Commissioning Group and provider Trusts including the Local Medical Committee and Primary Care Networks.

The Trust Board:

- **Received the report**

1513/20 **Item 12 Integrated Performance Report**

The Chair noted that the Committees had conducted due diligence to the relevant key performance indicators (KPIs) and areas of focus during September. The report presented provided limited assurance however was developing in to an informative report detailing information on actions being taken.

1514/20 The Director of Finance and Digital noted that all aspects had been covered in the upward reports from the Committees and a further review of KPIs was being undertaken to ensure there was clarity on the outcomes required.

1515/20 Dr Gibson noted that the sickness absence graph demonstrated a steady adverse trend since January 2019 and raised concern about the position as the Trust moved forward to a winter of winter pressures, Covid-19 surge and maintaining elective care.

1516/20 The Director of People and Organisational Development agreed with the comment made and noted this reflected the increasing pressure upon staff in the organisation. A significant portion of sickness would be stress related however the Trust had a comprehensive health and well-being offer in place that was further enhanced during Covid-19.

1517/20 The Integrated Improvement Plan contained a work stream in relation to managing absence and the Trust were currently implementing an absence management system. This would allow managers to more effectively manage absence and work with Occupational Health to

support staff. Regular reports were received by the People and Organisational Development Committee and a continued focus remained on the employee relations team working with hotspot areas.

1518/20 The Chief Operating Officer noted that the deterioration was consistent with national acute hospital providers.

The Trust Board:

- **Received the report noting the limited assurance**

Item 13 Risk and Assurance

1519/20 **Item 13.1 Risk Management Report**

The Director of Nursing presented the report to the Board advising that the report presented was a summary with the detailed review having been undertaken by the Quality Governance Committee.

1520/20 The report received by the Quality Governance Committee was the developing report that provided clearer reporting and highlighted gaps in controls and mitigations. Changes were being seen within the register as detailed in the report.

1521/20 The Director of Nursing noted that the static nature of the risk profiles indicated that the mitigations were not reducing risk for the Trust and gaps in controls did not appear to be reflected, this would need to be addressed. The use of key performance indicators were being introduced in order to evaluate risks.

1522/20 It was recognised that there had been limited risk management training available to staff, this was now being put in place which should support progress and movement in the risk register. Movement of risks and ratings would enable the Board to be clear of the exposure to risk being held.

1523/20 Mrs Dunnett noted that there would be a need to review the EU Exit risk due to the transition period coming to a close. It would be helpful to see the risk reviewed, particularly in relation to gaps in supply and staffing.

Action: Director of Nursing 3 November 2020

1524/20 The Chair noted that the executive summary had been clear and identified where there had been increases in risk. The emerging format of the report had helped to provide focus to the risks and the mitigating actions.

The Trust Board:

- **Accepted the top risks within the risk register**
- **Received the report and noted the moderate assurance**

1525/20 **Item 13.2 Board Assurance Framework**

The Chair noted that the Board Assurance Framework had been reviewed by each of the Committees and noted that change of assurance rating for objective 4c from amber to red as advised through the assurance report from the People and Organisational Development Committee.

1526/20 The Trust Secretary advised the Board that the Quality Governance Committee had requested work from the Executive Leads regarding the content in relation to objective 1 and this would be completed and fed in to the October Committee meeting.

1527/20 The Chair noted that the report provided limited assurance and reflected the amount of red assurance ratings provided.

The Trust Board:

- **Received the report and noted the limited assurance**

1528/20 **Item 14 Board Forward planner**

The Board received the forward planner for information noting the content.

The Trust Board:

- **Received the forward planner**

1529/20 **Item 15 Any Other Notified Items of Urgent Business**

There were no other notified items of urgent business

The next meeting will be held on Tuesday 3 November 2020, arrangements to be confirmed taking account of national guidance

Voting Members	**5 Nov 2019**	**3 Dec 2019**	**4 Feb 2020**	**3 Mar 2020**	**7 Apr 2020**	**5 May 2020**	**2 June 2020**	**11 June 2020**	**7 July 2020**	**4 Aug 2020**	**1 Sept 2020**	**6 Oct 2020**
Elaine Baylis	X	X	X	X	X	X	X	X	X	X	X	X
Chris Gibson	X	X	X	X	X	X	X	X	X	X	A	X
Geoff Hayward	X	X	X	X	X	A	A	A	A	A	A	A
Gill Ponder	X	X	X	X	X	X	X	X	X	X	X	X
Neill Hepburn	X	X	X	X	X	X	X	X	A	X	X	X
Sarah Dunnett	X	X	X	X	X	X	X	X	X	X	X	X
Elizabeth Libiszewski	X	X	X	A	X	X	X	X	X	X	X	X
Paul Matthew	X	X	X	X	X	X	X	X	X	A	X	X
Andrew Morgan	X	X	X	X	X	X	X	X	X	X	X	X
Victoria Bagshaw	X	X	X									
Mark Brassington	X	X	X	X	X	X	X	X	X	X	X	X
Karen Dunderdale				X	X	X	X	X	X	X	X	X

PUBLIC TRUST BOARD ACTION LOG

Agenda item: 6

Trust Board date	Minute ref	Subject	Explanation	Assigned to	Action due at Board	Completed
1 October 2019	1576/19	Smoke Free ULHT	Post implementation review to be presented to the Board	Rayson, Martin	~~07/04/2020~~ 03/11/2020	Agenda Item for Private Board December
1 October 2019	1641/19 and 1642/29	NHS Improvement Board Observations and actions	Updated action plan to be presented to the Board and Audit Committee to receive reports and action plans	Warner, Jayne	~~03/12/2019~~ ~~4/12/2019~~ ~~13/07/2020~~ 03/11/2020	Audit Committee reviewed actions. Detail within Audit Committee Upward Report -Complete
5 November 2019	1747/19	Assurance and Risk Report Finance, Performance and Estates Committee	Business case review of fire works to be completed and reported back to Finance, Performance and Estates Committee detailing spend	Matthew, Paul	~~3/12/2019~~ ~~03/03/2020~~ ~~25/07/2020~~ 03/11/2020	Action Plan Agenda Item Private Board - Complete
4 February 2020	077/20	Assurance and Risk Report Quality Governance Committee	Review of TOM and governance to be presented to the Board	Evans, Simon	~~07/04/2020~~ ~~07/07/2020~~ 03/11/2020	Int Audit review still awaited – Chased - See Audit Committee Upward Report
3 March 2020	343/20	Staff Survey Results	Review staff survey indicator in relation to violence from patients to identify hot spots to focus activity and support	Rayson, Martin	~~07/04/2020~~ 07/07/2020	Task and finish group set up to review levels of violence Closed
6 October 2020	1433/20	Assurance and Risk Report Quality Governance Committee	CNST Board Development workshop to be arranged	Warner, Jayne	03/11/2020	Added to potential future items for Board Development Programme 2021 – Complete

PUBLIC TRUST BOARD ACTION LOG

Agenda item: 6

6 October 2020	1523/20	Risk Register	EU Exit risk to be reviewed due to reaching end of transition period in relation to gaps in supplies and staffing	Karen Dunderdale	03/11/2020	To be picked up in monthly review by Exec Leads

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Public Trust Board*
Date of Meeting	*3 November 2020*
Item Number	*Item number 6*
Chief Executive's Report	
Accountable Director	*Chief Executive*
Presented by	*Andrew Morgan, Chief Executive*
Author(s)	*Andrew Morgan, Chief Executive*
Report previously considered at	*N/A*

How the report supports the delivery of the priorities within the Board Assurance Framework	
1a Deliver harm free care	
1b Improve patient experience	
1c Improve clinical outcomes	
2a A modern and progressive workforce	
2b Making ULHT the best place to work	
2c Well Led Services	*X*
3a A modern, clean and fit for purpose environment	
3b Efficient use of resources	
3c Enhanced data and digital capability	
4a Establish new evidence based models of care	
4b Advancing professional practice with partners	
4c To become a university hospitals teaching trust	

Risk Assessment	*N/A*
Financial Impact Assessment	*N/A*
Quality Impact Assessment	*N/A*
Equality Impact Assessment	*NA*
Assurance Level Assessment	*Insert assurance level* • *Significant*

Recommendations/ Decision Required	• *To note*

Executive Summary

1. **System Issues**
   a) The NHS organisations across the system are continuing to focus on COVID/winter/service recovery and restoration. With the increasing incidence of COVID in the community and the increasing number of patients in hospital, all parts of the system are now very busy. The infection prevention and control requirements that need to be in place has meant that service delivery has not just reverted to the pre-March position.
   b) The social change campaign 'Let's do this together', which was the subject of a Board paper in October, officially launches on 5th November. The five positive behaviours that the campaign highlights can make a real difference to our NHS and to the people and communities of Lincolnshire are as follows: looking after yourself, eating healthy food and getting active; visiting a pharmacist before a GP; maintaining routine appointments; asking for a telephone or video appointment; calling or visiting 111 online before attending an urgent treatment centre or A&E.
   c) The next stage of the Acute Services Review process is a review by a NHS Midlands Regional Panel on 12th November. Various representatives from the Lincolnshire system will be in attendance to answer questions about the Pre Consultation Business Case (PCBC) that was submitted earlier in the year.
   d) The System Review Meeting (SRM) with regulators on the 7th October focused on infection prevention and control, COVID, winter and service recovery plans, urgent and emergency care performance, cancer performance and the Integrated Improvement Plan. Whilst there are some areas requiring further work and follow-up, the discussion was positive and constructive. NHS Midlands indicated that they were impressed with much of the work that was underway.
   e) The system has submitted both a system financial plan for the second half of the financial year 2020/21 and individual organisational financial plans. Further discussions will now take place, with a view to reaching a situation whereby there is a robust plan, backed up by action, which ensures that the year-end position is in line with the financial envelope that has been made available.

2. **Trust Issues**
   a) The Big Conversations with staff about the Integrated Improvement Plan (IIP) are continuing and the virtual sessions should come conclude at the end of October. Alternative arrangements are being worked up for those staff who have yet to participate in a session. The expectation is still that all staff will attend a session. The feedback from the sessions that have been held to date has been very constructive.
   b) The staff flu campaign is continuing, with a strong focus on peer vaccinators. At the time of writing, 40% of front-line staff had received their vaccination. An updated position will be provided to the Board on 3rd November.

c) The Trust has joined a national NHSE/I programme relating to better understanding the issues affecting rural acute hospitals. The first virtual workshop was held on 22nd October, involving Trusts from around the country. This work will focus on better understanding the issues affecting rural acute trusts; engaging such Trusts in policy discussions; testing ideas; and operating as a learning network. Further workshops are planned.
d) The 2020 National Staff Survey questionnaire has now been made available to staff. This is a confidential questionnaire distributed and analysed by the Picker Institute. This is a key way for the Trust to obtain the views of staff and it is hoped that the Trust will improve on the 50% response rate from last year.
e) The Trust has confirmed that it will be re-introducing car parking charges for patients and visitors with effect from 2nd November. The rates will be lower than those in place before the charges were suspended in March 2020.
f) A positive discussion was held with representatives from the University of Lincoln and the University of Nottingham about the operation and ongoing development of the Lincoln Medical School. Topics discussed included clinical placements, new academic posts, development of the curriculum, the education centre at Lincoln County Hospital and the promotion of the work of the Medical School.
g) The Trust has issued national adverts for the posts of Medical Director and Chief Operating Officer. Colleagues will recall that Neill Hepburn is returning to full-time clinical practice and that the Chief Operating Officer role is currently filled on an acting basis.

Report to:	Trust Board
Title of report:	Quality Governance Committee Assurance Report to Board
Date of meeting:	20th October 2020
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 groups according to an established work programme. The Committee worked to the 2020/21 objectives. The Trust are in the 'Restore' phase in response to Covid-19 and as such the meeting was held via Microsoft Teams with a reduced agenda to focus on key priorities
	Lack of Assurance in respect of SO 1a Issue: Deliver harm free care **Incident Management Report including SI Never Events** The Committee noted that there remained a large number of open actions following serious incidents and that work was underway to theme the actions. The Committee received the high profile case summary that would now again be routinely received by the Committee. The Committee noted that diabetic incidents would be themed and learning shared immediately following incidents. The Trust would work with the CCG in order to close any open SIs. **Nursing, Midwifery and AHP Assurance Report** The Committee received the assurance report and were advised that the Ward Accreditation process would be changing. The proposed changes would ensure that the Director of Nursing and Committee were sighted on the relevant quality metrics and that continuous review could be achieved. Accreditation would be made up of a number of spot checks and audits alongside unannounced inspection visits. A task and finish group had been identified to work through the criteria for the levels of accreditation that could be achieved by different wards/departments. The Committee requested quarterly reporting from January 2021.

	The Committee welcomed the revised approach to the accreditation programme noting that this would support the move forward of the quality and safety culture. **Infection Prevention and Control Assurance Report** The Committee noted that the Frontline Ownership (FLO) IPC audit had been embedded and was now being reported on a monthly basis. Limited assurance had been received in relation to water flushing and there had been positive progression with the hygiene code. The Committee requested a further report in relation to the hygiene code in order to be clear about the expectation of levels of achievement. Concern was noted that it may not be possible to achieve 100% due to the estate in which the Trust worked. **Infection Prevention and Control Annual Report** The Committee received the annual report noting that this highlighted the position against the hygiene code and the deterioration from the previously reported level of compliance. The Committee noted the positive achievements in relation to clostridioides difficile and flu vaccination. The Committee noted ongoing issues regarding water safety, non-achievement of mandatory training and inconsistency with surgical site infection reporting. The Committee noted that there had been a significant amount of work undertaken during 2019/20 in order to provide assurance in relation to IPC. The Committee acknowledged the quality of the annual report and looked forward to receiving an improved position in future reports. **Patient Safety Group Assurance Report** The Committee received the assurance report noting the areas for escalation including point of care testing pregnancy kits. The group identified issues with ordering processes that had resulted in quality assurance being carried out after an issue was identified. The group supported the move to a centralised ordering process to ensure quality testing was carried out by the Point of Care Team. A review would be conducted to identify if there had been any adverse effect on patients. The Committee requested that the group review other tests which may have been ordered outside of centralised processes to ensure there were no other areas of concern. The Group had requested an update on the maternity metrics that were causing concern and would be able to provide an update to the Committee next month.

	Monthly reports would be provided to divisions and corporate areas to detail any incidents, risks and actions that were due or overdue in order to provide focus. A Thrombosis Nurse Specialist had been recruited on a fixed term contract, following action from a serious incident, in order to support the Trust to reduce the risk of thrombosis incidents recurring. **Clinical Effectiveness Group Assurance Report** The Committee received the assurance report noting the summary of activity and review of guidelines and standard operating procedures the group had considered. **Maternity CNST Update** The Committee received an update from the Interim Head of Midwifery on the recently released CNST standards noting that the largest change was the new submission date of May 2021. The Committee were advised of additional criteria, mostly in relation to the Covid-19 response. There were three areas that required immediate action which were being addressed by the Divisional Head of Nursing and Midwifery. The Committee noted that all criteria were reported as amber as the evidence had not yet been collected. The Committee were advised that the two main areas of risk for the Trust were in relation to Maternity Medway and training. Monthly reports would be provided to the Committee to demonstrate progress and provide assurance of the position. The Committee noted the concern regarding Maternity Medway and were advised that this was a national issue with support being offered by the Director of Finance and Digital to work towards a resolution. A business case would be developed in order to explore alternative system providers. The Committee sought assurance on how the evidence collated would be quality assured prior to submission and an offer made from the Non-Executive Director Maternity Champion to provide lay person review of evidence. The Committee invited the Interim Head of Midwifery to attend to provide a monthly update. **Cumberlege Report** The Committee received the scoping paper which consider the three medical treatments within the Cumberlege report. The Committee were advised that the hormone pregnancy test, Primodos, this had not been used in the Trust and as such did not present a risk. The anti-epileptic drug sodium valproate is used by the Trust however the Committee were assured that appropriate processes were in place for its

	use. Vaginal mesh was no longer used in the Trust and a review was being undertaken in order that any further actions needed could be taken. The Committee noted that the report highlighted a paternalistic approach to patient care. A review would be undertaken linked to the patient safety culture work that the Trust is embarking on.
	Lack of Assurance in respect of SO 1b Issue: Improve patient experience **Complaints Annual Report** The Committee noted that 722 complaints had been received in 2019/20 and at the end of March 2020 159 of these remained open. The Committee noted the work that had been undertaken within the Team since the report had been produced and noted that the transfer of the complaints system to Datix had resulted in significant progress. The Committee noted the intention for the complaints team to work more closely with the divisions to provide support and training. It was noted that there would be future piece of work to ensure learning from complaints is embedded in the work programme of patient experience linked to the Integrated Improvement Plan. The Committee noted the position reported in respect of open actions relating to complaints and would receive a formal report to the November meeting. **Patient Experience Group Assurance Report** The Committee noted that the group had met twice and that this was still being re-established. Comprehensive assurance had been received from 2 divisions with engaging patient storied demonstrating the impact on both staff and patients. A patient panel had been established, following significant interest and work was underway to determine how the panels' time would be utilised. The inpatient survey action plan was being embedded, as the Committee had previously requested and asked that the action plan be submitted to the Committee. The Committee noted that the report did not provide sufficient assurance and sought improved reporting.
	Assurance in respect of other areas: **Clinical Audit Plan Report**

	The Committee received an update in relation to clinical audit noting that the plan had been developed to ensure divisional oversight. Concern was noted around the disparity of completion rates between divisions. It was noted that as the divisional governance teams became more effective this would enable better completion of audits. The Committee expressed concern that the action being taken may not directly address the concerns raised by the CQC during a previous inspection however noted that this would address issues with clinical audit in the round. **Clinical Governance Review** The Committee received the first draft of the action plan developed from the Clinical Governance Review noting that progress had been made against those actions identified as requiring immediate attention. Discussions would be held with the divisions regarding associated actions. The Committee noted that the review had been commissioned by the Director of Nursing who as such owned the action plan. The Committee had been asked to consider the findings of the review and noted that the majority related to actions being taken within the clinical governance team and the support from the clinical governance team to the divisions. The Committee accepted that elements of the action plan were business as usual and that these were known areas for improvement. Actions in place related to the functioning of the Committee and sub-groups and the requirement to strengthen assurances received at the Committee through sub-group reporting. A session had been arranged to consider how these are taken forward. A further group of identified actions relate to well led areas and are to be discussed with the Executive Team. Suggested actions relating to the BAF would be explored in the meeting to consider Committee actions **Committee Performance Dashboard** The Committee noted that there was a growing backlog of overdue incidents that had resulted in low/no harm. There had been increased support to divisions for training and advice to address the backlog. The Committee raised concern over the apparent delay in reporting of serious incidents and were advised that this was due to the medical examiners reviewing cases and identifying the need to report as an SI. There would be an expectation of an increase in SI reporting as the safety culture work progressed. Maternity was identified as an area of concern to the Committee and it was noted that a review was taking place in order to better understand the position and progress.

	The Committee noted the sustained reduction in pressure ulcers since January, the overall pressure ulcer position was improving. A benchmark would be set for un-stageable pressure ulcers that would provide focus and reduce variance. The Trust had achieved 100% compliance with duty of candour in August and September. **CQC Must and Should Do Update** The Committee received the update noting that internal quality review visits had commenced. These include both weekend and evening visits. The Committee were advised that the themes identified from the visits had been estates and staffing/culture. These were being addressed by attendance at the CQC Steering Group by an Estates representative and the Director of People and OD. The communications plan had been presented to the Board in October and was being cascaded to staff through various communication channels. The first round of confirm and challenge sessions led by the Director of Nursing had been undertaken and were working well. Corporate division sessions would be held during November. **Board Assurance Framework** The Committee reviewed the detail provided within the BAF noting that this went some way to addressing the updates requested from the previous month. The Committee considered the content and noted that further work was required to ensure that the sources of assurance detailed within the BAF were in fact received by the Committee.
Issues where assurance remains outstanding for escalation to the Board	The Committee wished to highlight to the Board the national issue with Medway with regard to CNST and the intention to develop a business case to seek an alternative provider.
Items referred to other Committees for Assurance	No items referred to other committees
Committee Review of corporate risk register	The Committee reviewed the risk register see comments below.
Matters identified which Committee recommend are escalated to SRR/BAF	None
Committee position on assurance of strategic risk areas that align to committee	The Committee considered the reports noting an increase in risk related to medical devices due to a review of the risk. The Committee raised concern of the review of risk at Director level

	noting that this would need to be addressed by the Executive Leadership Team.
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	A	X	X	X	X	X	X	X	X
Chris Gibson Non-Executive Director	A	X	X	X	X	X	X	X	X	X	X	X
Neill Hepburn Medical Director	X	X	X	X	X	X	X	X	X	X	X	X
Karen Dunderdale Director of Nursing				X	X	X	X	X	X	X	X	D
Michelle Rhodes/ Victoria Bagshaw Director of Nursing	X	X	X	X								
Simon Evans Chief Operating Officer								X	X	A	X	D

X in attendance A apologies given D deputy attended

Meeting	*Trust Board*
Date of Meeting	*Tuesday 3rd November 2020*
Item Number	*Item 8.2*
Incident Management Report (including Never Events & other Serious Incidents)	
Accountable Director	*Dr Karen Dunderdale, Director of Nursing*
Presented by	*Dr Karen Dunderdale, Director of Nursing*
Author(s)	*Paul White, Risk & Incident Lead*
Report previously considered at	*Quality Governance Committee, 20th October 2020*

How the report supports the delivery of the priorities within the Board Assurance Framework	
1a Deliver harm free care	*X*
1b Improve patient experience	
1c Improve clinical outcomes	
2a A modern and progressive workforce	
2b Making ULHT the best place to work	
2c Well Led Services	*X*
3a A modern, clean and fit for purpose environment	
3b Efficient use of resources	
3c Enhanced data and digital capability	
4a Establish new evidence based models of care	
4b Advancing professional practice with partners	
4c To become a university hospitals teaching trust	

Risk Assessment	*Non-compliance with patient safety regulations and standards (4043) – High risk (12)*
Financial Impact Assessment	*None*
Quality Impact Assessment	*None*
Equality Impact Assessment	*None*
Assurance Level Assessment	*Moderate*

Recommendations/ Decision Required	*The Trust Board is invited to review the content of the report and advise if any further action is required to improve the management of patient safety incidents at this time*

Executive Summary

- The Trust's patient incident reporting rate per 1,000 bed days has remained at an average of 38 throughout the past 18 months, compared with a national average in 2019 of 50
- The number of incidents reported each month, and the severity of harm, are in line with the national average for acute hospital trusts
- The Trust has reported an average of 870 patient incidents per month so far this financial year
- The number of open patient incidents on Datix as of 1st October 2020 was 1,717 (up by 47 since last month)
- 68% of open patient incidents are overdue, compared with 58% last month
- 21 Serious Incidents were declared in September, the most in any month in the last 2 financial years to date
- 1 Never Event has been declared so far this financial year, in August
- 2 independent SI investigations (both occurring within Maternity) are currently being investigated by the HSIB (see Appendices)
- There are 67 open Serious Incident investigations, up by 13 from last month; there are 41 awaiting CCG approval
- There are 25 open Divisional Investigations and 17 complete investigations that are awaiting divisional approval
- As of 1st October 2020 there were 1,808 open actions arising from incident investigations recorded on Datix, of which 90% were overdue (1,631)
- There were 27 open actions relating to Never Events, of which 26 were overdue
- The strategic risk register has been updated in relation to compliance with patient safety regulations and standards; this remains as a High risk (12)
- Implementation of the new national Patient Safety Incident Response Framework (PSIRF) has been put back to Spring 2021; a review of the implications for ULHT will be provided in November 2020

1. Purpose

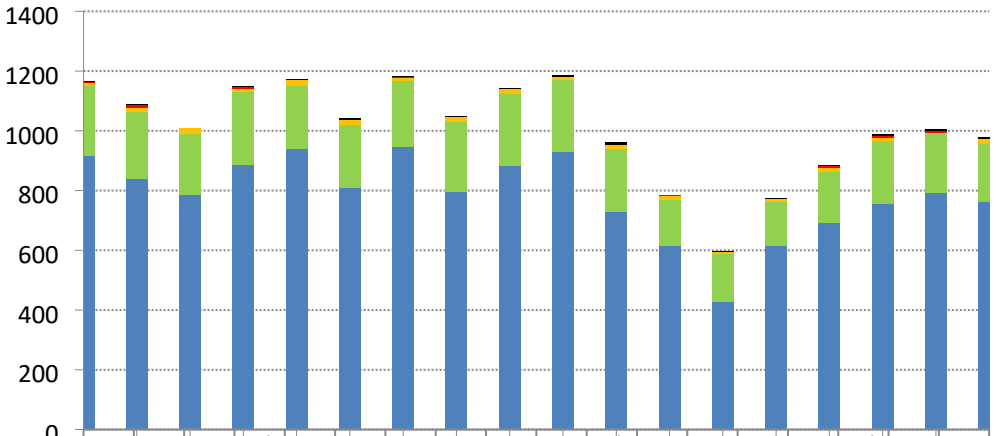
1.1 The purpose of this report is to enable the Trust Board to review the effectiveness of the Trust's incident management policy and procedures (including the management of Never Events and other Serious Incidents).

2. Introduction

2.1 The Trust uses the Datix Risk Management System for the reporting and review of unexpected or unintended incidents that have caused or could have caused harm to patients. The Datix system is also used to support the management of incidents affecting staff, visitors and assets. The scope of this report is limited to incidents affecting patients, as other types of incident fall within the remit of other groups.

3. Patient safety incidents

3.1 **Chart 1** shows the number of patient safety incidents reported on Datix each month since the start of April 2019, by date of reporting and severity of harm:



	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020	Apr 2020	May 2020	Jun 2020	Jul 2020	Aug 2020	Sep 2020
5 - Death	1	2	0	2	1	4	3	2	3	4	8	0	1	1	3	4	5	4
4 - Severe Harm	2	8	0	4	2	2	1	3	1	1	0	1	1	0	4	7	5	0
3 - Moderate Harm	11	15	19	11	17	16	12	15	15	8	12	11	4	12	13	11	6	18
2 - Low Harm	235	223	201	247	211	213	220	234	244	243	214	157	161	147	171	211	195	194
1 - No harm	916	840	788	885	942	808	947	796	881	929	727	614	429	615	693	756	794	763

3.2 This chart shows the impact of the Covid-19 pandemic on the number of patient incidents reported each month (between February and June 2020). Analysis of reporting rates has shown that this reduction in incident numbers was in line with reduced bed occupancy due to service changes during this period. The Trust's patient incident reporting rate per 1,000 bed days has remained at an average of 38 throughout the past 18 months, compared with a national average in 2019 of 50 patient incidents per 1,000 bed days. The highest rate during this period was recorded in March 2020, at 42 incidents per 1,000 bed days.

3.3 The average number of patient incidents reported each month of the 2020/21 financial year to September is 871. This is in line with the national average for

acute hospital trusts for incidents reported in 2019 (the most recent comparative data available).

3.4 A breakdown of these patient incidents by severity of harm shows that 79% of incidents reported by the Trust resulted in no harm; 19% in low harm; and 2% in moderate harm, severe harm or death. This is also in line with the national average.

Open patient safety incident investigations

3.5 **Table 1** shows a breakdown of the 1,717 open patient safety incident investigations (as of 1st October 2020) by division and Clinical Business Unit (CBU) or corporate department (excluding Serious Incidents and Division Investigations, which have extended timescales and are covered later in this report) and the change since last month's report (on 4th September 2020):

Division & CBU	Open patient incidents	Change (since last month)
Medicine Division	**779**	**+25**
Cardiovascular CBU	43	-12
Specialty Medicine CBU	236	+13
Urgent & Emergency Care CBU	500	+19
Surgery Division	**427**	**+69**
Surgery CBU	143	+30
Theatres & Critical Care CBU	162	+30
Urology, Trauma & Orthopaedics and Ophthalmology CBU	122	+9
Family Health Division	**171**	**-5**
Children & Young Persons CBU	29	-10
Women's Health and Breast CBU	142	+5
Clinical Support Services Division	**301**	**-37**
Cancer Services CBU	61	0
Diagnostics CBU	90	+4
Outpatients CBU	72	-3
Path Links (Pathology)	15	-42
Pharmacy CBU	58	+11
Therapies & Rehabilitation CBU	5	-1
Corporate Services	**39**	**-5**
Estates & Facilities	12	+1
Finance & Digital	3	+1
Human Resources & Organisation Development	3	+2
Medical Directorate	2	-4
Nursing Directorate	5	-5
Operations	14	0
Total	**1717**	**+47**

3.6 This represents an increase of 367 open patient incidents in the last 3 months, although the rate of increase has slowed this month which illustrates

the progress that has been made within some business units with the review of open incidents.

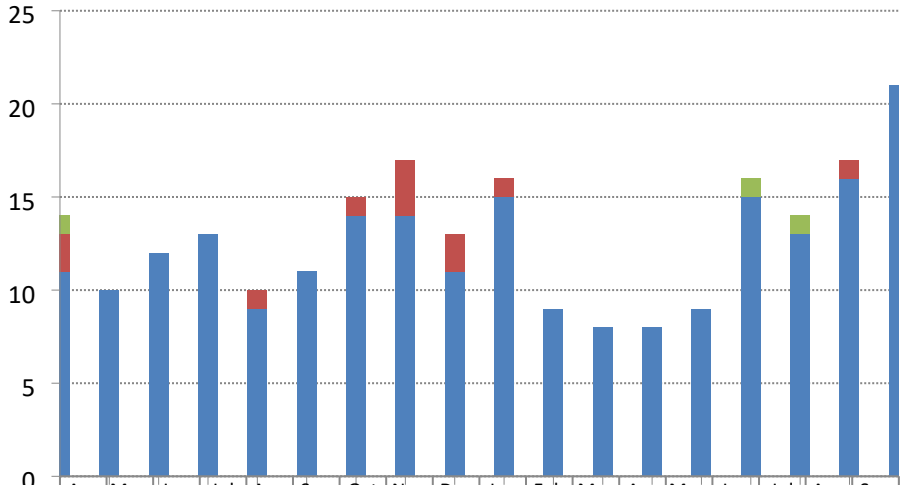
3.7 Of these open patient incidents, 68% were reported on Datix prior to the start of September 2020 and are therefore overdue (the Trust's incident Management Policy states that departmental investigations should be completed within 4 weeks of reporting). This is an increase from 58% overdue last month and 54% the month before that. All divisions currently have a significant proportion of overdue incidents. The breakdown of overdue investigations by division is shown on **Table 2**:

Division	Number overdue	Number open	% overdue	% overdue last month
Clinical Support Services	208	301	68%	68%
Corporate	35	39	85%	80%
Medicine	553	779	72%	55%
Surgery	275	427	65%	61%
Family Health	86	171	51%	44%
Total	**1157**	**1717**	**68%**	**58%**

3.8 This table shows that a growing backlog of overdue incidents in all clinical divisions apart from CSS, with a particularly large increase in Medicine Division. The largest proportion of these overdue incidents are in Urgent & Emergency Care CBU. Additional support is being provided to this CBU to enable these overdue incidents to be reviewed; Datix access has also been granted to additional medical and nursing staff within the CBU.

4. Serious Incidents (including Never Events)

4.1 **Chart 2** shows the number of Serious Incidents declared by the Trust each month since the start of April 2019, by date of reporting on the national Strategic Executive Information System (StEIS) and level of investigation:



	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020	Apr 2020	May 2020	Jun 2020	Jul 2020	Aug 2020	Sep 2020
Independent Serious Incident investigation (StEIS)	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0
Never Event Serious Incident (StEIS)	2	0	0	0	1	0	1	3	2	1	0	0	0	0	0	0	1	0
Serious Incident (StEIS)	11	10	12	13	9	11	14	14	11	15	9	8	8	9	15	13	16	21

4.2 The 2 independent SI investigations recorded in June and July 2020 are being carried out by the Healthcare Safety Investigation Branch (HSIB) and both relate to Maternity services.

4.3 The Trust declared 21 Serious Incidents in September 2020, the highest number declared in a single month during the last 2 financial years. Of those 21 Serious Incidents, 7 actually occurred in September. The highest number of Serious Incidents in any month so far this financial year was in July, when there were 19 including 1 Never Event (which was declared on StEIS in August).

4.4 There were 10 Never Events declared by the Trust in 2019/20 and 1 to date in 2020/21. **Table 3** shows a summary of all Never Events declared by the Trust in 2019/20 and 2020/21 (to the end of September 2020) by division, CBU and Never Event type:

Division & CBU	Wrong site surgery	Wrong implant / prosthesis	Retained foreign object post procedure	Administration of medication by the wrong route	Misplaced naso- or oro-gastric tubes	Total
Medicine Division						
Specialty Medicine CBU	0	0	0	0	2	**2**

Division & CBU	Wrong site surgery	Wrong implant / prosthesis	Retained foreign object post procedure	Administration of medication by the wrong route	Misplaced naso- or oro-gastric tubes	Total
Urgent & Emergency Care CBU	0	0	0	1	0	**1**
Surgery Division						
Surgery CBU	3	0	0	0	0	**3**
Urology, Trauma & Orthopaedics and Ophthalmology CBU	1	1	0	0	0	**2**
CSS Division						
Diagnostics CBU	0	0	1	0	0	**1**
Family Health Division						
Women's Health and Breast CBU	0	0	2	0	0	**2**
Total	**4**	**1**	**3**	**1**	**2**	**11**

4.5 The Trust has declared 5 different types of Never Event since the start of April 2019, across 6 business units and all 4 clinical divisions. The classification of an incident as a Never Event is based on the existence of control measures that should be in place throughout the NHS to prevent that particular occurrence. The identification of 11 Never Events in the last 18 months, 8 of which relate to invasive procedures that should be managed in accordance with agreed safety checklists, indicates that these control measures are not functioning effectively within the Trust.

4.6 **Table 4** shows the number of Serious Incidents open within the Trust, broken down by division (as of 4th August 2020):

Division	Serious Incident (StEIS)	Never Event Serious Incident (StEIS)	Independent Serious Incident (StEIS)	Total	Change (since last month)
Medicine	36	0	0	36	+7
Surgery	21	0	0	21	+5
Family Health	6	0	2	8	+1
Clinical Support Services	1	1	0	2	-1
Total	**64**	**1**	**2**	67	**+13**

4.7 The number of Serious Incident investigations open within the Trust has been steadily increasing throughout the 2020/21 financial year to date (there were 32 open at the end of March 2020). The majority of SI investigations continue to be carried out by the temporary SI Team within Clinical Governance. Consideration is being given to the need for temporary additional resource in to the team to stay on top of the number of SI investigations.

4.8 At the time of reporting there were no Serious Incident investigations overdue their deadline to the CCG. However, the Trust has informed the CCG that 1 investigation will not be completed by its deadline as the Serious Incident Panel has requested further work to identify key contributory factors.

4.9 It should also be noted that during the Covid-19 pandemic response the CCG was not enforcing the standard 60 working day deadline for completing SI investigations, therefore no SI investigations have been overdue so far this financial year. However, the Trust continued to work to the following internal deadlines:

- SIs declared in March, April or May: 120 working days to complete
- Declared in June: 100 working days
- Declared in July: 80 days
- Declared from August onwards: working 60 days

5. Divisional Investigations

5.1 A Divisional Investigation is a comprehensive level of investigation, used for incidents that do not meet the Serious Incident criteria but nevertheless have significant potential for learning and improvement.

5.2 **Table 5** shows the number of open Divisional Investigations by division (as of 4th August 2020):

Division	Divisional investigations open	Change (since last month)
Medicine	17	+1
Surgery	5	0
Family Health	2	0
Clinical Support Services	1	0
Total	**25**	**+1**

5.3 The number of open Divisional Investigations (DIs) has been steadily reducing over the past 6 months as the backlog has been reviewed and investigations have been completed, although there has been an increase of 1 this month in Medicine Division. 8 of the open DIs are Pressure Ulcer incidents, 2 are Patient Falls incidents. These investigations are overseen by their respective Scrutiny Panels. The Risk & Incident Team are supporting the completion of the remaining 15 investigations.

5.4 There were 17 DIs overdue at the time of reporting (the Trust's Incident Management Policy states that DIs should be completed within 40 working days of the decision to set the level of investigation). This is an improvement of 2 on the previous month and reflects continuing progress with reviewing the backlog.

5.5 In addition to the 25 open Divisional Investigations, there were 16 completed DIs awaiting divisional approval:

- 9 in Medicine Division

- 5 in Surgery Division
- 1 in CSS Division

6. Improvement actions

6.1 As of 1st October 2020 there were 1,808 open actions arising from incident investigations recorded on Datix. This is a reduction of 47 from the previous month.

6.2 Of those 1,808 open actions, 1,631 (90%) were overdue at the time of reporting. This is the same number as were overdue at the start of last month. Pharmacy is the only CBU without any open actions at the present time.

6.3 **Table 6** shows a breakdown of all open actions from incidents, by division and CBU:

Division & CBU	Overdue	Total	% overdue
Medicine Division			
Cardiovascular CBU	90	104	87%
Urgent & Emergency Care CBU	514	548	94%
Specialty Medicine CBU	435	509	85%
Surgery Division			
Surgery CBU	95	103	92%
Theatres & Critical Care CBU	13	13	100%
Urology, Trauma & Orthopaedics and Ophthalmology CBU	141	155	91%
Family Health Division			
Children & Young Persons CBU	31	31	100%
Women's Health and Breast CBU	117	138	85%
Clinical Support Services Division			
Cancer Services CBU	62	70	89%
Diagnostics CBU	14	14	100%
Outpatients CBU	2	4	50%
Therapies & Rehabilitation CBU	1	1	100%
Corporate Services			
Digital (ICT)	1	1	100%
Estates & Facilities	9	9	100%
Human Resources & Organisation Development	2	2	100%
Nursing Directorate	0	1	0%
Operations	104	105	99%
Total	**1631**	**1808**	**90%**

6.4 There were 27 open actions arising from Never Event investigations as of 1st October 2020. This compares with 56 open actions at the start of September and 132 at the start of August. 26 of those 27 open actions are overdue their original planned completion date.

6.5 The work that has been taking place to review open actions has identified a significant proportion that relate to aspects of the incident management process, such as completion of Duty of Candour or team and personal reflection to learn from the incident. From now on these types of actions will no longer be included in action plans, they will be documented in the incident report as an integral part of the investigation process. This will make future actions plans more focussed on service improvements designed to make a measurable difference in reducing risk.

6.6 The divisional governance support team are currently working with divisions to review all open actions, identifying those that can be closed where they relate to administrative processes or can be themed together to provide greater clarity and focus on actions that remain outstanding.

7. Risks

7.1 The risk of non-compliance with patient safety regulations and standards, leading to regulatory action, is recorded as a core risk on the strategic risk register (Risk ID 4043) with a current rating of High risk (12).

7.2 Since the last report the following updates have been made to this risk (the overall risk rating remains the same):

- The risk mitigation plan regarding the frequency of Never Events has been updated and remains rated as High risk
- Plans to address the increase in volume of open patient safety incidents has been added, currently rated as High risk but this will remain under review as plans and actions are embedded
- Plans to address the volume of overdue improvement actions arising from patient safety incidents, currently rated as High risk but this will remain under review as plans and actions are embedded

7.3 As part of the national Patient Safety Strategy a new Patient Safety Incident Response Framework (PSIRF) is currently being trialled within a small number of trusts. The current National Reporting and Learning System (NRLS) and Strategic Executive Information System (StEIS) will be replaced with a new national patient safety system. The initial documentation has been published for information and represents a significant change in approach.

7.4 The latest update on implementation of the PSIRF is that it is likely to take place from Spring 2022. The original plan was to roll out from Spring 2021. To take account of other recent developments with the PSIRF, a report on the implications for ULHT and a gap analysis against current ULHT policy and procedure will be undertaken and will report to the Patient Safety Group in November 2021. Until that time current arrangements for managing serious incidents will remain unchanged.

8. Conclusions & recommendations

8.1 The Director of Nursing's recent review of aspects of the Trust's clinical governance arrangements considered and commented on the Trust's incident management arrangements and the risk issues identified within this report. A number of recommendations for strengthening existing incident

management arrangements have been made within the report from that review and an improvement plan is in progress, which includes the following priority actions:

- Agreement of a ‘support offer’ which Clinical Governance will provide to divisions
- A clear plan and trajectory for resolving the backlog of incident investigations
- Close monitoring of the completion of actions from incidents
- Tighter control over timescales within the Serious Incident / Rapid review process & more timely decision making
- Clinical Governance assistance with written follow-up Duty of Candour letters
- Integration of the clinical harm review process with incident management & the use of Datix
- Development of investigation training and supporting documentation

8.2 The Trust Board is invited to review the content of the report and advise if any further action is required to improve the management of patient safety incidents at this time.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*3rd November*
Item Number	
Director of Nursing Safe Staffing Report	
Accountable Director	*Dr Karen Dunderdale, Director of Nursing*
Presented by	*Dr Karen Dunderdale*
Author(s)	*Debrah Bates, Deputy Director of Nursing*
Report previously considered at	*People & OD Committee*

How the report supports the delivery of the priorities within the Board Assurance Framework	
1a Deliver harm free care	*X*
1b Improve patient experience	*X*
1c Improve clinical outcomes	*X*
2a A modern and progressive workforce	*X*
2b Making ULHT the best place to work	*X*
2c Well Led Services	*X*
3a A modern, clean and fit for purpose environment	
3b Efficient use of resources	*X*
3c Enhanced data and digital capability	
4a Establish new evidence based models of care	*X*
4b Advancing professional practice with partners	
4c To become a university hospitals teaching trust	

Risk Assessment	*N/A*
Financial Impact Assessment	*N/A*
Quality Impact Assessment	*N/A*
Equality Impact Assessment	*N/A*
Assurance Level Assessment	*Insert assurance level* • *Significant*

Recommendations/ Decision Required	• *Receive the report* • *Make recommendations and propose further actions where appropriate*

Executive Summary

The Trust is committed to providing safe, effective, caring, responsive and well led care that meets the needs of our patients. It is recognised that decisions in relation to safe clinical staffing require a triangulated approach which consider Care Hours per Patient Day (CHPPD) together with staffing data, acuity, patient outcomes and clinical judgement. This report provides evidence that processes are in place to record and manage Nursing and Midwifery staffing levels across all settings and that any concerns around safe staffing are reviewed and processes put in place to ensure delivery of safe care.

This report is for nurse staffing figures for the month of September 2020.

Of note are the following;

- The use of temporary staffing to maintain safe staffing levels across the Trust has plateaued again in September, but remains below pre-pandemic levels
- The top four reasons for temporary staffing usage has not changed for the third successive month
- The volume of agency usage has continued to fall through September with the cost also decreasing as more agencies have moved to the lower rates that we offer.
- The highest users of agency nursing across the Trust continues to be in both Emergency Departments
- A reduction in registered nurse vacancy levels to 15.5% from 17%

MONTHLY NURSE STAFFING and WORKFORCE REPORT

1. PURPOSE OF REPORT

This is the monthly safe staffing report for September 2020, which has been reported to the People and OD Committee. The report is being presented at a time when activity in the Trust continues to increase as departments and wards have returned back to their 'business as usual' whilst also dealing with a second spike in Covid19 cases, and additional activity to catch up on the backlog that build through the initial stages of the pandemic.

It is the expectation that this report will form the basis of the staffing report that is required to be presented at Trust Board in accordance with the requirements of the updated National Quality Board (NQB 2016) Safe Sustainable and Productive Staffing Guidance and the National Institute for Health and Care Excellence (NICE) guidance issued in July 2014.

The Trust is committed to providing safe, effective, caring, responsive and well led care that meets the needs of our patients. It is recognised that decisions in relation to safe clinical staffing require a triangulated approach which consider Care Hours per Patient Day (CHPPD) together with staffing data, acuity, patient outcomes and clinical judgement. This report provides evidence that processes are in place to record and manage Nursing and Midwifery staffing levels across all settings and that any concerns around safe staffing are reviewed and processes put in place to ensure delivery of safe care.

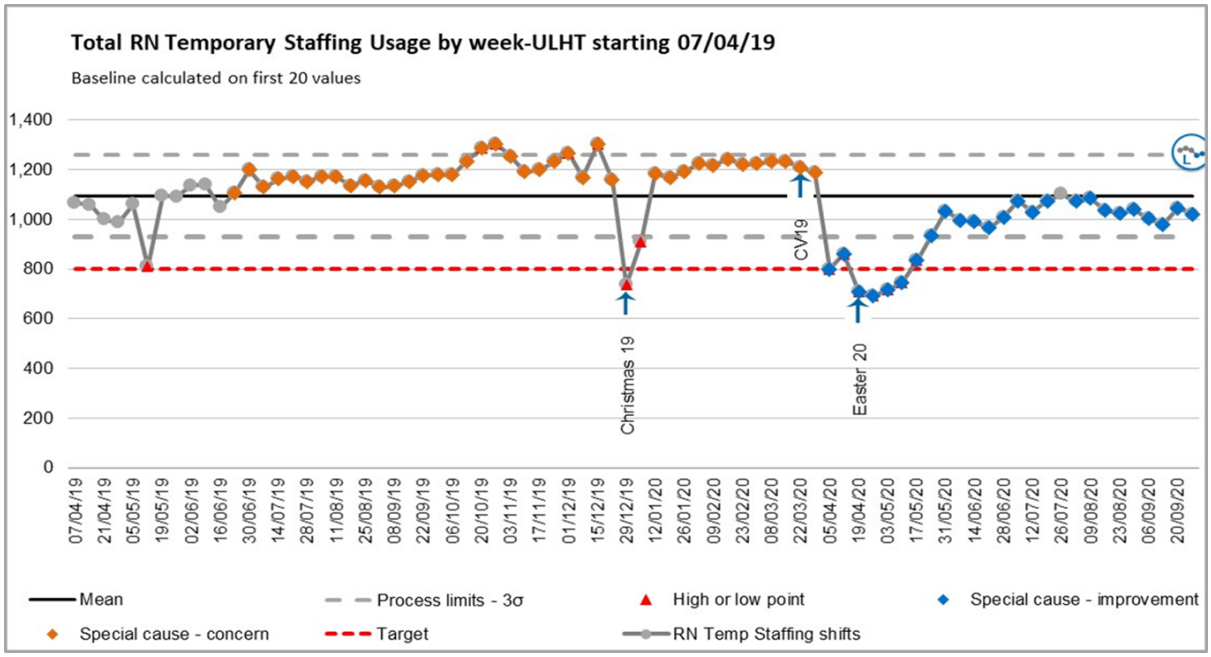
Progress is reported against the four key workstreams that are identified in the nursing workforce transformation programme – Temporary Staffing; Rostering; Workforce Development; Establishments

Please note that unless stated, all data is sourced from the Allocate HealthRoster system.

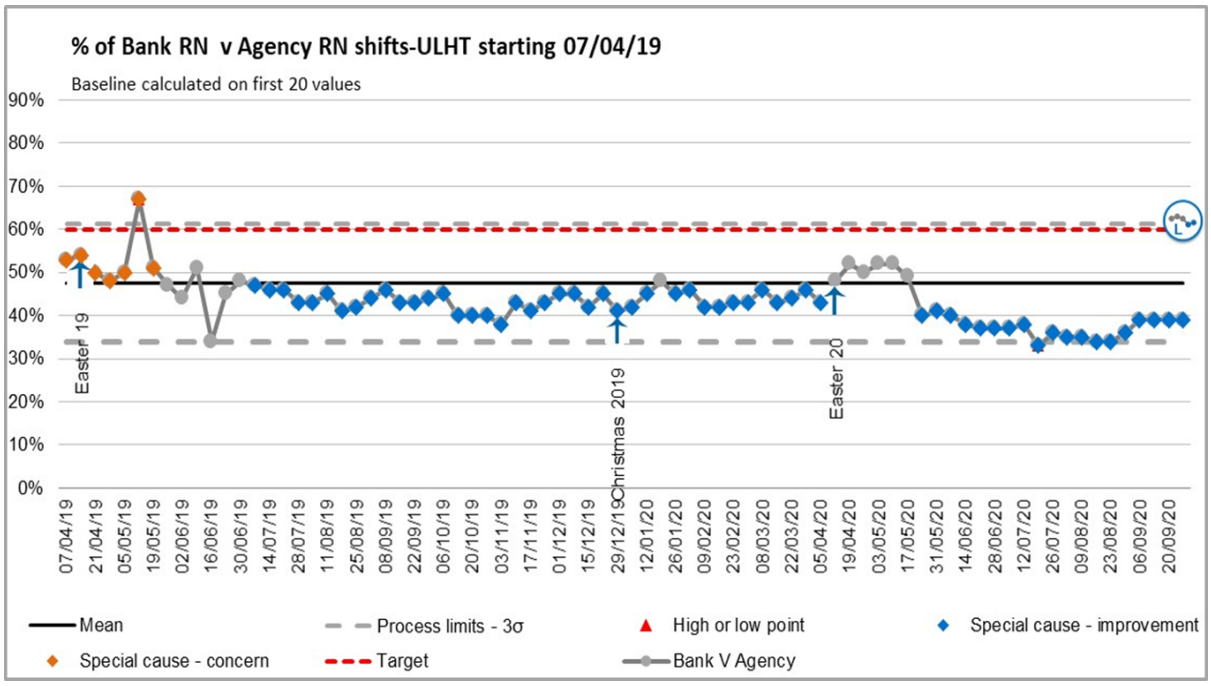
2. PROGRESS UPDATE

2.1 Temporary Staffing

The use of temporary staffing to maintain safe staffing levels across the Trust has plateaued again in September, and remains below pre-pandemic levels. This continues to be managed through the Nursing Workforce Transformation Programme (NWTP) and has been a focus of attention at the newly established roster management clinics that are in place monthly. At these meetings each ward/ department is challenged on their roster management and their ability to manage safe staffing levels within agreed key performance indicators such as annual leave levels and sickness rates.

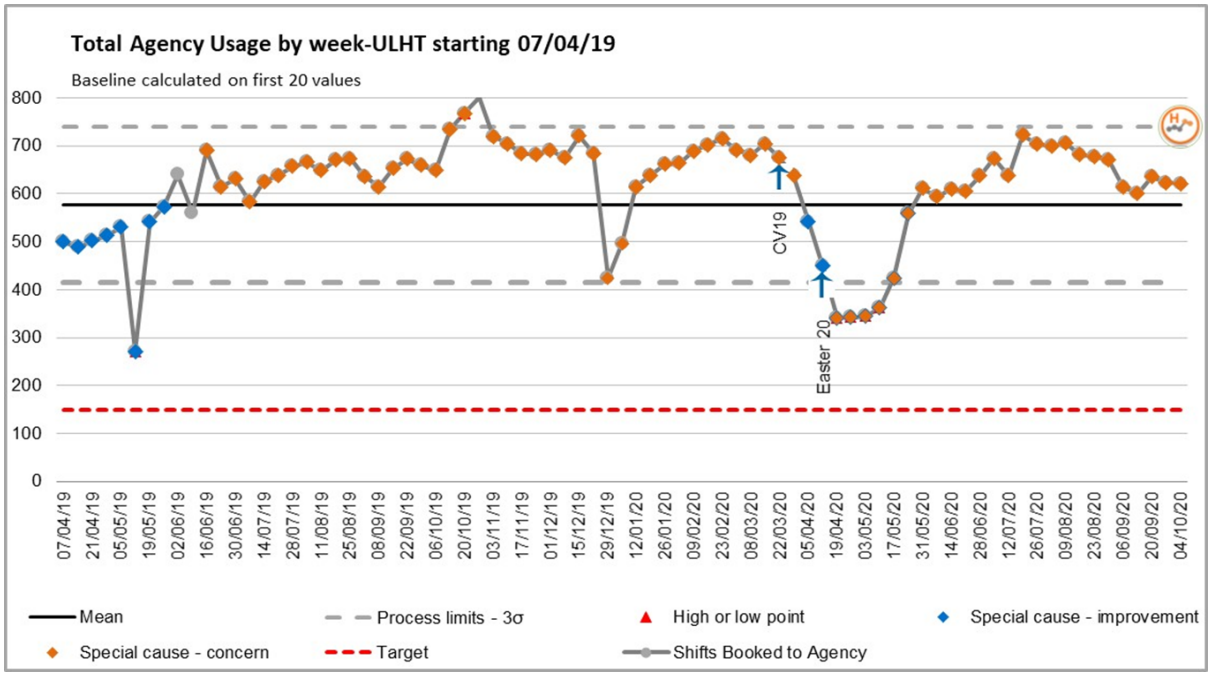


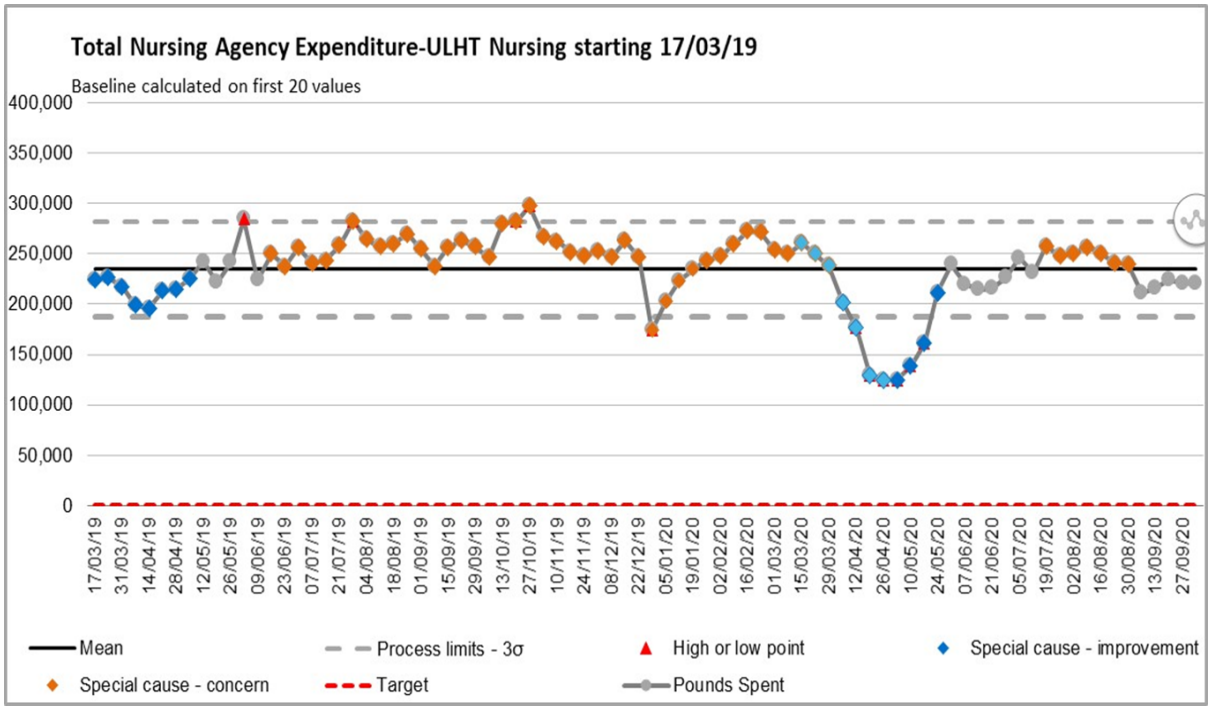
Temporary staffing is made up of both bank and agency staff. In reviewing the temporary staffing figures, the use of bank has plateaued and is still adrift of our aim to ensure 50% of temporary staffing shifts are filled by bank staff rather than agency.



As a result of this position, the Nursing Workforce Transformation Group is leading further projects around streamlining the policies and processes that support our bank staff, and the option of reviewing incentives that will encourage more uptake in bank shifts to reverse the current position.

The volume of agency usage has continued to fall through September with the cost also decreasing as more agencies have moved to the lower rates.





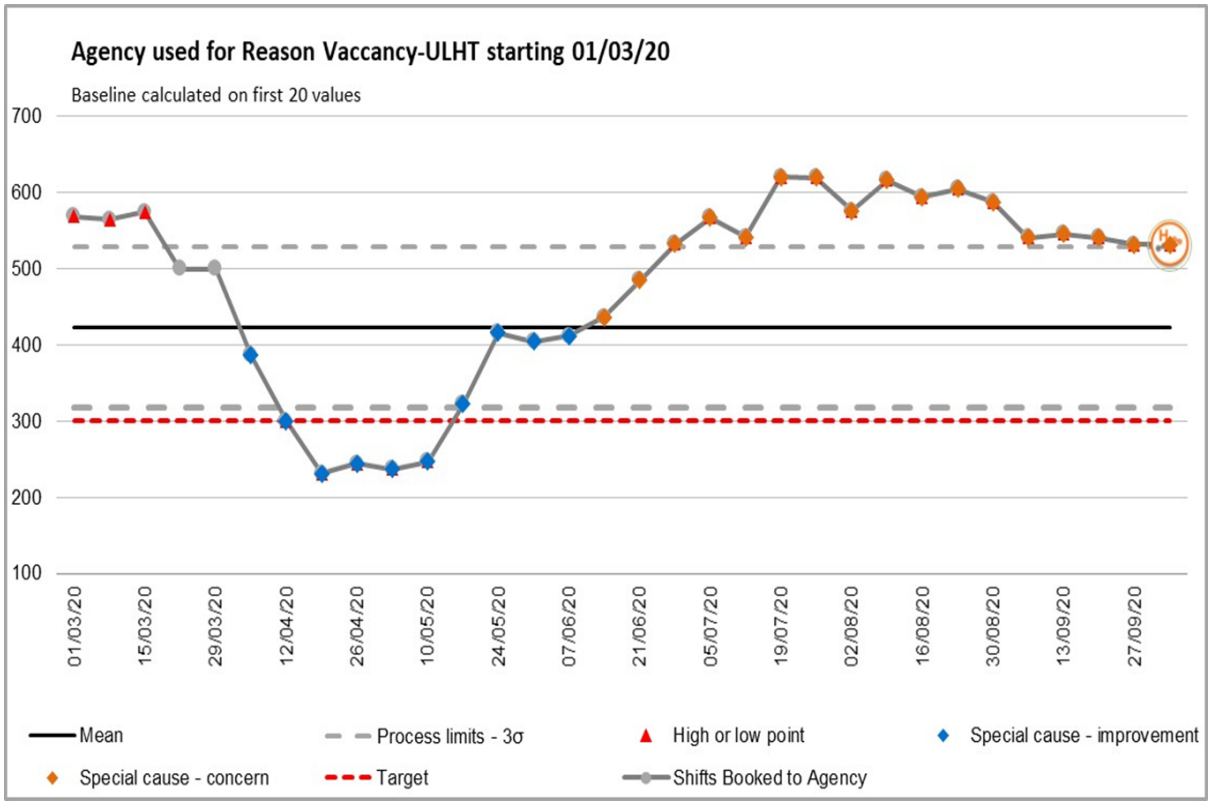
It is expected that the next report presented will also be able to demonstrate the direct impact that the Newly Qualified nurses will have on agency usage, as during October they should have competed their supernumerary status.

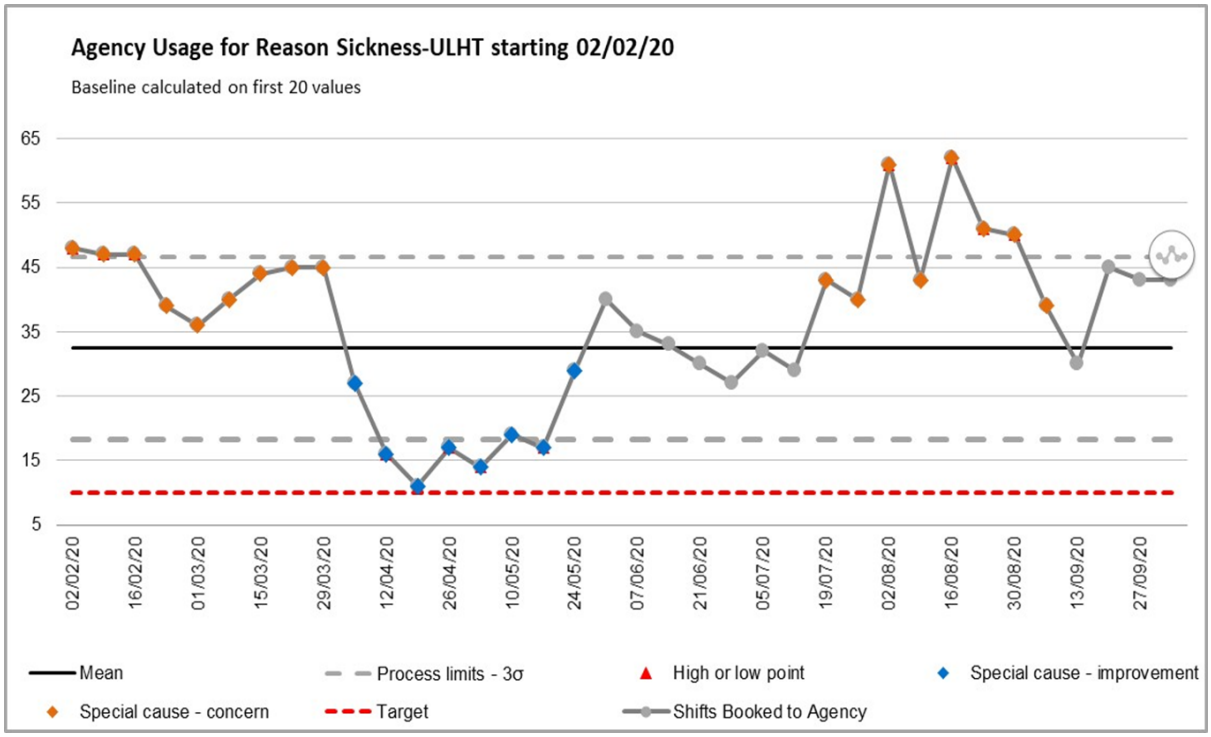
The top four reasons for temporary staffing usage has not changed for the third successive month, and continues to be;

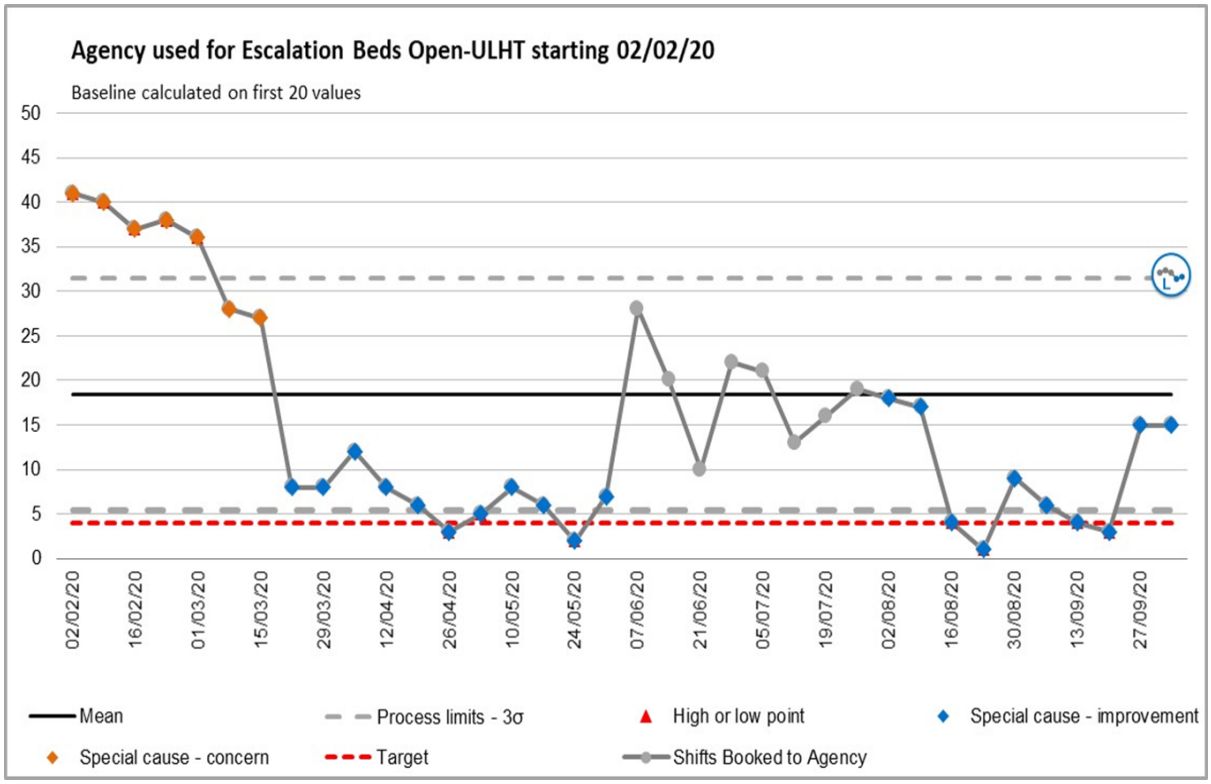
- Vacancy,
- Sickness,
- Escalation Beds
- Sick Leave Cover (COVID)

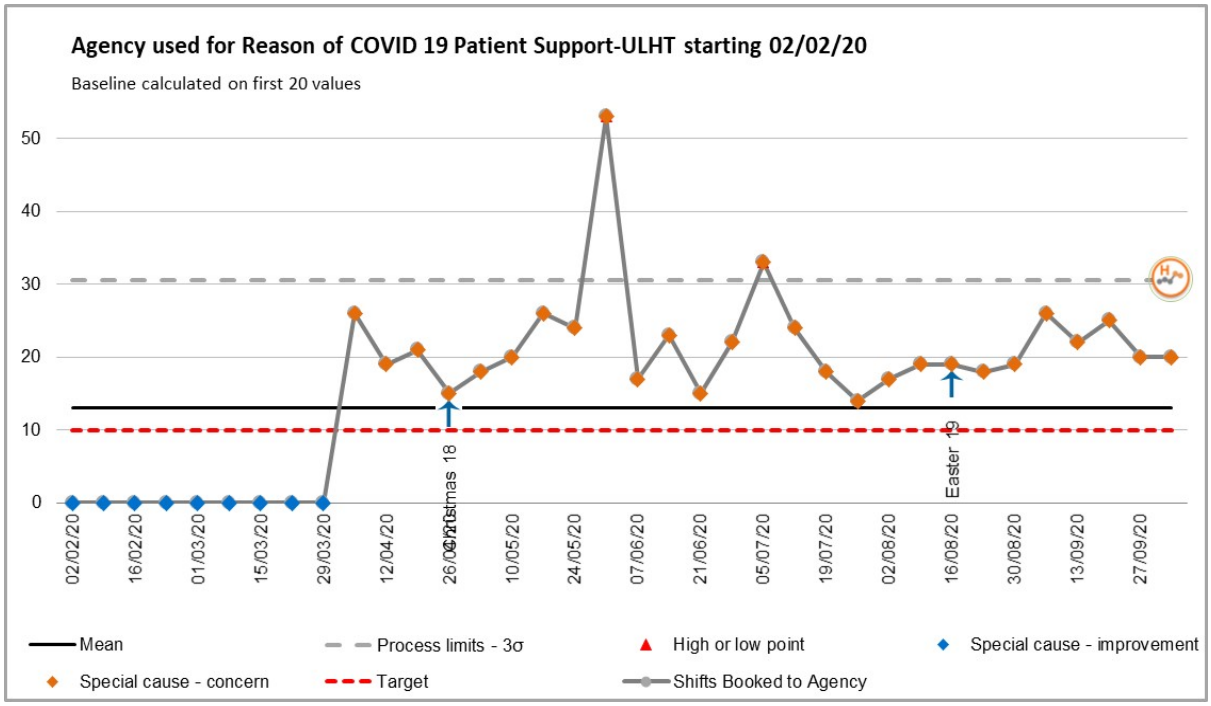
However, the use of agency for sickness has seen a small decrease, the use of agency for vacancy has plateaued, usage attributed to escalation has increased in all divisions other thank Clinical Support Services, and there has been no change in the usage for COVID sickness cover over the past month.

The use of agency bookings attributed to sickness as a reason, has seen a decrease which may be indicative of a workforce that is beginning to recover from the consequences of the Pandemic.

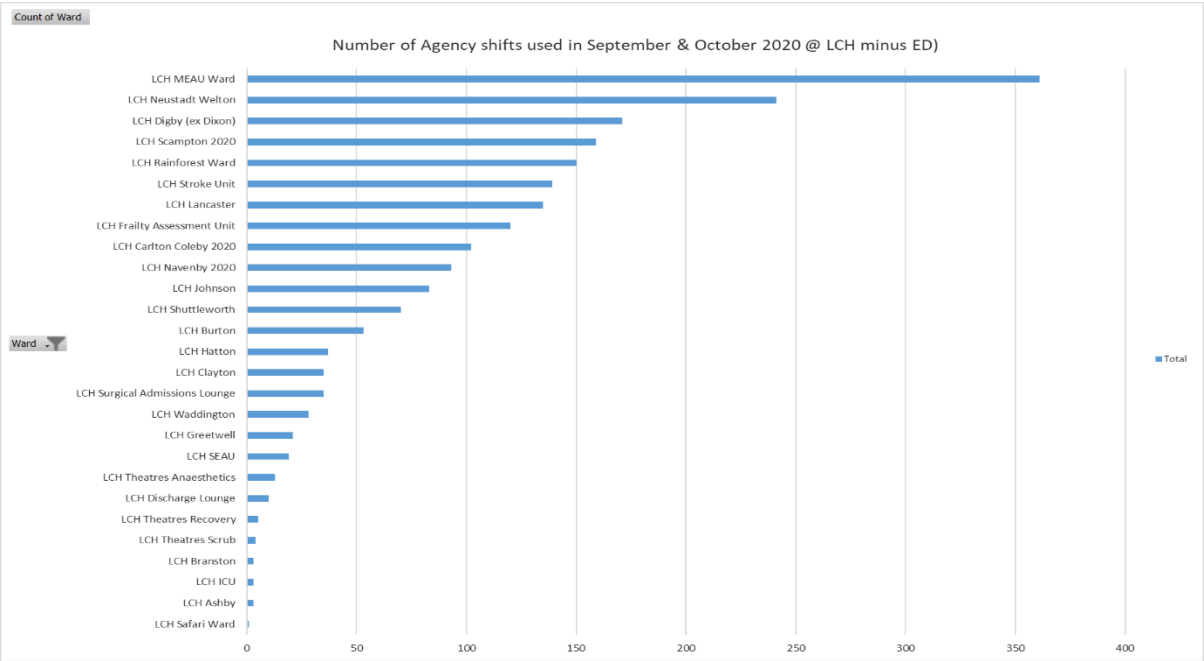


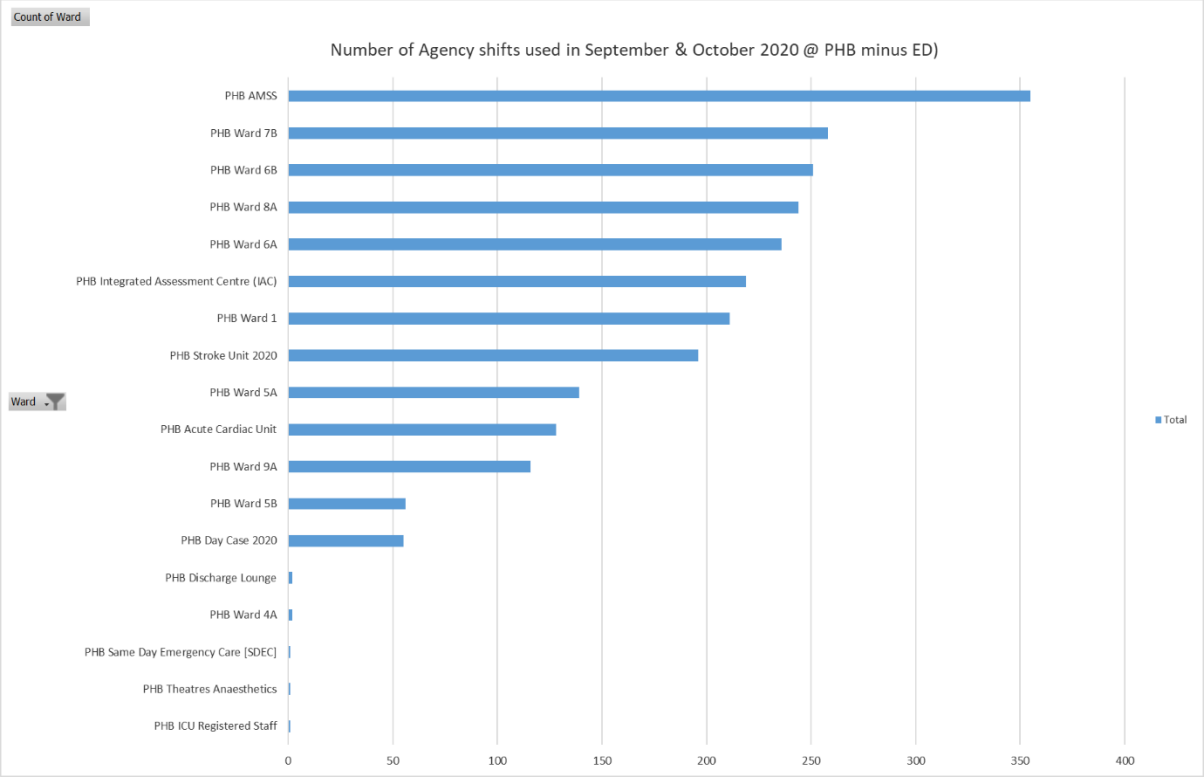

Agency Usage for Reason Sickness-ULHT starting 02/02/20
Baseline calculated on first 20 values
65
55
45
35
25
15
5
02/02/20
16/02/20
01/03/20
15/03/20
29/03/20
12/04/20
26/04/20
10/05/20
24/05/20
07/06/20
21/06/20
05/07/20
19/07/20
02/08/20
16/08/20
30/08/20
13/09/20
27/09/20
Mean
Process limits - 3σ
High or low point
Special cause - improvement
Special cause - concern
Target
Shifts Booked to Agency


Agency used for Escalation Beds Open-ULHT starting 02/02/20
Baseline calculated on first 20 values
50
45
40
35
30
25
20
15
10
5
0
02/02/20
16/02/20
01/03/20
15/03/20
29/03/20
12/04/20
26/04/20
10/05/20
24/05/20
07/06/20
21/06/20
05/07/20
19/07/20
02/08/20
16/08/20
30/08/20
13/09/20
27/09/20
Mean
Process limits - 3σ
High or low point
Special cause - improvement
Special cause - concern
Target
Shifts Booked to Agency



The highest users of agency nursing across the Trust continues to be in both Emergency Departments at Lincoln and Pilgrim, this is a direct result of high vacancy. The medicine division are currently recruiting to posts and are development workforce plans. The other high agency users are listed below for both Lincoln and Pilgrim sites. Of note in the tables below is the position Neustadt Welton from a Lincoln site perspective, this ward being the Covid19 ward for some time, and the position of AMSS at Pilgrim, which has seen escalated levels of open beds over the past month.





2.1.2 Shift Fill

Shift fill rates data is no longer a mandatory reporting requirement of Trusts, as it has been replaced by Care Hours Per Patient Day (CHPPD) as a metrics for comparison. However, both the planned and actual fill rate is still a point of discussion within the NWTP, and can be seen in Appendix 1; the variance is a discussion point in the NWTP. Also of note is that the Trust Board has agreed with the recommendations of the nursing establishment review, one of which is to move to a 95% registered nurse fill rate which will be seen in the next roster period.

The average fill rate for registered nurses in September 2020 was;

- 76.4% registered, 79.4% unregistered for day shifts
- 84.8% registered, 87.2% Unregistered for night shifts

Of note is that the fill rate is a reflection of roster template figures and not the actual patient need, which is assessed on the day via the acuity and dependency scoring. All roster templates have been reviewed through the establishment review and ward sisters charge nurses are all in agreement with the 95% shift plans.

2.1.3 CHPPD

The CHPPD data also demonstrates variation between planned and actual, once again, indicative of the way the Pandemic has affected services. This is monitored closely.

The data below demonstrates the CHPPD for August across the Trust

Hospital	CHPPD Rates for Staffing					
	Registered		Unregistered		Total (Includes Others)	
	Planned CHPPD	Actual CHPPD	Planned CHPPD	Actual CHPPD	Planned CHPPD	Actual CHPPD
Grantham	72.2	13.7	43.4	5.4	115.5	19.1
Lincoln	5.3	4.5	3.0	2.7	8.3	7.3
Pilgrim	5.4	4.6	3.2	2.8	8.7	7.4
Trust	5.8	4.6	3.4	2.8	9.2	7.4

Source NStf submission

The full NHS Digital upload information is presented in Appendix 1. Note that the information presented for the Grantham site as highlighted is reflective of the temporary change in model of care and closed clinical areas, and is not reflective of the true picture.

2.1.5 Daily staffing Reviews

Meetings to discuss staffing levels and staffing gaps continue to happen twice daily, with an aim of identifying and applying a priority to the shift gaps in order to secure temporary staffing cover and to develop an operational staffing plan.

The need to adopt a forward view has been emphasised at Divisional level, which will be particularly important going into winter with the Pandemic continuing as well.

The daily staffing meetings will thus continue going forward.

3 Recruitment and retention

3.1 Vacancies

The current vacancy position continues to be a high priority. The latest vacancies rates are detailed below drawn from ESR data.

The impact made on these figures by the newly qualified nurses is notable from the previous month with registered nurse vacancy levels reducing from 17% to 15.5%. This will reduce further with the international nurses that have been recruited, of which 11 are currently undertaking the preparation for the OSCE exam in November. A further 25 candidates are expected to join the Trust and are booked to take their OSCE in January 2021.

Nursing excluding B3 & B4 Student Nurses

Staff Group	FTE Budgeted	FTE Actual	Vacancy FTE	Vacancy %	Vacancy as a % of Total
Unregistered Nursing Band 2-4	1019.24	933.73	85.51	8.39%	17.18%
Registered Band 4	81.23	22.31	58.92	72.54%	11.84%
Registered Band 5 and above	2280.15	1926.81	353.34	15.50%	70.98%
Total	**3380.62**	**2882.85**	**497.77**	**14.72%**	**100.00%**

Source ESR

3.2 Recruitment

In September 11 International Nurses joined the Trust from overseas. The recruitment plan for overseas nurses is continuing, aiming to recruit up to 15 per month until the end of March 2021.

The next cohort of trainee nursing associates will start their programme in October 2020.

Discussions are ongoing around the funding mechanisms for all apprenticeship roles in nursing, including the trainee nursing associate apprenticeship, the top up from registered nursing associate to registered nurse and the advanced clinical practitioner apprenticeship.

The Trust has also agreed to expand the number of clinical placements for student nurses / midwives by 20%. There have been 228 adult, 16 child, and 33 midwifery student places offered via the university of Lincoln for September this achieves the 20% increase. Placement offers have also been extended to other HEIs throughout the East Midland and Humber regions.

4.0 CONCLUSIONS

The report is presented to the Committee to reflect the on-going challenges that are faced within Nursing, and to reference the work that is being undertaken through the Nursing Workforce Transformation Programme.

It will, as it develops in the future, continue to reflect the progress being made and the improvements in grip and control across temporary staffing and rosters in particular but enhanced by workforce developments and agreed safe establishments according to national guidance and best practice.

5.0 RECOMMENDATIONS

The Committee is requested to note the report and make recommendations as necessary.

Appendix 1: Digital Data submission for September 2020

Safe Staffing Performance Dashboard - Sep-20										
	CHPPD Rates for Staffing						Fill Rates			
	Registered		Unregistered		Total		Total Day		Total Night	
SITE/ Ward	Planned CHPPD	Actual CHPPD	Planned CHPPD	Actual CHPPD	Planned CHPPD	Actual CHPPD	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
GRANTHAM HOSPITAL										
Ward 1	0.00	0.00	0.00	0.00	0.00	0.00	0.0%	0.0%	0.0%	0.0%
Ward 2	29.62	14.36	13.45	5.67	43.07	20.03	50.4%	63.1%	44.7%	15.6%
Ward 6	0.00	0.00	0.00	0.00	0.00	0.00	0.0%	0.0%	0.0%	0.0%
EAU	0.00	0.00	0.00	0.00	0.00	0.00	0.0%	0.0%	0.0%	0.0%
Acute Care Unit	0.00	0.00	0.00	0.00	0.00	0.00	0.0%	0.0%	0.0%	0.0%
LINCOLN COUNTY HOSPITAL										
Ashby	3.60	3.22	3.21	3.37	6.81	6.59	83.7%	108.5%	100.0%	101.8%
Bardney	13.47	12.81	8.51	8.08	21.98	20.89	90.7%	96.9%	101.0%	92.6%
Branston	11.35	8.88	5.02	3.36	16.37	12.23	67.3%	77.2%	100.0%	49.7%
Burton	3.25	2.94	2.90	3.02	6.15	5.95	86.2%	105.6%	98.5%	101.7%
Carlton Coleby	0.00	0.00	0.00	0.00	0.00	0.00	80.8%	84.5%	99.1%	99.8%
Clayton	3.49	3.16	2.23	2.19	5.72	5.35	77.1%	98.8%	113.6%	97.6%
Dixon	3.64	3.10	2.92	2.60	6.56	5.70	79.0%	81.5%	95.3%	106.0%
Frailty Assessment Unit	3.79	3.21	3.20	3.12	6.99	6.33	95.2%	96.4%	73.3%	99.4%
Greetwell	0.00	0.00	0.00	0.00	0.00	0.00	0.0%	0.0%	0.0%	0.0%
Hatton	6.17	4.41	1.92	2.74	8.09	7.15	68.5%	122.5%	75.4%	192.6%
ICU	31.44	25.78	3.64	1.57	35.09	27.35	85.3%	59.8%	78.7%	10.0%
Johnson	9.20	8.63	3.34	3.55	12.54	12.18	92.0%	104.8%	96.1%	109.8%
Lancaster	3.29	2.84	3.29	3.17	6.57	6.01	80.2%	91.7%	98.6%	105.2%
MEAU	5.52	5.26	3.04	2.99	8.57	8.25	96.7%	96.1%	93.2%	101.2%
Navenby	4.73	3.94	4.88	2.72	9.61	6.65	79.3%	51.5%	88.3%	64.5%
Nettleham	1.26	1.23	3.25	2.87	4.52	4.10	92.8%	85.5%	102.7%	93.6%
Neustadt Welton	0.00	0.00	0.00	0.00	0.00	0.00	0.0%	0.0%	0.0%	0.0%
Neonatal (SCBU)	23.55	16.73	10.05	5.98	33.61	22.71	63.9%	53.2%	80.1%	71.6%
Rainforest	6.12	7.23	2.72	4.36	8.84	11.59	111.0%	158.9%	128.8%	163.3%
Scampton	3.28	2.95	3.52	3.08	6.80	6.02	84.5%	83.9%	100.2%	93.8%
SEAU & SAU	5.82	4.61	3.33	2.54	9.15	7.14	74.6%	67.3%	86.3%	92.8%
Shuttleworth	4.23	3.51	2.63	2.50	6.86	6.01	77.4%	91.7%	92.0%	101.7%
Stroke Unit	4.67	4.02	2.74	2.44	7.42	6.46	82.2%	82.9%	92.8%	102.1%
Waddington Unit	5.00	4.17	2.32	2.06	7.32	6.23	76.2%	81.8%	94.8%	117.3%
PILGRIM HOSPITAL, BOSTON										
Acute Cardiac Unit	5.24	4.04	2.29	1.91	7.53	5.95	76.5%	76.7%	77.8%	98.8%
Acute Medical Short Stay	3.50	3.07	2.72	2.97	6.22	6.04	86.3%	96.2%	89.9%	133.6%
Bostonian	4.51	4.33	3.04	2.68	7.55	7.01	95.5%	83.4%	97.2%	97.1%
IAC	6.54	5.91	3.84	3.28	10.38	9.19	86.4%	83.5%	95.8%	87.6%
ICU	29.76	25.65	0.00	0.00	29.76	25.65	80.8%	0.0%	93.1%	0.0%
Labour Ward	30.62	27.72	6.09	7.38	36.70	35.10	90.6%	125.1%	90.4%	117.0%
Neonatal Unit (SCBU)	18.76	15.41	9.46	6.58	28.22	21.98	83.0%	63.2%	81.2%	83.3%
Stroke Unit	4.15	3.49	3.25	2.70	7.40	6.18	77.9%	75.5%	94.4%	99.1%
1B	6.11	6.33	4.85	2.87	10.96	9.20	106.0%	69.6%	100.8%	34.8%
5A	3.99	3.32	2.78	2.70	6.77	6.03	73.4%	95.6%	103.5%	101.5%
5B	4.85	3.73	3.02	2.55	7.87	6.28	68.6%	84.1%	94.6%	85.4%
6A	3.80	3.31	3.31	2.84	7.11	6.14	82.9%	74.8%	95.7%	104.5%
6B	4.64	3.31	3.73	2.94	8.37	6.25	82.1%	81.0%	58.0%	75.8%
7A	0.00	0.00	0.00	0.00	0.00	0.00	0.0%	0.0%	0.0%	0.0%
7B	4.69	3.88	3.33	2.85	8.02	6.73	77.5%	80.1%	91.7%	99.2%
8A	4.04	3.49	3.16	2.74	7.20	6.23	84.9%	80.3%	88.6%	97.7%
9A (formerly 3B)	3.45	3.25	2.57	2.36	6.02	5.61	89.1%	86.9%	103.4%	103.3%
M1	6.74	6.18	4.50	3.78	11.23	9.95	92.6%	81.5%	90.2%	90.0%
Ward 1	7.03	4.86	3.73	2.72	10.77	7.58	67.7%	67.2%	70.9%	80.2%

Source NStf download

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*3rd November 2020*
Item Number	*Item 8.4*
Accountable Director	*Dr Karen Dunderdale, Director of Nursing*
Presented by	*Dr Karen Dunderdale, Director of Nursing / DIPC*
Author(s)	*Kevin Shaw, Deputy DIPC*
Report previously considered at	*Quality Governance Committee 20th October 2020*

How the report supports the delivery of the priorities within the Board Assurance Framework	
1a Deliver harm free care	*X*
1b Improve patient experience	*X*
1c Improve clinical outcomes	
2a A modern and progressive workforce	
2b Making ULHT the best place to work	
2c Well Led Services	
3a A modern, clean and fit for purpose environment	*X*
3b Efficient use of resources	
3c Enhanced data and digital capability	
4a Establish new evidence based models of care	
4b Advancing professional practice with partners	
4c To become a university hospitals teaching trust	

Risk Assessment	*Insert risk register reference*
Financial Impact Assessment	*Insert detail*
Quality Impact Assessment	*Insert detail*
Equality Impact Assessment	*Insert detail*
Assurance Level Assessment	• *Limited*

Recommendations/ Decision Required	• *To note the IPC Annual Report*
	•
	•

Executive Summary

The Annual Report for IPC summarises the overall activity through 2019 / 20. It recognises that a number of IPC performance issues were identified by external partners. This prompted a review by the Director of Nursing which consequently highlighted significant failings in the systems and processes in place through IPC.

The Annual Report highlights a number of actions being taken through forward planning and concludes that changes have been made and continue to be implemented to address the failing performance and make improvements across a range of IPC activities.

Limited assurance is offered around IPC performance as demonstrated through the Annual Report for 19 / 20.

Director of Infection Prevention and Control Annual Report 2019 - 2020

United Lincolnshire Hospitals NHS Trust

Version Control

Version	**0.1**
Type	**Draft Annual report**
Directorate	**Corporate**
Author	**Mr Kevin Shaw, Deputy Director Infection Prevention and Control**
Contributors	**Dr Bethan Stoddart, Consultant Microbiologist and Infection Prevention and Control Doctor.** **Mrs Balwinder Bolla, Consultant Antimicrobial Pharmacist** **Mr Stephen Kelly, Nurse/Business Manager, Occupational Health** **Mr Christopher Farrah, Associate Director Estates and Facilities**
Approving Person	**Dr Karen Dunderdale, Director of Nursing and Director of Infection Prevention and Control**
Approval Date	
Issue Date	
Frequency of Review	
Review Date	

Version	Section/Paragraph/ Appendix	Description of amendments	Date	Author/Amended by
0.1	Whole document	Complete first draft	09/10/2020	Kevin Shaw
0.2				
1.0				

Contents

Section 1 Forward

This is the United Lincolnshire Hospitals NHS Trust's annual Infection Prevention and Control Report for the 2019/2020 financial year. This has been a very challenging year from an Infection Prevention and Control perspective and towards the end of the year the organisation found itself responding to the COVID-19 pandemic.

Throughout the 2019/20 financial year, there were some changes to the senior management and in particular the Director of Nursing and Director of Infection Prevention and Control. This role changed hands 3 times throughout the year with myself taking up the post in February 2020.

During the year the Trust had visits from the CQC and they identified some concerns with hand hygiene. This triggered a visit by NHS England and Improvement who found other concerns relating to cleanliness and environment. As soon as I commenced in post I instructed a full review of the Trusts compliance to the hygiene code in response to these findings and it became clear that some of the systems and processes in place were in need of a refresh.

The timing of the NHS England and Improvement report also coincided with the Trusts COVID-19 pandemic response so there was a significant amount of activity required by all to ensure that progress could be made despite the operational challenges facing the organisation.

It is clear from this report that much work is needed to achieve the level of compliance to the Code of Practice on the prevention and control of infections and related guidance (the Hygiene Code) as part of Regulation 12 of the Health and Social Care Act 2008 (Revised 2015)[1] and the associated 10 criteria expected by our patients, visitors, staff and regulators however this process has begun and the high standards will be achieved.

Dr Karen Dunderdale
Director of Nursing and Director of Infection Prevention and Control
United Lincolnshire Hospitals NHS Trust

1 http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted

Section 2 Executive summary

Infection Prevention and Control (IP&C) performance in 2019/20 has been challenging for United Lincolnshire Hospitals NHS Trust (ULHT). There were significant issues identified in terms of cleanliness, suitability of the physical environment and governance by external inspectors and regulators.

In May 2017 NHS England and Improvement visited ULHT and rated the organisation as 'red' for IP&C. the Trust was expected to carry out significant improvements in order to improve the performance position. By November 2017 the Trust was rated as 'Amber' and further visits were planned for the following year. In May 2018 and November 2018 NHS England and Improvement visited ULHT as part of their biannual IP&C inspection programme. Both of these inspections rated the Trust as 'Green' for IP&C and as a result the organisation was de-escalated from the biannual visits.

In July 2019 the CQC inspected ULHT and reported some concerns relating to hand hygiene practice in some clinical areas. Following this report, NHS England and Improvement visited the organisation in January 2020 and gave ULHT a red rating for IP&C performance. There were key issues identified relating to cleanliness, condition of the physical environment, escalation of concerns and governance arrangements. The NHS England and Improvement report coincided with the start of COVID-19 preparations and the commencement of the newly appointed Director of Nursing and Director of Infection Prevention and Control.

During February and March 2020 the primary focus was the Trusts management of the COVID-19 pandemic response however plans for IP&C improvement continued and once the response moved in to the 'restore' phase the Director of Nursing instructed a fully comprehensive review of the hygiene code which measured the trusts compliance against all 135 compliance requirements. A key element of this instruction was to assess if the compliance items were embedded in practice. On completion of the review, it transpired that the Trust was only compliant in 5 out of the 10 hygiene code criteria. A full and comprehensive action plan was developed to address the non-compliant line items and formed the basis of the Trust IP&C action plan for 2020/21.

Section 3 Introduction

United Lincolnshire Hospitals NHS Trust is an acute NHS Trust within a largely rural setting. It provides services from 3 acute hospitals in Lincolnshire - Lincoln County Hospital, Pilgrim Hospital, Boston, and Grantham and District Hospital. The Trust also provides a wide variety of outpatient, day case and inpatient services from a range of other community hospitals operated by Lincolnshire Community Health Services or local GP clusters. These include: Louth County Hospital, John Coupland Hospital (Gainsborough), Johnson Community Hospital (Spalding) and Skegness and District General Hospital.

United Lincolnshire Hospitals NHS Trust provides a wide range of healthcare services delivered by over 7,500 highly trained staff. These services cost more than £390 million each year to provide. In an average year, we treat more than 180,000 accident and emergency patients, over 600,000 outpatients and almost 100,000 inpatients, and deliver over 5,000 babies,

The Trust primarily serves the 757,000 residents of Lincolnshire which is one of the fastest growing populations in England. The Trust also provides a wide variety of outpatient, day case and inpatient services from a range of other community hospitals operated by Lincolnshire Community Health Services or local GP clusters. These include: Louth County Hospital, John Coupland Hospital (Gainsborough), Johnson Community Hospital (Spalding) and Skegness and District General Hospital.

To ensure that United Lincolnshire Hospitals NHS Trust delivers the very quality best services in terms of quality and safety, good infection prevention and control practices are essential. During the financial year 2019/20, it became apparent in the latter part of the year that significant work would be required to meet the standards of the hygiene code and to demonstrate that sustained progress could be demonstrated especially with the emergence of the COVID-19 pandemic.

Infection prevention and control is everybody's responsibility and all members of staff, patients and visitors to ULHT are expected to take the necessary steps to reduce the risks of themselves or others acquiring or transmitting infections. The primary purpose of the infection prevention and control team in ULHT is to maintain patient safety by supporting and advising staff, visitors and patients as needed to ensure that those responsibilities are met.

This report will demonstrate the work undertaken during 2019/20 to monitor and manage infection prevention and control systems and processes. The main body of the report will follow the format of the Code of Practice on the prevention and control of infections and related guidance (the Hygiene Code) as part of Regulation 12 of the Health and Social Care Act 2008 (Revised 2015)[2] and the associated 10 criteria.

2 http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted

The hygiene code compliance criterion.

Compliance criterion	What the registered provider will need to demonstrate
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.
5	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
7	Provide or secure adequate isolation facilities.
8	Secure adequate access to laboratory support as appropriate.
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

Section 4 Performance report

NHS

Criterion 1: Systems to manage and monitor the prevention and control of infection.

ULHT continues to acknowledge its collective responsibility for keeping to a minimum the risks of health care associated infection. Although a governance structure was in place, it was clear that there were weaknesses that allowed for IP&C practice to deteriorate without the correct level of escalation and ownership needed to maintain the high standards expected.

In July 2019 the CQC inspected ULHT and reported some concerns relating to hand hygiene practice in some clinical areas. Following this report, NHS England and Improvement visited the organisation in January 2020 and gave ULHT a red rating for IP&C performance. There were key issues identified relating to cleanliness, condition of the physical environment, escalation of concerns and governance arrangements.

Throughout quarter 2 of the 2019/20 financial year, there were changes in DIPC leadership and therefore IP&C management and governance processes. These changes affected the audit and ward visit programme and reduced the level of focussed IP&C visits to clinical areas. IP&C audits became part of the ward accreditation process and the IP&C team supported these visits by inspecting against the IP&C metrics of this process. This change resulted in reduced visibility in areas not being accredited.

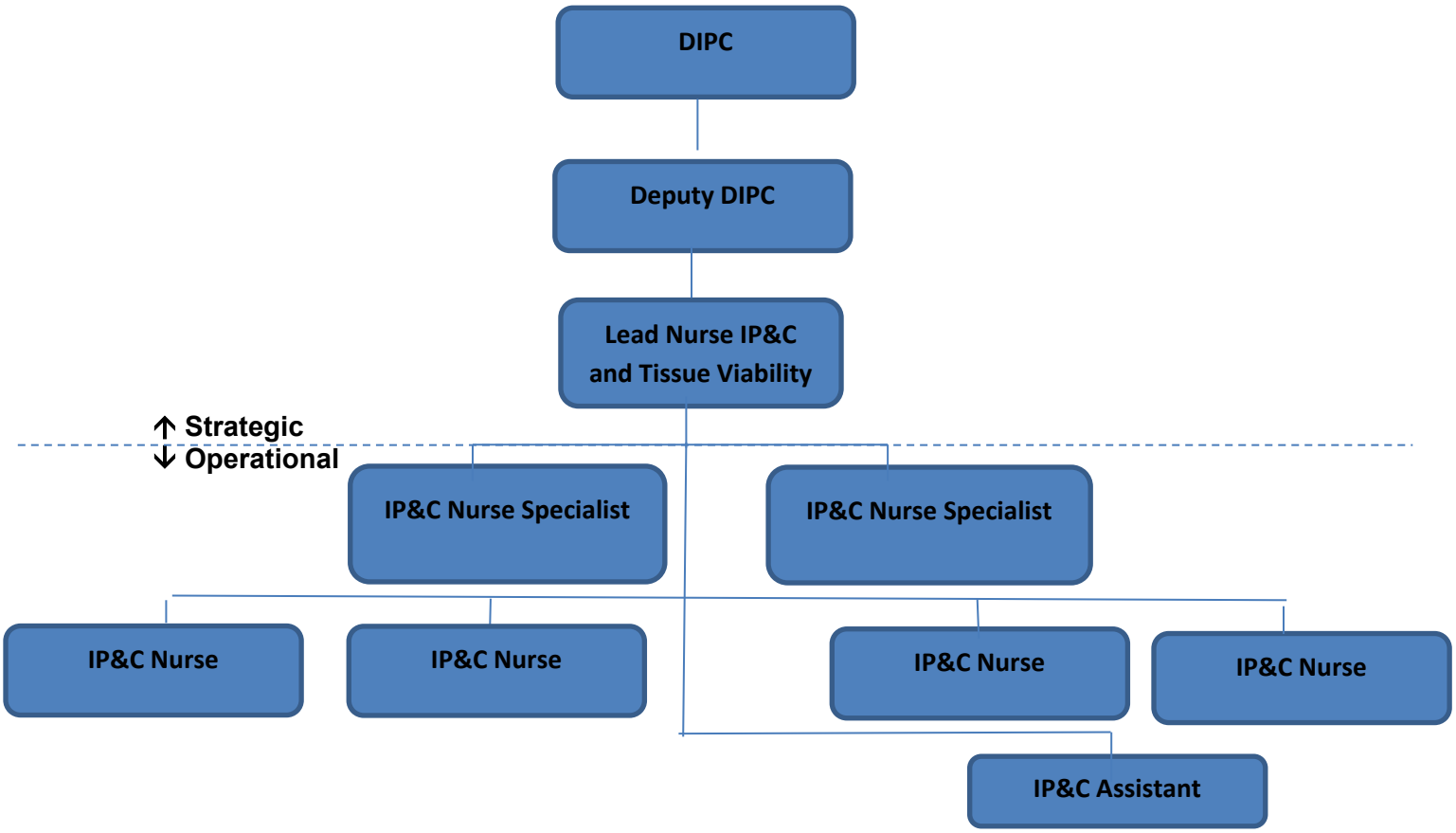
There had been further progress with compliance to the Hygiene Code gap analysis which consists of 135 compliance line items however it appeared that the recorded compliance was not being sustained at an operational level and the changes in the IP&C service delivery meant that the organisation was not properly sighted on the deteriorating levels of IP&C practice that were identified in the subsequent visits.

The structure of the IP&C function also meant that there was no full time IP&C lead in post as this role had been split in order to manage Tissue Viability services with a focus on pressure ulcer reduction. This split significantly reduced the leadership capacity for IP&C and limited the time available to deliver the programmes effectively. When the new Director of Nursing commenced in post in February 2020, this was changed and the IP&C Lead Nurse role was converted to a full time position.

Throughout 2019/20 there were monthly IP&C committee meetings and were chaired by either the Director of Nursing and DIPC, the Deputy Director of Nursing or the Lead Nurse for IP&C. These committee meetings were structured to provide upward assurance to the Executive leadership. Following a review of this meeting the new Director of Nursing and DIPC, it was noted that although there was at times comprehensive data supplied, it did not provide the required assurance and therefore the structure and format was changed.

Although the IP&C team was reorganised into a corporate model that could be utilised more effectively based on operational need, it was clear that the service did not have the required capacity to fully support the organisation. In February and March 2020, the Director of Nursing and DIPC has recognised this and a full service review will form part of the work undertaken in 2020/21.

The Infection Prevention and Control structure (April 2019 to January 2020) was made up of the following:



Strategic IP&C leadership

The main focus of the strategic element of the IP&C function was to deliver the trust strategy. This included providing assurance evidence of compliance the hygiene code. The trust was expected to deliver and sustain improvements in quality and safety. As previously stated, for the majority of the 2019/20 financial year, the strategic leadership for IP&C did not have a full time dedicated IP&C presence.

Operational IP&C delivery

The core purpose of the operational element of the IP&C function was to provide an effective and efficient IP&C support service to the trust. This included (but not limited to):

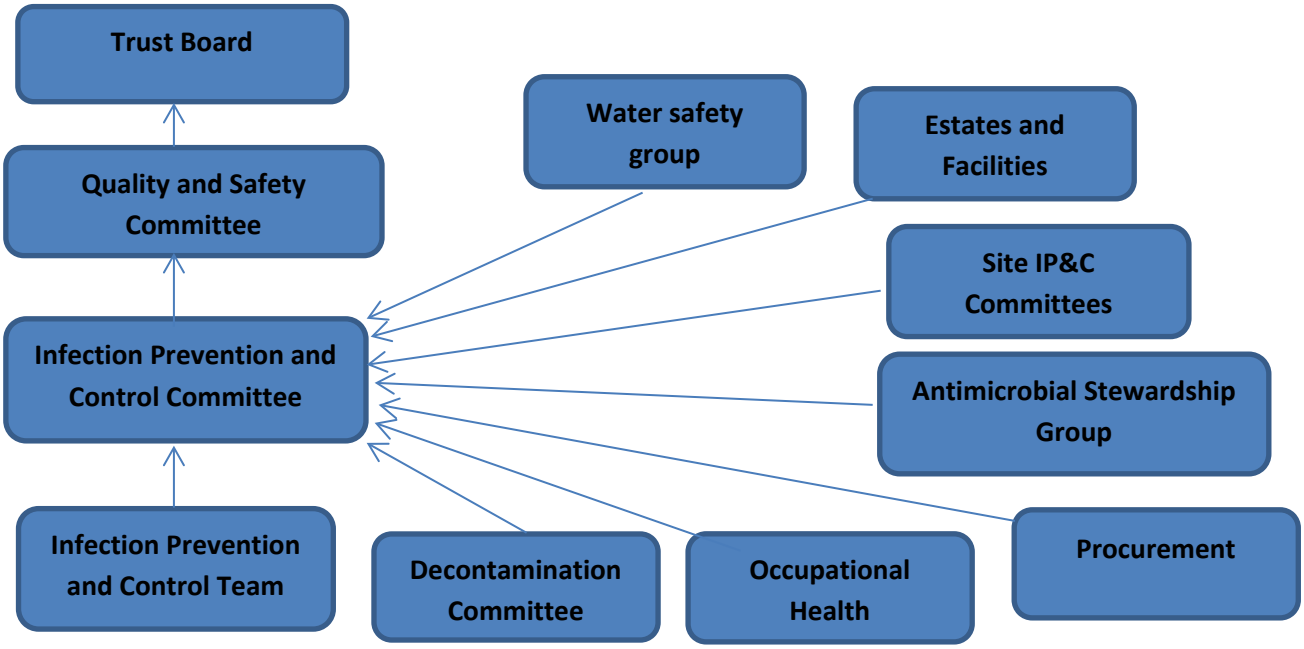
- Leadership and support visits to clinical areas and areas where patients access services
- Daily contact with all wards to check side room availability
- Daily support to the operational hub to aid in bed management
- Running an IP&C Link Practitioner network
- Support for Root Cause Analysis investigations relating to HCAI incidents
- IP&C advice and support for routine and reactive issues (including outbreaks etc.)
- Leading on trust wide training requirements (induction and core learning etc.)
- Alert organism surveillance
- Leading on Trust wide projects and initiatives
- Support and leadership to estates and facilities for IP&C specification relating to the physical decontamination of environments.
- Support to specialty services
- To link in with the strategic aims of the function and assist with the delivery of these.
- To support the work undertaken by the medical devices decontamination services.
- Antimicrobial Audits looking specifically at 72-hour review of patients where sepsis is diagnosed or suspected.
- Weekly *Clostridioides difficile (C.diff)*/Glutamate Dehydrogenase (GDH (the enzyme that indicates C.diff is present)) ward rounds as a collaborative effort with IPC nurses, antimicrobial pharmacists and microbiologists where possible.
- Antimicrobial advice and support for all levels of prescriber and non-medical staff where requested.

The IP&C team were a visible and proactive within the trust however in quarters 2, 3 and part of quarter 4, their focus was to support ward accreditation visits.

Governance

- Throughout 2019/20 a number of reports were required by the trust. Monthly IP&C surveillance reports that provided data on infection numbers by type
- Site meeting reports that were used for assurance reporting to the Trust Committee
- Water safety reports that were used to give assurance on water quality and safety
- Antimicrobial Stewardship reports which gave details on prescribing matters
- Environmental cleanliness audit score reports were used for assurance reporting to the Trust IPC committee
- PLACE audit reports that were used for assurance purposes
- Occupational Health reports gave updates on vaccination programmes

Below is a diagram illustrating the routine reporting pathway that was in use for assurance during 2019/20.



Surveillance

Performance data overview 2019 – 2020

Clostridium difficile infections 2019/20

The annual trust threshold for CDI for 2019-20 was set as 110 cases by NHS England. This is based on a new set of working parameters that include moving from day 4 to day 3 post discharge as being acute trust attributable and any case within 4 weeks post discharge from ULHT.

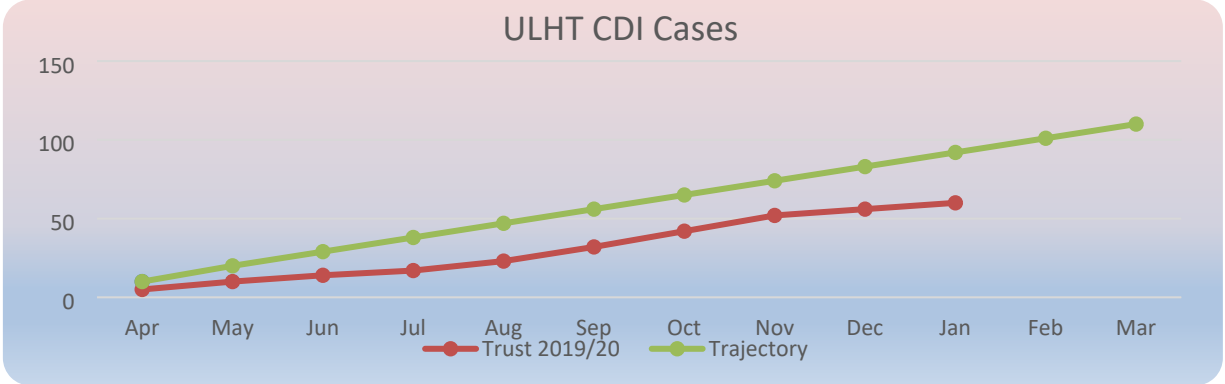
Throughout the year, a joint working team of IP&C Nurses, Antimicrobial Pharmacists and Microbiologists have initiated weekly targeted hotspot visits to areas where inpatients have been identified as either *C.diff* or GDH positive. During these visits, the team challenge prescribing decisions, care pathways and IP&C practices.

Each of the cases were investigated and the key themes related to antibiotic prescribing. Although in most cases the antibiotics were justified and in line with the prescribing formulary, the key lesson is educating prescribers on possible alternative antibiotics that pose fewer risks for *C.diff* infection. The trust ended the year by achieving a significant under trajectory result.

2019/20 data was: -

2019/20	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Trajectory	10	10	9	9	9	9	9	9	9	9	9	9
Actual acute cases	5	5	4	3	6	9	10	10	4	4	5	5
+/- Trajectory	-5	-10	-15	-20	-24	-24	-23	-22	-28	-33	-37	-40
Acute Cumulative actual	5	10	14	17	23	32	42	52	56	60	65	70

ULHT Clostridioides difficile cases 2019/20



MRSA bloodstream infections

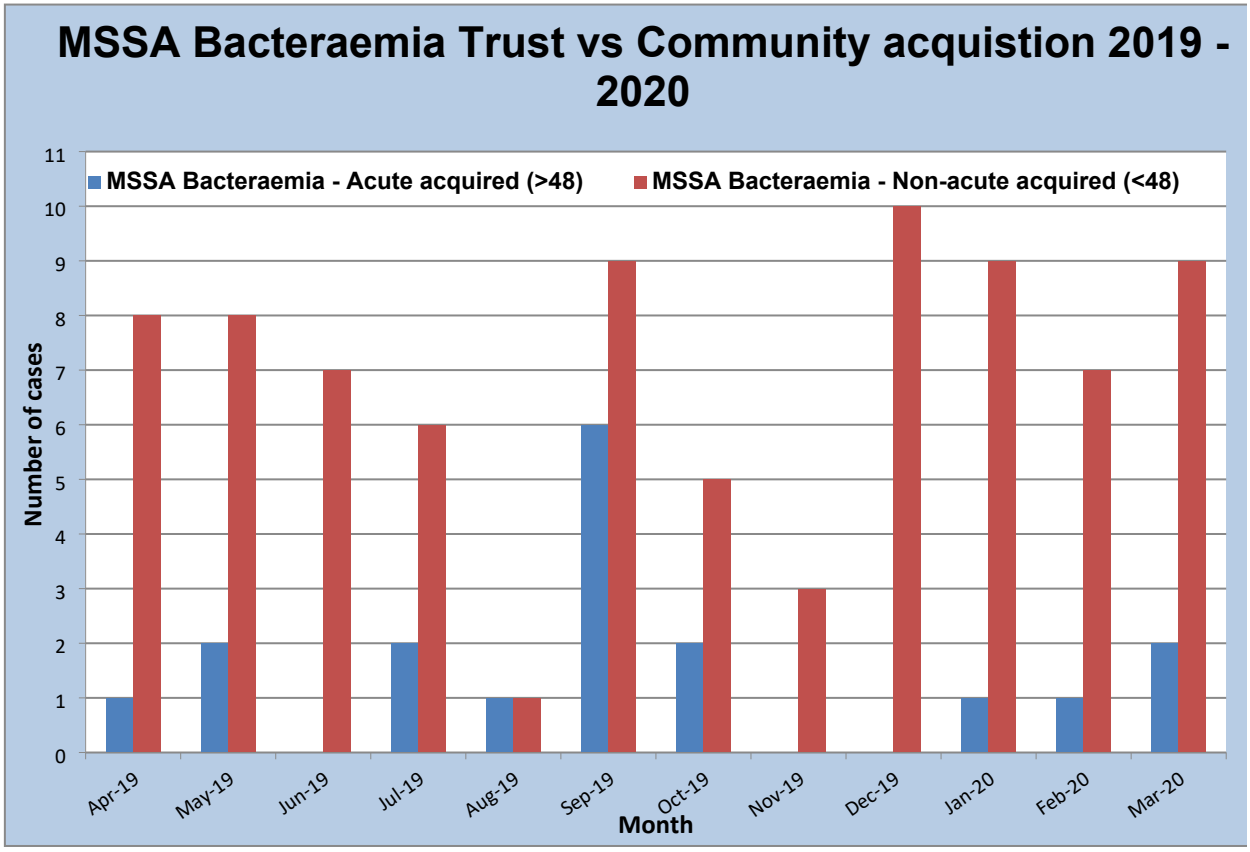
Over the past 12 months ULHT had reported 3 cases of MRSA bloodstream infections against a trajectory of zero. All three cases were fully investigated using Root Cause Analysis (RCA) and all 3 were deemed to be unavoidable. Although the trust reported 3 cases throughout 2019/20, ULHT was identified as low incidence organisation and as such will no longer be required to report MRSA bloodstream infections through the Public Health England Post Infection Review (PIR) process. ULHT will continue to treat MRSA bloodstream infections as a serious matter and will continue to investigate each case accordingly using the RCA process and cases will be discussed and overseen at the trust infection prevention and control committee.

MRSA bacteraemia performance 2019-20

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Louth	0	0	0	0	0	0	0	0	0	0	0	0
LCH	0	0	0	1	0	0	1	0	0	0	0	0
PH	0	0	0	0	0	0	0	1	0	0	0	0
GDH	0	0	0	0	0	0	0	0	0	0	0	0
Total	0	0	0	1	0	0	1	1	0	0	0	0
Cumulative	0	0	0	1	1	1	2	3	3	3	3	3

Hospital attributable MSSA bloodstream infections 2019/20

The Trust returns data on the number of cases of MSSA bloodstream infections to Public Health England. Cases are labelled as either Trust attributable or community acquired: there is no annual objective for MSSA bloodstream infection cases.



Gram-negative bloodstream infections

The following tables of E coli, Klebsiella and Pseudomonas bloodstream infection cases demonstrate data collected as part of the mandatory HCAI reporting to PHE. The tables demonstrate the number of trust-attributed cases of Gram-negative bloodstream infection by individual organisms for 2018/19.

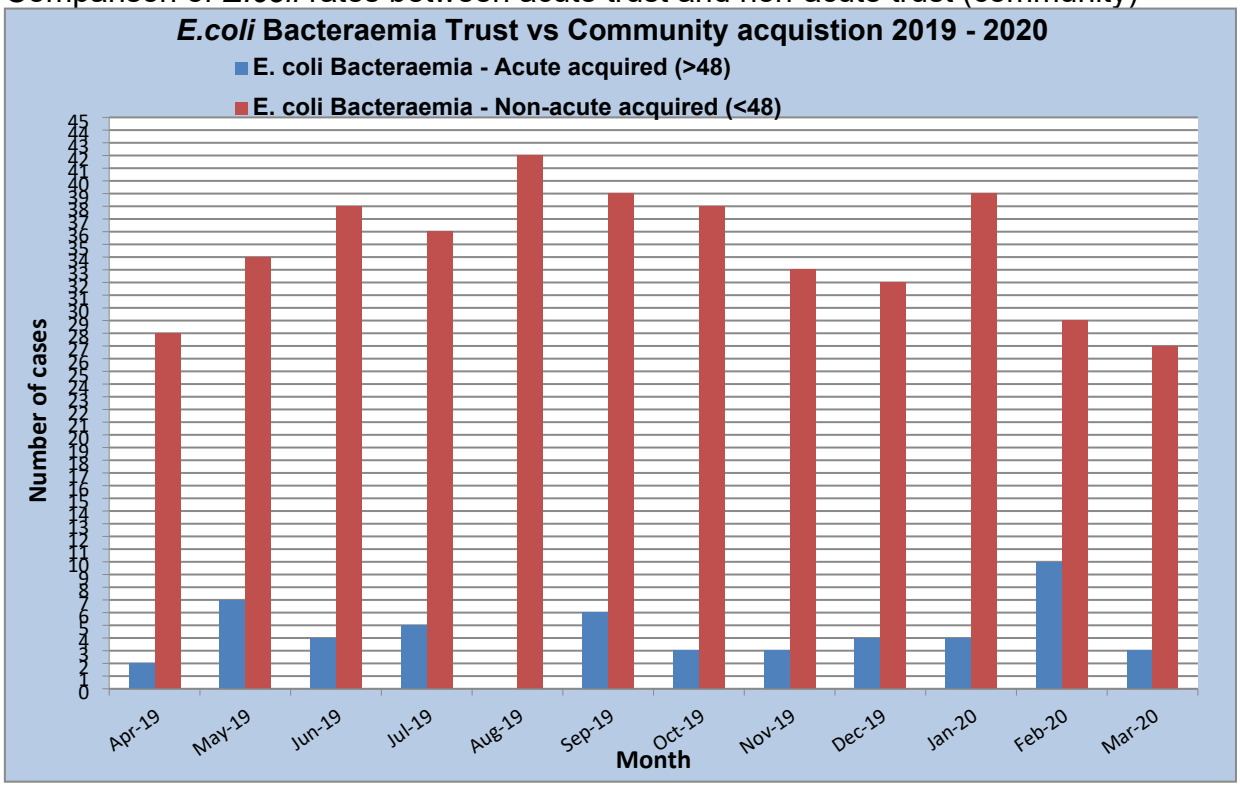
No thresholds for these organisms are currently in place for acute hospital trusts. Action planning to reduce Gram-negative bloodstream infection (GNBSI) rates is being led by the CCG through the Whole Health Economy IP&C group work with the ambition of reducing Gram negative bloodstream infections by 50% by 2021.

The vast majority of Gram-negative bloodstream infections are caused by *E.coli* and therefore the primary focus is on reducing the common types of infections such as Urinary Tract Infections (UTI), Catheter Associated UTI and hepatobiliary infections.

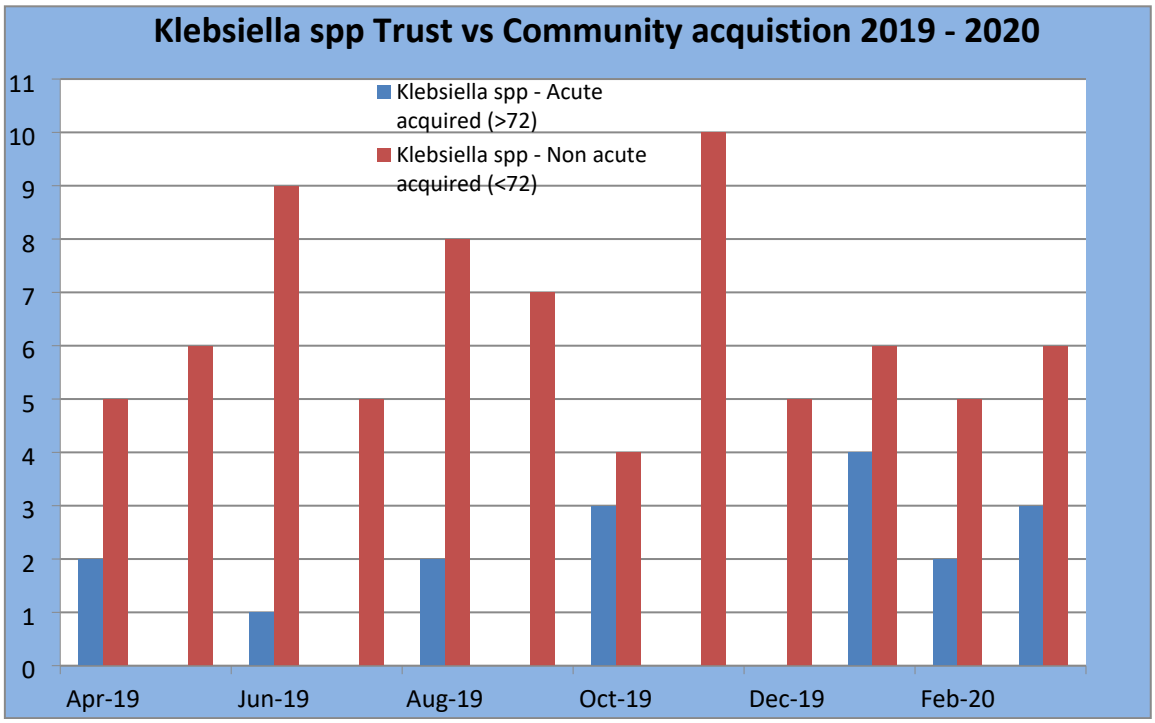
The 2019/20 ambition for ULHT was to sustain progress against the trust GNBSI action plan which the trust achieved. A whole health economy action plan has been produced with tasks linked to respective organisations. ULHT is a key member of the whole health economy and will deliver on all agreed actions.

The Trust is still performing relatively well in terms of Gram negative bloodstream infections. Due to organisational changes in the whole health economy partners, the system wide Gram negative plan had not been progressed. This was further suspended with the onset of the COVID-19 pandemic.

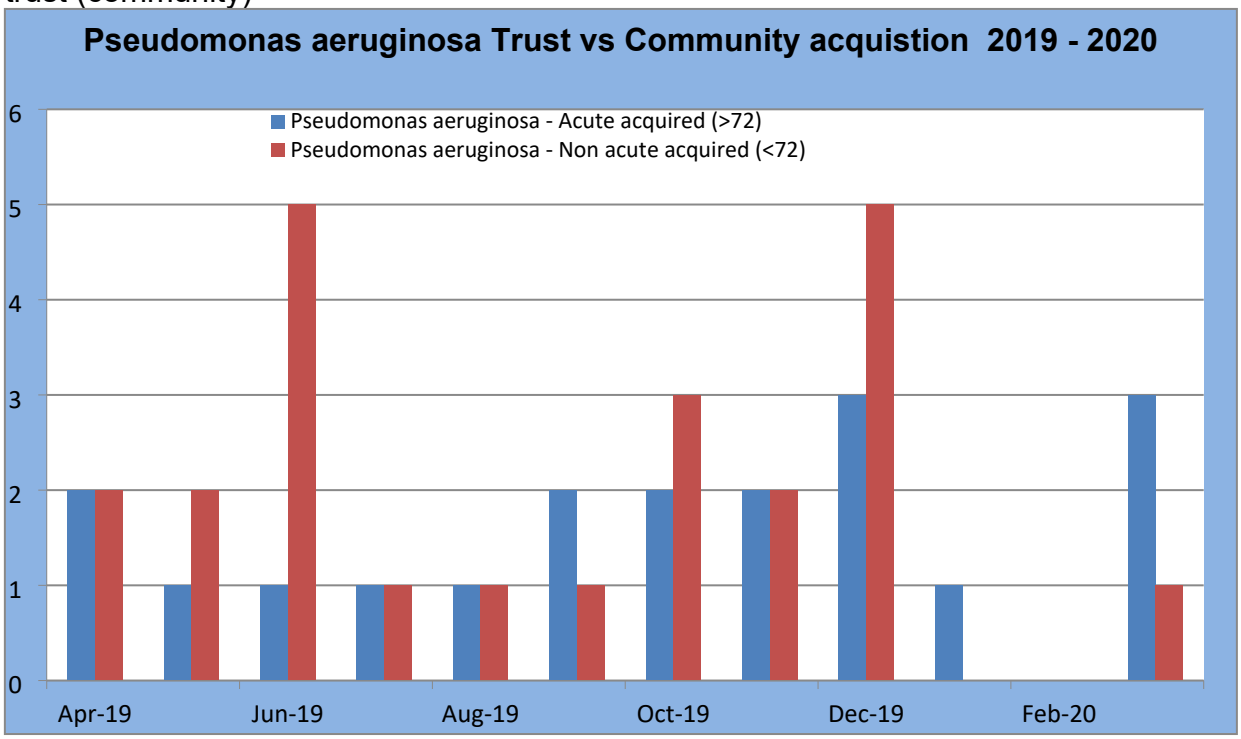
Comparison of *E.coli* rates between acute trust and non-acute trust (community)



Comparison of *Klebsiella spp*. rates between acute trust and non-acute trust



Comparison of *Pseudomonas aeruginosa* rates between acute trust and non-acute trust (community)



Surgical Site Infection (SSI) Surveillance

The Trust SSI programme was found to be not robust in its reporting. The activity for 2019/20 was as follows:

Orthopaedic surgical site infection (SSI) has been included in the mandatory healthcare associated infection surveillance system since April 2004. All NHS Trusts or facilities undertaking orthopaedic surgery must do surveillance in one or more of the orthopaedic categories - total hip replacement, hip hemi-arthroplasty, knee replacement and open reduction of long bone fracture. In any financial year, surveillance must be continued for a minimum of three consecutive months, commencing at the start of a calendar quarter.

Currently the surveillance scheme is coordinated by the Healthcare-associated Infection and Antimicrobial Resistance (HCAI & AMR) Department of the Communicable Disease Surveillance Centre (CDSC) at the Public Health England (PHE) in Colindale. The PHE web based data capture system collates data from a number of other categories of surgery which Trusts can complete on a voluntary basis. AT ULH the orthopaedic surgeries include, Total Hip replacement, including revision, Total Knee replacement, including revision, fractured neck of femur. Collection of data at Lincoln and Grantham sites takes place during January to March of each year, whereas surveillance at Pilgrim hospital is continuous. All patients should be tracked during the year after surgery to ensure that any post-operative infections can be added to the data collection. To make data collection even more difficult, the Trust performs surgeries across three sites and currently there is no one surveillance nurse who can co-ordinate the data collection.

Unfortunately, although there is evidence of collection of data for all patients undergoing these surgeries, there is no robust follow up to identify post discharge infections. Some patients are followed up with personal phone calls but there is no current evidence to demonstrate any follow up using the return of Post Discharge Questionnaires, alerts for readmissions within 1 year of surgery or even checking of microbiology data to look for evidence of post-operative infection. This means that data returns from PHE demonstrate that ULH has no/ intermittent evidence of infections, which means that The trust has been highlighted as an outlier.
There are a large number of surgery categories included within the National Surveillance program, although currently the Trust does not participate in any of these. There is, however a plan to move forward with this during 2020-21 to include open cholecystectomy.

PHE no longer provide a National facility for C.section surveillance, it is planned that data collection for this category will be internally collated for all patients undergoing this procedure. This will entail follow up with checking details against pathology results, this can be confirmed with discharge surveillance data from the community midwives. This will then provide the W&C Division with a clearer overview of the risks to parents undergoing this procedure.

Lincoln	**Hip Replacement**	**PDQ**	**SSI**	**Knee Replacement**	**PDQ**	**SSI**	**Fractured neck of femur**
Jan – March 2017							
Jan – March 2018							
Jan -March 2019							
Jan- March 2020							
Pilgrim	**Hip Replacement**	**PDQ**	**SSI**	**Knee Replacement**	**PDQ**	**SSI**	**Fractured neck of femur**
April – June 2019	18	0	0	18	0	0	85
July – Sept 2019	31	0	0	20	0	0	96
Oct - Dec 2019	20	0	0	5	0	0	78
Jan- March 2020	22		0				86
Grantham	**Hip Replacement**	**PDQ**	**SSI**	**Knee Replacement**	**PDQ**	**SSI**	**Fractured neck of femur**
Jan – March 2017	39		0	42		0	
Jan – March 2018	46		0	29		0	
Jan -March 2019	119		0	148		0	
Jan- March 2020	88		0	143		0	

Criterion 2: Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.

Cleanliness

Continuous measurement and management of performance of Estates and Facility Services is fundamental in the control of hospital acquired infection. Cleanliness remains high on the Trust agenda and regular meetings have continued to be held at all levels of the organisation to discuss housekeeping provision, and improvements to MiC4C cleanliness. The monitoring of clinical areas has been undertaken by the Facilities Department on a weekly and monthly basis following the National Standards of Cleanliness guidelines (2007) using "MiC4C", which is a cleanliness monitoring software product. The results are then fed back to Ward and Department Leaders, Matrons, and Divisional Nurses. The scores and any actions required have been discussed at the site IP meetings as well as the Trust IP Committee meeting. Louth is now added to the system and auditing is due to commence in June.

Housekeeping

Following the Housekeeping review and the subsequent Business Case and additional funding, the transfer of the entire ward housekeeping staff to Facilities was completed by February 2019. Initial challenges to the running of the housekeeping services were the volume of vacancies that were inherited and recruitment on all 3 sites has been undertaken. Further monitoring of the transfer and opportunities for improved standards and cost savings will be progressed.

Deep Clean Programme

Without the facility to decant wards, there was no effective deep cleaning programme delivered throughout 2019/20. Deep cleans did occur when requested following outbreaks or terminal cleans. In February 2020, the new Director of Nursing instructed that a deep clean programme was planned and delivered.

Waste Management

The trust is required to complete a Pre Acceptance Audit for all sites annually to ensure it remains compliant with regard to Waste Segregation as part of a mandatory requirement for the Environmental Agency.

PLACE

PLACE aims to promote the principles established by the NHS Constitution that focus on areas that matter to patients, families and carers:

- Putting patients first;
- Active feedback from the public, patients and staff;
- Adhering to basics of quality care;
- Ensuring services are provided in a clean and safe environment that is fit for purpose.

Separate reports for PLACE assessments are available through the Estates and Facilities Directorate

Water Safety Group
Many of the challenges presented to ULH in respect of water 2019/2020 have been achieved and this has resulted in some significant improvements in water quality at all three main sites.

These challenges include the management of old water systems and plumbing in all sites that increase the risk of organisms such as legionella and pseudomonas. Removal of pipework no longer used (dead legs etc.) and increased water treatment solutions have reduced some of the risks however much work is still needed.

There remain a number of key challenges which have carried through from 2019/2020 into 2020/2021. Perhaps the greatest of these is managing an ageing water infrastructure which has the potential to impact on both hot and cold water systems.

The Water Safety Group, which has been meeting on a monthly basis as part of the management strategy. This is a reflection on the impact this group has had on "getting the job done" and the water quality improvements attained.

The WSG must be a multi-discipline group to ensure "work in progress" areas are transformed into achievements. Both Legionella and Pseudomonas water testing results have recorded steady improvements. There have been a number of excursions where failures have been identified but in the majority of cases a rapid response and intervention by the estates team has resolved the issue. The surveillance programme remains in place and unless challenged by external influences would expect to see the current levels maintained.

Design, construction, renovation and refurbishment programme
The IPT has continued to contribute to the design, construction and renovation projects across the Trust as requested by Estates. In line with HBN 00-09 "Infection Control in the Built Environment" as part of ward/department refurbishments and the fire improvement works the opportunity has been taken to upgrade wash hand basins/taps and other water related items to assist with the provision of safe water services.

Criterion 3: Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance

The Trust Antimicrobial Stewardship Strategy Group (ASSG) is set up in line with recommendations from criterion 3 of the Hygiene code, and NICE NG15, since 2016. The forum allows dialogue with IPC Team, clinicians, PathLinks, sepsis leads, acute care practitioners, and primary care around antimicrobials specifically.

The monthly meeting duration has been increased to 2 hours to accommodate a more comprehensive and engaging agenda. Minutes are disseminated to relevant forums including IPCC, Drug and Therapeutics (DTC), Medicines Optimisation and Safety Committee (MOpS). Attendance and engagement at ASSG has improved, with significant factor being introduction of an antimicrobial support worker in the team to co-ordinate meetings and papers. There has also been consistent microbiologist and DIPC representation.

Repeat cancellation of room bookings being overruled by other high level meetings did have a counteractive effect on new clinician interest but the group still made good progress in tackling stewardship issues and work streams for the Trust.

Terms of reference, meeting dates and minutes are made available on the Trust intranet. The ASSG actively seeks out input/expertise from the specialists required for the relevant issues arising. Calls for improving membership are sent out intermittently via e-newsletter, email via PGME and twitter, and have a good momentum going. DTC have the ASSG minutes on their agenda and papers as a standing item and take keen interest in supporting actions.

The Antimicrobial Stewardship Strategy is working well and is available on intranet http://ulhintranet/antimicrobial-stewardship, and on http://ulhintranet/assg. This directs the structure and agenda of ASSG. The next review of this document will draw on the successful set up and progressive development of the Lincolnshire AMS Group, and the new virtual 'normal' will also bring new gains. It is of note that AMS Lincolnshire has been recognised and recommended by NHSI AMR leads for UK as a great model for other local health economies to develop the same.

In addition to the Trust Antimicrobial Guidelines devised by PathLinks and the various local guidance on managing specific infections, there is a Trust Antimicrobial Prescribing Policy which covers the main aspects of prudent antimicrobial prescribing, with information and direction on penicillin allergy, documenting appropriate indication, documenting antimicrobial review, pharmacy supplies of restricted antimicrobials, how to obtain urgent antimicrobials during (and out of) pharmacy hours, etc. The policy directs prescribers to follow guidelines where they are seeking antimicrobial choices for management of infections, as they reflect national and local resistance patterns. The policy has been developed taking into account national guidance, patient safety alerts from PHE, national legislation and toolkits, local guidelines and policies. Whilst it is unlikely that the policy is read with enthusiasm on induction, it has certainly been utilised by pharmacy in enforcing key decisions (only supplying 24 hours of a restricted antimicrobial where outside of guidelines and microbiologist approval no documented). The policy has surpassed the review date, and the intention is to incorporate elaboration on Day 3 antimicrobial prescribing review. Next version will include utilisation of new ULHT resources including access to the Antimicrobial Pharmacy Team and Microguide App, as well as outlining audit standards with a data collection tool which is being used successfully across the Trust for numerous antimicrobial audits with good effect.

ULHT has 5 Key Performance Indicators used as antimicrobial prescribing standards applied in the Trust for AMS, as part of our work to tackle AMR. These were introduced successfully as part of a locally commissioned CQUIN in 2016. These can be viewed on this page of the intranet http://ulhintranet/antimicrobial-stewardship-cquin and are incorporated into many antimicrobial audits over the year. They are well embedded in the Trust as expected standard of care, and feature in teaching sessions, being supported in practice by the ULHT prescription chart too.

Restricted antimicrobials are managed by simple but effective means, with support from the pharmacy department and numerous prescriber quality improvement projects under Antimicrobial Consultant supervision. 'Pink slip supplies' of sepsis antibiotics are available on each low risk ward, whereas high risk wards keep those antibiotic wards as stock. This is to provide a suitable compromise and working solution to ensuring correct antimicrobials are available for immediate use, versus the AMR challenges of not being able to track how ward stock is used.

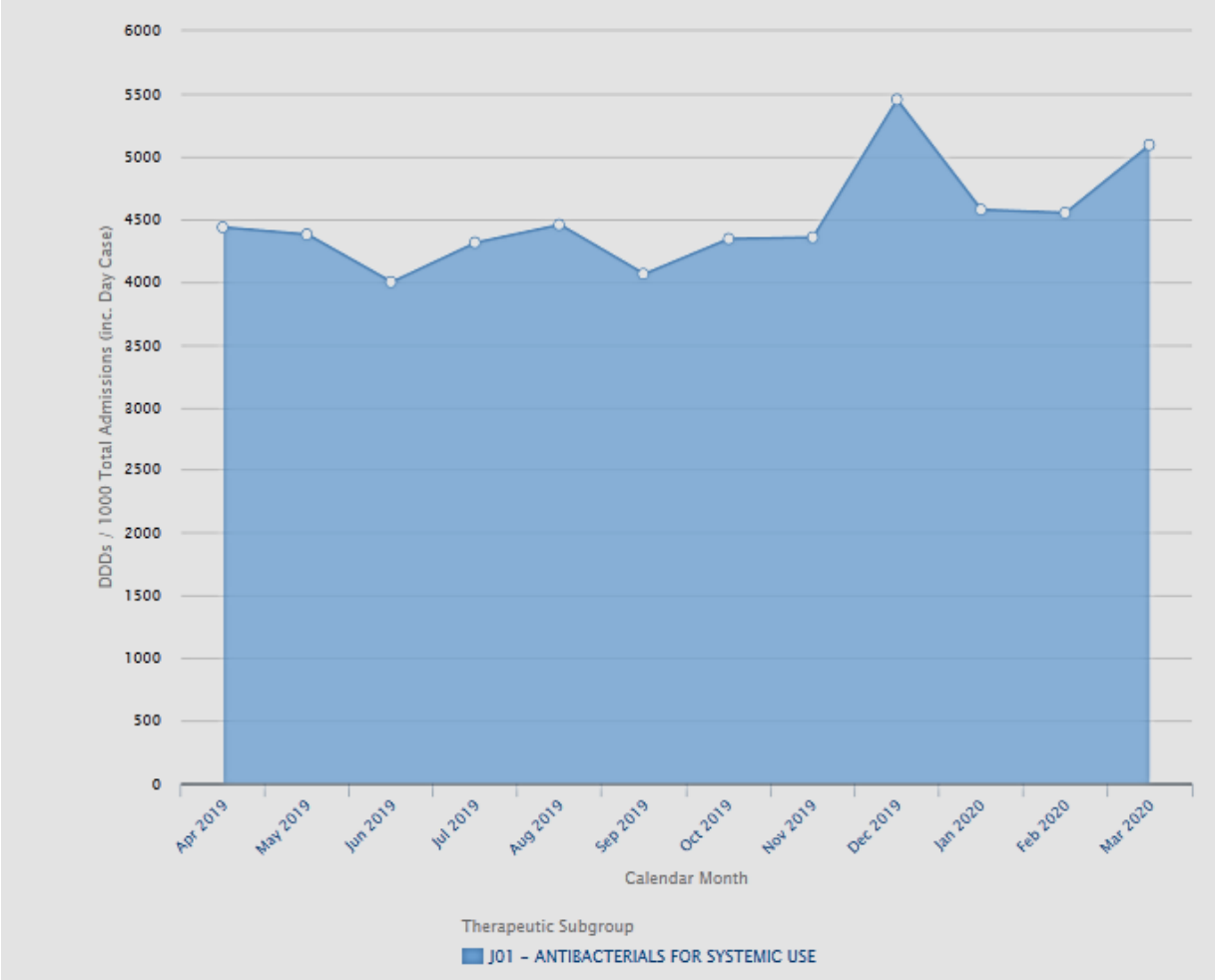
Electronic prescribing will open up more efficient opportunities for managing ward stock use of antibiotics and ensuring appropriateness, but plans to initiate this development were stalled by COVID.

There is a restricted antibiotic list in section 3 of antibiotic guidelines – Junior doctors can contact antimicrobial pharmacy team for approval/advice on these drugs and antibiotics/infection management in general. Regular reminders are sent out and very well utilised as a service from various staff groups

Training and education on AMS for various staff groups can be viewed on the Trust intranet http://ulhintranet/antimicrobial-education-and-training. There are regular slots for antimicrobial teaching on the junior doctors training programme which receive excellent feedback. In 20/21 many of the PowerPoint files will need to be revised to videos to allow for a more socially distanced and virtual form of teaching programme, as they are having to move away from classroom teaching in light of COVID.

With the introduction of the Antimicrobial Support worker and release of Antimicrobial Pharmacist time to focus on specialist tasks, surveillance of antimicrobial use across the Trust has improved greatly with monthly overview at ASSG. This was a key achievement as the database required alignment to the new divisional model, and the antimicrobial support worker was pivotal in undertaking that aspect of the work stream. There are automated reports now available to all pharmacists supporting clinical business units and they are able to provide regular overview through the governance meetings. Antimicrobial Pharmacists are providing additional support and guidance to clinical teams where unexpected and potentially inappropriate peaks in antibiotic use are noted.

Graph 1 showing consumption trend for antibacterials (systemic use, all agents) against Trustwide activity, over 2019-20



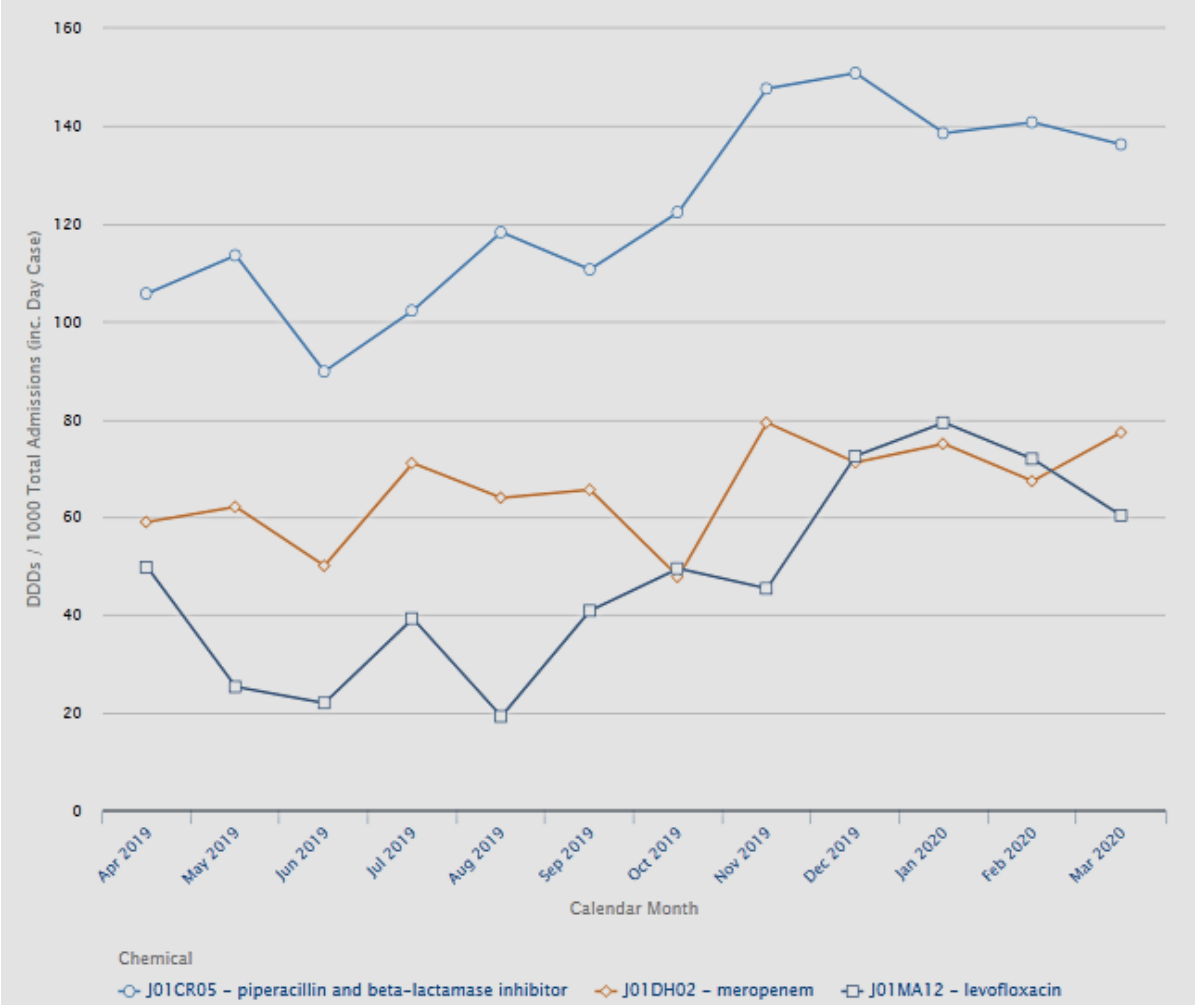
Antibacterial use accounts for most of the antimicrobial agents used in terms of quantity. There is always an increase in use over the winter pressures period due to the nature of patient presentations with chest infections in particular over this period. A second peak is seen in March, coinciding with COVID, and benchmarking shows that over the course of the year, this trend is in keeping with other Trusts across the East midlands region, and nationally.

Much of the antibacterial trend follows the use of co-amoxiclav. Again this is similar to the picture seen nationally.

Piperacillin-tazobactam and meropenem are on regular surveillance as much has been done over the past few years to contain inappropriate use, with good effect. Again, a peak is seen over winter pressures every year. Shortage of Co-amoxiclav injection, a national supply shortage understood to be caused by COVID impact, resulted in a prolonged use of these two agents to substitute in many cases.

Levofloxacin use has increased steadily since January 2019 as expected following increased recommendation in the antimicrobial guidelines for Adults. This is in line with NICE recommendations and the communications around caution with fluoroquinolones has also been strongly re-iterated as part of the risk benefit analysis.

Graph 2 showing consumption trend for targeted height antibacterials (piperacillin tazobactam, meropenem, levofloxacin) against Trustwide activity, over 2019-20



Doctors, junior pharmacists and any interested staff are encouraged to join audits on antimicrobial stewardship and this motivates them in ensuring they are working in these principles too. There is very keen interest and engagement. Over 2019/20, the antimicrobial team have supervised over 20 junior doctors and pharmacists through antimicrobial audits and QIPs to progress AMS, needs of the trust and the stewardship strategy. Many have presented to ASSG, and one of the projects has made it to publication looking to introduce local and national change in management of IV antibiotic administration process to avoid drug dose loss in infusion sets when not flushed through.

Examples of antimicrobial audits conducted over this year

5KPIs on ITU at LCH Improving antimicrobial prescribing standards on ITU at LCH as noted poor documentation as a concern for step down wards hence rolling audit to see quality improvement. Very successful in improving above standard.

GAP Audit with League table: Annual point prevalence audit this year used the 5KPIs we apply to antimicrobial prescribing across the Trust, and taking average of all 5. Standard is 85%. Feedback given to all wards, and prizes handed out to 'top of the league' wards. This was very successful in gaining further interest and engagement with antimicrobial stewardship.

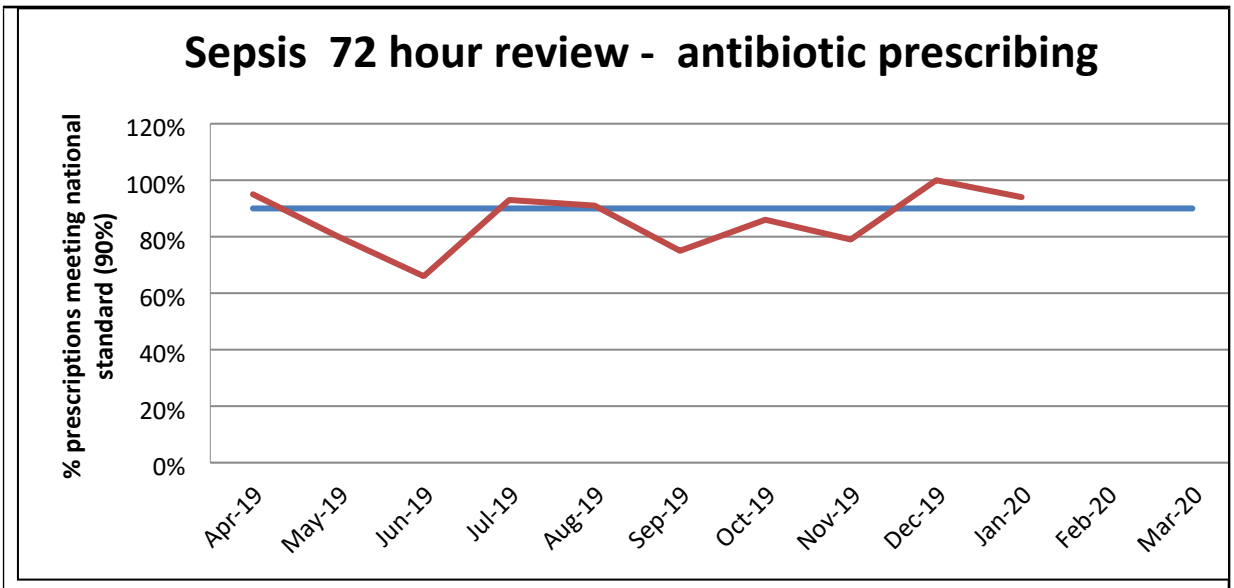
H@N audit following reports of excessive antimicrobial requests out of hours which were inappropriate. Causality identified and actions implemented with good effect.

Hips and Knees snapshot audit to ascertain compliance with antimicrobial surgical prophylaxis guidelines to determine if improved since last audit and identify whether some cases of inappropriate prescribing highlighted to team were widespread or infrequent issue. Positive improvement noted, showing that guidelines for antibiotic prophylaxis have been implemented well.

CAP Audit looked into how we are managing Community Acquired Pneumonias with antibiotics. Found excessive tendency to go for broad spectrum combination rather than the recommended choices. Identified practical actions for improvement, communicated at consultant medical meetings and to prescribers across ULHT, pharmacists for intervention, e-newsletter, twitter. Well received and seems to have been in good time for COVID as we have seen many examples of timely rationalisation when patients with pneumonia have presented over this pandemic.

Sepsis audit (rolling monthly) following on from the Sepsis AMR CQUIN over 2017-19, we have kept this work going as a good checkpoint of practice and to target areas for improvement. Standard is 90% for all relevant factors to be considered and actioned. Two month gap in audit that needs tracking back post COVID, as halted request of patient notes in light of potential for urgent request if admitted. Will continue over 2020-21 and beyond as a very helpful tool. **Results as per graph below. Actions taken to improve performance in best practice included reminders to wards and prescribers via PGME to contact Antimicrobial team or microbiology for advice, utilising ward pharmacists to look out for signs of poor prescribing and complex cases needing input, providing positive feedback to those teams and prescribers that are noted to show good prescribing in the audit, and addressing medical/surgical consultants at one of their group CPD meetings on each site.**

Graph 3 showing quality of sepsis antimicrobial review at 72 hours over 2019-20, against national standard.



Penicillin allergy audit local and increasing national concern of inappropriate penicillin allergy label being applied to patients. This has implications for patient outcomes, and for AMR. This project is a point prevalence to kick start momentum to drive this being addressed. Also collaborating with colleagues across the East Mids. are and wider in the UK.

PII audits are undertaken on the relevant wards to identify and improvements in prescribing. Where needed, a rolling programme of follow up audit is taken on, to ensure improvements are made and embedded, especially around documentation and handover of antibiotic plan, as well as the usual checkpoint of appropriateness.

Adherence to prescribing guidance was audited as part of the annual antimicrobial audit 2019 which also includes compliance with hospital post prescribing review at 48-72 hours. This review is commonly referred to as the Day 3 prescribing decision at ULHT, mainly due to this being how it was promoted, with the idea of being undertaken within 3 days of initiating antibiotics for an infection.

There are antibiotic guidelines on intranet, and also links to posters which are also mandated for display on wards and clinical areas. The sepsis poster has been very good at helping with timely administration of the suitable antibiotics when unknown origin. The blue man poster provides a quick reference to antibiotic choices in common indications. Since we have introduced these, they have contributed significantly to reducing our use of carbapenems. The display of these posters on the ward continues to have positive effect but does require regular check up to ensure they remain on display. This involves liaison with the ward sister/charge nurse to ensure accountability for this information being displayed in a suitable and accessible place on the ward that prescribers can refer to.

In 2020-21 the antimicrobial pharmacists will be introducing an antimicrobial app with both ULHT and primary care antimicrobial guidelines on it. This app has been tried and tested in many NHS Trusts and has great user feedback. It is currently going through the IT governance processes.

The progress made this year is exciting and reassuring for further development as antimicrobial pharmacy team is strengthened with further support to allow OPAT and Antifungal stewardship, and the promise of effective technology to guide prescribing, making better use of the teams expertise with the time efficiency they will bring.

Criterion 4: Provide suitable and accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion

The ULHT IP&C team had developed a set of patient information leaflets, care documents and up to date information on the trust website that provides advice, support information and contact details for patients and visitors needing further support.

All patient information has been ratified through the relevant governance processes prior to being issued to ensure that it is user friendly and fit for purpose. A catheter passport was developed by the Lincolnshire Whole Health Economy IP&C group which has enables all patients and service users to hold their own catheter information so that whichever service they need to access; the care providers have an up to date record of details relating to the catheter management plan.

The trust website has a dedicated page for infection prevention giving advice on matters such as hand hygiene and the latest infections data. The annual reports can also be found on this page. This demonstrates the transparency of the organisation to provide 'live' information on a public facing platform.

There is a leaflet on the general principles on the prevention of infection which is available in other languages, large print, audio and braille formats via the Public Involvement Team. Other leaflets include information on reporting concerns relating to hygiene and cleanliness including hand hygiene, MRSA, Clostridium difficile. GDH, Isolation precautions and use of antibiotics.

In February 2020, the new Director of Nursing instructed a full review of the hygiene code and as part of this, the information for patients and visitors was deemed to be insufficient. All of these information sets will be reviewed and refreshed or replaced as necessary.

The leaflets are focussed on common infection risks and their prevention and include MRSA, C.diffidile, hand hygiene and antibiotic medicines.

Criterion 5: Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing infection to other people

The trust DIPC, Deputy DIPC and Lead Nurse for Infection Prevention and Tissue Viability for ULHT recognised that having site based teams with specific areas of responsibility could leave the organisation vulnerable if the IP&C team had a period of reduced capacity (vacancies, long term sickness etc.) or if site pressures / incidents increased demand for the service. As part of the new service plan and strategy, the current structure of the IP&C team has been amended in a way that better serves the organisation. This means that more 'corporate' approach can be used to cover all sites as the situation demands. This has provided a degree of protection for clinical services no matter where they may be located.

Although the IP&C team are available during normal working hours to provide advice and support, ULHT has 24hr access to a microbiologist for out of hours IP&C advice. The IP&C team also support operational matters by attending daily bed meetings and by providing a daily side room availability assessment for use by the operations teams.

The trust is a key member of the whole health economy IP&C structure and works closely with external partners (such as PHE, CCG and NHS Improvement) to ensure they given up to date and relevant information on any outbreaks and incidents. Throughout 2018/19, all partners were kept informed of any events where needed and local working partners are members of the trusts IP&C committee.

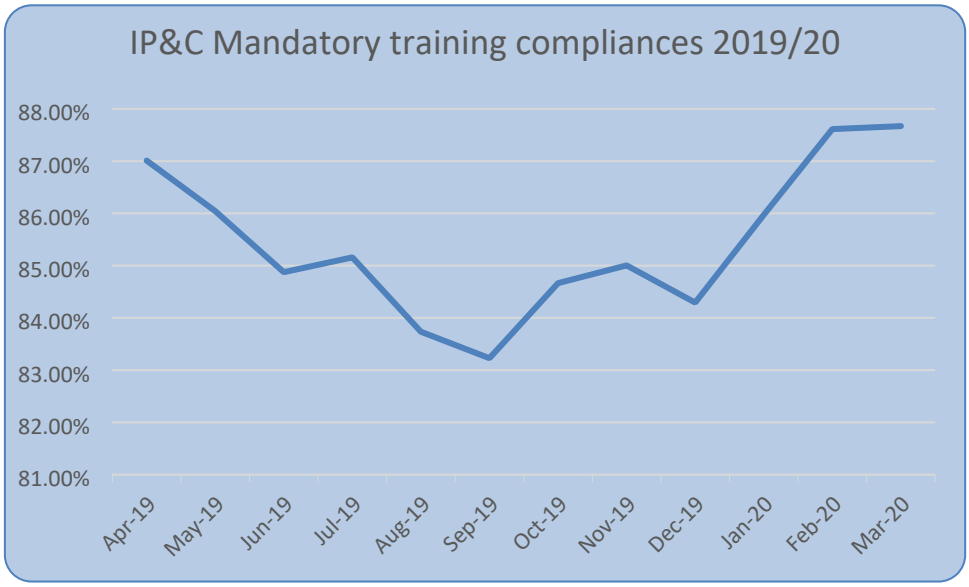
Criterion 6: Ensure all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection

Training

2019/20 has seen a marked variation in the level of training compliance by ULHT staff for IP&C. In 2018/19 the trust achieved 90% compliance at year end whereas year end compliance for 2019/20 showed compliance below the minimum level of 90%. The IP&C team delivered core and induction training (face to face) and the e-learning pack has been updated. The IP&C also target clinical areas to encourage staff to maintain competency by undertaking their core training.

A review of the methods of training delivery will be undertaken in line with hygiene code gap analysis work being undertaken in 2020/21

IP&C core learning compliances 2018/19



Aseptic Non-Touch Technique (ANTT)

As part of the overall hygiene code gap analysis work, it was identified that specific ANTT training had not been delivered to the trusts clinical staff for a number of years. It was therefore decided that the IP&C team would purchase the ANTT training packs. Clinical Educators delivered the package to the clinical teams to ensure that a robust and sustainable system of training and competency assessment is in place.

Infection Prevention Link practitioners

Infection Prevention Link's (IPL's) are registered nurses or healthcare support staff and multi-disciplinary team (MDT) members. All have an interest in infection prevention and work as a link between the infection prevention specialist service and their clinical area. Many areas have chosen to have more than one staff member sharing the role and they are nominated by the senior nurse or professional within the clinical area. The IPL's come from a range of different clinical disciplines, and are fundamental to successfully implementing and embedding ownership at ward or department level. They play a key role in informing, educating and supporting their colleagues in the clinical area. They also undertake frequent audits of key aspects of clinical practice.

During 2019-20 IPL's study days were held on a quarterly basis for the trust IPL's, rotating the venue between hospital sites. These days provide focussed education, networking with colleagues and keep the IPL's updated with relevant issues internally, locally and nationally. They also provide a forum for exchanging ideas, sharing best practice and for discussion around key issues. The delivery of IPL sessions was suspended in February 2020 due to the COVID-19 pandemic response however throughout February and March key messages were delivered through routine communications, SBAR and ELT live sessions. The topics delivered throughout 2019/20 included Hand Hygiene, PPE, Influenza and Norovirus, TB management, antibiotics and microbiology, ANTT, Waste management and C.diff.

Contracted workers

All contracted workers working in any of the trust sites are expected to complete an induction. This includes an IP&C element and the IP&C work closely with the Estates and Facilities teams to ensure that risk assessments and controls are in place prior to any works being undertaken in with the national standards (Health Building Note HBN 00-09 Infection Control in the built environment). The IP&C team have produced a specific risk matrix to support contracted workers in the trust to ensure that they have the required controls in place to protect patients prior to commencing planned works.

The IP&C team responds rapidly to any breaches in controls that may affect patient safety and works with managers, estates and facilities and contractors to resolve any IP&C related issues.

Criterion 7: Provide and secure adequate isolation facilities

It is widely recognised within ULHT that there is a lack of side room availability and the ability to cohort patients during outbreaks. This is largely due to the ageing estate and would have required a significant investment and refurbishment to overcome. In recent years this has had a direct impact on outbreak management decisions and as a result alternative plans were needed to address this problem.

There are currently no fully compliant negative pressure facilities within the Trust. The Estates Team did produce a costing report that highlighted what would be necessary to achieve compliance and was being progressed through their directorate process.

In 2018/19 a revised plan was implemented that focussed on better management of the current facilities during outbreak management scenarios. Emphasis was placed on having a risk based approach to side room usage so that if isolation facilities were required urgently, lower risk patients could be safely transferred to other beds and managed appropriately.

In addition to the revised plan, the IP&C team attended daily bed management meetings and provide a full side room availability sheet which is based on IP&C risk assessment so that operational teams can clearly see who can be moved out of side rooms at relatively short notice. In February 2020, the daily bed meetings were no longer attended by the IP&C team due to changes in the activity in line with pandemic preparation however they did provide a daily situation report to the operational teams with a risk based matrix for patients in isolation with infectious illness. The use of isolation facilities was reassessed in preparation of the COVID-19 pandemic response. Throughout February and March 2020 and beyond, changes were made to the physical environment in key areas to better support cohort isolation of patients.

Some of the most vulnerable areas for outbreaks in hospitals are in admissions units. These units tend to have large bed numbers and cannot be easily closed to admissions due to operational pressures. In MEAU on Lincoln site, this has been acknowledged as particular problem. Therefore, it was agreed to fit doors to the bays of the assessments area in 2019 so that cohort nursing can take place without the need to close the entire unit. These works are now complete.

Criterion 8: Secure adequate access to laboratory support as appropriate

Microbiology laboratory and clinical services are provided by Path Links which is a partnership between ULHT and North Lincolnshire and Goole NHS trust (NLG), which is the host organisation. UKAS accredited microbiology laboratories are situated at Boston and Scunthorpe hospitals.

Laboratory SOPs are based on the UK standards for microbiology investigations (SMI), and can be provided on request. A continuous program of turnaround time and laboratory audits demonstrates compliance with expected standards. The laboratory undertakes internal quality assurance, and participates in relevant external schemes. National standard KPIs are monitored and reported to the relevant bodies. Routine reference samples are sent to Viapath.

The COVID-19 pandemic has dominated microbiology laboratory activity since the beginning of 2020. Despite that, there have been many developments in the laboratory service, although in some cases implementation has been delayed. These include embedding cartridge based PCR for norovirus and influenza, and now also SARS-CoV-2.

There are currently 4.0WTE substantive consultants in post with a 1.0WTE long term locum, alongside a full time specialty doctor based on the Lincoln site, between them covering ULH, NLG, LCHS and primary care. Each WTE microbiology post has 1PA weekly dedicated to IP&C activity, split between NLaG and ULHT. There are 2.0WTE vacancies, and as for microbiology services across the UK, recruitment is proving challenging. During the pandemic surge, the rota was re-arranged and microbiologists now cover their own sites during the day, and cross cover out of hours and for periods of leave. There is 24/7 cover for clinical, laboratory and infection prevention advice.

The nominated lead infection prevention doctor for ULHT is Bethan Stoddart. Ongoing microbiologist involvement includes support for day to day and strategic IP&C activity. The IPC doctor aims to be involved in all aspects, including water safety, antibiotic stewardship and decontamination. Once a lead for decontamination has been recruited, there will be a need to develop the decontamination governance structure further.

The principle objectives for the clinical microbiology department in support of IP&C for the coming year are:

- Further developing diagnostics for SARS-CoV-2 and other respiratory viruses
- Introduction of MALDI-TOF and automated sensitivity testing
- Recruitment to the vacant consultant posts
- Further repatriation of PCR testing including CMV and EBV and other viral panels
- Implementation of the Abbott AlinityM for batch PCR

Criterion 9: Have and adhere to policies designated for the individual's care that will help to prevent and control infections

The ULHT IP&C team hold a number of separate policies that make up the trust IP&C manual. This is readily available in the trust intranet and the policies are updated as and when required using a policy management matrix. There are 5 sections of policy within the manual and all are listed in this report.

During February 2020, the Director of Nursing instructed that a full review of the hygiene code was needed. A significant element of the hygiene code compliance was related to having up to date IP&C policies. Many of the policies were in need of review and some were not fit for purpose. It was therefore decoded that all policies will be reviewed and ratified through the Trust IP&C Group meetings to ensure that the appropriate governance and sign for these key documents was achieved.

Section 1

1.04 Infection Prevention Surveillance Policy Surveillance of healthcare acquired infections (part of the infection control manual). Formerly 2.19.
1.05 Infectious Outbreak / Incident Policy including Major Outbreak Contingency plan for the outbreak of infection (part of the infection control manual) Formerly 1.12.
1.06 Infection Prevention and Control Policy for Antimicrobial Prescribing To provide a framework for Trust staff to ensure the safe and appropriate prescribing of antimicrobials to reduce the risk of infection from MRSA, other resistant bacteria and Clostridium difficile and maintain the effectiveness of antimicrobial agents in the treatment of infections by reducing the risk of bacteria developing antimicrobial resistance. Formerly 3.16.
1.07 Personal Protective Equipment for Infection Prevention and Control Policy Universal standard infection control precautions (part of the infection control manual. Formerly 1.03.
1.08 Hand Hygiene Policy Hand hygiene guidelines (part of the infection control manual. Formerly 1.05.
1.10 Aseptic Non-Touch Technique Policy Aseptic non touch technique policy (part of the infection control manual). Formerly 1.06
1.13 Blood Culture Protocol Protocol to reduce the risk of blood culture contamination and standardise practice in accordance with best practice recommendations.

Section 2

2.01 Guidelines for the control of Meticillin-Resistant Staphylococcus Aureus (MRSA) Guidelines for the control of meticillin-resistant staphylococcus aureus (MRSA) (part of the infection control manual). Formerly 2.02.
2.02 Guidance on the Infection Prevention and Control Management of Carbapenemase Producing Enterobacteriaceae (CPE) This guideline represents the ULHT response to the challenge of CPE. Formerly 2.23.
2.03 Policy for the Prevention and Control of Multi–Drug Resistant Gram-Negative Bacteria Formerly 2.17 Control of multiply-resistant micro-organisms including Vancomycin-resistant enterococcus (VRE).
2.04 Guidelines for the prevention and control of group A streptococcal infection Article from 2011 outlining the guidelines for the prevention and control of group A streptococcal infection. Formerly 3.22.
2.06 (GDH) Glutamate Dehydrogenase (GDH) Positive Nursing Guideline The contents of this guide applies to all nurses and members of the multi-disciplinary team (MDT) involved in the management of patients whose stool sample is positive for Clostridium difficile Glutamate Dehydrogenase (GDH) but toxin has not been detected.
2.06 Guideline for the management of patients with Clostridium difficile Infection The purpose of this guideline is to highlight the action than needs to be taken when a diagnosis of Clostridium difficile disease is suspected or proven. This guide should be used in conjunction with trust policies on infection prevention and control and the antibiotic formulary and prescribing advice. Formerly 1.14b.
2.07 Policy for the management of suspected and/or confirmed Norovirus cases This document is part of the Infection Control Manual which details the management of suspected and/or confirmed Norovirus cases (formerly 1.15).
2.09 Suspected or Confirmed Respiratory Tract Infection Policy This policy is intended to provide some general principles of isolation precautions required for patients with suspected or confirmed respiratory infection, why they are required and the rationale behind their use for the reduction and prevention of infections.
2.12 Post-Cataract Operation Endophthalmitis Protocol Post-Cataract Operation Endophthalmitis Protocol (part of the infection control manual). Formerly 3.01.

2.13 Management & control of PVL associated staphylococcal infections Management & control of PVL associated staphylococcal infections (part of the infection control manual). Formerly 2.21.
2.14 Management of Patients with Scabies Scabies prevention and control (part of the infection control manual). Formerly 1.11.
2.15 Management of Patients with chickenpox and shingles Infection control issues associated with chickenpox and shingles in patients and staff (part of the infection control manual). Formerly 2.09.
2.18 Guidelines on the management of patients with or at risk of Transmissible Spongiform Encephalopathies (e.g. Creutzfeldt-Jakob disease [CJD or vCJD]) with regard to Infection Control Guidelines on the management of patients with or at risk of Transmissible Spongiform Encephalopathies (e.g. Creutzfeldt-Jakob disease [CJD and vCJD]) with regard to infection control. Formerly 2.07
2.19 Management of Patients with Hazard Group/Category 4 Pathogens in particular Viral Haemorrhagic Fevers and Hendra and Nipah Virus Infections Viral haemorrhagic fevers (part of the infection control manual). Formerly 2.12.

Section 3

3.01 Isolation methods of communicable infections Isolation methods of communicable infections. Formerly 1.08
3.03 Management of Elective Orthopaedic & Vascular Patients in Ring Fenced Beds The purpose of this guideline is to highlight the action that needs to be taken when patients are admitted to the elective Orthopaedic wards – Neustadt-Welton Lincoln and 3A Boston and Vascular 5B at Boston. This guide should be used in conjunction with Trust policies on infection prevention and control and the antibiotic formulary and prescribing advice.
3.07 Operating theatres - guidance for the prevention and control of surgical site infection Operating theatres - guidance for the management of infection control (part of the infection control manual). Formerly 3.03.
3.09 Organisational Policy for the Decontamination of Reusable Medical Devices This policy sets out the Trust's arrangements for ensuring that appropriate management arrangements are in place for decontamination procedures and applies to all Trust and non-Trust staff that may be required to decontaminate Medical Devices and to staff who are required to manage or maintain equipment used to decontaminate Medical Devices. Formerly 3.17.

3.10 Single-use medical devices: implications and consequences of use This MRHA publication draws attention to the hazards and risks associated with reprocessing and reusing single-use medical devices. It covers the legal issues and regulatory requirements of such actions. It also considers the implications of damage to the materials or construction of the device and inadequate decontamination procedures.
3.11 Decontamination of endoscopes Decontamination of endoscopes (part of the infection control manual). Formerly 2.08.
3.18 Guidelines for Pets as Therapy and assistance dogs in hospitals Guidelines for animals on hospital premises (part of the infection control manual). Formerly 3.04.

Section 4

Current Public Health England Guidance For current guidance from Public Health England

Section 5

Inoculation Injury Report Form This form is used to record an inoculation injury.
Occupational Health & Wellbeing Services (OH&WBS) Communicable Diseases Guidelines This guidance is intended for use by all staff employed within United Lincolnshire Hospitals NHS Trust to provide advice for the management of staff who develop an illness or infection that can be transmitted to other staff members, patients or visitors to the Trust. It is to be used in conjunction with advice from the Occupational Health and Wellbeing Service (OH&WBS), Infection Prevention and Control (IPCT), Human Resources departments and Health Protection Agency (NHS England), as required.
Safe handling and disposal of sharps, management of sharps injuries and exposure to body fluids This policy provides guidance on the management for the safe handling and disposal of sharps, management of sharps injuries and exposure to body fluids.

Criterion 10: Ensure so far as reasonably practicable that care workers are free of and are protected from exposure to infections that caught at work and that all staff are suitably educated in the prevention and control of infection associated with the provision of health and social care

Seasonal Flu Vaccination

The Trust achieved a flu vaccination take up of 85% front line staff in ULHT for 2019/20. The Trust flu plan for 2020/21 is now in place and the vaccines are ordered for 2020/21. There was no CQUIN attached to this year's flu campaign however the aim for the Trust was to improve on the previous year's uptake of 87% with a focus on Medical staff and Nursing staff who were lower than expected. This was not achieved and the expectation for the 2020/21 campaign is for 100% of NHS staff to be vaccinated.

ULHT Acute	2019/20 Number of HCWs involved with direct patient care	Cumulative Seasonal Flu doses given since 1st September 2018	Vaccine uptake (%)
03/11/2019	6269	2387	38.08%
10/11/2019	6269	3085	49.21%
17/11/2019	6269	3315	52.88%
24/11/2019	6269	3352	53.47%
01/12/2019	6269	3598	57.39%
08/12/2019	6269	3788	60.42%
15/12/2019	6269	3908	62.34%
22/12/2019	**6269**	**3960**	**63.17%**
26/01/2020	**6269**	**4780**	**76.25%**
12/02/2020	**6260**	**5139**	**81.97%**
06/03/20	**6330**	**5380**	**85.0%**

Immunisations and Vaccinations

The issues of non-compliance with staff not being immunised this results from staff failing to attend their appointments has improved and continues to improve. All staff who are non-compliant their line manager is made aware and they are followed up until compliant

Inoculation injuries

The main reason for inoculation injuries continues to be in insulin pen needles and incorrect disposal of sharps from individual records a number of incidents involve sharps boxes. Sharps boxes being used incorrectly are a high risk to staff sometimes we are unable to identify the source patient, such incidents can cost certainty as to the nature of the risk and cause an increased psychological and emotional trauma to the individual and member of staff involved.

The incidence of Inoculation injuries is reported at both the Infection Prevention and health and safety committees. Safer sharps have been introduced in the trust where possible, a more detailed report shows that since the implementation of safer sharps the number of injuries has increased. This is due to the publicity and raising awareness of inoculation injuries and increased reporting. There are clear changes in practice in two areas which have reduced the number of inoculation injuries as with safer sharps in some areas the number of injuries has declined.

Section 5 Forward planning

Following the key events of 2019/20, namely the 2 key inspections, the appointment of the new Director of Nursing and Director of Infection Prevention and Control and finally

the challenges placed on the organisation due to the COVID-19 pandemic, the IP&C delivery will need to be very different for 2020/21.

The COVID-19 pandemic response by ULHT has led to serval changes to normal working. This includes the introduction of 'Green' site or pathways and 'Blue' site or pathway working. IP&C excellence is now at the very centre of all future planning for NHS services and this will mean complete refresh of all aspects of IP&C systems and process to meet this expectation.

The Director of Nursing and Director of Infection Prevention and Control instructed a full and comprehensive review of the hygiene code and this will form the basis of all key IP&C projects in 2020/21. New governance structures have been put in place to ensure the appropriate accountability is managed and escalated where needed.

Comprehensive Trust IP&C action plans have been produced along with the hygiene code gap analysis work. These will be used to monitor progress through the IP&C group monthly meetings where senior leaders can be held accountable for any delays in progress.

There will be a newly implemented investigation of health care associated infections using a refreshed approach to root cause analysis methodology. It will include more infection types and clinical teams will be fully supported by the IP&C team.

An entirely new approach to audit has been approved and is currently being delivered. This will ensure that proper oversight and scrutiny over the fundamentals of good IP&C standards of practice can be maintained. This new audit process gives ownership to the frontline leaders and will be periodically validated by the IP&C team and Matrons.

Two new sub-groups of the Trust IP&C Group have been created. The first is an Estates and Facilities/ IP&C Group which aims to bring together these two key functions to work more collaboratively and cohesively. The second is the Site IP&C Group and this includes divisional representation and IP&C team colleagues discussing site based challenges at an operational level. Both of these groups will meet monthly and escalate concerns to the Trust IP&C Group.

Finally, all Trust IP&C policies will be reviewed and will include the introduction of the 'Policy on a page' and 'Guidance at a glance'. These 2 new documents will be based on the comprehensive policies but will allow the clinical the rapid access to key information.

Section 6 Conclusion

This report has shown that the past 12 months has seen some significant challenges in IP&C for the Trust. Inspections by the CQC and NHS England and Improvement have highlighted that the organisational systems and processes were insufficient for the needs of the Trust and as a result, IP&C standards were not at the expected levels.

The production of the comprehensive hygiene code gap analysis will give the Trust a detailed list of both compliances and non-compliances that could be worked through in priority order with a detailed action plan which is progress checked at the monthly IP&C Group.

The New Director of Nursing and Director of IP&C has already begun to make significant headway in to improving the IP&C picture across the organisation and a change in culture is already evident.

It was identified that not all areas were being audited for IP&C compliance. The new frontline ownership (FLO) audit programme will include visiting all clinical areas and will help to inform the Trust as to where targeted actions may be required. The audit programme will also help to support the ward accreditation process currently being managed by the quality matrons.

Overall, the organisation can reflect on the challenges faced during 2019/20, acknowledge that already many improvements are being seen whilst understanding that there is still some way to go before comprehensive assurance can be offered for full IP&C compliance. The strong leadership and efficient use of resources within the IP&C service will undoubtedly mean progress momentum can be maintained and performance continuing to improve despite future pressures on the organisation.

The challenges faced by ULHT over the next year will be significant and the COVID-19 pandemic response will no doubt mean additional pressures however with the Trust now moving the right direction with improving IP&C standards, it will be well placed to face whatever scenario it is presented with.

United Lincolnshire Hospitals NHS Trust
Trust Headquarters
Lincoln County Hospital
Greetwell Road
Lincoln
LN2 5QY
(01522) 512512
www.ulh.nhs.uk
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OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*3rd November 2020*
Item Number	*XXXXX*
Complaints Annual Report 2019/20	
Accountable Director	*Dr Karen Dunderdale*
Presented by	*Dr Karen Dunderdale*
Author(s)	*Claire Tarnowski / Bernadine Gallen*
Report previously considered at	*Patient Safety Group and Quality Governance Committee*

How the report supports the delivery of the priorities within the Board Assurance Framework	
1a Deliver harm free care	
1b Improve patient experience	*x*
1c Improve clinical outcomes	
2a A modern and progressive workforce	
2b Making ULHT the best place to work	
2c Well Led Services	*x*
3a A modern, clean and fit for purpose environment	
3b Efficient use of resources	
3c Enhanced data and digital capability	
4a Establish new evidence based models of care	
4b Advancing professional practice with partners	
4c To become a university hospitals teaching trust	

Risk Assessment	*4081 - Quality of Patient Experience*
Financial Impact Assessment	*N/A*
Quality Impact Assessment	*N/A*
Equality Impact Assessment	*N/A*
Assurance Level Assessment	*Insert assurance level* • *Moderate*

Recommendations/ Decision Required	• *The Trust Board is asked to receive and note the Complaints Annual Report for 2019/20*

Executive Summary

- The Trust received 722 complaints during 2019/2020.
- The Trust responded to 754 complaints – this included responses from 2018/2019.
- 3 complaints are being investigated by the PHSO.
- 84 complaints were re-opened during 2019/2020.
- The main themes identified from complaints are staff behaviour / attitude and communication.
- The complaints process is continually being reviewed to ensure high quality and timely responses are sent to the complainants. The report provides details of actions planned and / or already underway during 2020/21.

Excellence in rural healthcare

NHS
United Lincolnshire Hospitals
NHS Trust

Annual Complaints Report 2019/2020

Patient centred . Excellence . Respect . Compassion . Safety

Introduction and Purpose

Complaints are a key source of feedback for the Trust and informs us about our patients' views regarding the quality of services and care provided. All formal complaints received are taken seriously and are responded to appropriately on an individual basis and are fully investigated through the Trust's complaints procedure. All staff are encouraged to respond to concerns raised by patients and relatives as soon as they become aware of them, rather than waiting to receive a formal written complaint and our PALs services support this.

Summary and Key Points

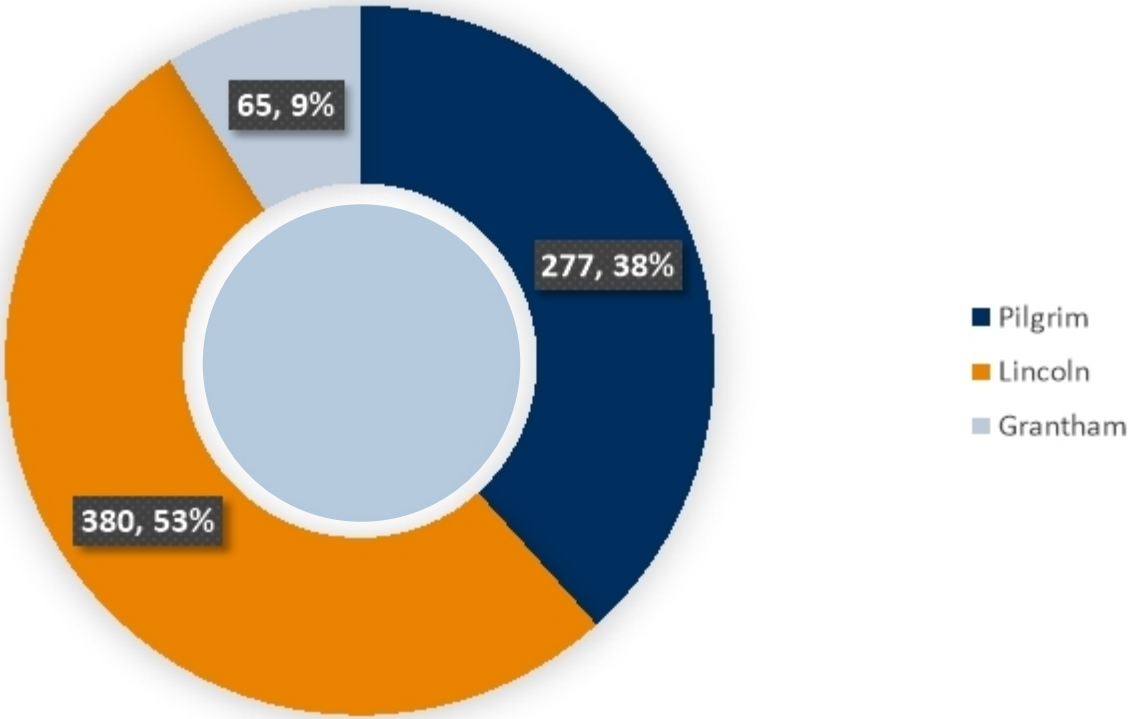
- 722 complaints received by the Trust.
- 754 complaints completed and responded to which includes complaints that were carried forward from 2018/2019.
- 159 complaints currently open which includes complaints that were re-opened from 2018/2019.
- 3 complaints are currently being investigated by the PHSO.
- 84 complaints were re-opened during 2019/20 of which 38 remained re-opened into 2020/21.

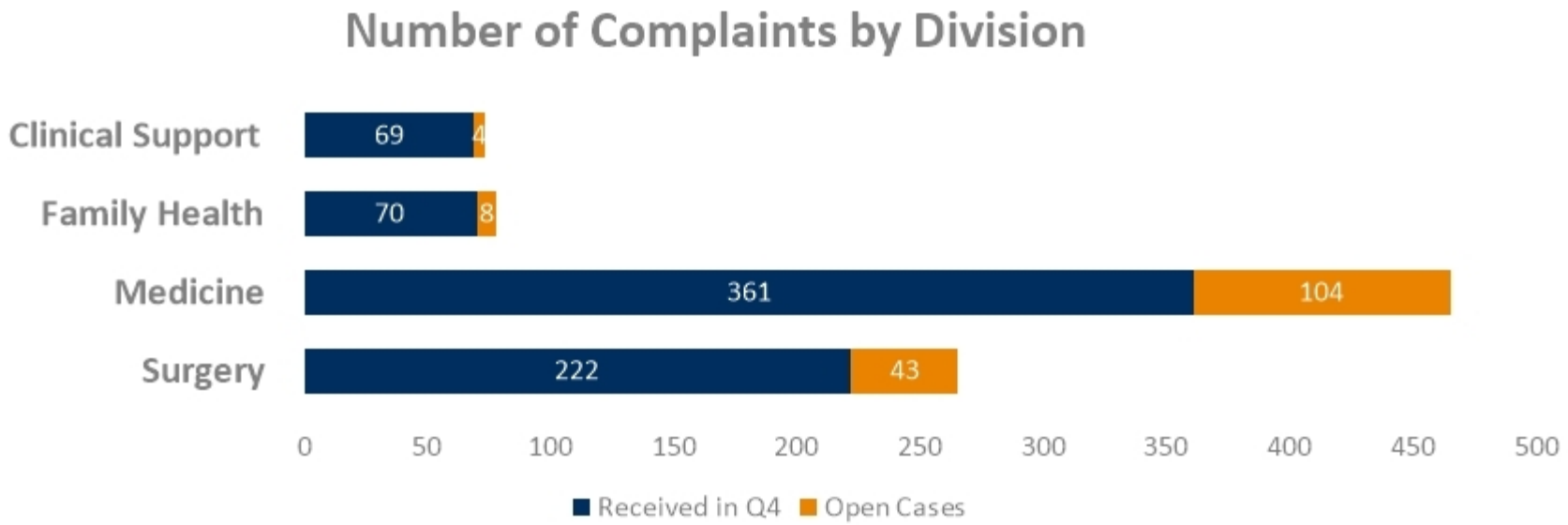
Summary and Key Points cont'd

- The Trust continues to use complaints as an opportunity to learn lessons and make changes and improvements to practice and processes
- Datix has been further developed to improve complaints processes.
- The Complaints Team have reviewed and strengthened processes for managing complaints and remain focused on producing high quality responses.
- A more robust Quality Assurance check is being implemented prior to Executive sign off.

[Further details are provided later in the report.]

Complaints Received by Hospital




Number of Complaints by Division
Clinical Support
69
4
Family Health
70
8
Medicine
361
104
Surgery
222
43
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50
100
150
200
250
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450
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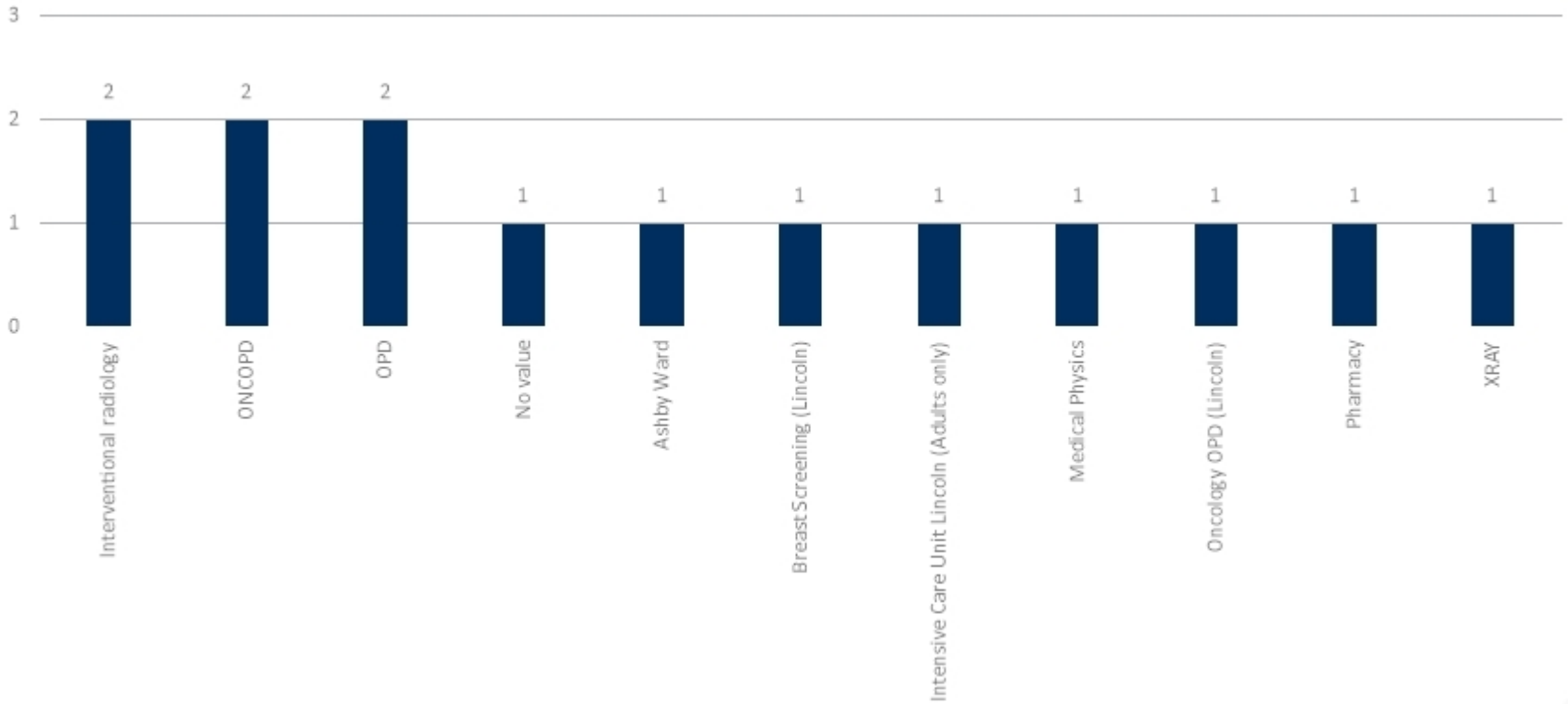
Received in Q4
Open Cases

Clinical Support Services



Clinical Support Services

Interventional Radiology:

- Delayed investigations and waiting times
- Communication – incorrect findings given to patient

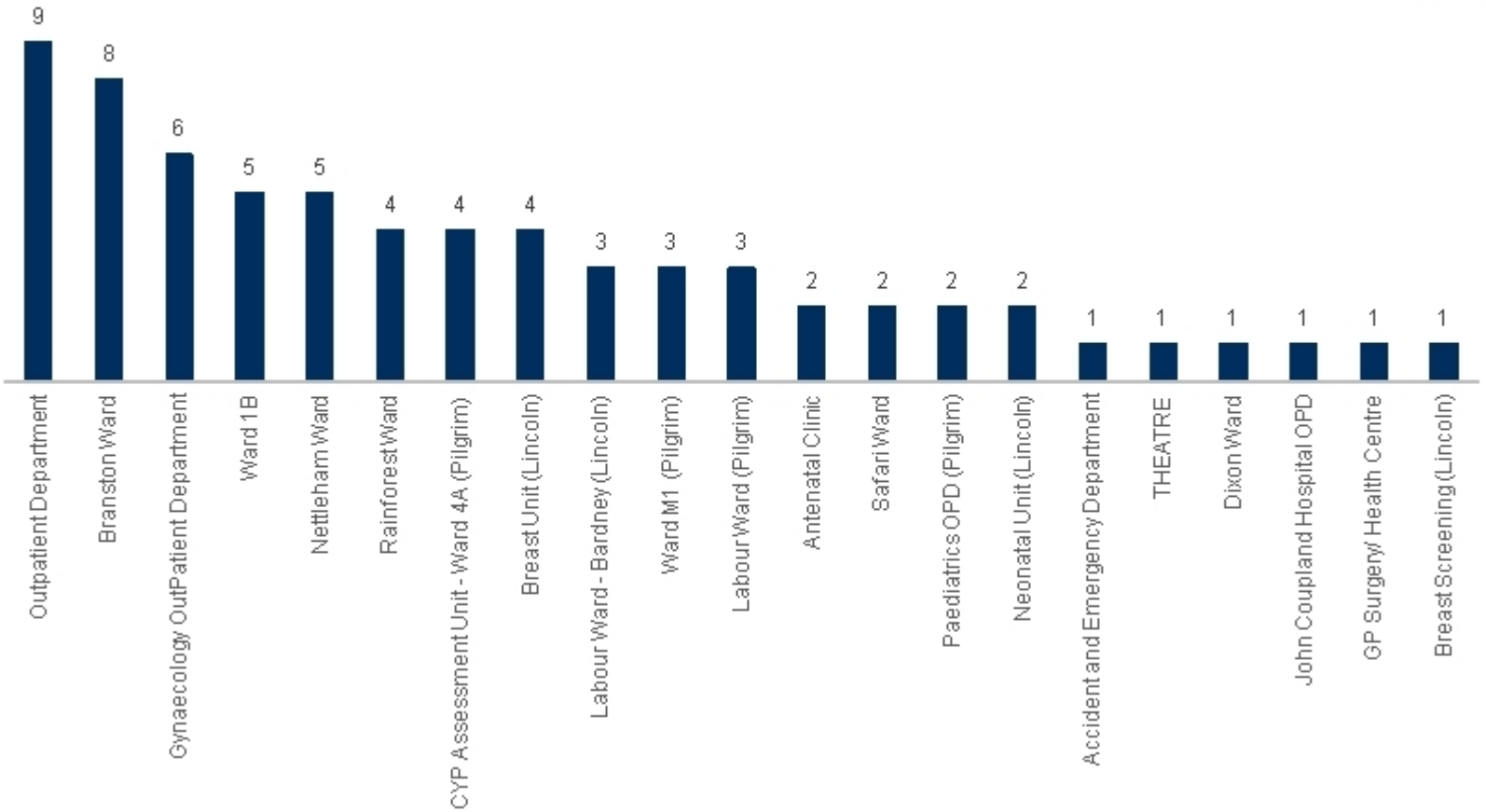
Oncology Outpatients Department:

- Poor care
- Staff attitude
- Lack of compassion and empathy
- Poor communication

Outpatients Department:

- Staff attitude
- Lack of communication

Family Health



Family Health

Branston Ward:

- Staff attitude
- Unnecessary wait in A&E
- Poor communication regarding procedure
- Information given to patient whilst in recovery
- Lack of communication regarding discharge arrangement
- Safeguarding concerns not taken seriously

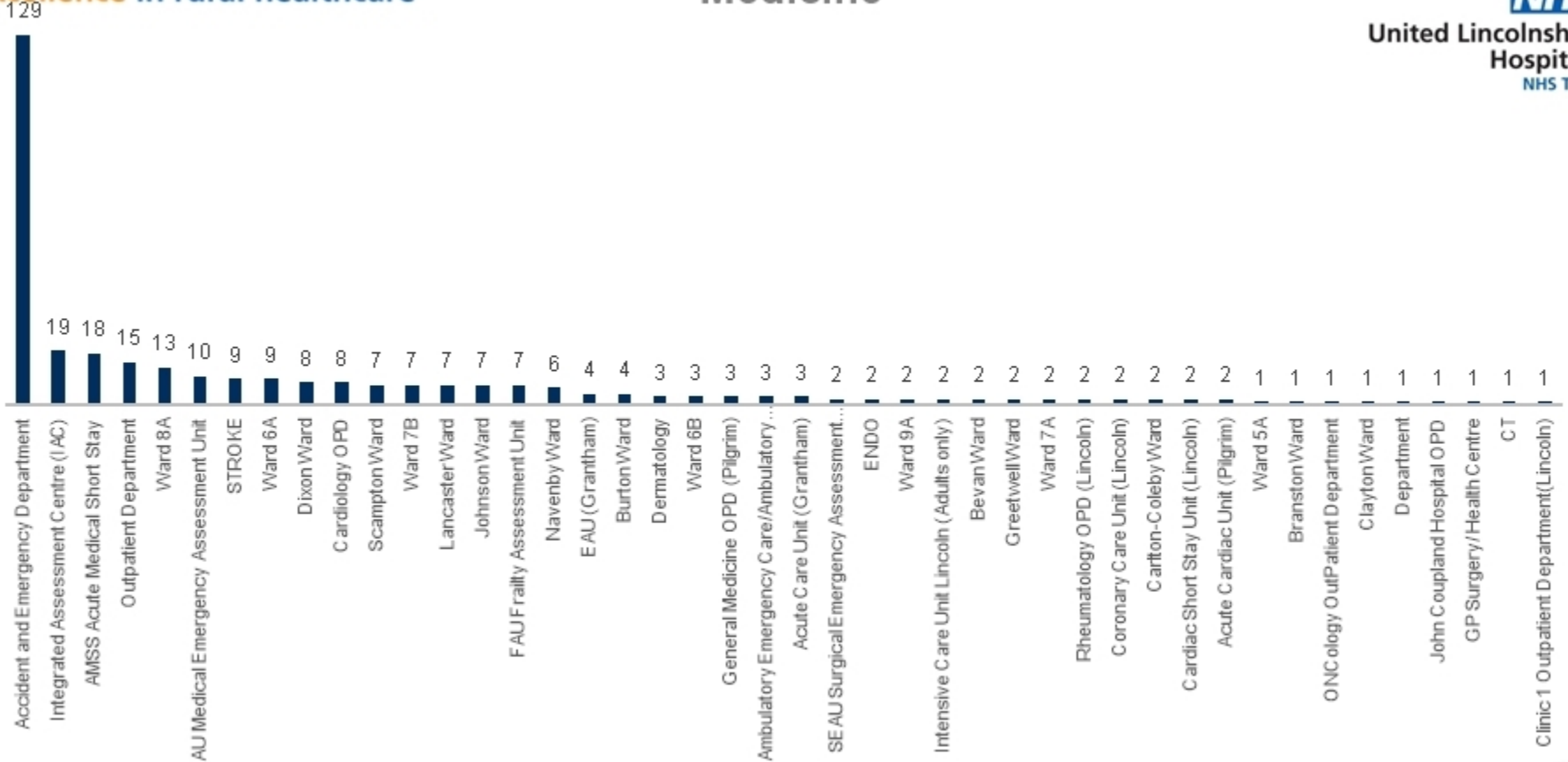
Rainforest Ward:

- Values and behaviours of staff
- Poor communication regarding treatment plan
- Attitude and behaviour of nursing staff
- Patient left with soiled sheets

Breast Unit:

- Delay in scans
- Access to treatment
- Delay in treatment

Medicine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Accident and Emergency Department
Integrated Assessment Centre (IAC)
AMSS Acute Medical Short Stay
Outpatient Department
Ward 8A
ME AU Medical Emergency Assessment Unit
STROKE
Ward 6A
Dixon Ward
Cardiology OPD
Scampton Ward
Ward 7B
Lancaster Ward
Johnson Ward
FAU Frailty Assessment Unit
Navenby Ward
EAU (Grantham)
Burton Ward
Dermatology
Ward 6B
General Medicine OPD (Pilgrim)
Ambulatory Emergency Care/Ambulatory ...
Acute Care Unit (Grantham)
SE AU Surgical Emergency Assessment...
ENDO
Ward 9A
Intensive Care Unit Lincoln (Adults only)
Bevan Ward
Greetwell Ward
Ward 7A
Rheumatology OPD (Lincoln)
Coronary Care Unit (Lincoln)
Carlton-Coleby Ward
Cardiac Short Stay Unit (Lincoln)
Acute Cardiac Unit (Pilgrim)
Ward 5A
Branston Ward
ONCology OutPatient Department
Clayton Ward
Department
John Coupland Hospital OPD
GP Surgery/Health Centre
CT
Clinic 1 Outpatient Department(Lincoln)

Medicine

A&E:

- No pain relief given
- Lack of compassion and empathy
- Poor staff attitude
- Reasons for treatment plan not explained
- Missed diagnosis of rib fractures
- Missed clavicle fracture (obvious fracture)
- Inadequate pain management
- Delay in analgesia being given
- Poor communication
- A&E waiting time in excess of 12 hours
- Yellow sticker for diabetes not placed on notes

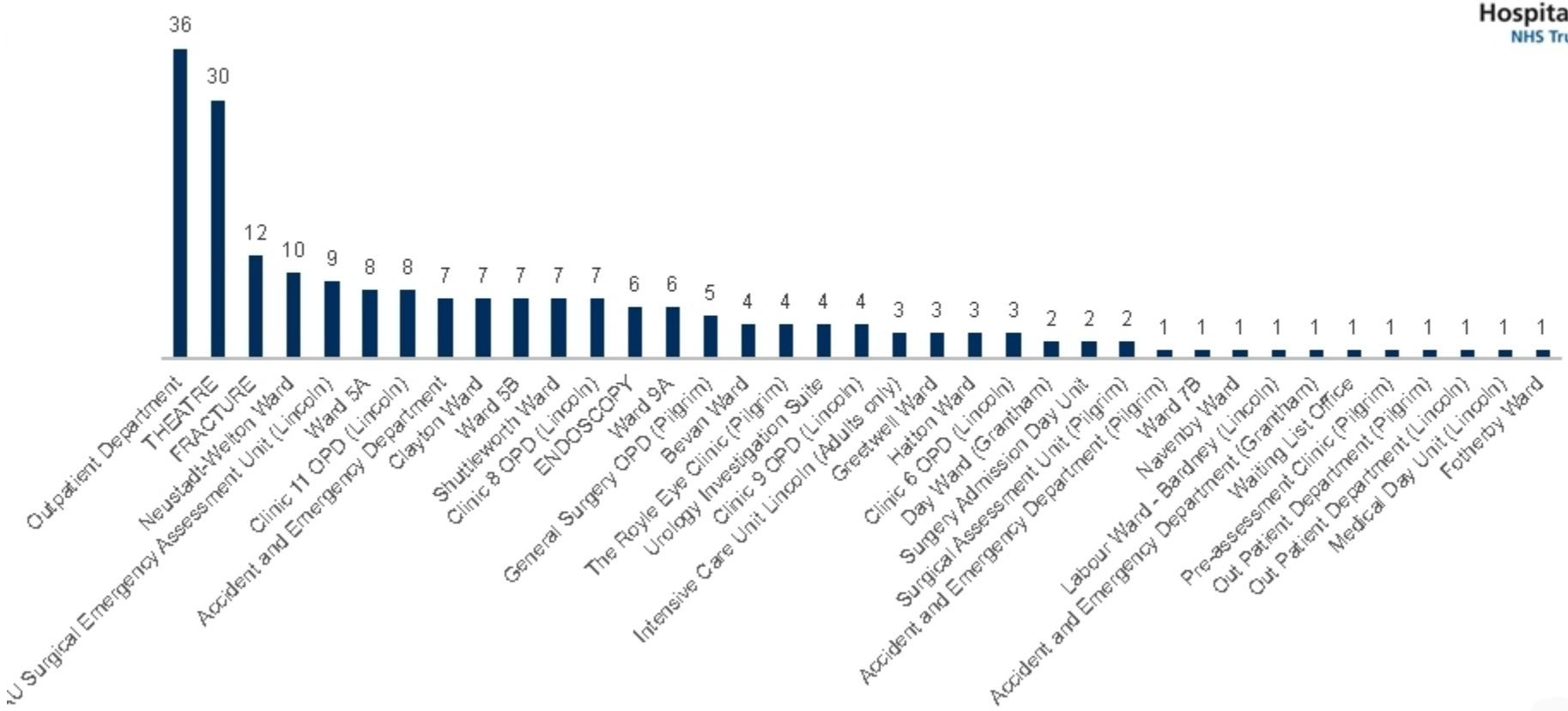
MEAU:

- Bed not available on admission
- Referral letter not sent with patient to ward, causing a delay in referral to oncology
- Poor communication - Family not contacted regarding medication lead them to believe that relative had received no treatment for a whole da
- Admission documentation inadequat completed
- Fall on MEAU and then further unwitnessed fall despite enhanced ca being in place

Integrated Assessment Centre:

- Patient not assessed adequately. Immobile but hoist not used to mobilise patient
- Patient suffering from dementia and advised she was mobile and as a result fell and broke her leg
- Behaviour of nursing staff, rude and dismissive
- No analgesia given despite request on several occasions due to pain
- Inappropriate discharge with no care package or pain medication

Surgery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Outpatient Department
THEATRE
FRACTURE
Neustadt-Welton Ward
U Surgical Emergency Assessment Unit (Lincoln)
Ward 5A
Clinic 11 OPD (Lincoln)
Accident and Emergency Department
Clayton Ward
Ward 5B
Shuttleworth Ward
Clinic 8 OPD (Lincoln)
ENDOSCOPY
Ward 9A
General Surgery OPD (Pilgrim)
Bevan Ward
The Royle Eye Clinic (Pilgrim)
Urology Investigation Suite
Clinic 9 OPD (Lincoln)
Intensive Care Unit Lincoln (Adults only)
Greetwell Ward
Hatton Ward
Clinic 6 OPD (Lincoln)
Day Ward (Grantham)
Surgery Admission Day Unit
Surgical Assessment Unit (Pilgrim)
Accident and Emergency Department (Pilgrim)
Ward 7B
Navenby Ward
Labour Ward - Bardney (Lincoln)
Accident and Emergency Department (Grantham)
Waiting List Office
Pre-assessment Clinic (Pilgrim)
Out Patient Department (Pilgrim)
Out Patient Department (Lincoln)
Medical Day Unit (Lincoln)
Fotherby Ward

Surgery

Theatre:

- Procedure started without consent for anaesthesia
- Lack of explanation for need for patient to have to return to surgery
- Lack of understanding/communication as to why patient was discharge on same day as operation
- Cancellation of surgery
- Return to theatre due to tightrope being fitted too close to bone

Clinic 11 Out Patient Department:

- Lack of communication regarding treatment plan
- Delay in treatment
- Poor/lack of communication
- Delay in diagnosis and test result
- Failure to diagnose fracture in bac k

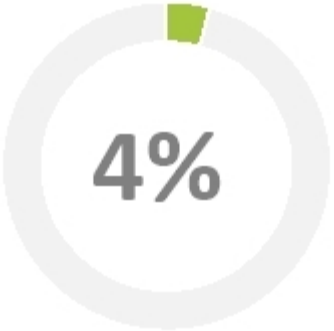
Neustadt Welton Ward:

- Discharged too early
- Discharge planning
- Breach of confidentiality
- Lack of communication
- Lack of clinical assessment

Number of Complaints Currently Open by Hospital

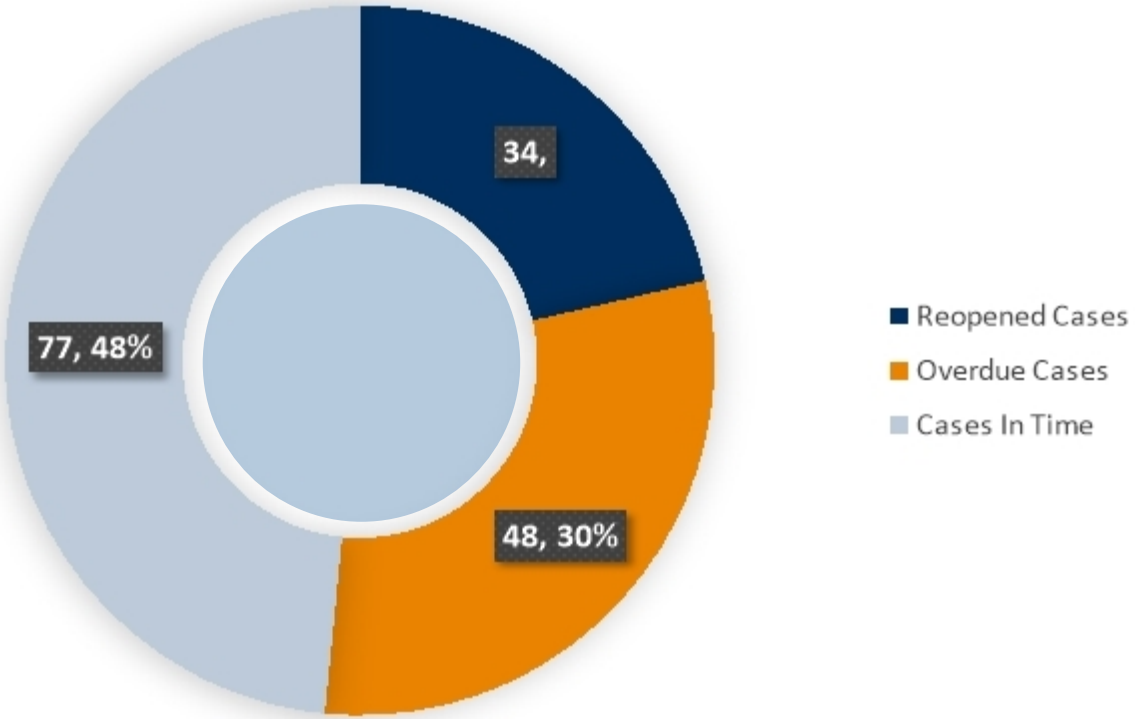
Pilgrim (71 cases)

Lincoln (81 cases)



Grantham (7 cases)

Cases Open



84 Cases Reopened during 2019/2020

- 30 Further clarity requested
- 39 Dissatisfied with response
- 10 Further questions raised
- 5 Accepted meeting offer

- 48 Lincoln
- 28 Pilgrim
- 8 Grantham

38 Reopened Cases Currently Active

- 15 Further clarity requested
- 5 Further questions raised
- 10 Dissatisfied with response
- 8 Accepted meeting offer
- Independent review being undertaken

- 21 Lincoln
- 15 Pilgrim
- 2 Grantham

Parliamentary and Health Service Ombudsman Cases

The Trust aims to resolve complaints at local level following thorough investigations, written responses, meetings with complainants and in some cases seeking an external opinion from a clinician outside of the organisation. However, when local resolution has been exhausted the complainant can refer their complaint to the Parliamentary & Health Service Ombudsman for consideration and investigation.

A total number of 18 complaints were referred to the Ombudsman during 2019/2020 compared to 24 complaints during 2018/2019. Of the 18 complaints, 3 were identified for formal investigation by the Ombudsman, 2 cases are still being assessed by the Ombudsman and 13 were rejected by the Ombudsman. 2 of the 13 cases were referred back to the Trust to undertake further work at local level. The remaining 11 did not meet the criteria for investigation because it was felt by the Ombudsman that the Trust had adequately addressed and resolved the concerns addressed.

The increase in cases rejected by the Ombudsman indicates that the quality of the responses being sent to complainants has improved and reflects the hard work that has been undertaken by the Trust to ensure that all of the concerns raised have been addressed and a comprehensive and through response completed.

Parliamentary and Health Service Ombudsman Cases

Review of the 18 cases referred to the Ombudsman did not highlight any specific patterns in terms of speciality area. Cases included Orthopaedics, Care of the Elderly, Stroke, Dermatology, ENT, Rehabilitation and Paediatrics. Complaint themes continue to centre around medical care including delay in diagnosis, poor communication (with patients and other NHS organisations), nutritional decisions, end of life care, radiology reporting standards and decisions around discharge planning.

In addition to the 18 cases referred to the Ombudsman in 2019/20 an additional 9 cases were closed. These cases were referred to the Ombudsman the previous year but closed during 2019/2020. Of these 9 cases, 1 case was upheld, 5 were partly upheld, 2 were not upheld and 1 case was referred back to the Trust for further investigation.

Where the Ombudsman considers that there has been injustice as a result of care/treatment provided to the individual, the Ombudsman can consider whether it would be appropriate to recommend a financial remedy payment. Financial remedy payments made to complainants during 2019/2020 totalled £1600. This was for two cases, £1250 and £350 totalling £1600.

Learning

The following are examples of learning from complaints during 2019/20:

- Handover of information to Healthcare support workers: A new accountability handover sheet has been developed and implemented to ensure that all information is documented correctly to provide the necessary personal care.

- As a result of the backlog for cardioversions due to hospital pressures causing reduction in theatre capacity which leads to cancelation of cardioversion lists, the Medicine Division senior team and Cardiology have reviewed how services are provided and are looking to increase capacity for Cardioversion work stream commencing at the Grantham site.

- Due to errors in consultant to consultant referrals being mislaid and not actioned causing a delay in chemotherapy for patients, a new strengthened process has been adopted.

Learning cont'd

- e-referral system for oncology review to be re-audited for effectiveness.
- Delay in ultrasounds scans being carried out: as a result of the delays Ultrasound are currently undergoing an expansion to incorporate two additional scan rooms. This will allow for an increase of scans to be undertaken.
- A review is being undertaken of guidelines currently in place regarding post-partem bleeding. This work will ensure that a second scan is considered even when the previous scan was normal to ensure correct diagnosis.
- Robust electronic referral system for referring patients identified with ulcers who require review by diabetic foot team is being implemented.
- Stroke clinicians to consider the use of chest x-ray as part of the diagnosis process if symptoms indicate a potential thoracic aneurysm.

Plan for 2020/2021

- Complaints Team to take responsibility of case managing all complaints that are received by the Trust. This will involve liaising with the appropriate personal to identify who is required to provide the necessary information.

- Complaint investigation paperwork under review to ensure it is more robust and user friendly.

- Sign off at Divisional Triumvirate level to be introduced to check the content of the response is factually correct and are happy for the complaint response to be sent to the Trust Executive Team for sign off.

- Quality check of responses to continue to be undertaken by senior member of the Complaints Team prior to Executive level sign off.

Plan for 2020/2021

- Communication training to be reviewed and implemented across the Trust.
- 'What good looks like' training pack and PowerPoint to be introduced to support those providing comments and involved in responding to complaints received by the Trust.
- External accredited training to be arranged for complaint handlers.
- Plan for weekly Divisional tracker highlighting their compliance with complaint responses. Included within this report will be an overview of their open complaint actions.
- A new strengthened process is being implemented for follow up of agreed actions and learning. This will be included in all of the weekly reporting to ensure that these are followed up and completed within an agreed timescale.
- Key Performance Indicators (KPI's) will be developed for complaints.

Report to:	Trust Board
Title of report:	People and OD Committee Assurance Report to Board
Date of meeting:	13th October 2020
Chairperson:	Geoff Hayward, Non-Executive Director
Author:	Karen Willey, Deputy Trust Secretary

Purpose	This report summarises the assurances received and key decisions made by the Workforce and OD Assurance Committee. The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board. This assurance committee meets monthly and takes scheduled reports according to an established work programme. The Committee worked to the 2020/21 objectives. The Trust are in the 'Restore' phase in response to Covid-19, the meeting was held via Microsoft Teams with a reduced agenda to focus on key priorities.
Assurances received by the Committee	**Assurance in respect of SO 2a** **Issue: A modern and progressive workforce** **Safer Staffing** The Committee noted that the establishment reviews for the nursing workforce had been completed and the volume of agency use and cost continued to fall during September. There had been a reduction in vacancies from 17% to circa 15% and a further impact was expected with the arrival of international nurses. The Committee noted that there was an 80% level of confidence in the use of Safe Care live and further work would be undertaken through the nursing workforce transformation programme to train staff regarding rostering practice. Birth Rate Plus was being introduced for maternity staff to support rostering as this was done differently to other nursing areas. The Committee noted that national guidance for other medical staff

	including AHPs in relation to establishment reviews was not available and that this would need to be formulated by the Trust, there would be a benefit to this being developed. The Committee noted that there had been a bid for funding to support further international recruitment and this would also support the 'on boarding' work being carried out to support the retention of staff.
	Assurance in respect of SO 2b **Issue: Making ULHT the best place to work** **Freedom to Speak Up** The Committee were advised that there had been a pause of submissions to the National Guardians office during Covid-19, as a result quarter 1 and 2 data were due to be submitted shortly. Referrals to the FTSU Guardian had been low during quarter 1 and 2 however there had been 25 referrals since the beginning October due to the promotion of Speak up Month within the Trust. The Committee were assured that the number of referrals were largely reflected in other Acute Trusts. It was however unclear if this was due to Covid-19 and the availability of other routes to raise concerns, for instance ELT Live events. The Committee were advised and supported the work that is underway to seek feedback from staff on how to take forward the appointment of a full time FTSU Guardian, this would not only support staff but would address the need for a dedicated resource, as identified by the CQC. The Committee were pleased to note that there had been 13 FTSU Champions identified with 8 having been trained. Further engagement work had been undertaken with the BAME network and it was hoped the Chair of the network would train to become a champion and improve links with the staff group. Consideration was also being given to champions within the Divisions and to continue to build links with the staff network groups. The Committee noted that a number of concerns raised through the Pulse Survey linked to those raised with the FTSU Guardian and were pleased that intelligence would be shared to address concerns raised.

	Preparation for Covid-19 second wave The Committee noted that there continued to be a number of staff absent due to contact with Covid-19 positive individuals or due to being positive themselves. The Committee expressed concern in relation to the workforce and noted that should there been a change to shielding this would pose a risk due to the numbers of staff who had previously shielded and been unable to work from home. The Committee noted that a workforce surge plan was in place and that further discussions would take place in relation to workforce planning. This would be more complex than phase 1 due to the intent to continue service delivery. The Committee were advised that Occupational Health were exceptionally busy due to the demands of track and trace as well as conducting normal activity. 100% of BAME and high risk staff had now completed risk assessments with 74% of the total workforce having been completed. The Trust hoped to achieved the set target of 95% by 20th October. Staff wellbeing checks, currently carried out at Grantham would be introduced across the Trust. Current flu vaccinations rates were at 20% for frontline staff.
	Lack of Assurance in respect of SO4c **Issues: To become a University Hospitals Teaching Trust** **Research Strategy** The Committee received the research strategy noting that the Team were going through a fundamental reorganisation. The 3 year strategy set out the current position and 5 strategic objectives that if achieved would move forward the achievement of the Trust objective to become a University Hospitals Teaching Trust. Once approved by the Board the Committee were advised that a strategic action plan would be developed. The Committee noted that there appeared to be a high level cost

	associated with the strategy however the benefits had not been clear. Timings with the Medical School would also need to be linked to ensure that delivery was achieved at the right time. The Committee requested that the Internal Audit Report recommendations in relation to research be included within the strategy along with quantitative outputs and the inclusion of resourcing and costings.
	Assurance in respect of other areas: **Board Assurance Framework** The Committee considered the Board Assurance Framework noting the assurance ratings provided and confirmed that based on the discussions held by the Committee there these were accurate. **Committee Performance Dashboard** The Committee received the dashboard noting that this had been further developed in line with the Integrated Improvement Plan and controls were in place to ensure there was improved risk rating against the BAF objectives. The Committee were advised that dates had been included against actions and a summary of progress included supporting the reported position. Progress was noted against the roll out of Empactics and it was anticipated that the whole organisation would be live on the system by February 2021. The Committee raised concern regarding appraisal rates across the organisation and the appearance of a decline in achievement of performance. It was noted that there had been issues identified within ESR affecting reporting, this was being addressed. The Committee were advised that Workpal was being introduced in November as an appraisal system that would demonstrate the quality of appraisals undertaken. The Committee noted concern that there had not been the anticipated reduction in medical agency use during the Covid-19 response however an improvement was now being seen. Nursing agency had reduced during Covid-19 but an increase was now being seen. Reduced rates

	had been negotiated with 5 suppliers and this had seen a positive impact on both spend and usage. The Committee noted positive recruitment in the past 12 months of 68 medical staff and 30 international nurses with a further 60 medical staff in the recruitment pipeline. The Committee were advised that there were approximately 25 international nurses being recruited per month. Concern was expressed in relation to core learning noting that there had been a reduction in compliance during the Covid-19 response. The Education and Learning Group had commenced a review of core learning however the completion of the associated audit actions had been delayed. **Internal Audit – Recruitment Audit Report** The Committee received the recruitment internal audit noting that the recommendations had been completed by the end of September with the exception of the recommendation relating to pre-employment checks. An internal spot check would be undertaken ahead of the November Committee to ensure recruitment guidance was being followed. The Committee noted that work was underway to review the structure of the recruitment team and the relationship between the transactional recruitment team, resourcing and the Business Partners. Recommendations from the review would be available at the end of October to address the audit. The Committee requested an update report be provided to the November Committee in order that this could be reported back to the Audit Committee.
Issues where assurance remains outstanding for escalation to the Board	None

Items referred to other Committees for Assurance	None
Committee Review of corporate risk register	The committee received the risk register noting that there were further developments to the report with risk KPIs included to evidence the current level of risk. The Committee noted the need to reflect the risk associated with the impact of the Covid-19 response and workforce availability.
Matters identified which Committee recommend are escalated to SRR/BAF	No areas identified
Committee position on assurance of strategic risk areas that align to committee	No areas identified
Areas identified to visit in ward 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**
Geoff Hayward (Chair)	X	X	X	A	A	No meetings held due to Covid-19			X	X	X	X
Sarah Dunnett	X	A	X	X	X				X	X	X	X
Non-Voting Members												
Martin Rayson	X	X	X	X	X				X	X	X	X
Matthew Dolling	A											
Simon Evans	X	A	A	A	D				X	D	D	D
Victoria Bagshaw	X	X	X	X								
Karen Dunderdale					A				X	X	X	X

Meeting	*Trust Board*
Date of Meeting	*3 November 2020*
Item Number	*Item 9.2*
Freedom to Speak Up – Quarterly Report July to Sept 2020	
Accountable Director	*Chief Executive*
Presented by	*Jayne Warner* *Freedom to Speak Up Guardian*
Author(s)	*Jayne Warner* *Freedom to Speak Up Guardian*
Report previously considered at	*People & OD Committee Oct 2020*

How the report supports the delivery of the priorities within the Board Assurance Framework	
1a Deliver harm free care	*X*
1b Improve patient experience	
1c Improve clinical outcomes	
2a A modern and progressive workforce	
2b Making ULHT the best place to work	*X*
2c Well Led Services	*X*
3a A modern, clean and fit for purpose environment	
3b Efficient use of resources	
3c Enhanced data and digital capability	
4a Establish new evidence based models of care	
4b Advancing professional practice with partners	
4c To become a university hospitals teaching trust	

Risk Assessment	*N/A*
Financial Impact Assessment	*N/A*
Quality Impact Assessment	*N/A*
Equality Impact Assessment	*N/A*
Assurance Level Assessment	*Insert assurance level* • *Limited*

Recommendations/ Decision Required	• *The Committee are asked to note the quarterly report and progress with improvement actions for speaking up arrangements within the Trust.*

Executive Summary

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

The Executive Leadership Team discussed speaking up arrangements and agreed that these should be reviewed to support the organisation moving forward. The Board will have noted that the national guardians office is raising its profile through reviews of Trusts and the requirements to demonstrate the impact of our FTSU arrangements is increasingly coming under scrutiny from the national office, NHSEI and the CQC. As an effective Board the organisation should review the approach to FTSU to ensure we are compliant with emerging guidance and have a robust process to embed learning any learning.

In 2020 the National Guardian's office published a Freedom to Speak Up Index report bringing together staff survey questions indicative of culture and ratings of the CQC. The index enabled Trusts to see how their FTSU culture compared to others. A positive speaking up culture is associated with high performing organisations, as rated by the CQC.

Freedom to Speak Up was identified as an area for improvement within the CQC reports in 2018 and 2019 with the CQC reporting that many staff were not aware of the role or who the Guardian was. The CQC highlighted that for an organisation of the size of ULHT the dedicated time allocated for the role of the Guardian was not considered sufficient.

The staff survey results for those areas within the FTSU index did see improvement in 2019.

The Board had identified speaking up as a specific areas of focus within year one of the Integrated Improvement Plan for the Trust and a project initiation document has been developed. In early 2020 the Trust appointed FTSU Champions to support better publicising with staff the role of the Guardian and greater awareness as well as providing further options for staff in who they could approach when they wanted to speak up. Covid 19 has meant that some of the planned activities for the Champions had to be curtailed. Champions meetings have now been reinstated virtually.

The Executive Leadership Team has agreed that as part of this review it is the intention moving forward to create a stand alone post of FTSU Guardian organisation.

Freedom to Speak Up
Guardian

Data Collection
The National Guardian's Office collect and publish quarterly data on FTSU. Data collection was delayed by the national office in response to covid. The most recent data collection is now due, requesting data from the Q1 and Q2 2020/21

Reporting Period	Apr 2020- June 2020
Number of issues raised	3
Number of issues raised anonymously	0
Number of issues raised with element of Patient Safety	2
Number of issues raised with elements of Bullying/ harassment	1
Did reporter describe having suffered detriment from speaking up	0
Staff Groups referrals came from	1 Doctor 2 Nurses
Feedback Obtained	0

Reporting Period	July 2020 – Aug 2020
Number of issues raised	6
Number of issues raised anonymously	0
Number of issues raised with element of Patient Safety	4
Number of issues raised with elements of Bullying/ harassment	5
Did reporter describe having suffered detriment from speaking up	0
Staff Groups referrals came from	6 Nurses
Feedback Obtained	0

Of the 9 referrals in Q1 and Q2 8 were Pilgrim based and 1 Grantham. Numbers seem low by comparison to previous quarters this may be due to the other routes available for raising concerns put in place during covid, gold command escalation, SBAR, ELT live.

Whistleblowing Notifications

During Quarter 1 and 2 of 2020/21 (April to Sept) there have been 0 notifications of whistleblowing to Human Resources.

There have been no new reports through the Local Counterfraud Service.

Issues highlighted Quarter 1 and 2

- PPE Concerns (early covid)
- Concerns about colleagues behaviours within teams

Freedom to Speak Up Guardian

National Update

The National Guardian's Office published their annual report for 2019/20 attached for information. A new case review from the National Guardian's office was published in June 2020. This is being considered for gap analysis. 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 trusts should refer to the report's findings, rather than the actions of the trust in response.

Local Update

Freedom to Speak Up was highlighted with a "should do" action in the October 2019 CQC report. The report stated that "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) ". Updates of actions being taken have been provided to the PMO. The difficulty has been in identifying an appropriate measure to assure the Trust that actions taken are having the impact of increasing awareness. The issue highlighted in the CQC report was evidenced as follows - The FTSUG had done work across the trust to improve their visibility this included visiting clinical areas across all sites, posters and a dedicated intranet page. During our focus groups with various staff groups and during our inspection of core services, very few staff knew of the FTSUG role or knew who the FTSUG was, this was the same at our last inspection.

The Guardian continues to liaise with other Guardians within Lincolnshire and across the wider region to share ideas for improving awareness.

The Guardian continues to have quarterly 1:1 meetings with the Chief Executive and six monthly meetings with the Non Executive Champion and Trust Chair specifically in relation to FTSU.

The Trust has launched the new network of FTSU Champions. There are now 13 identified Champions across 3 sites from a range of staff groups. Details of who the Champions are and how they can be contacted are on the Trust intranet page. In January eight of the Champions received the nationally recognised FTSU training.
October 2020 is national FTSU Month and the Guardian has worked with Communications to share the speaking up message with staff. Referrals for October are already exceeding those in Oct 2019

Report to:	Trust Board
Title of report:	Finance, Performance and Estates Committee Assurance Report to Board
Date of meeting:	16 October 2020
Chairperson:	Gill Ponder, Non-Executive Director
Author:	Jayne Warner, 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. The Committee worked to the 2020/21 objectives. The Trust are in the 'Restore' phase in response to Covid-19 and as such the meeting was held via Microsoft Teams with a reduced agenda to focus on key priorities.
Assurances received by the Committee	**Lack of Assurance** in respect of SO 3a A modern, clean and fit for purpose environment **Issue: Assurance/Exception Report Health and Safety Group** The Committee received the report noting that the October meeting had not yet taken place. The Committee re-iterated a request that they have sight of the Terms of Reference for the Group. The Chief Operating Officer explained that these were under review and reminded the Committee that staffside representatives were not attending the group at present as they were in dispute over the naming conventions used by the Trust. The Committee had sought assurance from the group on the health and safety impact for staff and patients of covid. The Chief Operating Officer stated that this would not come up to the Committee through the health and safety group but through the gold command meetings and the covid updates provided to committee and Board. **Issue: Fire Audit** The Committee received a Fire Safety Audit which had been commissioned by the Chief Operating Officer. The audit had been completed by the newly appointed Authorising Engineer and would be presented alongside a detailed action plan to the November Private Board meeting. The Authorising Engineer was supporting the Trust with expert advice on systems, process and legislation in respect of fire. The audit would see an assessment of the Estates structure to ensure it was able to deliver the necessary improvements to be fully compliant

	with Fire Safety and the enforcement notices from Lincolnshire Fire & Rescue.
	Lack of Assurance in respect of SO 3b Efficient Use of Resources **Issue: Finance Report** The Committee received the report noting the continued breakeven position at the end of Month 6 driven by the financial regime in place inclusive of £8.0m additional top-up funding. The Committee noted that the top-up requirement for the Trust had increased from the previous month as a result of the costs associated with the Gonerby Road Health Clinic. The Committee noted that the pay position had increased by £0.5m from August, and was below the draft plan. This increase had been driven mainly by agency costs. The Committee noted that work on the forecast for pay was underway. Non-pay costs were higher than the previous month and the Committee noted that some of this cost was associated with the new sites being used in the Grantham area. The Trust had achieved year to date delivery of CIP at £3.7m demonstrating that a focus has not been lost and progress was being made. The Committee were reminded that there had not been a requirement on delivery in the first 6 months of the year. The Trust aimed to deliver £7m in year with a stretch target of £9m. The Committee noted that additional project support was now in place. Revised capital funding levels were reported as £43.1m and the Committee received a breakdown of funding for areas across the Trust. The estimated level of capital spend for ED work was £9.5m against £17m allocation. The Capital Delivery Group was now in place to oversee and hold to account the delivery of the capital programme by 31st March 2021. The Committee received the CRIG Upward Report for information. The Committee received assurances about levels of cash held as a result of the interim covid measures put in place. The Committee considered the funding arrangements for the second half of the year and noted that the system were working to move to a breakeven position across all organisations. The gap currently sat at £4m. **Issue: Use of resources** The Committee noted the action plan was in place but further assessments were currently suspended.

	Assurance in respect of SO 3c Enhanced Data and Digital Capability **Assurance: Achievement of Data Security and Protection Toolkit standards** The Committee noted that the Trust was compliant with the toolkit for the first time. The Committee asked that those who had contributed to the improved performance were thanked for their efforts.
	Assurance in respect of other areas: **Committee Annual Report 2019/20** The Committee noted the final amendments which had been made to the annual report. This would be finalised if no further comments were received within the week. **Integrated Performance Report** The Committee noted the report and discussed the urgent care standards position in detail. There has been a continued decrease in standards which were reflective of pressure across the Trust but also consistent with pressure across the region and nationally. Attendances were exceeding pre-covid levels on some days, mainly Mondays and Tuesdays. Ambulance handover performance was also challenging as the departments are not big enough to deal with levels of conveyance and this had posed difficulties in our ability to release ambulance crews. Length of stay has seen an increase in emergency with difficulties in discharging for those needing supported care. Swabs and Covid-19 testing also impacted as there is a clear need to discharge patients safely. Cancer performance had deteriorated due to progress with clearing the backlog of patients waiting over 104 days. An improvement trajectory was in place that would ensure that the backlog would be cleared by the end of November, which would enable progress to then be made with clearing the 62 day backlog. The Trust's recover plans had been praised by the Regional Cancer Board and the Trust had been removed from regional oversight. **Committee Performance Dashboard** The Committee received the dashboard and noted the improved theatre utilisation. The Committee were alerted to a risk in terms of the non-elective length of stay. The Trust were working to reduce this due to the risk it posed.

	The Committee were alert to the fact that the 52 week wait data was higher than it had ever been. Regionally the Trust was one of the best performers with this. The Trust had managed lots of outpatient activity through telephone and e-consultations. There had also been a substantial impact from the Grantham Green Site. The 52 week wait was likely to increase again with the waiting times created during covid. The Ophthalmic unit had opened at Louth, which would help with clearing the backlog of patients in that specialty. Regional and national comparators of performance were helpful during these unusual times. A new system has been purchased that will give this and this data will be included in future reports. This development was welcomed by the Committee. **Performance Review Meeting upward report** The Committee noted the upward report from the PRMs and the need to further embed the risk discussions at the PRMs and also at the Trust Leadership Team meetings. **Car Parking charges** The Committee noted that the Board were to be briefed on the reintroduction of parking charges for visitors and the potential reputational risk. The Committee noted the ambition to reduce the charges in each parking band. **Integrated Improvement Plan Report** The Committee noted the continued improvement in reporting and the movement with the maturity of the project and infrastructure. The Committee received assurance that there were 56 active pieces of work, 44 of those on track. 2 completed but evidence needed. 4 fully complete. 6 projects were off track. Support and challenge session had been held led by executive directors. **Phase 3 Recovery Plan** The Committee were advised that feedback on the Trust phase 3 plan was that it had generated a low level of concern. The Committee noted that performance was projected to go backwards in outpatient procedures. The Chief Operating Officer advised that these were very difficult to forecast as not planned and largely resulted from first outpatient appointments. The region were satisfied that this may lead to some variation in performance.

	The Committee noted the additional theatre capacity – Theatre utilisation had not been at the highest rates but was improving. It was acknowledged that the introduction of new theatres will have a negative impact in the first couple of months. However the cold site will bring major headway in reducing cancellations with protected beds and protected theatres. The Committee were advised that this was a demanding but achievable plan and there were risks. The Committee asked for assurance that the risks in oncology were fully reflected by the paper, the Chief Operating Officer explained that there had been an escalation of the risk since the paper was drafted and there were a number of underlying at risk fragile services within the current climate. The Phase 3 plan cannot mitigate fully against those risks. The Trust would require a dynamic risk strategy.
Issues where assurance remains outstanding for escalation to the Board	No additional items to raise.
Items referred to other Committees for Assurance	No items
Committee Review of corporate risk register	The Committee reviewed the risk register and welcomed the planned changes in updating of the register
Matters identified which Committee recommend are escalated to SRR/BAF	The Committee was assured that the BAF was reflective of the key risks in respect of the strategic objectives of the organisation and asked for assurance on full alignment with the IIP as reporting progressed.
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	X	X	A	X	X	No meetings held due to Covid-19			X	X	X	X
Geoff Hayward, Non-Exec Director	X	X	X	X	X				X	X	X	X
Chris Gibson, Non-Exec Director	A	X	X	A	X				X	X	X	X
Director of Finance & Digital	X	D	X	X	X				X	X	X	X
Chief Operating Officer	X	X	X	D	A				A	D	X	X

Director of Estates & Facilities	D	X	D	X						
Director of Improvement & Integration									A	X

X in attendance A apologies given D deputy attended

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board Meeting*
Date of Meeting	*3rd November 2020*
Item Number	*Item 10.2*
Phase 3 – Accelerating return to Non Covid Health Services	
Accountable Director	*Simon Evans*
Presented by	*Simon Evans*
Author(s)	*Phil Browne/Michelle Harris*
Report previously considered at	*N/A*

How the report supports the delivery of the priorities within the Board Assurance Framework	
1a Deliver harm free care	*x*
1b Improve patient experience	*x*
1c Improve clinical outcomes	*x*
2a A modern and progressive workforce	
2b Making ULHT the best place to work	
2c Well Led Services	
3a A modern, clean and fit for purpose environment	
3b Efficient use of resources	
3c Enhanced data and digital capability	
4a Establish new evidence based models of care	
4b Advancing professional practice with partners	
4c To become a university hospitals teaching trust	

Risk Assessment	*4125 Capacity to manage emergency demand, 4176 Management of demand for planned care, 8006Risk of increased demand on ED services … Covid 19 related illness*
Financial Impact Assessment	*Assessments produced as part of Covid-19 planning and service changes*
Quality Impact Assessment	
Equality Impact Assessment	
Assurance Level Assessment	*Moderate*

Recommendations/ Decision Required	Phase 3 Plan – Winter Plan and Response to Recovery of Services are presented for information and review in line with NHSE/i Submission Guidance/Directives.

Executive Summary

This document contains a summary of the extensive Phase 3 plan submitted by ULHT and wider system partners in September 2020. The contents of this report are as follows:

1. Key Priorities

Key priorities for the third phase of the NHS response to COVID-19 were set out in Sir Simon Steven's Letter of 31st July 2020

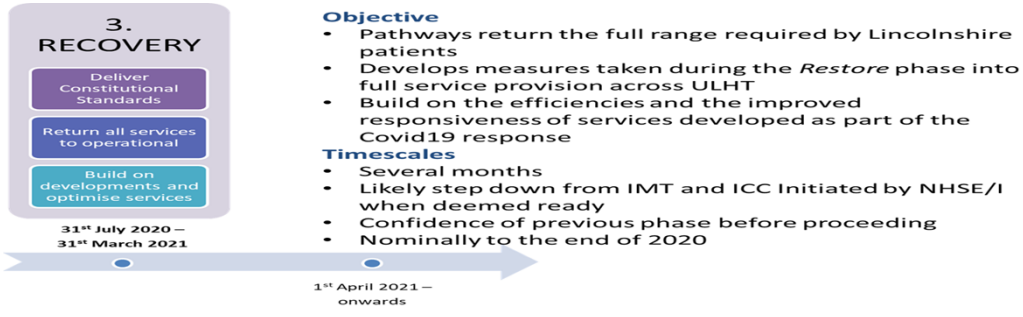
These key priorities can be summarised as follows:

• Accelerating the return to near-normal levels of non- COVID-19 health services, making full use of the capacity available in the 'window of opportunity' between now and winter

• Preparation for winter demand pressures, alongside continuing vigilance in the light of further probable COVID-19 spikes locally and possibly nationally.

• Doing the above in a way that takes account of lessons learned during the first COVID-19 peak; locks in beneficial changes; and explicitly tackles fundamental challenges including: support for our staff, and action on inequalities and prevention.

The Trust's campaign plan approved in May 2020 described the main objectives of Phase 3 as per below:



As part of the Phase 3 Recovery Plan, Systems were required to submit forecasts for performance against key targets. This document describes ULHT's and the Lincolnshire system's projected performance against the Phase 3 targets and articulates the key actions and assumptions that underpin our plans, along with the associated issues and risks.

Key areas for ULHT were as follows: -

- A1 Restore full operation of all cancer services
- A2 Recover the maximum elective activity possible between now and winter

- B2 Prepare for winter
- C1 Workforce

2. Plan Development

The plan was developed in partnership across the local system and is grounded in local knowledge, with a strong understanding of:

• The views of the people in Lincolnshire who use and deliver NHS services, established through the extensive engagement and research

• The current and future needs of the Lincolnshire population, established through detailed public health analysis

• The opportunities to improve our performance and remove unwarranted variation, established through benchmarking with other similar counties.

3. Summary of Compliance with Nationally Mandated Targets

The plan projects that most Phase 3 requirements will be met. There are some areas where it is anticipated that performance will comfortably exceed desired activity levels and backlogs will be tackled, e.g. Endoscopy.

Table 1 below summarises ULHTs compliance against the above key areas.

Phase 3 requirement	National target	STP projection
A1. Restore full operation of all cancer services		
Referrals for suspected cancer restored to pre-pandemic levels by Mar. 2021	100%	100%
No. waiting >62 days on urgent pathway back to pre-pandemic levels by Mar. 2021	100%	100%
No. waiting >31 days on treatment pathway back to pre-pandemic levels by Mar. 2021	*tbc*	Will meet
Immediate plan for managing those waiting longer than 104 days	100%	100%
A2. Recover the maximum elective activity possible between now and winter		
% of last year's activity for overnight electives by Sep. 2020	80%	67.4%
% of last year's activity for overnight electives by Oct. 2020	90%	78.6%
% of last year's activity for outpatient/daycase procedures by Sep. 2020	80%	80.3%
% of last year's activity for outpatient/daycase procedures by Oct. 2020	90%	78.2%
% of last year's levels for MRI by Oct. 2020	100%	100.8%
% of last year's levels for CT by Oct. 2020	100%	100.8%
% of last year's levels for endoscopy by Oct. 2020	100%	141%
% of last year's activity for 1st OP by Sep. 2020 (includes procedures)	97.6%	75%
% of last year's activity for FUPs by Sep. 2020 (includes procedures)	97.6%	82.1%
A3. Restore service delivery in primary care and community services		
% of general practice activity restored to usual levels (where clinically appropriate)	100%	100%
% of community activity restored to usual levels (where clinically appropriate)	100%	100%

% of optometry activity restored to usual levels (where clinically appropriate)	100%	100%
Backlog of childhood immunisations by Mar. 2021	-	Will meet
Backlog of cervical screening by Mar. 2021	-	Will meet
Enhanced support to care homes including programme of structured medication reviews	-	Achieved
% of GP practices offering virtual consultation	100%	100%
% of GP practices offering face-to-face appointments	100%	100%
Community health service crisis responsiveness enhanced in line with goals in the LTP	-	Awaiting funding
Hospitals, community health and social care partners fully embedded the discharge to assess processes by 1 Sep 2020	-	Principles agreed
Resume NHS CH assessments from 1 Sept. 2020 & work with LA using trusted assessor model.	-	Will meet
A4. Expand and improve mental health services and services for people with learning disability and/or autism		
Investment in mental health services in line with the MHIS	-	Will meet
Full resumption of IAPT services	-	In place
Retention of 24/7 crisis helpline for all ages	-	In place
Maintain growth in the no. of children and young people accessing care	-	In progress
Proactively review all patients on community mental health teams' caseloads	-	Completed
Ensure that local access to services is clearly advertised	-	In place
Use new capital to help eliminate mental health dormitory wards	-	Awaiting funding

Table 1: Phase 3 Complaince

4. Areas of Non Compliance

However, there will be a number of targets that will not be met. Table 2 highlights these and provides details of projected delivery until March 2021, with associated actions at a system level to address.

Area of non-compliance	Plans to address
Overnight electives 67.4% against target of 80% for September 78.6% against target of 90% for October **Outpatient/daycase procedures** 80.3% against target of 80% for September 78.2% against target of 90% for October	- Electives: Total % for Sep – Mar is 85.9% - Outpatient/daycase procedures: Total % for Sep – Mar is 85% - This is the best possible projection based on capacity identified to date. - ULHT is exploring two Vanguard theatres which would improve the position for elective and daycase. - Dialogue will continue with independent sector providers to identify further ad hoc capacity
Outpatients Firsts and Follow-ups Firsts: 75% against target of 97.6% for Sep Follow-ups: 82.1% against target of 97.6% for Sep	- Firsts: Total % for Sep – Mar is 92.7% - Follow-ups: Total % for Sep – Mar is 89.3% - Continue to increase uptake of advice & guidance - Expand specialty-scope of patient-initiated follow-ups - Looking to 2021/22 we are working on left-shift opportunities, mostly relating to long term condition management

Table 2 – Non Compliance.

5. Further Detail on Phase 3 - Section A Restoration of Elective Services

Accelerating the return to near-normal levels of non-COVID-19 health services, making full use of the capacity available in the 'window of opportunity' between now and winter

There are a number of risks/issues that are applicable to all of the services in the A1 and A2 sections:

Assumptions
• Social distancing continues
• Patients agree to travel to sites where available (including Grantham Green Site for Elective Procedures)
• The current projected activity/performance for elective, diagnostics and cancer is not directly related to/will not be affected by a COVID-19 2nd peak

Risks/issues and mitigations
ULHT have plans to introduce 7-day working in the immediate term this will require staff to work flexibly and volunteer whilst a larger HR consultation takes place to introduce the new way of working from December 2020. Supporting through regular, ongoing review of rostering to maximise efficiency, utilising bank staff as required. Clinical and Medical workforce reviews, active recruitment, and engagement with locum and agency providers.

Combined COVID-19 2nd Wave, Flu and Winter Pressures – increased demand on beds not mitigated across the system thus meeting the criteria for cessation of Green Pathway protection at Grantham. To be mitigated by robust system-wide winter planning.

Outpatient space will be a challenge across all providers, so we are looking to maximise the virtual and telephone alternatives. There is also work ongoing to scope use at peripheral sites however stretching workforce across multiple locations presents different challenges particularly for the medical specialties. These potential sites will include Louth, Spalding and Gainsborough for ULHT and Peterborough City Care Centre for NWAFT.

Alignment of staffing and estate capacity: Pan-divisional work across ULHT to ensure capacity planning is aligned with medical workforce, with ongoing redesign of clinic templates including utilisation of non face2face technologies. ULHT continues to sustain its increased utilisation of non-face2face technologies currently accounting for 48% of all OPD activity - further scoping of digital solutions to manage capacity including virtual appointments, patient notifications, patient-initiated follow ups will be done with the support of the system digital cell. ULHT is procuring a digital solution to check-in/patient calling to mitigate social distancing and increasing throughput.

Annual Leave: Review of rules for annual leave agreement and focussed management to protect capacity

Staff Resilience: Health and Wellbeing programme within ULHT promoted, supported and further reinforced by OD in addition to access to the system health and wellbeing offer including fast-track access to mental health services.

Loss of staffing due to sickness/COVID-19/fatigue/burn out: Working with staff and occupational health to support staff health and wellbeing, ensuring staff take their annual leave

Loss of staff due to quarantine and lockdown measures overseas: Remind all staff to comply with social distancing, hand hygiene measures.

Acute hospitals being seen as 'COVID-19-safe' by the public, supported by PHE and system comms campaigns.

Patient compliance to attend hospital when required or to accept a virtual appointment if clinically assessed. A system comms campaign has been planned to begin in October to highlight to patients the importance of attending for their procedure or appointment and to explain that the NHS is going to be different going forward. Patients will be assessed to see if a face to face appointment is necessary or whether this could be done virtually or over the phone.

The ability to recruit and retain the necessary workforce and the resilience of current staff.

Patients unwilling to travel to Green Site (or where diagnostic capacity is available): rearrange patients who are willing to travel.

Patient compliance with self-isolation requirements: mitigated through utilisation of Blue Pathways.

A1 Restore full operations of all cancer services

Phase 3 Ambition	STP projection
Restoring urgent 2WW referrals to pre pandemic levels	Partially achieved
Managing immediate growth - Surgery	Partially achieved
Increasing endoscopy capacity to normal levels	Achieved
Ensuring that sufficient diagnostic capacity is in place in COVID-19-secure environments	Partially achieved
Taking immediate action to reduce the long waiters, starting with those over 104 days	Partially Achieved
Fully restarting all cancer screening programmes	Achieved
Personalised stratified follow up- longer term	Plans in place
Implement RDC principles – include Site and Non Site-specific pathways	Partially Achieved

Restore public confidence in returning to hospital for diagnostics and treatment	Plan in place
Improving access to patients	Plan in place
Supporting Primary Care in DES development	Plan in place
Personalised follow up Pathway	Partially Achieved

Top Cancer Priorities

The following were identified as the top priorities for delivery at both Trust and System Level:-

Trust

• Endoscopy recovery: Endoscopy 62/104 backlog cleared and moved to live booking for cancer referrals

• Clear 62 Day backlog to pre-COVID-19 levels: 62 & 104 backlog clearance continues at expected rates, with recovery to pre-COVID-19 levels expected in November 20

• Maintain level of cancer activity on Green Site (increased use of IS for Ortho to support available green site capacity)

• Oncologist headcount and tumour site coverage sufficient for demand

System transformation work

• CCG-led reduction in referrals circa 250 per month due to changes in pathway and community testing e.g. Lung Direct Access (Sept 20), FIT Testing and RDC Oct 20

• Development of Rapid Diagnostic Concept

• Adoption of more direct access diagnostic pathways (currently only Lung with Upper GI being developed)

Planning assumptions

In developing these priorities a number of planning assumptions have been made: -

• Maintain 2ww capacity to meet GP referral demand with expectation it will continue at approx. 90% of Jan/Feb baseline (planning to provide activity at 2018 levels)

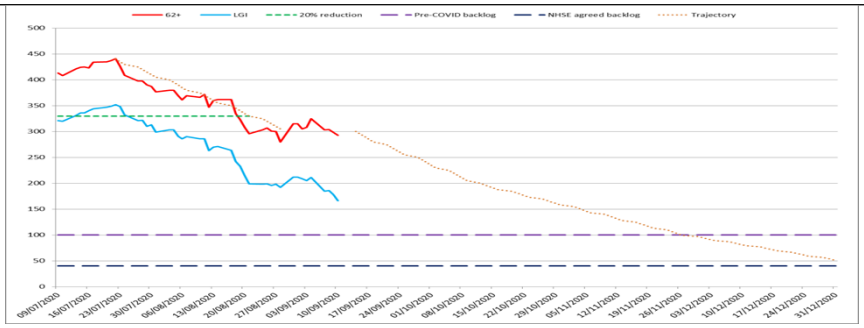
• Trust 14 Day performance impacted by current Breast Service One-Stop appointment alignment issues, trajectory to achieve standard from December

• 31 Day First trajectory to achieve standard from December

• 31 Day Drug & RT capacity is sufficient as demonstrated by performance maintained

Projected Performance

62 Day Backlog Clearance Rate and Trajectory



Capacity constraints and how these are being addressed
To mitigate the loss of capacity owing to no suitable alternative location for MRI and CT pads prior to ED development at LCH, resulting from a delay in securing a new location for the CT and MRI mobile scanners (Approx. 20% reduction in CT and MRI capacity), approval has been sought and received to extend use of current mobile scanner.

As screening services have reopened, a significant impact is expected on Breast Services, and the requirement for Breast Radiology and capacity for Breast Surgery. Work is ongoing between Family Health and Clinical Support to ensure service requirements are met.

Late diagnosis of Cancer will impact directly on Oncology (Chemo & RT). With oncology resources already currently depleted there will be a need to carefully plan access to and commencement of treatment regimens

Risks and issues and how these will be mitigated
• Patient engagement: innovative Pre-Diagnosis CNS post recruited to support patients
• Screening services re-starting (particularly Breast and Bowel), increasing demand on diagnostic and treatment capacity
• GPs engaged and supportive of new cancer pathways (e.g. FIT, Direct Access, NG12): Implementation of FIT testing across Primary Care in line with new Colorectal pathway for suspected cancer
• Additional load on specialist equipment due to 7-day working: impact minimised by ensuring adherence to recommended servicing schedules
• Clinical engagement (rapid clinical reviews & FDS) being monitored by Medical Director
• Oncology Fragile Service review underway
• Swabbing capacity due to assay supply, machinery reliability and community outbreak volumes: fall-back pathway identified to utilise Leicester resource if necessary
• Oncology complexity due to patients' reluctance to report back pain resulting in greater volume of cord compression presentation and associated admissions

A2 Recover the maximum elective activity possible between now and winter

Projected performance for ULHT
Target: 80% of September, rising to 90% in October

ULHT projected performance Elective: Partially achieve - achieve and sustain from Dec 20

Day-case: Partially achieve – achieve by year end

OPD Procedure: Not achieve (*Modelling of transition to non face2face OPD activity is having an adverse effect on Day Procedure numbers resulting in potentially artificially low numbers)*

Elective	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Sum of 19/20 OT	648	726	653	745	759	687	737	708	626	627	599	521
Sum of NHSE/I Target					532	550	664	638	564	565	540	469
Sum of 20/21 FOT					405	419	510	506	568	552	543	579
Submission % 19/20					53.4%	61.0%	69.1%	71.5%	90.7%	88.1%	90.7%	111.1%
% achievement against target					76.1%	76.1%	76.7%	79.3%	100.7%	97.7%	100.6%	123.4%
NHSE/I target					70.0%	80.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%

Daycase	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Sum of 19/20 OT	5,294	5,780	5,256	5,688	5,263	5,029	5,731	5,346	4,912	5,522	5,179	4,543
Sum of NHSE/I Target					3,685	4,024	5,158	4,812	4,421	4,970	4,662	4,089
Sum of 20/21 FOT					3,379	4,042	4,338	4,347	4,252	4,611	4,314	4,484
Submission % 19/20					64.2%	80.4%	75.7%	81.3%	86.6%	83.5%	83.3%	98.7%
% achievement against target					91.7%	100.5%	84.1%	90.3%	96.2%	92.8%	92.5%	109.7%
NHSE/I target					70.0%	80.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%

Outpatient Procedures	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Sum of 19/20 OT	9,418	9,275	8,814	9,817	8,680	9,302	10,192	9,155	8,127	9,665	8,086	6,469
Sum of NHSE/I Target					6,076	7,442	9,173	8,240	7,315	8,699	7,278	5,823
Sum of 20/21 FOT					3,994	4,680	7,382	7,244	8,120	7,785	6,905	4,950
Submission % 19/20					46.0%	50.3%	72.4%	79.1%	99.9%	80.5%	85.4%	76.5%
% achievement against target					65.7%	62.9%	80.5%	87.9%	111.0%	89.5%	94.9%	85.0%
NHSE/I target					70.0%	80.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%

Electives

ULHT's current trajectory describes only partial achievement from December but then sustained through to March 20. The need to continue to deliver secure green pathways constrains the current activity levels. The Independent Sector (IS) is being extensively used within the limits of what each IS site can offer. Ongoing activity is planned across the IS provider base at monthly volumes of circa 320 per month. It should be noted this activity is on an IPT arrangement and therefore will not appear within ULHT volumes.

Planned mitigation of the shortfall in activity in the form of ULHT weekend working is adversely affected by increased levels of IS activity. The main constraints are resource: trained and qualified staff. Increased IS activity compromises ULHT's ability to deliver weekend sessions owing to competing demands for a limited workforce, as Lincoln mirrors the national picture in an overall shortage of qualified theatre staff, relying heavily on staff volunteering to undertake weekend working. The Trust continues to develop its plans for a true 7-day rostered working model to provide a more reliable and sustainable increase in capacity. Recent IPC guidance also supports increase theatre throughput.

However, as part of the tactical response to COVID-19 the elective green pathway at Grantham is significantly protected and as further mitigation against both current overall reduction in theatre capacity and the challenges of weekend working and completion for staffing from the IS, ULHT is exploring the opportunity to place x2 Vanguard theatres on the Grantham green site, aiming for placement in November and December respectively. It is anticipated that this would provide sufficient capacity to close the elective gap and provide by year end an aggregate achievement of the target. It should be noted that these theatres are accompanied by a significant increase in costs at circa £2.5million pa per unit.

OPD Procedures

Owing to idiosyncrasies in the modelling of OPD Procedures against the transfer of OPD activity to digitally supported modes of delivery, the numbers attached are an alternative scenario to the figures submitted in the return and provide a best and worst case scenario of potential achievement.

Risk/Issues and mitigations

• Lack of national available pre-op swabbing capacity for the community surgery scheme procedures. The system is scoping the potential to use pillar 1 testing capability.

• Patient attendance: There will be scripted narratives and the implementation of a trial of a 48-hour pre check-in for all Ophthalmology patients attending Louth

• There are reduced theatre lists across most surgical specialties due to green pathways. ULHT are scoping the possibility of opening up further theatre capacity for green pathway patients as well as weekly conversations with ISPs to ascertain additional capacity to the plan. St Hugh's and BMI Lincoln have committed to the required sessions from NHSEI but have agreed locally to provide more capacity for patients that are transferred from NHS providers where possible

• Ramsay Boston West are looking into ways to increase their capacity back to last year's but due to the configuration of the site they have reduced capacity to adhere to the infection control and social distancing guidelines

• NWAFT will not be able to meet the day case target until March 2021 due to workforce constraints and the limited availability of being able to recruit during short timeframes

• Insufficient IS capacity is being minimised by engaging across multiple providers in and out of county to maximise capacity utilisation. However increased IS usage engages ULHT staff required to support weekend theatre lists. The Trust is exploring the possibility of two vanguard theatres to increase weekday capacity for Grantham green pathway.

OPD 1st / OPD F/U

Key strategic actions and assumptions

The recovery trajectory relies upon a number of factors for development and/or maintenance to achieve delivery.

The continued development of Patient Initiated Follow Up, following the inclusion of ULHT in the national NHSEI programme (pilot specialties have already commenced) will be key, as will the continued uptake of the GPs of Advice and Guidance along with the continued development of non-face2face appointments as clinically appropriate.

Operationally the re-opening of Louth Fotherby ward as an outpatient facility will enable the increase of activity from the draft submission by an additional 2000 ophthalmology appointments per month and there is an agreed subcontract with Specsavers for 350 audiology appointments.

ULHT have begun an outpatient transformation programme which covers most specialties. The system planned care team are linked into the evolution groups and GPs with specific interests have been identified to work on pathway improvements. This is a continuation and expansion of the system planned care work programme agreed by stakeholders in December 2019.

In order to maximise capacity and mitigate the effects and requirements of social distancing within ULHT test the market and move to procure a digital check in and patient calling app to maximise the activity that can be done, subject to patient compliance re travelling to alternative Trust sites from those they might usually access.

In order to maximise throughput and capacity the plans for 7 day working being explored by the Trust must include the outpatient workforce.

Projected performance for ULHT

Target: 100% from September through balance of the year.

ULHT projected performance OPD 1st Appts: Partially Achieve – achieve by year end

OPD Follow Up Appts: Partially Achieve – achieve and sustain from Nov 2020

Outpatient Firsts, No Procedures	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Sum of 19/20 OT	11,726	11,833	11,381	13,370	10,767	12,039	12,826	11,690	10,287	12,056	11,380	8,759
Sum of NHSE/I Target					9,691	12,039	12,826	11,690	10,287	12,056	11,380	8,759
Sum of 20/21 FOT					7,476	10,196	11,472	11,365	10,533	11,330	10,793	11,779
Submission % 19/20					69.4%	84.7%	89.4%	97.2%	102.4%	94.0%	94.8%	134.5%
% achievement against target					77.1%	84.7%	89.4%	97.2%	102.4%	94.0%	94.8%	134.5%
NHSE/I target					90.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Outpatient Follow Ups, No Procedures	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Sum of 19/20 OT	18,664	19,054	17,731	20,593	16,999	18,217	19,417	18,135	16,178	19,331	17,195	16,106
Sum of NHSE/I Target					15,300	18,217	19,417	18,135	16,178	19,331	17,195	16,106
Sum of 20/21 FOT					13,672	15,928	17,972	18,551	17,249	19,343	17,223	18,871
Submission % 19/20					80.4%	87.4%	92.6%	102.3%	106.6%	100.1%	100.2%	117.2%
% achievement against target					89.4%	87.4%	92.6%	102.3%	106.6%	100.1%	100.2%	117.2%
NHSE/I target					90.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Risk/Issues and mitigations

• Patient Transport: there is an increasing patient reliance on Patient Transport Services. The system is communicating and working closely with TASL to support the delivery of OPD.

• Capacity: Revision of staff redeployed from out-patients to return to support activity

Diagnostics

Overall projected performance for ULHT

Target: 90% with ambition to reach 100% by October.

ULHT projected performance Endoscopy – Achieve and sustain

CT – Achieve and sustain
MRI – Achieve and sustain

Endoscopy	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Sum of 19/20 OT	1,007	1,013	724	891	692	674	893	990	623	902	631	955
Sum of NHSE/I Target					623	607	893	990	623	902	631	955
Sum of 20/21 FOT						1,609	1,611	1,451	1,291	1,291	1,291	1,291
Submission % 19/20					0.0%	238.7%	180.4%	146.6%	207.2%	143.1%	204.6%	135.2%
% achievement against target					0.0%	265.1%	180.4%	146.6%	207.2%	143.1%	204.6%	135.2%
NHSE/I target					90.0%	90.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

MRI	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Sum of 19/20 OT	2,785	3,127	2,875	2,710	2,677	2,789	3,213	3,198	3,199	3,283	3,297	2,896
Sum of NHSE/I Target					2,410	2,511	3,213	3,198	3,199	3,283	3,297	2,896
Sum of 20/21 FOT						2,834	3,271	3,275	3,260	3,349	3,360	2,945
Submission % 19/20					0.0%	101.6%	101.8%	102.4%	101.9%	102.0%	101.9%	101.7%
% achievement against target					0.0%	112.9%	101.8%	102.4%	101.9%	102.0%	101.9%	101.7%
NHSE/I target					90.0%	90.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

CT	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Sum of 19/20 OT	5,409	5,645	5,776	6,018	5,629	5,819	6,276	5,669	5,571	6,067	5,969	4,862
Sum of NHSE/I Target					5,067	5,238	6,276	5,669	5,571	6,067	5,969	4,862
Sum of 20/21 FOT						5,924	6,395	5,805	5,660	6,188	6,100	4,945
Submission % 19/20					0.0%	101.8%	101.9%	102.4%	101.6%	102.0%	102.2%	101.7%
% achievement against target					0.0%	113.1%	101.9%	102.4%	101.6%	102.0%	102.2%	101.7%
NHSE/I target					90.0%	90.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Key assumptions underpinning Diagnostic projected performance

Endoscopy
In order to address the considerable backlog following the Wave 1 guidance from BSG and JAG, Surgical and Medical Endoscopists have supported provision of extra endoscopy sessions in place of other job plan commitments to provide additional capacity.

In addition the insourcing of Medinet has been undertaken to provide 8 teams every weekend for an initial 12 weeks, to support additional capacity for backlog clearance . Once the backlog has been cleared and on the assumption that demand remains stable, there is currently sufficient staffing to reduce the current reliance on Medinet. In conjunction with the insourcing of Medinet, outsourcing to the independent sector (Ramsay/Boston West) has been utilised for routine and surveillance cystoscopies to provide additional capacity for backlog clearance, whilst more urgent and cancer patients are concentrated within ULHT. (To note, the cancer backlog of 104+ and 62-104 days cleared at 17th August, the Trust is now live booking all new 2ww cancer referrals).

Further mitigation of demand is being explored via the development of transnaso-endoscopy as an alternative to endoscopy with support at the EM Cancer Alliance Network, with the Trust considering up to 3 gastroenterologists to be trained in this new procedure and up to 2 nurses to be trained to support the new programme.

BSG/IPC guidance was updated around the management of AGP (aerosol generating procedures) on 26th August and implementation has enabled the service to get back to 10 points per list and be back to pre-COVID-19 capacity by October 2020.

Computed Tomography - CT
It is assumed that demand in 2020/21 matches 2019/20. Usual demand increase year on year circa 8%. The planned additional capacity will deliver this potential increase, and that arising from the change in GI Pathway.

Additional capacity at Boston is now in place following some delays owing to issues with the approach road substrate.

Recovery is reliant on a stable workforce and this being maintain through the recovery period. In addition the availability of Bank / Locums is key to support the investment in more service (e.g. extended days/weekends at peripheral sites).

Magnetic Resonance Imaging - MRI
Whilst current demand is down circa 7,000 per annum it is assumed that 2020/21 demand will broadly match 2019/20

The recovery trajectory is again predicated on maintaining a stable workforce and the extension of the (blue) mobile MR scanner at Grantham, now confirmed. It also relies on a level of patient engagement, in an ability and willingness to travel to sites with available capacity prior to Grantham relocatable becoming operational on 4 November 2020.

In order to deliver the above there are a number of key actions to be undertaken specifically to support both CT and MRI: -

• Replacement of Boston and Grantham CT scanners commencing 28 Sept 2020.
• Move relocatable CT scanner to Lincoln (contracted until 31 October 2020 but now extended to 31 March 2021)
• Relocatable CT scanner from NHSE to Boston, operational from 24 September 2020 for 12 months
• CT scanner at Moy Park subject to funding, as yet unsecured
• In-Health mobile CT scanner to Boston Sat / Sunday weekend service funded by PHE
• Create new 'pad' for mobile CT and MRI at Lincoln prior to ED/UTC building works to ensure continuity of service
• Actively sourcing additional mobile / relocatable CT scanner to Boston
• Complete replacement of MRI scanner at Grantham (Green)
• Trust commitment to relocatable MRI at Grantham 4 November 2020 to 31 March 2021

Workforce Requirements/Considerations to support delivery of Elective Care and Diagnostic Activity.

Specific workforce considerations for elective care and diagnostics
Outpatients: temporary increase in Registered Nurses (4 WTE) to cover swabbing within OPD. Currently outpatient nursing establishment for Gynae pan-Trust is inadequate to accommodate sessions required to deliver recovery plans. Nursing establishment to be reviewed to achieve adequate capacity for increased demand within Breast/Women's Health. Need to review options surrounding 7-day working for main Community Children's Nursing Team and required increase in team capacity. May need to enhance team during winter months if COVID-19 spike affects vulnerable children as predicted.

Virtual triaging & assessment relevant to individual case management operating: Apposite recruitment underway

Elective care – moving to a 7-day model at Grantham: Need to develop in-year a mini team to deliver children's pre-operative assessment work out-with existing funding, through potential uplift in registered and support cadre, albeit numbers are minimal.

Diagnostics: a case of need is being prepared to increase the nursing establishment to support the implementation of 7 day working across all 4 sites. In regards to Radiographer support a business case is being written for 20 WTE radiographers to adapt to demand and establishment shortfalls leading to us being able to provide a resilient 7 days service. Administration supporting is challenging due to the GP booked appointment system which is now indicating an additional 7000 appointments per month. AI/Bots are being considered to mitigate this risk and help current administrative staff with the process. The current sonographer trainee will qualify December 2020.

ULHT endoscopy: case of need approved for additional 2 WTE Non-Medical Nurse Endoscopists

7 radiologists to be recruited over a phased/graduated 6-month period

Successful consultation with staff regarding 7-day working. Currently low take up of volunteers to undertake 7 day working. Aspects of service delivery to be translated to Private Sector delivery

RTT Waiting List and 52+ week waits

Owing to the impact of significant levels of focussed work on the 40+week waiters pre Covid-19 ULHT has not seen similar rises in 52+week waiters experienced across the region*. (Hull Teaching Hospitals have significant 52-week breaches which total over 24.5k)* However, it is not immune to the effects of significantly reduced OPD and Elective output over the initial Covid-19 period.

Key strategic actions and assumptions

• Maximise capacity and throughput within current constraints as outlined across this narrative. Whilst the system is not expecting to recover the 52-week position back to March 2020 levels, there is a significant reduction expected from the anticipated peak.

• Clinically urgent patients to be treated first, with next priority given to the longest waiting patients specifically those breaching or at risk of breaching 52 weeks by the end of March 2021

• Lincolnshire have good processes in place to manage 40 plus week patients to eliminate 52 week breaches. This resulted in long waiters being in single figures pre-COVID-19. All providers are monitored by the system planned care team in conjunction with contract and performance colleagues. Good relationships exist to request updates for Lincolnshire patients and facilitate any potential solutions.

• ULHT have excellent focus on ensuring long wait patients have plans and is the focus of weekly performance meetings with the individual specialties. Due to this, ULHT have seen a delayed increase in 52-week breaches when compared to other providers

• System wide collaboration regarding managing waiting lists with ISPs reporting their backlogs and waiting times on a weekly basis

• ULHT have planned additional weekend working, further use of the IS and the potential for the two Vanguard Theatres at Grantham which will support the reduction of 52-week

breaches although it is not anticipated that these will be entirely cleared by 31/03/21. Resource to support the vanguard theatres will be met through overtime and agency. Administrative and clinical review of the waiting lists is currently being undertaken. With external technical validation support also being explored.

• There is active engagement with alternative providers in the Lincolnshire system, both community and commercial sectors, to identify left-shift opportunities for Diabetes, Orthodontics and ENT. ULHT have initially agreed a contract for 350 with Specsavers for audiology appointments and negotiations regarding a longer-term relationship and significantly higher numbers are ongoing.

Projected performance for ULHT

	Apr-20	May-20	Jun-20	July-20	Aug-20	Sept-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
RTT												
The total number of incomplete RTT pathways at the end of the month	38,046	38,574				44196	45006	45487	45719	46156	47719	48346
The number of incomplete RTT pathways (patients waiting to start treatment) of 52 weeks or more at the end of the reporting period	3	31				230	135	510	944	823	701	579

6. Further Details on Phase 3 - Section B Preparation for Unplanned Services and Winter

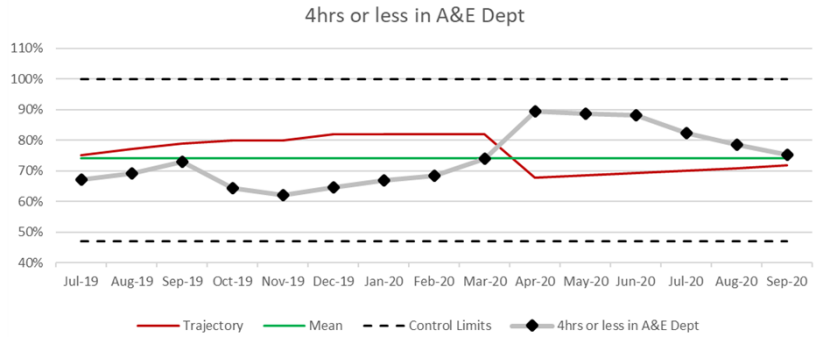
Accelerating the return to near normal levels of non Covid-19 health services, making full use of the capacity available in the window of opportunity between now and winter.

B2 Prepare for Winter

The Lincolnshire UEC system is a collaboration of system partners that share a consistent strategic approach to Phase 3 planning and operational resilience leading up to, and throughout winter. Phase 3 strategic actions are aligned to the Lincolnshire Urgent Emergency Care priorities.
Several Phase 3 and winter planning initiatives are in place to manage demand in the urgent care pathway which are designed to reduce the burden on ULHT. These include CAS demand management, increased use of SDEC on both sites and the enhanced capacity within the UTC to support ED and Cat 3 & 4 dispositions/conveyances.

Additionally, ULHT can now expand the footprint of the Emergency Departments through central government funding.

A&E attendances
In 2019/20, ULHT experienced an increase in A&E and UTC attendances compared to the previous year, with a similar level of growth continuing in 2020/21 post-COVID-19 peak. Forecasting therefore continues to suggest that the winter months will see a higher level and higher acuity of emergency attendances than has ever been seen before. Despite growth, the Trust has made positive steps to improve performance against the 4-hour care target (95%). Whilst it is our expectation to continue to make progress against the 4-hour target throughout the winter, the current performance against the 4-hour target is challenged.



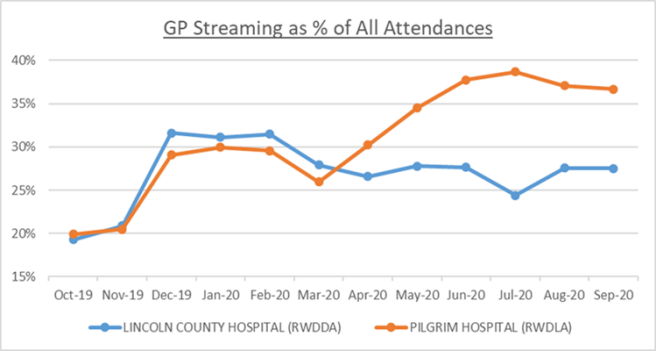
Minimise demand on A&E services
It is well known the pressure on emergency departments and the system is greatest during the winter months, with more people with complex needs requiring admission to hospital. To support a reduction in demand on A&E, as a system, we have looked at how we can keep people well and reduce emergency department attendances, better manage the flow of patients attending emergency departments and avoid unnecessary admissions and ensure early discharge.

Coping with additional demand, or even a reduced demand whilst maintaining IPC precautions is heavily dependent on changes to environment in A&Es. Following the award of funding from central government for both Lincoln County Hospital (£15m) and Pilgrim Hospital Boston (£2m), plans haven developed to increase the physical capacity in the departments during winter. The Pilgrim Hospital plans are based on an internal reconfiguration and schemes should be in place by 31st December. The plans developed for Lincoln County include a new build and as such, will not be fully realised until February/March 2021.

The creation of Priority Admission Response Units (PARU) will assist in the de-escalation of our emergency departments when pressure is caused through patients waiting for inpatient beds. These units are not in addition to our core or escalation beds. They act as a safe transient facility whilst either an assessment unit bed or speciality bed is made available. The proposed locations of these units are MEAU at Lincoln County and IAC at Pilgrim Hospital and will be achieved through reconfiguration of current services. In the case of Pilgrim Hospital, the PARU will be established in the recently vacated SDEC area and in the case of Lincoln County this will be with the support of a modular build. The latter is referred to later in this paper.

High Intensity users: As a System, we are developing our approach to address support needs of high intensity users. ULHT and System Partners are working toward an approach that allows care plans for high intensity users to be shared across local primary, community, EMAS and acute organisations, developing data sharing agreements and patient consent. The initial target group has annual ED attendances of between 15 and 90 and include patients who have complex profiles of multiple physical, mental and social conditions. General Practice supported by Neighbourhood teams are working with high intensity users as is LPFT since a high proportion are mental health patients.

UTCs: The attendances through the UTCs aligned to ULHT has increased over the past 12 months.



The UTCs have a robust streaming process in place and is working to implement a more formal redirection process for patients who could be more appropriately seen in Primary care by supporting patient to first use NHS 111.

Further work to reduce variation in the way UTCs operate is in train, with best practice implemented through adherence to national and local standards and clear/effective referral pathways. CAS and UTCs work in partnership with the home visiting service to provide care in the community and within a patient's home.

A step-up pathway is now in place from the Acute Trust front door to intermediate care beds, across the county. This provides an opportunity for patients who are not acutely unwell but require a period of rehabilitation in a bedded unit, as they unsafe to return home. This

pathway provides an alternative to hospital admission and support rapid recovery and return home.

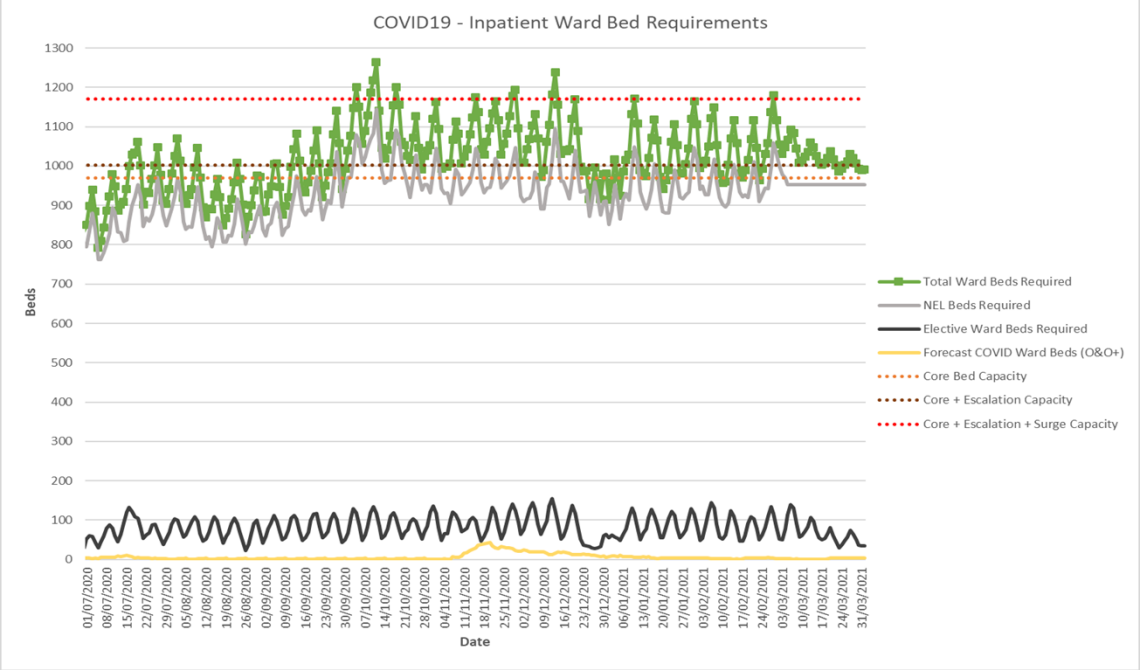
Non-Elective Admissions (including 0 vs +1 length of stay)
A continued rise in NEL admissions at ULHT will exert additional pressure on the system to continue to deliver a safe system for patients.

Our approach is to reduce overnight NEL admissions and A&E attendances (18-74yrs) by increasing activity through, and optimising SDEC. Actions to achieve this in the current review of existing pathways to extend the current criterion and to develop and agree direct access pathways into SDEC for CAS and GPs to reduce A&E attendances such as mild to moderate asthma and respiratory conditions since in the winter months. In order to facilitate this expansion, SDEC at Pilgrim Hospital has been successfully relocated into a larger clinical space and the footprint for SDEC at Lincoln County has been increased.

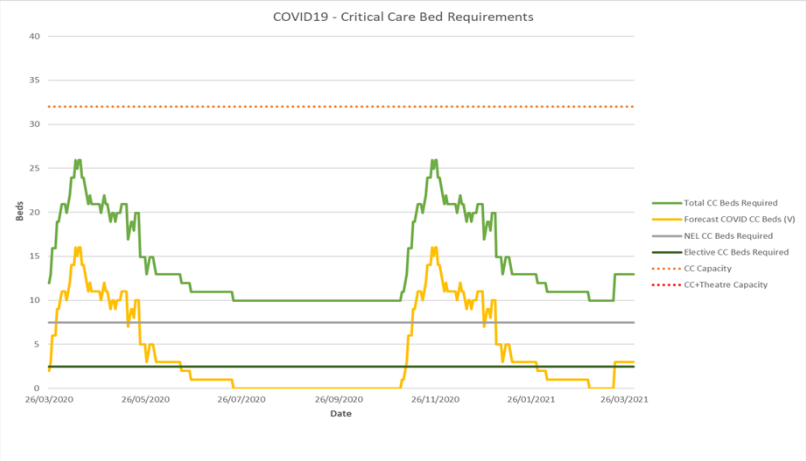
Available G&A beds and occupancy
ULHT undertook several bed modelling assumption exercises. The calculations were based on actual impact of the first wave of COVID-19 being mirrored in the second wave, NEL activity from October 2019 to March 2020 and no reduction in elective activity. ULHT produced a 'best case scenario' and 'likely/worst case scenario'.

The modelling assumptions were also based on a reduction on length of stay and an occupancy of 88%

<u>Bed Modelling - Best-case scenario</u>
Assumptions:
• COVID-19 2nd peak, half of 1st peak, from 1st November
• NEL demand initially at 90% of seasonal level, 95% from Sept and 100% from October
• NEL LOS 4.0 (4.7 historical, reduced for use of chairs, discharge lounge, etc)
• NEL Bed Occupancy 88%, reduced by 10% for COVID-19
• EL demand initially at 70% of seasonal level, 80% from Sept, 90% from Oct, 100% from Dec
• EL LOS, 2.7 (historical)
• EL Bed occupancy 88%



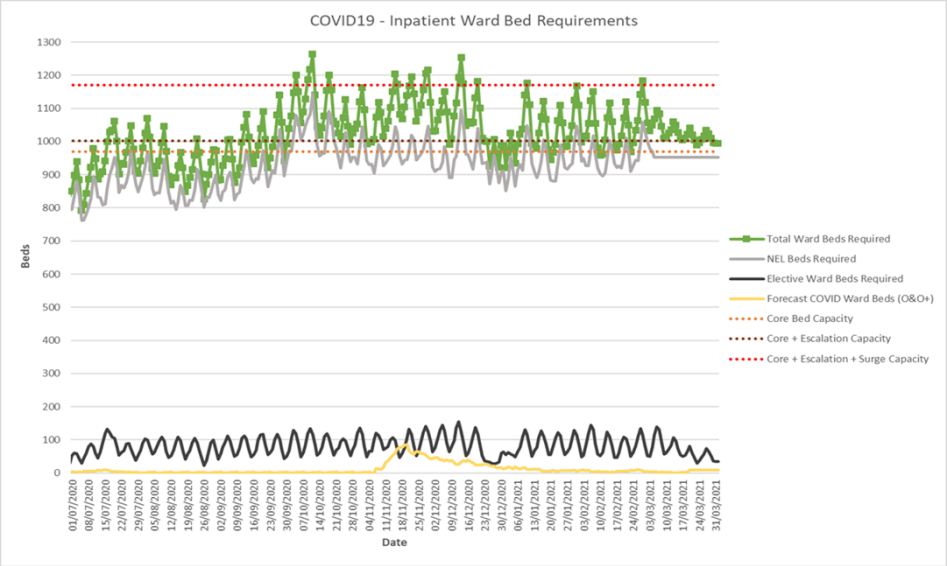
Critical Care bed demand remains within available capacity at Trust level.



<u>Likely/Worst Case Scenario</u>

ULHT Modelling assumptions

- COVID-19 2nd peak, identical to 1st peak from 1st November
- NEL demand initially at 90% of seasonal level, 95% from Sept and 100% from October
- NEL LOS **4.0** (4.7 historical, reduced for use of chairs, etc).
- NEL Bed Occupancy 88%, reduced by 10% for COVID-19
- EL demand initially at 70% of seasonal level, 80% from Sept and 90% from Oct 100% from December
- EL LOS, 2.7 (historical)
- EL Bed occupancy 85%.



COVID-19 resurgence modelling assumptions:

The modelling suggests that Core and Escalation ward bed capacity will regularly be exceeded from late September onwards. A sustained period from 15th November to 20th December suggests that Surge ward bed capacity will be exceeded. At peak demand, overall deficit of 83 wards beds if we included ALL beds and c129 if we exclude Grantham Hospital and other modified clinical areas, for example, the move of SDEC at Pilgrim Hospital to Bevan Ward.

Note: Use of 12 Surge beds at Boston (Bevan Ward) will require SDEC to stop. Use of 34 Surge beds at Grantham (EAU & ACU) will require non-green pathway at that site. If these beds are not available, deficit of 129 ward beds at peak demand.

As previously stated, our planning suggests a shortfall in beds of c130 in the peak of a second wave coupled with increased winter demand based on a reduced acute trust NEL LoS from 4.7 to 4 days. Availability of beds and addressing the shortfall will be delivered by reducing LoS, further utilisation of community beds including nursing and care homes. We know we have on average 200 empty beds in the community and access to these beds needs to be increased. To date, Lincolnshire Community Health Services (LCHS) have identified 104 surge capacity beds from the ask of 120 surge capacity beds

The table below describes the positive Covid-19 cases by Region and in Lincolnshire by district. To date we have a total of 45 positive Covid-19 as inpatients in our trust with the highest number at Pilgrim.

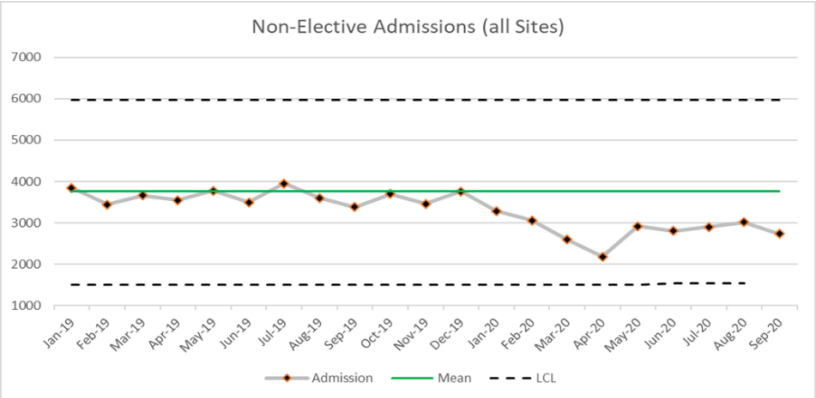
UTLA	Last Week Total Increased By (Cases)	Daily Updates 27/10/2020	Current Increase This Week
Derbyshire	2369	10410	759
Lincolnshire	1180	6513	388
Leicestershire	1889	9778	614
North East Lincolnshire	519	1652	181
North Lincolnshire	343	2013	118
Northamptonshire	1078	8109	244
Nottingham	1841	10602	381
Nottinghamshire	3016	12427	744
Peterborough	282	2584	65

LTLA	Last Week Total Increased By (Cases)	Daily Updates 27/10/2020	Current Increase This Week
Boston	88	778	30
East Lindsey	224	856	73
Lincoln	215	1093	89
North Kesteven	160	781	45
South Holland	143	1058	46
South Kesteven	211	1216	57
West Lindsey	139	731	48
Newark & Sherwood	261	1536	70

Our challenges continue to be balancing IPC guidance/excellence on both acute sites and in the community whilst maintaining bed availability through increased flow. We have experienced 2 outbreaks at ULHT and 1 outbreak within LCHS that have impacted on capacity and flow. Digby Ward at Lincoln County, ACU at Pilgrim Hospital and Scarborough Ward at Skegness Hospital.

ULHT have secured a 12-bed modular building at Lincoln County to support the isolation of infectious patients and decrease the necessity to close beds. This will be in place in November 2020. The addition of this modular build will require some reconfiguration on the Lincoln County site to create a Priority Admissions Unit.

The ULHT current position in respect of NEL Admissions is displayed in the graph below and describes a reduction in admissions for September. Discharges increased during September as detailed below.



Sustain reduction in Length of Stay through effective discharging

The ambition of the Trust is to achieve a 4.0-day length of stay. We are currently at 4.53-day length of stay. The timely discharge of medically optimised patients from ULHT via pathway 1,2 and 3 is well established but continues to be compromised by the need for a valid covid-19 swab result. The introduction of a local patient swabbing agreement for all patients requiring on going care within Adult Social Care is still causing some discharge delays of >72 hours. Whilst this process has received national recognition as exemplar practice, this is now causing delays in creating insufficient capacity to meet the emergency demand and is increasing length of stay. September experienced an increase in super

stranded patients, form 82 in August to 102 in September. ULHT recognise that pressures exist in the Community Trust and Social Care to maintain capacity but we, as a Trust, need to apply more focus to pathway zero patients. This pathway applies to 50% of our patient population.

The diagram below describes the discharge pathways

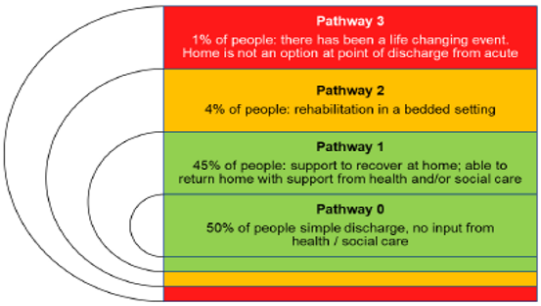
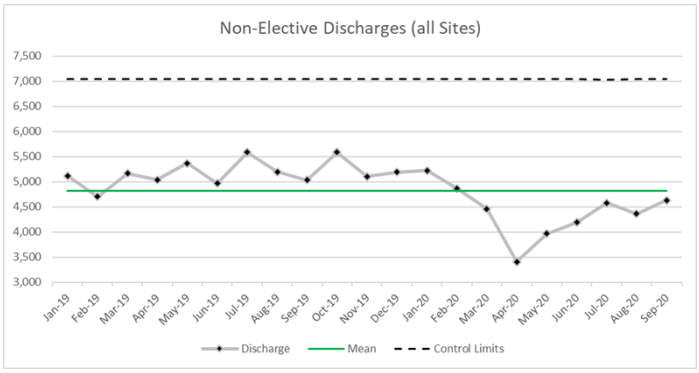


Figure 1: Discharge to Assess model

The graph below demonstrates the discharge profile for ULHT



7. ULHT Additional Actions

- A revised Urgent and Emergency Care Improvement Programme is in development and will act as the vehicle to drive sustained changes going forward.
- Review of all ED and SDEC pathways. ED should only have 10 pathways that need an acute Type 1 response
- A comprehensive discharge pathway review is in train including a MADE event for Lincoln County specifically.
- A clinically led task and finish Group has been established to focus on discharge including the creation of a discharge dashboard.

8. System Actions to reduce the burden placed upon ULHT

This paper has described the ULHT response to Winter Planning and Covid Resurgence, but our delivery and the sustainability of our plans are reliant upon our System Partners delivering theirs. These include:

- Increase % utilisation of NHS111/111 Online through the implementation of 111 first
- Increase utilisation of available General Practice appointments via direct booking – 76 practices have confirmed that they are live with appointments for NHS 111 to book via GP connect, setting aside 1 appointment per 1000 patients per day.
- Increase % Hear and Treat/See and Treat supported by a new team of specialist paramedics

- Increase use of alternate community pathways available to EMAS supported by CAS
- Increase support for the Enhanced Health in Care Homes programme
- Reduce % tests and investigations in A&E
- Effectively manage staffing and resource levels should reflect the increase in activity levels in A&E departments, not necessarily increase in attendances (we know the departments have increased the number of diagnostics in the department which is disproportionate to the number of patients then being discharged without treatment)
- Continued roll out of D2A
- Increase NHS 111 & CAS direct booking to GP in-hours and UTCs – 111 can currently book into all Lincolnshire UTCs and work is going to increase the number of appointments made available at each site.
- Increase NHS 111 ED and ambulance clinical revalidation - clinically reviewing ED DoS profiles to ensure codes are profiled to UTCs
- Increase Hear and Treat, and See and Treat; EMAS is part of national pilot with YAS and SCAS for 6 weeks with certain AMPDS codes for C3 and C4 calls going directly to H&T

Mental health-specific initiatives include: Continued promotion of the 24/7 Mental Health helpline to prevent people escalating to crisis, with crisis café capacity available for additional support; Roll out of the 'universal offer' which includes interim funding for a number of VCSE projects where funding was planned to end in December to ensure they are sustained throughout the winter period; Expansion of mental health liaison team at Lincoln County (subject to securing NHSE Transformation funds); Expansion of crisis alternatives (subject to securing NHS E transformation funds); Introduction of Night Light Cafes; Tier 2 professional helpline for advice and guidance from crisis team; Expansion of MH workforce in ambulance control room; Rapid mobilisation of a new 15 bed acute treatment ward due to launch Q3/4.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Public Trust Board*
Date of Meeting	*03/11/2020*
Item Number	*Item 10.3*
Patient and Visitor Car Park Charges Update	
Accountable Director	*Simon Evans, Chief Operating Officer*
Presented by	*Paul Matthew, Director of Finance & Digital*
Author(s)	*Sharron Reetham, Vanessa Treasure and John Kileen*
Report previously considered at	Public Trust Board 3 March 2020

How the report supports the delivery of the priorities within the Board Assurance Framework	
1a Deliver harm free care	
1b Improve patient experience	
1c Improve clinical outcomes	
2a A modern and progressive workforce	
2b Making ULHT the best place to work	
2c Well Led Services	
3a A modern, clean and fit for purpose environment	*X*
3b Efficient use of resources	*X*
3c Enhanced data and digital capability	
4a Establish new evidence based models of care	
4b Advancing professional practice with partners	
4c To become a university hospitals teaching trust	

Risk Assessment	*N/A*
Financial Impact Assessment	*Details in main report*
Quality Impact Assessment	*N/A*
Equality Impact Assessment	*Revised charges take into account the national requirements to provide free parking for disabled badge holders.*
Assurance Level Assessment	*Significant*

Recommendations/ Decision Required	*Board is asked to note paper in relation to the reinstatement of visitor parking charges with effect from 2nd November 2020 with reduced rates from those that ceased in March / were planned to be implemented in April 2020.*

Executive Summary

At the Public Trust Board meeting on 3 March 2020 it was agreed to revise the tariffs for patient parking with effect from 1st April. Subsequently the Trust made car parking free for all patients in April as a result of Covid-19.

As activity increases across the hospital sites pressure on the availability of car parking is beginning to increase. This along with the national financial regime expectation around commercial income returning to 19/20 levels and the contract the Trust has in place for running the car parks means that charges need to be put back in place with effect from Monday 2nd November 2020. The new tariff is also compliant with the national guidance for car parking issued by the Department of Health and Social Care in December 2019.

During the period of free parking it has been recognised that commuters and staff from nearby organisations have been utilising the free car park facility.

Recognising the impact that Covid-19 continues to have on our patients and visitors the Trust has decided to reduce the rates that it will be charging from those previously in place. In particular introducing free 30 minutes of parking to help with drop off and pick up of patients.

The table below outlines the rates that were in place and those that will be in place from 2nd November 2020.

Duration	Current	Proposed 1st April 2020	Proposed 2nd November 2020
Up to 30 minutes	-	Free	Free
Up to 1 hour	£1.70	£2.00	£1.00
1 to 4 hours	£4.20	-	£2.00
1 to 2 hours	-	£3.00	-
2 to 3 hours	-	£4.00	-
Over 4 hours	£5.00	£5.00	£5.00
Motorcycle parking	As above	Free	Free
Blue Badge holders	As above	Free	Free

The rates will be in place until 31st March 2021 at which point, they will be reviewed again against the Covid-19 situation, national NHS financial regime for 21/22 (yet to be published), operational impact of the lower tariff and local factors such as local authority parking charges.

Hand sanitising facilities will be made available at the payment machines along with a cleaning regime for the machines and patients / visitors encouraged to pay using the online system from their smartphone.

Appendix 1 -Comparison to Local and other NHS Parking Charges

The NHS car parking guidance recommends that NHS hospital sites that are close to city/town centres should ensure their car-parking charges are not lower than local car-parks otherwise commuters and visitors may be tempted to use their car-parks instead. Local Authority, NCP and other local NHS Trust parking charges are as follows:

Neighbouring Trust parking charges

Duration	Nottingham City Hospital	Leicester Royal Infirmary	Peterborough City Hospital	ULHT proposed
Up to 30 mins	FREE	FREE	FREE	FREE
Up to 1 hour	£2	£1.70		£1.00
1- 2 hours	£4	£2.90		
2 -3 hours		£3.40		
0.5 -3.5 hours			£2.60	
Over 3 hours				
Up to 4 hours	£5.50	£4.50		£2.00
3.5 - 4.5 hours			£4.20	
Over 4 hours				£5.00
4.5 – 5.5 hours			£5.20	
5.5 – 6.5 hours			£6.30	
Over 6.5 hours			£10.40	
Up to 8 hours	£6.50	£6.70		
8 – 12 hours		£11.30		
Up to 24 hours	£8.00	£13.30		
Evening charges 8pm-6am		£2.30		
Weekly	£20			
Monthly	£30			

Local car parking charges

Duration	Lincoln - Lucy Tower St (Council Car Park)	Grantham - Guildhall Street. (Council Car Park)	Boston- Market (NCP Car Park)
Up to 30 mins		£0.70	
1 hour	£1.60	£1.00	£1.60
1 – 1.5 hours			£2.10
1.5 -2 hours			£2.60
2 hours	£3.20	£1.70	
2-24 hours			£3.10
3 hours	£4.80	£2.30	
4 hours	£6.20	£3.80	
Over 4 hours	£8.50	£5.00	
24 hours	£8.50		
Evening charges	£3.80		

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*3rd November 2020*
Item Number	*Item 11.1*

Research & Innovation Strategy

Accountable Director	*Dr Neill Hepburn*
Presented by	*Dr Neill Hepburn*
Author(s)	*Hannah Finch*
Report previously considered at	*People & OD Committee*

How the report supports the delivery of the priorities within the Board Assurance Framework	
1a Deliver harm free care	*X*
1b Improve patient experience	*X*
1c Improve clinical outcomes	*X*
2a A modern and progressive workforce	*X*
2b Making ULHT the best place to work	*X*
2c Well Led Services	*X*
3a A modern, clean and fit for purpose environment	
3b Efficient use of resources	
3c Enhanced data and digital capability	
4a Establish new evidence based models of care	*X*
4b Advancing professional practice with partners	*X*
4c To become a university hospitals teaching trust	*X*

Risk Assessment	*4154 – Very low risk*
Financial Impact Assessment	*NA*
Quality Impact Assessment	*NA*
Equality Impact Assessment	*NA*
Assurance Level Assessment	*Moderate*

Recommendations/ Decision Required	We request that the Trust Board considers this Strategy for approval

Executive Summary

The purpose of this Strategy is to set out the vision and five Strategic Objectives of the Trust in relation to R&I from 2021-2024.

For each Objective, key Priorities are identified, and Actions and expected Outcomes are described. Following feedback from the People & OD Committee, the Year One initiatives are more fully described with measurable outcomes and expected cost impact.

By putting this Initiative at the heart of the department we will ensure we focus on the right things - the things that will allow our staff, patients and service users to access high quality research and innovation opportunities.

Our R&I Strategic Initiative will see us stabilise the foundations of the department and grow to take advantage of the many opportunities and partnerships surrounding the Trust. It also provides a clear statement of our intent, commitment and a plan for the next stages of our journey.

During May 2020 the Trust seconded to the position of 'Head of Research & Innovation', this appointment has undertaken activities to develop an R&I Strategic Initiative.

The CQC "Should Do" plan highlights that: "The Trust should ensure leaders and staff strive for continuous learning, improvement and innovation through participation in appropriate research projects.

The expected outcome is a: "Comprehensive Research Strategy in place which is understood and owned by Divisions."

The last 5 months has seen targeted, informal consultation with internal and external stakeholders around the vision and strategic direction of the R&I Department. However, to achieve the output of 'ownership' by the divisions, a fuller consultation with Divisional stakeholders will be needed. To this end, we have separated the Strategy into two phases. Year One which will focus on putting the foundations in place internally and engaging in wider consultation. Years Two and Three will see implementation of actions based on the objectives already developed plus actions to build on the consultations conducted in Year One.

This work directly links to the Integrated Improvement Plan 5-year priority area: "To become a University Hospitals Teaching Trust", through the year 1 work stream of:

"Refresh of our Research, Development and Innovation (R,D&I) Strategy"

We have produced a Strategy which, upon implementation, will facilitate a culture of research and innovation throughout the Trust, will improve the magnitude, breadth and scope of the Trust's research offer and strengthen the Trusts ambition to become a University Hospitals Teaching Trust.

Main Body

Purpose

Our three-year Research & Innovation (R&I) Strategy and the operational plan that will underpin it, marks an important step forward for our Trust.

Research within ULHT has delivered growth over 10 years, with active pockets across three of our sites (Lincoln County Hospital, Pilgrim Hospital, Boston and Grantham and District Hospital). However, a change of leadership within the department and the subsequent unprecedented changes as a result of the Covid-19 pandemic have provided a unique opportunity to review the department, consider our ambitions for R&I and plan how we are going to get there. A plan that will help to make a real difference for our research active staff members, our departmental workforce, our patients and our partners.

The purpose of this Strategic Initiative is to set out the vision and objectives of the Trust in relation to R&I from 2021-2024, demonstrating how we will meaningfully embed R&I plans into the core business of the Trust.

It identifies the key priorities for the R&I Department over the next three years, ensuring that we focus on the right things - the things that will allow our staff, patients and service users access to high quality research and innovation opportunities.

Our new R&I Strategy will see us stabilise the foundations of the department and grow to take advantage of the many opportunities and partnerships surrounding the Trust. This is important as effective partnerships across the Lincolnshire health community are vital for achieving our overall goals and we are committed to working as one health and care system. Likewise, we recognise we are an important partner to the University of Lincoln, Bishop Grosseteste University and the East Midlands Clinical Research Network and are dedicated to playing an active role in these networks.

This Strategy aims to provide a clear statement of our intent, a strong commitment to Research & Innovation and a direction for the next stages of our journey. The development of the Strategy has included a review by:

- Members of the R&I Department
- Lincolnshire Research Patient and Public Forum
- Select ULHT clinical research leaders
- University of Lincoln
- Clinical Research Network East Midlands
- R&I leaders from local healthcare providers and other acute Trusts in the East Midlands

We also received useful feedback from the Trust People & OD Committee, specifically around the need for measurable outputs and financial impact information. These deliverables and their financial implications will be worked up fully during year one of the strategy.

Key messages

Clinical Research outputs can be complex and we do not have the tools currently to capture data on the breadth of potential measures. However, using the simple metric of participants recruited to NIHR Portfolio research studies, when benchmarked against 10 acute organisations similar in terms of hospital attendance; we can see that ULHT are not recruiting to the same levels. We do not know the reasons for this, but it could be factors such as:

- Studies available (and their recruitment targets)
- Size of infrastructure supporting study delivery (R&I Staff, Principal Investigators, Trust supporting services)
- Size of infrastructure supporting follow up work

To achieve our ambitions as expressed through the Integrated Improvement Plan (IIP), the Research & Innovation Department needs to strengthen, both through improved governance and finance processes but also through recognition as an important part of the Trust services.

The R&I Department will work with the Trust to secure routes to develop the capacity and capability of the Trust workforce to take on roles in clinical research. This will include raising awareness of research in the Trust, valuing the contributions of our staff and demonstrating to the Trust the value of being a research active organisation.

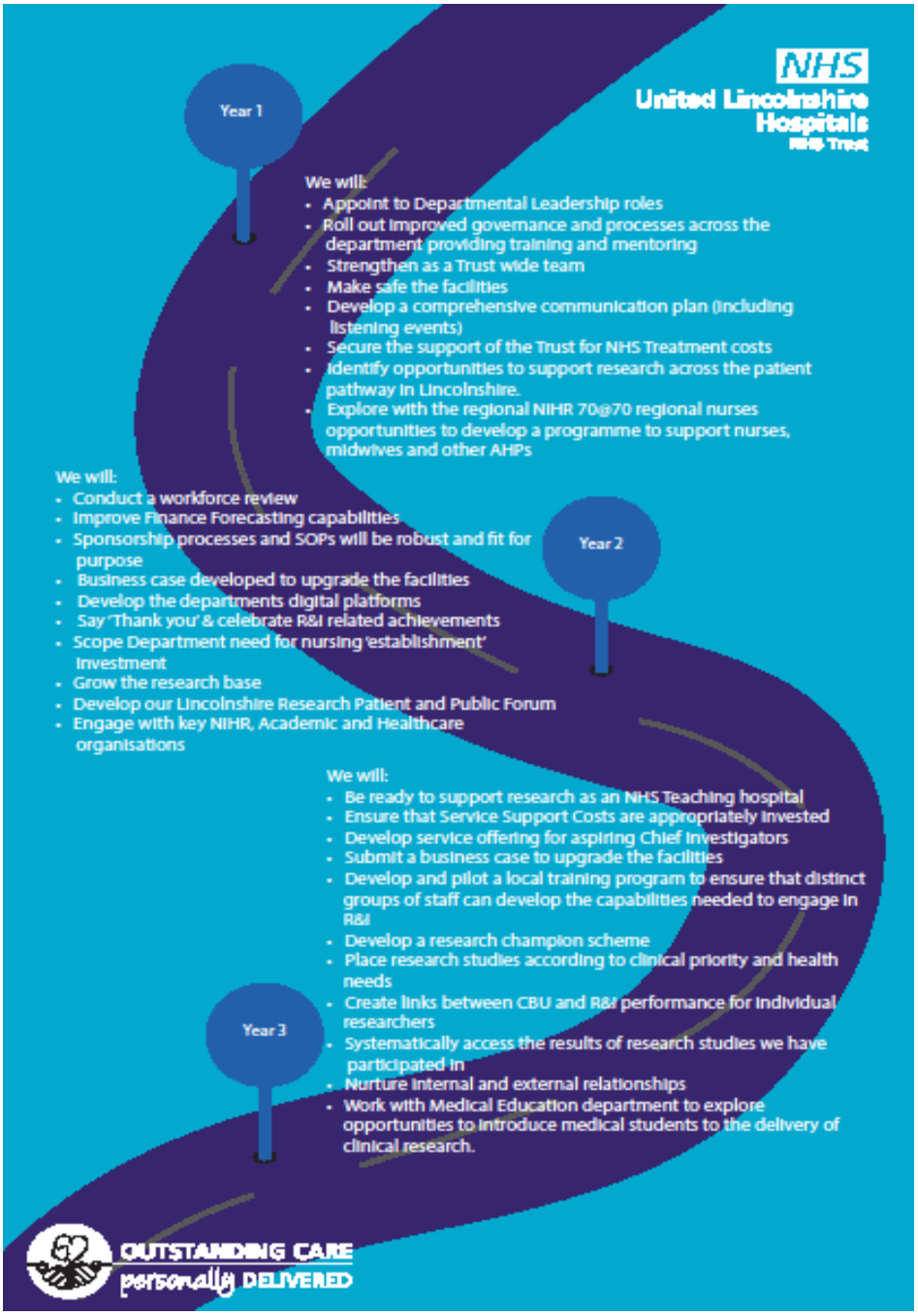
We will bring the patient / service user and public of Lincolnshire into a research specific conversation with the Trust, to understand the level of patient opportunity to take part in research. We will work with our Lincolnshire Research Patient and Public Forum to raise awareness, gain understanding of what people think about research and take action to ensure participants in research feel valued and informed.

The R&I endeavours of ULHT will be more powerful and far reaching if we strengthen our network. We will proactively engage with our local partners in the healthcare, academic and local authority sectors. We will seek out opportunities to deliver research as a Lincolnshire System and support high quality academic interests locally.

Working with key internal departments, we will strengthen internal links. We will also ensure that we look outwards and maximise partnership working with organisations such as the National Institute of Health Research and the Academic Health Science Network.

We will take steps to address the lack of clarity around, and availability of, a recognised and supported research pathway for interested members of staff.

Over the next three years, R&I will follow a pathway of operational actions that will support the delivery of our 5 Strategic Objectives:



Conclusion/Recommendations

To achieve the plans described in the Trust IIP the Research & Innovation endeavours of the Trust will need to increase in volume, breadth and impact.

The R&I Strategy maps out the vision and direction for the first three years of action needed to assist United Lincolnshire Hospitals NHS Trust to achieve its IIP outputs.

We request that the Trust Board considers this Strategy for approval.

NHS
United Lincolnshire Hospitals
NHS Trust

Our Research & Innovation Strategy 2021- 2024

OUTSTANDING CARE
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Research & Innovation Actions Roadmap

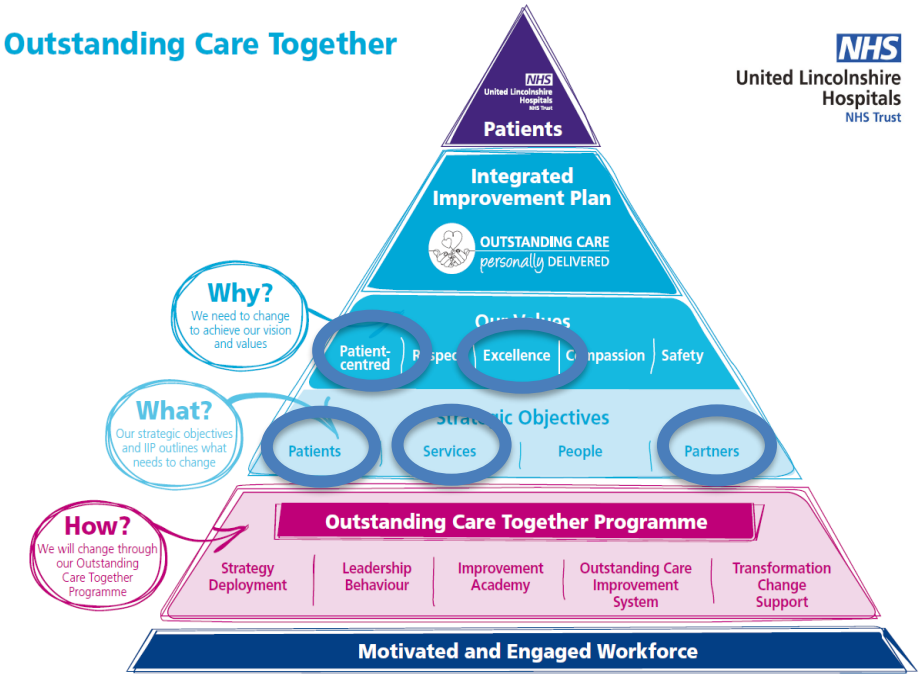
Executive Summary: Initiatives by year

Priority	Year 1	Year 2	Year 3
Strategic Objective 1: Strengthen the R&I Department ***The R&I Department will have the structure, direction, standards, development and working environment it deserves. Transforming it into a valued and recognised part of the ULHT, which can in turn improve patient care and develop the research workforce of the future.***			
Support Our Team	Appoint to Departmental Leadership roles	Conduct a consultation around the scope and roles within the Department and make changes if necessary	Plan to appoint to any gaps identified in Year 2
	Working with the Organisational Development we will form as a team, getting to know each other and exploring ways of working together	Ensure individuals within the department receive training to give them the tools to drive forward the transformational change that the department needs	
Improve Our Facilities	Take immediate action and investment to make safe the facilities at Lincoln County	Develop a business case to upgrade the facilities at Lincoln County and Grantham and District Hospital sites	Submit a business case to upgrade accommodation
Department Governance (including Financial Integrity)	Establish the Departmental Governance flows by engaging fully in Trust governance	The processes and SOPs associated with sponsored research studies will be refreshed to ensure they are robust and fit for purpose	A training programme for perspective Chief Investigators will be developed and piloted
	The processes and SOPs associated with hosted research studies will be refreshed to ensure they are robust and fit for purpose		
	Roll out new financial processes across the department providing training and mentoring	Develop forecasting capabilities	Invest NHS Service Support Costs appropriately
Raising Awareness	Develop a comprehensive communication plan to maximise reach of communications (including newsletters, Trust induction, NIHR produced materials, posters, videos and events)	Develop our digital platforms, to ensure information is easy to find and up-to-date	Develop a research champion scheme to be piloted
Demonstrating Clinical Relevance		Explore how to effectively access the findings of research studies and agree a process of informing others in ULHT	Develop a system to place research studies according to clinical priority and health needs
Strategic Objective 2: Build our capacity & capability ***We will build the capacity and capability of our current and future workforce to embrace and actively engage with research and innovation. Encouraging participation from all professional groups.***			
Valuing Contributions	Roll out the 'R&I Certificate Scheme' across the portfolio of research studies	Develop, pilot and roll out plans to say 'Thank you' to the ULHT staff who support research studies & to celebrate R&I related achievements	Explore opportunities to create links between CBU and R&I performance for individual researchers.
Increasing Capacity	Secure the support of the Trust for NHS Treatment Costs and Excess Treatment Costs	Scope department need for a nursing 'establishment' investment, to allow increased research delivery activity	
	Hold a series of stakeholder listening events	Develop outputs from the stakeholder events into actions to support the growth of the research base	
Developing Capability			Develop and pilot a local training program to ensure that various staffing groups can develop research capabilities.

Strategic Objective 3: Engage with our patients, service users and the public ***We will plan and nurture interactions with our patients and service users to develop awareness of and engagement in clinical trials.***			
Understand opportunities to take part in research	Access the national NHS patient survey results around opportunity to take part in research	Plan & hold a "Research Conversation" with the patients of ULHT and the public of Lincolnshire	Analyse the outputs of the Research Conversation, and plan further actions
Participants valued and informed		Develop and pilot plans to say 'Thank you' to the participants of research held at ULHT	Develop and test a process to send participants the findings of the research they have participated in
Integrate our Patient and Public Forum	Work with our Lincolnshire Research Patient and Public Forum to provide direction , structure and clarity for the group	Understand how best to engage LRPPF in the development of ULHT sponsored research	Agree a process for Chief Investigators to best access the input of our LRPPF
Strategic Objective 4: Develop a strong Network ***We will explore and strengthen relationships with local and regional partners, allowing synergies to develop and to collaborate with a system-wide focus to the benefit of the patients of the healthcare system in* Lincolnshire.**			
Local Healthcare Providers	Continue to be an active partner in the regular meeting with the NHS organisations in Lincolnshire. Identify opportunities to support research across the patient pathway in Lincolnshire	Together with LCHS, LPFT and EMAS agree a programme of work to improve research opportunity across Lincolnshire	Deliver the projects identified in Year two
Academic Partners	Working with the University of Lincoln develop a Memorandum of Understanding on Joint Working for Effective Research Governance	Working with key departments at the 2 local Universities we will re-engage efforts to identify areas of interest which could benefit from a collaborative approach	Work with the University to understand the requirements of the Research Evaluation Framework
		Develop a plan to increase Research Capability Funding to levels required as a UHTT	Prepare conversations with the University of Lincoln to allow the development of a joint research strategy once the Medical School is transferred to them
Other Stakeholders	Proactively seek out and nurture relationships with local NIHR organisations (ARC, CRN and RDS) and the Academic Health Science Network		
Strategic Objective 5: Develop a recognised Researcher Pathway ***We will develop our offering to research interested staff members, forging a clear pathway from supporting delivery of clinical research, through becoming a Principal Investigator and on to aspiring Chief Investigators working to attract research grants. The Department will be aware of and support the research leaders of the future through their pathway.***			
Recognise	Conduct a survey of the ULHT workforce to identify areas of research interest and aspirations.	Hold a stakeholder event to further explore with research interested staff how ULHT can support them in their research pathways.	Work with Medical Education department to explore opportunities to introduce medical students to the delivery of clinical research.
Support	Explore with the NIHR 70@70 regional nurses the potential to develop a programme which will support nurses, midwives and other AHPs to lead research	Engage with the NIHR RDS and CRN East Midlands to ensure all opportunities for workforce development are being recognised and accessed	Launch the programme of support developed through the R&I Listening event and the work with the NIHR 70@70 Nurses

Foreword:

The ULHT Research & Innovation Department is undertaking an ambitious and exciting 3-year improvement journey. This is vital for the Trust, its' staff, patients and service users as research and innovation is a thread through the core of Trust business as described through the Integrated Improvement Plan.



Our R&I Strategy is laying the foundations for the people of Lincolnshire to benefit from the real opportunities created by an embedded and progressive R&I Department.

The vision and objectives described in this Strategy will set the direction for research and innovation in ULHT. It outlines our strong commitment to improvement and working with external partners (such as local universities, NHS organisations and the NIHR), to achieve our Trust vision of "Outstanding care Personally delivered".

Dr Neill Hepburn, Medical Director

Contents

The Purpose of the R&I Strategy

Welcome to our three-year Research & Innovation (R&I) Strategy. This Initiative, and the operational plans which will underpin it, mark an important step forward for our Trust.

Research within ULHT has delivered growth over 10 years, with active pockets across three of our sites (Lincoln County Hospital, Pilgrim Hospital, Boston and Grantham and District Hospital). However, a change of leadership within the department and the subsequent unprecedented changes as a result of the Covid-19 pandemic have provided a unique opportunity to review the department, consider our ambitions for R&I and plan how we are going to get there. A plan that will help to make a real difference for our research active staff members, our departmental workforce, our patients and our partners.

The purpose of this Strategy is to set out the vision and objectives of the Trust in relation to R&I from 2021-2024, demonstrating how we will meaningfully embed R&I plans into the core business of the Trust.

It identifies the key priorities for the R&I Department over the next three years, ensuring that we focus on the right things - the things that will allow our staff, patients and service users access to high quality research and innovation opportunities.

The first year of this work will see us stabilise the foundations of the department and then grow to take advantage of the many opportunities and partnerships surrounding the Trust. This is important as effective partnerships across the Lincolnshire health community are vital for achieving our overall goals and we are committed to working as one health and care system. Likewise, we recognise we are an important partner to the University of Lincoln, Bishop Grosseteste University and the East Midlands Clinical Research Network and are dedicated to playing an active role in these networks.

This Strategy aims to provide a clear statement of our intent, a strong commitment to Research & Innovation and a plan for the next stages of our journey.

Why does R&I matter?

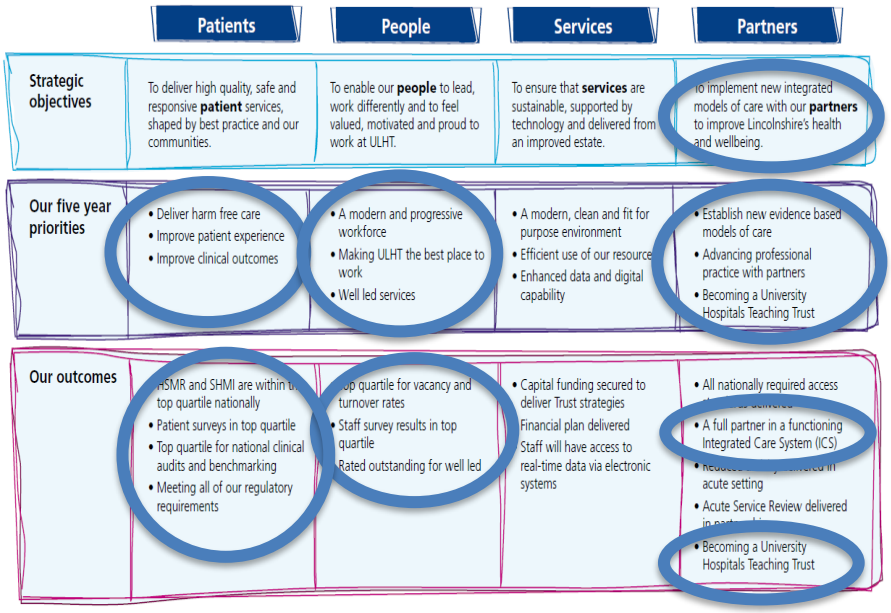
ULHT is undertaking a five-year Integrated Improvement Plan (IIP), ensuring we focus on the right things for both our patients and our staff. Through its IIP, we have made a clear statement that quality must be the organising principle of our health and care service. Quality matters to people who use our services and motivates and unites everyone working in health and care. In line with ULHTs IIP, we are committed to a value of Excellence, supporting innovation, improvement and learning throughout the Trust, and health Research is central to this.

ULHT recognises that there is a need for significant quality improvement, which can deliver better patient outcomes and improved operational, organisational and financial performance. Our improvement will be led effectively, embedded through the organisation and supported by systems and training. It will involve a process of continuously evaluating and improving what we do to make things better.

Research & Innovation is a central mechanism that is used to instigate improvements in many aspects of health and care. Research is conducted in all NHS settings, and without it clinicians would carry out their work in the same way without knowing if a new treatment or approach would be more effective. ULHT must harness and support its research activities in an improved way to allow the Trust to benefit from being a research active organisation.

We believe that a meaningful commitment to R&I is essential to achieving clinical excellence and will lead to better outcomes and experience for our patients and service users. Equally, we recognise that organisations with the R&I agenda at the core of their business attract and retain excellent staff and perform strongly. Our ambition to achieve University Hospital Teaching Trust status is an indication of the Trusts intentions. We cannot achieve this status without strengthening our research outputs considerably.

We are embarking upon a three-year plan that will bring R&I activities to the centre of the values which underpin the strategic direction of the organisation.



High profile external stakeholders also drive the need for quality research and innovation practice within the NHS:

UK Government

The Department of Health & Social Care established the National Institute for Health Research (NIHR) to improve the health and wealth of the nation through research. It is a framework through which to position, maintain and manage research, research staff and research infrastructure of the NHS in England.

The NHS Constitution describes how the NHS aspires to the highest standards of excellence and professionalism in the provision of care, and through its commitment to innovation and the promotion, conduct and use of research to improve the health and care of the population.

Patients & Service Users

Patients & the public expect research to be conducted within the NHS. A survey conducted in 2014 by the NIHR[1] found that 89% of people responding indicated they would be willing to take part in clinical research if they were diagnosed with a medical condition or disease. 95% said it was important to them that the NHS carries out clinical research.

Regulators

The Care Quality Commission recently included research in the 'well-led' domain of its inspection framework.

Research Evidence

Research into the benefits that are brought to research active Trusts was published in 2015[2] indicating that research active Trusts:

- Have lower mortality rates
- Increased patient benefits
- Are able to retain and attract talented clinical staff
- Are able to promote innovation, quality improvement and innovative clinical services development
- Are successful in the implementation of evidence based practices

We recognise that maintaining the present state is not always the best option for us as an NHS provider, nor the best option for our clinicians and patients. This Strategy sets out our intention to work in an innovative way, embracing research as part of the progress of the organisation. There has never been a more important time to invest in the research and innovation endeavours of ULHT. The clinical research landscape is complex, with many factors to navigate and the development of innovation has inherent risks - but with clear direction, planning and accountability, we will achieve the growth described within this Strategy.

[1] NIHR Survey, 2014 https://www.nihr.ac.uk/news/nine-out-of-ten-people-would-take-part-inclinical-research/2377
[2] Ozdemir et al (2015) Research Activity & the association with Mortality

Research Context

R&I within the healthcare setting

The 'UK Policy Framework for Health and Social Care Research' define research as:

> *"the attempt to derive generalizable or transferable new knowledge to answer or refine relevant questions with scientifically sound methods"*[3]

Health research aims to find knowledge that could lead to changes to treatments, policies or care. It assesses new treatments, technologies or methods, or can help better understand health and specific conditions. As new treatments develop, or as new applications of existing treatments are identified, the potential benefits and risks of the treatment are tested through clinical trials. "Research" can encompass a huge range of activities from laboratory based tasks through to treatment within a care setting.

ULHT could be a 'host' delivering another organisations research, with a Principal Investigator locally responsible. Alternatively, we could be the lead organisation, with the Chief Investigator being one of our staff members. Activities associated with the study will be carried out by the PI or CI, supported by a combination of R&I department workforce and other Trust staff, depending on the needs of the study. These requirements are communicated through key official documentation which include a Research Protocol and a contract or agreement.

There are 2 broad categories of research, distinguished by who is responsible for the piece of research (the Sponsor):

- **Commercial led research**

Commercial led research studies tend to be randomised controlled trials involving a medicinal product or device. The full cost of research sponsored by a commercial organisation will be funded by that organisation. They can be single site, or multi-site studies, with our investigators either the Chief Investigator of the research, or fulfilling the role of Principal Investigator.

Commercial companies also work collaboratively with NHS bodies or non-NHS research funders to support non-commercial research, which is primarily for the public benefit (rather than direct commercial benefit).

- **Academic or NHS led research (non-commercial)**

There are many types of academic or NHS led research, for example, these could be research completed by a student as part of an undergraduate or postgraduate degree, research focussing on staff members experience using questionnaires and interviews, or a multi-site, randomised controlled trial researching a medicinal product or medical device.

Research costs associated with these studies are funded through a number of routes,

[3] https://www.hra.nhs.uk/media/documents/Final_Accessibility_uk-policy-framework-health-social-care-research_.pdf

including self-funded (typical for student research), NIHR grants, Research Councils and Charity grants, awarded through open and transparent competition. The Treatment costs associated with these studies should be supported by the Trust or the Commissioning bodies (if a nationally recognised 'excess' cost). If the study is adopted on to the NIHR Portfolio, the Service Support Costs are funded through the Clinical Research Network East Midlands.

Phases of health Research

Research pathways take new treatments through four phases to become a new licenced medicine if it proves to be more effective than an existing treatment. Currently ULHT takes part in later phase trials (Phase 3 onwards).

Phase 1: Small numbers of people, often healthy volunteers, the medicine is being trialled in human volunteers for the first time. Researchers test for side effects and calculate what the right dose might be to use in treatment. Starting with small doses and only increase if the volunteers do not experience any (or minor) side effects.

Phase 2: The new medicine is tested on a larger group of people who are ill, to get an idea of its short term effects.

Phase 3: The medicine is tested in larger groups of people who are ill, and compared against an existing treatment or a placebo to see if it's better in practice and if it has important side effects. Trials often last a year or more and involve several thousand patients.

Phase 4: The safety, side effects and effectiveness of the medicine continue to be studied while it's being used in practice. This is not required for every medicine, and is only carried out on medicines that have passed all the previous stages and have been given a marketing licence (is available on prescription).

Innovation

Innovations, often the product of research, are new products, processes or services that offer a 'step-change' improvement. Innovation is central to the next 5 years at ULHT, and the R&I Department will be working closely with other internal partners in innovation (Improvement & Integration and Knowledge & Library Services), through the work stream 'To become a University Hospitals Teaching Trust'.

The NIHR

The National Institute for Health Research (NIHR) are an important organisation facilitating health research. They are the nation's largest funder and provide people, facilities, and technology that enable research to thrive.

Established in 2006 the NIHR mission is to improve the health and wealth of the nation through research. It delivers against this mission through five key work streams:

The NIHR Clinical Research Network (CRN) is part of the work stream which provides world-class infrastructure and a skilled delivery workforce. ULHT is a partner of the CRN East Midlands. This network includes the CRN team and 16 NHS Trusts and the CCGs across the geographic region of the East Midlands.

ULHT contributes to the delivery of the NIHR portfolio of studies and we benefit from receiving funding which is invested to enable the delivery of high-quality health and care research.

Through this partnership ULHT also accesses national and local resources and activities that support our organisation, staff, patients and service users to be research active. For example:

- Specialist training and workforce development
- Information systems to manage and report research
- Patient and public involvement and engagement initiatives
- Communications materials and expertise

Academic Research

Universities are a natural partner for the NHS in the pursuit of new knowledge through research. The relationships between academic institutions and NHS provider are key to realising research opportunities, through research programmes and clinical academic roles.

Within Lincolnshire we are lucky to have 2 academic institutions, both with relevant research interests and a desire to work more closely with ULHT.

The University of Lincoln research themes include 'Health and Wellbeing', and has experts leading multi-disciplinary studies. Potential areas of opportunity may lie with the Lincoln International Institute for Rural Health, the Community and Health Research Unit, the Diabetes Research Group at Lincoln, Image Engineering, Lincoln Medical School, the Lincoln nursing programmes and the Lincoln School of Pharmacy.

The Bishop Grosseteste University also has a suite of compatible interest areas, including Counselling, Children & Young people, Wellbeing & Resilience and Health & Social Care.

We can support academic research by facilitating students to develop their research skills as they conduct research as part of their qualification, or a more formal relationship can be demonstrated through the appointment of Clinical Academic posts. These are qualified doctors who combine working as a specialist doctor with research and teaching responsibilities with University partners.

Individuals aspiring to follow this path will be academic high achievers, with passion and drive to make new discoveries. They will need a higher degree, often achieving a PhD before consultant level.

These are exciting roles, but it is a very competitive field. Currently ULHT have few clinical academics with a research or teaching focus. This development pathway is not fully understood, or supported by the R&I Department. With plans to become a University Hospitals Teaching Trust, this is an area that the Trust is committed to addressing.

Workforce

A skilled clinical research delivery workforce is crucial to making research happen in the NHS. The delivery of high quality clinical research care requires clinical research nurses and midwives, allied health professionals, social care professionals, doctors, dentists and clinical research practitioners.

Alongside the development of a skilled academic research workforce, the NIHR provides a steer to invest in developing those with an interest in delivering research, but not necessarily wanting to become a clinical academic. This could include opportunities for those who may or may not have NIHR clinical research experience already, and should include the whole cross section of clinical staffing roles including pharmacists, radiographers, occupational therapists, nurses, midwives, doctors, physiologists, physiotherapists, radiotherapists, biomedical scientists and healthcare managers.

Regulation

Research in the NHS is well regulated by a number of bodies associated with the Department of Health & Social Care, these include the:

- **Health Research Authority** protects the interests of patients and the public by ensuring studies comply with relevant legislation and guidelines, and obtain approval and input from Ethics Committees and appropriate Advisory Groups.
- **Medicines and Healthcare products Regulatory Agency** protects and improves public health with responsibility for ensuring that medicines and medical devices meet applicable standards.
- **Human Tissue Authority** regulates organisations that remove, store and use human tissue for research.

Commercial Research

Commercial contract research undertaken in the NHS could be pharmaceutical clinical trials, biotechnology agents or medical devices. There are two main routes for commercially sponsored research to be placed at ULHT.

- Commercial sponsors are interested in sites that deliver what they say they will (usually complete data sets), within the timeframe that they say they will. They will develop a relationship with an NHS Trust, and will place future business with those that have performed well.
- The NIHR CRN work closely with industry partners to showcase the UK as the place to deliver research. Part of the service offering is to place studies with sites who will set up quickly and efficiently, in line with a nationally agreed costing template and utilising model contracts. Also delivering the number of participants as agreed and ensuring a high standard of data returns.

There has been growth in the number of commercial contract research conducted in the NHS over the last 10 years and work continues to reduce set up times to ensure increased pace of healthcare innovation.

NHS Providers are obliged to recover the full costs of any commercial contract research they undertake to avoid subsidising this with tax payer funds. This is achieved through use of the NIHR Industry Costing template, which agrees a study specific price.

Research Cost Attribution

As a core activity the NHS is committed to supporting a portfolio of commercially and non-commercially funded research. It is important that the cost of a research study is identified and properly funded.
The Department of Health & Social Care guidance “Attributing the cost of health and social care Research & Development (AcoRD) provides a framework to identify, attribute and recover the various costs associated with research in the NHS. Research studies go through a process of identifying component activities and attributing them to a ‘type’ of activity:

- Research Costs - the costs of the research itself that end when the research ends. They relate to activities that are being undertaken primarily to answer the research questions.
- NHS Treatment Costs - the patient care costs, which would continue to be incurred if the patient care service in question continued to be provided after the research study had stopped.
- NHS Support Costs - the additional patient care costs associated with the research, which would end once the research study had stopped, even if the patient care involved continued to be provided.

The application of these principles can be challenging, and the R&I community utilise ‘AcoRD Experts’ to assist with the attribution process. The attribution decision for a specific research-related activity is driven by the primary purpose of the activity, and works on the premise that the NHS bears the cost of caring for its patients even when they are involved in a research study.

Funding Streams

The funding of non-commercial research frequently involves a number of partner organisations which can introduce a degree of complexity. For non-commercial studies the normal funding streams for research are (broadly):

- Research costs are met by grant funders through the award of a research grant (for example through the NIHR, an NHS body, a Charity, a large Research Institute, a University or UK Research and Innovation).

- NHS Support costs are met by the Department of Health & Social Care budget, via the NIHR Clinical Research Network.

- NHS Treatment costs are met through normal commissioning process. In practice this means that the Commissioners support treatment activities through the NHS Tariff.

In addition, we might be asked to deliver research studies which are only part-funded or are un-funded, for example student research where no funds are transferred.

Excess Treatment Costs (ETCs)

A research study may deliver a patient care service that differs from standard treatment, and the associated NHS Treatment Costs may be less or may be greater. If greater, the difference is referred to as an Excess Treatment Costs, and these are attributed as Treatment Cost.

These are identified as part of a research funding application. The Chief Investigator is required to complete a Schedule of Events Cost Attribution Template (SoECAT) form. This form captures the different costs associated with the research and then calculates an average per patient ETC value for the study.

Studies identified as linked to specialised or NHS England's other direct commissioning functions may be asked to complete another template to finalise payable ETCs.

ETCs are paid to the recruiting research site and the payment due is calculated by multiplying the ETC per patient value by the number of study participants recruited there.

Each provider has an annual ETC threshold (ULHTs is circa £45,000) that must be reached before additional payments are made. When a provider has reached this threshold, ETC payments will then be made on a quarterly basis in arrears through the NIHR Local Clinical Research Networks.

The threshold does not apply to studies where NHS England is the responsible commissioner. Payments for these studies are made to the recruiting site directly by NHS England via the normal contractual route.

With regard to treatment costs after a study has ended, ethical approval requirements of the Health Research Authority mean that any post-trial funding arrangements will be determined before the trial begins.

For non-commercial research NHS England may provide continued funding for an on-going intervention after a trial. For commercially funded trials these arrangements are the responsibility of those commercial parties.

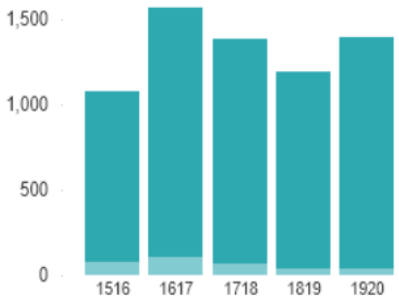
Where are we now?

Activity

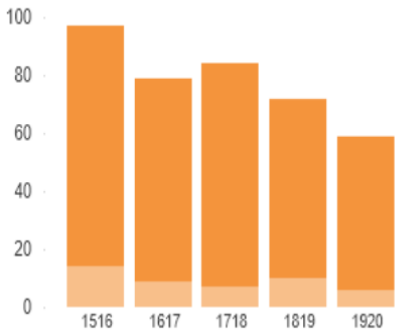
Research activity in the NHS can be difficult to measure consistently across organisations. Activities could include time to develop a grant application, time taken to share local information as part of site selection, setting up a study, screening and identifying potential participants, obtaining informed consent, treatment related activities, solving data queries, conducting follow up activities.

Most organisations use a proxy measurement for research activity, based on the NIHR Clinical Research Network High Level Objectives. In line with this approach, we will illustrate ULHTs performance over the last five years in terms of the number of Recruits (consent) into NIHR Portfolio studies and the number of active (recruiting) NIHR Portfolio studies.

Number of recruits



Number of studies

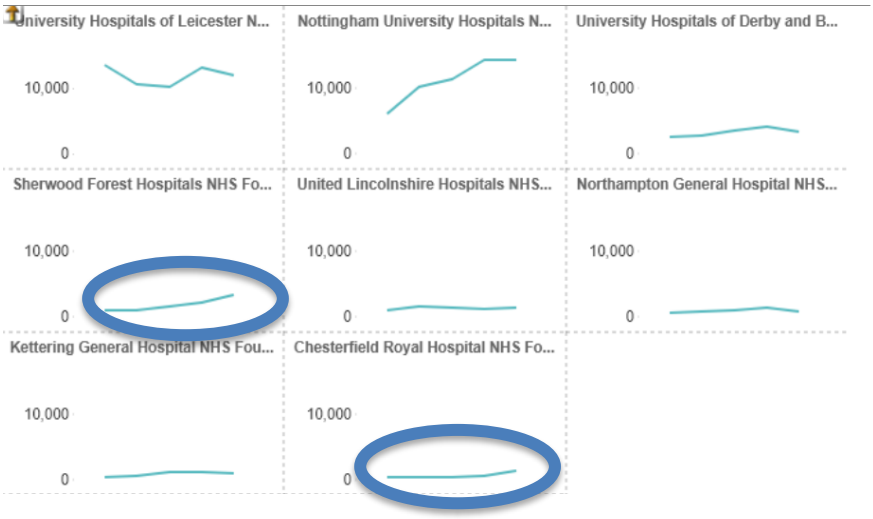


FY	Commercial recruits	Non-Commercial recruits	Total	Commercial studies	Non-Commercial studies	Total
1516	78	995	1073	14	83	97
1617	109	1454	1563	9	70	79
1718	69	1313	1382	7	77	84
1819	42	1152	1194	10	62	72
1920	37	1356	1393	6	53	59
Total	335	6270	6605	31	169	200

These recruitment figures present a broadly static picture, perhaps a dip in the number of studies recruiting in 2019-20 – but with some significant changes in staffing within the R&I department this impact is to be expected.

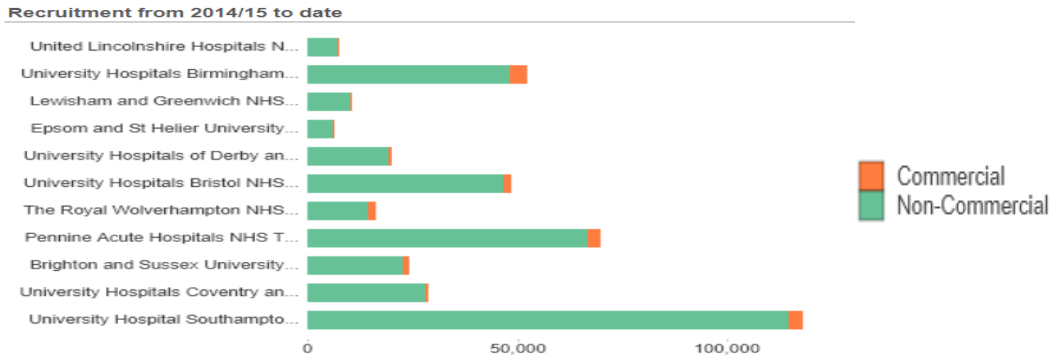
When considering the recruitment performance in the other acute settings within the East Midlands, it can be seen that some have been increasing the proportion of their recruitment contribution.

Recruitment by year 2015-16 to 2019-20



Tracking data back to the year 2014-15, we can see that from April 2014 to March 2019 ULHT has contributed 4.16% of the acute setting recruitment in the East Midlands (8388 recruits out of a total of 201,442 recruits from 8 acute settings).

When benchmarking ULHT research activity to 10 acute organisations similar in terms of hospital attendance, we can see that ULHT are not recruiting to the same levels:



The charts show the most similar organisations at the top, with similarity decreasing down the chart.

Department Governance

During 2019 Grant Thornton conducted an audit of the Research & Innovation Department, focussing on the potential risks:

- Research and development governance arrangements are not robust. Roles and responsibilities, management oversight, monitoring and reporting arrangements are not in place.
- Inadequate or non-compliance with the Trust's research and development policies and procedures which may lead to inefficient / ineffective processes, including:

- inadequate budget setting, oversight and monitoring
- under achievement of income targets
- inappropriate expenditure
- non-utilisation of grant funding, inappropriate grant expenditure and/or inaccurate grant submissions

The audit concluded a partial assurance with improvement required**,** recognising some moderate weaknesses in the existing controls. The recommendations are being addressed, with immediate action and further work built into the R&I Strategy.

Funding

Funding for the department comes from three funding streams:

- ULHT Trust investment - The direct Trust investment is restricted to posts within the Management and Leadership of the department.
- NIHR - The majority of the R&I Department staff funding comes from the CRN East Midlands. This funding is provided to support the delivery of non-commercial portfolio research, through a dedicated workforce and associated supporting services (in essence the provision of NHS Service Support as described in the AcoRD framework). The amount of funding allocated is driven by 'activity' in previous years. For year 2020-21 the amount of funding awarded by the CRN East Midlands has been £975,332.22.

  The NIHR also make a payment of "NIHR Research Capability Funding" (RCF), which aims to help research-active NHS organisations to act flexibly and strategically to maintain research capacity and capability.

  As ULHT successfully recruited "at least 500 individuals" to non-commercial studies, conducted through the NIHR-Clinical Research Network (CRN), during the previous NIHR CRN reporting period, we therefore received £20,000 RCF in 2020-21.
- Income generated by research activity - Following the recommendations of the recent department audit, work is underway with a Trust Management Accountant to understand the financial situation of the department, including its earned income.

Department Staffing

The R&I Department staff are enthusiastic and committed individuals. They are a hardworking team, passionate about what they do. Their positivity for their role is not currently reflected throughout the Trust, with research being seen as a 'nice to have', an 'add on' or even a 'burden' or 'cost pressure'.

The transformations happening within the Trust over the next five years are exactly the opportunity that the R&I Department needs to become visible and valued by staff and

patients.

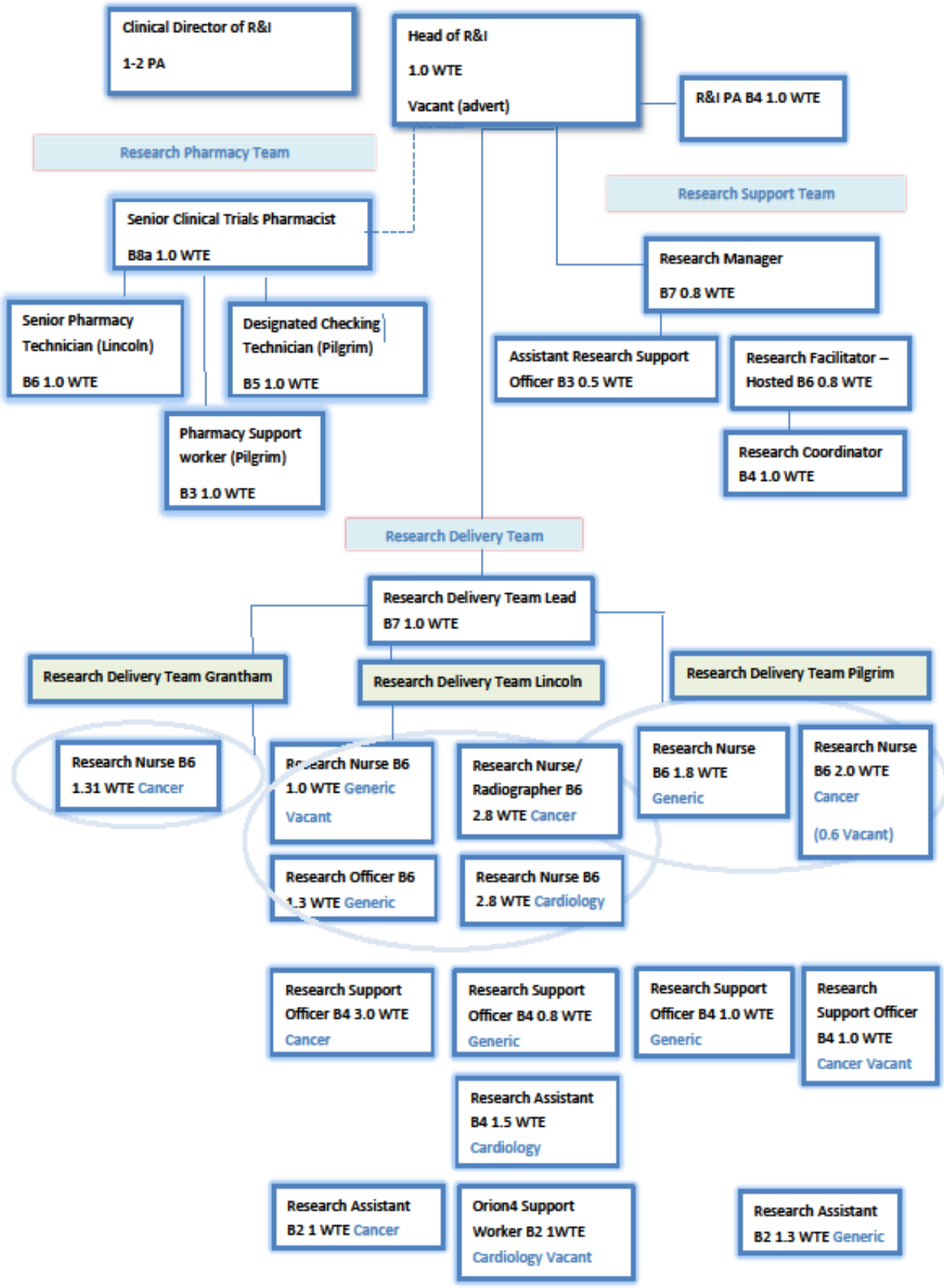
The department has undergone a period of instability, with a loss of leadership and management roles across the senior team of the department along with a reduction in other posts, team spirit has been eroded with individuals feeling undervalued.

The R&I Department currently consists of:

- a Support team (facilitating the set-up of research, sponsorship activities, data & reporting and department administration)
- a Research Delivery team (nurses, AHPs, Clinical Research Practitioners and administrators who support the delivery of research protocols within the Trust)
- a Research Pharmacy team (a pharmacist, technicians and a support worker who ensure that the pharmaceutical aspects of a clinical trial are managed properly, including dispensing, specialist handling and preparation)

The current structure of the department needs to be strengthened to achieve our vision. Currently the Support team lacks resource specifically around portfolio management, supporting professional development, relationships within the organisation, grant development and sponsorship (including specialist services like statistical support). Research Delivery will require growth to allow research to become part of the expected activities across the Trust. The current staffing levels (including vacancies) are:

Team	AFC Band	Number of individuals	WTE
Head	8c	1	1
Support	7	1	0.6
Support	6	1	0.8
Support	4	2	2
Support	3	1	0.5
Pharmacy	8a	1	1
Pharmacy	6	1	1
Pharmacy	5	1	1
Pharmacy	3	1	1
Delivery	7	1	1
Delivery	6	16	13.01
Delivery	4	8	7.3
Delivery	2	4	3.3
TOTAL		39	33.51


Clinical Director of R&I
1-2 PA
Head of R&I
1.0 WTE
Vacant (advert)
R&I PA B4 1.0 WTE
Research Pharmacy Team
Research Support Team
Senior Clinical Trials Pharmacist
B8a 1.0 WTE
Research Manager
B7 0.8 WTE
Senior Pharmacy Technician (Lincoln)
B6 1.0 WTE
Designated Checking Technician (Pilgrim)
B5 1.0 WTE
Assistant Research Support Officer B3 0.5 WTE
Research Facilitator – Hosted B6 0.8 WTE
Pharmacy Support worker (Pilgrim)
B3 1.0 WTE
Research Coordinator B4 1.0 WTE
Research Delivery Team
Research Delivery Team Lead
B7 1.0 WTE
Research Delivery Team Grantham
Research Delivery Team Lincoln
Research Delivery Team Pilgrim
Research Nurse B6
1.31 WTE Cancer
Research Nurse B6
1.0 WTE Generic
Vacant
Research Nurse/ Radiographer B6
2.8 WTE Cancer
Research Nurse
B6 1.8 WTE
Generic
Research Nurse
B6 2.0 WTE
Cancer
(0.6 Vacant)
Research Officer B6
1.3 WTE Generic
Research Nurse B6
2.8 WTE Cardiology
Research Support Officer B4 3.0 WTE
Cancer
Research Support Officer B4 0.8 WTE
Generic
Research Support Officer B4 1.0 WTE
Generic
Research Support Officer B4 1.0 WTE
Cancer Vacant
Research Assistant
B4 1.5 WTE
Cardiology
Research Assistant
B2 1 WTE Cancer
Orion4 Support Worker B2 1WTE
Cardiology Vacant
Research Assistant
B2 1.3 WTE Generic

The model of the Trust-wide Research Pharmacy has recently begun to transform from a very isolated team, to one more integrated with the Trust Pharmacy service. This allows the research pharmacy team to keep up their competencies in pharmacy whilst members of the pharmacy team are being trained in research activities.

The Support team are based at Lincoln County Hospital with the Delivery and Research Pharmacy teams working at three sites (Lincoln County Hospital, Pilgrim Hospital, and Grantham and District Hospital). Some members of the department will travel to any site to work, others remain at their base site. We have recently instigated monthly team meetings for all of the R&I Department to attend. Individual teams based at our sites also hold regular 'huddle' meetings.

Trust workforce involvement

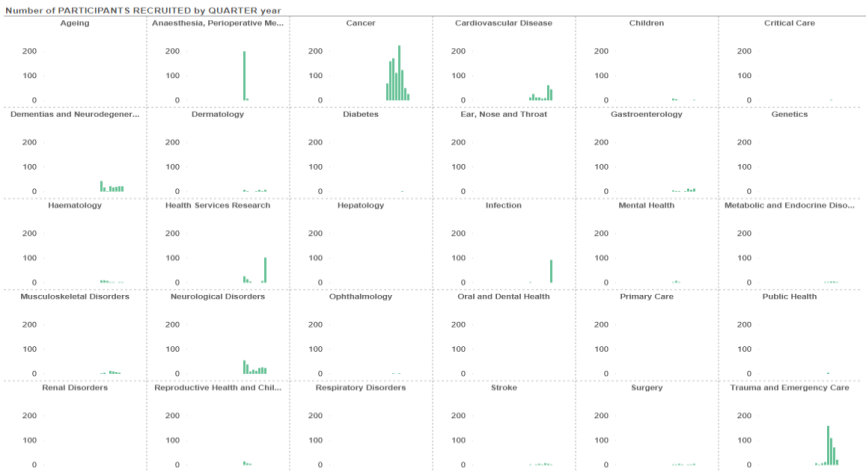
We currently hold Service Level Agreements with a number of supporting departments to secure their services to enable the delivery of research studies (for example Radiology, Pathology, Radiotherapy). The activities carried out tend to be NHS Treatment activities.

The Trust employs a handful of individuals who are active in seeking to obtain research grants and assume the role of Chief Investigator, in addition to their clinical role. The capacity to carry out these activities is met in an inconsistent way, with most fitting in these activities in their own time, some having time allocated in job planning.

We do not currently have any Chief Investigators actively delivering a study sponsored by ULHT with externally secured funding.

The Trust relies on a pool of around 50 Principal Investigators (PI) to deliver hosted research studies. The PI cover at each site varies and is impacted by the clinical service and personal interest. The funding structure to support PI time is inconsistent, with some receiving PA time for research, or research and audit, and others not. There is currently a lack of clarity around this within the R&I Department and the Trust. Most of our Principal Investigators are medics or surgeons.

Data split by the NIHR 30 clinical specialties for the years 2018-19 and 2019-20 shows significant activity levels in Cancer (including oncology and malignant haematology), Cardiovascular Disease and Trauma & Emergency.



There are opportunities for more NIHR Portfolio studies to be placed here at ULHT. The Portfolio is vibrant and active in all 30 of their speciality categories. The limiting factors for ULHT are:

- the availability of willing, interested and supported potential Principal Investigators
- the capacity of the R&I Delivery workforce to take on additional studies whilst balancing the current active work plus the follow up visits, data collection and queries
- the capacity of supporting services needed to deliver the protocol requirements
- the buy in from the Clinical Business Units to welcome the research and support it to deliver its outcomes

Facilities

The R&I facilities at the Lincoln County Hospital and Grantham & District Hospital sites are in a poor state of repair, with estate issues impacting upon the working environment. Recent Health & Safety audit findings noted leaking ceilings, cracked masonry, ruined carpets and impractical steps. The Pharmacy team have small areas of space allocated within Pharmacy, which pose a challenge ergonomically and in terms of storing vital research study files close to hand. While R&I provision at Pilgrim is very impressive - it is modern and well laid out. There is space for the whole team based in that location to work together in a department, with a small laboratory to process and store samples and clinic room in which to see patients.

Department SWOT

The key current Department SWOT is captured in this analysis:

Strengths	Weaknesses
Engaged, enthusiastic and skilled Principal Investigators	General low levels of awareness of and support for research
Good skill mix across the R&I Department	Lack of knowledge of research interests within the Trust
Pockets of significant research activity - Commercial Haematology and Cardiology portfolios are very strong	Geographical spread of the Trust - cost of replicating staffing across sites
Highly motivated R&I workforce	Out dated and inadequate departmental governance (including poor financial management processes)
	A lack of research inclusion in Doctors job planning and no robust link between research performance and appraisal process
	Heavy reliance on medical workforce to lead research

Opportunities	Threats
Chance to galvanise the department and Trust – including department restructure, review / develop key job descriptions Covid-19 has increased the profile of clinical research both nationally and locally Relationships growing with healthcare partners in the county of Lincolnshire Common interests with academics from both the University of Lincoln and the Bishops Grossette University Trust Executive team supportive of clinical research – in line with an aspiration to become a Teaching Hospital	Low confidence that activities completed are being are being invoiced for CRN activity driven funding model NHS England Excess Treatment Cost system approach means ULHT is unlikely to bring income in to support Excess Treatment Costs incurred as part of research (unless activity increases). A lack of formal succession planning for Principal Investigators of the future No clear feedback of research findings Low numbers of Chief Investigators and successful grants where ULHT is the lead

Development of the Strategy

The R&I Strategy and Vision have been developed through targeted, informal consultation with internal and external stakeholders (as listed in Appendix 1) including:

- Patients & service users through the Lincolnshire Research Patient & Public Forum
- Research management leaders from Lincolnshire (EMAS, LCHS and LPFT)
- Local Authority / Local Universities
- R&I Department staff / ULHT staff
- R&I Managers from other similar Trusts
- NIHR Clinical Research Network East Midlands

We have taken this document to the ULHT People & OD Committee. They have provided constructive feedback particularly around the need for measureable outputs and a cost impact.

We recognise that to consult with our stakeholders fully will take more time and have therefore separated the Strategy into two phases:

- Year one which will focus on putting the foundations in place internally and engaging in wider consultation with ULHT staff, patients and service users, academic institutions, other healthcare providers and the NIHR.
- Years two and three which will implement actions based on the objectives already developed, but with scope to build on the consultations conducted in Year one.

The initiatives and actions proposed for Year one mostly involve an investment of staff time, mainly within the R&I Department, however the actions will allow the Trust to have a better understanding of the current financial situation of the Department and a transparency around where the responsibility for defined costs actually sit.

During Years two and three there is likely to be a need for financial investment in the R&I initiatives proposed. These investments will be fully costed and approved, and will have measurable outputs described as part of the scoping work of each initiative prior to each kick off process.

Where do we want to be?

By 2024 supporting the delivery of research and innovation will be an expected part of working at ULHT. With patients across our healthcare system being given the opportunity to take part in high quality, relevant research.

Our Board, our leaders, our clinicians and supporting staff will be aware of research and innovation, and the findings of research and new innovations will be made available to the Trust in a timely fashion.

Our vision, strategically aligned to the ULHT Vision of “Outstanding Care, Personally Delivered” is:

Research and Innovation are embedded as part of our high quality, patient-centred care

What success looks like

In 2024 departmental leadership will be in place, with clear role and remit. The Leadership of our Department will be engaged with the Trust IIP and will network across the organisation and beyond, to ensure that we are leading and supporting the ULHT Excellence value with everything we do. The leadership will be accountable to the Executive Leadership Team via the Medical Director of ULHT, and will ensure that the Department continues to evolve to meet the Trust aspiration to become a University Hospitals Teaching Trust.

The R&I department will work together as a ‘team’ with a culture of ‘one’. Displaying behaviours that reflect trust, respect and cooperation. We will understand the purpose of our roles, and our contribution to the R&I Strategy and the vision of the Trust. We will feel valued and supported, with opportunities to develop and contribute to “Outstanding Care, Personally Delivered”. The R&I team will have adequate facilities to carry out its work in safety and comfort. With clear plans in place to develop a professional and modern space. Trust staff (including the R&I Department) will have access to appropriate research related learning and training opportunities. The Department will offer a range of services to support the development and delivery of research.

The R&I Department Governance will be robust, reporting into the Trust governance structure. Departmental Standard Operating Procedures and processes will be, up-to-date and fit for purpose, with all relevant staff aware of these.

The Department will have good visibility of its current financial position, and its forecast income and expenditure. There will be clarity around the split of earned income between the Principal Investigator and the R&I Department – with PIs having visibility of, and appropriate access to these funds. Those conducting 'Service Support Cost' activities will receive funding back to their Department.

The contribution of the Lincolnshire Research Patient & Public Forum is valued throughout the R&I Department. The Forum itself will be well supported, and linked to the Trust Patient Experience team, and similar Forums within the Lincolnshire region. The group has clear purpose, direction and outputs. The Chief Investigators of the Trust and Lincolnshire-wide stakeholders will value the contributions of the Forum to their design and delivery of research.

Staff, patients and service users of ULHT and the public of Lincolnshire will know that we are a research active organisation. There will be visual evidence of our commitment to research and innovation throughout the organisation. Staff members will hear about research during their induction period and regularly thereafter, during their early years of their careers and onwards.

The R&I Department and Clinical Business Units will support our researchers. Departments will work with students to support the delivery of research as part of an academic qualification; we will nurture those interested in research fellowships. Time spent supporting the delivery of research will be seen as part of a clinician's role, a valuable contribution and appropriately accounted for in workload planning.

Becoming a Principal Investigator will be celebrated as an example of excellence in contributing to innovation. Our research active clinicians will have time to perform their research activities.

Research will be valued by our clinical areas, with studies placed according to clinical need, and research findings available in a timely way.

The R&I department will have a knowledge of the research interests and aspirations of its staff members (including nurses, midwives, AHPs, medics and surgeons). A strong link developed with departments such as the Improvement Academy and the Audit and Service Evaluation team, allowing intelligence to develop around where people are seeking to understand and improve.

We will define a 'researcher pathway' which clearly indicates levels of involvement in clinical research from student research, to supporting the delivery of a hosted piece of research, to taking a lead on this, to fellowship pathways and developing unique research questions and securing funding to deliver this research. We will recognise where individuals are in terms of their research experience, and provide appropriate support.

For our researchers who aspire to secure grants and deliver their own research studies, the R&I Department and Clinical Business Units will ensure that time is given for this activity and that agreed outputs are seen through. It is recognised that securing research funding is highly competitive and we will ensure we are working to give our researchers the best possible chance at success.

The R&I department will offer a range of services to support our researchers tailored to where they are on the pathway and their professional group, with a goal of increasing chances of success.

In line with the national AcoRD guidance, the Trust will pay for the NHS Treatment costs incurred during a research study. This high-level agreement will increase the effectiveness of the study set up process, and will release CRN Infrastructure funding to increase the capacity of the R&I Delivery Team. Additional potential growth will be explored in recognition of the R&I Delivery & Pharmacy teams conducting NHS Treatment activities. We will understand if it is appropriate for the Trust to contribute a 'nursing establishment' to the Department.

The R&I department will be engaged in dialogue with the patients and service users of ULHT. We can be confident that we understand the level of opportunity to take part in research. With growth in our department and the research active specialties of the Trust, the patients of Lincolnshire will have an increased opportunity to take part in high quality clinical research.

Participants in research will feel valued and learn how their input has contributed to new knowledge, by receiving both a "thank you" and the results of the research.

We will network beyond our organisation borders to deliver research as a healthcare system. We will work closely with EMAS, LCHS and LPFT, seeking out common purpose and opportunity to improve what we do together. Our county-wide healthcare partners will be able to develop research with our full participation and support; and will know that areas of common purpose are being actively sought out, to ensure a joined up Lincolnshire response. We will also see past the traditional boundaries to ensure that patients or service users within our neighbouring healthcare providers can take part in studies that require input from the ULHT, in a streamlined and seamless fashion.

Our relationships with our academic partners are an indicator of our success in creating a research culture. Our research managers will be well linked and working towards common goals and to achieve clinical research strategic aspirations. Partnerships will develop between academics and clinicians across a broad range of subject areas, including clinical, social sciences and management studies. We will set up and deliver academic driven research in a timely fashion (both student and faculty staff). For our academic partners in Lincolnshire, they will feel confident that they can work with us to deliver their research endeavours in a streamline way.

Initiatives with the University of Lincoln will be critical to achieving our Trust ambition of becoming a University Hospital Teaching Trust. We will have preparations in place to satisfy the research criteria of becoming a University Hospital Teaching Trust.

We will be recognised as an engaged partner of the NIHR (including the Clinical Research Network and Research Design Service). The Clinical Research Network East Midlands will know us as a fully engaged partner in our joint activities. They will know that they can count on our input in network business and ULHTs contribution in terms of delivering NIHR Portfolio research effectively. They will be able to use initiatives in ULHT as an example of excellent practice to share with others. We will ensure that we provide perspective as part of the on-going partnership working.

How will we get there?

We are currently well underway with delivering some immediate improvements, tackling the most urgent departmental governance issues highlighted by the recent audit and changing the operations of the department in line with the pandemic situation.

We plan to transition from this short-term, reactive action to a more comprehensive and planned approach to growth and partnership. We will do this by planning to meet five Strategic Objectives. Our Year 1 measurable outcomes are detailed in Appendix 2.

Strategic Objective 1: Strengthen the R&I Department **The R&I Department will have the structure, direction, standards, development and working environment it deserves. Transforming it into a valued and recognised part of the ULHT, which can in turn improve patient care and develop the research workforce of the future.**
Our 3-year priorities • **Support Our Team** • **Improve Our Facilities** • **Department Governance (including Financial Integrity)** • **Raise Awareness** • **Demonstrating Clinical Relevance**
Year 1 2021 -2022
Priority: Support Our Team
Action Appoint to Departmental Leadership roles. **Expected Outcome** The Departmental Leadership will drive forward the Strategic development of R&I within ULHT.
Action Working with Organisational Development we will form as a team, getting to know each other and exploring ways of working together. **Expected Outcome** The R&I Department will develop relationships and understanding of each other's roles within the department and recognise opportunities for improvement.
Priority: Improve Our Facilities
Action Take immediate action and investment to make safe the facilities at Lincoln County

Hospital site.

Expected Outcome
Minimising the risk of staff coming to harm during the course of their work at ULHT.

Priority: Department Governance

Action
Establish the Departmental Governance flows by engaging fully in Trust governance – reporting upwards to the Quality Governance Committee with a Departmental Governance meeting.

Expected Outcome
Established lines of accountability internally and within the ULHT structure.

Action
The processes and SOPs associated with hosted research studies will be revised, ensuring they are robust and fit for purpose.

Expected Outcome
The department will be working to up-to-date, efficient and effective processes.

Action
We will roll out new financial processes across the department providing training and mentoring.

Expected Outcome
Well understood and transparent processes ensuring we can understand the potential cost implications and income associated with each study, and be assured that income streams due are being received.

Priority: Raising Awareness

Action
Working with the Trust Communication department develop a comprehensive communication plan including newsletters, Trust Induction, NIHR produced materials, posters, videos etc.

Expected Outcome
The plan will maximise reach of R&I communications, raising the profile of research within ULHT with research becoming visible to staff and patients within the hospitals. Interested individuals will be able to find information easily.

Year 2 2022 -2023

Priority: Support Our Team

Action
Conduct a consultation around the scope and roles within the Department to ensure we have the right roles for a modern, forward looking R&I department and make changes if necessary.

Expected Outcome Roles that are suitable for an effective R&I function, filled by well-trained and suitably skilled workforce.
Action Ensure individuals within the department receive training to give them the tools to drive forward the transformational change that the department needs. **Expected Outcome** An empowered workforce with the skills to undertake improvement that will have a beneficial impact on their work.
Priority: Improve Our Facilities
Action We will develop a business case (including an options appraisal and financial breakdown) to upgrade the accommodation at Lincoln County and Grantham and District Hospital sites. **Expected Outcome** Clarity around the potential options available and the cost implications.
Priority: Department Governance
Action The processes and SOPs associated with sponsored research studies will be refreshed to ensure they are robust and fit for purpose. **Expected Outcome** We will have the necessary SOPs in place to allow us to recommence the sponsorship of research.
Action Forecasting capabilities will be develop allowing a realistic picture of research income to be established. **Expected Outcome** An ability to make strategic investment into the R&I Department and the clinical specialties.
Priority: Raising Awareness
Action Develop our digital platforms, to ensure information is easy to find and up-to-date. **Expected Outcome** ULHT staff can easily access up to date information about the R&I services.
Priority: Demonstrate Clinical Relevance
Action Explore how to effectively access the findings of research studies and agree a process of informing others in ULHT.

Expected Outcome
Departments and stakeholders will be informed of the outcomes of the research they have supported.

Year 3 2023-2024

Priority: Support Our Team

Action
Appoint to any gaps remaining in the Department structure following the exercise conducted in year 2.

Expected Outcome
A Department with all appropriate staffing levels throughout the three teams.

Priority: Improve Our Facilities

Action
We will submit a business case to upgrade the accommodation at Lincoln County and Grantham and District Hospital sites.

Expected Outcome
The Department will hope to gain the support of the Trust Board to move to improved, adequate facilities.

Priority: Department Governance

Action
A training programme for prospective Chief Investigators will be developed and piloted.

Expected Outcome
Assurance that roles and responsibilities are clearly communicated and understood by potential Chief Investigators wishing ULHT to act as Sponsor for their research.

Action
Launch an initiative to invest NHS Service Support Costs back to the department that incurred the costs. Making a plan for the Departmental CRN budget to contain a line to support this scheme

Expected Outcome
Clinicians/departments who consent patients into research studies will receive the financial recognition due for this activity.

Priority: Raising Awareness

Action
Develop a research champion scheme to be piloted and rolled out through the ULHT

Expected Outcome
Within each CBU there will be Champions available to raise awareness of the research being conducted in that area, and provide a link to the R&I department.

Priority: Demonstrate Clinical Relevance

Action
Work with CBU leaders to develop a system to place research studies according to clinical priority and Lincolnshire health needs.

Expected Outcome
The Trust and our patients would receive true benefit from the research delivered at ULHT.

Strategic Objective 2: Build our capacity & capability
We will build the capacity and capability of our current and future workforce to embrace and actively engage with research and innovation. Encouraging participation from all professional groups.

Our 3-year priorities

- **Valuing Contributions**
- **Increasing Capacity**
- **Developing Capability**

Year 1 2021 – 2022

Priority: Valuing Contributions

Roll out the 'R&I Certificate Scheme' across the portfolio of research studies.

Expected Outcome
Staff will receive an award to celebrate their research delivery achievement, and show that we value their contribution.

Priority: Increasing Capacity

Action
Work to obtain agreement that Treatment Costs will be funded by the Trust / CBU (including investigational medicinal products). Ensuring awareness and understanding of the NHS England Excess Treatment Cost pilot with agreement to fund ETCs up to the point of the threshold (approx. £45,000 per annum).

Expected Outcome
Clarity around responsibilities for supporting activities associated with research in accordance with the costing framework for research studies (AcoRD). Effective set up of research studies and R&I Funding currently used to support Treatment Costs reinvested. Adherence to the NHS England pilot on improving research.

Action
We will hold a series of stakeholder listening events.

Expected Outcome
An opportunity for us to hear the barriers and enablers to getting involved in research. A set of ideas and issues can then be used to further develop plans for the development of R&I in ULHT.

Year 2 2022 – 2023
Priority: Valuing Contribution
Action Develop, pilot and roll out plans to say 'Thank you' to the ULHT staff who support specific research studies. In addition develop a mechanism to learn about and celebrate R&I related achievements. **Expected Outcome** Those who have given their time and skills will know that their efforts are recognised, celebrated and appreciated. Others will learn of the progressive actions of their colleagues and may become inspired.
Priority: Increasing Capacity
Action Work with the Director of Nursing to understand if R&I can make a case to the Trust for a nursing 'establishment' investment, to allow increased research delivery activity. **Expected Outcome** This commitment from the Trust would allow the Research delivery team to support more research studies.
Action Develop outputs from the stakeholder events into actions to support the growth of the research base, to include growth through CBUs and staff group. **Expected Outcome** A set of plans to begin to grow the involvement of researchers in the ULHT.
Year 3 2023 – 2024
Priority: Valuing Contributions
Action Explore opportunities to create links between CBU and R&I performance for individual researchers. **Expected Outcome** Research valued as part of individual roles / job plan and appraisals.
Priority: Developing Capability
Action Work with subject matter experts (for example the CRN East Midlands and the Association of Research Managers & Administrators) to develop and pilot a local training program to ensure that distinct groups of staff within the ULHT can develop the capabilities needed to perform their role in research and innovation.

Expected Outcome
A training offering for the research interested workforce.

Strategic Objective 3: Engage with the our patients, service users and the public
We will plan and nurture interactions with our patients and service users and the public of Lincolnshire to develop awareness of and engagement in clinical trials.

Our 3-year priorities

- **Understand opportunities to take part in research**
- **Participants valued and informed**
- **Integrate our Patient and Public Forum**

Year 1 2021 – 2022

Priority: Understanding opportunities

Action
Work with the Trusts Patient Experience team to access the results of the national patient surveys, specifically the data around opportunity to take part in research.

Expected Outcome
To understand how the Trust performs against the measure, and how other similar Trusts perform.

Priority: Integrate our Patient and Public Forum

Action
We will work with our Lincolnshire Research Patient and Public Forum to provide direction, structure and clarity for the group.

Expected Outcome
The Forum will feel well supported and recognise that their efforts are truly benefiting the research and innovation endeavours of ULHT. There will be a clear strong relationship between the Department and the Forum.

Year 2 2022 – 2023

Priority: Understanding opportunities

Action
Work with the Lincolnshire Patient and Public Forum and the Trust Patient & Public involvement group to plan a “Research Conversation” with the patients and service users of ULHT and develop a questionnaire to measure understanding of the value of being involved in clinical research.

Expected Outcome

The conversation will begin to give the R&I Department an insight into what our patients, service users and the public think of when it comes to 'research' and 'innovation'. It will also give us a baseline measurement of the understanding of the value of being involved in clinical research.

Priority: Participants valued and informed

Action

Develop and pilot plans to say 'Thank you' to the participants of research.

Expected Outcome

People who have given their time will know that their efforts are appreciated.

Priority: Integrate our Patient and Public Forum

Action

We will work with our Lincolnshire Research Patient and Public Forum to understand how we can best engage them in the development of ULHT Sponsored research.

Expected Outcome

An understanding of how logistically this would be most efficient from the Forums perspective.

Year 3 2023 – 2024

Priority: Understanding opportunities

Action

Work with the Lincolnshire Patient and Public Forum to analyse the topics/themes coming from our Research Conversation, and plan further actions to develop this work stream as necessary.

Expected Outcome

The outcome of this action will be a targeted plan to raise the profile and understanding of research and innovation with our patients, service users and public of Lincolnshire.

Priority: Participants valued and informed

Action

Investigate, develop and test a process of accessing the results of research studies we have participated in, and then share those with participants.

Expected Outcome

The Trust and our research participants will be aware of the findings of the studies we have been involved in, and will know that we place value on that contribution.

Priority: Integrate our Patient and Public Forum

Action

Agree a process for our Chief Investigators to best access the input of our Patient and Public Forum.

Expected Outcome

The Forum will be able to benefit the Chief Investigators of ULHT, by providing a lay

perspective to the design and development of research protocols.

Strategic Objective 4: Develop a strong Network
We will explore and strengthen relationships with local and regional partners, allowing synergies to develop and to collaborate with a system-wide focus to the benefit of the patients of the healthcare system in Lincolnshire.

Our 3-year priorities

- **Local NHS Healthcare providers**
- **Academic partners**
- **Other stakeholders**

Year 1 2021 – 2022

Priority: Local NHS Healthcare providers

Action
Continue to be an active partner in the regular meeting with the NHS organisations in Lincolnshire. Identify opportunities to support research across the patient pathway in Lincolnshire.

Expected Outcome
This forum is allowing the research office leaders from ULHT, LPFT, LCHS and EMAS to get to know and understand skills, strengths and their organisational drivers. Research studies will be delivered seamlessly across boundaries in true partnership. Giving patients and service users opportunities that would otherwise be unavailable to them.

Priority: Academic Partners

Action
Working with the University of Lincoln develop a Memorandum of Understanding on Joint Working for Effective Research Governance

Expected Outcome
This will allow academic research studies to move through set up in the most streamlined way possible.

Priority: Other Stakeholders

Action
We will proactively seek out and nurture relationships with local NIHR organisations (ARC, CRN and RDS) and the Academic Health Science Network.

Expected Outcome
Be well connected and able to identify any opportunities to benefit ULHT.

Year 2 2022 – 2023

Priority: Local NHS Healthcare providers

Action Together with LCHS, LPFT and EMAS agree a programme of work to improve research opportunity across Lincolnshire. **Expected Outcome** A plan of joint improvement projects that will be scheduled for kick off during year 3.
Priority: Academic Partners
Action Working with key departments at the 2 local Universities we will re-engage efforts to identify areas of interest which could benefit from a collaborative approach. **Expected Outcome** A plan of joint improvement projects that will be scheduled for kick off during year 3.
Action Develop a plan to increase Research Capability Funding to levels required as a University Hospital Teaching Trust status. **Expected Outcome** A clear direction around increase in activity needed for this purpose.
Year 3 2023 – 2024
Priority: Local NHS Healthcare Providers
Action Together with research leaders across Lincolnshire, deliver the projects identified in year 2. **Expected Outcome** Experience of working collaboratively on value adding projects.
Priority: Academic Partners
Action Work with the University to understand the requirements of the Research Evaluation Framework. **Expected Outcome** A solid understanding of how ULHT could support this requirement as a University Hospital Teaching Trust.
Action Prepare conversations with the University of Lincoln to allow the development of a joint research strategy once the Medical School is transferred to them **Expected Outcome** Foundation discussions in place to allow this collaboration when the time is appropriate
Strategic Objective 5: Develop a recognised Researcher Pathway

We will develop our offering to research interested staff members, forging a clear pathway from supporting delivery of clinical research, through becoming a Principal Investigator and on to aspiring Chief Investigators working to attract research grants. The Department will be aware of and support the research leaders of the future through their pathway.

Our 3-year priorities

- **Recognise**
- **Support**

Year 1 2021 – 2022

Priority: Recognise

Action

Conduct a survey of the ULHT workforce to identify areas of research interest and aspirations.

Expected Outcome

The R&I Department will have an awareness of which staff members are interested in research, at what 'level' they are at, and what areas of research they are interested in.

Priority: Support

Action

Explore with the NIHR 70@70 regional nurses (in particular Nottingham University Hospitals Trust) the potential to develop a programme which will support nurses, midwives and other AHPs to lead hosted and own research.

Expected Outcome

An opportunity to support our non-medical workforce to develop research aspirations, learning from those with robust experience in this area.

Year 2 2022 – 2023

Priority: Recognise

Action

Hold a stakeholder event to further explore with research interested staff how ULHT can support them in their research pathways.

Expected Outcome

This listening event will lead to the development of a plan to support the varied staff groups and experience levels to continue with their research journey.

Priority: Support

Action

Engage with the NIHR RDS and CRN East Midlands to ensure all opportunities for

workforce development are being recognised and accessed. **Expected Outcome** Our workforce will have the opportunity to access high quality workforce development specifically for researchers or research interested individuals.
Year 3 2023 – 2024
Priority: Recognise
Action Work with the ULHT Medical Education department to explore opportunities to introduce medical students to the delivery of clinical research. **Expected Outcome** The identification of potential areas to develop to allow trainees to think about clinical research delivery as part of their role within the NHS.
Priority: Support
Action Launch the programme of support developed through the R&I Listening event and the work with the NIHR 70@70 Nurses. **Expected Outcome** A number of initiatives to enable our staff members to become more research active.

How will we be monitored?

The development of the R&I Strategy is an agreed Improvement Scheme within the Trust Integrated Improvement Plan. Monitoring has been through the IIP route.

We anticipate that the delivery of the R&I Operational Action Plan will also be monitored through the Integrated Improvement Plan, with monthly oversight by the Executive Team chaired by the CEO.

Each Operational Action will have an identified lead and a delivery lead for each project. These will report regularly to the senior responsible officer (the Head of R&I).

In line with the R&I Operational Action Plan the Head of R&I will produce regular Performance Highlight Reports. These reports will report by exception, focussing on progress, sharing success stories and escalating risks and issues for intervention.

It is hoped that the R&I Strategy will be incorporated into the Trust annual plan from 21/22 onwards, this is a fantastic step towards integrating R&I into the core business of ULHT.

Appendix 1

Informal consultation

During the development of this Strategy many of the stakeholders of Research & Innovation in ULHT have been consulted. This has mostly taken place through discussion and utilising some formal survey results. The parties consulted have included:

- Research participants through the NIHR Patient Research Experience Survey
- Patients & service users through the Lincolnshire Research Patient & Public Forum
- Research management leaders from Lincolnshire (EMAS, LCHS and LPFT)
- Local Authority
- University of Lincoln
- Bishop Grosseteste University
- R&I Department staff
- ULHT staff (including members of the Executive Leadership Team, members of the Divisional Leadership Team and some ULHT Principal Investigators / Chief Investigators)
- R&I Managers from other similar Trusts
- NIHR Clinical Research Network East Midlands
- NIHR Research Design Service

During the first year of the Strategy formal consultation will be conducted through initiatives within all 5 Strategic Objective areas. These consultations will feed into initiatives designed for years 2 and 3 of the Strategy.

Appendix 2

Year 1 – Measurable Outcomes

Securing the Foundations for growth

Priority	What does 2024 look like?	Year 1 Initiatives	Year 1 Measurable Outcome	Cost implication
Strategic Objective 1: Strengthen the R&I Department ***The R&I Department will have the structure, direction, standards, development and working environment it deserves. Transforming it into a valued and recognised part of the ULHT, which can in turn improve patient care and develop the research workforce of the future.***				
Support Our Team	Departmental leadership is in place with clear role and remit. R&I work together as a 'team' with a culture of 'one'. Behaviours that reflect trust, respect and cooperation.	Develop the role descriptions for Head of R&I and Clinical equivalent, advertise, appoint and induct into role.	Head of R&I and Clinical Director of R&I appointed	No additional cost
		Working with the Organisational Development, we will undertake the "Building Respectful Teams" programme.	An improvement in the 'Pulse Check' staff survey (from survey taken at kick off of BRT project)	No additional cost
Improve Our Facilities	The R&I team has adequate facilities to carry out its work in safety and comfort.	Take immediate action and investment to make safe the facilities at Lincoln County	Trust Health & safety audit finds no shortcomings in the safety of the facilities.	Potential cost to make safe steps
Department Governance (including Financial Integrity)	The R&I Department will conduct its local Governance meeting that will report into the Trust governance structure. Departmental Standard Operating Procedures and processes will be robust, up-to-date and fit for purpose, with all relevant staff aware of these. The Department will have good visibility of its current financial position, and its forecast income and expenditure. There will be clarity around the split of earned income between the Principal Investigator and the R&I Department – with PIs having visibility of, and access to these funds. Those conducting 'Service Support Cost' activities will receive funding back to their Department.	Establish the Departmental Governance flows by engaging fully in Trust governance	R&I Report presented regularly at relevant Trust Committee meeting.	No additional cost
		Refresh the processes and SOPs associated with hosted research. SOPs approved through the Department Governance meeting and shared with appropriate staff.	100 % of R&I Department staff signed off against 100% of hosted SOPs.	No additional cost
		Roll out new financial processes across the department providing training and mentoring	100 % of R&I Department staff signed off against 100% of R&I Finance SOPs.	No additional cost
Raising Awareness	Staff, patient and service users of ULHT and the public of Lincolnshire will know that the ULHT is a research active organisation. There will be visual evidence of our commitment to research and innovation throughout the organisation. Staff members will hear about research during their induction period and regularly thereafter.	Develop a comprehensive communication plan to maximise reach of R&I communications (including newsletters, Trust induction, NIHR produced materials, posters, videos).	Plan in place and agreed through RIGG	£1,000 materials budget
		Develop a measure against this Objective. For example, work with the Trust to include a question around research awareness in the Staff Survey / Visual stocktake around the Trust.	Agree measure with Communication Department.	No additional cost
Demonstrating Clinical Relevance	Research will be placed according to clinical need. Research findings will be made available to the clinical areas that took part in those studies in a timely way.	NA	NA	NA

Strategic Objective 2: Build our capacity & capability ***We will build the capacity and capability of our current and future workforce to embrace and actively engage with research and innovation. Encouraging participation from all professional groups.***				
Valuing Contributions	The R&I Department will acknowledged Staff supporting the delivery of research. They will know that R&I and their CBU value their contribution.	Roll out the 'R&I Certificate Scheme' across the portfolio of research studies.	Increase in the number of Research Certificates issues to the staff of ULHT during the year 2021-22 (baseline taken in March 2021).	No additional cost
	Our research active clinicians will have time to perform their research activities. In line with the national AcoRD guidance, the Trust will pay for the NHS Treatment costs incurred during a research study. The R&I Department will give the CBU a potential cost / cost saving breakdown of each study taken forward. A high-level agreement to fund these costs will increase the effectiveness of the study set up process, and will release some CRN Infrastructure funding to increase the capacity of the R&I Delivery Team. In recognition that the R&I Delivery & Pharmacy teams conduct NHS Treatment activities, we will scope and understand if it is appropriate for the Trust to contribute a 'nursing establishment' to the Department.	Secure the agreement of the Trust to fund NHS Treatment Costs and Excess Treatment Costs (developing an indicative Cost Statement and process for confirming potential cost)	Agreement from the Executive Lead for Finance that the Trust will support the cost of the NHS Treatment costs incurred during research.	Potential cost of NHS Excess Treatment Costs up to £45,000
Developing Capacity			One year data of the NHS Treatment Cost / Saving resulting from Research to be reported to the Executive Lead for Finance.	No additional cost
		Throughout the year, hold a series of stakeholder listening events to understand the barriers to taking on research responsibilities.	Events held across all 4 Divisions with attendance from managers, administrators, medics, surgeons, nurses, midwives and other AHPs.	No additional cost – virtual platforms utilised This is likely to lead to costs in years two and three
Developing Capability	The Trust staff (including the R&I Department) will have access to appropriate learning and training opportunities. The R&I Department offer a range of services to support the development and delivery of research.	NA	NA	NA
Strategic Objective 3: Engage with our patients and service users ***We will understand our patients and service users opportunities to take part in research, we will plan and nurture interactions with our patients and service users, and take action to increase opportunity to become involved.***				
Understand opportunities to take part in research	The R&I department is engaged in dialogue with the patients and service users of ULHT. We can be confident that we understand patients opportunities to take part in research	We will gain access to the national NHS survey's to understand the current position of our organisation in terms of % of patients offered an opportunity to take part in research.	Report to the Trust the current position of patients offered a research opportunity.	No additional cost
Participants valued and informed	Participants in research studies will know that their contribution is valued by the Trust, and they will be made aware of the findings of the research study they took part in.	NA	NA	NA
Integrate our Lincolnshire Research Patient & Public Forum	The contribution of the Lincolnshire Research Patient & Public Forum is valued throughout the R&I Department. The Forum itself is well supported, and linked to the Trust Patient Experience team, and similar Forums within the Lincolnshire region. The group has clear purpose, direction and outputs. The Chief Investigators of the Trust and Lincolnshire-wide stakeholders will value the contributions of the Forum to their design and delivery of research.	Provide direction, structure and clarity for the Lincolnshire Research Patient & Public Forum.	Forum Terms of Reference, Role Description and PPIE Strategy developed and agreed by the Research & Innovation Governance Group.	Additional time invested by R&I Department Staff
Strategic Objective 4: Develop a strong Network ***We will explore and strengthen relationships with local and regional partners, allowing synergies to develop, shared interests to be developed and to collaborate with a system-wide focus to the benefit of the patients of the healthcare system in Lincolnshire. We will also prepare the foundations for an application to become a University Hospital Teaching Trust.***				

Local NHS Healthcare Providers	We will network beyond our organisation borders to deliver research as a healthcare system. We will work closely with EMAS, LCHS and LPFT. We will seek out common purpose and opportunity to improve what we do together.	Drive regular meetings with the NHS organisations in Lincolnshire. Through these, identify opportunities to support research across the patient pathway in Lincolnshire.	Number of studies delivered with an involvement from one of our neighbouring NHS Trusts.	No additional cost
Academic Partners	Our relationships with our academic partners are an indicator of our success in creating a research culture. We will work together to achieve each partners clinical research strategic aspirations, encourage partnerships between academics and clinicians, and setting up and delivering academic driven research in a timely fashion (both student and faculty staff research interests). Our relationship with the University of Lincoln will be critical to achieving our Trust ambition of becoming a University Hospital Teaching Trust. We will have preparations in place to satisfy the research criteria of becoming a University Hospital Teaching Trust.	Develop a Memorandum of Understanding on Joint Working for Effective Research Governance with the University of Lincoln.	MoU approved by both the Trust and the University.	No additional cost
Other Stakeholders	ULHT recognised as an engaged partner of the NIHR (including the Clinical Research Network and Research Design Service).	Develop a plan with the RDS to support the Trust to make successful grant applications.	Plan approved by the RIGG	No additional cost – but may lead to further costs in years two and three
		Ensure regular communication with the CRN.	Evidence of regular meetings throughout the year.	No additional cost
Strategic Objective 5: Develop a recognised Researcher Pathway ***We will develop our offering to research interested staff members, forging a clear pathway from supporting delivery of clinical research, through becoming a Principal Investigator and on to aspiring Chief Investigators working to attract research grants. The Department will be aware of and support the research leaders of the future through their pathway.***				
Recognise	The R&I department will have a knowledge of the research interests and aspirations of its staff members; these could be non-clinical staff, nurses, midwives, AHPs, medics or surgeons. We will also recognise where those individuals are in terms of their research experience. A strong link developed with departments such as the Improvement Academy and the Audit and Service Evaluation team, allowing intelligence to develop around where people are seeking to understand and improve.	Conduct a survey of the ULHT workforce to identify areas of research interest and aspirations.	Staff survey completed and analysed by the R&I Department.	No additional cost – will utilise Trust supported software to develop questionnaires
Support	We will define a 'researcher pathway' which clearly indicates levels of involvement in clinical research from student research, to supporting the delivery of a hosted piece of research, to taking a lead on this, to fellowship pathways and developing unique research questions and securing funding to deliver this research. The R&I department will offer a range of services to support our researchers tailored to where they are on the pathway and their professional group, with a goal of increasing chances of success.	Explore with the NIHR 70@70 regional nurses the potential to develop a programme which will support nurses, midwives and other AHPs to lead research	Indication from the NIHR if this is possible.	No additional cost – may lead to costs in years two and three

Meeting	Trust Board
Date of Meeting	3rd November 2020
Item Number	Item 12
Integrated Performance Report for September 2020	
Accountable Director	Paul Matthew, Director of Finance & Digital
Presented by	Paul Matthew, Director of Finance & Digital
Author(s)	Sharon Parker, Performance Manager
Report previously considered at	N/A

How the report supports the delivery of the priorities within the Board Assurance Framework	
1a Deliver harm free care	*X*
1b Improve patient experience	*X*
1c Improve clinical outcomes	*X*
2a A modern and progressive workforce	
2b Making ULHT the best place to work	
2c Well Led Services	*X*
3a A modern, clean and fit for purpose environment	*X*
3b Efficient use of resources	
3c Enhanced data and digital capability	
4a Establish new evidence based models of care	
4b Advancing professional practice with partners	
4c To become a university hospitals teaching trust	

Risk Assessment	*N/A*
Financial Impact Assessment	*N/A*
Quality Impact Assessment	*N/A*
Equality Impact Assessment	*N/A*
Assurance Level Assessment	*Insert assurance level* • *Limited*

Recommendations/ Decision Required	• *The Board is asked to note the current performance. The Board is asked to approve action to be taken where performance is below the expected target.*

Executive Summary

Quality

Falls with Harm

There have been 2 falls resulting in moderate harm and 1 fall resulting in death this month. These incidents are being investigated in line with Trust policy and work is underway as described in the exception report to ensure that the Trust is able to engage and involve teams to promote early learning, sharing and changes in practice.

Serious Incidents

The number of Serious Incident investigations open within the Trust has been steadily increasing throughout the 2020/21 financial year to date. The Trust declared 21 Serious Incidents in September, 7 actually occurred in September, 8 in August and the remainder in April, June and July. All of the incidents are under active investigation and any themes will be taken to the Patient Safety Group for further discussion and analysis.

Mortality

1.SHMI
SHMI is above the 100 target at 108.92 based on the most recent period available (March 2019 to March 2020), increasing from the previous reporting period but is 'within expected limits'. SHMI includes both deaths in-hospital and within 30 days of discharge but will not be including COVID-19 deaths. In hospital SHMI is 96.07 and is below threshold limits.

2.HSMR

HSMR for the financial year is showing above the expected at 102.26 for the Trust which is in expected limits.

Clinical Audit and Effectiveness

National Audit Participation Rate

Performance against this metric has been impacted by COVID-19 and the resulting changes to national data collections and cancellation of elective procedures. However performance for September 2020 has improved and is currently at 95% against a trajectory of 98%.

eDD within 24 hours

The Trusts compliance of sending eDDs within 24 hours for September 2020 was 93.1%. Compliance for eDDs sent anytime in August was 96.3%. Of the 3538 admissions, 130 eDD's have not been sent.

Sepsis

Intravenous antibiotics within an hour (Paediatric ED)

Compliance for intravenous antibiotics for children in ED has fallen for September to 71.4% (5 out of 7) against a trajectory of 90%. The harm reviews undertaken for those children who did not receive a screen have revealed no harms or concerns. The escalation report identifies further actions that are being taken within the ED's.

Operational Performance

On 5th March 2020, in response to the Covid-19 pandemic, the Trust enacted the Pandemic Flu plan and elements of the Major Incident Plan and put in place Command and Control systems. This response continued until 1st August when nationally the national Emergency Response Level was reduced to Level 3. This signified the start of the Recovery Phase of the response to Covid-19 pandemic.

Operational performance for the periods of August-Sept where data is available reflects the Recovery Phase where services are being reinstated as part of this Phase 3 Recovery programme. From August 1st this recovery commenced with ambitions to returning to pre-Covid-19 levels of waiting lists, response times and constitutional standards, in line with expectations as set out in Sir Simon Stevens' letter of 31st July 2020.

A & E and Ambulance Performance

4-hour performance for September was 75.27%, against a trajectory of 71.72%, achieved against a backdrop of slightly reduced demand in September ED attendances. The Trust is performing above the pre-Covid-19 target trajectory and has done for the last five months. Performance remains stronger than 2019 levels at 8% better position. ED triage performance improved slightly by 1.28% to 87.39% compared to 86.11% in August; it continues to be above the mean performance and well within control limits. Measures are in place to ensure this metric achieves its improvement trajectory.

During Sept there were 250>59-minute ambulance handover delays across the Trust, a deterioration from August's position of 194, despite a 3.99% reduction in conveyances across all sites. Amongst load sharing strategies handover and alternative pathway, RAT has been reinstated and the Trust has been successful in securing £17million to increase the footprint of both LCH and PHB Emergency Departments, to ensure environments are fit for purpose and safely deliver care in socially distanced spaces. NHSE/I are supporting improvement strategies including further engagement with the System to reduce overall ambulance conveyances.

Referral to Treatment

RTT performance for August was 51.16% compared to 47.33% in July. The Trust reported 269 incomplete 52 week breaches for August end of month. Root cause analysis and harm reviews have not indicated any concerns with patients coming to harm, however as the number of delays increases risk stratification and prioritisation will becomes more and more important. Regionally ULHT continue to have proportionately few 52 week delays representing the work undertaken by teams with telephone and e-consultations, however this number is likely to continue to rise until recovery plans start to take effect in September/October in line with recovery plans and implementation.

Waiting Lists

Overall waiting list size has increased from July to August with the total waiting list increasing by 1727 to 44,033, compared to an increase of 2725 from June to July. Original trajectories forecasting the impact of Covid-19 forecast a much greater increase, and so in future months with some services being Restored and the impact of the Recovery plans from September this increase is likely to start to reduce at the end of September. New trajectories are being developed in line with the Recovery phase.

Diagnostics

Diagnostics access performance for September (56.98%) has improved compared with August(52.81%). With restoration of endoscopy, now booking cancer patients within 7-10days and imaging capacity, modelling continues to demonstrate a strong recovery against key Recovery Targets (CT and MRI). The hire of the mobile MRI to support continued improvement through the Recovery Phase has been extended and whilst the CT modular unit failed to be deployed as planned in September at Pilgrim, it is now installed and provides resilience to the existing scanner at Pilgrim although other modalities and diagnostic services are not expected

to fully recover until much later in the year as focus remains on Urgent Care and clinically urgent patients.

Cancer
As forecast in last month's report the 62 Day classic performance for August deteriorated (by 6.1%), with performance at 68.9% compared to 75.0% in July, owing to the ongoing focus on backlog clearance, putting us below the national average. 2 Week Wait performance was 80.83% (against a 93% target).

Backlog number of patients waiting more than 62 and 104 days remains a priority and is part of Covid-19 Recovery phases. September has shown a continued reduction in 104+ numbers from 70 at the end of August, to 36 by the end of September (from a peak of 163 in mid-July). Colorectal cancer capacity remains a challenge and accounts for approx. 50% of long waiting patient. 31 day 1st treatment was maintain in August although remains below the target of 96% and was predominantly affected by Covid and reductions in capacity owing to social distancing combined with an ongoing reluctance of a high number of patients who were unfit or unwilling to engage with the NHS at this time.

Workforce

Pay, Bank & Agency
September's substantive pay is lower than the usual run rate by £7m.This is because we were accruing a notional employers' pension contribution which was reversed out M1-5 in M6 at NHSI's request. This has impacted the pay variance figure this month and, if this were discounted, the figure would remain around 10%.

Phase 3 planning requires delivery of our existing recruitment plans and more to create the increased capacity required. This is a significant risk, particularly where recruitment pathways are less well-defined (outside medical and nursing). The risk is that we will either not deliver the service capacity required, or agency spend will increase. The mitigation is that we pay increased attention to recruitment in CSS in particular.

Overall agency spend is significantly below levels in July and those seen in September 2019. Medical agency spend in September was £1.7m. Spend in August was actually at a similar level, but this was adjusted by £290k of release from shifts not actually worked in previous months. These though are the lowest monthly spend figures in 28 months.

Medical bank is now at 40%, a continuous upward trend which is reducing the agency bill, savings above starting position of 20% bank with all costs removed are now at £237,000.

Vacancies & Turnover
September has seen a reduction in vacancy rates at Trust level and across the three key areas of medical, nursing and AHPs. The increase in August, caused by data issues for the medical workforce in July and August, has reversed and the overall downward trend continues.

However, the medical vacancy rate in September is at the highest level since January however, largely because of increases in establishment.

We are starting work on a programme of medical workforce transformation. We need to look at the construct of the medical workforce if we are to resolve the challenges of vacancy rates and levels of agency spend.

Overall turnover is at around 10% and we are no long on the NHSE/I watch list for turnover.

Sickness Absence
The number of staff absent due to COVID reasons remained low in September, but has started to rise at the beginning of October – more prevalence in the community + impact of school children being asked to isolate

The Attendance Management System has successfully gone live with our first 2 Cohorts – corporate back office staff not in Healthroster and ICT. As agreed by the Executive Team we are aiming to achieve full implementation by the new year with Surgery, CSS, Estates & Facilities and Outpatients Lincoln and Louth scheduled for go live in mid-November.

Appraisals
There has been a sharp rise in the percentage of appraisals completed in August and September, following the action taken to tackle the issue – all managers required to give dates when appraisals will be completed.

Core Learning
Compliance rate for Core Learning was consistently above 90%, but dipped when COVID impacted the organisation. From a low point in June, the rate has started to rise again. The Trust achieved the 95% compliance rate for IG training during September.

Paul Matthew
Director of Finance & Digital
October 2020

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NHS United Lincolnshire Hospitals NHS Trust

PERFORMANCE OVERVIEW

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	Jul-20	Aug-20	Sep-20	YTD	YTD Trajectory	Latest Month Pass/Fail	Trend Variation	Kitemark
Deliver Harm Free Care	Clostridioides difficile position	Safe	Patients	Director of Nursing	9	6	7	8	41		P		
	MRSA bacteraemia	Safe	Patients	Director of Nursing	0	0	0	0	1		P		
	MSSA bacteraemia cases counts and 12-month rolling rates of hospital-onset, using trust per 1000 bed days formula	Safe	Patients	Director of Nursing	TBC	0.04	0.04	0.02	0.06				
	E. coli bacteraemia cases counts and 12-month rolling rates, per 1000 bed days formula	Safe	Patients	Director of Nursing	TBC	0.04	0.18	0.01	0.07				
	Never Events	Safe	Patients	Director of Nursing	0	0	1	0	1		P		Timeliness, Completeness, Validation, Process
	New Harm Free Care	Safe	Patients	Director of Nursing	99%								Timeliness, Completeness, Validation, Process
	Pressure Ulcers category 3	Safe	Patients	Director of Nursing	4.3	3	3	1	9		P		
	Pressure Ulcers category 4	Safe	Patients	Director of Nursing	1.3	0	0	0	1		P		Timeliness, Completeness, Validation, Process
	Pressure Ulcers - unstageable	Safe	Patients	Director of Nursing	19/20 will be used as a benchmark	9	7	4	30				
	Summary Hospital Mortality Indicator (SHMI) (rolling year data 6 month time lag)	Effective	Patients	Medical Director	100	108.42	107.56	108.92	109.04		F		
	Hospital Standardised Mortality Ratio - HSMR (rolling year data 3 month time lag)	Effective	Patients	Medical Director	100	95.73	100.90	102.26	97.37		F	A	
	Sepsis screening (bundle) compliance for inpatients (adult)	Safe	Patients	Director of Nursing	90%	86.50%	91.20%	90.10%	86.82%		P		
	Sepsis screening (bundle) compliance for inpatients (child)	Safe	Patients	Director of Nursing	90%	86.30%	93.30%	95.90%	89.27%		P		
	IVAB within 1 hour for sepsis for inpatients (adult)	Safe	Patients	Director of Nursing	90%	94.00%	92.60%	90.90%	92.42%		P		
	IVAB within 1 hour for sepsis for inpatients (child)	Safe	Patients	Director of Nursing	90%	90.00%	100.00%	100.00%	87.50%		P		

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5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	Jul-20	Aug-20	Sep-20	YTD		Latest Month Pass/Fail	Trend Variation	Kitemark
Deliver Harm Free Care	Sepsis screening (bundle) compliance in A&E (adult)	Safe	Patients	Director of Nursing	90%	94.11%	91.70%	94.30%	93.02%		P	A	
	Sepsis screening (bundle) compliance in A&E (child)	Safe	Patients	Director of Nursing	90%	100.00%	88.10%	90.60%	91.23%		P	A	
	IVAB within 1 hour for sepsis in A&E (adult)	Safe	Patients	Director of Nursing	90%	97.30%	97.50%	96.40%	96.37%		P		
	IVAB within 1 hour for sepsis in A&E (child)	Safe	Patients	Director of Nursing	90%	100.00%	100.00%	71.40%	95.23%		F		
	Rate of stillbirth per 1000 births	Safe	Patients	Director of Nursing	4.20	2.59	2.39	2.39	2.16		P	B	
	Number of Serious Incidents (including never events) reported on StEIS	Safe	Patients	Director of Nursing	14	14	17	21	85		F		Timeliness, Completeness, Validation, Process
	Catheter Associated Urinary Tract Infection	Safe	Patients	Director of Nursing	1				0				
	Falls per 1000 bed days resulting in moderate, severe harm & death	Safe	Patients	Director of Nursing	0.19	0.15	0.18	0.11	0.15		P		Timeliness, Completeness, Validation, Process
	Reported medication incidents per 1000 occupied bed days	Safe	Patients	Medical Director	4.3	5.10	6.26	5.50	5.14		P	B	
	Medication incidents reported as causing harm (low /moderate /severe / death)	Safe	Patients	Medical Director	10.7%	12.60%	10.40%	13.60%	13.58%		F		
	Potential under reporting of patient safety incidents / Reported incidents (all harms) per 1,000 bed days	Safe	Patients	Medical Director	30	37.80	36.86	34.03	36.53		P		
	Patient Safety Alert compliance (number open beyond deadline)	Safe	Patients	Medical Director	0	0	0	0	2		P		
	National Clinical audit participation rate	Effective	Patients	Medical Director	98%	89.00%	93.00%	95.00%	92.67%		F		
	7 day Services Clinical Standard 2 (all patients have a Consultant review within 14 hours of admission)	Effective	Patients	Medical Director	90%	Not Collected audit done twice a year							
	7 day Services Clinical Standard 8 (ongoing review)	Effective	Patients	Medical Director	90%	Not Collected audit done twice a year							
	Venous Thromboembolism (VTE) Risk Assessment	Safe	Patients	Medical Director	95%	98.30%	98.10%	97.60%	97.13%		P		
	eDD issued within 24 hours	Effective	Patients	Medical Director	95%	90.00%	93.20%	93.10%	93.87%		F		

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5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	Jul-20	Aug-20	Sep-20	YTD	YTD Trajectory	Latest Month Pass/Fail	Trend Variation	Kitemark
A Modern and Progressive Workforce	Overall percentage of completed mandatory training	Safe	People	Director of HR & OD	95%	88.95%	88.96%	89.49%	89.01%		F		
	Number of Vacancies	Well-Led	People	Director of HR & OD	12%	11.88%	12.74%	12.43%	12.51%		F		
	Sickness Absence	Well-Led	People	Director of HR & OD	4.5%	5.07%	5.02%	5.00%	5.02%		F	A	
	Staff Turnover	Well-Led	People	Director of HR & OD	12%	10.80%	10.73%	10.76%	10.89%		P		
	Staff Appraisals	Well-Led	People	Director of HR & OD	90%	68.52%	70.86%	75.91%	70.56%		F		
					£'000	£'000	£'000	£'000	£'000				
	Agency Spend	Well-Led	People	Director of HR & OD	TBC	-£3,674	-£3,060	-£3,163	-£19,918				

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	Jul-20	Aug-20	Sep-20	YTD		Latest Month Pass/Fail	Trend Variation	Kitemark
Improve Patient Experience	Mixed Sex Accommodation breaches	Caring	Patients	Director of Nursing	0	0	0	0	0		P		Timeliness, Completeness, Validation, Process
	% Triage Data Not Recorded	Effective	Patients	Chief Operating Officer	0%	0.15%	0.82%	0.40%	0.32%		F		
	Duty of Candour compliance - Verbal	Safe	Patients	Medical Director	100%	82.00%	100.00%		89.40%		P		
	Duty of Candour compliance - Written	Responsive	Patients	Medical Director	100%	71.00%	100.00%		81.40%		P		

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5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	Jul-20	Aug-20	Sep-20	YTD	YTD Trajectory	Latest Month Pass/Fail	Trend Variation	Kitemark
Improve Clinical Outcomes	4hrs or less in A&E Dept	Responsive	Services	Chief Operating Officer	71.72%	82.37%	78.46%	75.27%	83.70%	69.72%	P		
	12+ Trolley waits	Responsive	Services	Chief Operating Officer	0	0	0	0	0	0	P		
	%Triage Achieved under 15 mins	Responsive	Services	Chief Operating Officer	88.5%	93.03%	86.12%	87.39%	92.17%	88.50%	F	A	
	52 Week Waiters	Responsive	Services	Chief Operating Officer	0	149	269		486	0	F		
	18 week incompletes	Responsive	Services	Chief Operating Officer	84.1%	47.33%	51.16%		57.42%	84.10%	F	L	
	Waiting List Size	Responsive	Services	Chief Operating Officer	37,762	42,306	44,033		n/a	n/a	F		
	62 day classic	Responsive	Services	Chief Operating Officer	85.4%	75.00%	68.89%		70.30%	85.39%	F		
	2 week wait suspect	Responsive	Services	Chief Operating Officer	93.0%	98.74%	80.83%		90.17%	93.00%	F		
	2 week wait breast symptomatic	Responsive	Services	Chief Operating Officer	93.0%	74.15%	29.55%		70.26%	93.00%	F		
	31 day first treatment	Responsive	Services	Chief Operating Officer	96.0%	92.37%	92.37%		94.91%	96.00%	F		
	31 day subsequent drug treatments	Responsive	Services	Chief Operating Officer	98.0%	98.25%	96.72%		97.73%	98.00%	F		
	31 day subsequent surgery treatments	Responsive	Services	Chief Operating Officer	94.0%	90.38%	87.18%		87.66%	94.00%	F		
	31 day subsequent radiotherapy treatments	Responsive	Services	Chief Operating Officer	94.0%	94.74%	88.68%		93.49%	94.00%	F		
	62 day screening	Responsive	Services	Chief Operating Officer	90.0%	0.00%	0.00%		18.75%	90.00%	F	?	

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NHS United Lincolnshire Hospitals NHS Trust

PERFORMANCE OVERVIEW

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	Jul-20	Aug-20	Sep-20	YTD	YTD Trajectory	Latest Month Pass/Fail	Trend Variation	Kitemark
Improve Clinical Outcomes	62 day consultant upgrade	Responsive	Services	Chief Operating Officer	85.0%	79.87%	86.21%		80.80%	85.00%	P		
	Diagnostics achieved	Responsive	Services	Chief Operating Officer	99.0%	57.89%	52.81%	56.98%	50.71%	99.00%	F	?	
	Cancelled Operations on the day (non clinical)	Responsive	Services	Chief Operating Officer	0.8%	1.00%	1.16%		1.23%	0.80%	F		
	Not treated within 28 days. (Breach)	Responsive	Services	Chief Operating Officer	0	0	5		61	0	F		
	#NOF 48 hrs	Responsive	Services	Chief Operating Officer	90%	90.63%	94.74%		87.91%	90%	P		
	#NOF 36 hrs	Responsive	Services	Chief Operating Officer	TBC	78.13%	80.26%		73.72%				
	EMAS Conveyances to ULHT	Responsive	Services	Chief Operating Officer	4,657	4,700	4,688	4,501	4,370	4,657	P	B	
	EMAS Conveyances Delayed >59 mins	Responsive	Services	Chief Operating Officer	0	81	194	250	111	0	F	B	
	104+ Day Waiters	Responsive	Services	Chief Operating Officer	5	116	70	36	429	30	F		
	Average LoS - Elective (not including Daycase)	Effective	Services	Chief Operating Officer	2.80	3.38	2.19	2.63	2.91	2.80	P		
	Average LoS - Non Elective	Effective	Services	Chief Operating Officer	4.50	4.37	4.35	4.53	4.07	4.5	F		
	Delayed Transfers of Care	Effective	Services	Chief Operating Officer	3.5%	Submission suspended			3.13%	3.5%			
	Partial Booking Waiting List	Effective	Services	Chief Operating Officer	4,524	19,789	21,853	22,738	19,955	4,524	F	H	
	Outpatients seen within 15 minutes of appointment	Effective	Services	Chief Operating Officer	70.0%	33.3%	41.9%	37.1%	37.02%	70.00%	F		
	% discharged within 24hrs of PDD	Effective	Services	Chief Operating Officer	45.0%	34.8%	36.2%	38.2%	36.86%	45.00%	F		

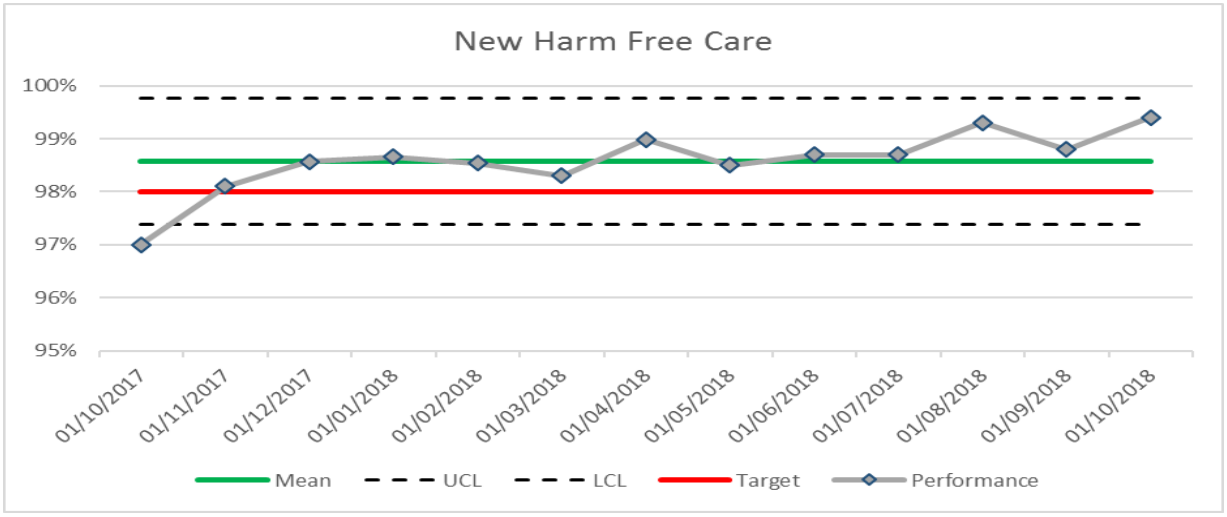
STATISTICAL PROCESS CONTROL CHARTS

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:



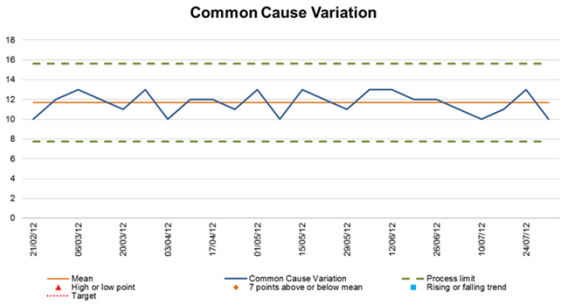
Normal variations in performance across time can occur randomly- without a direct cause, and should not be treated as a concern, or a sign of improvement, and is unlikely to require investigation unless one of the patterns defined below applies.

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

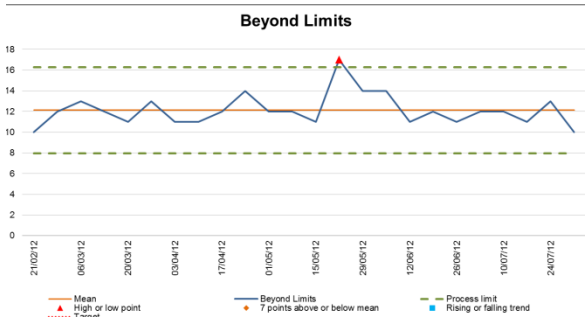
- Normal variation – (common cause) fluctuations in data points that sit between the upper and lower control limits
- Extreme values – (special cause) any value on the line graph that falls outside of the control limits. These are very unlikely to occur and where they do, it is likely a reason or handful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

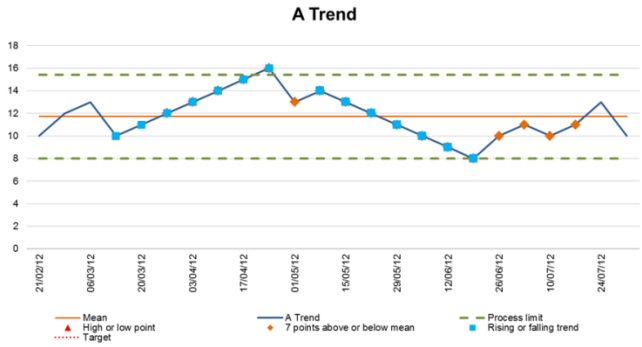


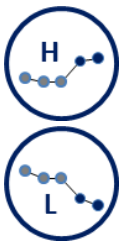
Extreme Values



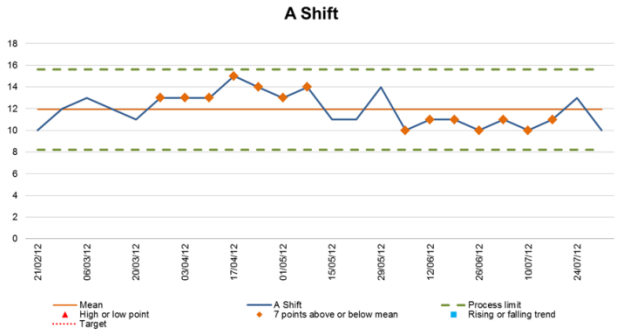
There is no Icon for this scenario.

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

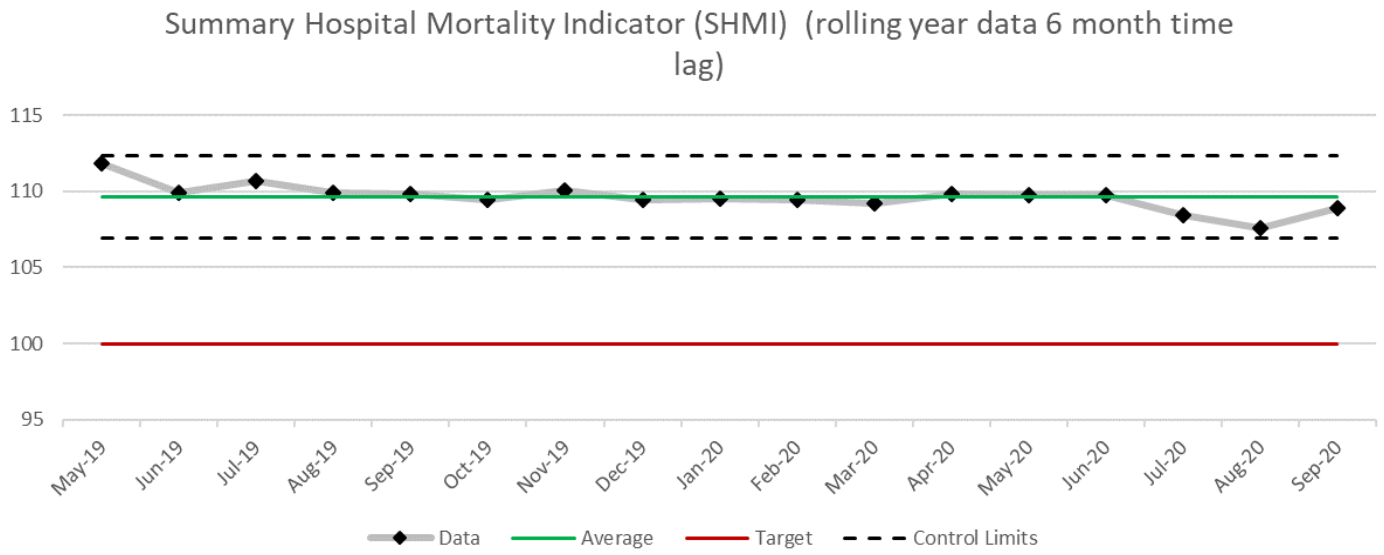
Where the target has been missed for at least 3 of the most recent data points in a row, or in a string of 7 of the most recent data points, at least 5 out of the 7 data points have missed.

DELIVER HARM FREE CARE – MORTALITY SHMI

Executive Lead: Medical Director

CQC Domain: Effective

Strategic Objective: Patients



Challenges/Successes

ULHT are in Band 2 within expected limits with a score of 108.92, an increase from the last reporting period. SHMI includes both deaths in-hospital and within 30 days of discharge. The data is reflective up to March 2020.
Current in-hospital SHMI is 96.07 and is below threshold limits.
Alerts:
Pneumonia: alerting on 'all deaths'. This is the second month alerting.
Acute Myocardial Infarction: alerting on 'all deaths' and 'in hospital deaths' for the first month.

Actions in place to recover:

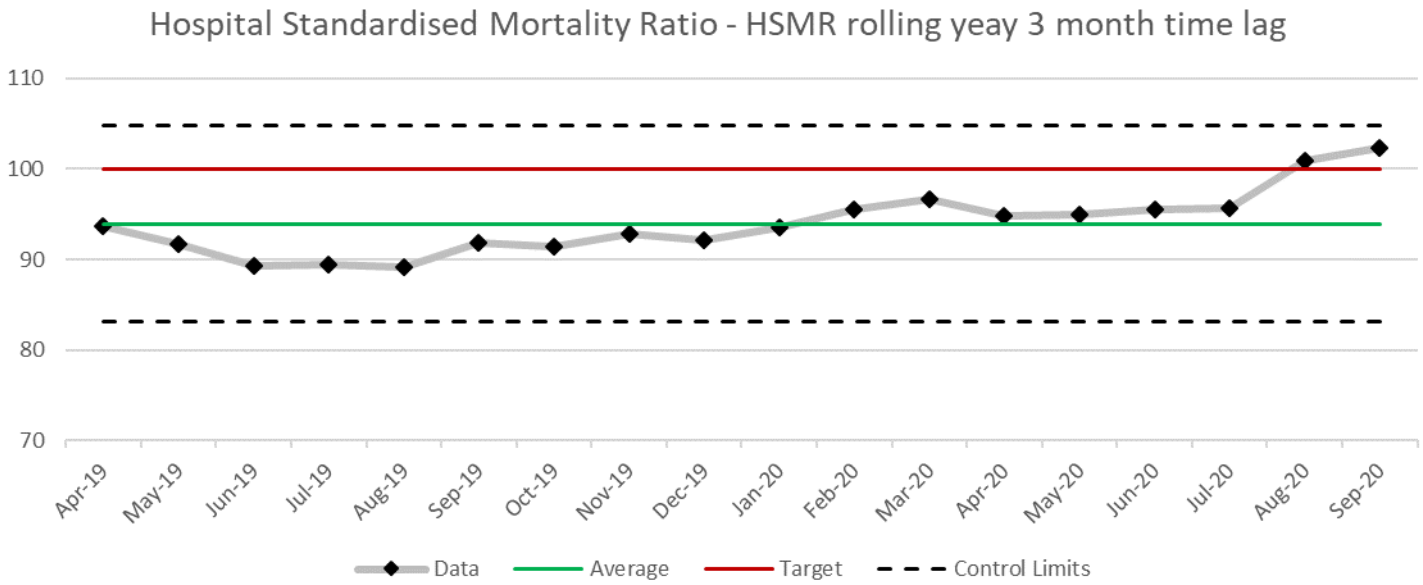
Lincolnshire Collaborative have adapted the terms of reference to encompass system wide learning.

DELIVER HARM FREE CARE – MORTALITY HSMR

Executive Lead: Medical Director

CQC Domain: Effective

Strategic Objective: Patients



Challenges/Successes

ULHT's HSMR is at 102.26, which is within expected limits.
Lincoln site is outside the expected limits at 111.07 for the rolling year; with 100 more deaths than predicted (1011 Observed: 911 Predicted).
Pilgrim and Grantham are achieving better than the expected threshold limits for the rolling year.
HSMR for the financial year is showing above expected for the Trust and Lincoln and Pilgrim sites. However, due to the COVID-19 pandemic this was to be expected.
Alerts

- Leukemia: alerting for the third month at Trust level; no longer at Pilgrim - case note review completed.
- Septicaemia (except in labour): alerting for the fourth month at Lincoln, and now at Trust case notes requested.
- Intestinal obstruction without hernia: alerting for the second month at Lincoln.
- Non-infectious gastroenteritis: alerting for the fourth month at Pilgrim - case notes requested to review coding.
- Skin and subcutaneous tissue infections: First month alerting at Grantham (This is a rolling period, Jul-19 to Jun-20).

Actions in place to recover:

From MorALS it was agreed we would start to look at some of the highlighted issues:

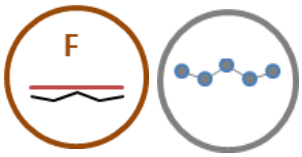
- ReSPECT—Deputy Medical Director to speak with the Medical Director.
- Fluid Balance—to be added to the agenda of the Harm Free Care group.
- Patient moves—to be discussed at Patient Safety Group. Discharge policy to be reviewed. Mortality process have been agreed with all CBUs and all specialties have now provided a nominated contact.

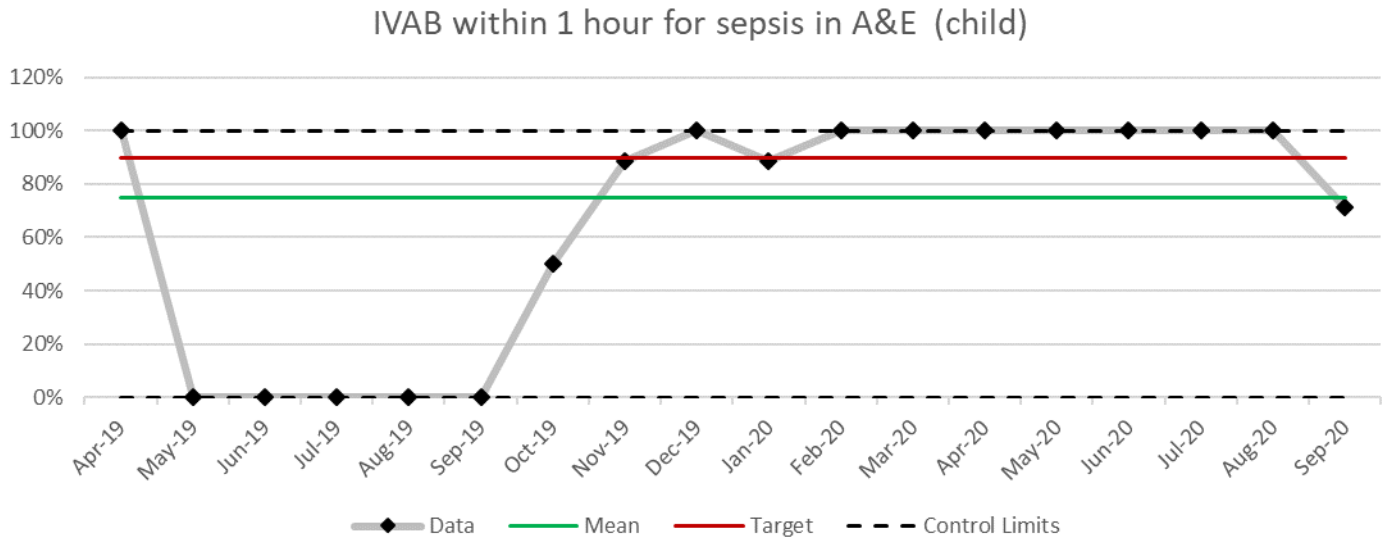
DELIVER HARM FREE CARE – SEPSIS SCREENING

Executive Lead: Director of Nursing

CQC Domain: Safe

Strategic Objective: Patients





Challenges/Successes

Compliance for Children's sepsis screening in A&E has fallen short of the 90% standard achieving 71.4% for September (5 of 7 patients). The harm reviews undertaken for those children who did not receive treatment within an hour have revealed no harms or concerns.

Actions in place to recover:

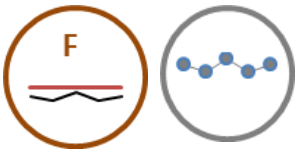
The designated paediatric Resuscitation and Sepsis Practitioner has successfully piloted an engagement project at one site where the Paediatric and ED staff meet monthly to share experiences and knowledge and this is bolstered by a quarterly education forum that covers sepsis as part of the programme. Sepsis Practitioners continue to support ED and attend daily safety huddles.

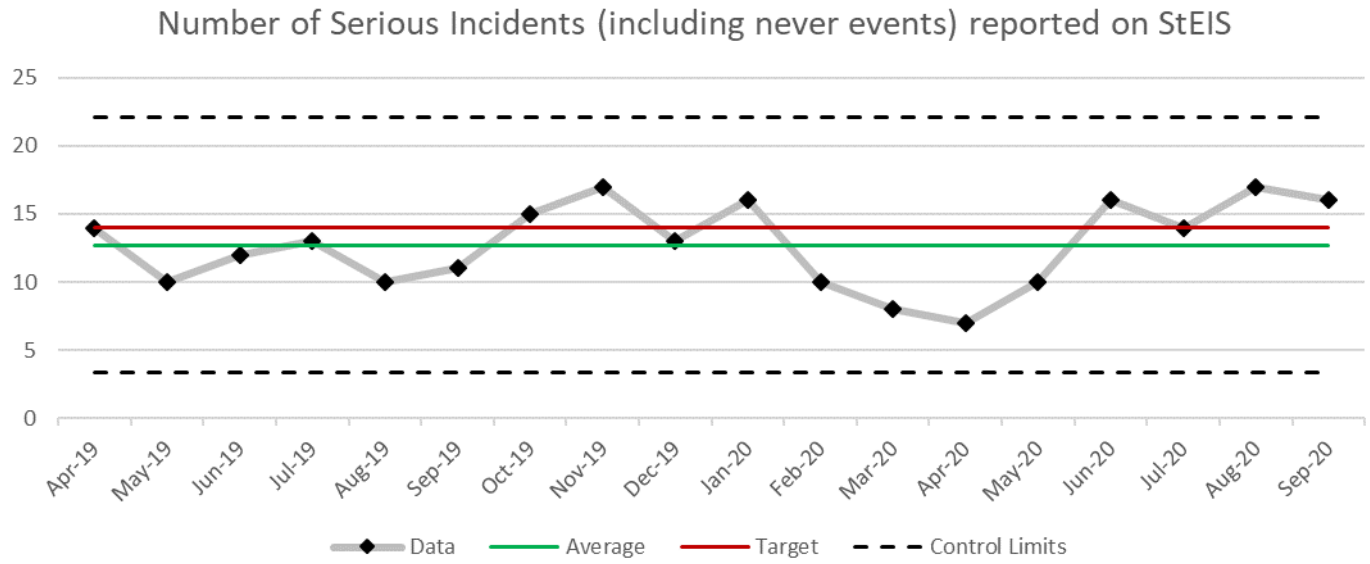
DELIVER HARM FREE CARE – SERIOUS INCIDENTS ON StEIS

Executive Lead: Director of Nursing

CQC Domain: Safe

Strategic Objective: Patients





Challenges / Successes:

- The Trust declared 21 Serious Incidents in September 2020, which is significantly higher than the monthly average of 12 for the 2019/20 financial year.
- Of those 21 incidents, 7 actually occurred in September 2020; 8 occurred in August; 4 in July; 1 in June; and 1 in April.
- There have been some particular themes highlighted in recent Serious Incidents, specifically involving the use of Non-Invasive Ventilation (NIV); the diagnosis and treatment of diabetic ketoacidosis (DKA); and the use of Local Safety Standards for Invasive Procedures (LocSSIPs).

Actions in place to recover:

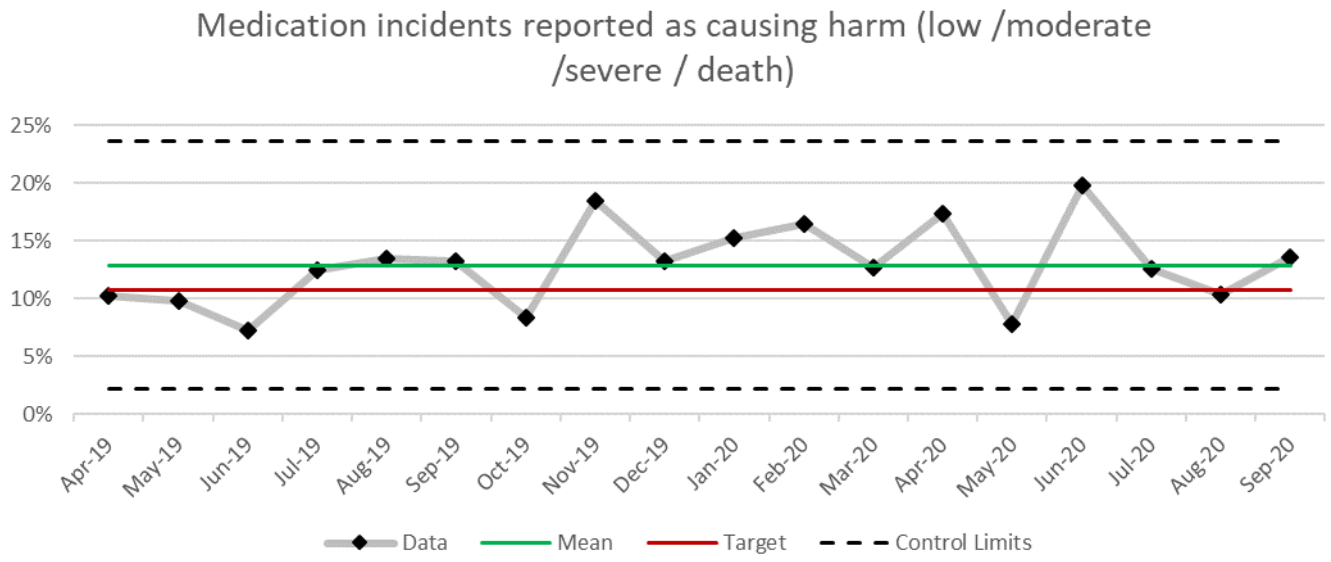
- All of the incident themes highlighted above are subject to current Serious Incident investigations that are looking not just at the most recent incidents but at other related incidents, so as to maximise opportunities for learning to reduce the risk of reoccurrence

DELIVER HARM FREE CARE – MEDICATION INCIDENTS

Executive Lead: Medical Director

CQC Domain: Effective

Strategic Objective: Patients



We are below peers (@15.1%).

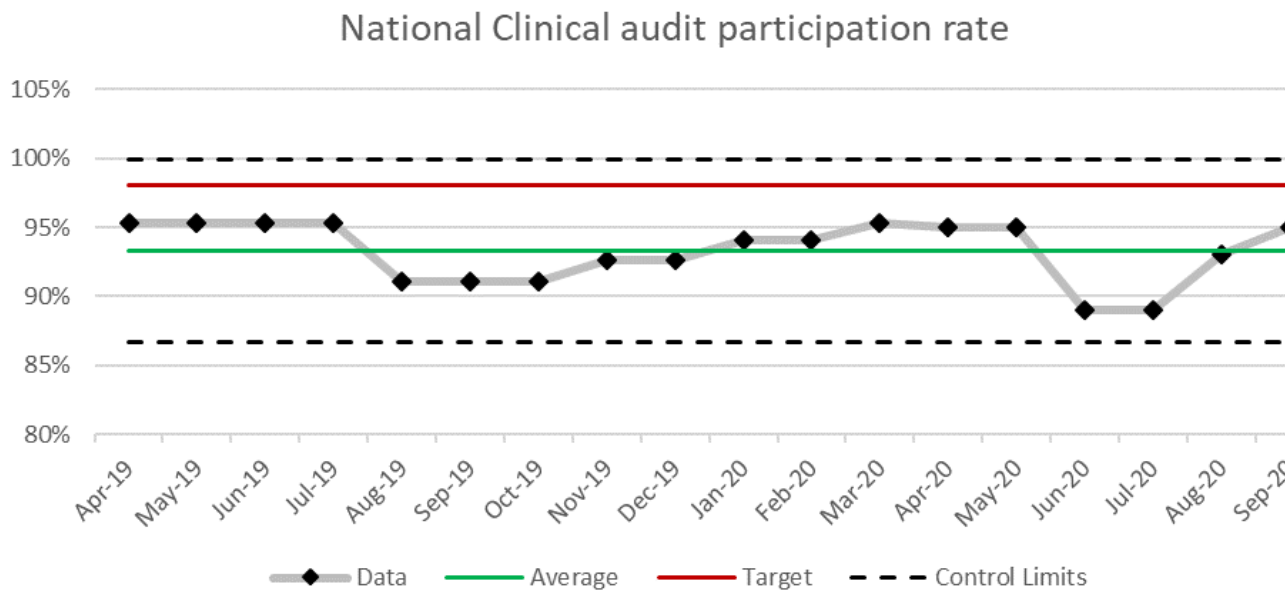
To improve the harm % we need to encourage the reporting of no harm incidents. This had declined during the Covid peak.

DELIVER HARM FREE CARE – NATIONAL CLINICAL AUDIT RATE

Executive Lead: Medical Director

CQC Domain: Effective

Strategic Objective: Patients



Challenges/Successes

The % participation National Clinical Audit rate has increased to 95% for the month of September 2020 compared to a target of >98% the following is not compliant with data submissions;

Actions in place to recover:

- None Participation in the National IBD audit to be clarified with the Gastroenterologists as the latest National report lists all other eligible Trusts are participating, there is a participation fee to be paid by each Trust it's not clear if this is the reason for none participation

Elective procedures cancelled in line with NHS England Guidance

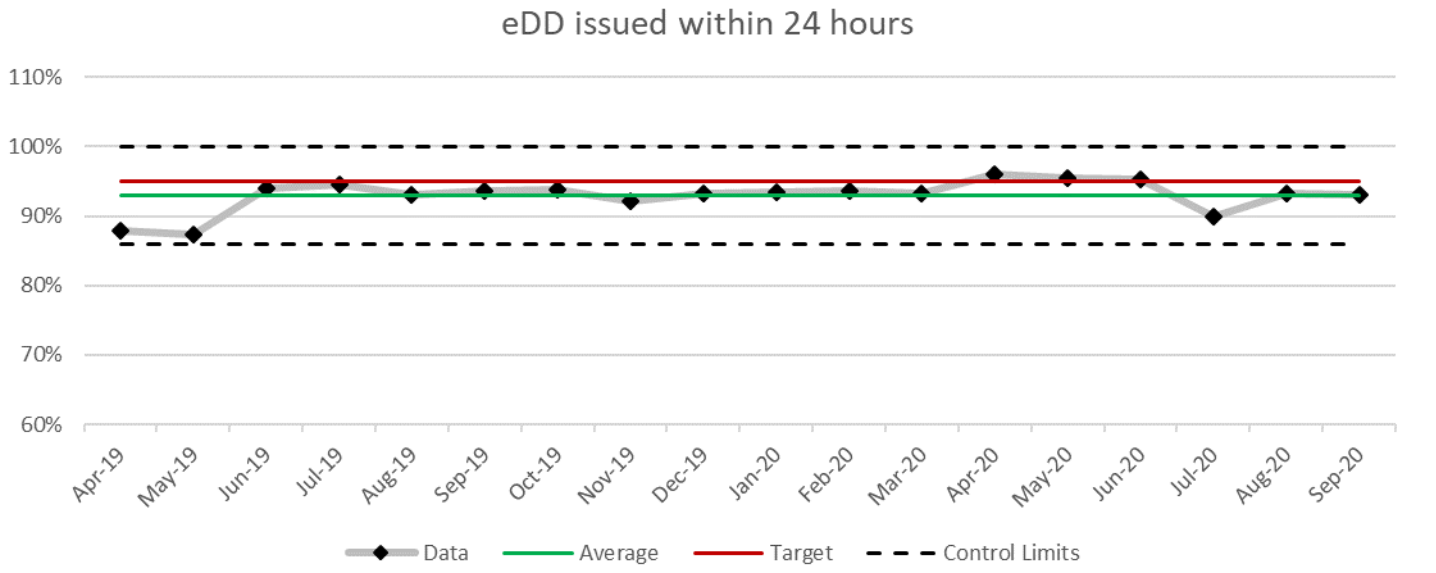
- Procedures now taking place this should improve participation submissions with the Green site restoration phase.

DELIVER HARM FREE CARE – eDD ISSUED WITHIN 24 HOURS

Executive Lead: Medical Director

CQC Domain: Effective

Strategic Objective: Patients



Challenges/Successes

The Trust achieved 93/1% compliance with sending eDDs within 24 hours for September 2020. 96.3% were sent anytime during the month of September. Of the 3,538 admissions, 130 eDDs have not been sent.

Actions in place to recover:

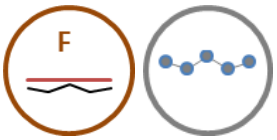
Monthly Divisional compliance is discussed at Governance Meetings. Backlog is monitored at the eDD group.

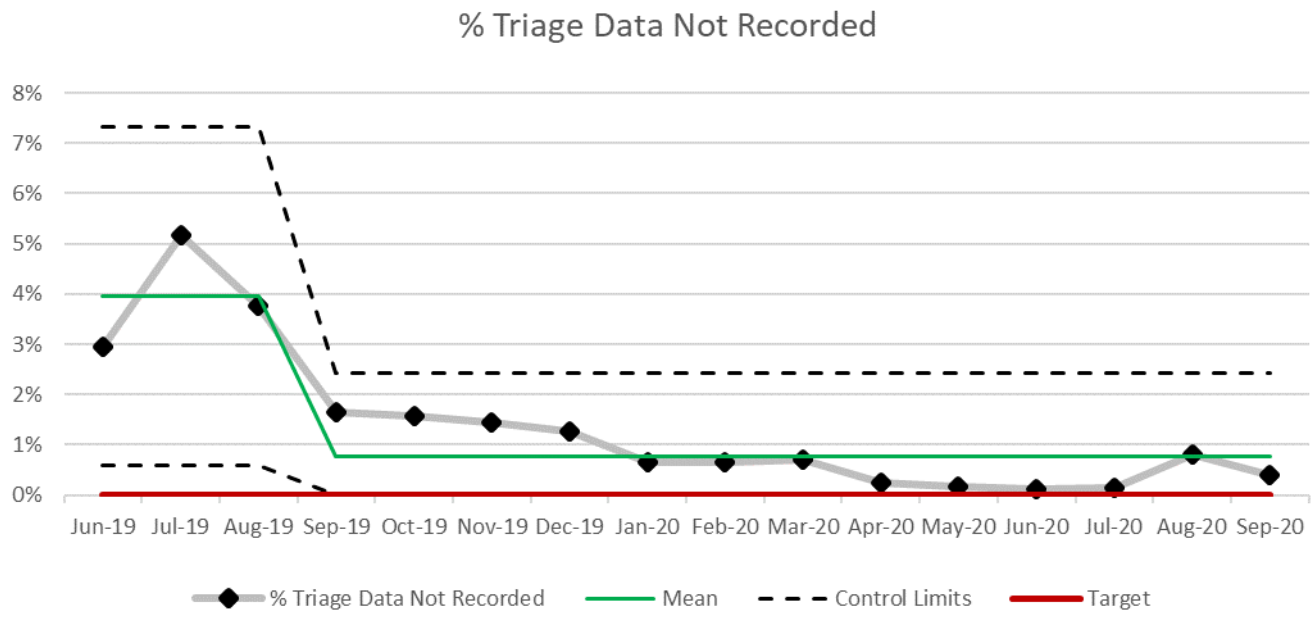
IMPROVE PATIENT EXPERIENCE – % TRIAGE DATA NOT RECORDED

Executive Lead: Chief Operating Officer

CQC Domain: Effective

Strategic Objective: Patients





Challenges/Successes

- September demonstrated a 0.36% positive variation in performance compared with August and remains well within control limits.
- Achievement against this metric remains co-dependent upon having a fully trained and compliant staffing rota as well as the individual compliance of staff. Improvements were seen on both sites. There remain issues overnight at Lincoln County.
- The ability to provide two triage streams has also improved.
- The UEC Operational Leads have been proactive in addressing recording compliance in real time.

Actions in place to recover:

- The actions against this metric are repetitive but still valid.
- The Deputy Divisional Director of Nursing/Lead Nurse, Urgent and Emergency Care (UEC) ensures increased compliance and maintenance against this target and improvements continue to be realised.
- Additional training is ongoing.

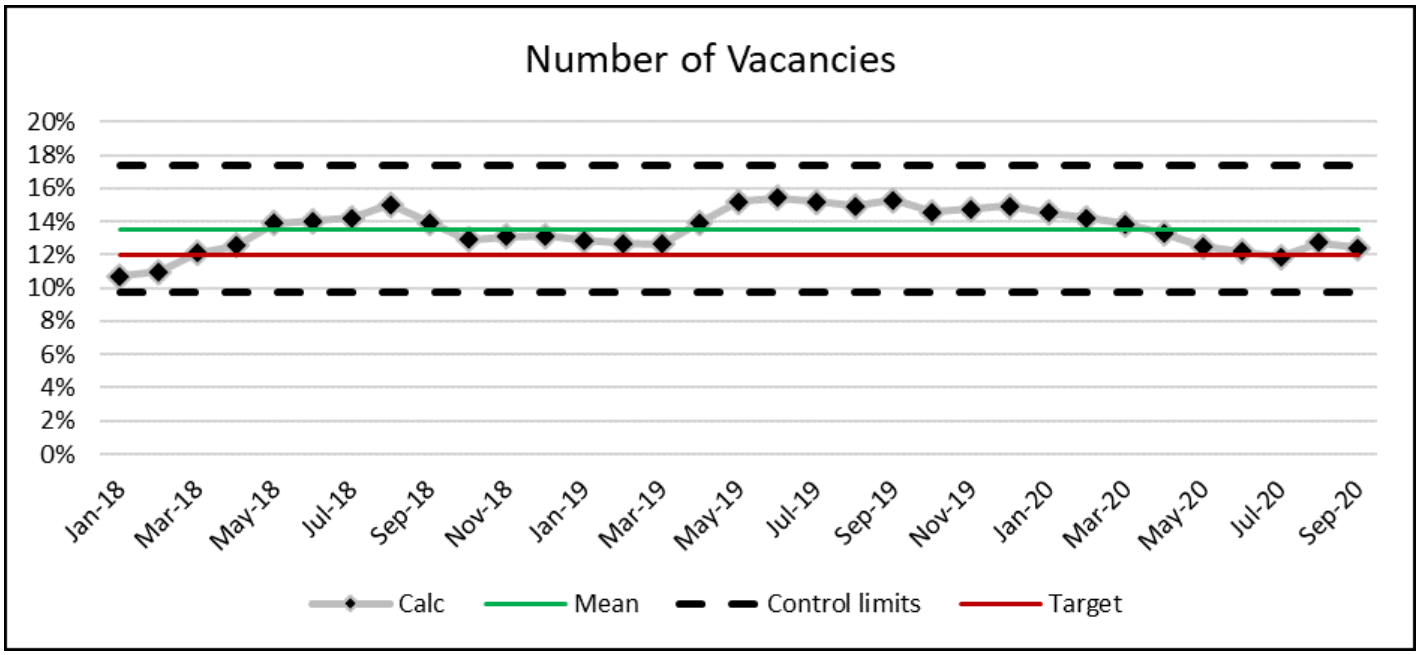
Triage time is a key patient safety performance indicator and forms an essential part of the department huddles. Overview, scrutiny and challenge continues to be provided through the 3 x daily Capacity and Performance Meetings and support.

A MODERN AND PROGRESSIVE WORKFORCE – VACANCY RATES

Executive Lead: Director of HR & OD

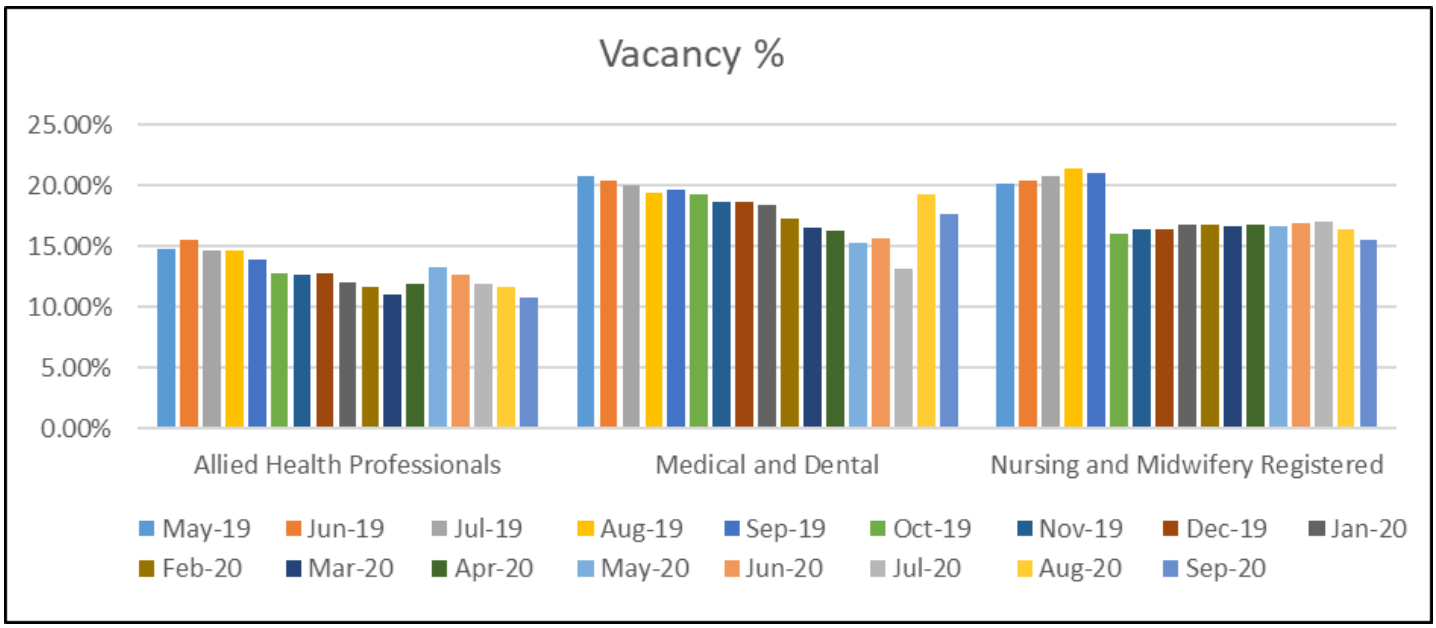
CQC Domain: Well-Led

Strategic Objective: People



Challenges/Successes

September has seen a reduction in vacancy rates at Trust level and across the three key areas of medical, nursing and AHPs. The increase in August, caused by data issues for the medical workforce in July and August, has reversed and the overall downward trend continues.



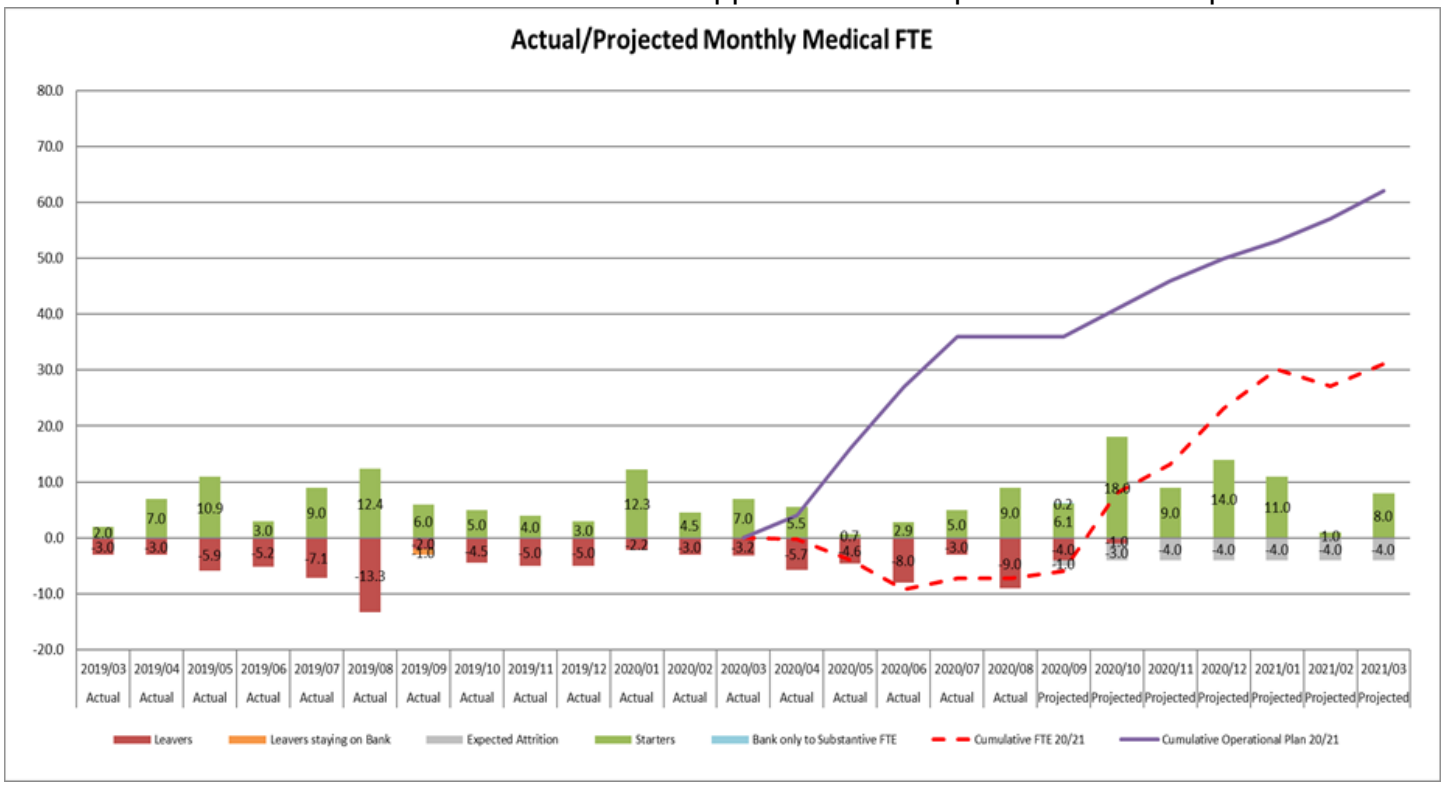
Staff Group	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20
Allied Health Professionals	12.76%	12.68%	12.82%	12.00%	11.71%	11.02%	11.93%	13.33%	12.66%	11.90%	11.66%	10.81%
Medical and Dental	19.24%	18.64%	18.62%	18.43%	17.31%	16.58%	16.27%	15.31%	15.66%	13.21%	19.28%	17.65%
Nursing and Midwifery Registered	16.06%	16.40%	16.40%	16.74%	16.82%	16.67%	16.75%	16.69%	16.87%	17.08%	16.36%	15.50%

Medical Staff Vacancy Rate

Further improvement in consultant and SAS Doctor Vacancy Rates are built into the 2020/21 Operational Plan (red dotted line), however the timeline for this planned improvement has shifted to the right with the impact of the COVID pandemic on international starts but are now starting to be actively planned for the next few months.

There has been a decrease in medical vacancies in September, a difference of 1.63% from August. This irons out the blip in August and September. The Trainee Grades have reduce their vacancies from 60.53 FTE in August to 44.79 FTE in September. The rate in September is at the highest level since January however, largely because of increases in establishment

A 6 month digital marketing campaign starts with JustR to attract Consultants to the ICU department, the desired outcome is to increase the calibre of applicants and help fill 5 Consultant positions.

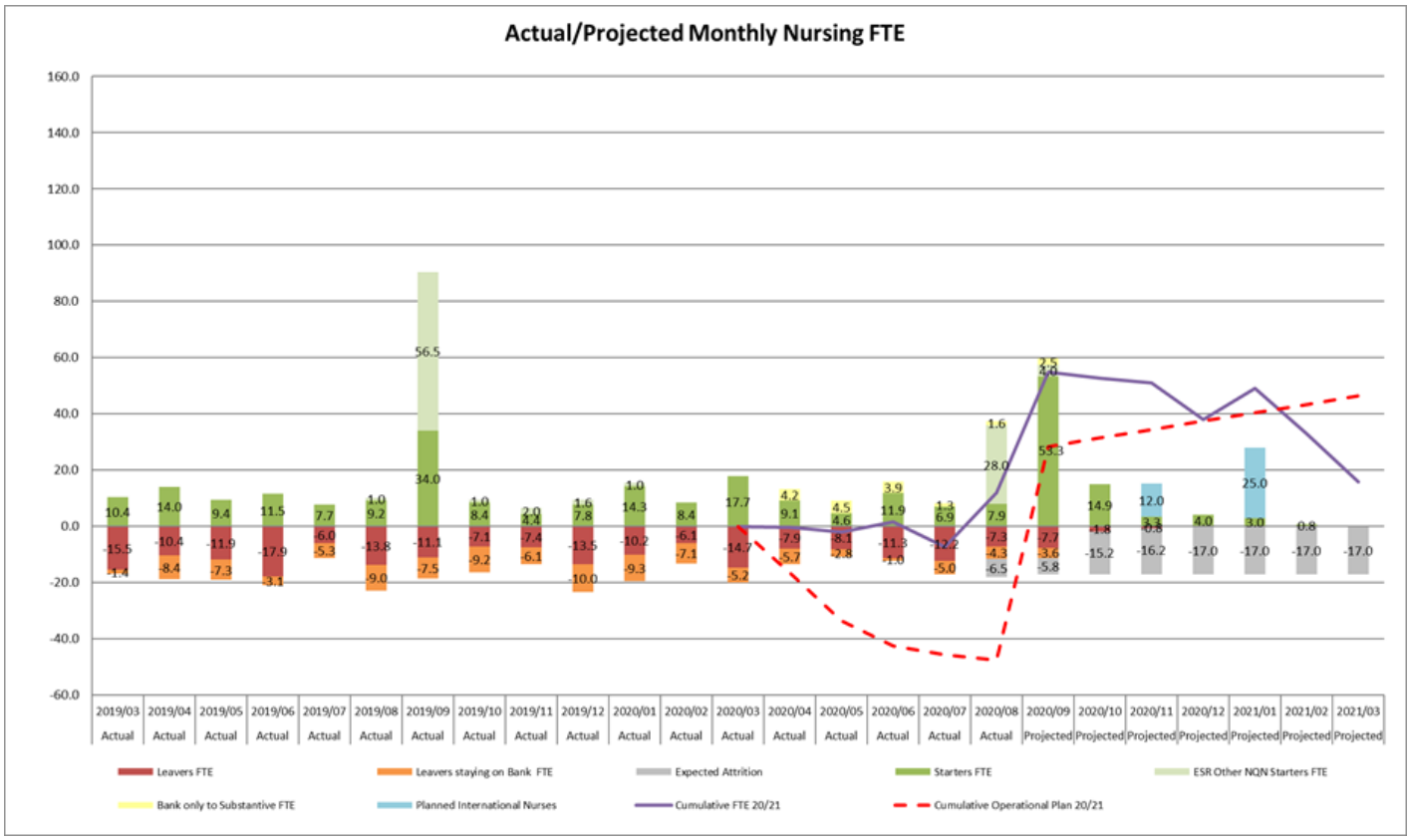


Graph as at 28 Sep 20

Nursing Vacancy Rate

Improvement in the vacancy rate for nursing also continues with a further reduction in vacancy rate of 0.86%.

International Nursing - Given the initial delays due to covid, the first cohort of nurses arrived in September (12 in total). The next cohort will arrive in October 20 (total of potentially 22 to arrive in the month again dependent on Visa offices reopening and flight availability). We are bidding for additional NHS resources to support the on-boarding of existing recruits and to bolster the numbers in our pipeline (investment in nurse educators, resourcing team)

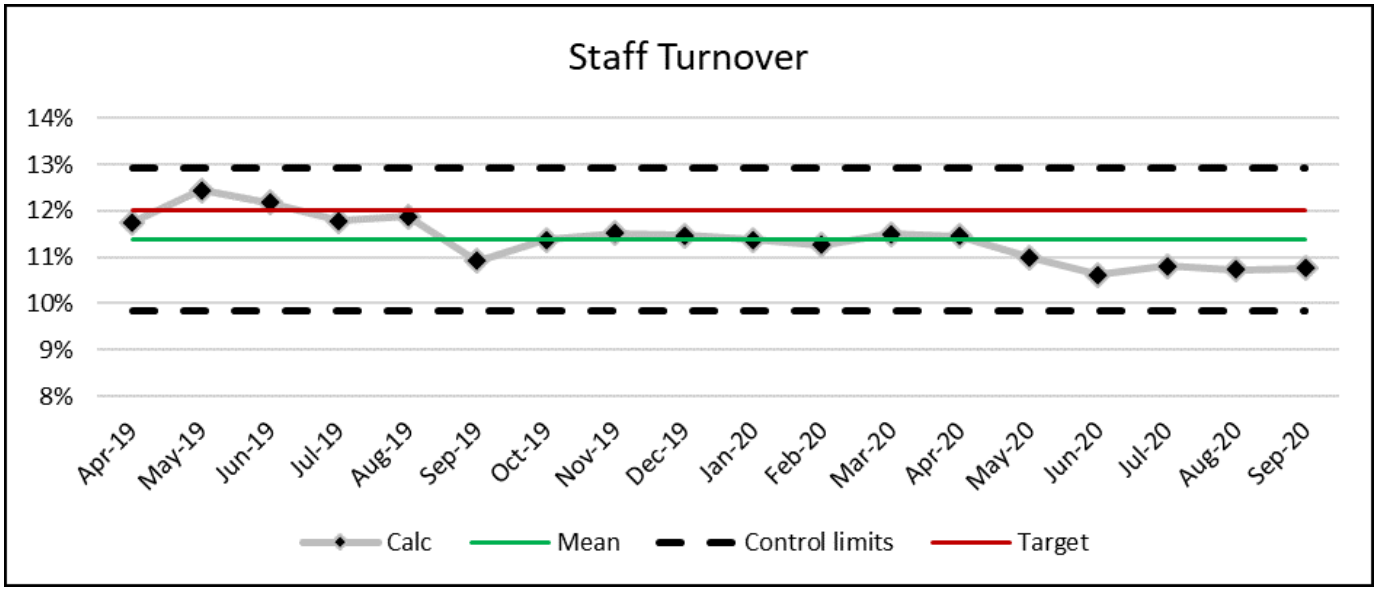


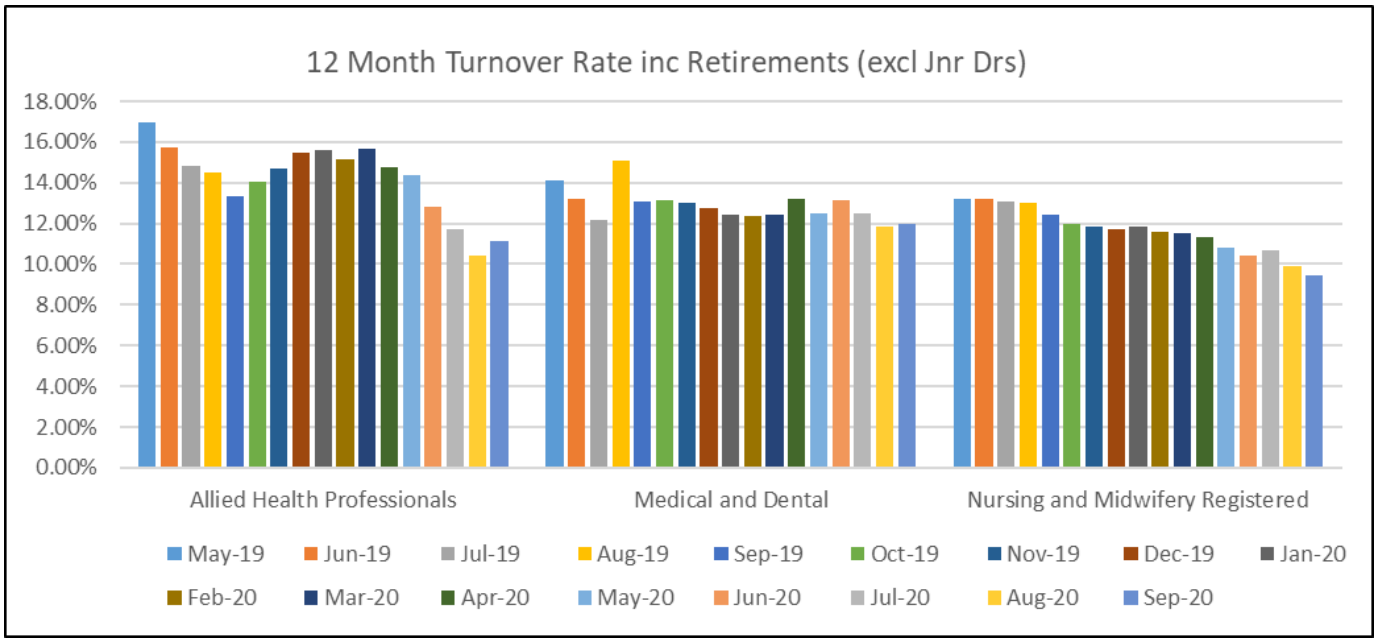
A MODERN AND PROGRESSIVE WORKFORCE – VOLUNTARY TURNOVER

Executive Lead: Director of HR & OD

CQC Domain: Well-Led

Strategic Objective: People





Staff Group	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20
Allied Health Professionals	14.02%	14.69%	15.46%	15.60%	15.16%	15.64%	14.73%	14.37%	12.79%	11.74%	10.43%	11.14%
Medical and Dental	13.11%	13.04%	12.78%	12.46%	12.36%	12.44%	13.21%	12.49%	13.14%	12.49%	11.87%	11.98%
Nursing and Midwifery Registered	11.96%	11.81%	11.70%	11.82%	11.56%	11.50%	11.32%	10.80%	10.42%	10.71%	9.93%	9.48%

Challenges/Successes

Longer-term trends for turnover remain positive, with the nursing rate close to national median rates. Nursing turnover rates have continued to reduce over the last 3 months. AHP turnover rate vacancy rate remains below 12%. Overall turnover is at around 10% and we are no long on the NHSE/I watch list for turnover.

Assurance Actions

- 12 month trend of improvement in KPIs
- Continued strong pipeline for Consultant and SAS recruitment – 61 in pipeline
- Divisions continue to use the 'plan for ever post' approach to all vacant posts and there is greater triangulation with associated agency costs. (Nearly all consultant and SAS vacancies are actively being progressed). Reviewing set up with Deputy Director of Finance.
- High number of AACs planned for 20/21 with an increasing standard on the bar to be met for appointment as a ULHT consultant. Increasing number of applicants for posts.
- JustR, digital recruitment specialists, engaged to support a 6 months campaign to recruit ICU consultants.
- International strategic partnership fully mobilised with further Divisional engagement events to take place.
- Multiple medical forums in place to engage and retain our doctors.
- Medical Engagement OD Lead working with the SAS Tutor to implement a calendar of development interventions targeting our SAS doctors
- International nursing recruitment through strategic partner in progress.
- Fully engaged with HEE GLP programme
- First International nursing cohorts landed.
- Strong engagement with student nurses and guaranteed employment offers
- Recruitment times have reduced from around 90 days, to around 60 days

Further Improvement Required

- Continuing to build engagement around retention across the Trust
- The SAS Portal and Consultant Portal has been completed redesigned and launched with up-to-date and relevant information for our doctors
  - http://ulhintranet/for-consultants
  - http://ulhintranet/for-sas-grades

- First SAS Engagement Forum launched since the start of covid with very good engagement from SAS Doctors.
- Calendar of learning interventions launched for our SAS Doctors – dates and topics published on the SAS portal
- Widen 'plan for every post' to Nursing and AHP vacancies.
- A number of digital media recruitment campaigns planned.
- Further improvement on progressing known leavers is required.
- Plan to move to single position numbers in ESR to further support triangulation of associated agency costs with vacant posts.
- Risk to medical pipeline from an historical agency addressed.
- The improvement plan related to the recruitment process has been delayed due to COVID and is being re-profiled. It is essential that it is delivered to ensure sustained improvement

Risks

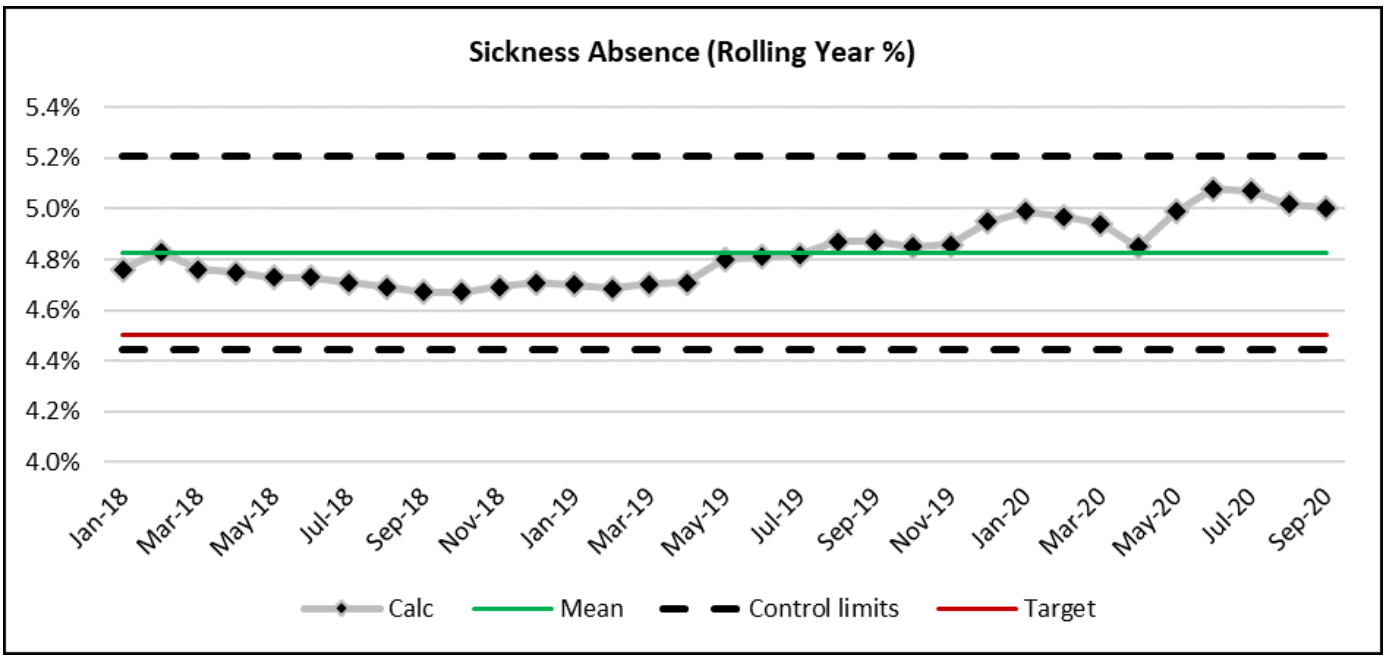
- Continued delay in international starts due to COVID and increased risk of attrition of international recruits from offer to start
- Divisional timely processing of known leavers and lost opportunity for early planning of local intelligence of anticipated staff moves.
- Translation of improvement in substantive vacancy rate into reduction in temporary staffing costs.
- Period of higher 'risk of retirement' numbers.
- OSCE capability for paediatric nursing
- Continued distraction from COVID Recovery phase.
- AHP retention and attraction.
- Phase 3 planning requires delivery of our existing recruitment plans and more to create the increased capacity required. This is a significant risk, particularly where recruitment pathways are less well-defined (outside medical and nursing). The risk is that we will either not deliver the service capacity required, or agency spend will increase. The mitigation is that we pay increased attention to recruitment in CSS in particular.

A MODERN AND PROGRESSIVE WORKFORCE – SICKNESS

Executive Lead: Director of HR & OD

CQC Domain: Well-Led

Strategic Objective: People



Challenges/Successes

The 12 month rolling absence figure remains at 5.0%.

Clearly COVID has had an impact on sickness levels. The table below indicates that this is adding between 0.23% and 0.08% to the monthly sickness figure:

Month	Non Covid %	Covid Related %	Total %
June	4.38%	0.23%	4.61%
July	4.38%	0.14%	4.52%
August	4.42%	0.08%	4.50%

Sickness Absence – Assurance, Actions In Place To Improve and Risks

Assurance Actions

- The number of staff absent due to COVID reasons remained low in September, but has started to rise at the beginning of October – more prevalence in the community + impact of school children being asked to isolate.
- Employee Relations Adviser Assistants are working on an analysis of trends and statistics to understand the Trust current position regarding sickness absence in order to support the ER Advisors to focus on the hot spot areas within the Divisions

- Short term and long term absences meetings are continuing to ensure staff are supported and monitored appropriately and to support reducing absence where possible. Work load is heavy and unpredictable so although progress is being made it is at a slower pace than required.
- We are continuing to hold meetings via Microsoft Teams to reduce face to face ensuring we continue to support social distancing whilst maintaining momentum in completing meetings to avoid any further delays. This is in conjunction with the risk assessments as advised by the Trust.
- The ER Team are continuing to contact those employees who are showing new symptoms and are in quarantine following foreign travel and provide support to managers.

Further Performance Actions

- New ER Assistant advisers have started with the Trust, working on Absence reporting and management and supporting the current Employee Relations activity including absence management.
- Stress and Anxiety continues to be highest reason for sickness absence. All staff have been contacted to provide health and wellbeing support Where appropriate meetings are booked to ensure appropriate management with line manager and ER Adviser. In some cases, the COVID pandemic is an added contributing factor to staff already absent due to stress and anxiety. We continue to promote our COVID well-being offer.
- COVID 19 report continues to be generated on a daily basis, to monitor trends and take actions where necessary. There has been a small increase in daily cases, however the report overall remains consistent at around 50 cases. There has been an increase at the beginning of October, which we are monitoring closely.
- All cases regarding Capability in relation to ill health are now being discussed at the fortnightly Agenda for Change ER Activity meetings to ensure that managers maintain momentum in managing this process in a timely manner.
- Bespoke training sessions for attendance management happening on request for deputy managers and new managers as required in Family Health, Surgery and Corporate divisions.

Update on the Attendance Management System

- The Attendance Management System has successfully gone live with our first 2 Cohorts – corporate back office staff not in Healthroster and ICT. As agreed by the Executive Team we are aiming to achieve full implementation by the new year with Surgery, CSS, Estates & Facilities and Outpatients Lincoln and Louth scheduled for go live in mid-November.
- The remaining cohorts – Family Health, Medicine and Doctors are scheduled to go live in December however plans are being reviewed to adhere to payroll and AMS shutdown.
- The case management module will be implemented at the start of the new year, with an indicative timeframe for full implementation being February. This will help the Assistant ER advisers and ER advisers in managing attendance in each division going forward.
- Assistant ER advisers are supporting managers with managing attendance in line with policy.

Risks

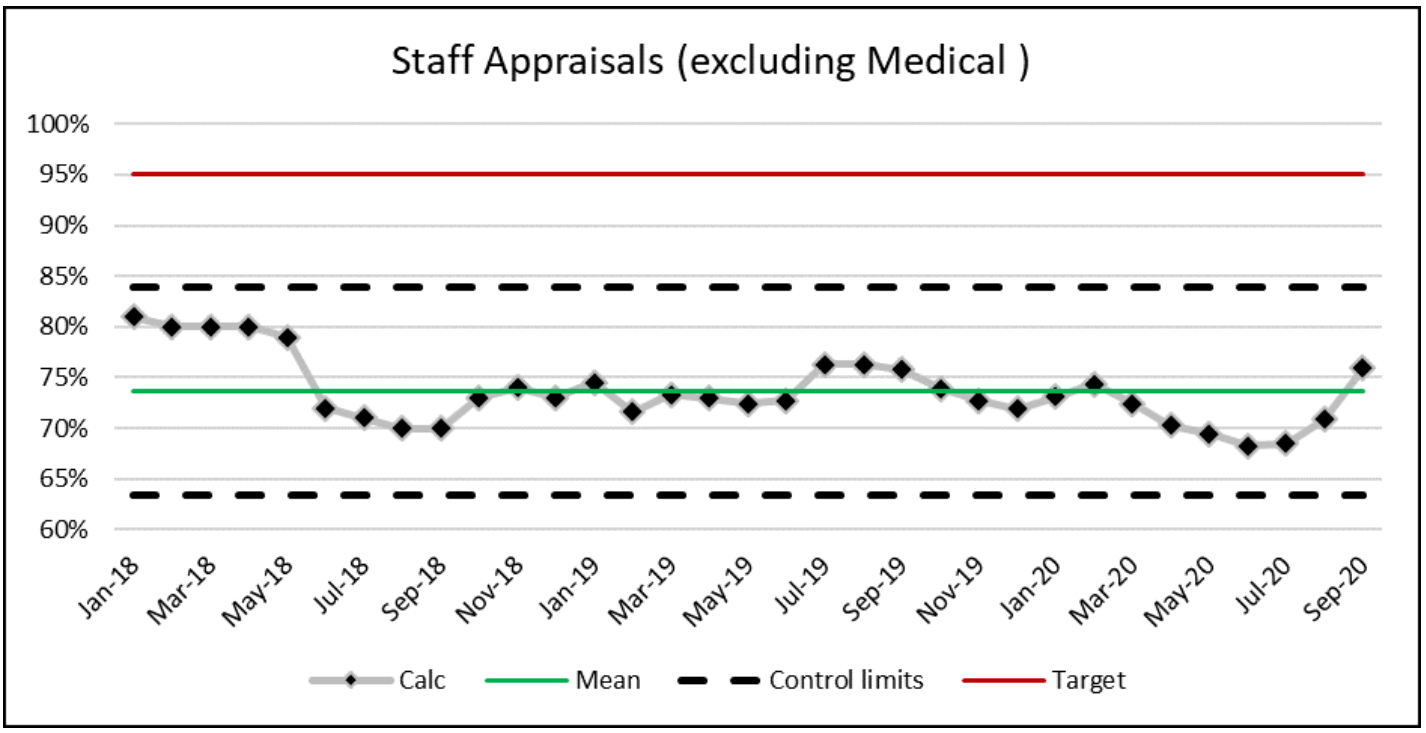
- A second spike of COVID, alongside annual leave and winter pressures continues to be a risk.in sickness absence, also staff who travel abroad risk 14day quarantine if travel guidance changes.
- COVID preventing some employees attending meetings, especially if unable to use the TEAMs app. In exceptional circumstances a risk assessment for a socially distanced room will be sourced. This could delay a return to work.

A MODERN AND PROGRESSIVE WORKFORCE – APPRAISALS

Executive Lead: Director of HR & OD

CQC Domain: Well-Led

Strategic Objective: People



Challenges/Successes

There has been a sharp rise in the percentage of appraisals completed in August and September, following the action taken to tackle the issue – all managers required to give dates when appraisals will be completed.

Appraisal – Assurance, Actions In Place To Improve and Risks

Points for assurance

- Trustwide – Appraisals continue to be a focus of attention.

Actions being taken to improve performance

- NHS People Plan (August 2020) requires that from September 2020 every member of the NHS should have a health and wellbeing conversation and develop a PDP reviewed annually. A wellbeing checklist to be used as a framework for this conversation has been issued.
- Appraisals will be monitored through weekly league tables published to TLT on completion rates within divisions. Managers are being asked to indicate the date on which appraisals will be held for all those that are outstanding

Risks

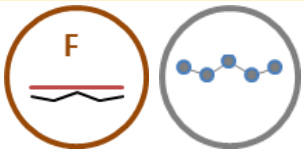
- Appraisal rates continue to fall due to a second surge and/or winter pressures

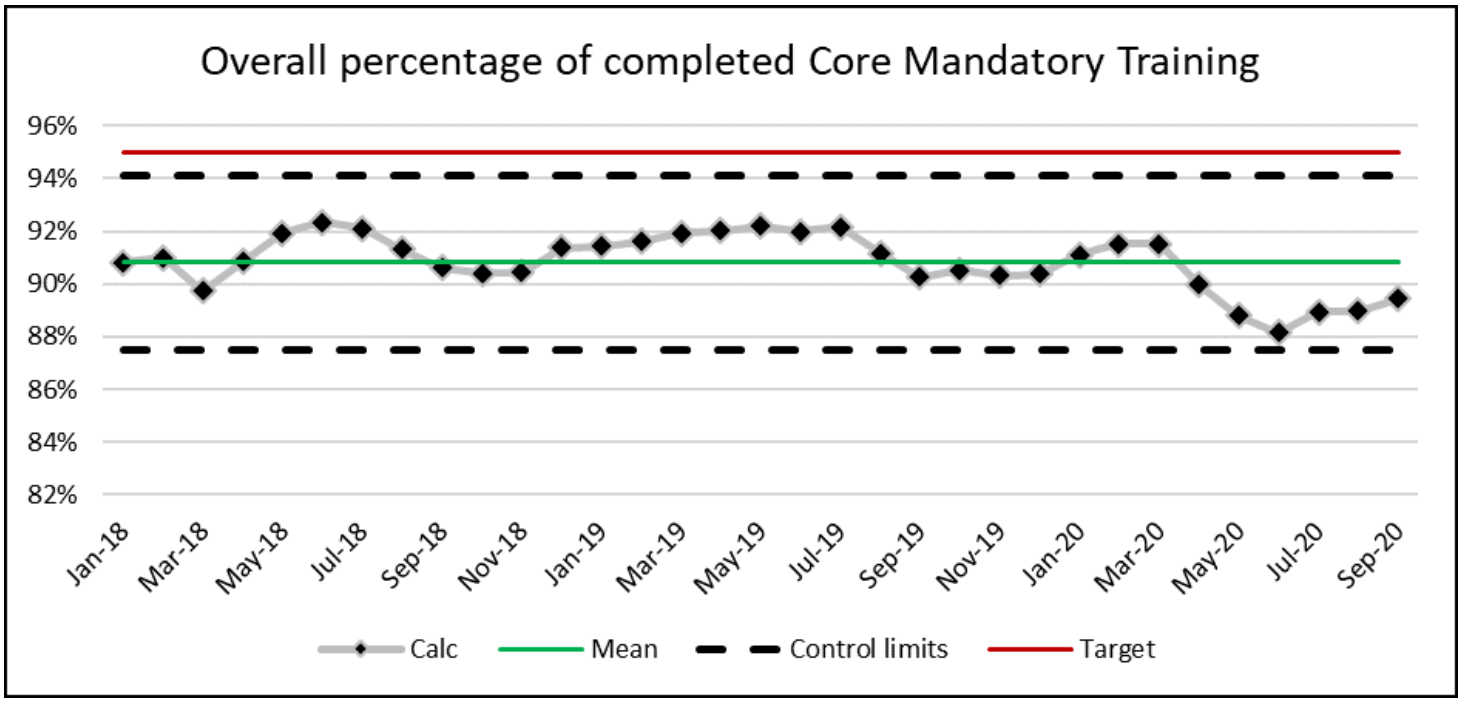
A MODERN AND PROGRESSIVE WORKFORCE – CORE LEARNING

Executive Lead: Director of HR & OD

CQC Domain: Well-Led

Strategic Objective: People





Challenges/Successes

Compliance rate for Core Learning was consistently above 90%, but dipped when COVID impacted the organisation. From a low point in June, the rate has started to rise again.

New starters are now able to complete some of their Core Learning before commencing with the Trust. A complete e-learning Induction course is now in place due to Coronavirus outbreak

The 95% target for IG training compliance was achieved.

Core Learning – Assurance, Actions In Place To Improve and Risks

Points For Assurance

- Core learning is consistently running at around 90-92%
- Most face to face activity ceased with a number of topics becoming E-learning package
- Induction continued through COVID as an E-learning induction
- E-induction commenced in March 2020

Actions Being Taken To Improve Performance

- Socially distanced classroom training is being reintroduced where possible while ensuring that social distancing is maintained.
- Topic Specialists are now looking at other ways of delivering training
- The Fire Safety Team are shortly trialling delivering their Core Fire Safety training through Microsoft Teams
- The Safeguarding team have launched new e-learning packages

- Core learning to become a performance target and is reviewed through PRMs

- Establishment of additional venues, such as the restaurant at Lincoln, giving access to Trust computers, to make it easier for staff to complete e-learning courses.

Risks

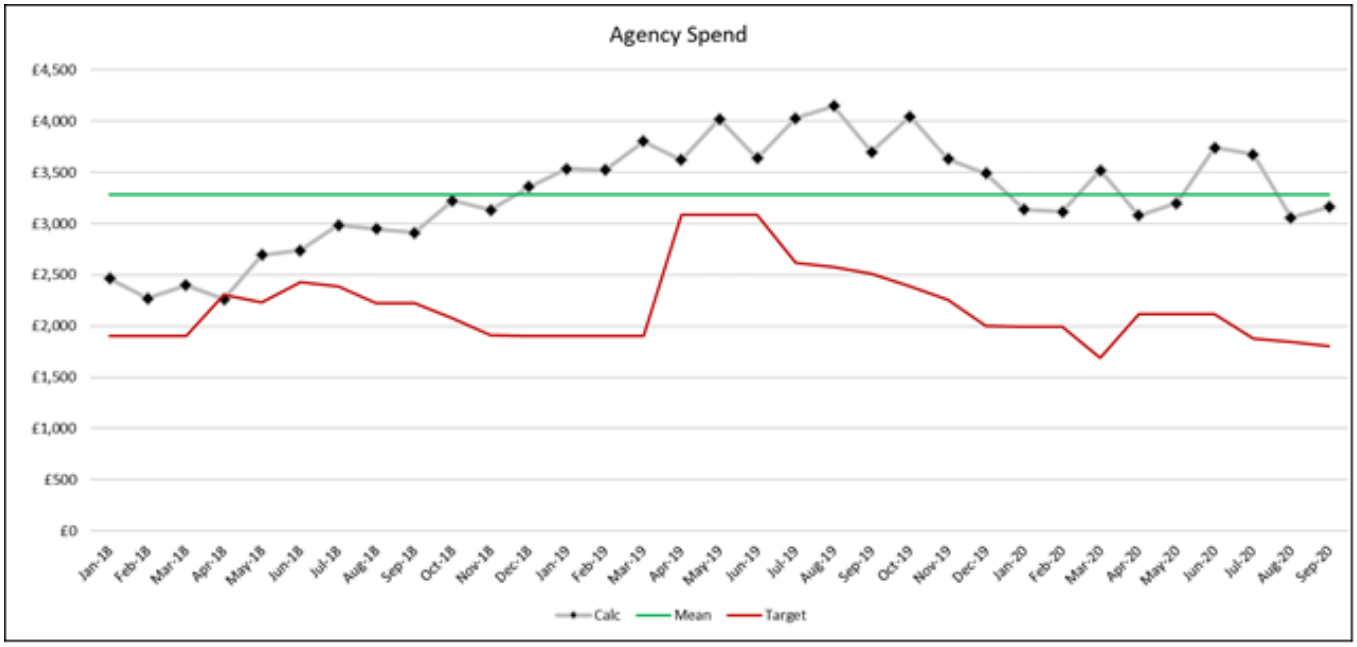
- Managers not releasing staff to undertake training as part of the restoration/recovery phase
- Failure of social distancing in classroom setting leading to potential social isolation requirement for larger numbers of staff, as occurred recently at Hillingdon Hospital.
- A second spike in Coronavirus
- Lack of staff access to E-learning
- Specialities not replacing face to face ongoing without alternatives

EFFICIENT USE OF OUR RESOURCES – AGENCY SPEND

Executive Lead: Director of HR & OD

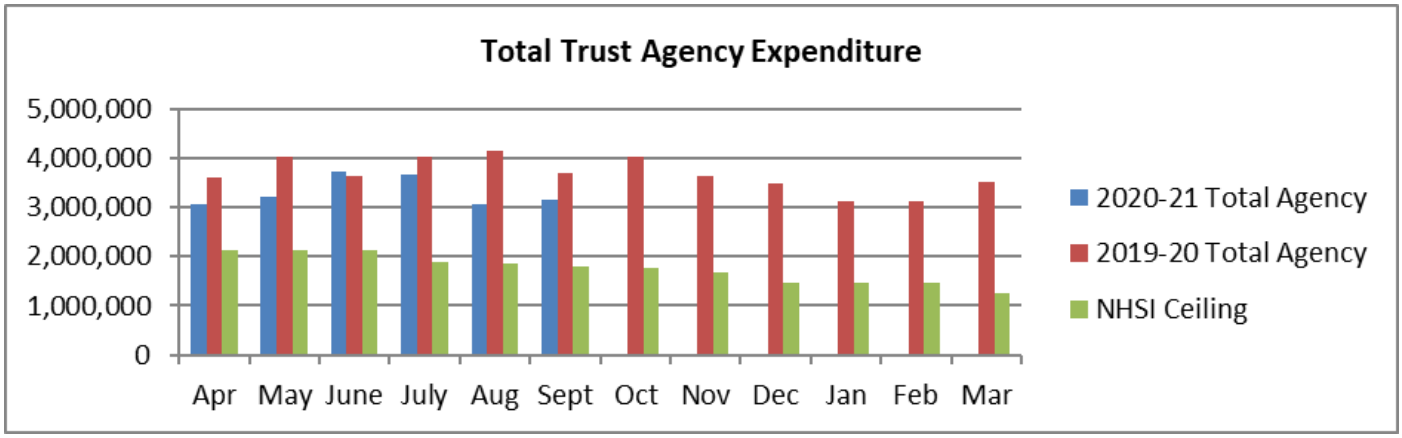
CQC Domain: Well-Led

Strategic Objective: People

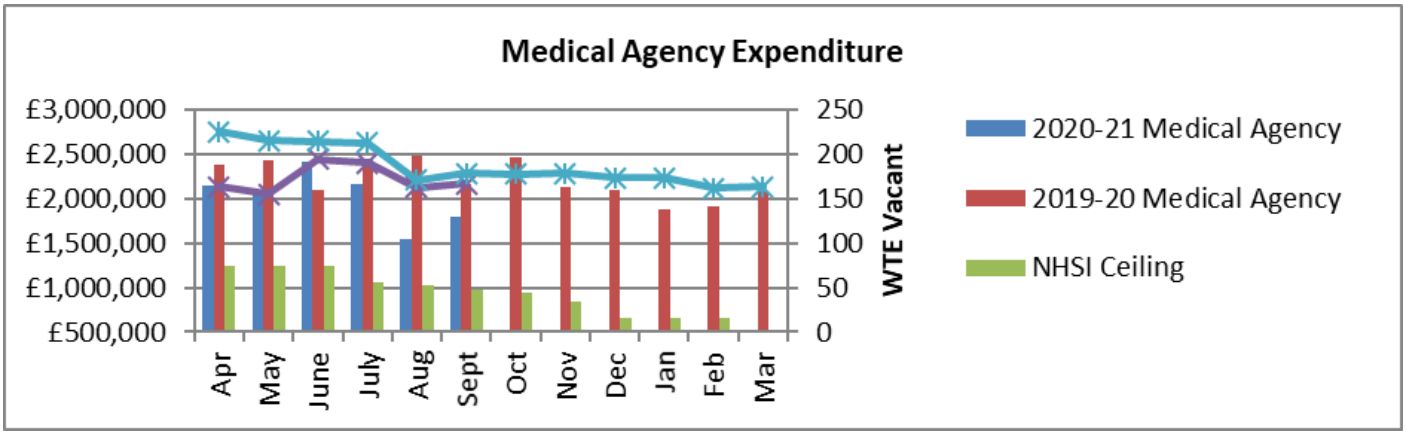


Challenges/Successes

September's substantive pay is lower than the usual run rate by £7m.This is because we were accruing a notional employers' pension contribution which was reversed out M1-5 in M6 at NHSI's request. This has impacted the pay variance figure this month and, if this were discounted, the figure would remain around 10%.



Total agency spend increased slightly on the August figure, but there were a number of adjustments in August which artificially reduced the spend level. A more realistic comparison is with July and there was a very significant reduction (and on equivalent spend levels in 2019). We do, of course, remain above the NHSE/I ceiling levels.



NB The lines represent vacancy rates

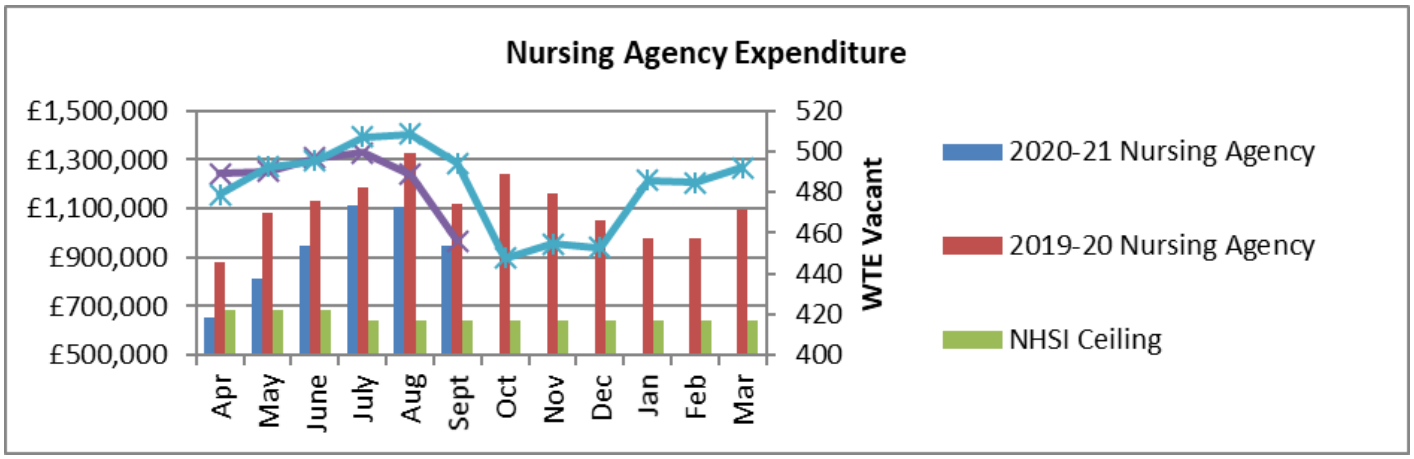
Medical agency spend in September was circa £1,767,297. Spend in August was actually at a similar level, but this was adjusted by £290k of release from shifts not actually worked in previous months. These though are the lowest monthly spend figures in 28 months.

Medical bank is now at 40%, a continuous upward trend which is reducing the agency bill, savings above starting position of 20% bank with all costs removed are now at £237,000.

The trend continues in reduced number of hours requested and booked which contributes to reduced agency bill

DE savings for the month of September were at £316,500 taking the last 12 months total to £4.30million. The DE efficiency was at 98.8% with only no shifts being VAT applicable.

We have no off framework bookings at present.



Nursing agency has reduced significantly in M6. The average number of agency shifts provided per week in September 615 (to week ending 27/9). This was a reduction from 687 per week in August (to week ending 30/8).

Assurance & Initiatives

The Nursing Workforce Transformation Project Group (NWTPG) continues to provide oversight and direction relevant to nursing workforce recruitment, retention and deployment. Each of these aspects impact on prospective nursing agency spend.

Initiatives include:

- Scrutiny of nursing vacancies and oversight of plans to recruit to vacant positions.
- Review of 'time to recruit' metrics and identification of remedial plans.
- Oversight and amelioration of roster design metrics, including: roster-forecast planning (6-week standard); and staff distribution/allocations within rotas (such as annual and study leave authorisation).
- Development of a Business Intelligence (BI) model in conjunction with NHSIE relevant to workforce metric oversight.
- Production of Standard Operating Procedure (SOP) for last minute shift escalations.
- Scrutiny of workforce shielding metrics, maximising opportunity for return to work.
- Allocate and e-Roster training to assist managers with roster production and reporting functionality.
- Rostering policy under review to support smart rostering.
- Project plan aimed at increasing Nurse Bank shift fill rates in development.
- Daily staffing meetings to confirm shift prioritisation and staff deployment.

Risks

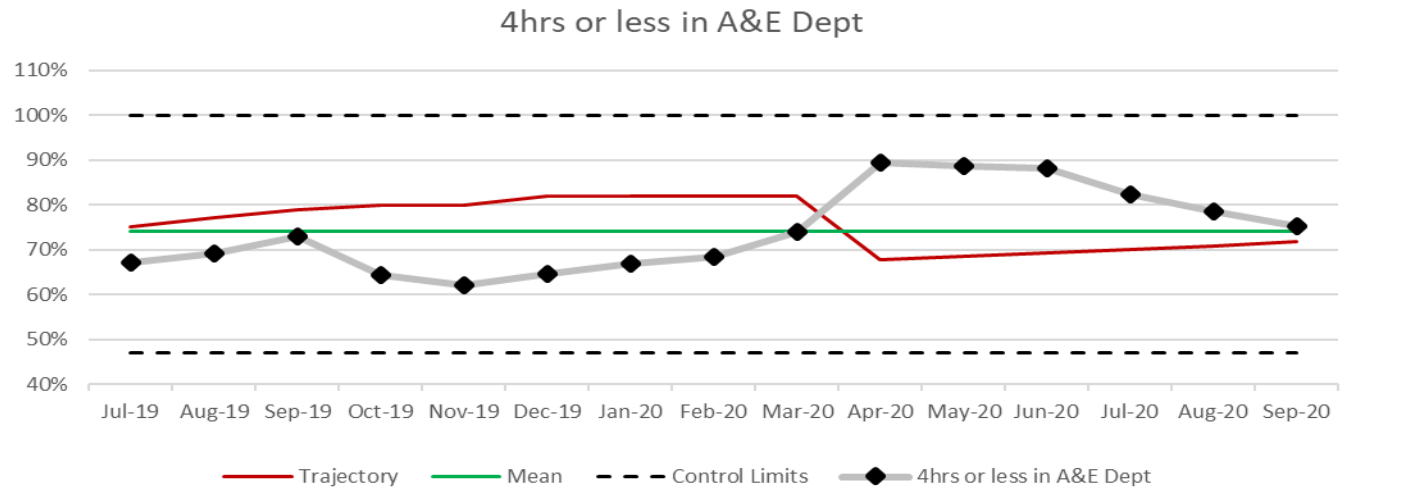
- Continued delay in international starts due to COVID.
- Direct COVID activity and expenditure is continued.
- Current run rate will breach NHSE/I cap by greater than 150% limiting UoR Assessment Rating

IMPROVE CLINICAL OUTCOMES – A&E 4 HOUR WAIT

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services



Challenges/Successes

- The Urgent Care Treatment Centres and Emergency Departments attendances experienced a 4.54% decrease in September and a further deterioration in in performance.
- September ED type 1 and streaming was 16,036 attendances verses 16,797 in August. This represents a 4.54% decrease. By site LCH experienced a 2.3% decrease in attendances, PHB saw a decrease of 4.01%. Grantham also experienced a decrease in UTC attendances of 6.53%
- September overall outturn for A&E type 1 and primary care streaming delivered 75.27% against an agreed trajectory of 71.72%.
- This demonstrates a further deterioration in performance. 3.19% compared with August outturn. Although this is still an improvement against trajectory of 3.55%, performance has deteriorated for 5 consecutive months and is of significant concern both regionally and nationally.
- By site, for September, LCH delivered 72.47%, a 0.23% improvement on August's performance, PHB delivered 69.94%, a deterioration of 8.92%. GDH achieved 97.97% which was an improvement of 0.33% compared to August. This includes type 1 and type 3.
- The highest days of delivery by the Emergency Departments only was 27th September when PHB delivered 83.02% and on 13th September when LCH achieved 84.30%. The performance uplift from the UTCs was 6.36% at PHB (86.65%) and 5.48% at LCH (89.18%). Conversely, the lowest day of delivery by the Emergency Departments was 17th September, when LCH only achieved 44.07% and on 5th September when PHB only achieved 41.32%. The performance uplift from the UTCs activity was 14.48% (58.75%) and 17.92% (59.24%) respectively.
- Streaming at PHB experienced a slight deterioration in performance, 94.26% in September compared to 94.80% in August, as did LCH 98.81% in September verses 99.20% in August.

Actions in place to recover:

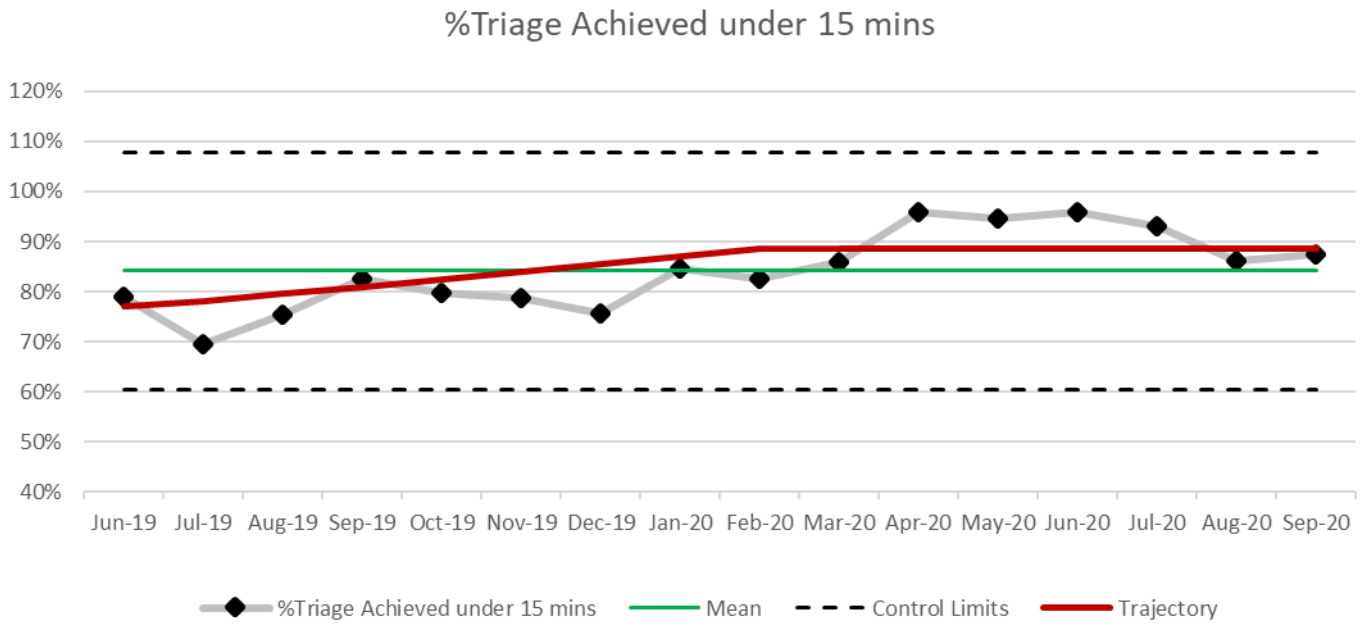
- Those process improvements, not affected by volume, have now been reflected in the Recovery phase of COVID management.
- A revised Urgent and Emergency Care Improvement Programme is in development and will act as the vehicle to drive sustained changes forward.
- The ability to respond dynamically in all urgent and emergency care access areas will support patients to be seen by the right person in the right service.

IMPROVE CLINICAL OUTCOMES – %TRIAGE ACHIEVED UNDER 15

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services



Challenges/Successes

- Triage under 15 minutes improved in September by 1.28%. 87.39% in September verses 86.11% in August. The balance between managing the blue pathway and green pathway in both our Emergency Departments and our Assessment Units continues to be problematic, especially at times of increased volume of patients in the departments.
- The ability to provide two triage streams has also improved.
- Measures are in place to ensure this key metric continues to achieve its improvement trajectory toward 100%.
- This metric continues to be captured as part of the daily and weekly CQC assurance reporting and performance is discussed daily by clinicians as part of the ED safety huddles.

Actions in place to recover:

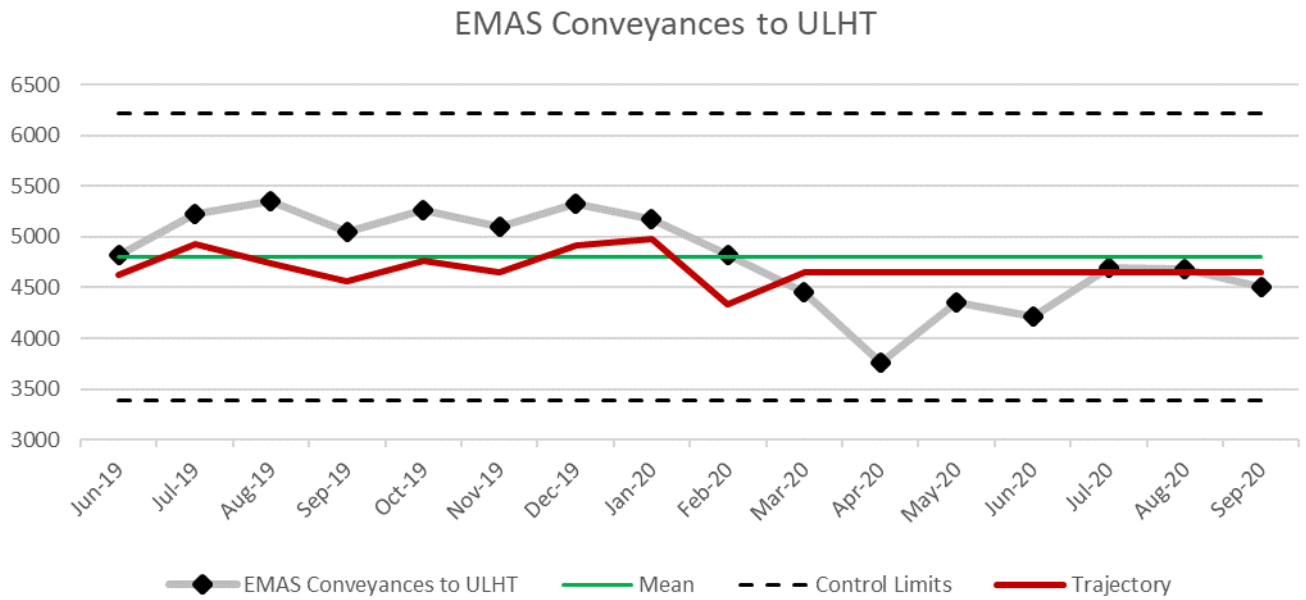
- Pre-COVID19 levels of attendances have been exceeded, although the Trust experienced a reduction in attendances in September, the focus must remain on achievement of this safety metric.
- All key operational posts have now been appointed to within Urgent and Emergency Care and the expectation of action and remedy has been made explicit.
- Clear action and recovery plans are scrutinised at the three times daily Performance and Capacity. Staffing deficits that may impact on the ability to maintain a second triage stream both in and out of hours are highlighted and addressed.

IMPROVE CLINICAL OUTCOMES – AMBULANCE CONVEYANCES

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services



Challenges/Successes

- Ambulance conveyances for September were 4501 compared to 4688 in August. This represents a 3.99% reduction in conveyances across all sites.
- By site, LCH conveyances were 2735 in September compared with 2835 in August, a 1.65% decrease, PHB was 1776 in September compared with 1910 in August, a 7.02% decrease. There remain issues on load share for conveyances from GDH. LCH remain the 'preferred choice' to convey from GDH. GDH continued to experience a reduction in conveyance, 35 in September compared to 43 in August. A reduction of 18.61%
- The continued challenge, within our recovery phase, whilst maintaining the segregated pathways, will be managing our overall conveyances. We continue to work with the System to reduce our overall attendances and conveyances by ensuring all admission avoidance pathways are robust and communicated clearly. We still need clarification of the benefit from EMAS introducing 'Hear and Treat' and 'See and Treat' which is set at regional level rather than a local level. This has been challenged by the Lincolnshire System.

Actions in place to recover

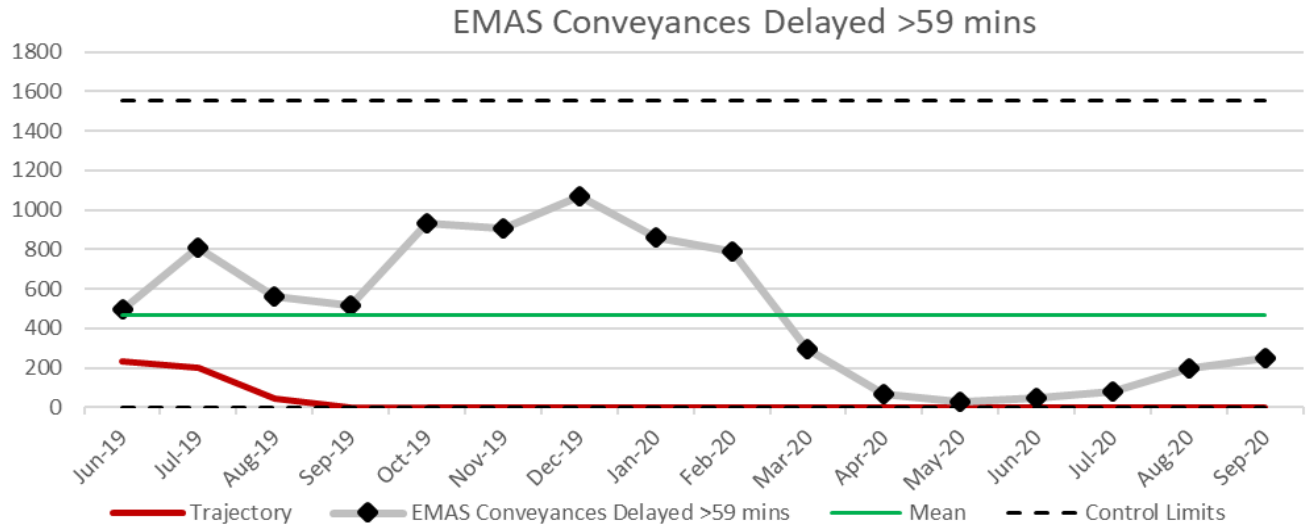
- Recovery plans being put in place by the Trust for urgent and emergency care (UEC) include patients being appropriately clinically managed through alternative streams to avoid large numbers of patients in the emergency department leading to possible delays in handover.
- An increase to the overall footprint of our Emergency Departments is currently underway with secured funding, with LCH receiving significant funding of £15m split over 20/21 and 21/22
- Key to delivering this and the Trust's UEC Recovery plan is the understanding, transparency and assurance of the Recovery plans developed and agreed by our partners in EMAS, LPFT, ASC and LCHS and agreed regionally and nationally. These plans need to reduce the burden placed upon the Acute Trust.

IMPROVE CLINICAL OUTCOMES – AMBULANCE HANDOVER >59

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services



Challenges/Successes

- During September there were 250 >59-minute ambulance handover delays. This is an increase of 56 compared to August. This represents a 22.4% increase in >59-minute ambulance handover delays. LCH had 164 >59-minute ambulance conveyances in August compared with 141 in August. This represents a 14.03% increase in September compared to August. PHB had 86 >59-minute ambulance conveyances in September compared with 52 in August. This represents a 39.54% increase.
- Delays experienced at LCH and PHB are, in the main, as a result of a continued inability to 'flex' the segregated pathways more responsively, the pattern of conveyance and poor flow, especially at LCH.
- We are now considered the worst performer in the region against this target. Daily meetings with System partners and NHSe/I colleagues review the performance and reasons for the >59 minutes delays.

Actions in place to recover

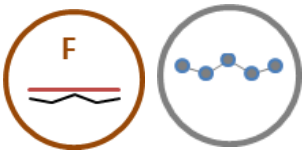
- As part of recovery and following confirmation of additional monies to enhance our urgent care facilities, working is underway to bring these plans to fruition. This will include a larger footprint for RAT and the addition of Priority Admissions Response Units (PARU)on both the PHB and LCH sites. The latter will reduce the number of patients waiting in the departments for access to inpatient care. These measures seek to significantly reduce >59mins handover delays.
- Work continues within the System to reduce the overall ambulance conveyances to ULHT through implementing robust alternative pathways.
- All ambulances at 30 minutes post arrival are now escalated to the Clinical Site Manager (CSM) if there is no robust plan to 'off load'. The CSM will work to resolve.

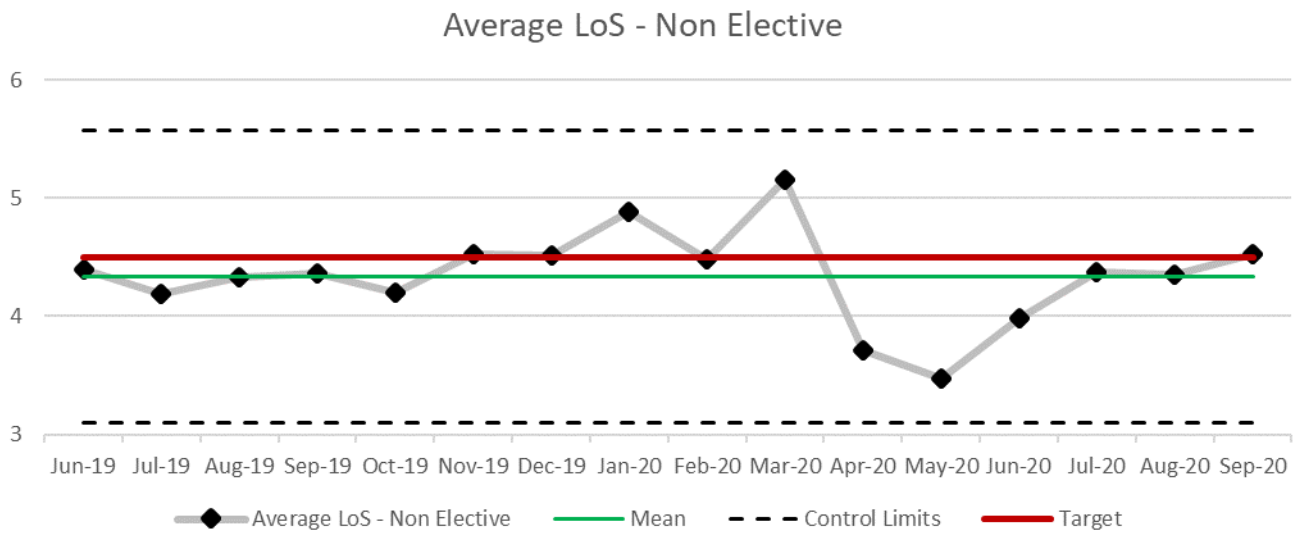
IMPROVE CLINICAL OUTCOMES – AVERAGE LOS NON-ELECTIVE

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services





Challenges/Successes

- Average LOS for non-elective admissions (NELA) saw a deterioration during September, delivering 4.53 ALOS compared to 4.35 compared in August. This represents a negative variation of 0.18 days and now above the trust target of 4.50 days.
- During September the numbers of patients with a LLOS increased from 81 in August to 102 in September. An increase of 21 patients.
- The work of the system wide discharge cell continues to address inequalities in access for both Community care and adult social care.
- The introduction of a local patient swabbing agreement for all patients requiring on going care within Adult Social Care is still causing some discharge delays of >72 hours. Whilst this process has received national recognition as exemplar practice.
- The System is exploring options to commission care homes who will support patients with pending swabs, especially pathway 1 where the demand is the greatest.
- Non elective admissions decreased in September by 9.32%. 2735 in September compared to 3016 in August. We are still below pre-covid levels. A September 2019 admission comparison to September 2020 shows a 19.09% decrease in non-elective admissions. 3380 NELA in September 2019 verses 2735 in September 2020.
- G&A core bed availability within ULHT has reached its tolerance at PHB and LCH. This was compounded by a Coronavirus outbreak on Digby Ward which rendered several beds unusable.
- A 'reset' of AMSS at PHB was undertaken in September to facilitate it's return to an acute medicine short stay unit. This has proved successful and daily discharges from this area have increased.

Actions in place to recover

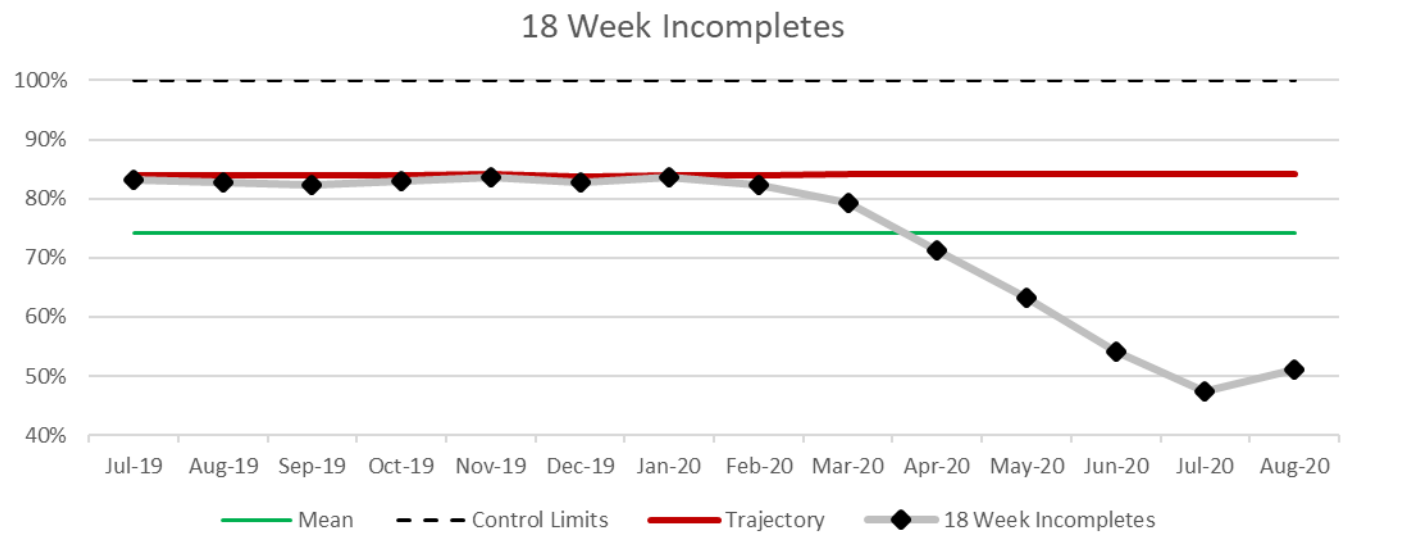
- Multi-agency discharge meetings continue take place daily, seven days a week. Line by line reviews take place against each patient on pathway 1,2 and 3. This process is now robust and an increase the discharge of medically optimised patients across the entire week (7days) is being realised.
- Long length of stay meetings for each hospital site remain in place to support more complex patients through their discharge pathway.
- More work is required in respect of the discharge pathways, in particular, pathway zero and especially at LCH. A MADE event is being planned for October. This will be led by the Deputy Chief Operating Office for Urgent Care in collaboration with Clinical Business Units, Corporate Teams and System Partners.

IMPROVE CLINICAL OUTCOMES - RTT 18 WEEKS INCOMPLETES

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services



Challenges/Successes

RTT performance is currently below trajectory and standard.

August saw RTT performance of 51.16%, +3.84% better than July.

Maxillo-Facial Surgery, Orthodontics and Oral Surgery is the lowest performing specialty, from 20.63% last month to 30.06% (+9.42%). Neurology has deteriorated this month with a 3.10% decrease from 45.36% last month to 42.27% in August.

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

- Ophthalmology - 4029 (Increased by 12)
- Trauma & Orthopaedics - 2296 (Increased by 75)
- ENT - 2077 (Decreased by 235)
- Maxillo-Facial Surgery + Orthodontics + Oral Surgery - 1906 (Decreased by 194)
- General Surgery - 1520 (Decreased by 3)

Actions in place to recover:

As detailed above, performance across most specialties continues to decline. Ophthalmology and Trauma & Orthopaedics have seen the largest decrease in performance.

The re-introduction of routine elective work for both admitted and non-admitted continues in line with recovery plans.

The Endoscopy service are working closely with the divisions identifying their longest waiting routine patients and prioritising these.

Specialties achieving the 18 week standard for August were:

- Clinical Oncology 93.84%

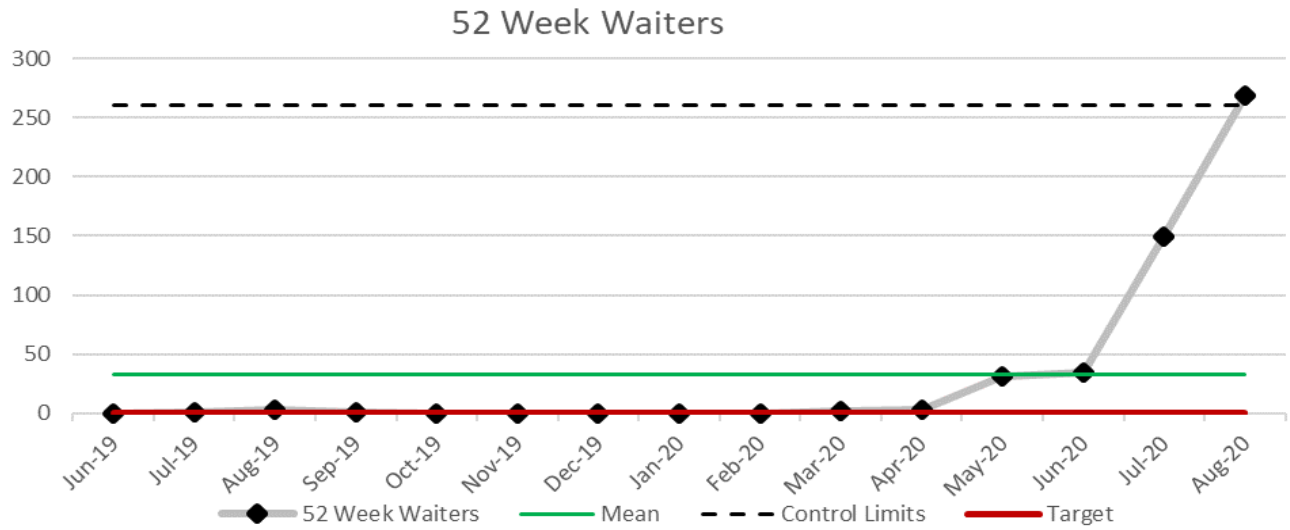
This is due to the continuation of Cancer services throughout the pandemic.

IMPROVE CLINICAL OUTCOMES – 52 WEEK WAITERS

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services



Challenges/Successes

The Trust reported two hundred and sixty-nine incomplete 52 week breaches for August end of month.

Breach Reason	
COVIDCapacity	252
Capacity	1
Unknown	1
Incorrect data entry	15
Total	**269**

Root cause analysis (RCA) and harm reviews will be completed by the relevant division for each patient. Where required, discussions around the incorrect data entry will be had with relevant staff and necessary actions implemented.

As anticipated there are an increased number of breaches declared each month. However, full focus is on these patients at the weekly PTL meeting to ensure that there is a plan for every patient.

Actions in place to recover

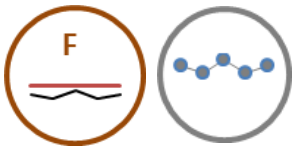
Recovery plans continue to be implemented; accounting for a changing environment.
Across the Trust outpatient services continue to use all available media to consult with patients.

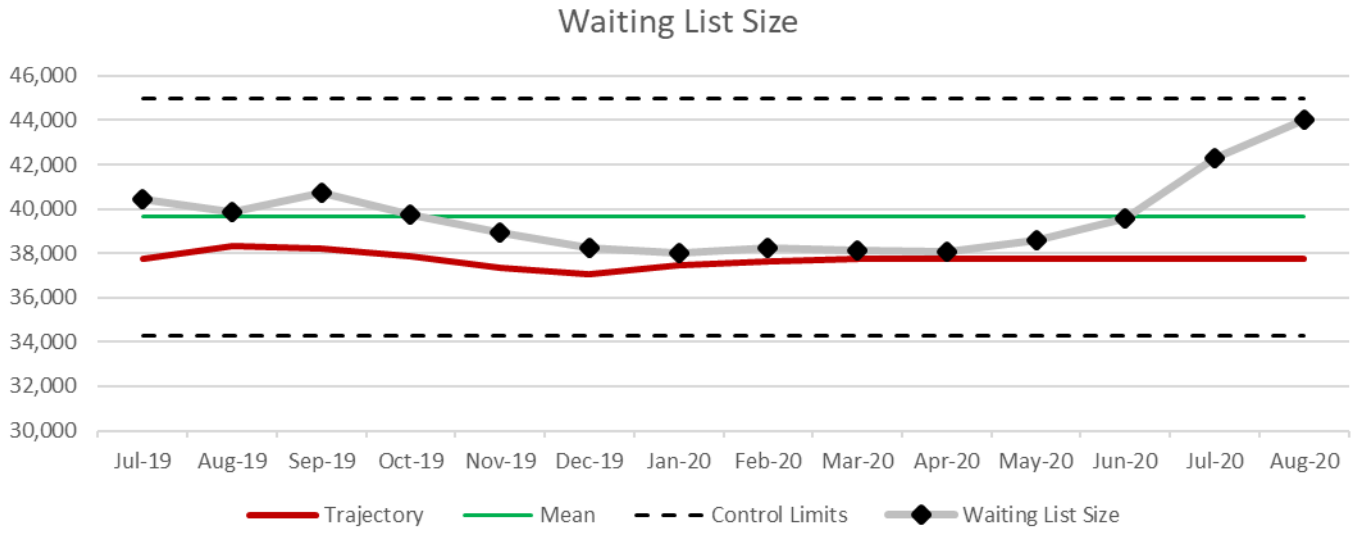
IMPROVE CLINICAL OUTCOMES – WAITING LIST SIZE

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services





Challenges/Successes

Overall waiting list size has increased from July, with August total waiting list increasing by 1727 to 44,033. The incompletes position for August is now approx. 5001 more than the March 2018 (39,032) target.

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

- Dermatology + 316
- Ophthalmology + 283
- Trauma & Orthopaedics + 265
- General Surgery + 205
- Gynaecology (+ 125)

The five specialties showing the biggest decrease in total incomplete waiting list size from July are:

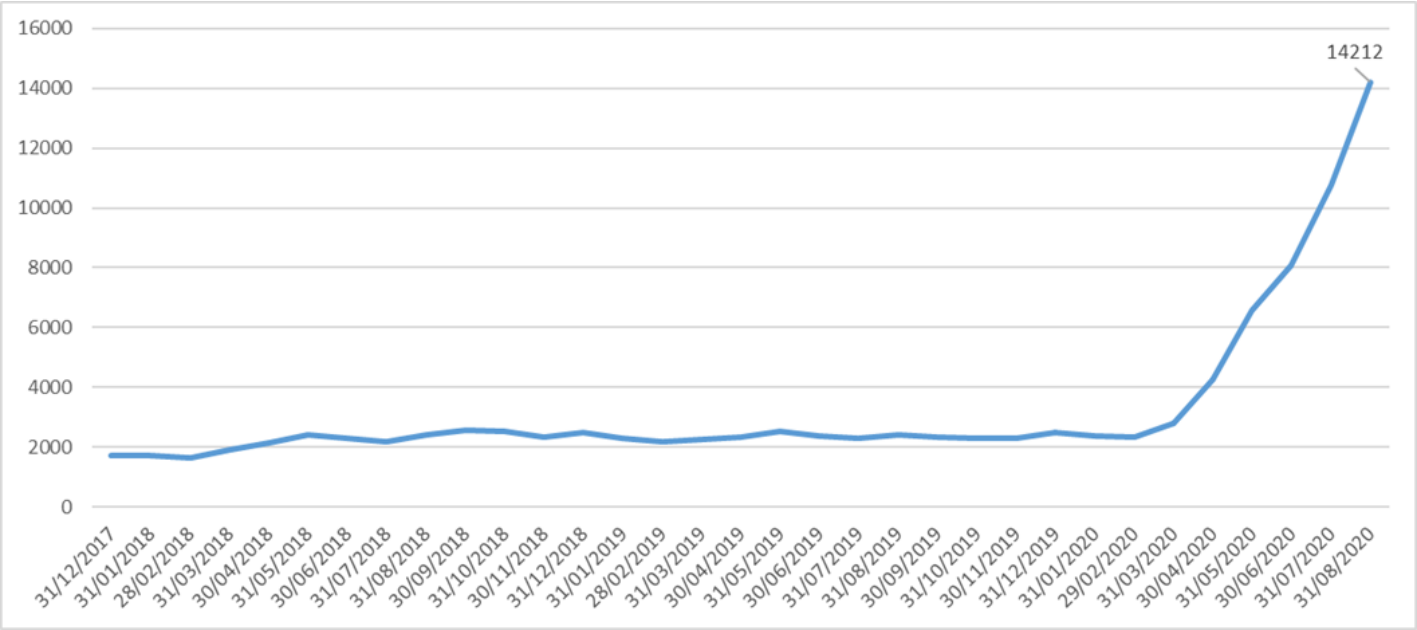
- Community Paediatrics - 65
- Neurology - 33
- Clinical Oncology - 23
- Geriatric Medicine – 7
- Respiratory Physiology – 6

Actions in place to recover

The longest waiting patients are tracked and discussed at the weekly PTL meeting. July to August saw an increase of patients waiting over 40 weeks, +782, with Ophthalmology (+267) showing the largest increase. Six specialties reduced their position compared to last month, with Diabetic Medicine showing the best improvement of -4 patients from last month.

The chart below shows progress up to 31st August, with an increase of 3431 patients from July. The largest increase was seen in Ophthalmology, +946. No specialties decreased their position

Total Number of Incomplete Patient Pathways at 26 Weeks and Above for ULHT by Month

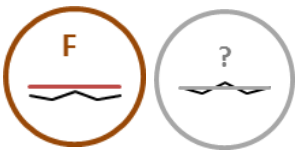


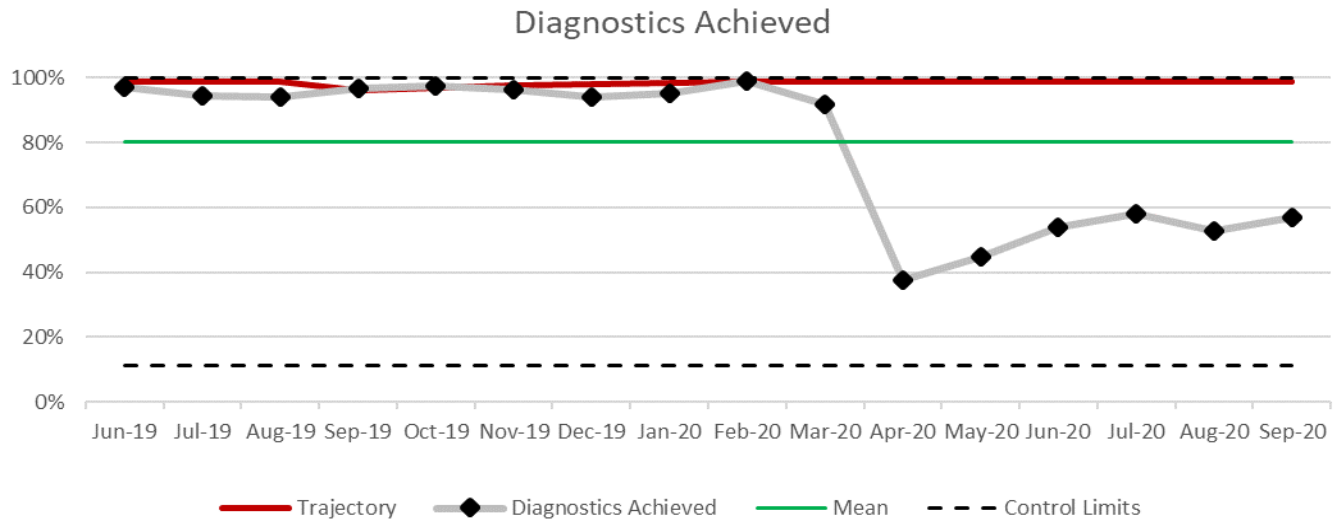
IMPROVE CLINICAL OUTCOMES – DIAGNOSTICS

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services





Challenges/Successes:

September performance was 56.98% which was a slight improvement on August 52.81%

Actions in place to recover:

Endoscopy is now booking cancer patients within 7-10 days and is now working on the urgent request backlog which we are now booking under 6 weeks. At the present time routine patients are still not being booked but will be when the backlog of urgent is dealt with. Still using Medinet to offer additional support a weekends on Lincoln Louth and Grantham.

Audiology have successfully negotiated with Specsavers to take on 251 patients off the ULHT backlog. These patients will be seen for 3 years under Specsavers. ENT have uncoupled some of their audiology ENT joint clinics, we are aware of 450 patients on the PBWL requiring an audiology diagnostic appointment. These are additional diagnostic requests and will now be reported will under the DM01. Under Covid social distancing this will be considerably hard to deal with this increase in demand. Plans are being pulled together as to how this additional work and existing backlog due to Covid will be undertaken. We are extremely close to delivering 100% pre covid activity levels

CT capacity was lost in September due to the failed delivery of the CT modular unit. This has now been delivered in October so will supply additional capacity at Pilgrim and resilience to the aging scanner at Pilgrim. This will help with cancer urgent and routine outpatient referrals. There is still difficulty in getting patients to attend their appointments as they want to wait until: Is over. This has been raised in the cancer Fort nightly meeting with Charlie Carol and we will look at a process to try and support these patients.

Neuro physiology. We now have 3 substantive staff in post and 1 agency so a total of 4 staff. We are struggling for clinic space at Pilgrim to undertake the additional clinics needed as there has been a Re configuration of that space. Neuro physiology is also very close to pre Covid activity levels

MRI is very close to pre covid capacity at around 87% there is very little uptake for the Green site scanner due to patient's not wanting to follow the IPC process to have the scan at Grantham. Plans

were in place to get an additional mobile MRI to cover that work. There was also a backlog of cardiac patients that radiology and cardiology are looking at to resolve. The MRI additional scanner at Grantham that was in place to offer an MRI service whilst the scanner was being replaced has now been extended to April. We are looking to use this from November as a blue scanner to offer additional capacity.

Cardio physiology I have taken this information from the cardiology physiology action plan please see attached

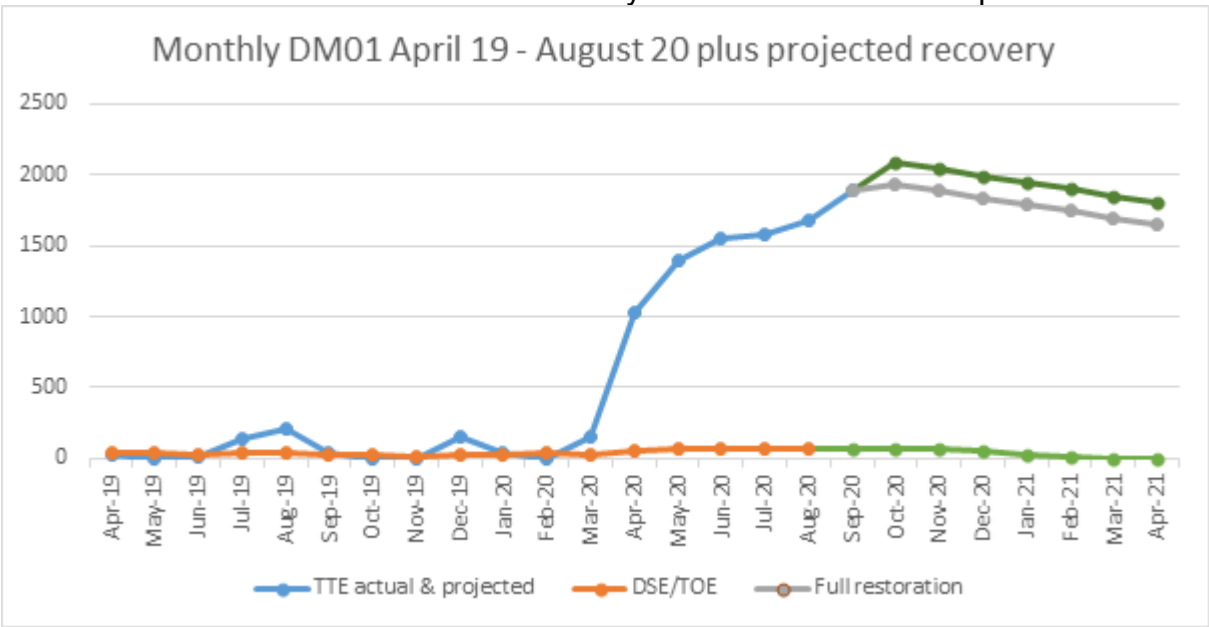
Service Recovery

As part of the phase three workings, based on the size of the current backlog it is estimated that 4.0wte B7 Physiologists (or equivalent agency) are required for circa 9 months to reduce the current backlog to pre-covid levels. This has been included as part of the wider CBU recovery plans, but as of yet, no confirmation has been received organisationally re. commencement of recovery activity.

Based on current in-progress restoration and changes, the following recovery trajectory (overleaf) is expected.

This takes into account:

- Additional 20 x specialised echoes per month at Lincoln site following estates work from December onwards.
- Additional 160 x TTE slots at Pilgrim site, following estates work at Pilgrim, and current student technician completing their degree. Active from December 2020.
- Restoration of 88 x TTE slots at Lincoln following repatriation of current ad-hoc specialised activity to new Physiology build (currently done in clinic 3) from December 2020 onwards.
- Current GDH work across Moy Park and Vine Street sites.
- Restoration of 32 x TTE slots currently lost due to additional inpatient focus at Pilgrim site.



The full restoration line (grey) shows the potential progression of recovery should Grantham site allow blue pathways to be restored in Cardiac Physiology. This would facilitate the restoration of a further 154 slots on GDH site.

The numbers calculated are based on assumptions of:

- 881 referrals per month (based on August's referrals total of 771, plus an average 110 PBWL echoes per month)
- No list cancellations due to increased inpatient demand
- No significant staff absence levels due to COVID-19.

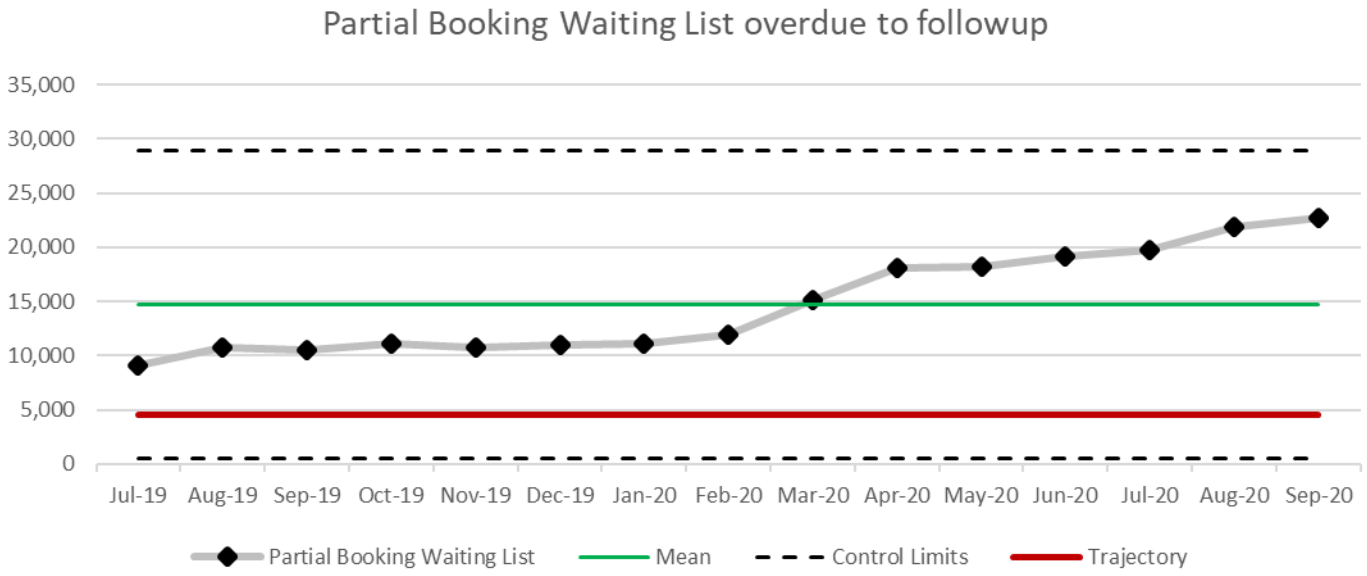
Please note, this trajectory is formulated based on current demand vs. emerging capacity and has not factored in additional rapid recovery proposed as part of Stage 3 recovery.

IMPROVE CLINICAL OUTCOMES – PARTIAL BOOKING WAITING

Executive Lead: Chief Operating Officer

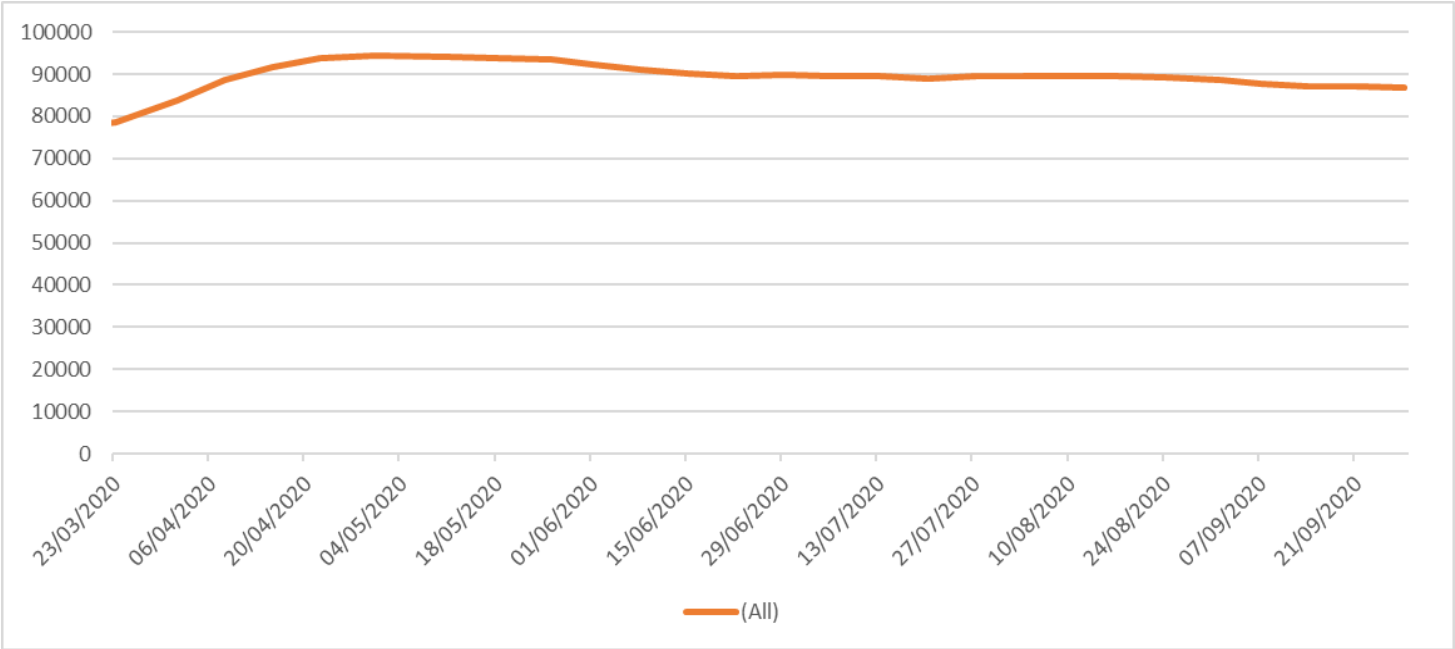
CQC Domain: Responsive

Strategic Objective: Services



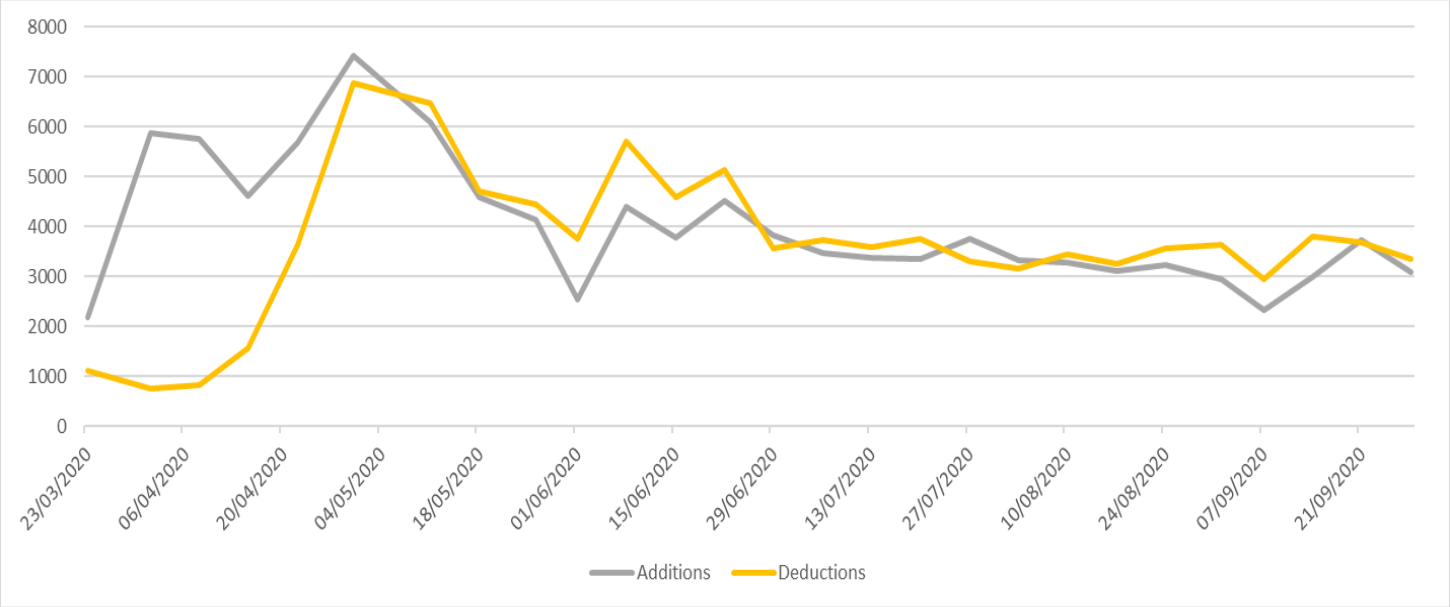
Challenges/Successes:

Following a period of growth through March to May due to a significant reduction in routine outpatient activity because of the Trust's response to COVID-19, the overall partial booking waiting list size has reduced / been stable, as illustrated in the chart below. The overdue PBWL is still a significant concern as it continues to rise, although the increase has slowed, As illustrated in the chart above. The next challenge is how we put the actions in place safely to increase the activity to pre covid levels and reduce the overdue waiting list size.



Actions in place to recover:

Our recovery actions include administrative validation, clinical triage and the scaling up of technology enabled care. The specialities have submitted their plans to increase activity back to last year's activity levels within outpatients, although through less sites. The actions are challenged at a weekly PBWL review meeting and progress is reported through the Trust SBAR. We are monitoring and challenging at the PBWL meetings to ensure deductions are outrunning additions, leading to the reduction in overall waiting list size.

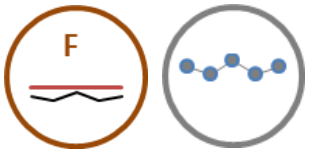


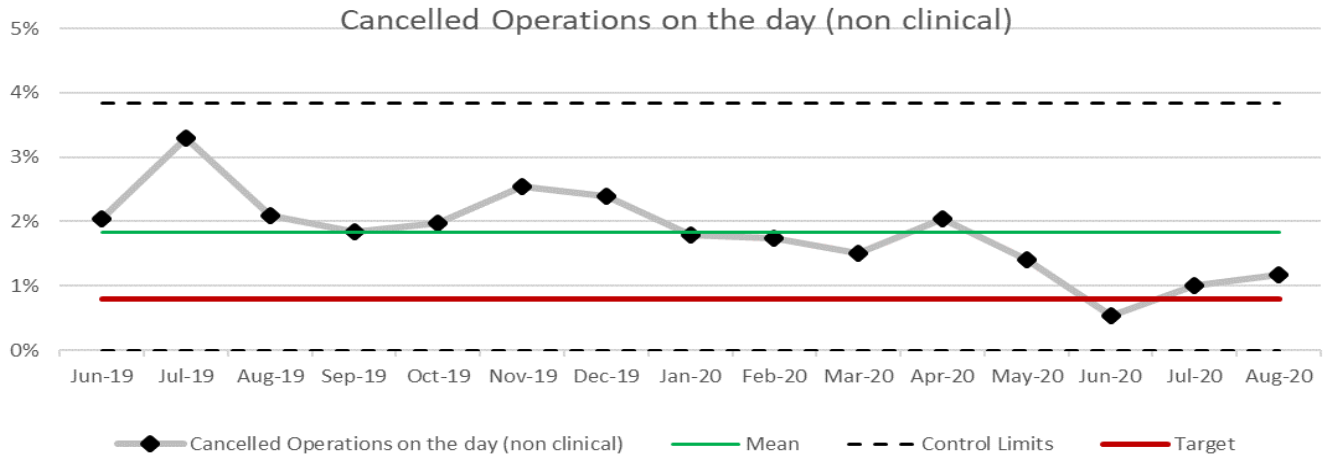
IMPROVE CLINICAL OUTCOMES – CANCELLED OPS

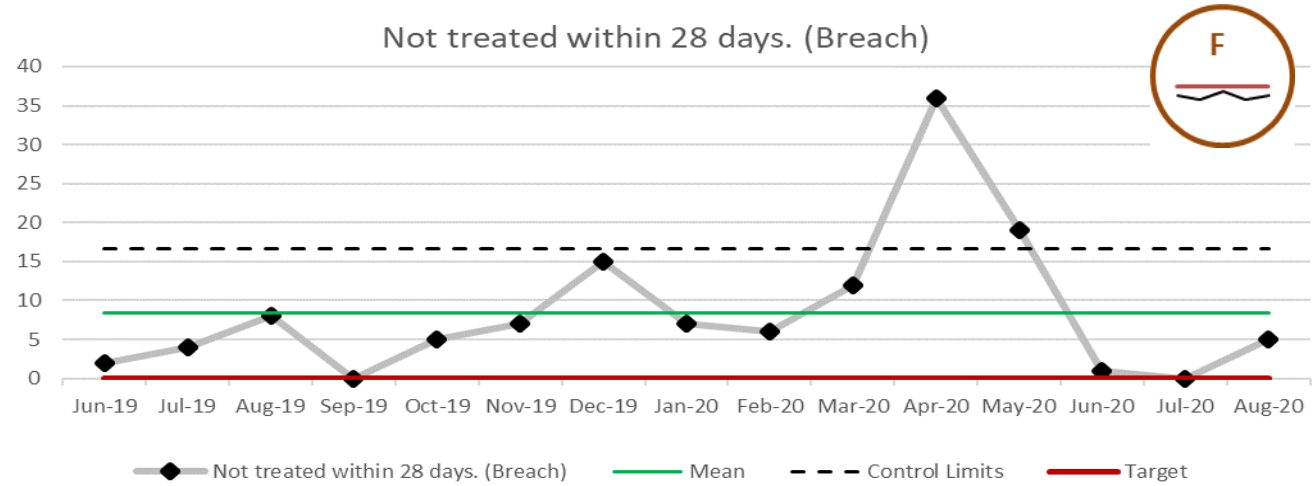
Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services







Challenges/Successes:

There has been an increase in the number of on the day cancellations due to a variety of reasons – patients being medically unfit, further tests required, lack of theatre time, patient cancellations due to being unwell and DNA's.

Complexity of surgery due to passage of time is resulting in some cases taking longer than planned and resulting in cancellations.

Actions in place to recover:

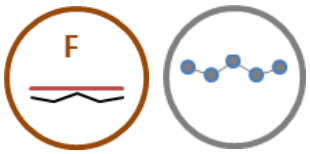
Theatre activity and list utilisation is being reviewed weekly to identify and address issues.

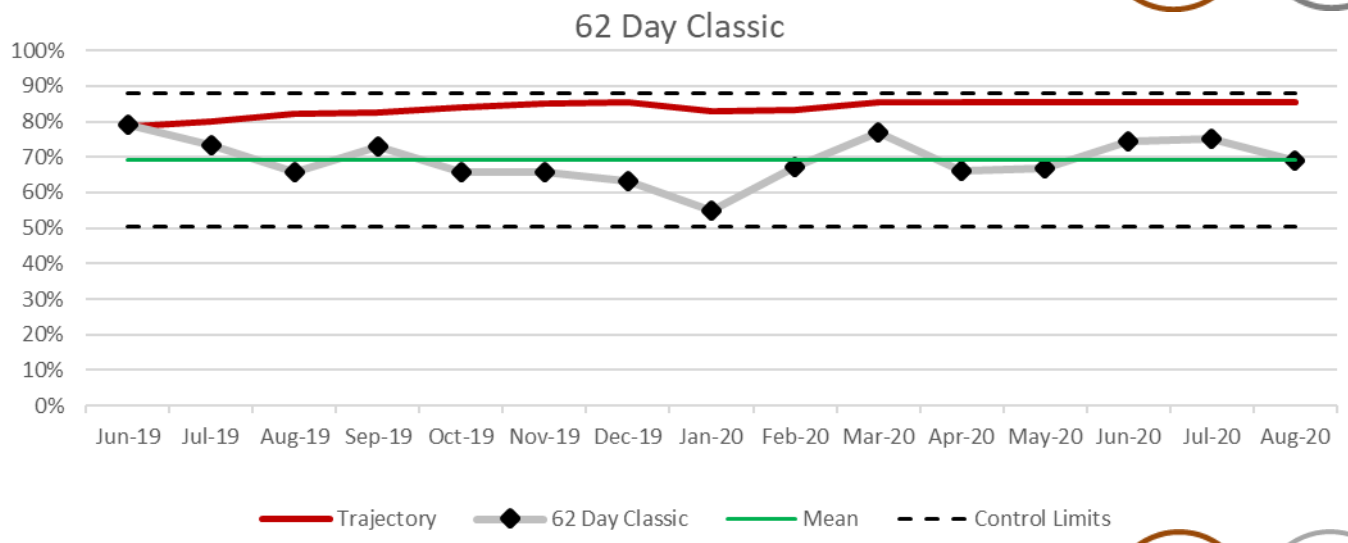
IMPROVE CLINICAL OUTCOMES – CANCER 62 DAY

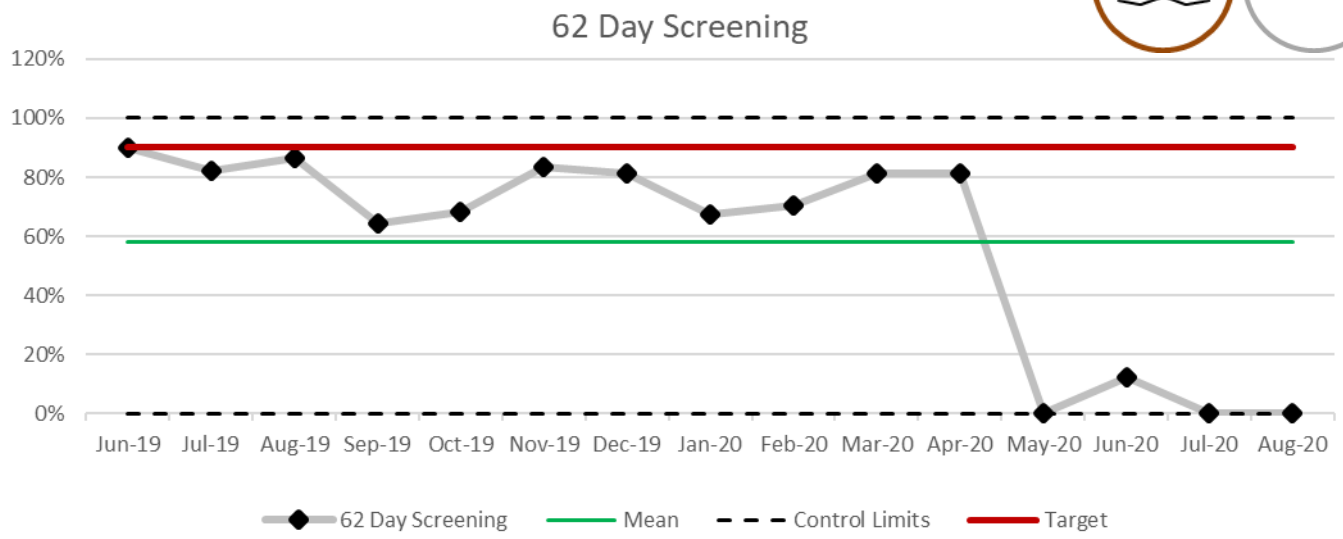
Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services

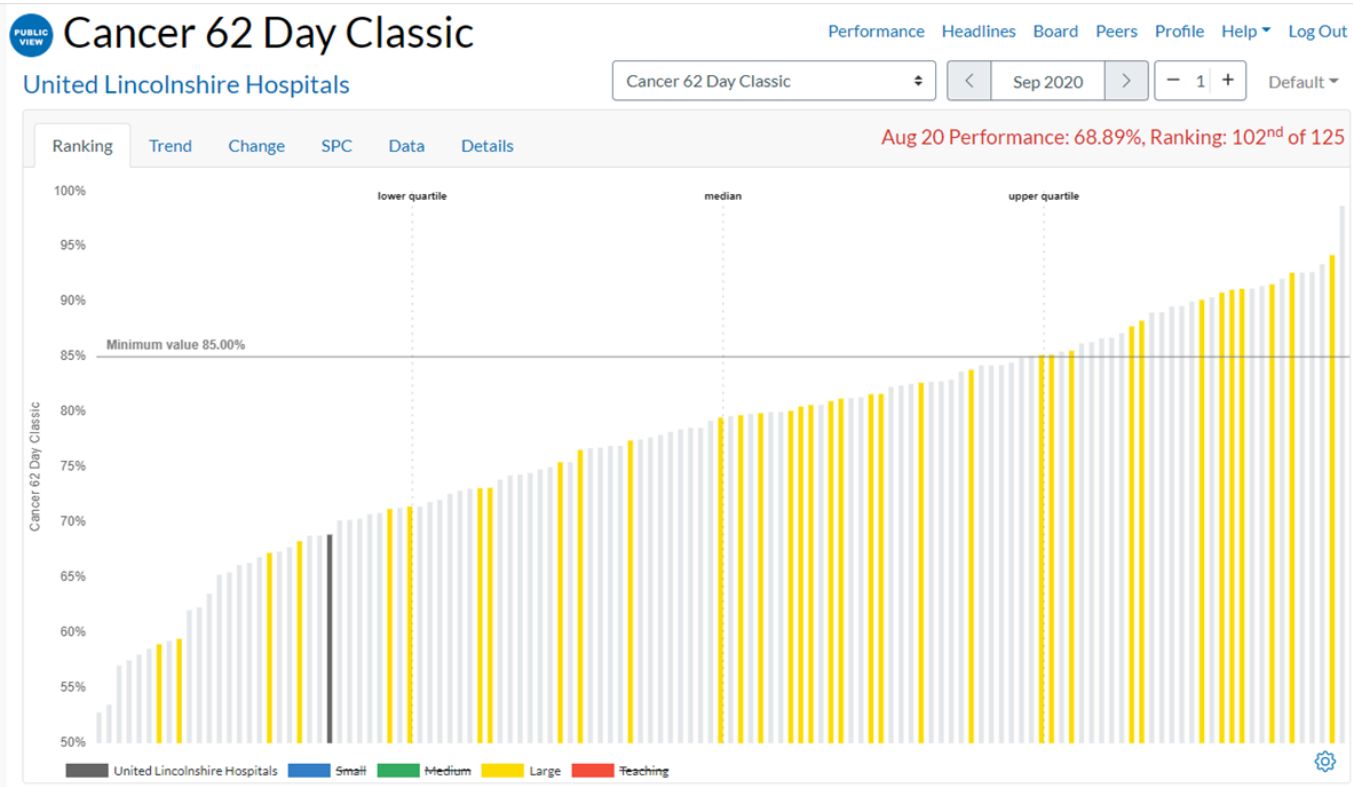






Challenges/Successes

In August our 62 Day Classic performance fell 6.1% compared to August, at 68.9% and putting us below the national average (77.9%) and putting us in the lower quartile



Early indications are that our September 62 Day Classic performance will be circa 65%.

Challenges to our performance include:

- Inappropriate referrals from GPs (eg not having face-to-face appointment before referral)
- Patient engagement in diagnostic process (reluctance to visit hospitals during COVID-19)
- Increased time to book diagnostics with patients due to COVID requirements (for Endoscopy it has increased from 6 mins to 16 mins per patient)
- Capacity not always where patient is willing to travel
- Patient acceptance & compliance with swabbing and self-isolating requirements
- Limited outpatient capacity due to social distancing requirements
- Reduced theatre capacity across the Trust, all Specialties vying for additional sessions
- Severely restricted access to Independent Sector capacity relative to regional colleagues
- Recognition that backlogs created during COIVD-19, due to stopped/reduced services, are still progressing through diagnostic and treatment pathways (ie breaches need to be treated before performance is able to improve)
- 62 Day backlogs significantly in excess of pre-COVID levels for in Colorectal, Gynaecology, Head & Neck and Urology
- Clinical capacity to engage in clinical reviews & FDS
- Capacity within Divisions to give necessary attention to Cancer
- Lost treatment capacity due to short notice cancellation of patients (unwell on the day of treatment or day before), not allowing time to swab replacement patients

Actions in place to recover:

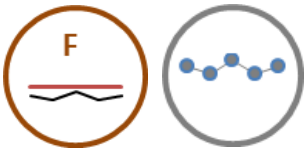
- 28 Day FDS identified as Trust's single cancer performance workstream in the Integrated Improvement Program
- Additional theatres being installed at Grantham for Breast & Gynaecology
- Breast Services review
- Review of Colorectal theatre list scheduling to better align with clinician availability
- Additional relocatable CT at Boston
- Bid for 'blue' CT at Grantham
- Endoscopy booking team working additional hours (application to recruit 3 WTE)
- New Endoscopy decontamination facility on line giving improved turn-around times
- Dedicated admin resource within Colorectal CBU to support clinical engagement
- Return of H&N consultant (from sabbatical) and third post appointed (starting December)
- Oncology Fragile Service Review

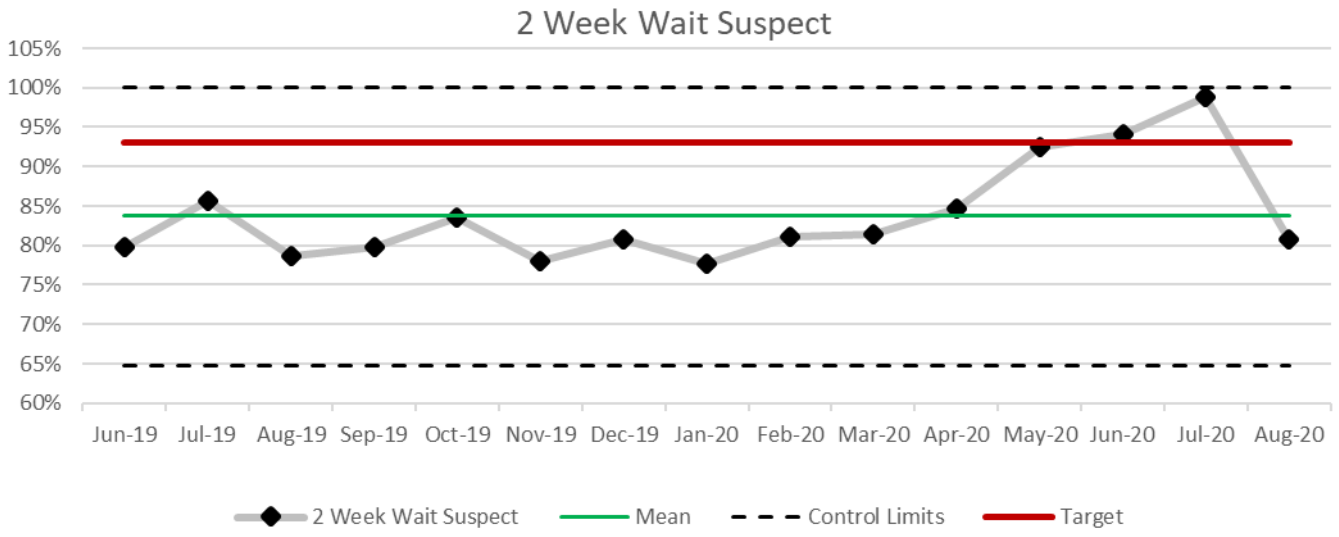
IMPROVE CLINICAL OUTCOMES – CANCER 2 WEEK WAIT

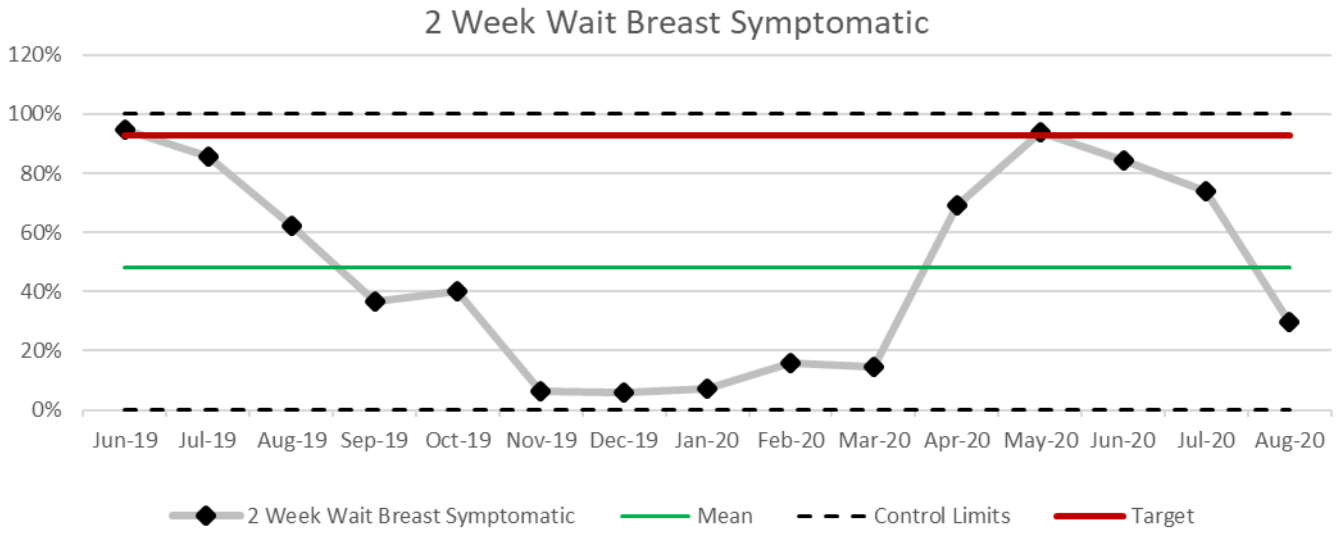
Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services

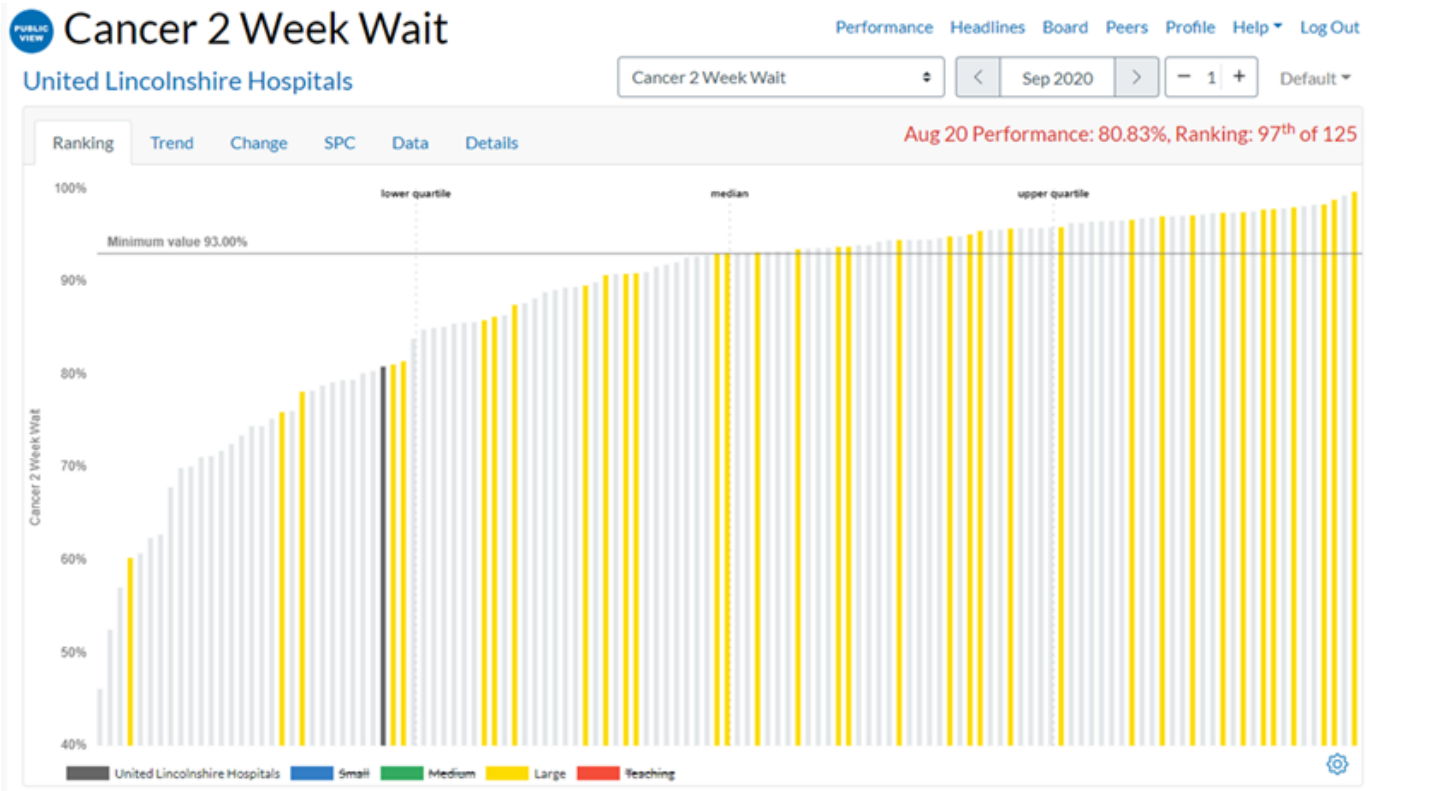






Challenges/Successes

The Trust's 14 Day performance continues to be significantly impacted by the current Breast Service One-Stop appointment alignment issues. The other tumour sites that considerably under-performed include Gynaecology, Lung, Upper GI and Urology. The Trust was in the lower quartile for both 14 Day standards.



Actions in place to recover:

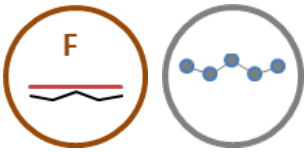
- Alignment of all 2ww Referral forms to NG12
- External Breast Service review
- Consideration of the Gynae ultrasound provision with potential to establish Direct Access pathway
- H&N Neck Lump Direct Access pathway to be implemented
- Lung Direct Access pathway to commence Trustwide
- Pilot of triaging all Skin 2ww referrals
- Project to establish Upper GI Direct Access pathway by Jan 21
- Urology review of cystoscopy provision (particularly at Louth)

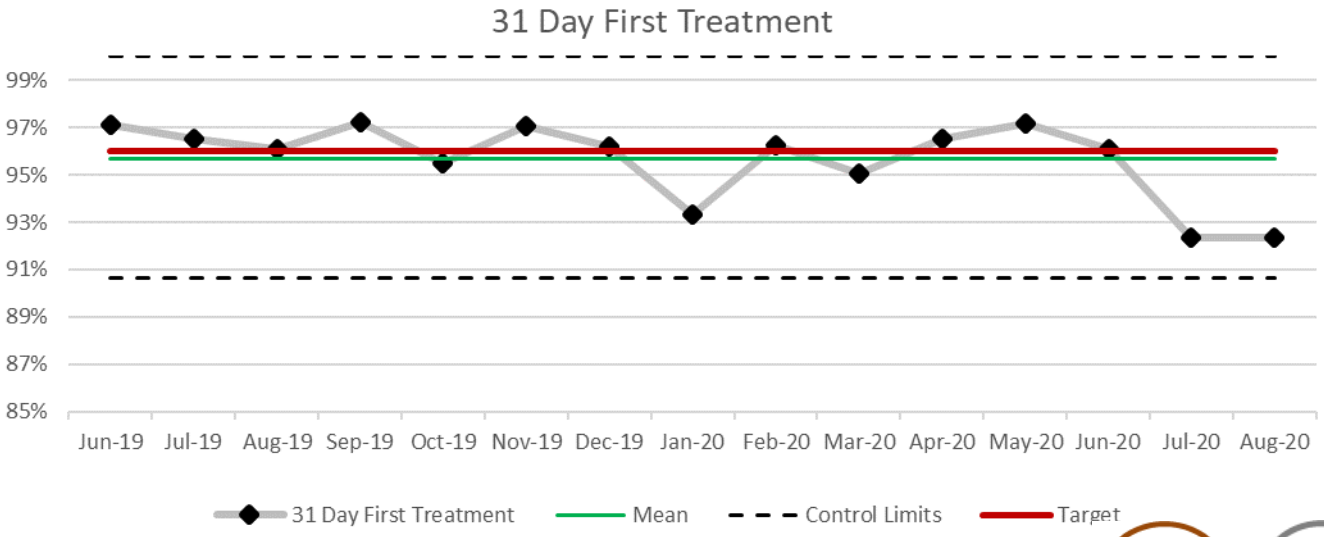
IMPROVE CLINICAL OUTCOMES – CANCER 31 DAY

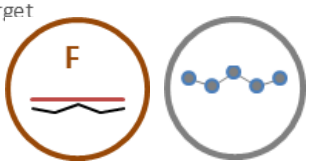
Executive Lead: Chief Operating Officer

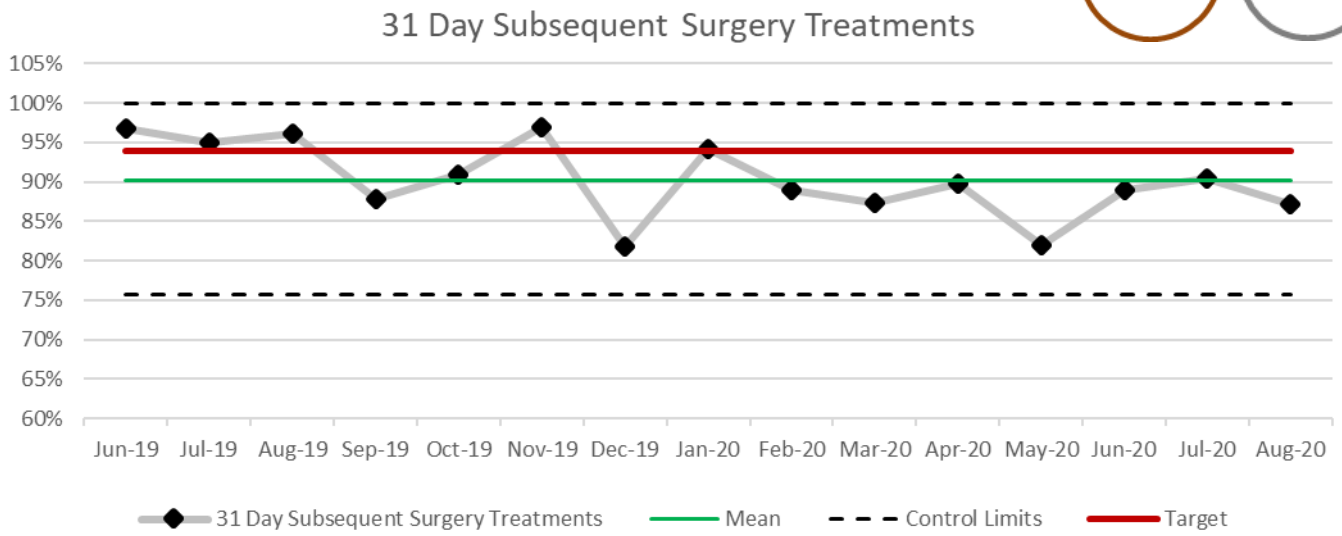
CQC Domain: Responsive

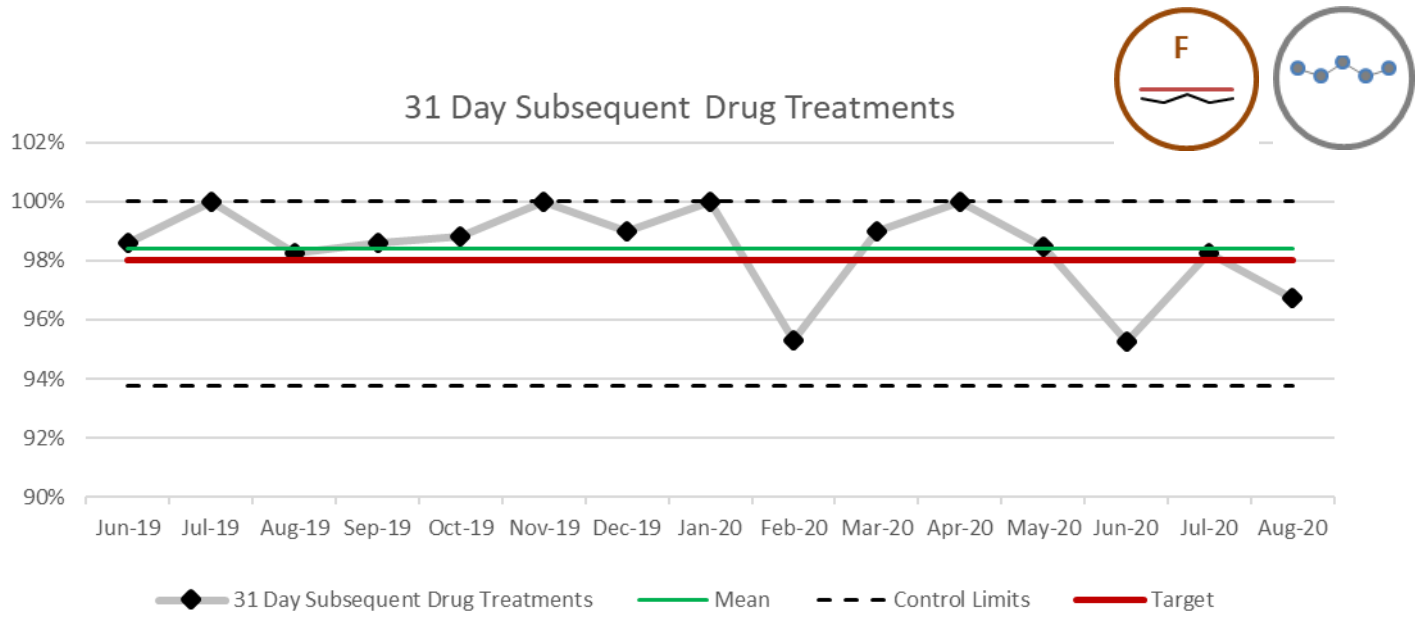
Strategic Objective: Services

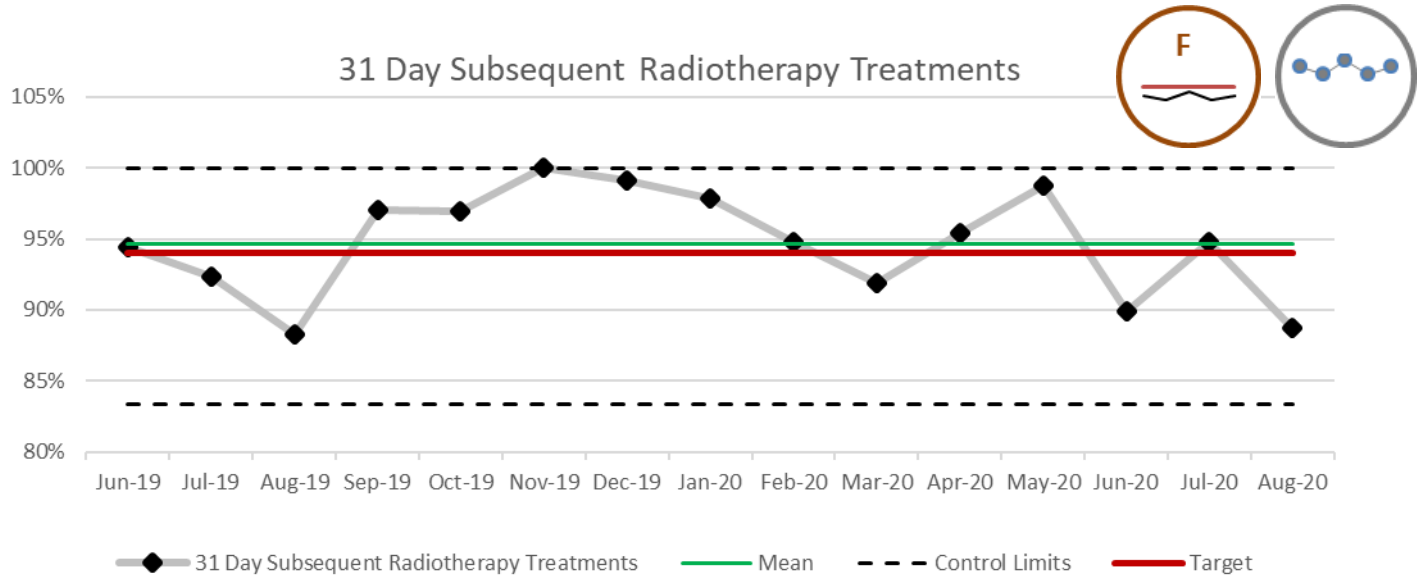












Challenges/Successes

The 31 Day standards were missed primarily due to the impact of COVID (the reduction in capacity due to social distancing and patient reluctance to attend hospitals) and medical reasons.

Actions in place to recover:

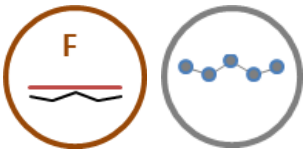
- Additional theatres being installed at Grantham for Breast & Gynaecology
- Review of Colorectal theatre list scheduling to better align with clinician availability
- Return of H&N consultant and third post appointed to (starting December)
- Oncology Fragile Service Review

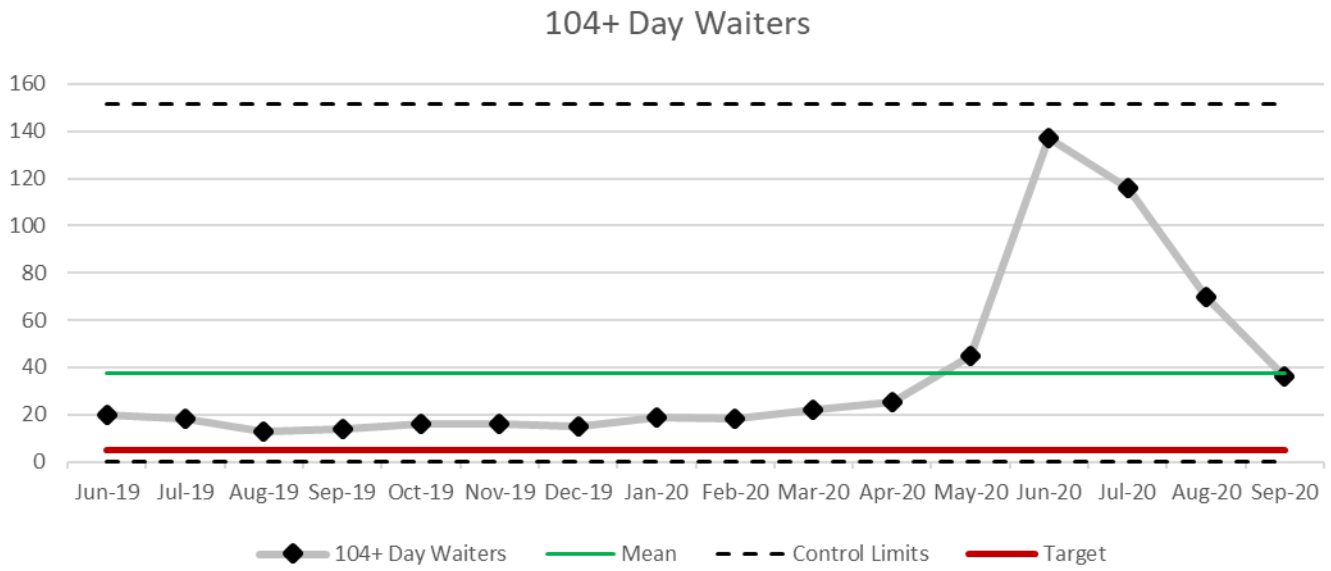
IMPROVE CLINICAL OUTCOMES – CANCER 104+ DAY WAITERS

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services





Challenges/Successes

The 104+ Day backlog was stabilising week-on-week pre-COVID but the crisis temporarily stopped diagnostics and treatments, both at ULHT and tertiary centres, and this has had a significant impact on these numbers. As of 5th October there remain 40 patients waiting over 104 days, significantly down from the highpoint of 163 patients in mid-July. Of the long waiting patients, approx 50% are on a Colorectal pathway, with half awaiting further diagnostic procedures.

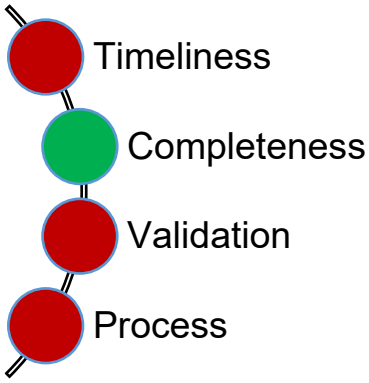
Actions in place to recover:

As for the 62 Day actions:

- 28 Day FDS identified as Trust's single cancer performance workstream in the Integrated Improvement Program
- Additional theatres being installed at Grantham for Breast & Gynaecology
- Breast Services review
- Review of Colorectal theatre list scheduling to better align with clinician availability
- Additional relocatable CT at Boston
- Bid for 'blue' CT at Grantham
- Endoscopy booking team working additional hours (application to recruit 3 WTE)
- New Endoscopy decontamination facility on line giving improved turn-around times
- Dedicated admin resource within Colorectal CBU to support clinical engagement
- Return of H&N consultant (from sabbatical) and third post appointed (starting December)

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

Meeting	*Trust Board*
Date of Meeting	*Tuesday 3rd November 2020*
Item Number	*Item 13.1*
Strategic Risk Report	
Accountable Director	*Dr Karen Dunderdale, Director of Nursing*
Presented by	*Dr Karen Dunderdale, Director of Nursing*
Author(s)	*Paul White, Risk & Incident Lead*
Report previously considered at	*N/A*

How the report supports the delivery of the priorities within the Board Assurance Framework	
1a Deliver harm free care	*X*
1b Improve patient experience	*X*
1c Improve clinical outcomes	*X*
2a A modern and progressive workforce	*X*
2b Making ULHT the best place to work	*X*
2c Well Led Services	*X*
3a A modern, clean and fit for purpose environment	*X*
3b Efficient use of resources	*X*
3c Enhanced data and digital capability	*X*
4a Establish new evidence based models of care	
4b Advancing professional practice with partners	
4c To become a university hospitals teaching trust	

Risk Assessment	*Multiple – please see report*
Financial Impact Assessment	*None*
Quality Impact Assessment	*None*
Equality Impact Assessment	*None*
Assurance Level Assessment	*Moderate*

Recommendations/ Decision Required	*Trust Board is invited to review the report and identify any areas requiring further action*

Executive Summary

Quality & safety risk profile:

- All current strategic quality and safety risks remain at the same rating as the previous month, although there is some evidence of a reduction in risk within A&E
- The threat of Covid-19; safe management of emergency demand; safe management of medicines; potential outbreak of infectious disease; and medical device availability are the highest strategic quality and safety risks at present

Finance, performance & estates risk profile

- The current strategic risk profile for finance, performance and estates risk shows no material change since the last report
- The highest rated strategic risks at present are the capacity to manage emergency demand; substantial unplanned expenditure or financial penalty; and deliver of the Financial Recovery Programme

People & organisational development risk profile:

- The current strategic and operational risk profiles for people and organisational development both show that the Trust is exposed to a significant amount of workforce risk at present, although there are signs that the implementation of planned mitigating actions are having a positive effect and that these risks are reducing
- There are dedicated work-streams within the Trust's Integrated Improvement Plan (IIP) to address areas of workforce capacity, capability and morale risk
- Risks in relation to the workforce capacity impact of responding to the Covid-19 pandemic, and the reputational impact if the planned Medical Education Centre project is not delivered, have now been added to the strategic risk register

Purpose

The purpose of this report is to enable the Trust Board to:

- Review the management of risks throughout the Trust and consider the extent of risk exposure at this time
- Evaluate the effectiveness of the Trust's risk management processes

Key messages

1. Introduction

1.1 The Trust's risk registers are recorded on the Datix Risk Management System. They are comprised of two distinct layers, which are defined in the Trust's current Risk Management Strategy as:

- Strategic risk register – used to manage significant risks to the achievement of Trust-wide or multi-divisional objectives
- Operational risk registers – used to manage significant risks to the objectives of divisional business units and their departments or specialties

1.2 Each strategic risk has an Executive lead, with overall responsibility for its management; and a Risk lead, who is responsible for reviewing the risk and updating the risk register in accordance with the Trust's Risk Management Policy. The majority of strategic risks are also aligned with the appropriate assurance committee of the Trust Board and assigned to a lead group to enable regular scrutiny of risk responses and mitigation plans to take place.

1.3 Each operational risk has a divisional lead and a business unit risk lead. Operational risks are also aligned with the Trust's assurance committee and lead group governance arrangements.

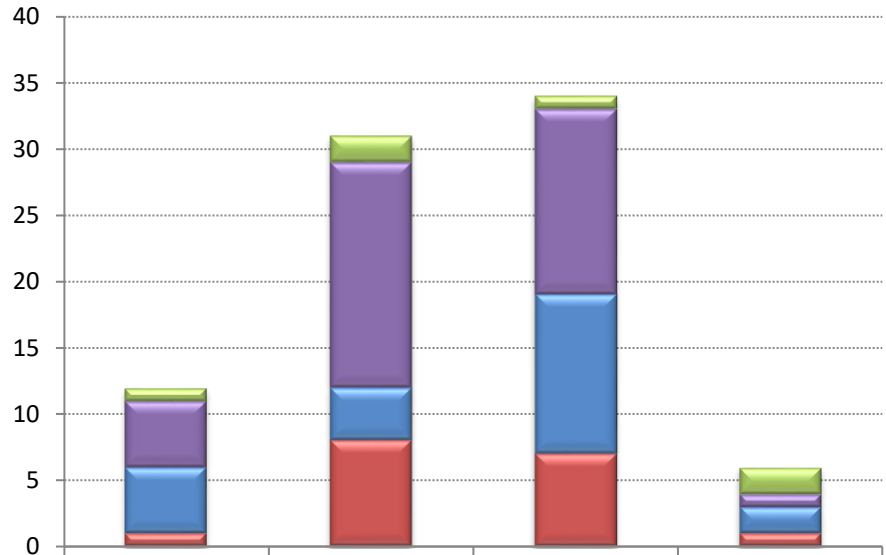
1.4 Strategic and operational risk registers consist of two types of risk:

- Core risks – that are set by the Risk Management Strategy and remain open on the appropriate risk register even when managed down to an acceptable level, so as to continue to provide valuable assurance as to their effective management
- Non-core risks – that are added in response to the identification of a specific threat or vulnerability that is outside of the scope of the core risk register

1.5 All entries on the strategic or operational risk registers should be formally reviewed and updated on a quarterly basis as a minimum requirement, although they may be updated in the interim if there is evidence that the level of risk has changed. The current round of quarterly risk reviews are due to be completed by the end of September 2020.

2. Strategic Risk Profile

2.1 **Chart 1** shows the number of strategic risks by risk type and current risk rating (taking account of existing controls):



	Low risk	Moderate risk	High risk	Very high risk
Finances	1	2	1	2
Reputation / compliance	5	17	14	1
Service disruption	5	4	12	2
Harm (physical or psychological)	1	8	7	1

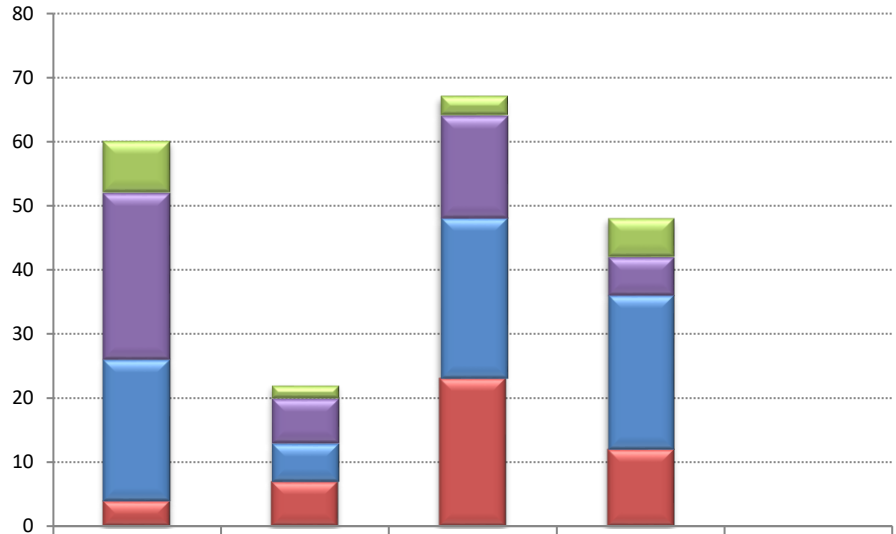
2.2 40 out of 83 strategic risks recorded on Datix are currently rated as Very high or High (48% of the total). This a reduction of 1% from last month.

2.3 There is one new strategic risk that has been added since the previous report, which concerns the reputational risk should the Trust not deliver the new Medical Education Centre in accordance with planned timescales, budget and specifications. This risk is currently rated as Moderate (8) and will be included in future risk reports to the People and Organisational Development Committee.

2.4 A summary of all risks currently recorded on the Strategic Risk Register is attached as **Appendix 1.**

3. Operational Risk Profile

3.1 **Chart 2** shows the number of operational (divisional business unit) risks by current (residual) risk rating:



	Very low risk	Low risk	Moderate risk	High risk	Very high risk
Finances	8	2	3	6	0
Reputation / compliance	26	7	16	6	0
Service disruption	22	6	25	24	0
Harm (physical or psychological)	4	7	23	12	0

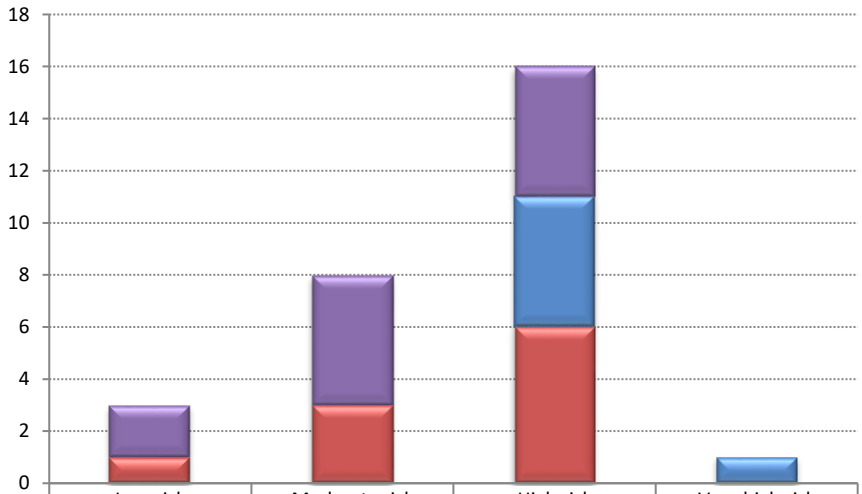
3.2 Of the 197 risks recorded on divisional business unit risk registers, 48 (23%) are currently rated as High or Very high. This is the same proportion as reported last month.

3.3 A summary of current High and Very high operational risks is attached as **Appendix 2.**

4. Quality & Safety Risk Profile

4.1 The Quality Governance Committee (QGC) is the lead assurance committee responsible for oversight of the quality and safety risk profile. The QGC continued to meet throughout the Covid-19 pandemic, although with a reduced agenda. The Committee is currently running with a full agenda. Most lead groups have also continued to meet wherever possible.

4.2 **Chart 3** shows a breakdown of strategic quality and safety risks by current risk rating and type:



	Low risk	Moderate risk	High risk	Very high risk
Finances	0	0	0	0
Reputation / compliance	2	5	5	0
Service disruption	0	0	5	1
Harm (physical or psychological)	1	3	6	0

4.3 There are 28 quality and safety risks recorded on the strategic risk register. 16 of these are currently rated as High risk (12-16), 1 is rated Very high risk (20-25). This is unchanged from the previous report.

4.4 The 1 strategic quality & safety risk with a current rating of Very high risk is as follows:

Risk title (ID)	Local impact of the global coronavirus (Covid-19) pandemic (4480)		
Current risk rating	Very high (25)	**Risk lead**	Kevin Shaw
Lead group	Infection Prevention & Control Group		

Key Risk Indicators (KRIs):

- Number of in-patient admissions due to Covid-19 – significantly lower at present than at the height of the pandemic
- Number of patients in intensive care due to Covid-19

- Number and severity of patient safety incidents linked to Covid-19 – monthly average has reduced from 85 at the height of the pandemic to 63 in the last 2 months; proportion resulting in harm has reduced from 20% to 10%

Gaps in control & mitigating actions:

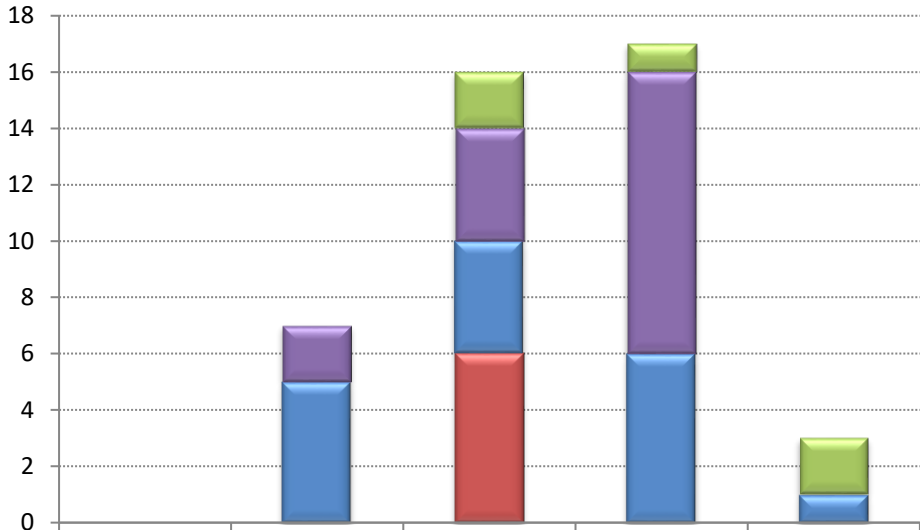
- Lack of an approved vaccine and limited effective treatment options available; the Trust has enacted the agreed national response plan and has been reintroducing suspended services now that demand has reduced
- There remains a high degree of uncertainty over the potential for a second wave, along with the threat from regular winter pressures and the impact on staff wellbeing from dealing with the pandemic both professionally and personally

4.5 Of the 63 operational quality and safety risks recorded on business unit risk registers, 15 (24% of the total) are currently rated as High risk (12-16). This is an increase of 1% from last month's report.

5. Finance, performance and estates risk profile

5.1 The Finance, Performance and Estates Committee (FPEC) is the lead assurance committee responsible for oversight of the finance, performance and estates risk profile. FPEC did not meet regularly during the earlier stages of the Covid-19 pandemic response, but reconvened from July 2020.

5.2 **Chart 4** shows a breakdown of strategic finance, performance and estates risks by current risk rating and type:



	Very low risk	Low risk	Moderate risk	High risk	Very high risk
Finances	0	0	2	1	2
Reputation / compliance	0	2	4	10	0
Service disruption	0	5	4	6	1
Harm (physical or psychological)	0	0	6	0	0

5.3 There have been no material changes to this risk profile since the last report. Of the 43 strategic finance, performance & estates risks currently recorded, 17 are rated High risk (12-16) and 3 are rated Very high risk (20-25). This accounts for 47% of the total.

5.4 The 3 strategic finance, performance & estates risks with a current rating of Very high risk are as follows:

Risk title (ID)	Capacity to manage emergency demand (4175)		
Current risk rating	Very high (20)	**Risk lead**	Simon Evans
Lead group	Divisional Performance Review Meetings (PRMs)		

Key Risk Indicators (KRIs):

- A&E waiting times against the constitutional standard – remains below 80%, but performing above the pre-Covid-19 target trajectory since June 2020 despite rising A&E attendances

- Ambulance handover times – in August 2020 there were 194 >59 minute ambulance handover delays

Gaps in control & mitigating actions:

- Specific concerns relate to ambulance handover delays, increased non-elective admissions, stranded and super-stranded patients
- Lincoln site reconfiguration plans & business case for investment on Pilgrim site (with government funding)
- The U&EC improvement programme has undertaken an internal review of process, key stakeholders and original milestones where off track clear rectification plans are now in place
- A system wide resilience review has also been commissioned and completed
- System Resilience Group (SRG) is the vehicle by which assurance will be given, for example the 13 government funded schemes for LCC
- Partnership working within the system and a more intuitive winter plan at ULHT will support a more proactive response and delivery to system need

Risk title (ID)	Substantial unplanned expenditure or financial penalties (4383)		
Current risk rating	Very high risk (20)	**Risk lead**	Jon Young
Lead group	Financial Turnaround Group		

Key Risk Indicators (KRIs):

- Expenditure against budget – reported year to date financial position at Month 5 was a breakeven I&E position against plan and actual, as per the interim national financial framework and funding

Gaps in control & mitigating actions:

- Continued reliance upon a large number of temporary agency and locum staff to maintain the safety and continuity of clinical services across the Trust, at substantially increased cost
- Financial Recovery Plan schemes include recruitment improvement; medical job planning; agency cost reduction; workforce alignment
- Interest rate may increase and the Trust won't have access to FRF; PSF; and MRET if there is adverse deviation from plan in the financial year
- Maintenance of grip & control on expenditure; use of PRM process to hold divisions to account and develop mitigating schemes where needed

Risk title (ID)	Delivery of the Financial Recovery Programme (4382)		
Current risk rating	Very high risk (20)	**Risk lead**	Jon Young
Lead group	Financial Turnaround Group		

Key Risk Indicators (KRIs):

- Value of cost reduction achieved against plan - CIP delivery year to August was £3.1m; since July the Year to Date adverse variance to plan has increased by £438k

Gaps in control & mitigating actions:

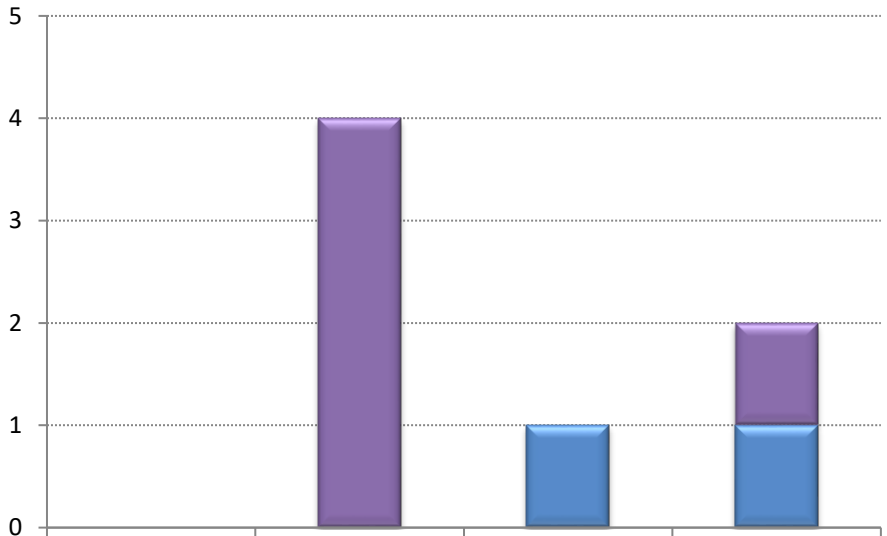
- If assumptions for the level of efficiency to be delivered by identified schemes prove to be inaccurate, or if there are capacity & capability issues with delivery, it may result in failure to deliver these scheme
- The Finance PMO team works with divisions to manage planned schemes and identify mitigating schemes - 3 Efficiency Project Managers are now in post to assist with CIP delivery
- Utilisation of additional external resource to support delivery

5.5 Of the 109 operational finance, performance and estates risks recorded on business unit risk registers, 24 (22% of the total) are currently rated as High risk (12-16). There is 1 risk that was previous rated as Very high (20) and has been reduced to High risk (16) on review in October: Availability of essential equipment & supplies (Diagnostics CBU). This reduction in risk is reflective of progress with replacing ageing equipment within diagnostic services.

6. People & organisational development risk profile

6.1 The People & Organisational Development Committee (PODC) is the lead assurance committee responsible for oversight of the people & organisational development risk profile. The PODC did not meet regularly during earlier stages of the Covid-19 pandemic response but reconvened from July 2020.

6.2 **Chart 5** shows the number of strategic people & organisational development risks by current risk rating and type:



	Low risk	Moderate risk	High risk	Very high risk
Reputation / compliance	0	4	0	1
Service disruption	0	0	1	1

6.3 Of the 7 strategic people & organisational development risks currently recorded, 2 are rated Very high risk (20-25) and 1 is rated High risk (12-16). This is unchanged since the last report.

6.4 The 2 strategic people & organisational development risks with a current rating of Very high risk are as follows:

Risk title (ID)	Workforce capacity & capability (recruitment, retention & skills) (4362)		
Current risk rating	Very high (20)	**Executive lead**	Martin Rayson
Lead group	Workforce Strategy Group		

Key Risk Indicators (KRIs):

- Staff vacancy rates – overall vacancy rate has been reducing, although significant hotspots remain; nursing and medical vacancy rates have reduced over the last three months

- Sickness absence rates – sickness rates have been increasing; staff absence related to Covid-19 is increasing
- Mandatory training compliance – Core Learning showed a consistent pattern of over 90% compliance through to the start of the Covid pandemic; slightly below 90% in recent months

Gaps in control and mitigating actions:

- Workforce supply is a work-stream in the Integrated Improvement Plan
- Director of Nursing has initiated a Nurse Transformation Programme to look at demand and supply issues around nursing
- Introducing a Medical Transformation Programme; risk now driven by shortages in key fragile services
- Focus in Restoration and Recovery phases on ensuring agency spend does not increase
- Medical agency usage reduced in August, consequence of reduced vacancies and introduction of medical bank
- Occupational Health staff health checks & testing regime; Health and well-being offer to staff; Implementation of new Absence Management System (Empactis); use of bank / agency staff to fill rota vacancies; & operational command structure for Covid response

Risk title (ID)	Workforce engagement, morale & productivity (4083)		
Current risk rating	Very high (20)	**Executive lead**	Martin Rayson
Lead group	Workforce Strategy Group		

Key Risk Indicators (KRIs):

- Staff appraisal rates - appraisal rates across the Trust remain below 80% each month
- People Pulse survey results – almost 900 staff completed the first survey (in July 2020), a response rate of around 12%; 85% of staff felt informed (+0.6 vs NHS overall); 63% felt confident in local leaders (equal to NHS overall); 61% felt supported (-5.7 vs NHS overall); 59% felt they had a good work-life balance (-2.5 vs NHS overall)
- NHS National Staff Survey (NSS) results – some improvement in results of 2019 staff survey across two thirds of the questions, still below average for acute trusts; less than 50% of staff would recommend ULHT as a place to work; the Trust's score for the bullying & harassment theme in the NSS stayed relatively unchanged in 2019 at 7.6 against a national average of 7.9

Gaps in control and mitigating actions:

- Work on morale is part of the Integrated Improvement Plan and a number of work-streams within it
- New approaches to interacting with staff during Covid response; feedback has been positive and was reflected in results from the NHS Pulse Survey

6.5 Of the 13 Clinical Business Units (CBUs) within the Trust, 9 are now showing a workforce capacity and capability risk that is rated as High (12). This quarter the risk has been reduced in the following areas:

- Urgent & Emergency Care CBU (Medicine Division)
- Urology, Trauma & Orthopaedics and Ophthalmology CBU (Surgery Division)
- Theatres, Anaesthetics & Critical Care CBU (Surgery Division)

7. Strategic communication and engagement risks

7.1 The following 3 strategic risks do not currently align within any of the assurance committee risk profiles (all are unchanged from the previous report):

- Public consultation and engagement (rated Moderate risk)
- Internal corporate communications (rated Moderate risk)
- Adverse media or social media coverage (rated Low risk)

8. Conclusions & recommendations

8.1 The Trust's strategic and operational risk profiles continue to show a high level of risk exposure, although there is evidence from incident trends and KPIs that the level of risk may be reducing in some areas including patient safety within A&E departments; in financial sustainability and in workforce capacity.

8.2 The Trust's risk profile may also be affected by issues with completing regular quarterly risk reviews and updating risk mitigation plans. To support this process, each division will from November 2020 onwards be provided with a monthly risk summary that highlights any risks and actions that are due or overdue for review. This information will also feed into divisional Performance Review Meetings (PRMs) as part of a revised report. Corporate departments will receive this information from December 2020 onwards.

8.3 The Trust Board is invited to review the report and advise of any further action required at this time to improve the management of strategic and operational risks or to strengthen the Trust's risk management framework..

Appendix 1 - Summary of all risks recorded on the Strategic Risk Register:

ID	Title	Division	Risk Type	Rating (current)	Risk level (current)
4558	Local impact of the global coronavirus (Covid-19) pandemic	Corporate	Harm (physical / psychological)	25	Very high risk
4175	Capacity to manage emergency demand	Medicine	Service disruption	20	Very high risk
4362	Workforce capacity & capability (recruitment, retention & skills)	Corporate	Service disruption	20	Very high risk
4083	Workforce engagement, morale & productivity	Corporate	Reputation / compliance	20	Very high risk
4382	Delivery of the Financial Recovery Programme	Corporate	Finances	20	Very high risk
4383	Substantial unplanned expenditure or financial penalties	Corporate	Finances	20	Very high risk
4480	Safe management of emergency demand	Medicine	Harm (physical / psychological)	16	High risk
4437	Critical failure of the water supply	Corporate	Service disruption	16	High risk
4403	Compliance with electrical safety regulations & standards	Corporate	Reputation / compliance	16	High risk
4384	Substantial unplanned income reduction or missed opportunities	Corporate	Finances	16	High risk
4144	Uncontrolled outbreak of serious infectious disease	Corporate	Service disruption	16	High risk
3520	Compliance with fire safety regulations & standards	Corporate	Reputation / compliance	16	High risk
3688	Quality of the hospital environment	Corporate	Reputation / compliance	16	High risk
3690	Compliance with water safety regulations & standards	Corporate	Reputation / compliance	16	High risk
3720	Critical failure of the electrical infrastructure	Corporate	Service disruption	16	High risk
4156	Safe management of medicines	Clinical Support	Harm (physical / psychological)	16	High risk
4044	Compliance with information governance regulations & standards	Corporate	Reputation / compliance	16	High risk
4405	Critical infrastructure failure disrupting aseptic pharmacy services	Clinical Support	Service disruption	12	High risk
4481	Availability of patient information	Corporate	Service disruption	12	High risk

ID	Title	Division	Risk Type	Rating (current)	Risk level (current)
4556	Safe management of demand for outpatient appointments	Clinical Support	Harm (physical / psychological)	12	High risk
4176	Management of demand for planned care	Surgery	Service disruption	12	High risk
4181	Significant breach of confidentiality	Corporate	Reputation / compliance	12	High risk
4179	Major cyber security attack	Corporate	Service disruption	12	High risk
4157	Compliance with medicines management regulations & standards	Clinical Support Services	Reputation / compliance	12	High risk
4043	Compliance with patient safety regulations & standards	Corporate	Reputation / compliance	12	High risk
4145	Compliance with safeguarding regulations & standards	Corporate	Reputation / compliance	12	High risk
4146	Effectiveness of safeguarding practice	Corporate	Harm (physical / psychological)	12	High risk
3689	Compliance with asbestos management regulations & standards	Corporate	Reputation / compliance	12	High risk
3503	Sustainable paediatric services at Pilgrim Hospital, Boston	Family Health	Service disruption	12	High risk
4142	Safe delivery of patient care	Corporate	Harm (physical / psychological)	12	High risk
4081	Quality of patient experience	Corporate	Reputation / compliance	12	High risk
4082	Workforce planning process	Corporate	Service disruption	12	High risk
4368	Efficient and effective management of demand for outpatient appointments	Clinical Support	Reputation / compliance	12	High risk
4300	Availability of medical devices & equipment	Corporate	Service disruption	12	High risk
4385	Compliance with financial regulations, standards & contractual obligations	Corporate	Reputation / compliance	12	High risk
4402	Compliance with regulations and standards for mechanical infrastructure	Corporate	Reputation / compliance	12	High risk
4406	Critical failure of the medicines supply chain	Clinical Support	Service disruption	12	High risk
4423	Working in partnership with the wider healthcare system	Corporate	Service disruption	12	High risk

ID	Title	Division	Risk Type	Rating (current)	Risk level (current)
4476	Compliance with clinical effectiveness regulations & standards	Corporate	Reputation / compliance	12	High risk
4353	Safe use of medical devices & equipment	Corporate	Harm (physical / psychological)	12	High risk
4497	Contamination of aseptic products	Clinical Support	Harm (physical / psychological)	10	Moderate risk
4567	Working Safely during the COVID -19 pandemic (HM Government Guidance)	Corporate	Reputation / compliance	9	Moderate risk
3951	Compliance with regulations & standards for aseptic pharmacy services	Clinical Support	Reputation / compliance	8	Moderate risk
4526	Internal corporate communications	Corporate	Reputation / compliance	8	Moderate risk
4528	Minor fire safety incident	Corporate	Harm (physical / psychological)	8	Moderate risk
4553	Failure to appropriately manage land and property	Corporate	Finances	8	Moderate risk
4483	Safe use of radiation	Clinical Support	Harm (physical / psychological)	8	Moderate risk
4486	Clinical outcomes for patients	Corporate	Harm (physical / psychological)	8	Moderate risk
4424	Delivery of planned improvements to quality & safety of patient care	Corporate	Reputation / compliance	8	Moderate risk
4467	Impact of a 'no deal' EU Exit scenario	Corporate	Service disruption	8	Moderate risk
4404	Major fire safety incident	Corporate	Harm (physical / psychological)	8	Moderate risk
4389	Compliance with corporate governance regulations & standards	Corporate	Reputation / compliance	8	Moderate risk
4397	Exposure to asbestos	Corporate	Harm (physical / psychological)	8	Moderate risk
4398	Compliance with environmental and energy management regulations & standards	Corporate	Reputation / compliance	8	Moderate risk
4399	Compliance with health & safety regulations & standards	Corporate	Reputation / compliance	8	Moderate risk
4400	Safety of working practices	Corporate	Harm (physical / psychological)	8	Moderate risk
4401	Safety of the hospital environment	Corporate	Harm (physical / psychological)	8	Moderate risk

ID	Title	Division	Risk Type	Rating (current)	Risk level (current)
4363	Compliance with HR regulations & standards	Corporate	Reputation / compliance	8	Moderate risk
4138	Patient mortality rates	Corporate	Reputation / compliance	8	Moderate risk
4141	Compliance with infection prevention & control regulations & standards	Corporate	Reputation / compliance	8	Moderate risk
3687	Implementation of an Estates Strategy aligned to clinical services	Corporate	Service disruption	8	Moderate risk
3721	Critical failure of the mechanical infrastructure	Corporate	Service disruption	8	Moderate risk
3722	Energy performance and sustainability	Corporate	Finances	8	Moderate risk
4003	Major security incident	Corporate	Harm (physical / psychological)	8	Moderate risk
4177	Critical ICT infrastructure failure	Corporate	Service disruption	8	Moderate risk
4180	Reduction in data quality	Corporate	Reputation / compliance	8	Moderate risk
4182	Compliance with ICT regulations & standards	Corporate	Reputation / compliance	8	Moderate risk
4351	Compliance with equalities and human rights regulations, standards & contractual requirements	Corporate	Reputation / compliance	8	Moderate risk
4352	Public consultation & engagement	Corporate	Reputation / compliance	8	Moderate risk
4579	Delivery of the new Medical Education Centre	Corporate	Reputation / compliance	8	Moderate risk
4061	Financial loss due to fraud	Corporate	Finances	4	Low risk
4277	Adverse media or social media coverage	Corporate	Reputation / compliance	4	Low risk
4386	Critical failure of a contracted service	Corporate	Service disruption	4	Low risk
4387	Critical supply chain failure	Corporate	Service disruption	4	Low risk
4388	Compliance with procurement regulations & standards	Corporate	Reputation / compliance	4	Low risk
4438	Severe weather or climatic event	Corporate	Service disruption	4	Low risk

ID	Title	Division	Risk Type	Rating (current)	Risk level (current)
4439	Industrial action	Corporate	Service disruption	4	Low risk
4440	Compliance with emergency planning regulations & standards	Corporate	Reputation / compliance	4	Low risk
4441	Compliance with radiation protection regulations & standards	Clinical Support	Reputation / compliance	4	Low risk
4469	Compliance with blood safety & quality regulations & standards	Clinical Support	Reputation / compliance	4	Low risk
4482	Safe use of blood and blood products	Clinical Support	Harm (physical / psychological)	4	Low risk
4502	Compliance with regulations & standards for medical device management	Corporate	Reputation / compliance	4	Low risk
4514	Hospital @ Night management	Corporate	Service disruption	4	Low risk

Appendix 2 – Summary of all High and Very high operational risks recorded on divisional business unit risk registers:

ID	Title	Division	Risk Type	Rating (current)	Risk level (current)
4426	Availability of essential equipment & supplies (Diagnostics CBU)	Clinical Support Services	Service disruption	16	High risk
4425	Workforce capacity & capability (Diagnostics CBU)	Clinical Support Services	Service disruption	16	High risk
4340	Workforce capacity & capability (Cancer Services CBU)	Clinical Support Services	Service disruption	15	High risk
4324	Access to essential areas of the estate (Cardiovascular CBU)	Medicine	Service disruption	12	High risk
4435	Access to essential areas of the estate (Diagnostics CBU)	Clinical Support Services	Service disruption	12	High risk
4394	Access to essential areas of the estate (maintained by Estates & Facilities)	Corporate	Service disruption	12	High risk
4311	Access to essential areas of the estate (Specialty Medicine CBU)	Medicine	Service disruption	12	High risk
4287	Access to essential areas of the estate (Therapies & Rehabilitation)	Clinical Support Services	Service disruption	12	High risk
4334	Access to essential areas of the estate (Urgent & Emergency Care CBU)	Medicine	Service disruption	12	High risk
4392	Availability of essential equipment & supplies (Estates & Facilities)	Corporate	Service disruption	12	High risk
4168	Availability of essential equipment & supplies (Pharmacy)	Clinical Support Services	Service disruption	12	High risk
4191	Availability of essential equipment & supplies (Surgery CBU)	Surgery	Service disruption	12	High risk
4116	Availability of essential equipment & supplies (TACC CBU)	Surgery	Service disruption	12	High risk
4262	Availability of essential equipment & supplies (Urology, T&O and Ophthalmology CBU)	Surgery	Service disruption	12	High risk
4429	Availability of essential information (Diagnostics CBU)	Clinical Support Services	Service disruption	12	High risk
4169	Availability of essential information (Pharmacy)	Clinical Support Services	Service disruption	12	High risk
4372	Compliance with regulations & standards (Outpatient Services)	Clinical Support Services	Reputation / compliance	12	High risk
4201	Compliance with regulations & standards (Surgery CBU)	Surgery	Reputation / compliance	12	High risk

ID	Title	Division	Risk Type	Rating (current)	Risk level (current)
4335	Compliance with regulations & standards (Urgent & Emergency Care CBU)	Medicine	Reputation / compliance	12	High risk
4452	Compliance with regulations & standards (Women's Health & Breast Services CBU)	Family Health	Reputation / compliance	12	High risk
4315	Delayed patient diagnosis or treatment (Cardiovascular CBU)	Medicine	Harm (physical or psychological)	12	High risk
4416	Delayed patient diagnosis or treatment (Children & Young Persons CBU)	Family Health	Harm (physical or psychological)	12	High risk
4301	Delayed patient diagnosis or treatment (Specialty Medicine CBU)	Medicine	Harm (physical or psychological)	12	High risk
4194	Delayed patient diagnosis or treatment (Surgery CBU)	Surgery	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
4333	Delayed patient discharge or transfer of care (Urgent & Emergency Care CBU)	Medicine	Reputation / compliance	12	High risk
4317	Exceeding annual budget (Cardiovascular CBU)	Medicine	Finances	12	High risk
4415	Exceeding annual budget (Children & Young Persons CBU)	Family Health	Finances	12	High risk
4396	Exceeding annual budget (Estates & Facilities)	Corporate	Finances	12	High risk
4305	Exceeding annual budget (Specialty Medicine CBU)	Medicine	Finances	12	High risk
4289	Exceeding annual budget (Therapies & Rehabilitation)	Clinical Support Services	Finances	12	High risk
4331	Exceeding annual budget (Urgent & Emergency Care CBU)	Medicine	Finances	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
4391	Health, safety & security of staff, patients and visitors (Estates & Facilities)	Corporate	Harm (physical or psychological)	12	High risk

ID	Title	Division	Risk Type	Rating (current)	Risk level (current)
4304	Health, safety & security of staff, patients and visitors (Specialty Medicine CBU)	Medicine	Harm (physical or psychological)	12	High risk
4193	Health, safety & security of staff, patients and visitors (Surgery CBU)	Surgery	Harm (physical or psychological)	12	High risk
4328	Quality of patient experience (Urgent & Emergency Care CBU)	Medicine	Reputation / compliance	12	High risk
4322	Safety & effectiveness of patient care (Cardiovascular CBU)	Medicine	Harm (physical or psychological)	12	High risk
4303	Safety & effectiveness of patient care (Specialty Medicine CBU)	Medicine	Harm (physical or psychological)	12	High risk
4461	Safety & effectiveness of patient care (Women's Health & Breast Services CBU)	Family Health	Harm (physical or psychological)	12	High risk
4565	Service impact during the Covid-19 pandemic response (Surgery Division)	Surgery	Service disruption	12	High risk
4320	Workforce capacity & capability (Cardiovascular CBU)	Medicine	Service disruption	12	High risk
4420	Workforce capacity & capability (Children & Young Persons CBU)	Family Health	Service disruption	12	High risk
4170	Workforce capacity & capability (Pharmacy)	Clinical Support Services	Service disruption	12	High risk
4302	Workforce capacity & capability (Specialty Medicine CBU)	Medicine	Service disruption	12	High risk
4196	Workforce capacity & capability (Surgery CBU)	Surgery	Service disruption	12	High risk
4297	Workforce capacity & capability (Therapies & Rehabilitation)	Clinical Support Services	Service disruption	12	High risk
4460	Workforce capacity & capability (Women's Health & Breast Services CBU)	Family Health	Service disruption	12	High risk

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*3 November 2020*
Item Number	*Item 13.2*
Board Assurance Framework (BAF) 2020/21	
Accountable Director	*Andrew Morgan Chief Executive*
Presented by	*Jayne Warner, Trust Secretary*
Author(s)	*Karen Willey, Deputy Trust Secretary*
Report previously considered at	*N/A*

How the report supports the delivery of the priorities within the Board Assurance Framework	
1a Deliver harm free care	*X*
1b Improve patient experience	*X*
1c Improve clinical outcomes	*X*
2a A modern and progressive workforce	*X*
2b Making ULHT the best place to work	*X*
2c Well Led Services	*X*
3a A modern, clean and fit for purpose environment	*X*
3b Efficient use of resources	*X*
3c Enhanced data and digital capability	*X*
4a Establish new evidence based models of care	*X*
4b Advancing professional practice with partners	*X*
4c To become a university hospitals teaching trust	*X*

Risk Assessment	*Objectives within BAF referenced to Risk Register*
Financial Impact Assessment	*N/A*
Quality Impact Assessment	*N/A*
Equality Impact Assessment	*N/A*
Assurance Level Assessment	*Insert assurance level* • *Limited*

Recommendations/ Decision Required	• *Board to consider assurances provided in respect of Trust objectives noting that framework has been reviewed through committee structure*

Executive Summary

The relevant objectives of the 2020/21 BAF were presented to all Committees during October.

A significant review of strategic objectives 1a – Deliver Harm Free Care, 1b – Improve Patient Experience and 1c – Improve Clinical Outcomes, has been undertaken by the Director of Nursing and Medical Director. The review of the objective responds to the request made by the Quality Governance Committee in September to provide further clarity of the control gaps and to refine the reference to Covid-19.

Additional controls had also been included against objective 4a – Establish new evidence based models of care.

Assurance ratings have been provided for all objectives and have been confirmed by the Committees. The Board should note that objective 4a has improved from red to amber.

The following assurance ratings have been identified:

Objective		Rating at start of 2020/21	Previous month (September)	Assurance Rating (October)
1a	Deliver harm free care	R	R	R
1b	Improve patient experience	R	R	R
1c	Improve clinical outcomes	R	R	R
2a	A modern and progressive workforce	R	R	R
2b	Making ULHT the best place to work	R	R	R
2c	Well led services	A	A	A
3a	A modern, clean and fit for purpose environment	R	R	R
3b	Efficient use of resources	G	R	R
3c	Enhanced data and digital capability	A	A	A
4a	Establish new evidence based models of care	R	R	A

4b	Advancing professional practice with partners	**G**	**G**	**G**
4c	To become a University Hospitals Teaching Trust	**A**	**A**	**R**

Board Assurance Framework (BAF) 2020/21 - October 2020

Strategic Objective	Board Committee
Patients: To deliver high quality, safe and responsive **patient** services, shaped by best practice and our communities	Quality Governance Committee
People: To enable our **people** to lead, work differently and to feel valued, motivated and proud to work at ULHT	People and Organisational Development Committee
Services: To ensure that **services** are sustainable, supported by technology and delivered from an improved estate	Finance, Performance and Estates Committee
Partners: To implement integrated models of care with our **partners** to improve Lincolnshire's health and well-being	Trust Board

Ref	Objective	Exec Lead	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Controls in place during Covid	How identified control gaps are being managed	Source of assurance	Assurances in place during Covid	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating
SO1	**To deliver high quality, safe and responsive patient services, shaped by best practice and our communities**												
1a	Deliver Harm Free Care	Director of Nursing/Medical Director	Failure to manage demand safely Failure to provide safe care Failure to provide timely care Failure to use medical devices and equipment safely Failure to use medicines safely Failure to control the spread of infections Failure to safeguard vulnerable adults and children Failure to manage blood and blood products safely Failure to manage radiation safely Failure to deliver planned improvements to quality and safety of care Failure to provide a safe hospital environment	4558 4480 4142 4353 4146 4556	CQC Safe	Developing a safety culture Theatre Safety Group Improving the safety of Medicines management through Medicines Quality Group Ensuring early detection and treatment of deteriorating patients Ensuring safe surgical procedures Ensuring a robust safeguarding framework is in place to protect vulnerable patients and staff Maintaining our HSMR and improving our SHMI Delivering on all CQC Must Do actions and regulatory notices Ensure continued delivery of the hygiene code Ensuring continued incident investigations, harm reviews and assurance of learning Speciality governance programme Patient Safety Group Clinical Effectiveness Group	Level 4 EPRR stepped down to Level 3 incident throughout the UK with regional NHSE/I command and control. Gold Recovery Steering Group established CQC actions monitored through QGC meeting during COVID19 19 streamlined governance arrangements Separate care pathway for urgent and planned care to aim to eliminate risk of nosocomial infection Reduce the risk of nosocomial transmission when care cannot be delayed and testing status not known Elective care patients assessed by test and symptoms to be Covid-19 risk minimised Urgent and emergency care in a defined zone Establishment of Grantham 'Green Site' & temporary repurposing of A&E to an Urgent Treatment Centre under LCHS management	National guidance followed on PPE / infection prevention & control; Pandemic Flu Plan initiated; separate care pathways for urgent & planned care; Lincoln A&E reconfiguration project; Pilgrim A&E re-development project Replacement of manual prescribing processes with an electronic prescribing system; improvements to medication storage facilities; strengthening of Pharmacy involvement in discharge processes Review of Never Events & effectiveness of LocSSIPs / theatre safety programme; improved timeliness & delivery of NIV; revised policies, procedures & training to support deteriorating patients; implementation of Trust-wide electronic patient handover system; strengthening of discharge processes; clinical service review of Respiratory Medicine Implementation of a central database of medical device user training records Updated policy & training in use of chemical restraint / sedation; strengthening of pathways & training to support patients with mental health issues Proposals to address staffing capacity gaps and estates availability issues to improve appointment slot utilisation; measures required to manage risks associated with use of virtual consultations as default option - assessment in progress	Trust Wide Accreditation Programme Reports National and Local Harm Free Care indicators Safeguarding, DoLS and MCA training Safety Culture Surveys Sepsis Six compliance data HSMR and SHMI data Flu vaccination rates Audit of response to triage, NEWS, MEWS and PEWS CQC Ratings and progress on delivery of Must Do and Should Do actions and regulatory notices Monitoring nosocomial infection rates National Clinical Audits Dr Foster alerts Patient safety indicators in the IPR Quality and Safety Risk Report Incident Management Report Mortality Report Upward Reports of the: Safeguarding Group Medicieins Optimisation and Safety Group Patient Safety Group (incorporating sub-groups)	Assurance received through daily/weekly briefing processes with Chair/CEO/ Execs Gold recovery meeting 3 times per week	Assurance gaps to be identified through Trust Board streamlined governance process and Quality Governance Committee	Quality Governance Committee	R

Ref	Objective	Exec Lead	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Controls in place during Covid	How identified control gaps are being managed	Source of assurance	Assurances in place during Covid	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating
1b	Improve patient experience	Director of Nursing	Failure to provide a caring, compassionate service to patients and their families Failure to provide a suitable quality of hospital environment	3688 4081	CQC Caring	Greater involvement in the co-design of services working closely with Healthwatch and patient groups Greater involvement in decisions about care Deliver Year 3 objectives of our Inclusion Strategy Redesign our communication and engagement approaches to broaden and maximise involvement with patients and carers	Level 4 EPRR stepped down to Level 3 incident throughout the UK with regional NHSE/I command and control. Gold Recovery Steering Group established CQC actions monitored through QGC meeting during COVID19 19 streamlined governance arrangements Pandemic Flu Plan initiated Informed consent re risks Agreement to comply with requirements Access controlled by exemplary IPC and PPE compliance Access controls maintain equitable access to healthcare	Estates works planned across Lincoln, Pilgrim and Grantham hospitals to address identified through the PLACE survey (Patient-Led Assessment of the Clinical Environment) - including decoration of walls, windows & fascias; flooring; and bed space curtains / track systems. IIP projects specifically: co-design; Schwartz Rounds; engaging with patients and families; real time surveying, involving in decisions about care. Ensure Patient Panel optimised and continue current work to embed patient voice and experience within QSIR programmes.	Getting real time patient and carer feedback Hold 6 listening events Thematic reviews of complaints and compliments, Quarterly/Annual Reports User involvement numbers National patient surveys Number of locally implemented changes as a result of patient feedback Patient experience indicators in the IPR Patient Experience Group Upward Report Quality and Safety Risk Report	Assurance received through daily/weekly briefing processes with Chair/CEO/ Execs	Assurance gaps to be identified through Trust Board streamlined governance process and Quality Governance Committee	Quality Governance Committee	R
1c	Improve clinical outcomes	Medical Director	Failure to provide effective diagnosis and treatment that deliver positive patient outcomes Failure too provide timely diagnosis and treatment that deliver positive patient outcomes	4558	CQC Responsive CQC Effective	Ensuring our Respiratory patients receive timely care from appropriately trained staff in the correct location Ensuring recommendations from Get it Right First Time (GIRFT) Reviews are implemented Ensuring compliance with local and national clinical audit reports Review of pharmacy model and service	Level 4 EPRR stepped down to Level 3 incident throughout the UK with regional NHSE/I command and control. Gold Recovery Steering Group established CQC actions monitored through QGC meeting during COVID19 19 streamlined governance arrangements Pandemic Flu Plan initiated	Clearance of backlog of NICE guidelines and technical appraisal assessments Developing the use of national and local clinical audit data to evaluate clinical effectiveness Strengthening the management of clinical effectiveness at divisional level through improved information and reporting	Numbers of NIV patients receiving timely care Numbers of unplanned ITU admission numbers Monitoring the implementation of GIRFT recommendations Implementation of recommendations with local and national clinical audit reports Clinical effectiveness indicators in the IPR Clinical Effectiveness Group Upward Report	Assurance received through daily/weekly briefing processes with Chair/CEO/ Execs	Assurance gaps to be identified through Trust Board streamlined governance process and Quality Governance Committee	Quality Governance Committee	R

Ref	Objective	Exec Lead	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Controls in place during Covid	How identified control gaps are being managed	Source of assurance	Assurances in place during Covid	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating
SO2	**To enable out people to lead, work differently and to feel valued, motivated and proud to work at ULHT**												
2a	A modern and progressive workforce	Director of People and Organisational Development	The response to the COVID incident through the manage and restore phases, has delayed the projects in our Integrated Improvement Plan related to "People". There have been positives in our response to COVID, such as staff communication and engagement and management of risks to staff. We will progress the IIP through the recovery phase	4362	CQC Safe CQC Responsive CQC Effective	Embed Robust workforce planning and development of new roles Targeted recruitment campaigns to include overseas recruitment Delivery of annual appraisals and mandatory training Creating a framework for people to achieve their full potential Embed continuous improvement methodology across the Trust Reducing absence management Deliver Personal and Professional development	Level 4 EPRR stepped down to Levle 3 incidnet throughout the UK ith regional NHSE/I command and control CQC actions monitored through QGC meeting during Covid 19 streamlined governance arrangements Pandemic Flu Plan initiated We are now starting to reintroduce at some pace key IIP projects, including international recruitment, absence management, appraisals and mandatory training and talent management. Workforce planning will be a key part of the COVID Recovery Plan and planning for 2021/22. We will reprofile action plans and reset PI improvement for the year	Covid Command and decision making structure alongside Board agreed lean governance arrangements have been in place during the COVID incident. We have re-established the Workforce Strategy Group, who are overseeing delivery of the People workstreams of the IIP and have designed a report to give assurance to the Workforce and OD Committee, highlighting actions to manage control gaps. The Operational Equality and Diversity Group will undertake a similar role for workforce equality and diversity issues.	Vacancy rates Turnover rates Rates of appraisal/mandatory training compliance Learning days per staff member Staff survey feedback Sickness/absence data Reported progress on the implementation of the NHS People Plan and the Lincolnshire System Workforce Plan	Assurance received through daily/weekly briefing processes with Chair/CEO/ Execs	Assurance gaps to be identified through Trust Board streamlined governance process and People and Organisational Development Committee	People and Organisational Development Committee	**R**
2b	Making ULHT the best place to work	Director of People and Organisational Development	The response to the COVID incident through the manage and restore phases, has delayed the projects in our Integrated Improvement Plan related to "People". There have been positives in our response to COVID, such as staff communication and engagement and management of risks to staff. We will progress the IIP through the recovery phase	4083	CQC Well Led	Embedding our values and behaviours Reviewing the way in which we communicate with staff and involve them in shaping our plans Adapting our responsibility framework and leadership programmes in line with the NHS Leadership Compact Revise our diversity action plan for 2021/22 to ensure concerns around equity of treatment and opportunity are tackled Agree and promote the core offer of ULHT, so our staff feel valued, supported and cared for Implementing Schwartz Rounds Embed Freedom to Speak Up and Guardian of safe Working Celebrate year of the Nurse/Midwife	We are now starting to reintroduce at some pace key IIP projects, including international recruitment, absence management, appraisals and mandatory training and talent management. Workforce planning will be a key part of the COVID Recovery Plan and planning for 2021/22. We will reprofile action plans and reset PI improvement for the year. We will embrace enhancements introduced during COVID, such as the more regular meetings with staffside, the revised Staff Engagement Group and the ELT Live sessions on Facebook and Teams	Covid Command and decision making structure alongside Board agreed lean governance arrangements have been in place during the COVID incident. We have re-established the Workforce Strategy Group, who are overseeing delivery of the People workstreams of the IIP and have designed a report to give assurance to the People and OD Committee, highlighting actions to manage control gaps. The Operational Equality and Diversity Group will undertake a similar role for workforce equality and diversity issues.	WRES/ WDES Data Staff survey feedback - engagement score, recommend as place to work Number of staff attending leadership courses Number of Schwartz rounds completed (once implemented) Protect our staff from bullying, violence and harassment - measure through National Staff Survey Reports on progress in implementing the NHS People Plan and the Lincolnshire System Workforce Plan Use of NHSI Covid pulse survey			People and Organisational Development Committee	**R**

Ref	Objective	Exec Lead	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Controls in place during Covid	How identified control gaps are being managed	Source of assurance	Assurances in place during Covid	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating
SO3	**To ensure that services are sustainable, supported by technology and delivered from an improved estate**												
3a	A modern, clean and fit for purpose environment	Chief Operating Officer	Covid-19 impact on supplier services who are supporting the improvement, development, and maintenance of our environments. Availability of funding to support the necessary improvement of environments (capital and revenue)	3720 3520 3688 4403 3690	CQC Safe	Develop business case to demonstrate capital requirement Delivering environmental improvements in line with Estates Strategy Continual improvement towards meeting PLACE assessment outcomes Review and improve the quality and value for money of Facility services including catering and housekeeping Continued progress on improving infrastructure to meet statutory Health and Safety compliance	Declared as a level 4 incident throughout the UK. NHSE nationally and then regionally coordinate NHS response through a command and control process. Major incident (Gold Command Structure) employed locally. Estates and Facilities Cell reviews the key elements of environmental conditions to support the increasing demands on IPC, and complex infection control measures required. Health & Safety conditions are reviewed in the context of Estates and Facilities Cell and are reviewed by Silver Incident command and then subsequently Gold sign off.	Control gaps identified and reported through to Gold Command Structure where Covid related. Water/Fire safety meetings are in place and review of controls are part of external validation from authorised engineers. Now that additional capital funding has been secured for critical infrastructure a new Forum will be created to capture progress and feed back into governance systems how risks are mitigated and alleviated. Audits of changes are carried out internally and externally as part of NHSE change processes as well as contained within internal reviews.	PLACE assessments 6 Facet Surveys Reports from authorised engineers Staff and user surveys MiC4C cleaning inspections Response times to urgent estates requests Estates led condition inspections of the environment Response times for reactive estates repair requests Progress towards removal of enforcement notices	Assurance received through daily/weekly briefing processes with Chair/CEO/ Execs Monthly and where necessary extraordinary board meetings review the response to Covid which include measures required to ensure environments are suitable/fit for purpose in the context of Covid. Business Cases for deployment of emergency capital bids and feedback on delivery against those deployment plans. Datasets and additional reporting measures are in place that describe key environmental issues (supply of oxygen in wards as an example) to NHSE in addition to local usage for assurance purposes.	Assurance gaps identified are addressed through the command structure governance process, and mitigation steps taken. Additional reporting by exception is put in place to provide evidence and contribute to assurance process. No Covid-19 related gaps identified are escalated through estates and facilities group as part of upward reporting and where urgent or significant impact to Exec Leadership Team, where immediate actions can be taken.	Finance, Performance and Estates Committee	R

Ref	Objective	Exec Lead	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Controls in place during Covid	How identified control gaps are being managed	Source of assurance	Assurances in place during Covid	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating
3b	Efficient use of our resources	Director of Finance and Digital	Efficiency schemes do not cover extent of savings required - £27.0m Continued reliance on agency and locum staff to maintain services at substantially increased cost Failure to achieve recruitment targets increases workforce costs Unplanned expenditure (as a result of unforeseen events) or financial penalties Failure to secure all income linked to coding or data quality issues National requirements and Trust response to Phase 3 - Recovery.	4382 4383 4384	CQC Well Led CQC Use of Resources	Delivering £27m CIP programme in 20/21 Delivering financial plan Utilising Model Hospital, Service Line Reporting and Patient Level Costing data to drive focussed improvements Implementing the CQC Use of Resources Report recommendations Working with system partners to deliver the Lincolnshire Plan. Detailed activity modelling aligned to resource requirements to support Trust and System response to Phase 3.	Deliver a monthly break-even position after taking Coivd-19 (including Restore and Recovery) costs into account.	Divisional Financial Review Meetings Centralised agency & bank team Financial Strategy and Annual Financial Plan Performance Management Framework System wide savings plan Internal Audit: Integrated Improvement Plan - Q2 Temporary Staffing - Q1 Education Funding - Q3 Estates Management - Q4 Workforce Planning - Q2	Delivery of CIP Achievement of Financial Plan Closing the Model Hospital opportunity gap Improve service line profitability	Financial Reporting to Board Covid-19 financial governance process Suspension of national financial regime	Management of control gaps being reintroduced in a phased way from July 2020. Continue to await national guidance. Whilst further national guidance has been released this has been focused on recovery and cost control and projections. Further guidance in respect of CIP is expected in due course.	Finance, Performance and Estates Committee	R
3c	Enhanced data and digital capability	Director of Finance and Digital	Tender for Electronic Health Record is delayed or unsuccessful Tactical response to Covid-19 may impact in-year delivery. Major Cyber Security Attack Critical Infrastructure failure	4177 4179 4180 4182 4481	CQC Responsive	Improve utilisation of the Care Portal with increased availability of information Commence implementation of the electronic health record Undertake review of business intelligence platform to better support decision making Implement robotic process automation Improve end user utilisation of electronic systems Complete roll out of Data Quality kite mark	Cyber Security and enhancing core infrastructure to ensure network resilience. Roll-out IT equipment to enable agile user base.	Digital Services Steering Group Digital Hospital Group Operational Excellence Programme Outpatient Redesign Group	Number of staff using care portal Delivery of 20/21 e HR plan Number of RPA agents implemented Ensuring every IPR metric has an associated Data Quality Kite Mark Delivering improved information and reports Implement a refreshed IPR	Schemes paused to enable tactical response to Covid-19. Limited progress being made where possible.	Management of control gaps being reintroduced in a phased way from July 2020. Steady implementation of PowerBI through specific bespoke dashboards and requests. Continue to review this as part of wider BI platform Workplan being drafted to ensure compliance before end of Financial year, delayed by resource availability.	Finance, Performance and Estates Committee	A

Ref	Objective	Exec Lead	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Controls in place during Covid	How identified control gaps are being managed	Source of assurance	Assurances in place during Covid	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating
SO4	**To implement integrated models of care with our partners to improve Lincolnshire's health and well-being**												
4a	Establish new evidence based models of care	Director of Improvement and Integration	Specifiic projects paused during the Covid 19 manage phase, specific projects are now progressing with delivery throughout the Covid Recovery Phase		CQC Caring CQC Responsive CQC Well Led	Supporting the implementation of new models of care across a range of specialties - in progress Support Creation of ICS - commencing Support the development of an Integrated Community Care programme - on hold Support the consultation for Acute Service Review (ASR) Phase 1. Assurance panel to be held with NHSE/I to review the Pre-Consultation Business Case. Dates for NHSE/I panel either 4th or 12th November Improvement programmes for cancer, outpatients and urgent care in progress, programme for theatres is on hold Development and Implementation of new pathways for paediatric services - in progress Implementing the Outstanding Care Together Programme to support the Organisation to focus on high priority improvements.	Declared as a level 4 incident throughout the UK from March 2020. Now NHSE are coordinating phase 3 of the recovery phase, returning urgent and non-urgent services back to capacity and provision as it was pre-covid. During this period of recovery, work is in progress on specific projects to introduce new evidence based models of care as highlighted in column G. In addition, benefits from service changes made as a result of the need to change due to Covid will be locked in for the future, at the same time as addressing any impact on equality for patients who may have poorer clinical outcomes.	Control gaps identified and reported through to Gold Command Structure Delivery of service transformation aligned to the IIP overseen by the Trust Leadership Team.	Numbers of new models of care established Delivery of ASR Year 1 objectives Improvement in health and wellbeing metrics	Assurance received through daily/weekly briefing processes with Chair/CEO/Execs COVID reporting to Trust Board monthly	Steady implementation of the Outstanding Care Together Programme to identify Strategic priorities for the remainder of 2020/21 and for 2021/22 aligned to the IIP. Roll out of Outstanding Care Improvement System has started with Wave 1 in Medicine Outpatient Transformation work has been escalated from the perspective of moving to virtual and telephone consultations which has also enabled outpatient activity to continue safely during the Covid Pandemic. The Lincolnshire system has agreed a new system architecture to support the implementation of an Integrated Care System. In the new architecture, ULHT has been allocated the system lead role for cancer and access. Simon Evans is the SRO for access and Dr Neill Hepburn the SRO for cancer. The SRO's has been asked to scope out their programmes for 2021/22.	Finance, Performance and Estates Committee	A

Ref	Objective	Exec Lead	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Controls in place during Covid	How identified control gaps are being managed	Source of assurance	Assurances in place during Covid	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating
4b	Advancing professional practice with partners	Director of Nursing	Specific projects paused during Covid 19 response		CQC Caring CQC Responsive CQC Well Led	Supporting the expansion of medical training posts Support widening access to Nursing and Midwifery and AHP Support expansion of Paediatric nursing programme Developing System wide rotational posts Scope framework to support staff to work to the full potential of their licence Ensure best use of extended clinical roles and our future requirement	Nursing, Midwifery and AHPs have been feeding into the practice placement offers as coordinated by Health Education England, and have employed students who have opted in to extended clinical placements throughout the COVID pandemic. This includes all branches of nursing and midwifery.	Students who are on placement have been allowed to choose where they wish to work and have been supported in their request. There is a formal route of raising any concern via HEE, HEIs and locally. Any issues have been managed in a timely manner	Increase in training post numbers Numbers on Apprenticeship pathways Numbers of dual registrants Numbers of joint posts and non medical Consultant posts Numbers of pre-reg and RN child	Feedback has been sought from the students in practice and the Assistant Director of Nursing has engaged in the weekly strategic calls hosted by HEE	The Medical Director would be required to add information around medical staffing		G
4c	To become a University Hospitals Teaching Trust	Medical Director	Specific projects paused during Covid 19 response			Developing a business case to support the case for change Gap analysis and Tracker Increasing the number of Clinical Academic posts Refresh of our Research, Development and Innovation Strategy Improve the training environment for medical students and Doctors Tracker vs Framework	Quarterly Review meetings	Gap analysis and Tracker developed and updated quarterly against national criteria	Progress with application for University Hospital Trust status Numbers of Clinical Academic posts RD&I Strategy and implementation plan agreed by Trust Board GMC training survey Stock check against checklist	Reintroduction of students		People and Organisational Development Committee	R

Ref	Objective	Exec Lead	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Controls in place during Covid	How identified control gaps are being managed	Source of assurance	Assurances in place during Covid	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

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*3 November 2020*
Item Number	*Item 13.3*
Audit Committee Upward Report	
Accountable Director	*Sarah Dunnett, Audit Committee Chair*
Presented by	*Sarah Dunnett, Audit Committee Chair*
Author(s)	*Jayne Warner, Trust Secretary*
Report previously considered at	*N/A*

How the report supports the delivery of the priorities within the Board Assurance Framework	
1a Deliver harm free care	
1b Improve patient experience	
1c Improve clinical outcomes	
2a A modern and progressive workforce	
2b Making ULHT the best place to work	
2c Well Led Services	*X*
3a A modern, clean and fit for purpose environment	
3b Efficient use of resources	*X*
3c Enhanced data and digital capability	
4a Establish new evidence based models of care	
4b Advancing professional practice with partners	
4c To become a university hospitals teaching trust	

Risk Assessment	*N/A*
Financial Impact Assessment	*N/A*
Quality Impact Assessment	*N/A*
Equality Impact Assessment	*N/A*
Assurance Level Assessment	*Insert assurance level* • *Moderate*

Recommendations/ Decision Required	• *Ask the Board to note the upward report and the actions being taken by the Committee to provide assurance to the Board on strategic objective 2c*

Executive Summary

The Audit Committee met via MS Teams on the 12th October 2020 and considered the following items:

NHSE/I Board and Committee Observations and Actions

The Committee reviewed the latest position statements against recommendations received following Board and Committee observations by NHSE/I. The Committee were pleased to note that most recommendations had been responded to and were closed. There were two actions relating to the way in which the Board managed the public questions section of their Public Board meeting. These were on hold whilst covid restrictions remained in place. The Committee suggested that these actions could be the subject of a future Board development session within a wider discussion about how the Trust engage with the public. The Committee noted that the Chair of the Quality Governance Committee had sought to ensure that all recommendations were embedded within the Committee programme of work for the year. The Medicines Management and Optimisation Group was noted as the area where there were still matters to address. The CSS Division would be reporting to the Committee on the areas of concern in November 2020.

Committee Terms of Reference and Work Programme

The Committee agreed the updated Terms of Reference and Work Programme. The terms of reference are attached for approval by the Board and include comments made by the Committee.

Internal Audit

The Committee were advised of progress against the Internal Audit Plan 2020/21. The Trust Internal Audit providers were able to confirm that they had delivered 30% of the plan. Assurance was sought from the Committee that the capacity was available to deliver the plan. This was confirmed. An escalation process had been agreed with the Trust for where delays were experienced in the turnaround of final reports.

The Committee received final reports on the Data Security and Protection Toolkit (Significant Assurance with some improvement required) and Recruitment (Partial Assurance with Improvement Required). Both reports would be considered by relevant assurance committee.

The Committee sought assurance on the outstanding review of the Trust Operating Model. The Internal Audit provider advised that this report was not yet with the Trust. The Committee sought a speedy conclusion to this review which had been ongoing for some months and circulation on completion rather than waiting for the next meeting in January.

The Committee noted that there were 36 outstanding audit actions, two high risk, 21 medium risks and 13 low risks. The Committee noted that this was an

improved position but that it was essential that momentum was maintained and that audit recommendations completion dates should not be allowed to unnecessarily extend. The Committee noted that the audit tracking system was now live for the Trust which was an essential aid to managing and closing down actions.

External Audit

The Trust's newly appointed External Audit Provider joined the Committee for the first time. Introductions were made with the offer of individual meetings for all audit committee members.

Counter Fraud

The Committee received and approved the Local Counter Fraud Specialist Progress Report. The Committee were aware that the Trust had identified that it did not have sufficient counterfraud capacity and were seeking to address this. The Committee asked that the risk of insufficient capacity to enable timely counterfraud investigations be included on the Trust risk register.

Compliance Report

The Committee received the regular report on compliance noting that this covered the period from July 2020 to September 2020. The Committee noted the level of waivers of standing orders continued to be significantly higher than in previous periods. The Committee noted that the response to Covid-19 had impacted on this area.

The Committee noted that the regulatory and enforcement actions had been updated following the notification from the CQC of an intention to pursue an investigation.

The Committee remained concerned about overpayments to leavers noting that assurance was being sought by the People and OD Committee.

Policies Management

The Committee received a report against progress with the actions to address outstanding policies. This supported the assurance rating for the well led objective within the Trust Board Assurance Framework.

Board Assurance Framework

The Committee confirmed that the Board Assurance Framework remained relevant and effective for the Trust and the focus was on the appropriate risks. The Committee noted that objective 2c – Well Led Services was the remit of the Audit Committee. The Committee noted that the work programme had been updated accordingly to reflect the assurances that the Committee would seek in respect of this. The Committee confirmed the Amber rating for objective 2c.

One element of objective 2c was the implementation of a robust policy management system. The Committee received a report and noted the limited assurance provided. The Committee noted the actions in place to improve processes and ensure policies were adequately maintained and used.

The Committee noted a need to identify how assurance would be received on shared decision making processes as this sat within objective 2c – well led.

Risk Management

The Committee noted the increasing number of overdue risks. The Risk Manager advised of the actions being taken to support divisions and corporate areas in review and updates. The Committee noted that an improvement plan was in place to strengthen reporting and links to the BAF with closer scrutiny by leadership.

Audit and Risk Committee
Terms of Reference

1. Authority

The Audit and Risk Committee is appointed by the Trust Board in line with the powers set out in the Trust Standing Orders.

The Audit and Risk Committee holds only those powers as delegated in these Terms of Reference as determined by the Trust Board.

The Standing Orders and Standing Financial Instructions of the Trust, as far as they are applicable, shall apply to the Committee and any of its established groups.

The Committee is authorised by the Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the committee. The Committee is authorised by the governing body to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

2. Purpose of the Committee

The Audit and Risk Committee exists to scrutinise the robustness of and provide assurance to the Trust Board that there is an effective system of governance and control for risk, the accounting policies and the accounts of the organisation, the planned activity and results of both internal and external audit and assurances relating to the corporate governance requirements for the organisation.

The relevant strategic objectives assigned to the Audit and Risk Committee for 2020/21 are:

- Well Led Services

3. Membership

The members of the Committee are:

- Non-Executive Director (Chair)
- Non-Executive Director (FPEC Chair)
- Non-Executive Director (QGC Chair)
- Non-Executive Director (P&OD Chair)

The following roles will be routine attendees at the Committee:

- Director of Finance and Digital
- Trust Secretary/Deputy Trust Secretary
- Representative from Internal Audit
- Representative from External Audit
- Counter Fraud Representative (at least twice annually)
- Deputy Director of Finance

The Accountable Officer should discuss at least annually with the committee the process for assurance that supports the governance statement and should attend the committee when it considers the draft annual governance statement and the annual report and accounts.

Executive Directors/ Senior Managers may be invited to attend when the committee is discussing areas of risk or operation that are the responsibility of that director/manager.

4. Attendance and Quorum

The Committee will be quorate when three of the four Non-Executive Director members are present.

5. Frequency

The committee will not meet less than five times per year. At least once a year the committee will meet privately with the internal and external auditors.

6. Specific Duties

The Audit and Risk Committee will:

Integrated governance, risk management and internal control:

- Review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisations activities (clinical and non-clinical), that supports the achievement of the organisations objectives
- Review the adequacy and effectiveness of all risk related disclosure statements (in particular the annual governance statement) together with any accompanying head of internal audit opinion, external audit opinion or other appropriate independent assurances, prior to submission to the Trust Board
- Review the adequacy and effectiveness of the underlying assurance processes that indicate the degree of achievement of the organisation's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements
- Review the adequacy and effectiveness of the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications
- Review the adequacy and effectiveness of the policies and procedures for all work related to counter fraud, bribery and corruption as required by NHSCFA

Internal Audit:

- Consider the provision of the internal audit service and the costs involved.

- Review and approve the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework.
- Consider the major findings of internal audit work (and management response) and ensuring coordination between the internal and external auditors to optimise the use of audit resources.
- Ensure that the internal audit function is adequately resourced and has appropriate standing within the organisation.
- Monitor the effectiveness of internal audit and carry out an annual review.

External Audit:

- The Committee shall review and monitor the external auditors independence and objectivity and the effectiveness of the audit process. In particular the Committee will review the work and findings of the external auditors and consider the implications and management's responses to their work
- Consider the appointment and performance of external auditors, as far as the rules governing the appointment permit (and make recommendations to the Trust Board when appropriate).
- Discuss and agree with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan.
- Discuss with the external auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee.
- Review all external audit reports, including the report to those charged with governance (before its submission to the Trust Board) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

Other Assurance Functions:

- The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation. Including but not limited to any reviews by DHSC arm's length bodies or regulators/inspectors for example, the CQC, NHS Resolution, Royal Colleges, accreditation bodies etc.
- The Committee will review the work of other committees within the organisation whose work can provide relevant assurance to the audit committee's own areas of responsibility.
- The Committee will satisfy itself on the assurance that can be gained from the clinical audit function through its review of the work of the Quality Governance Committee.

Counter Fraud:

- The Committee shall satisfy itself that the organisation has adequate arrangements in place for counter fraud, bribery and corruption that meet NHSCFA's standards and shall review the outcomes of work in these areas.
- The Committee will refer any suspicions of fraud, bribery and corruption to the NHSCFA.

Management:

- The Committee shall request and review reports, evidence and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

- The Committee may request specific reports from individual functions within the organisation

Financial Reporting:

- The Committee shall monitor the integrity of the financial statements of the organisation and any formal announcements relating to its financial performance.
- The Committee will ensure that the systems for financial reporting to the governing body, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided.
- The Committee shall review the annual report and financial statements before submission to the Trust Board focussing particularly on
    - The wording in the annual governance statement and other disclosures relevant to the terms of reference of the committee.
    - Changes in and compliance with, accounting policies, practices and estimation techniques
    - Unadjusted misstatements in the financial statements
    - Significant judgements in preparation of the financial statements
    - Significant adjustments resulting from the audit
    - Letters of representation
    - Explanations for significant variances

Whistleblowing:

- The Committee shall review the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial, clinical or safety matters and ensure that any concerns are investigated proportionately and independently.

7. Administrative support

The Committee will operate using a work plan to inform its core agenda. The agenda will be agreed with the Chair prior to the meeting.

Agendas and supporting papers will be circulated no later than 7 days in advance of meetings. Any items to be placed on the agenda are to be submitted no later than 8 working days in advance of the meeting. Items which miss the deadline for inclusion on the agenda may be added with permission from the Chair.

Minutes will be taken at all meetings, presented according to the corporate style, circulated to members within 7 days along with the action log and ratified by agreement of members at the following meeting.

8. Accountability and Reporting Arrangements

The Chair of the Committee shall report to the Board after each meeting and provide a report on assurances received, escalating any concerns where necessary.

The Committee shall report at least annually to the Trust Board on its work in support of the annual governance statement, specifically commenting on:

- The fitness for purpose of the Board Assurance Framework
- The completeness and embeddedness of risk management in the organisation
- The integration of governance arrangements
- The appropriateness of the evidence that shows the organisation is fulfilling regulatory requirements relating to its existence as a functioning business
- The robustness of the processes behind the quality accounts

The annual report should also describe how the committee has fulfilled its terms of reference and give details of any significant issues that the committee has considered in relation to the financial statements and how they were addressed.

9. Monitoring effectiveness and Compliance with Terms of Reference

The Committee will complete an annual review of its effectiveness and provide an annual report to the Board on its work in discharging its responsibilities, delivering its objectives and complying with its terms of reference, specifically commenting on relevant aspects of the Board Assurance Framework and relevant regulatory frameworks.

10. Review of Terms of Reference

The Terms of Reference for the Committee will be reviewed annually by the Committee and submitted to the Trust board for approval.

The Committee will on an annual basis review and approve the terms of reference and work programmes of all of its reporting groups.

Approved:12 October 2020
Approved by: Audit Committee
Next Review Date: October 2021

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*3 November 2020*
Item Number	*Item 13.4*
CQC Must Do and Should Do Actions and Regulatory Notices	
Accountable Director	*Karen Dunderdale, Director of Nursing*
Presented by	*Karen Dunderdale, Director of Nursing*
Author(s)	*Karen Dunderdale, Director of Nursing* *Angie Davies, Deputy Director of Nursing*
Report previously considered at	*CQC Steering Group – 07/10/2020* *Quality Governance Committee – October 2020*

How the report supports the delivery of the priorities within the Board Assurance Framework	
1a Deliver harm free care	*X*
1b Improve patient experience	*X*
1c Improve clinical outcomes	*X*
2a A modern and progressive workforce	
2b Making ULHT the best place to work	
2c Well Led Services	*X*
3a A modern, clean and fit for purpose environment	
3b Efficient use of resources	
3c Enhanced data and digital capability	
4a Establish new evidence based models of care	
4b Advancing professional practice with partners	
4c To become a university hospitals teaching trust	

Risk Assessment	*Link to strategic risks:-* *4405; 4083; 4175; 3688; 3951; 4156; 3503; 4041; 4081; 4145; 4300; 4476*
Financial Impact Assessment	*N/A*
Quality Impact Assessment	*Through governance process of IIP.*
Equality Impact Assessment	*Through governance process of IIP.*
Assurance Level Assessment	*Moderate*

Recommendations/ Decision Required	• *The Trust Board is asked to note the activity that has occurred with the CQC.*
	• *The Trust Board is asked to note the progress of delivery of improvements against the CQC Must Do and Should Do's.*

Executive Summary

To provide the Trust Board with an update against all CQC activity including progress against Must Do and Should Do Actions.

The report and action plan (appendix A) provide an update against the CQC Must Do and Should Do's. This includes the current month's performance.

1. Introduction

The CQC published its inspection report in October 2019 following the July 2019 Core Inspection. The Trust has been taking action to address these areas for improvement. This paper and attached appendices provides the Quality Governance Committee with an update on that progress and includes more recent requirements, following the Winter Assurance Visits, to the Lincoln and Pilgrim Hospitals' Emergency Departments. It also includes information related to other activities undertaken with and related to the CQC in the preceding month.

2. Progress to Date

2.1 Monitoring Process

The attached action plan (Appendix A) provides an update against each of the Must Do and Should Do areas.

During September any potential risks against delivery for the next months and what mitigation is in place and any additional support that may be required has been updated.

2.2 Progress Against Must Do and Should Do Areas for Improvement

Progress against all the areas for improvement has been documented and an Executive Summary has now been embedded within the CQC Action Plan to support in pointing out key points, risk and issues and progress against actions (Appendix A).

Since end of July we have started the internal Quality Review Ward Visits, which are assessed against a set of criteria's aligned to the CQC inspection assessment. To-date there have been over 30 quality visits undertaken which have included evening and weekend visits. These Quality Review Ward Visits will continue monthly until the formal CQC Inspection has occurred.

Feedback from these ward visits is being received and discussed at the weekly CQC Steering Group and themes are starting to emerge. The themes are namely:-

i. Estates - across a variety of areas including hard and soft Estates & Facilities issues. A plan is being developed to address this given the scale of the issues and ongoing work that is required. This plan will be received at the weekly CQC Steering Group and escalated to Executive Leadership Team (ELT). There is a representative from Estates & Facilities at the CQC Steering Group.

ii. Staffing/Culture issues – a number of mixed views from staff regarding their experiences of working at the Trust, and their experience of working through the COVID-19 peak. An escalation management process has been established through the weekly ELT meeting. This ensures these types of

findings are communicated in a timely manner to ELT and acted on as appropriate.

A Comms Plan, which includes a range of activities (see below), has been presented at both ELT and Trust Board (06/10/2020) and has been approved.

i. Staff briefing and preparation.
ii. Board preparation
iii. Information sharing.
iv. Weekly blogs from Directors – this will come to the weekly CQC Steering Group and require sign off at ELT.

In addition a Staff Guide has been produced and presented at both ELT and Trust Board (06/10/2020) and has been approved. The Staff Guide has been designed to support staff and their teams to feel confident and prepared for a Care Quality Commission (CQC) inspection.

Following on from the Staff Guide and to support our staff further, from the middle of October there are planned Staff Briefings taking place. These briefings will include a presentation of the Staff Guide and also allow staff to ask any questions around the forthcoming CQC inspection and to help support with any concerns they will raise. It is also an opportunity for our staff to speak about good practices/improvements that have and continue to take place in their work areas.

Throughout September Comms have cascaded about the Trust's Time to Shine. This is where we are asking our staff to be inspiring and encouraging them to recognise what they are doing well and helping them to describe it. The Trust is asking to get us ready for our CQC inspection, all wards and departments are being encouraged to take some time to reflect on how far they have come, as well as where their improvement areas are, and share that with each other and their patients. A Time to Shine will also be part of the Staff Briefings.

The first round of Confirm and Challenge Sessions with each Division are coming to an end. The sessions are being used to assess progress against the CQC action plan, assist in identifying any barriers or remaining challenges but also any support requirements. The sessions also provide the opportunity for Divisions to highlight positive success stories which they would wish to share with the CQC. A second round of Confirm and Challenge Sessions will be arranged when the Trust receives its annual Routine Provider Information Request. The sessions have been welcomed and supported by Divisions. The next phase of work will focus on collating the evidence of compliance in order to provide further assurance to the Quality Governance Committee and Trust Board.

The initial focus of the Confirm and Challenge Sessions was primarily on the operational Divisions, however, this is now being extended to the corporate actions of the CQC Action Plan. This sessions is being arranged for early November.

A number of Must Do and Should Do's have been identified where there is an issue/risk of completion in a timely manner and prior to the next CQC Inspection.

These relate to:

i. There is an issue that due to the Trust's response to COVID-19, updates have been difficult to obtain which will result in partially completed upward reporting for both internal and external stakeholders. This has been mitigated by providing a dedicated quality matron to support the operational teams with their actions. The Divisional Confirm and Challenge Sessions are also helping in providing additional information and assurance as regards improvement actions.

ii. Those areas where the Trust has limited control. These include areas where the provision of services is owned by another organisation or delays have occurred as a result of activity focussed on managing the COVID-19. For example, Speech and Language Therapy services are commissioned and delivered via an SLA with Lincolnshire Community Health Services and QSIR training has been cancelled along with all non-mandatory training. Where appropriate the need for the required mitigations is being escalated through the Divisional Confirm and Challenge Sessions.

iii. Those within the Urgent Care domain as the pace of change are slower than anticipated. Whilst improvements have been made, a revised approach to the urgent care improvement programme is in place that aligns to the Integrated Improvement Programme (IIP), which is delivering greater transparency against defined outcomes. This will give improved understanding where actions may need to be adjusted. A suite of additional actions were put in place following receipt of the CQC Section 31 notice. These have clear and defined KPIs and are being monitored and reported against weekly. Additionally, a new daily assurance tool has been implemented, which is delivering robust information about the care and safety of patients in the department. However, the concern remains that some of the areas for improvement relate to the size and condition of the Pilgrim ED estate and limited improvements can be made without the capital developments.

3. Request for Removal/Variation of Conditions Applied as Part of Section 31 Notices during the 2018, 2019 and January 2020 CQC Inspections

Since the last report, the Trust submitted an application to the CQC to have conditions on its licence removed and variations of conditions applied during the 2018, 2019 and 2020 inspections. These conditions form part of the Section 31 notices received in 2018 (four conditions) and 2019 (three conditions). The Trust has now received confirmation back from the CQC on the detail of which conditions have been removed and varied.

On 22 June the Trust received notification that the two remaining (2019) conditions that are reported weekly can now be reported fortnightly to align with the 2020 conditions. This request has been signed off at Deputy Chief Inspector level and the Trust commenced fortnightly reporting from 10 July 2020.

4. Completion and Submission to the CQC of the Required Action Plan Related to the 'Must Do's' Issued as Part of the Winter Assurance Visits to Lincoln and Pilgrim Hospitals Emergency Departments

The Hospital Inspection report from the January 2020 Winter Assurance Visits of the Emergency Departments included five further Must Do's. These Must Do's are similar to the Section 31's issued following the core inspection but apply to both Emergency Departments. To meet CQC requirements an action plan was submitted on 25 March 2020. The Must Do's have been mapped to the Trust's internal processes and include all the actions taken as part of the immediate and current actions taken to address the Section 31.

5. Conclusion/Recommendations

In conclusion, actions have been taken to close existing conditions and warning notices with the CQC and progress improvements against Must and Should Do actions.

The Trust Board is asked to note CQC associated activity and the progress against the delivery of improvements mapped to the CQC Must Do and Should Do's.

CQC Must Do / Should Do Actions

Executive Lead: Karen Dunderdale, Director of Nursing
Senior Responsible Officer: Angie Davies, Deputy Director of Nursing
Progress Review Date As At: 09-10-2020

Background

In preparation for the Trust's CQC Well-Led Announced Inspection, during June 2019 the Trust underwent a series of unannounced CQC inspections for five of our core services. The core services were:-

> Maternity
> Children & Young People
> Urgent & Emergency Care
> Critical Care
> Medicine

Following the unannounced visits the Trust's Well-Led Inspection took place in July 2019 and the CQC published its inspection report in October 2019. Within the CQC's published report there are a number of Must Do and Should Do actions to be undertaken for each of the core services. In addition the Trust underwent their Winter Pressure Assessment in January 2020 of their Emergency Departments at both Lincoln and Pilgrim Hospitals. The CQC sent its inspection report to the Trust in February 2020.

The purpose of this document is to provide the governance and assurance on the progress being made to date around these actions.

Summary / Key Points

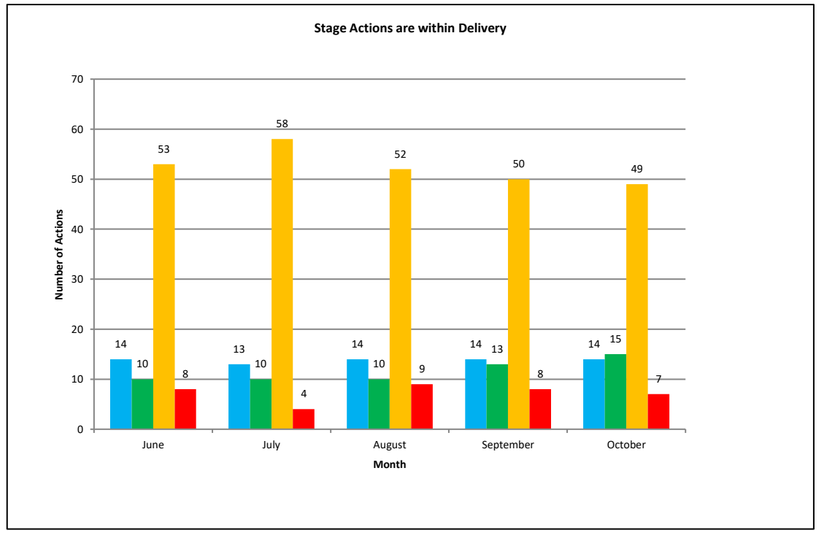
> A specific Pharmacy and Medicines Management CQC Confirm and Challenge Session is arranged for 15 October to focus in more detail on the Must Do and Should Do actions (Ref Nos: 39, 66, 67, 73-75).
> Relaunch of the Integrated Improvement Plan Big Conversations throughout September and October (Ref Nos: 2, 4).
> A training needs analysis is currently underway to understand from leaders and teams, across all services, what support they require to support with risks and issues. To be completed by October 2020 (Ref No 10).
> Comms 'topic of the month' is Freedom to Speak Up Guardian (Ref No 15).
> Commencement of works at Lincoln and Pilgrim Emergency Departments (Ref No 31).

Issues

Currently no issues.

Risks

> Due to COVID-19, there is a potential for non-delivery of CQC expectations for Must Do and Should Do actions. Mitigation: Being closely monitored on a weekly basis by Improvement Director, Quality Matron and PMO.
> There is currently no Service Level Agreement between LCHS and ULHT for our Speech and Language Therapy Services (SaLT), the service has now reached a point where there is insufficient workforce capacity and capability to maintain the full range of services. Mitigation: SaLT staff moved where possible to provide the most effective cover across the whole service.
> Due to the slow pace in the delivery of the Improvement Plan for Urgent & Emergency Care, actions are not being completed within timescales. A further Section 31 was issued in January 2020 following the CQC Winter Pressure Assessment. Mitigation: Revised Improvement Plan with clearly defined KPI's. Monitored weekly.
> Pilgrim ED is not fit for purpose due to the size and condition and does not meet patients needs or national standards, ie, sound levels. There will be delays in improving this environment without capital input. Mitigation: New £23.6m master plan for Pilgrim ED will address the risk.
> There is slow pace in the delivery and receiving updates of the Pharmacy CQC expectations for Must Do and Should Do actions. Mitigation: Discussions are taking place within the Division of Clinical Support Services regarding further help and support that is required.



RAG Rating Matrix	
Blue	Completed and embedded.
Green	Completed but not yet full embedded/evidenced.
Amber	In progress/on track.
Red	Not yet completed/significantly behind agree timescales.

OUTSTANDING CARE personally DELIVERED

CQC Must Do / Should Do Actions

Executive Lead: Karen Dunderdale, Director of Nursing
Senior Responsible Officer: Angie Davies, Deputy Director of Nursing
Progress Review Date As At: 09-10-2020

RAG Rating Matrix	
Blue	Completed and embedded.
Green	Completed but not yet full embedded/evidenced.
Amber	In progress/on track.
Red	Not yet completed/significantly behind agree timescales.

NHS United Lincolnshire Hospitals NHS Trust

Ref No	Core Service	Action Source	Must Do / Should Do / Section 31	Action	Executive Lead	Divisional/ Department Lead	IIP Strategic Objective	Reporting / Monitoring / Assurance	Expected Outcome	Key Deliverables & Activities completed since last report	Key Deliverables & Activities to be completed by next report	Key Performance Indicator / Milestone	Actual Performance	RAG
1	Well Led	Core Inspection	Must Do	The Trust must ensure the Executive Leadership Team have the capacity and capability to deliver current priorities and challenges.	CEO	N/A	People	Executive Leadership Team (monthly IIP oversight) ↑ WOD ↑ Workforce Strategy Group	1. A substantive Executive Leadership Team who are clear on their responsibilities. 2. Clarity throughout the organisation on Executive portfolios.	1. Completed.	1. Completed.	1. Director / Directorate / Portfolio changes implemented. 2 Senior leadership capacity and capability to be formally reviewed. 3. 100% of Executive Director posts recruited to.	1. Director of Finance commenced in role from December 2019. 2. Implemented Director/Directorate/Portfolio changes with further changes expected. 3. Director of Improvement and Integration post created and recruited to. 4. New COO in post- Jan 2020. 5. 100% of Executive Director posts are now recruited to.	Blue
2	Well Led	Core Inspection	Must Do	The Trust must ensure the leadership team have oversight of current priorities and challenges and are taking actions to address them.	CEO	N/A	People	Executive Leadership Team (monthly IIP oversight) ↑ WOD ↑ Workforce Strategy Group	1. Divisions are held to account for delivery against their priorities and for delivery on performance metrics. 2. Timely and appropriate action is taken by the Executive and Divisional Leads to address issues as they arise. 3. Clarity throughout the organisation on the top priorities ensuring teams are focused on delivering Trust objectives.	1. No further updates at this moment in time as work continues. 2. Priority has been around Grantham Green site as part of the Restoration Plan.	1. As part of Phase 3 of COVID-19, the Trust is now in the Recovery Phase and work continues to deliver the Trust's current priorities. 2. During September/October the relaunch of the Integrated Improvement Plan has now commenced.	1. New leadership structures implemented. 2. Revised ToR, agendas and reports for ELT and TLT. 3. Implementation of a Integrated Improvement Plan (IIP).	1. New leadership structures are in place. 2. Revised Terms of Reference have been completed. 3. IIP are now in delivery and reported monthly since July to FPEC. Monitor until December 2020.	Green
3	Well Led	Core Inspection	Must Do	The Trust must ensure leadership structures have a continued focus to ensure they embed across the organisation.	Deputy CEO	N/A	People	Executive Leadership Team (monthly IIP oversight) ↑ WOD ↑ Workforce Strategy Group	1. Delivery of the Trust/Divisional priorities as per Divisional IIP work streams. 2. Divisions will have the staff in post equipped with the skills required to deliver the Trust/Divisional IIP work streams.	1. No further updates at this moment in time as work continues. 2. Priority has been around Grantham Green site as part of the Restoration Plan.	1. To understand if establishment vacancy data can be further filtered out to drill down to Divisional senior and middle management vacancy rates.	1. 100% of Divisions have the required governance structures in place with appropriate membership and attendance. 2. Divisional vacancy rate for Triumvirate and middle management teams is below 10%.	Currently under development of how this information will be collated.	Amber
4	Well Led	Core Inspection	Must Do	The Trust must ensure staffs understand how their role contributes to achieving the strategy.	CEO	N/A	People	Executive Leadership Team (monthly IIP oversight) ↑ WOD ↑ Workforce Strategy Group	1. Divisions are held to account for delivery against their priorities and for delivery on performance metrics. 2. Staff members can articulate both the Trust priorities and what their role is in helping to deliver these.	1. No further updates at this moment in time as work continues. 2. Priority has been around Grantham Green site as part of the Restoration Plan.	1. During September/October the relaunch of the Integrated Improvement Plan (IIP) has now commenced. 2. Relook at capturing attendance rates for the relaunch of IIP.	1. Attendance figures for IIP Big Conversations.	1. Trust recently relaunched IIP Big Conversations. Currently looking at capturing attendance figures.	Amber

Ref No	Core Service	Action Source	Must Do / Should Do / Section 31	Action	Executive Lead	Divisional/ Department Lead	IIP Strategic Objective	Reporting / Monitoring / Assurance	Expected Outcome	Key Deliverables & Activities completed since last report	Key Deliverables & Activities to be completed by next report	Key Performance Indicator / Milestone	Actual Performance	RAG
5	Well Led	Core Inspection	Must Do	The Trust must ensure there is timely progress against delivery of the strategy and local plans continue to be monitored and reviewed.	Deputy CEO	Julie Pipes Karen Sleigh	People	Executive Leadership Team (monthly IIP oversight) ↑ WOD ↑ Workforce Strategy Group	1. Divisions are held to account for delivery against their priorities and for delivery on performance metrics. 2. Timely and appropriate action is taken by the Executive and Divisional Leads to address issues as they arise.	1. Work to develop the implementation detail of the Centre of Excellence model into the Improvement Academy and training of the Core Team and Faculty Members. 2. IIP dashboard and supporting process to measure and report delivery against the 2020/21 annual plan aligned to the IIP.	1. Monthly reports submitted to FPEC since July for reassurance and assurance of the delivery of the strategy.	IIP Dashboard	Monthly reports since July go to FPEC. On target.	Amber
6	Well Led	Core Inspection	Must Do	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.	HRD	Martin Rayson Helen Nicholson	People	Executive Leadership Team (monthly IIP oversight) ↑ WOD ↑ Workforce Strategy Group	Retention rates and staff satisfaction scores will both improve as staff start to feel more valued and respected.	1. Continuation of Staff Well-Being brochure. 2. Continuation of Staff Well-Being Group with escalation of key issues. 3. Activity at Grantham to support staff wellbeing. 4. Working with system partners to agree system mental health wellbeing offer. 5. Developing a plan to support shielding staff retuning to work.	1. Continuation of Staff Well-Being brochure. 2. Continuation of Staff Well-Being Group with escalation of key issues. 3. Activity at Grantham to support staff wellbeing. 4. Working with system partners to agree system mental health wellbeing offer. 5. Developing a plan to support shielding staff returning to work.	1. Staff turnover below 12%. 2. 20% (or 8 point) improvement on staff survey scores for recommending ULHT as a place to work.	(Source of Information: Trust's Integrated Performance Report)	Amber
7	Well Led	Core Inspection	Must Do	The Trust must work at pace to ensure sufficient numbers of suitably qualified, competent, skilled and experienced medical and nursing staff across all services.	HRD	Martin Rayson Jenny Makwana	People	Executive Leadership Team (monthly IIP oversight) ↑ WOD ↑ Workforce Strategy Group	Staff retention rates will improve and both patient and staff satisfaction rates will improve .	1. Visa Centres to begin to open across the world and also OSCE centres are due to open for international nurses.	1. Visa Centres to begin to open across the world and also OSCE centres are due to open for international nurses.	Monitoring of the Trust's overall number of vacancies. In-month target of 12%.	(Source of Information: Trust's Integrated Performance Report)	Amber
8	Well Led	Core Inspection	Must Do	The Trust must ensure there are effective governance processes throughout the service and with partner organisations.	CEO	N/A	People	Executive Leadership Team (monthly IIP oversight) ↑ WOD ↑ Workforce Strategy Group	1. Robust monitoring of delivering performance and quality improvements throughout the organisation via governance structures. 2. Greater ownership of delivery by Divisions and timely action taken to resolve issues.	1. Governance processes continue to be monitored to ensure their effectiveness.	1. Governance processes continue to be monitored to ensure their effectiveness and this will be reiterated through the IIP Big Conversations.	100% of Divisions have the required governance structures in place with appropriate membership and attendance.	Currently under development of how this information will be collated.	Amber
9	Well Led	Core Inspection	Must Do	The Trust must ensure systems to manage performance are embedded across the organisation.	DoF	Shaun Caig	People	Executive Leadership Team (monthly IIP oversight) ↑ FPEC	1. Improvements in delivery of performance. 2. Divisions will feel more supported and equipped to deliver against Trust priorities	1. To continue review of Strategy Deployment Programme of work with KPMG. 2. Operational Excellence work continues.	1. To continue review of Strategy Deployment Programme of work with KPMG. 2. Operational Excellence work continues.	1. To have an Operational Excellence model to align strategy to local delivery plans. 2. 100% of Performance Review Meetings planned for the year ahead.	1. Work is underway with KPMG to implement an Operational Excellence model (please refer to Ref No 5). 2. All Performance Review Meetings are scheduled and invites have been distributed for financial year 2020/21 (evidence file ref 9.1).	Amber

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10	Well Led	Core Inspection	Must Do	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.	DoN	Helen Shelton Paul White	People	Executive Leadership Team (monthly IIP oversight) ↑ QGC ↑	1. Greater understanding and ownership of risk management within the Divisions. 2. Reduction in the number of incidents arising as a result of unidentified risks.	1. Continues to be managed via speciality governance. 2. Agree metrics for the embedding Divisional governance including risk management training.	1. Training needs analysis is currently underway and will be completed by October 2020.	1. Zero out of date risks on risk registers. 2. Training delivered to all relevant Divisional staff on risk management and risk awareness.	1. This milestone is not currently reported on. 2. Drop In sessions currently being delivered on risk management but this data is not reported on yet.	Amber
11	Well Led	Core Inspection	Must Do	The Trust must ensure all staff is committed to continually learning and improving services.	Deputy CEO	Karen Sleigh Maria Wilde	People	Executive Leadership Team (monthly IIP oversight) ↑ WOD	Greater ownership of issues at Divisional level with staff taking the lead on identifying and delivering improvements required.	1. Completed delivery of the QSIR Virtual pilot with the SAS doctors. 2. Delivery of the QSIR Virtual with ward managers.	1. Delivery of the QSIR Virtual with ward managers commences in October.	1. Attendances at QSIR for efficacy returns to the ACT Academy. 2. Attendances at the QI cohort.	1. All attendees for QSIR are signed in and recorded against the ACT Academy Compact 2. All attendees for QSIR are included in the Improvement Academy Year Book and submit a Project Up-Date for the Catalogue. 3. All attendees for QI are signed in and recorded against the QI register. 4. All attendees for QI are included in the Improvement Academy Year Book and submit an improvement poster for the Catalogue. 5. Shared Decision Making Councils attend a bespoke QI day.	Amber
12	Well Led	Core Inspection	Must Do	The Trust must ensure systems or processes are established and operated effectively, across all services, in line with national guidance.	DoN	Helen Shelton Bernie Gallen	People	Executive Leadership Team (monthly IIP oversight) ↑ QGC ↑	Patient outcomes will improve as a result of compliance with national guidance.	1. 2020/21 audit plan to be linked to IIP priorities now that the IIP has been re-energised.	1. Clinical audit lead training. 2. Update Divisional reporting from feedback from Divisional Cabinets. 3. Review and update NICE Policy.	Annual local audit plan in place linked to IIP priorities.	Local ULHT clinical audit plan for 2020/21 will be cross referenced to IIP priorities.	Amber
13	Well Led	Core Inspection	Must Do	The Trust must ensure premises across all services are suitable for the purpose for which they are being used and properly maintained.	COO	Paul Boocock	Services	Executive Leadership Team (monthly IIP oversight) ↑ FPEC	1. An estates risk system in place with no outstanding critical risks. 2. Infection rates will be within or better than national average.	1. Project plans for E&F PM's in place reflecting IIP requirements. PM's progressing with initial actions and work identified. Particularly IPC matters and estates risks for the environment.	1. Project plans for E&F PM's in place reflecting IIP requirements. PM's progressing with initial actions and work identified. Particularly IPC matters and estates risks for the environment.	Trust Wide MIC4D for wards and departments above 95%.	Data received but currently not collected in this format.	Amber
14	Well Led	Core Inspection	Should Do	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.	HRD	Martin Rayson Tim Couchman	People	Executive Leadership Team (monthly IIP oversight) ↑ WOD ↑ Workforce Strategy Group	BAME staff will report having equality of opportunity for career development.	1. Work continues with staff from a BAME background, particularly completion of risk assessments in line with COVID-19.	1. Work continues with staff from a BAME background, particularly completion of risk assessments in line with COVID-19.	Annual Workforce Race Equality Standard.	Currently in the financial year of collating this data. Next report due June/July 2020.	Amber

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15	Well Led	Core Inspection	Should Do	The Trust should ensure there is an increased awareness of the role of the Freedom to Speak Up Guardian role.	CEO	Jayne Warner	People	Trust Board ↑ WOD Committee	Staff will feel confident in being able to raise concerns without fear of retribution.	1. Draft job description for FTSU Guardian post. 2. Survey organisation about FTSU Guardian post. 3. Plan for celebrating Speak Up Month in October. 4. FTSU champions to pull plan together for how we can restart the actions on hold due to COVID-19 and continue to move forward with the awareness roll out.	1. Comms 'topic of the month' is Freedom to Speak Up Guardian. Comms have been cascaded throughout the organisation to encourage staff to speak up.	Staff survey scores for "I would feel secure raising concerns about unsafe clinical practice".	Currently awaiting the publication of the 2020 staff survey scores, but previous scores are as follows:- 2018 - 65.1% (national average 69.3%) 2019 - 66% (national average 70.4%)	Amber
16	Well Led	Core Inspection	Should Do	The Trust should ensure there is a clear process for the Guardian of Safe Working (GOSW) report to the Board and that issues raised through the GOSW are appropriately addressed.	MD	Paul Dunning Stuart Selkirk	People	Executive Leadership Team (monthly IIP oversight) ↑ WOD ↑ Workforce Strategy Group	Junior medical staff will feel supported and able to undertake their role effectively.	1. Completed.	1. Completed.	1. Quarterly reports to Trust Board. 2. Annual Report to Trust Board.	Reports to Trust Board:- Q2 July/Sept 2019 Q3 Oct/Dec 2019 Q4 Jan/Mar 2020 Annual Report to Trust Board submitted for April 2020.	Blue
17	Well Led	Core Inspection	Should Do	The Trust should ensure divisional leads are fully engaged in decisions about financial improvement and have oversight of their divisional budgets.	DoF	Jonathon Young David Picken	Services	Executive Leadership Team (monthly IIP oversight) ↑ FPEC ↑ Performance Review	Currently under review in light of introduction of Finance Review Meeting (FRM).	1. Finance Review Meetings for all five Divisions are scheduled for w/c 17/08/2020. The main agenda item will be around medical agency.	1. Continuation of Finance Review Meetings for monitoring and holding to account.	Action Log and Attendance Register of Finance Review Meetings.	All past action logs and attendance register are available for review through the PMO Manager.	Amber
18	Well Led	Core Inspection	Should Do	The Trust should ensure leaders and staff strive for continuous learning, improvement and innovation through participation in appropriate research projects.	MD	Hannah Finch	Partners	QGC ↑ ↑ Divisional Cabinet	Comprehensive Research strategy in place which is understood and owned by Divisions.	1. Final draft signed off by project Sponsor.	1. Paper submitted to QGC for approval	1. Revised Research and Innovation Strategy.	Divisional Leads and Director of Nursing have been contacted to arrange meetings to discuss the strategy. Two meetings are in place.	Amber
19	Urgent & Emergency Services	Core Inspection	Must Do	The Trust must ensure all patients who attend the department are admitted, transferred and discharged from the department within four hours.	COO	Ciro Rinaldi David Cleave Debbie Pook	Services	Executive Leadership Team (monthly IIP oversight) ↑ FPEC ↑ Performance Review	Patients will receive the right care in a timely manner and adverse harm incidents will reduce.	1. Final approval of plans for capital works. 2. Commencement of works at Lincoln and Pilgrim Eds. 3. Works progressing LCHS and CCG regarding UTC commissioned service. 4. Bevan to open as SDEC at Pilgrim.	1. Meeting to discuss enhanced pathways through SDEC 2. Undertake AMBS at triage	95% of patients seen and treated within four hours of arrival at the Emergency Department. (ULHT in month target of 82%)	(Source of Information: Trust's Integrated Performance Report)	Amber
20	Urgent & Emergency Services	Core Inspection	Must Do	The Trust must ensure information is readily available for patients to take away details of what signs or symptoms they needed to look out for that would prompt a return to hospital or seeking further advice.	COO	Ciro Rinaldi Debbie Pook David Cleave	Services	Executive Leadership Team (monthly IIP oversight) ↑ FPEC ↑ Performance Review	Patients and carers will be appropriately informed and better able to seek the correct advice if needed.	1. Matron arranging visit to Sherwood to review their leaflets and information. 2. Reviewing RCEM information leaflets available online. 3. Huddle updates to advise on usage of RCEM leaflets where appropriate.	1. No update submitted for this reporting period.	95% of notes audited will evidence safety netting advice given to the patient.	Not yet achieved.	Amber

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21	Urgent & Emergency Services	Winter Pressure Inspection	Must Do	The Trust must ensure that ambulance handovers are timely and effective. (Lincoln and Pilgrim Hospitals)	COO	Ciro Rinaldi Debbie Pook David Cleave	Services	Executive Leadership Team (monthly IIP oversight) ↑ FPEC ↑ Performance Review	Patients will receive assessment and treatment in a safe environment.	1. Continued collaboration at weekly EMAS meetings. 2. Capital bid works to be finalised and approved - initial works to commence.	1. Capital bid works to be commenced	15/30 minute handover >59 minute handover >120 minute handover	(Source of Information: Trust's Integrated Performance Report)	Amber
22	Urgent & Emergency Services	Winter Pressure Inspection	Must Do	The Trust must ensure that all patients are assessed in a timely manner and ensure that patients receive assessment and treatment in appropriate environments and on appropriate beds. (Lincoln and Pilgrim Hospitals)	COO	Ciro Rinaldi Debbie Pook David Cleave	Patients	Executive Leadership Team (monthly IIP oversight) ↑ QGC/FPEC ↑ / Performance Review	Patients will receive assessment and treatment in a safe environment.	1. Final approval of plans for capital works. 2. Commencement of works at Lincoln and Pilgrim ED. 3. Contractor now appointed for works	1. Commencement of works at Lincoln and Pilgrim ED.	Capacity modelling and agreement by Board to deliver 50% within 60 minutes	(Source of Information: CQC Regulatory Notification submission)	Amber
23	Urgent & Emergency Services	Winter Pressure Inspection	Must Do	The Trust must ensure that consultant and nurse cover in the department meets national guidelines. (Lincoln and Pilgrim Hospitals)	COO	Ciro Rinaldi Debbie Pook David Cleave	People	Executive Leadership Team (monthly IIP oversight) ↑ QGC/FPEC ↑ / Performance Review	Patients will receive care from an appropriate healthcare professional in a timely manner.	1. Continued monitoring though Golden hour and ward lead assurance.	1. Chase tool to measure for nursing guidelines 2. Continue monitoring for Consultant cover currently achieved	1. Continuous review of the fill against template on every shift by the department and how this compares with requested shifts 2. Monitoring TTFA for Medical staff to achieve 50% patients seen within 60 minutes 3. Triage	1.Achieved.	Green
24	Urgent & Emergency Services	Winter Pressure Inspection	Must Do	Fully implement the Trust Wide actions to reduce overcrowding in the department. (Lincoln and Pilgrim Hospitals)	COO	Ciro Rinaldi Debbie Pook David Cleave	Services	Executive Leadership Team (monthly IIP oversight) ↑ QGC/FPEC ↑ / Performance Review	Patients will receive assessment and treatment in a safe environment.	1. Final approval of plans for capital works. 2. Commencement of works at Lincoln and Pilgrim ED. 3. Finalise plan for location of PARU (Priority Admission Review Unit) at Lincoln. 4. Continued monthly MDT Meetings between ED and specialties to improve pathways and compliance with IPS.	1. Continues monthly meetings between ED and specialties. 2. Finalise plan for location of PARU (Priority Admission Review Unit) at Lincoln 3. Commencement of works at Lincoln and Pilgrim ED.	All patients will transfer within 30 minutes of a bed being identified.	(Source of Information: Trust's Integrated Performance Report)	Amber
25	Urgent & Emergency Services	Winter Pressure Inspection	Must Do	The Trust must ensure that the privacy and dignity of patients receiving care and treatment in the Emergency Department is maintained at all times. (Pilgrim Hospital)	COO	Ciro Rinaldi Debbie Pook David Cleave	Patients	Executive Leadership Team (monthly IIP oversight) ↑ QGC ↑	Patient experience will improve.	1. Complete - ED Assurance fully embedded with weekly meeting to review themes and trends and put in place actions to address any issues identified.	1. Complete - ED Assurance fully embedded with weekly meeting to review themes and trends and put in place actions to address any issues identified.	1. Refer to Section 31 report 2. Ward accreditation - Integrated Performance Report 3. New Trust wide quality dashboard	(Source of Information: Trust's Integrated Performance Report)	Green
26	Urgent & Emergency Services	Winter Pressure Inspection	Section 31	The Trust must ensure it implements an effective system to ensure all patients who present to the Emergency Department at Pilgrim Hospital, Boston, commence active treatment within 60 minutes of arrival. i.e. all patients should be seen by a clinical decision maker who can diagnose the problem, decide a plan of care and start or arrange the necessary treatment.	COO	Ciro Rinaldi Debbie Pook David Cleave	Patients	Executive Leadership Team (monthly IIP oversight) ↑ QGC ↑	All patients are seen by a senior decision maker within 60 minutes of arrival. This cross references to the Section 31 report submitted weekly.	1. Rotas and new medical staffing model fully embedded. Achieving 50% patients seen in 60 minutes as per Trust target. Review to take place October regarding uplift to Silver Model.	1. Paper to be reviewed by executive team for approval	Patients seen within 60 minutes	(Source of Information: Trust's Integrated Performance Report)	Green

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27	Urgent & Emergency Services	Winter Pressure Inspection	Section 31	The Trust must ensure that there are systems in place across the Emergency Department at Pilgrim Hospital, Boston so that patients are assessed and cared for in the area appropriate for their acuity at all times.	COO	Ciro Rinaldi Debbie Pook David Cleave	Patients	Executive Leadership Team (monthly IIP oversight) ↑ QGC ↑	1. An efficient and speedy triage process. 2. Appropriate patients will be seen by UTC and it is expected that these numbers will increase. 3. Appropriate patients will be seen in SDEC with the aim of avoiding admissions.	1. Final approval of plans for capital works. 2. Commencement of works at Lincoln and Pilgrim Eds.	1. Commencement of works	1. Datix harms for fail to rescue or unsighted deterioration. 2. Compliance with hourly rounding in ED.	Currently under development of how this information will be collated.	Amber
28	Urgent & Emergency Services	Winter Pressure Inspection	Section 31	The Trust must ensure that the systems make provision for effective monitoring of the service user's pathway through the Emergency Department at Pilgrim Hospital, Boston.	COO	Ciro Rinaldi Debbie Pook David Cleave	Services	Executive Leadership Team (monthly IIP oversight) ↑ QGC ↑	Effective pathway monitoring is maintained.	1. Still awaiting clarity on expectations for reporting on this action.	1. Still awaiting clarity on expectations for reporting on this action.	Currently under review.	Currently under development of how this information will be collated.	Amber
29	Urgent & Emergency Services	Winter Pressure Inspection	Section 31	The Trust must ensure there are appropriate systems in place to monitor the condition and risk of deterioration for all patients awaiting admission (e.g. on ambulances or in corridor areas awaiting triage) to the Emergency Department at Pilgrim Hospital, Boston.	COO	Ciro Rinaldi Debbie Pook David Cleave	Patients	Executive Leadership Team (monthly IIP oversight) ↑ QGC ↑	Patients are monitored and a system in place to immediately detect a deterioration of a patient.	1. Collation of evidence regarding completion of 2 hourly huddles. NIC to ensure that review of at risk patients is documented on each ED risk tool.	1. Embedding of the discussion of patients at risk by the NIC to continue and recording on the ED risk tool	1. Datix harms for fail to rescue or unsighted deterioration. 2. Compliance with hourly rounding in ED.	Currently under development of how this information will be collated.	Amber
30	Urgent & Emergency Services	Winter Pressure Inspection	Section 31	The Trust must ensure that appropriate Emergency Department escalation procedures are maintained and followed by all staff including at times of peak capacity and demand at Pilgrim Hospital, Boston.	COO	Ciro Rinaldi Debbie Pook David Cleave	People	Executive Leadership Team (monthly IIP oversight) ↑ QGC ↑	All relevant staff will know the position of the department and will know how to escalate issues and concerns either related to safety or performance.	1. Complete - covered in all EPIC training sessions. Spot checks on understanding completed weekly and recorded.	1. Continued monitoring of knowledge via spot checks in the department of the protocols	1. Review of appropriateness and relevance of escalation against the flow chart. 2. To share learning at Business Governance meetings .	Improvements across all key indicators, for example Ambulance Handover, Triage, TTFA.	Green
31	Urgent & Emergency Services	Winter Pressure Inspection	Section 31	The Trust must ensure that at all times, there is sufficient capacity in the Emergency Department to accommodate all patients at risk of deterioration or who require time critical care and treatment; this must be provided in an appropriate clinical setting.	COO	Ciro Rinaldi Debbie Pook David Cleave	Patients	Executive Leadership Team (monthly IIP oversight) ↑ QGC ↑	Patients who are at high risk of deterioration are cared and monitored for appropriately within ED.	1. Final approval of plans for capital works. 2. Commencement of works at Lincoln and Pilgrim Eds.	1. Commencement of works at Lincoln and Pilgrim Eds. 2. Harm review to be completed on any patients who can not be accommodated in Resus	1. ED Risk Tool 2. Risk Management system 3. Harm reviews	Currently under development of how this information will be collated.	Amber
32	Urgent & Emergency Services	Core Inspection	Should Do	The Trust should ensure governance and performance monitoring and management are strengthened at operational level.	COO	Ciro Rinaldi Debbie Pook David Cleave	People	FPEC/QGC ↑ / Performance Reviews ↑ Divisional Cabinet	Divisions are held to account for delivery against their priorities and for delivery on performance metrics.	1. Continued monitoring.	1. Continued monitoring.	Attendance (agree % attendance required annually)	Monitored through Medicine Cabinet.	Green
33	Urgent & Emergency Services	Core Inspection	Should Do	The Trust should ensure consistent arrangements for pain relief and nutrition are developed for patients who are in the Emergency Department.	COO	Ciro Rinaldi Debbie Pook David Cleave	Patients	QGC ↑ / Performance Reviews ↑ Divisional Cabinet	Patients within ED will receive timely pain relief and their nutritional needs will be met.	1. Continued monitoring.	1. Continued monitoring.	1. ED Assurance Report.	Achieved.	Green
34	Urgent & Emergency Services	Core Inspection	Should Do	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.	COO	Ciro Rinaldi Debbie Pook David Cleave	Services	FPEC ↑ Performance Review ↑ Divisional Cabinet	Patients will receive care in a timely manner receiving the appropriate specialist treatment if required.	1. Matron leading on work with site sisters and clinical lead to review and update role responsibilities.	1. Continuation of last months action - developing role cards and sharing role responsibilities with staff	IPS scorecard being developed.	Not currently achieved.	Amber

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35	Urgent & Emergency Services	Core Inspection	Should Do	The Trust should consider training key staff in customer care skills.	COO	Ciro Rinaldi Debbie Pook David Cleave	Patients	WOD ↑ Workforce Strategy Group ↑ Divisional Cabinets	Patient satisfaction will improve.	1. Further training to take place.	1. To explore online provision due to current guidelines of stopping face to face training	Monthly target will be measured against plan.	Not currently achieved.	Amber
36	Quality Governance (Urgent & Emergency Services)	Core Inspection	Should Do	The Trust should formulate a formal clinical audit plan with identified roles and responsibilities and review dates.	MD	Ciro Rinaldi Helen Shelton	Patients	QGC ↑ ↑ Divisional Cabinet	Patient outcomes will improve through the delivery of evidence-based care.	1. Currently no update since July.	1. Clinical audit lead training. 2. Update Divisional reporting from feedback from Divisional Cabinets. 3. Review and update NICE Policy.	As a minimum contribution to mandatory clinical audits.	Not currently achieved.	Amber
37	Estates & Facilities (Urgent & Emergency Services)	Core Inspection	Should Do	The Trust should consider how sound levels might be reduced in the Emergency Department, Pilgrim Hospital.	COO	Paul Boocock	Services	FPEC ↑ Performance Review ↑ Divisional Cabinet	1. Improved physical patient flows through the ED thereby creating a calm patient environment 2. Improved spatial standards and acoustic measures incorporated in between rooms and within doors. 3. The use of materials and sound deadening barriers within the environment to improve acoustics. 4. Waiting and circulation spaces which support a movement strategy aimed at introducing calming quiet environments.	1. OBC was agreed at Trust Board and will now be submitted to NHSE.	1. Currently no further update.	Improvement in FFT scores for Urgent Care.	% improvement currently being finalised.	Amber
38	Clinical Support Services - Therapies & Rehabilitation (Medical Care)	Core Inspection	Must Do	The Trust must ensure patients receive timely review by specialist consultants when required, including speech and language therapy.	COO	Ciro Rinaldi David Cleave Anita Cooper	Patients	Executive Leadership Team (monthly IIP oversight) ↑ FPEC ↑ Performance Review	Patients will receive care in a timely manner receiving the appropriate specialist treatment if required.	1. Meeting with LCHS review plan for newly released funding.	1. Awaiting further date for CRIG as last meeting oversubscribed. 2. Review triage process 3. Review proposal from LCSH for increase of services	Understand outcome of management of change process and LCHS plans for further recruitment.	Business case approved in principle at CSS Clinical Cabinet in July while awaiting finance information from LCHS. This is now received and BC finalised. For review with DMD and Senior Finance. Manager on 8 Sept.	Amber
39	Clinical Support Services - Pharmacy (Medical Care)	Core Inspection	Must Do	The Trust must ensure that processes are being followed related to proper and safe management of medicines.	MD	Colin Costello	Patients	Executive Leadership Team (monthly IIP oversight) ↑ QGC ↑	There will be a reduction in medicines management related incidents with no harm.	1. Meeting arranged with CSS on 16th September for BC sign off. 2. First meeting of MQG occurred in August. 3. Aseptic new build in planning phase. Staffing review aligned to capacity on-going.	1. BC signed off at CSS, sent to CRIG, date TBC. 2. MM actions now being managed at MQG. 3. Aseptic new build plan agreed with Boole Technology Centre and Bassaire. Staffing review aligned to capacity and 7-day cancer planning is on-going.	PID Milestone Plans. Business case approval and funding. Aseptic build completion.	IIP PID Milestone Plans and resource requirement for PID agreed. Business case written, agreed with CSS and submitted to CRIG, date TBC. Aseptic build planned early 2021.	Red
40	Medical Care (including older people's care)	Core Inspection	Must Do	The Trust must ensure patients are treated with dignity and respect at all times.	DoN	David Cleave	Patients	Executive Leadership Team (monthly IIP oversight) ↑ QGC ↑	Patient satisfaction will improve.	no update given	1. Monitoring through matrons assurance tool. 2. Start of patient experience rounds	1. Improvement in Patient FFT scores. 2. Reduction in complaints relating to staff attitude. (NB % improvement currently being finalised for both KPI's)	Actions in place with monitoring against FTT and complaints.	Amber

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41	Medical Care (including older people's care)	Core Inspection	Must Do	Ensure beds ring-fenced for non-invasive ventilation and for thrombolysis are available for these patients and have trained, competent staff always available.	COO	Ciro Rinaldi Debbie Pook David Cleave	Patients	Executive Leadership Team (monthly IIP oversight) ↑ FPEC ↑ Performance Review	Having a bed available and ready for transfer so patients will receive care/specialist treatment in a timely manner.	No update given	1. Continue weekly meetings with external partners and executives 2. writing paper for board	1. Monitoring of Carlton/Coleby Ward and Ward 7B NIV/thrombolysis bed availability. 2. Datix when there are exceptions to this to monitor.	Achieved on a bed availability perspective and as part of the policy page 10. Move to green if staffing managed to reflect this.	Amber
42	Medical Care (including older people's care)	Core Inspection	Should Do	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.	DoN	David Cleave	Patients	FPEC ↑ Performance Review ↑ Divisional Cabinet	Patients will receive safe care during the conscious sedation procedure.	1. No update on Policy	1. Meeting with Associate director of Nursing to finalise policy. 2. work with ITU to develop plan for training staff with face to face restrictions	Policy is in place.	Policy not yet in place and training not delivered.	Amber
43	Medical Care (including older people's care)	Core Inspection	Should Do	The Trust should ensure that patient notes and confidential information are stored securely.	MD	Ciro Rinaldi David Cleave	Services	FPEC ↑ Performance Review ↑ Divisional Cabinet	There will be no breaches of patient confidentiality.	1. IG compliance, scores currently 84.62%. To be discussed at CBU level and cabinet and 1-2-1 nursing level.	1. Explore adding IG compliance to Drs induction 2. Monitor through Matrons audit	Ward accreditation. Ward assurance to take place by leaders to monitor. 95% of staff will be compliant with IG training	Divisional IG Training compliance.	Amber
44	Medical Care (including older people's care)	Core Inspection	Should Do	The Trust should ensure that there is an inpatient adult pain team that is sufficiently staffed for patients to be referred to.	DoN	David Cleave	Patients	QGC ↑ ↑ Divisional Cabinet	Patients will receive a review by a member of the Pain Team in a timely manner.	Continued support with delivering epidural and PCA training to wards	Continued delivering of training with additional Entonox training.	A fully established Pain Team is in place.	Achieved.	Green
45	Clinical Support Services - Pharmacy (Medical Care (including older people's care)	Core Inspection	Should Do	The Trust should ensure patients are appropriately assessed for self-administration of medicines and that their own medicines are in date.	MD	David Cleave Colin Costello	Patients	QGC ↑ ↑ Divisional Cabinet	Patients will have greater involvement in administration of their medicines.	1. Complete the business case following amendments. 2. The policy has been sent to DTC and CEG for ratification. Planned meeting to discuss scoping of areas and roll out plan.	1. Business case being written for submission to CSS. 2. The policy has been sent to DTC and CEG for ratification. Scoping of areas and roll out plan to be agreed.	Policy in place to support patient self administration. Further agreement needed on % of appropriate patients using in practice.	1. Inconsistencies found on one ward by CQC, not found to be embedded. 2. Many wards unable to do SAM 3 as they require appropriate and safe POD lockers.	Red
46	Medical Care (including older people's care)	Core Inspection	Should Do	The Trust should establish a process that identifies patients on MEAU that require a specialist consultant review.	COO	Ciro Rinaldi David Cleave	Patients	FPEC ↑ Performance Review ↑ Divisional Cabinet	Patients will receive care in a timely manner receiving the appropriate specialist treatment if required.	1. Process in place to identify reviews required. Discussions taking place regarding IPS and response times of specialties to review patients in MEAU.	1. Data collection and audits to measure the response of the times of the specialties to MEAU and SEAU-	Reconfiguration milestones being worked up.	Length of stay MEAU. 0-1 day LoS on specialty wards.	Amber
47	Medical Care (including older people's care)	Core Inspection	Should Do	The Trust should consider reducing the amount of patient moves during the night.	COO	Ciro Rinaldi Debbie Pook David Cleave Ops Centre	Services	FPEC ↑ Performance Review ↑ Divisional Cabinet	Patient experience and satisfaction will improve.	1. Ensure daily board rounds take place.	1. On going audit process going forward. Looking at actions to improve flow earlier in day to further minimise non clinical transfers after 10 pm.	Monitoring and recording of patient moves over night, zero moves excluding assessment areas or unless clinically indicated, otherwise clear approval by silver on call.	Partially achieved.	Green
48	Medical Care (including older people's care)	Core Inspection	Should Do	The Trust should review arrangements for discharge to ensure that there are no delays due to transport or waits for to take away medications.	COO	Ciro Rinaldi Debbie Pook David Cleave	Services	FPEC ↑ Performance Review ↑ Divisional Cabinet	No patient will experience unnecessary delays.	1. Ensure staffing to template is in place each day - additional middle grade twilight or overnight shift to provide support to juniors.	1. New system discharge policy. 2. Reviewing 7 days clinical standards to maximise senior review and discharges.	1. Measure compliance with pathways. 2. 35% medically optimised patients to be discharged by midday. 3. Identification of 10 patients by 10 am for discharge in line with national guidelines.	Partially achieved.	Amber

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49	Medical Care (including older people's care)	Core Inspection	Should Do	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.	COO	Ciro Rinaldi Debbie Pook David Cleave	Services	FPEC ↑ Performance Review ↑ Divisional Cabinet	Patients will receive care in a timely manner receiving the appropriate specialist treatment if required.	1. Ensure daily board rounds take place.	1. Continue monitoring daily board rounds are completed	1. Monitor time to specialty review, measure referral to review stay >23hrs. 2. Golden hour.	Baseline and target to be agreed. Not currently achieved.	Amber
50	Medical Care (including older people's care)	Core Inspection	Should Do	The Trust should ensure the leadership team in the Stroke Service are supported to resolve the backlog of open incident reports.	MD	Ciro Rinaldi Debbie Pook David Cleave	People	QGC ↑ Performance Review ↑ Divisional Cabinet	Appropriate actions and learning will occur in a timely manner reducing the risk of a similar incident occurring again.	1. Completed.	1. Completed.	Incidents to all be current with timely investigation and completion of actions.	One open incident for area and monitored at governance.	Blue
51	Clinical Support Services - Haem & Oncology Wards (Medical Care)	Core Inspection	Should Do	The Trust should consider implementing more robust medical handover processes for patients being cared for as inpatients on Haematology or Oncology Wards.	MD	Aurora Sanz Torres Vicky Medlock	Services	FPEC ↑ Performance Review ↑ Divisional Cabinet	A robust medical handover process is embedded and incorporated as business as usual on Trust wide Haematology and Oncology Wards.	1. Sustainability has been achieved. Collating evidence for this action and to be quality assured through the Weekly CQC Meeting.	1. Sustainability achieved and evidence to be reviewed in new CQC review meeting	Implementation from 01/04/2020.	Assurance to be monitored through CSS Clinical Divisional Cabinet.	Green
52	Medical Care (including older people's care)	Core Inspection	Should Do	The Trust should review medical staffing on the IAC so that junior doctors have appropriate support and can provide care safely within their abilities.	COO	Ciro Rinaldi Debbie Pook David Cleave	People	FPEC ↑ Performance Review ↑ Divisional Cabinet	Satisfaction will improve for junior doctors and they will be able to access support and training.	1. Ensure staffing to template is in place each day - additional middle grade twilight or overnight shift to provide support to juniors.	1. Ensure staffing to template is in place each day - additional middle grade twilight or overnight shift to provide support to juniors.	1. Eight consultants on per day to be able to support.	Assurance to be monitored through medicine cabinet.	Amber
53	Children & Young People	Core Inspection	Must Do	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.	DoN	Simon Hallion David Cleave Bridy Clark Debbie Flatman	Services	Executive Leadership Team (monthly IIP oversight) ↑ QGC ↑	Clarity on pathways to support Children & Young People with on-going needs in transition to Adult Services.	1. Business case and job description completed for transition nurse specialist and application and submitted Roald dahl charity. 2. Medical director confirmed as Executive lead. 3. Project management support for transition from improvement team identified	1. Await outcome of charity application. 2. If unsuccessful then internal business case for post 3. Identify lead for transition within adult services 4. To identify a consultant paediatrician to lead on transition	Milestone outcomes to align to the agreed ones within the transition programme when signed off.	Programme commenced February. Mid-March to April programme suspended due to COVID-19.	Amber
54	Children & Young People	Core Inspection	Must Do	The Trust must ensure all staff comply with good hand hygiene practice.	DoN	Simon Hallion Becky Thurlow Kevin Shaw	Patients	Executive Leadership Team (monthly IIP oversight) ↑ QGC ↑	Routine compliance demonstrated via hand hygiene audits.	1. Completed.	1. Completed.	1. Compliance with hand hygiene audit. 2. Compliance with BBE audit.	Compliance has improved and improvement noted on recent NHSi visit. Hand hygiene is now monitored on a quality dashboard and is tracked monthly with actions to complete should compliance slip.	Blue
55	DoN - Safeguarding (Children & Young People)	Core Inspection	Must Do	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.	DoN	Craig Ferris Elaine Todd	Patients	Executive Leadership Team (monthly IIP oversight) ↑ QGC ↑	The Trust is compliant with Section 11 of the Children's Act 2004.	1. Medicine Division convening meeting to discuss and update (postponed due to their Clinical activity). Suggestions received from CSS and FH. Deputy Director of Safeguarding reiterated need for responses in a timely manner.	Medicine Division to convene meeting (5/10/20) to discuss their response. Meeting scheduled with Surgery Division (9/10/20) to discuss their response. To continue to discuss at Operational and SG Group meetings. Plan re-circulated to wider services (HR/Complaints, etc.) to elicit a response. Named	Submission of compliance documents (for moderation) against section 11 of the Children's Act by 26th February 2021.	Data under collection. Period of monitoring in place (September 2020).	Green

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56	DoN - Safeguarding (Children & Young People)	Core Inspection	Must Do	The Trust should ensure children's safeguarding lead is in receipt of regular one to one safeguarding supervision.	DoN	Craig Ferris Elaine Todd	Patients	Executive Leadership Team (monthly IIP oversight) ↑ QGC ↑	Children's safeguarding lead has supervision session in line with intercollegiate guidance.	1. Continue to dial into local and Regional NHS Leads meetings, as availability allows. 2. 1:1 session undertaken 13/8/20	1. Supervision sessions to be attended as scheduled (bi-monthly). Next due 20/10/20. Attendance at Regional and Local Provider Forums to be attended as capacity allows.	Attendance at supervision session scheduled for 20/10/20.	Regional Leads Forum attended 28th May 2020. Unable to attend August session due to AL. Weekly local NHS Leads meetings now re-scheduled to monthly and will be attended as calendar allows. Supervision with external Supervisor attended 13th August 2020, as scheduled.	Blue
57	DoN - Safeguarding (Children & Young People)	Core Inspection	Must Do	The Trust should ensure staff are in receipt of regular group safeguarding supervision.	DoN	Craig Ferris Elaine Todd	Patients	Executive Leadership Team (monthly IIP oversight) ↑ QGC ↑	Staff satisfaction will improve and care will be delivered in line with best practice.	1. Continued with scheduled and ad-hoc sessions. 2. Continue to attend Staff meetings - some meetings were cancelled by the Ward. 3. Continued to support debrief sessions, as required.	1. Continue to deliver sessions in line with schedule and to attend staff meetings as scheduled.	1. Supervision sessions delivered in line with Trust Policy (delivered monthly with expected attendance minimum of 3 monthly). 2. Staff meetings attended as scheduled.	1. Safeguarding supervision delivered in September. 2. Staff meetings attended by Safeguarding Children rep and Safeguarding information relayed in line with staff members' requests (when meetings have taken place - cancelled meetings have been recorded in calendar). Register maintained.	Green
58	Children & Young People	Core Inspection	Must Do	The Trust should ensure there is a medical lead for safeguarding.	MD	Suganthi Joachim	Patients	Executive Leadership Team (monthly IIP oversight) ↑ QGC ↑	Having an MDT approach to safeguarding will help improve medical engagement in this agenda.	1. Completed.	1. Completed.	Completed.	Medical lead for safeguarding is Dr Margaret Crawford. Post holder was in role at the time of CQC visit.	Blue
59	DoN - Infection Prevention Control (Children & Young People)	Core Inspection	Should Do	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.	DoN	Kevin Shaw	Patients	QGC ↑ ↑ Divisional Cabinet	Robust management process in place for the monitoring of staff adherence to infection prevention and control principles particularly high Impact interventions.	1. Completed.	1. Completed.	Reports generated via Clinical Business Units, Divisional Cabinet and PRM. And reported to Trust wide IP Group.	Reports delivered to appropriate committees.	Blue
60	Surgery - Theatres (Children & Young People)	Core Inspection	Should Do	The Trust should ensure it improves the separation of children and young people from adults in the operating recovery areas.	COO	Narmatha Thiagarajan John Boulton	Patients	QGC ↑ ↑ Divisional Cabinet	Separate operating recovery areas for children and young people.	1. Paediatric green pathway under review for COVID working. 2. Current mitigation to ensure segregation of children from adults in recovery includes the use of a recovery room or empty theatre, or if not available then child to be recovered in theatre and returned direct to the paediatric ward. 3. SOP to be developed.	1. Paediatric green pathway under review for COVID working. 2. Current mitigation to ensure segregation of children from adults in recovery includes the use of a recovery room or empty theatre, or if not available then child to be recovered in theatre and returned direct to the paediatric ward. 3. SOP to be developed.	1. Unannounced audits to ensure compliance is maintained.	Currently in progress.	Amber
61	Surgery - Theatres (Children & Young People)	Core Inspection	Should Do	The Trust should review the provision of paediatric emergency drugs in the operating theatres.	MD	Suganthi Joachim Narmatha Thiagarajan John Boulton	Patients	QGC ↑ ↑ Divisional Cabinet	Completed.	1. Completed.	1. Completed.		Review undertaken by CCG following the CQC visit. The conclusion was the current arrangements are appropriate.	Blue
62	Quality Governance (Children & Young People)	Core Inspection	Should Do	The Trust should improve processes for the communication of learning from incidents to ensure they are robust.	DoN	Helen Shelton	Patients	QGC ↑ ↑ Divisional Cabinet	A reduction in repetition of incidents through improved awareness and learning.	1. Continues to be managed via speciality governance. 2. Agree metrics for the embedding Divisional governance which includes leaning from incidents.	1. Quarterly newsletter to be developed for each Division in addition to a quarterly Trust wide newsletter. 2. Intranet site to include lessons learnt.	Improvements aligned to PID in progress.	Under development.	Amber

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63	Estates & Facilities (Children & Young People)	Core Inspection	Should Do	The Trust should improve facilities for children and young people visiting adult outpatient areas.	COO	Simon Evans Paul Boocock	Services	QGC ↑ ↑ Divisional Cabinet	To have an outpatient environment that is in line with best practice for children and young people in accordance with guidance 'Friendly healthcare environments for children and young people'(NHS Estates, 2003) and HBN 23, 'Hospital accommodation for children and young people'.	1. Plans identified in collaboration with Family Health Division.	1. Plans identified in collaboration with Family Health Division.	Delivery of improvements in line with the 'Hidden Child' action plan.	Metric under development.	Amber
64	DoN - Learning Disabilities (Children & Young People)	Core Inspection	Should Do	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.	DoN	Jennie Deeks	Patients	QGC ↑ ↑ Divisional Cabinet	Equity of access for all patients.	1. Resource has been in place for some time and is actively working through reviewing and supporting all Divisions with their identified actions in the action plan.	1. Resource has been in place for some time and is actively working through reviewing and supporting all Divisions with their identified actions in the action plan.	Delivery of improvements in line with the 'Hidden Child' action plan.	Delivery of improvements in line with the 'Hidden Child' action plan.	Amber
65	DoN - Learning Disabilities (Children & Young People)	Core Inspection	Should Do	The Trust should improve training of staff in the requirements of children and young people with learning disabilities and/or autism.	DoN	Jennie Deeks	Patients	QGC ↑ ↑ Divisional Cabinet	Children and young people with LD/autism will receive care from appropriately trained staff and their experience will improve as a result.	1. Resource has been in place for some time and is actively working through reviewing and supporting all Divisions with their identified actions in the action plan.	1. Resource has been in place for some time and is actively working through reviewing and supporting all Divisions with their identified actions in the action plan.	Regular training to occur and accessibility to a sensory environment.	Training has occurred.	Amber
66	Clinical Support Services - Pharmacy (Critical Care)	Core Inspection	Should Do	The Trust should ensure there is adequate pharmacist cover for the Critical Care Unit at Lincoln Hospital.	MD	Colin Costello	Patients	QGC ↑ ↑ Divisional Cabinet	Pharmacy service to comply with Core Standards for Intensive Care Units.	1. Meeting arranged with CSS on 16th September for BC sign off.	1. Business case signed-off at Divisional level and discussed at CRIG in September. Further actions are required following CRIG. 2. Specific Pharmacy & Medicines Management CQC Confirm & Challenge Session arranged for 15 October to focus in detail on the CQC actions.	Business case approval and funding.	Business case written, agreed with CSS and submitted to CRIG, date TBC	Red
67	Clinical Support Services - Pharmacy (Critical Care)	Core Inspection	Should Do	The Trust should ensure a pharmacist attends multidisciplinary ward handover meeting daily.	MD	Colin Costello	Patients	QGC ↑ ↑ Divisional Cabinet	Pharmacy service to comply with Core Standards for Intensive Care Units.	1. Meeting arranged with CSS on 16th September for BC sign off.	1. BC signed off at CSS, sent to CRIG, date TBC.	Business case approval and funding.	Business case written, agreed with CSS and submitted to CRIG, date TBC	Red
68	Clinical Support Services - Therapies & Rehabilitation (Critical Care)	Core Inspection	Should Do	The Trust should ensure therapist cover includes dietetics, physiotherapists and speech and language therapists seven days a week.	COO	Catherine ODwyer Ciro Rinaldi Bridy Clark Anita Cooper Carl Ratcliff	Services	FPEC ↑ Performance Review ↑ Divisional Cabinet	A seven days a week SaLT Service is in place and maintained.	1. Meeting with LCHS review plan for newly released funding.	1. Awaiting further date for CRIG as last meeting oversubscribed. 2. Review triage process 3. Review proposal from LCSH for increase of services	To provide seven days a week SaLT Service which is maintained.	BC approved at Surgery Clinical Cabinet but concern raised at CRIG about Should do and Must do elements. Way forward to be agreed at ELT - awaiting feedback.	Red
69	Critical Care	Core Inspection	Should Do	The Trust should ensure the new senior leadership team has oversight of the Critical Care Unit, as this level was not currently robust.	COO	Catherine ODwyer Mark Lacey Bridy Clark John Boulton	People	FPEC ↑ Performance Review ↑ Divisional Cabinet	Robust oversight and governance arrangements for Critical Care will be in place.	1. Completed.	1. Completed.	1. Monthly CBU Performance Meetings in place. 2. Monthly Divisional Clinical Governance meetings in place.	To obtain evidence on a rolling three months of minutes of these two meetings.	Blue
70	Director of Finance (Critical Care)	Core Inspection	Should Do	The Trust should ensure finances for the ventilator replacement programme.	DoF	David Picken Paul Bulman	Services	FPEC ↑ Performance Review ↑ Divisional Cabinet	Expected outcome is successful replacement of ventilators with continued support.	1. Completed.	1. Completed.	1. Identify funding. 2. Procure correctly. 3. Deliver and install.	Completed.	Blue

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71	Critical Care	Core Inspection	Should Do	The Trust should consider identifying support with staff moves to improve morale on ICU, Lincoln.	COO	Catherine ODwyer Bridy Clark John Boulton	People	WOD ↑ Performance Review ↑ Divisional Cabinets	Morale of staff will improve.	1. SOP written and staff training package in development to provide staff with core skills to work in acute ward environments.	1. SOP written and staff training package in development to provide staff with core skills to work in acute ward environments.	1. Minimal staff movement with a rotation in place of staff moved. 2. Demonstrate of Welfare Support.	Monitoring in progress.	Amber
72	Critical Care	Core Inspection	Should Do	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.	DoN	Bridy Clark John Boulton	Services	QGC ↑ ↑ Divisional Cabinet	Increased assurance on delivery of care.	1. Currently no update since July as awaiting outcomes from weekly audits.	1. Weekly audits completed and now being analysed.	Ward manager assurance and new ward assurance process	Accreditation process on hold for the organisation. New system of ward assurance being implemented by Angela Davies	Amber
73	Clinical Support Services - Pharmacy (Critical Care)	Core Inspection	Should Do	The Trust should ensure a pharmacist attends the Pilgrim Hospital Critical Care Unit daily multidisciplinary handover meeting.	MD	Colin Costello	Patients	QGC ↑ ↑ Divisional Cabinet	Having a pharmacist's presence at handover will reduce risk of medication errors/incidents.	1. Meeting arranged with CSS on 16th September for BC sign off.	1. BC signed off at CSS, sent to CRIG, date TBC.	Business case approval and funding.	Business case written, agreed with CSS and submitted to CRIG, date TBC	Red
74	Clinical Support Services - Pharmacy (Critical Care)	Core Inspection	Should Do	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.	MD	Colin Costello	Patients	QGC ↑ ↑ Divisional Cabinet	Having a pharmacist's presence at handover will reduce risk of medication errors/incidents.	1. Meeting arranged with CSS on 16th September for BC sign off.	1. BC signed off at CSS, sent to CRIG, date TBC.	Business case approval and funding.	Business case written, agreed with CSS and submitted to CRIG, date TBC	Red
75	Clinical Support Services - Pharmacy (Critical Care)	Core Inspection	Should Do	The Trust should ensure the on-call pharmacist is available to attend the Pilgrim Hospital Critical Care Unit when necessary.	MD	Colin Costello	Patients	QGC ↑ ↑ Divisional Cabinet	Having on-call pharmacy availability will reduce risk of medication errors/incidents.	1. All on-call pharmacists have now signed the on-call SOP to demonstrate compliance.	1. Pharmacy site leads to confirm all pharmacists have signed the on-call SOP.	All on-call pharmacists sign the on-call SOP to show compliance.	On-call SOP written and approved and signed by all on-call pharmacists.	green
76	Critical Care	Core Inspection	Should Do	The Trust should ensure swallowing assessments are carried out to prevent delays with patient weaning.	DoN	Catherine ODwyer Bridy Clark John Boulton	Patients	QGC ↑ ↑ Divisional Cabinet	Patients will receive timely assessment and treatment.	1. Work continues.	1. Work continues.	Timely access to SALT assessment and treatment in line with SLA.	Monitoring process under development.	Amber
77	Critical Care	Core Inspection	Should Do	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.	MD	Catherine ODwyer Mark Lacey Bridy Clark	People	QGC ↑ ↑ Divisional Cabinet	Patients will receive evidence based care.	1. Delayed start due to COVID preparations and recovery phase. Review to start August 2020.	1. Following Confirm & Challenge Meeting, a breakdown of policies and guidelines is to be incorporated within the Divisions Performance Review Meeting outlining what are in date and out of date and what progress has been achieved since last year's visit.	Policies and procedure updated in line with the trajectory.	Monitoring process under development.	Amber
78	Critical Care	Core Inspection	Should Do	The Trust should consider administrative support for risk and governance for the Pilgrim Hospital Critical Care Service.	MD	Catherine ODwyer Mark Lacey Bridy Clark	People	QGC ↑ ↑ Divisional Cabinet	Improved administration support will aid delivery of the governance agenda.	1. Governance meetings moved to every two weeks post surge. 2. Continuous monitoring in place.	1. Governance meetings moved to every two weeks post surge. 2. Continuous monitoring in place.	Administrative support in place.	Administration support been in place for past six weeks as at 09/06/2020.	Green
79	Maternity	Core Inspection	Should Do	The Trust should ensure they continually review audits and implement measures to improve patient outcomes for low performance metrics.	MD	Suganthi Joachim Simon Hallion Libby Grooby	Patients	QGC ↑ ↑ Divisional Cabinet	An integrated audit schedule and outcomes into CBU/Divisional working.	1. Completed.	1. Completed.	Demonstration of an integrated audit schedule and outcomes incorporate into CBU/Divisional working.	Monitoring process in place.	Blue

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80	Maternity	Core Inspection	Should Do	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.	MD	Suganthi Joachim	People	WOD ↑ Performance Review ↑ Divisional Cabinets	Vulnerable patients will receive appropriate care from a safeguarding perspective.	1. Awaiting release date for eLearning package to share with teams to enable planning trajectory for completion.	1. Trajectory for training requested	Mandatory training monitored in line with Trust guidance for each specific element.	Monitoring process in place.	Amber
81	Maternity	Core Inspection	Should Do	The Trust should ensure they implement systems to monitor waiting times in line with national standards.	COO	Suganthi Joachim Simon Hallion Libby Grooby	Services	FPEC ↑ Performance Review ↑ Divisional Cabinet	Patients will not experience unnecessary delays in access to treatment.	1. Completed.	1. Completed.	Continuous monitoring of waiting times occurs.	Completed.	Blue
82	Maternity	Core Inspection	Should Do	The Trust should ensure risks are clearly identified and documented in an appropriate format.	MD	Suganthi Joachim Simon Hallion Libby Grooby	People	QGC ↑ ↑ Divisional Cabinet	Risks will be identified in a timely manner and mitigation actions taken to reduce the risk.	1.Met with risk team and reviewed 80%	1. Another meeting planned to finalise with risk team	Comprehensive risk register in place and being used and reviewed appropriately by the Division	Partially complete.	Green
83	Maternity	Core Inspection	Should Do	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.	DoF	Sujatha Motkur Lorri Allport	Services	QGC ↑ / Performance Review ↑ Divisional Cabinet	Women will receive timely care from the appropriate healthcare professional.	1. Completed.	1. Completed.	No women will exceed the required wait times to be seen by midwives and obstetric consultant.	Monitoring in place.	Blue
84	Maternity	Core Inspection	Should Do	The Trust should ensure Labour Ward coordinators are supernumerary in line with national guidance.	DoN	Simon Hallion Libby Grooby	People	WOD ↑ Performance Review ↑ Divisional Cabinets	There will be improved supervision and support for staff on Labour Ward.	1. Completed.	1. Completed.	Labour coordinator supernumerary 100%.	Monitoring in place through the Maternity Dashboard. If in the rare occasions when the Labour Ward Coordinators are used outside of being supernumerary, there is a clear escalation process in place to address this immediately.	Blue
85	Maternity	Core Inspection	Should Do	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).	MD	Suganthi Joachim Simon Hallion Libby Grooby	Patients	QGC ↑ / Performance Review ↑ Divisional Cabinet	Women will receive evidence based care and incidents will reduce.	1. Visits planned with other Trusts to discuss the review and management of induction of labour and how this can be done differently.	1. Planned rescheduled meeting via teams as cancelled due to coved restrictions. 2. This session has been offered as a learning opportunity .	Maternity Dashboard	Monitoring in place through the Maternity Dashboard.	Amber

OUTSTANDING CARE
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Trust Board Forward Planner

	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug
Standing Items													
Chief Executive Horizon Scan	X	X	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	X	X
Integrated Performance Report	X	X	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	X	X
Declaration of Interests	X	X	X	X	X	X	X	X	X	X	X	X	X
Governance													
Audit Committee Report	X			X			X						
Strategic Objectives for 2019/2020							X						
BAF Sign off for 2019/20								X					
Annual Accounts, Annual Report and Annual Governance Statement Approval										X			
Quality Account										X			
Strategic Risk Register	X	X	X	X	X	X	X	X	X	X	X	X	X
NHS Provider Licence Self Certification										X			
NHSI Board Observation Actions		X											
Strategic Objective 1 –To deliver high quality, safe and responsive patient services, shaped by best practice and our communities													
Quality Governance Committee Assurance and Risk Report	X	X	X	X	X	X	X	X	X	X	X	X	X
Safer Staffing Report			X	X	X	X	X	X	X	X	X	X	X
Safeguarding Annual Report			X										
Annual Report from DIPC					X								

	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug
Strategic Objective 2 – To enable our people to lead, work differently and to feel valued, motivated and proud to work at ULHT													
Workforce, OD and Transformation Committee Assurance and Risk Report	X	X	X	X	X	X	X	X	X	X	X	X	X
Staff Survey Results								X					
Freedom to Speak Up Report (aligned to national data submissions)				X			X			X			X
Report from Guardian of Safe Working			X				X						
WRES/WDES Annual Submission	X												X
Strategic Objective 3 – To ensure that services are sustainable, supported by technology and delivered from an improved estate													
Finance, Performance and Estates Committee Assurance and Risk Report	X	X	X	X	X	X	X	X	X	X	X	X	X
Financial Plan and Budgets							X						
Clinical Strategy Update	tbc												
Operational Plan Update	tbc												
Emergency Preparedness, Resilience and Response (EPRR) NHS Core Standards		X											
Strategic Objective 4 - To implement integrated models of care with our partners to improve Lincolnshire's health and well-being													