Bundle Trust Board Meeting in Public Session 6 October 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 Public Questions
Chair

3 Apologies for Absence
Chair

4 Declarations of Interest
Chair

5.1 Minutes of the meeting held on 1st September 2020
Chair
Item 5.1 Public Board Minutes September 2020v1.docx

5.2 Matters arising from the previous meeting/action log
Chair
Item 5.2 Public Action log September 2020.docx

6 Chief Executive Horizon Scan Including STP
Chief Executive
Item 6 Chief Executive's Report, 061020.docx

6.1 Green Site Quarterly Review
Chief Operating Officer
Item 6.1 Grantham Review Paper Final 29.09.20.pdf
Item 6.1 Append 1.docx
Item 6.1 Append 2.pdf

7 Patient/Staff Story
Director of Nursing

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

7.1 BREAK

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

8.1 Assurance and Risk Report from the Quality Governance Committee
Chair of Quality Governance Committee
Item 8.1 QGC Upward report September 2020 v1.doc

8.2 Patient Safety and Incident Management Report
Director of Nursing
Item 8.2 Incident Management Report - including Never Events & other Serious Incidents - October 2020.docx

8.3 CQC Update
Director of Nursing
Item 8.3 CQC Comms Plan.docx

8.4 Safeguarding Annual Report
Director of Nursing
Item 8.4 Safeguarding Annual Report.docx

8.5 Establishment Review
Director of Nursing
Item 8.5 Front Cover - Nurse Establishments - Oct 2020.docx
Item 8.5 Summary Estab Review 2020.xlsx

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	Assurance and Risk Report from the People and Organisational Development Committee *Chair of People and OD Committee* Item 9.1 POD - Upward Report - September 2020.doc
10	Strategic Objective 3 To ensure that services are sustainable, supported by technology and delivered from an improved estate
10.1	Assurance and Risk Report from the Finance, Performance and Estates Committee *Chair of Finance, Performance and Estates Committee* Item 10.1 FPEC Upward Report September 2020 v2.docx
11	Strategic Objective 4 To implement integrated models of care with our partners to improve Lincolnshire's health and wellbeing
11.1	CQC Lincolnshire System Provider Collaboration Review *For information* Item 11.1 20200731 Feedback Presentation Lincolnshire FINAL.pdf
11.2	System Wide Social Marketing Campaign *Director of Communications and Engagement* Item 11.2 system social marketing campaign.docx Item 11.2 NHS Lincolnshire campaign guide.pdf
12	Integrated Performance Report *Director of Finance and Digital* Item 12 Integrated Performance Report - Trust Board.docx
13	Risk and Assurance
13.1	Risk Management Report *Director of Nursing* Item 13.1 Strategic Risk Report - October 2020.pdf
13.2	Board Assurance Framework *Trust Secretary* Item 13.2 BAF 2020-21 Front Cover October 2020.docx Item 13.2 BAF 2020-2021 v30.09.2020.xlsx
14	Board Forward Planner *Trust Secretary* *For Information* Item 14 Board Forward Planner 2020 v 2.doc
15	Any Other Notified Items of Urgent Business
16	The next meeting will be held on Tuesday 3 November 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 1 September 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
Ms Cathy Geddes, Improvement Director, NHS Improvement
Mr Paul Matthew, Director of Finance and Digital

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

Apologies
Mr Geoff Hayward, Non-Executive Director
Dr Chris Gibson, Non-Executive Director
Dr Maria Prior, Healthwatch Representative

1161/20 **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 in public session 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.

1162/20 The Chair moved to questions from members of the public.

Item 2 Public Questions

Q1 from Richard Rawlins

'Given ULHNHST's declaration in respect of clinical effectiveness that: "All care needs to reflect clinical best practice and meet national guidelines to ensure that patients get the right treatment at the right time, every time" - please may I have sight of any and all evidence that is in the hands of ULH NHST's CEO; the Medical Director and/or the

Trust's Ethics Committee, and in any patient consent literature - as to any benefit or harm caused by energies generated by Reiki therapists, and which are expected to benefit patients if applied at ULH NHST by an appointee to this advertised post?'

The Medical Director responded:

This was a complimentary therapy which does not sit comfortably in the evidence based medicine paradigm. The British Medical Association definition of complementary medicine is those therapies that can work alongside and in conjunction with conventional medicines, BMA 1993. The House of Lords Select Committee on Science and Technology report on the use of complementary and alternative therapies in 2000, categorised therapies in to three core groups, Reiki was listed in group 2. The report states, as quoted that the Select Committee were 'satisfied that many therapies listed in our Group 2 give help and comfort to many patients when used in a complementary sense to support conventional medical care' and goes on to say 'in relieving stress, in alleviating side effects (for example of various forms of anti-cancer therapy) and in giving succour to the elderly and in palliative care they often fulfil an important role'.

There are many papers that agree there are mixed benefits to Reiki on patients, for example in addition to patients voices used to inform services and decision making, a study of 168 patients at the University College Hospital in 2010, showed that Reiki as the most popular complementary therapy. In United Lincolnshire Hospitals NHS Trust, there is a range of services offered to patients that sit alongside our normal view of clinical based practice. These include hairdressers, music, craft and massage for example. The aim of the interventions is to provide patients with a better environment and wider life experience whilst at the Trust, for what are often extremely difficult times and where patients are undergoing life-changing treatment. The Trust plan for Reiki to sit alongside treatments, not to alter the normal medical plan for treatments. The normal consent process for treatment and paper work would apply in this case.

The Chief Executive added that to put this in to context, this would be a part time post that was funded by a charity, employed by the Trust. The charity has funded such posts in a number of other Trusts across the country. When the post was advertised, as expected, there was considerable social media commentary both for and against the post. The Trust were not stating that a Reiki Therapist would be a replacement for conventional clinical care for patients who have cancer and conventional clinical care would continue. Neither however were the Trust saying that a Reiki Therapist could prevent, treat or cure cancer. It is important to place these points on the record, it is clear from the evidence presented by the Medical Director that some patients receive psychological benefit and support from such posts.

The decision was that in some cases patients see a benefit and as the post was funded by a charity why would the Trust want to prevent offering psychological support to patients. The media commentary to this had been interesting as a number of people had made the point that if the Trust were against providing such support then they presumed that the Trust would revisit the funding of chaplaincy services and anything else of that sort. The post had generated a strong feeling and as stated by the Medical Director this was a complementary post and not a substitute for conventional clinical care.

Q2 from Councillor Ray Wootten

Madam Chairman, may I once again pay tribute to all staff at ULHT for the dedication and hard work which is appreciated by myself, colleagues at LCC and I am sure by the population at large.

On page 191 it states that the Committee received a report noting that the Trust had maintained a breakeven position at the end of Month 4 in line with the financial regime in place as a result of Covid-19.

You will recall that in April the government wrote off £324m debts and Director of Finance and Digital Paul Matthews said in a press statement 'This is fantastic news for the Trust and the people of Lincolnshire as the burden of historic debt is removed'

You are now seeking a top up of £4.1 million, is this due to an overspend relation to COVID-19 or are you not forensically examine every pound of public money that you are spending and heading back into debt?

The Director of Finance and Digital responded:

In April 2020 due to Covid-19, the national financial regime for the NHS changed and Trusts were funded on a block payment based on the run rate spend as at December 2019. The meant that for the first four months of the year, April 2020 to July 2020, the Trust spent £12.2m on the overall response to Covid-19. As a result of this the Trust could not consume £4.2m of costs within the block funding, therefore the Trust requested top up from the centre. The Trust were in line with every other Trust in the country and were working against the mechanisms in place, the Trust were not an outlier and the underlying spend rate had been contained.

It was important to note the historic debt of £377m had been written off with £342m for the revenue position and £35m for capital monies, received mainly for fire works over the past few years. The transaction had taken place with the Trust formally having the debt written off. The benefit to the Trust would come from saving on interest payments associated with the debt. The writing off of historic debt however would not resolve the overall financial issues of the Trust. The Trust spends more than its income but the mechanisms for the way this is treated has been changed. The Trust continues, even during the Covid-19 response, to spend time analysing and working through how it spends income and tax payers money to the best extent.

Q3 from Jody Clark

In the Horizon Scan, it talks about the draft summary plan in response to phase 3 recovery.

So I wanted to ask if we will get some of our services restored at Grantham Hospital before winter? Obviously, the changes have resulted in more people travelling to Lincoln and Boston for routine appointments and tests. Which has caused upset, cost and time. These issues will be exacerbated if we get a frosty or snowy winter. So I hope we get some of those services returned to reduce the amount of Grantham residents travelling and equally those around the county, trying to get to Grantham.

The Chief Operating Officer responded:

Since the decision was made to pursue the green site model at Grantham Hospital on June 11th, a number of extensions to a greater degree of services. In previous reports there had been an increase seen in the number of site operating in the Grantham areas including the Gonerby Road site that had increased services. This was expected to continue, even before the Phase 3 letter had been received and the Trust were already expecting to increase services at the clinic. There would, from this week, be the introduction of the pre-operative assessment capacity at the clinic. The Trust fully expected to do this and as part of the Phase 3 response the Trust were looking to not only restore but put on more services to pre-Covid-

19 levels. This would allow the Trust to catch up on some activity and appointments that had not been able to be undertaken in the first stages of the pandemic.

1163/20 **Item 3 Apologies for Absence**

Apologies were received from Mr Geoff Hayward, Non-Executive Director, Dr Chris Gibson, Non-Executive Director and Dr Maria Prior, Healthwatch Representative.

1164/20 **Item 4 Declarations of Interest**

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

1165/20 **Item 5.1 Minutes of the meeting held on 4 August 2020 for accuracy**

The minutes of the meeting held on 4 August 2020 were agreed as a true and accurate record.

1166/20 **Item 5.2 Matters arising from the previous meeting/action log**

1576/20 Smoke Free ULHT – The post implementation review had been deferred due to Covid-19. The review would now be undertaken and reported to the November 2020 Board meeting, this would be 1 year post implementation

1641/19 and 1642/19 – NHS Improvement Board Observations and actions – Audit Committee to review at October 2020 meeting

1747/19 – Assurance and Risk Report Finance, Performance and Estates Committee – The business case review of fireworks was anticipated to be presented to the Board in November 2020. A number of updates had been received by the Committee since the action was opened

077/20 – assurance and Risk Report Quality Governance Committee – Internal audit review of the Trust Operating Model and Governance expected and would be scheduled for the October 2020 Committee meeting, this would then be reported to the Board in November 2020

343/20 – Staff Survey Results – The review of the staff survey indicator in relation to violence from patients to identify hot spots to focus activity and support remained deferred due to Covid-19

1062/20 – Cancer Strategy – Shared with Board members in iBabs – Complete

1091/20 – WRES/WDES Annual Submission – The Director of People and Organisational Development continued to gather information from other Trusts to determine what support the Non-Executive Directors could offer in relation to an intendent review of the disciplinary process. A meeting would be held with the Chair to discuss how this could be achieved – Complete

1167/20 **Item 6 Chief Executive Horizon Scan including STP**

The Chief Executive presented the report to the Board noting that the Trust were now in Phase 3 of the Covid-19 response. The first draft of the system plan in response to phase 3 was due to be submitted with the final plan due 21st September 2020.

1168/20 Various review meetings would be held with NHS Midlands colleagues and it was important that the plan was owned by the local system, Chairs, Chief Executives and others.

1169/20 The purpose of the plan was to deliver the three priorities of accelerating the return to near-normal levels of non-Covid-19 health services, preparing for winter demand pressures alongside continuing vigilance in light of a probable covid-19 peak and doing these two things in a way that would take account of the lessons learned during the first Covid-19 peak but also predominantly to include numbers and dates to detail when services would be reinstated.

System Issues

1170/20 The Chief Executive noted that there was engagement with NHS Midlands colleagues to review the readiness of the system to become an Integrated Care System (ICS) by 1st April 2021, the review would take place on 2nd September and the national guidance was being reviewed.

1171/20 The first meeting of the NHS Midlands Leadership Team had taken place consisting of the Executive Team for NHS Midlands and the STP/ICS leads. The Lincolnshire STP member would be John Turner.

1172/20 The next system quarterly review meeting with NHS Midlands was due to take place on 9th September and the slide packs were being prepared. This would give the opportunity for a review of operational resilience, finance, workforce and the position in relation to phase 3 of Covid-19.

1173/20 The NHS People Plan for 2020/21 had been issued a few weeks prior and this had not received the degree of coverage expected, this however was not a surprise given the current situation. The plan provided the areas of focus that people who work in the NHS should expect to see action on; this was underpinned by the NHS People Promise.

Trust Specific Issues

1174/20 The Chief Executive noted that the Integrated Improvement Plan (IIP) launch was paused in March due to Covid-19. There was a need and want to return to communicating this to the whole workforce and as such a series of virtual launch events had been arranged.

1175/20 Additional funding had been received in relation to Accident and Emergency at Pilgrim Hospital and a press statement had been released.

1176/20 The Chief Executive noted that colleagues would be aware of the work in relation to the Trusts Charity and when out and about in the Trust staff were interested in making the most effective use of the charitable funds received. A relaunch for the Charity was planned.

1177/20 The Trust's Medical Director had announced that he would be returning to full time clinical practice with a view to this coming in to effect in the New Year. The Trust would push ahead with a national advert for the post.

1178/20 The advert for a substantive Director of Nursing had closed and appointment to the post would be progressed.

1179/20 Mrs Dunnett supported the point made in relation to the Trust's Charity, noting that the Committee had recently met for the first time since January 2020. Momentum was building for the relaunch.

1180/20 The Chair noted that there was a sense of system first and a focus on the system engaging with regulators, particularly in relation to the phase 3 letter and ICS. It was positive to see that the IIP was being relaunched with staff.

1181/20 The Chair noted the Medical Director's intention to return to clinical practice noting that the occasion would be marked nearer the time.

The Trust Board:

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

1182/20 **Item 7 Covid-19 Update**

The Chief Operating Officer presented the paper to the Board noting that this provided the monthly update on Covid-19 activities.

1183/20 The report sat between 2 phases of the response including the past months update and having just received the letter describing the move to Phase 3 and recovery. As part of the recovery phase an extensive planning cycle had commenced, this would demonstrate the intention to put plans in place until the end of the year. This would be to recover back, to not only pre-Covid-19 but to build on the good work and innovation put in place to improve services for the Lincolnshire population.

1184/20 The report presented to the Board was light in relation to the recovery plans due to the first draft only recently being submitted. The Chief Operating Officer proposed that the report to the October Board would contain further information in relation to the plan and outcomes set to achieve. It would be recommended that the October report would be the final time the Board received a direct Covid-19 update and that this would moving forward be reported through to the Finance, Performance and Estates Committee. The Committee would receive updates on progress and the planning cycle incorporate in to the usual governance process.

1185/20 As described in the June 11th report it was anticipated that the Grantham Green Site review would be presented to the Board. The process has commenced in order to understand the implications of the green site configuration changes that were put in place temporarily. A comprehensive report would provide detail to the Board at the October meeting.

1186/20 The report presented described the updates on the restoration of services and the letter that had been received, there were 3 areas including recovery of planned care including cancer, urgent care, additional services such as screening and an additional element of considering what had gone well, ensuring services in the future were designed, in an inclusive way that considered health inequalities. As such plans the Trust had been working on had focused on health inequalities across Lincolnshire to understand how services may be provided differently in the future.

1187/20 A breakdown of performance had been presented in the report. The Chief Operating Officer noted the need for a correction in some of the charts presented. Whilst the data was correct, the analysis was inverted. Where an area was identified as a concern, these were positive and vice versa. The targets on some of these had been set at zero as forward trajectories and targets had not yet been included. All other narrative was correct and described the position.

1188/20 In terms of planned care restoration from a diagnostic perspective there was a positive message. The Trust had greatly increased provision of diagnostic modalities with endoscopy and radiology worthy of note as these had exceeded the level of appointments pre-Covid-19. Major headway was being made on the waiting lists for those areas. Endoscopy was now operating within the constitutional standard for cancer, 14 days, thanks to the effort of the

team to get services back online. The Trust were ahead of plan and the request made in the phase 3 letter.

1189/20 Other areas were not as positive, activity and appointments had increased in outpatients but recently, as services and breadth increased and more operating came back, outpatients had reduced slightly. The Trust was not overly concerned as it was still yet to go through phase 3 increase in services and were yet to switch on additional site capacity.

1190/20 Another positive element had been operating capacity and overnight operations and elective cases. In terms of day cases, those who go home the same day, had significantly increased and continued on an upward trajectory. This had been supported by Grantham Hospital. The Trust had not met the 25 cases per day but had continued to increase, in recent weeks 19 cases per day had been achieved.

1191/20 Urgent Care demand had continued to increase and it was positive that patients and the public across Lincolnshire had increased confidence in accessing services. There had been a particular increase seen at Lincoln Hospital in recent weeks to pre-Covid-19 levels and above. This had started to put more pressure on the urgent care system however it remained considerably better than at this point last year. The Trust had managed to maintain improvements and capitalised on those elements put in place due to Covid-19.

1192/20 The Chair noted the positive position acknowledging that challenges remained but there was assurance of progress where needed.

1193/20 Mrs Ponder stated that the Trust had fallen short of the 25 cases per day and in view of the impact on waiting lists was interested to know what the barriers had been to meeting the target and what was being done to remove those barriers.

1194/20 The Chief Operating Officer stated that this had been explored and the Trust continued to look to improve. It was noted that firstly this had been around the assumptions around what would be happening. Originally consideration had been given to use the theatres as greater endoscopy capacity, there were relatively quick procedures. In some cases pre-Covid-19, those theatres operating in endoscopy would have been able to greatly exceed the 25 cases. However for a number of reasons the decision had been taken not to use theatres in this manner, partly due to the availability and ability to move equipment.

1195/20 Another barrier had been due to air barriers and infection prevention and control in relation to endoscopy procedures and their classification as aerosol generating procedures (AGP). This had resulted in extra precautions being taken due to the risk of transmission. Theatres at Grantham Hospital, whilst some of the better estate, still required an increased amount of time between cases. Devices were in place to support the decrease of turnaround times but this did not fully resolve the issue. The Trust remained committed to achieving the 25 cases per day target.

1196/20 Mr Hayward had submitted a question through the Chair challenging the real capacity of theatres. Mr Hayward noted that Covid-19 and the cleaning regime had significantly reduced the capacity to handle the number of patients per day, as the Trust were trying to move Grantham to 7 day working this was only for a small number of total theatres. Mr Hayward asked if winter demand was considered in addition to the pent up demand caused by Covid-19, would there be a need for activity greater than pre-Covid-19 in order to catch up, and then continue to reduce patients waiting for treatment.

1197/20 The Chief Operating Officer advised that in relation to capacity the June 11th paper had described the limitations within theatres and site limitations being put in place to create green pathways. This had meant that for Lincoln and Pilgrim Hospitals there were theatres that

could not be used as the green pathways created gave limited capacity, using at most 2 theatres where patients could not get the level of service elsewhere in the county, particularly critical care services.

1198/20 This had been why it was important to get Grantham Hospital being used and it had now been possible to move to 7 day working and consideration was being given to running extended sessions in order to address capacity. There was a reluctance to move to overnight operating as this introduced risks including extended days for the workforce.

1199/20 There was a need for greater capacity than pre-Covid-19 and planning going in to phase 3 would consider this. Information would be presented to the Board in October to articulate how services would be restored to previous levels and how these could be built upon, this would include utilising Louth County Hospital and the independent sector to ensure an increase above pre-Covid-19 activity.

1200/20 The Chief Executive noted that this was not only about utilisation of theatre capacity but also about the types of cases being undertaken at Grantham Hospital. There had been a mix of cancer and other urgent clinical cases which had resulted in some cases taking some time due to the seriousness. It was right that these cases had taken precedence over others and that patients were cared for in the order of clinical priority and this was not just about achieving a target.

1201/20 Mrs Dunnett noted that health inequalities and provision would be an area of urgent national and local focus post Covid-19 and would welcome back at a future meeting the Trusts response to the actions and recommendations made as more information was received.

1202/20 Mrs Dunnett noted the positive position regarding urgent care and the level of communication that had resulted in people attending services at the Trust. Demand had increased significantly and assurance was sought that the demand being seen was appropriate and patients were accessing care in the right place.

1203/20 The Chief Operating Officer noted that the response to health inequalities would be provided from a system perspective as the Trust would not be able to address this alone. There was however planning and discussion but this was being supported by Public Health England, the Clinical Commissioning Group (CCG) and primary and community providers. Due to the nature of the request there was a need to gather data in order to provide clarity on the response, feedback could be provided to the Board.

1204/20 The number of people seen accessing services had increased with a disproportionate increase as walk ins. The cause for concern was that the emergency departments were being used by those who could access other services. Lincolnshire Community Health Services NHS Trust (LCHS) may be better placed in explaining the demand and if it is the right activity as they are providing a services that is increasing confidence. This had been a concern when a near 70% reduction was seen in overall demand as patients still needed to access urgent care.

1205/20 Those patients conveyed to the Trust by ambulance are appropriate and in some cases more poorly now than pre-Covid-19, from an urgent treatment care perspective it could be that patients being seen may be better being seen by other services.

1206/20 The Chief Executive noted that LCHS had the ‘talk before you walk’ campaign which detailed the alternative care options to the urgent treatment centres and emergency departments where advice could be sought. The question raised was also asked at the system review meeting with NHS Midlands. CCG colleagues were asked to consider GP issues to see if

there was anything happening in GP practices that had led people to accessing emergency care.

1207/20 The Chair noted that one of the 12 system priorities agreed between now and March 2021 was health inequalities, this priority sat with the CCG. The Chair would discuss this with the Chair of the CCG to understand how information could be shared with the provider Board to understand the position and contribution that could be made by the providers.

1208/20 Mrs Libiszewski requested that future reports contained learning from the Get It Right First Time programmes as that sight was not lost on best practice.

1209/20 The Chair noted that there was a need to celebrate and thank colleagues for the work being done in response to Covid-19 ensuring that patients were benefiting from the efforts being made.

1210/20 The Trust Board accepted the progress update and would receive the review of the green site at the October Board meeting. The Board agreed that following the October report to the Board that future reports would be received through standard governance processes.

The Trust Board:

- **Received the report noting the moderate assurance**
- **Agreed that future progress reports would be received by the Finance, Performance and Estates Committee**

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

1211/20 **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 18th August 2020 meeting.

1212/20 Mrs Libiszewski noted that the Board Assurance Framework and risks associated with the objectives that the Committee were responsible for had been reviewed.

1213/20 A lack of assurance had been received for objective 1a however a number of reports had been received. The Board were asked to note that a Deputy Director of Safeguarding had been appointed and was now working through a review of the Trusts position with safeguarding. There had already been issues identified and options put forward to progress training whilst not being able to offer face to face training.

1214/20 Significant improvements were being seen in relation to Infection Prevention and Control, specifically on the hygiene code compliance with continuous compliance. The updates received on the deep clean programme were positive.

1215/20 The Committee received the Patient Safety Report that was on the agenda for the Board with the Committee noting that there was a concern regarding patient moves. The Patient Safety Group were asked to identify what actions were being taken and how assurance would be provided.

1216/20 A report on the Never Event from July would be received and along with actions to be taken. There was also a concern regarding the significant number of actions regarding Never Events that had not yet been concluded. The Committee requested that updates in relation to actions be provided on a regular basis, both in relation to Never Events and Serious Incidents.

1217/20 The Board were advised that two referrals had been made to the Healthcare Safety Investigation Branch and the Committee would receive upward reports as the investigations proceeded.

1218/20 The Committee were not clear on the actions from the internal audit in relation to Medicines being complete and sought further evidence. It was recognised that some of this would sit with the Audit Committee but as the primary Committee with responsibility, the Committee wished to ensure the actions were complete.

1219/20 In relation to objective 1b, patient experience, the Committee received an action plan in relation to the National Inpatient Survey and the Committee requested that this be aligned to the IIP in order to understand there was a collaborative approach and that the Trust worked to a single plan.

1220/20 Progress was continuing against the Care Quality Commission (CQC) action plans but there would be further work to ensure clearer milestones. Further work in evidence gathering would be undertaken should the CQC require an evidence submission from the Trust.

1221/20 The Quality Account was presented for the final time to the Committee, this had been difficult to develop during Covid-19 however would be presented to the Board for approval. The Committee had reviewed the Quality Account on a number of occasions and felt that this was a fair and balanced account of the quality of services over the past year. Publication of the account was not required until December however the Committee felt it was important to have an account of the quality of patient care that had been delivered.

1222/20 Based on the discussions held by the Committee there had been no change to the Board Assurance Framework or risks.

1223/20 The Chair noted that it was important to align the patient experience work with what the Trust were trying to achieve for the IIP. The Chair felt that the CQC aspect of the report was thorough and had been pleased to see that the Divisions were involved in the confirm and challenge events. It was positive to see the improving position with Sepsis.

The Trust Board:

- **Received the assurance report**

1224/20 **Item 8.2 Patient Safety Incident Management Report**

The Director of Nursing presented the report to the Board noting that the report continued to evolve. There were a number of open incidents on Datix and whilst an improvement was being seen, as signalled through the Quality Governance Committee there was a large number of open actions.

1225/20 The Board were advised that there were over 1600 overdue actions arising from Serious Incidents and Never Events. These were being reviewed with Divisions in order to support divisional ownership of the actions. There was a need to see from these what lessons were being learnt.

1226/20 There would be a review of the Key Performance Indicators (KPIs) associated with Clinical Governance in order that the Board and Committees become better sighted with an awareness of risk associated through Never Events and Serious Incidents. It was intended that this would be presented to the September Quality Governance Committee.

1227/20 There had been 2 referrals to the Healthcare Safety Investigation Branch (HSIB), associated with 2 separate babies. The first baby received moderate harm following cardiotocography

(CTG) issues and was transferred to Nottingham for warming. There had been issues around the timeliness of escalations and themes related to on call out of hours attendance at the site. There had also been communication and documentation issues. The baby was doing well but the incident was graded as a Serious Incident and met the criteria to be referred to HSIB.

1228/20 Baby 2 had resulted in an intrapartum stillbirth. There had been a number of issues in relation to antenatal and labour care that could have contributed to the intrapartum stillbirth. Themes were associated with non-English speaking patients and how the Trust assess the resilience of translation and ensuring that patients understanding. There were also themes in relation to the failure of the mother not attending planned appointments and how the Trust assisted the mother and family. Again, in part CTG was a part of the baby's care.

1229/20 Both the Serious Incidents were under current investigation and were due to complete within timescales and would be received back in to the serious incident process and reported to the Clinical Commissioning Group.

1230/20 The Trust would work with HSIB through any themes or trends identified as part of the investigations.

1231/20 The Chair noted that further detailed information about the HSIB referrals would be available. Disappointment was noted in relation to the outstanding number of actions given the focus applied to improve serious incident reporting.

1232/20 The Chair asked if it was felt that actions hadn't been progressed or if this was relating to administration support that was needed. The Director of Nursing noted that this was in the early stages of review but it appeared to be both issues. Some would be easy to resolve but a number of actions needed to be quality assured.

The Trust Board:

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

1234/20 **Item 8.3 Quality Account**

The Medical Director presented the Quality Account to the Board noting this was the report of the Trust on the quality of services provided. The Quality Account was presented for final approval prior to publication.

1235/20 The Trust could have deferred publication to December however the Trust were keen that this be published as soon as possible.

1236/20 The priorities within the account had been aligned to the IIP and the Lincolnshire system quality priorities and Commissioning for Quality and Innovation (CQUINs). The Board were advised that the priorities within the account were care of respiratory patients, safe discharge of our patients, care of the deteriorating patient, delivering harm free care – developing our safety culture and infection prevention and control.

1237/20 The Board were advised that there had been a boost to research due to the Trusts involvement with Covid-19 research projects. This had offered an opportunity for a refocus of research efforts and the Trust were doing well when benchmarked with comparators.

1238/20 The draft report had been shared with the Clinical Commissioning Group, Healthwatch and the Health Overview and Scrutiny Committee. The Trust were grateful for the comprehensive feedback received.

1239/20

The Chair noted that the Quality Governance Committee had conducted the appropriate due diligence for the account and drew the attention of the Directors to annex 2 which set out the statement of directors' responsibilities.

1240/20 The Chair sought the Boards agreement that it had exercised its responsibilities and passed thanks on to the stakeholders who had provided valuable feedback, which had been taken in to account in the overall report.

The Trust Board:

- **Approved the Quality Account**

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

1241/20 **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 13th August 2020 meeting.

1242/20 The Committee had noted the work that had been undertaken on establishing the Workforce Strategy Group that would report to the Committee and were assured on the progress being made.

1243/20 There had been a significant review of safe staffing led by the Director of Nursing with a new reporting structure established.

1244/20 The Committee were pleased to note some of the innovation that had been happening across the Trust to support the workforce challenges, of particular note were the Doctors Support role and development of the Band 4 and Trainee Nurse Associate roles to support staff in professional careers.

1245/20 The Board were asked to note the improved vacancy rate demonstrating a positive position, particularly in relation to the progress of medical substantive recruitment. A reduction in the agency rate however was yet to be seen however, there was focus being applied by the Executive Team.

1246/20 The Committee had reviewed the gap analysis in relation to the NHS People Plan comparing the new national focus with those of the Trust's Integrated Improvement Plan. This particularly reflected on the need to strengthen the workforce in relation to Covid-19 and inclusivity, considering flexible working and retire and return schemes. This would be presented to a future Board meeting.

1247/20 Sickness levels remained a concern that had been complicated by the Covid-19 situation. Work was ongoing to support staff returning back to work.

1248/20 The Committee noted that Brexit remained a risk to the Trust and a number of European Union staff had resigned from the Trust. Work was underway to support staff to apply to the settlement scheme.

1249/20 The Director of People and Organisational Development advised the Board that the new absence management system had gone live in August and would be rolled out across all staff. Initial feedback had been positive.

1250/20 The Chair was pleased to see the innovation work regarding the Doctors support role and investment to Band 4 staff in relation to professional development. This would be worthwhile progressing subject to funding support. The Chair was also pleased that the Trust continued to support those staff who were worried about the impact of Brexit and was keen that the Trust continued to do what it could to support.

The Trust Board:

- **Received the assurance report**

1251/20 **Item 9.2 Safer Staffing Report**

The Director of Nursing presented the new monthly report to the Board noting that this would be presented to the People and Organisational Development Committee (P&ODC) on a monthly basis and that it was good practice to present to the Board.

1252/20 As detailed in the P&ODC upward report the use of temporary staff continued to increase since the lowest usage rates during the height of the pandemic.

1253/20 Weekly reviews of the nursing workforce were being undertaken and a suite of papers would be presented to the P&ODC following a review of processes and controls in relation to the higher rates of agency usage being seen.

1254/20 Although it is known that temporary staffing was a mix of bank and agency staff there had been a continued steady and static position of bank usage and an increase in agency. There were a number of Key Performance Indicators (KPIs) set around the ratio of bank to agency use and work was in train to reverse the position. This would involve some bank incentive schemes, whilst a number of schemes were in place some of these were no longer suitable.

1255/20 As safer staffing progressed the report would contain the top 4 reasons for temporary workforce usage in order of priority. Vacancy was one of the highest reasons however this did not appear to ring true when an improving position around vacancy had been reported. Work would be undertaken to provide focus in order to understand the accuracy of the data and information. This would allow for a challenge of data and review with teams.

1256/20 The Board were asked to note that the number of agency shifts booked for vacancy should start to decrease as student nurses gained NMC registration. A pipeline plan was in place with a trajectory of recruitment and retention and through establishment reviews, in line with ward leaders handbook there had been clarity on supernumery and supervisory time for clinical leaders. Clarity was being provided about clinical leaders being in post to clinically lead and set standards with a 60/40 split of time undertaking both elements of the role. This would have a positive impact on the vacancy position.

1257/20 A theme had been seen against agency use due to sickness as seen through P&ODC, there had been an increase in light of Covid-19 however significant work was underway to review this.

1258/20 The Director of Nursing highlighted to the Board that there would be a move away from the blanket approach of temporary workforce, the highest use areas were the emergency departments. Work would be undertaken in high use areas to understand the reasons and rationale for agency use as this would not necessarily be vacancy or sickness related.

1259/20 The Trust had been successful in negotiating rate reductions from 3 high volume suppliers and it was believed that the impact of this would be seen from October.

1260/20 The data being reported for safer staffing was split by site and division and it was noted that Medicine at Pilgrim was seeing the most agency use, this would enable a focus of effort.

1261/20 Regarding shift fill rates, there had been a lot of work undertaken and the report had shown that in June the fill rates were not where wanted and this was an area of concern. The Trust were working to a 95% fill rate and it was felt that this could be achieved with the temporary workforce. It was not possible to fill 100% of shifts 100% of the time and the KPI was being monitored to ensure wards and patients remained safe.

1262/20 All establishment had now been completed and would be sense checked with the Chief Operating Officer and Director of Finance and Digital prior to the review being presented to the Board in October.

1263/20 The Chair felt that the report was useful in gaining a sense of the detail of staffing levels and understanding the challenges being faced. Mr Hayward had submitted a question, in his absence to the Board, however this was referred back to the P&ODC in order that a detailed response could be directly provided.

1264/20 Mrs Ponder asked what more could be done to work with the local University in order to encourage a higher percentage of newly qualified nurses to join the Trust.

1265/20 The Director of Nursing advised that she had been working with the University since joining the Trust. There had been a lower number than previous years due to the impact of Covid-19 and students returning home rather than staying in the local area. It was anticipated that this year would see more students coming through due to the negotiation of the apprenticeship and top up programmes in addition to the traditional route.

1266/20 The Trust had offered to increase placements by 20-25% and it was felt that this would be managed comfortably, taking more students would hopefully result in more returning to the Trust for employment. The Director of Nursing was also keen to work through 'adopt a student'. This would mean that students would receive an employment promise to encourage them to spend time with the Trust during training, help to identify where they wished to work and help to place them in their first role upon qualifying.

1267/20 As part of the establishment reviews it had been clear that a number of areas had struggled to recruit to traditional roles. If the Trust were to advertise competency based roles this would result in support to individuals to gain skills post registration and would offer an attractive proposition to new qualified nurses.

1268/20 There was currently one entry and exit point in the year for trainees and with the increase in numbers and call to action from the Chief Nursing Officer this may not be sufficient. The Director of Nursing was currently in negotiation with the University regarding the introduction of two entry and exit points in the year. This would help to attract students in a different way as part of the recruitment and retention plans.

1269/20 The Chair noted the innovative work being described and looked forward to receiving the triangulated establishment review.

The Trust Board:

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

1270/20 **Item 9.3 Flu Best Practice Checklist**

The Director of People and Organisational Development presented the report to the Board noting that the annual flu campaign had commenced.

1271/20 In 2019/20 the Trust had achieved a vaccination rate of 85% with the 2020/21 target being 100%. The higher target reflected the challenges through the winter with Covid-19 and it was recognised that the Board being sighted on the flu plan would support achievement of the target. The Board were required to receive the best practice checklist.

1272/20 The challenges last year had been due to the availability of vaccines and the number of peer to peer vaccinators. There issues were being addressed.

1273/20 There was a proportion of staff reluctant to have a flu jab and given the target the Trust would have to work hard to persuade staff. This was not a mandatory vaccination but a matter of personal choice.

1274/20 A more detailed plan would be presented to the Executive Leadership Team regarding the delivery of vaccines and a strong communications plan. Communications would focus on the expectation that staff would have the vaccine to protect themselves, families and patients. Frequently asked questions could be included to address the issues raised that prevent people from having the vaccination.

1275/20 The Trust currently had sufficient vaccines to achieve the target for frontline staff although the ambition was to be able to provide the vaccine to all staff who wished to have it. There had been a national commitment by the NHS to supply additional vaccines. Having sufficient vaccines had currently been rated on the checklist as amber however this was not anticipated to be an issue.

1276/20 There weren't yet the required number of peer to peer vaccinators in place however the Trust were working to develop this and increase the number of vaccinators. If numbers could not be increased consideration would be given to alternative solutions to ensure the vaccine could be given.

1277/20 Further progress had been made in regard to drop in clinic locations, additional accommodation within Progress Housing was being acquired at Lincoln and with this the risk would move from red to amber until the space was secured.

1278/20 Storage of the vaccines remained an issue, these were currently stored in the fridges within the Occupational Health Department however there was no backup power supply. The risk related to the vaccines no longer being useable should there be a power outage. Work continued with facilities to find appropriate locations on the main hospital sites.

1279/20 The Chair noted that it would be disappointing if there Trust were not able to find appropriate locations and facilities for the storage of the vaccine. In order for the Board to maintain oversight of the flu vaccination programme, the intention was for the P&ODC to oversee and report to the Board through the standard governance route.

1280/20 The Chief Executive noted that this was an important issue and endorsed the efforts being made to ensure staff were able to receive the vaccine. The Trust wished to rule out as many reasons as possible as to why people say they could not have the vaccine.

The Trust Board:

- **Received the report noting the moderate assurance**
- **Approved the self-assessment**
- **Requested that the People and Organisational Development Committee oversee the delivery of the Flu Plan**

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

1281/20 **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 20th August 2020 meeting.

1282/20 The Committee received a lack of assurance from the upward report from the Health and Safety Group due to a number of issues. It was noted that there remained an issues with representation from Staff Side and the Committee requested that this was escalated to the Executive Leadership Team for resolution.

1283/20 The Committee were concerned that sufficient assurance reported particularly around the significant challenges the pandemic had posed to the health and safety of staff over recent months. This had been omitted from the report and the Committee felt strongly that a review should be provided in order to give the Board assurance that appropriate measures were being taken.

1284/20 The Committee took the decision to undertake a comprehensive review of the terms of reference and work programme for the group in order to receive assurance to provide onwards to the Board.

1285/20 The Emergency Planning Group upward reported was noted to have a lack of assurance relating to some key messages due to timescales and monitoring of achievements not being reported. Of particular note was an incident where a break glass call point have been disabled at Pilgrim Hospital. There had been no indication in the report about the nature of a comprehensive investigations to determine how this had happened and what was put in place to prevent recurrence, further information had been requested.

1286/20 The Committee received the finance report noting that the Trust had maintained a break even position at Month 4 in line with the financial regime in place as a result of Covid-19. The Trust had forecast £3.4m being required for Covid-19 costs during July however were £0.7m adverse to this with a top-up of £4.1m required. The Trust remained in good position relative to other Trusts.

1287/20 The Committee confirmed that a thorough check and challenge was undertaken on all monies reclaimed for Covid-19 and it was noted that income related to car parking and catering had fallen by £1.1m.

1288/20 Agency pay remained unchanged at £3.7m and bank pay had increased by £1.1m. This have been driven mainly by surge rota costs. The overall pay position increased by £0.1m as a result of substantive pay falling by £0.9m.

1289/20 The Director of Finance and Digital with the Medical Director and Director of People and Organisational Development were working on a medical transformation programme in a similar way to that of the nursing programme in order to gain control on agency spend.

1290/20 A comprehensive report had been received in relation to Covid-19 financial governance and the Committee noted that detailed governance in place during the restoration and recovery phases. The Committee were assured that the Trust were maintaining grip and control of the spend on Covid-19 and appropriate bids for funding were being pursued.

1291/20 The Committee reviewed the NHS Improvement observation action plan noting 2 of the 15 actions were yet to be completed. The Committee received the performance dashboard

noting the positive performance in Accident and Emergency even with the increase in demand. Build monies were available to the Trust that would support further improvement in Accident and Emergency.

1292/20 Disappointment was noted regarding theatre utilisation rates and the clearing of backlogs however Grantham Green Site was a major part of the restoration plan.

1293/20 The Committee received the first upward report from the Performance Review meetings noting that this would be further developed to provide a divisional breakdown.

1294/20 A draft Integrated Improvement Plan report was received and the Committee had the opportunity to provide feedback on the report to ensure this would provide the assurances required by the Committee. The Committee requested that improvement trajectories and timescales be added to the reports to ensure the Trust remained on track to meet its constitutional standards.

1295/20 The Committee referred a Performance Review meeting escalation item relating to liver biopsies to the Quality Governance Committee and reviewed the risk register and Board Assurance Framework. The Committee felt that these were reflective.

1296/20 The Chair noted that the narrative regarding the Health and Safety Group had been helpful and in the current context and environment it was important for the Committee to receive the right reporting with high quality information. It was a disappointing position however the Chair was pleased that this had been escalated and looked forward to seeing something more fit for purpose.

1297/20 The Board noted that the Committee had identified that the Trust had a good grip and control of the Covid-19 spend and that there had been scrutiny from the Committee.

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

1298/20 **Item 12 Integrated Performance Report**

The Board noted the content of the Integrated Performance Report and the limited assurance being provided. The Board were asked to note both the current performance and future performance projections.

1299/20 The Director of Nursing echoed the point made previously regarding the improvement in sepsis and advised the Board that in relation to children's sepsis a harm review for all children was undertaken. Even though there had been a small number that did not have a sepsis review undertaken these were picked up through the harm review process as a safety net and no harm had been seen.

1300/20 The Director of Nursing also noted that whilst performance for both verbal and written Duty of Candour was not at the expected level specific work was being undertaken through the Clinical Governance Team to address this.

1301/20 Mrs Libiszewski requested that Never Events be captured accurately within the report as the Never Event that had occurred during July was not reported. Mrs Libiszewski also noted that mandatory training within the report focused on Information Governance compliance to achieve accreditation. Whilst this was an important element of training Mrs Libiszewski was

concerned that the focus should be on wider mandatory training that focused on the key principle of core training, which was to equip staff to be able to care for patients and look after themselves. The focus felt misplaced.

1302/20 The Director of Finance and Digital noted that this was an articulation of the report however through the Performance Review Meetings there had been clear conversations regarding mandatory training. This had focused on the importance of mandatory training in the whole and the importance of needing a clear trajectory by Division to monitor delivery. The achievement of this was vital to the delivery of outstanding patient care.

The Trust Board:

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

Item 13 Risk and Assurance

1303/20 **Item 13.1 Risk Management Report**

The Director of Nursing presented the report to the Board. The risk register demonstrated that both core and non-core risks remained static month on month. This could be seen as both positive, that there was consistency, but could also lead to the question being asked of if risks were appropriate and being reviewed.

1304/20 An exercise to review the risk register was being undertaken to ensure that this was reflective of the organisations priorities, particularly in light of practice now in place and changes due to Covid-19. This would also allow for clear links to be detailed with the Integrated Improvement Plan and Board Assurance Framework. Currently these were not particularly clear.

1305/20 It was anticipated that this review would take place over the coming month and the Board were being alerted that a different report would be received going forward.

1306/20 The Chair noted that it was important for reviews of information presented to the Board to be undertaken alongside the format in which information was received. The Board would look forward to the refresh.

1307/20 The Chair noted that, following a significant period of time, there had now been movement in the high level aseptic risk, this had been revised and was now reducing.

1308/20 The Board reviewed the summary of risks presented noting that there were six risks rated at 20 or 25. The Board accepted these risks as the top risks to the organisation and were satisfied that mitigating actions described were appropriate.

The Trust Board:

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

1309/20 **Item 13.2 Board Assurance Framework**

The Chair noted that the Board Assurance Framework had been reviewed by each of the Committees along with the relevant risks to achievement of the strategic objectives.

1310/20 Mrs Dunnett noted that the People and Organisational Development Committee had requested that objective 4c - To become a University Hospitals Teaching Trust, be better populated to reflect the work being undertaken.

1311/20 The Director of Nursing noted that the Quality Governance Committee had recognised the need to ensure there was an assessment of risk in addition to the assurance.

1312/20 The Chair noted that there was a fine balance between risk and ensuring what was presented allowed a level of understanding and assurance at Board level. The work done this year had allowed the BAF to develop in to a document that could be worked with and gave a sense of the organisations position. The continual iterations strengthened the BAF month on month.

The Trust Board:

- **Received the report**

1313/20 **Item 14 Board Forward planner**

The Board received the forward planned for information and the Chair invited Executive colleagues to review the planner to ensure that this allowed for the opportunity to present items to the Board as required.

1314/20 The Board noted that this did not appear to be fully populated and the Chair and Trust Secretary would review the planner ahead of the winter period to support planning for the coming year.

The Trust Board:

- **Received the forward planner**

1315/20 **Item 15 Any Other Notified Items of Urgent Business**

There were no other notified items of urgent business

1316/20 The Chair reflected on the contributions of the Board and the quality of the papers. These were indicative of how the Trust were building levels of assurance in the organisation, therefore there had not been the need to spend a lot of time at Board level trying to gain an understanding of issues. There had been presented in the papers. The Chair expressed thanks to Executive colleagues for the quality of the papers presented and to the assurance committees for the effective governance processes reporting to the Board.

The next meeting will be held on Tuesday 6 October 2020, arrangements to be confirmed taking account of national guidance

Voting Members	**1 Oct 2019**	**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**
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	X	A
Geoff Hayward	X	X	X	X	X	X	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	X	A	X	X
Sarah Dunnett	X	X	X	X	X	X	X	X	X	X	X	X
Elizabeth Libiszewski	A	X	X	X	A	X	X	X	X	X	X	X

Paul Matthew	X	X	X	X	X	X	X	X	X	X	A	X
Andrew Morgan	X	X	X	X	X	X	X	X	X	X	X	X
Victoria Bagshaw	X	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

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	Review to be undertaken and reported to November Board
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 in Jan meeting. Review again at October Audit Committee
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	Fireworks reviewed at July FPEC meeting-BC review to November Board
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
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	Deferred due to Covid-19
4 August 2020	1062/20	Cancer Strategy	To be shared with Board	Neill Hepburn	01/09/2020	Shared in reading room on ibabs - Complete
4 August 2020	1091/20	WRES/WDES Annual Submission	Consideration of the opportunity for Non-Executive Directors to provide independent oversight to disciplinary reviews	Rayson, Martin	01/09/2020	A meeting would be held with the Chair to discuss how this could be achieved – Complete

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Public Trust Board*
Date of Meeting	*6 October 2020*
Item Number	*Item number:*
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	*N/A*
Assurance Level Assessment	• *Significant*

Recommendations/ Decision Required	• *To note*

Executive Summary

1. System Issues

a) The COVID-19 Phase 3 Recovery plans were submitted to NHSE/I on 21st September. This comprised the overarching narrative plan containing details of how the system will ensure the provision of as near normal levels of non-COVID activity as possible, in line with the national targets. Also submitted were the People Plan and the ICS Development Plan. Discussions are now taking place with NHSE/I about the detail of the plans, recognising that there is a changing national position in relation to a further surge in COVID cases. There is an expectation that non-COVID services will be maintained wherever possible.

b) The national Alert Level for COVID has moved up to Level 4. The NHS incident Level remains at Level 3, indicating that the focus needs to be on Regional action rather than National action. This is a recognition of the differing incidence levels of COVID around the country. Lincolnshire still has relatively low levels of COVID in the community compared to many parts of the country.

c) The financial envelope for the system for the remainder of 2020/21 has been issued by NHSE/I. The implications of this allocation are currently being worked through and more detail will be provided to all Boards/CCG Governing Body in due course.

d) As well as managing winter, Phase 3 recovery of non-COVID activity, and a second surge in COVID, it is clear that the system will also need to ensure that clear plans and actions are in place for managing the end of the Brexit transition period at the end of December 2020. This will focus amongst other things on securing the continued supply of goods and services and on maintaining staffing levels.

e) The System review with NHSE/I on 9th September was positive. The meeting focused on the restoration of essential services in Phase 2 of the pandemic; the Phase 3 recovery plans; the work to develop an ICS; the system financial position. There are a number of areas where further work is required. These are all areas where work is already underway. The system was commended on the strong partnership working that is evident and the strong leadership that has been shown.

f) The ICS review with NHSE/I took place on 2nd September. The follow-up issues relate to the establishment of clear leadership arrangements for the ICS including the appointment of a Chair for the Partnership Board; and what functions or services are appropriate at the Place level, as opposed to the system level or neighbourhood level.

g) The Acute Services Review Pre-Consultation Business case is still with NHSE/I for scrutiny. This stage of the process must be completed satisfactorily before the CCG can initiate any public consultation.

2. Trust Issues

a) The Trust continues to re-commence non-COVID services that were paused during the height of the pandemic. This is part of the Phase 3 work mentioned in Section 1 above. The first quarterly review of the temporary

changes made at Grantham and District Hospital has also taken place and there is a report on this elsewhere in the Board agenda.

b) The Trust has been successful in securing £7m of national capital for Lincoln County Hospital A&E improvements in 2020/21. It is anticipated that further capital will also be announced in 2021/22 in order to complete the full scope of the scheme. The Trust has also received £1.2m of national funding for the development of an Electronic Prescribing and Medicines Administration (EPMA) system.
c) The virtual Big Conversations with staff about the Integrated Improvement Plan (IIP) are continuing. The feedback so far has been very positive with staff welcoming the changes being proposed and offering help and assistance in making them a reality.
d) The staff flu campaign is underway, with the aim of ensuring that all staff have a flu vaccination in order to protect themselves, their families and their patients.
e) The winners of the Staff Awards for 2020 have been announced. Due to the social distancing requirements currently in place, it was not possible this year to have a main awards ceremony. Instead, either Mark Brassington or I were able to visit the winners in their wards/departments in order to present them with their trophy and certificates. Photographs were taken and a media release was issued to celebrate the winners. The Staff Awards for 2021 are now open for nominations.
f) As a follow-up to the feedback from the 2019 staff survey, the Trust has been holding appreciation weeks for support staff who sometimes do not get the recognition that they deserve. The week beginning the 28th September was the turn of our Estates and Facilities staff. Members of the Executive Leadership Team were able to get out and about thanking staff for all that they do in the Trust.
g) The final part of the Director of Nursing recruitment process takes place on 30th September. I hope to be in a position to confirm the name of the successful applicant at the Board meeting. The vacancy was subject to a national external advert.

Meeting	Public Trust Board
Date of Meeting	6th October 2020
Item Number	Item 6.1
Title	First Quarterly Review following temporary conversion of Grantham Hospital to a Covid-19 Green Site Model
Accountable Director	Simon Evans – Chief Operating Officer
Presented by	Simon Evans – Chief Operating Officer
Author	Simon Evans – Chief Operating Officer
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	*X*
4b Advancing professional practice with partners	
4c To become a university hospitals teaching trust	

Risk Assessment	4558 – Local Impact of the Global Coronavirus (Covid-19) Pandemic The paper is in direct response to mitigating this risk.
Financial Impact Assessment	The temporary establishment of a Covid-19 Green site at Grantham Hospital was as a direct response to a Level 4 National Incident, not requiring a detailed FIA to be considered; however clear processes to authorise financial expenditure in line with the agreed business case have been established to support a detailed evaluation to take place. De-escalation to a Level 3 National Incident on 1st August has not changed the protocols under which a detailed FIA is not required.
Quality Impact Assessment	*Completed June 2020*
Equality Impact Assessment	*Completed June 2020*
Assurance Level Assessment	*Significant*
Decision Required	The Trust Board are asked to consider the findings of the first quarterly review of Grantham Green site model and approve the primary recommendation for the continuation of the temporary changes in operation at Grantham. The timescale for this continuation to last for the duration of Covid-19 to at least 31 March 2021 Subject to such approval the Trust Board are asked to approve a further 9 recommendations to strengthen existing arrangements operationally and corporately.

Contents:

1. Executive Summary

The establishment of a Green Site at Grantham District Hospital within 18 days following the Board decision to do so in June was a significant undertaking. The subsequent implementation of these plans within 2 weeks was only achieved through the significant efforts and commitment of many colleagues across corporate and operational divisions.

The overarching objective of these proposals being to seek to address the requirements for urgent care in response to Covid-19 in addition to also addressing the need to re-establish and maintain access to elective care for the benefit of all patients across Lincolnshire.

The activity modelling presented in the original proposals in June were predicated upon the circumstances and assumptions known at that point. Some of these assumptions have changed due to the dynamic nature of the pandemic, making it difficult to evaluate actual delivery against plan. Notwithstanding this point it is clear that the changes made have delivered most of the expected benefits.

The establishment of a Green Site at Grantham being one important element of the Trust's overall Covid-19 Strategy and Recovery plan, however the evaluation and impact of which should be considered alongside the measured contribution that all 4 trust sites are making to the overall performance of the Trust.

There is also a clear opportunity for reflection on the findings from this review to ensure that the translation into wider organisational learning is not lost.

This detail within this review provides significant evidence of the achievement in full of the Trust's 3 strategic aims required to be met to support the implementation of the Green site model as RAG rated below.

Strategic Aims	RAG	Evidence
IPC excellence		No instances of Covid-19 Perioperative infection
Capacity to deliver at scale		There has been a 69% increase in overall activity
Future service resilience		All services have remained open in spite of ongoing and escalating Covid-19 status.

Strengthening existing arrangements for refining patient flow projections, revisiting specialty activity targets and developing the coordination and consistency by which performance is measured and reported upon with regard to the effectiveness of the Grantham Green site model with particular focus upon the impact for patients and staff will significantly improve the Trust's ability to continue to respond to the ongoing complexities presented by the evident second wave of the Covid-19 epidemic being experienced now across the UK.

A RAG rated summary of the degree to which the primary priorities and objectives of the Green site model have been achieved are presented below:

Priorities	RAG
To enable planned surgery to resume to a level which maintained the current waiting list level, ensuring no further deterioration.	
To bring the trusts overall cancer surgery activity back to pre Covid-19 levels and indeed aim to exceed this level so that within 3 weeks there will be no waiting list for cancer surgery	
To continue to treat the 80 patients historically receiving chemotherapy at Grantham, whilst transferring the treatment of 1932 patients from Lincoln and Pilgrim.	
To contribute to an increase in the trusts overall capacity to undertake urgent endoscopy work.	
To increase the number of patients receiving outpatient care by an indicative 9000 patients per annum.	

To provide UTC services 24/7 to the majority of patients who attended A&E – 20,014 attendances	

NB Amber RAG ratings reflecting incomplete information and the requirement for further data collection, validation and analysis.

Whilst there is no doubt that the services approved within the Green site model have been implemented as intended, the full effect of these changes upon other sites and services provided by the Trust remain to be fully quantified and understood. Whilst these interdependencies may be complex, strengthening the approach to evaluation going forward as suggested in this paper will develop a clearer understanding that will inform both organisational and system wide decision making as the NHS continues to respond to the Covid-19 pandemic.

The trust's original criteria to determine the return of Grantham Hospital to pre Covid-19 model are represented below:

- Regional or National Incident Override – where through the NHSE/I Command structure a request is made to revert to the pre Covid-19 model.
- Covid-19 alert level reduces to L2.
- Impact to other organisations - resulting in a request for mutual aid.
- Identified risks of threat to life or limb are identified with existing models of care.
- Overall waiting lists for Cancer patients reaches standards for 31 & 62 day, with all other treatments/surgeries reduced to pre Covid-19 levels.
- Winter pressures lead to activation of the surge plan – where emergency bed base, critical care demand and/or staffing requirements for critical care is not satisfied with Grantham model.

These 6 criteria have been designed to consider all known scenarios that should lead initially to a consideration of amendment of the model. They may in turn lead to reverting back to the original pre-Covid-19 model. They are sufficiently broad to consider the full range of risks to stakeholders. The criteria are highly visible and easy to communicate, so as to easily alert the Trust to a need to consider its response differently. An assessment of these criteria is detailed within this report, which confirm at this point that no criteria have been met that would suggest the need to substantially change the temporary model in place, or to drive a reversion back to pre-Covid configurations.

On the basis of information within this paper, the Trust Board is asked 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 next quarters activity data, which is available in early January 21 for the Trust Board's consideration in February 21. The Board is also asked to approve a further 9 recommendations relating to operational and strategic aspects of the Green Site model.

2 Purpose

This paper seeks to present the findings from a targeted desktop review undertaken regarding the delivery and performance of the Green site model established at Grantham Hospital from 29th June. Included is clarification of the circumstances leading up to the decision to establish a Green site model, the rationale and criteria used to evaluate options and a summary of the operating model and the impact assessments upon which implementation plans were predicated.

The review findings focus on an assessment of service delivery, primarily from an operational, safety and quality perspective as well as the experience of patients and staff. This assessment has been undertaken cognisant of opportunities to strengthen the temporary model and testing ongoing appropriateness with a view to identifying potential alternative considerations.

Specifically, the aim of this paper is to:

- Evaluate the extent to which the aims and intentions of the approved green site model at Grantham were achieved
- Identify and learning and subsequent opportunities for further improvement in any aspect of site specific and or trust wide performance
- Review the ongoing need and potential timescales for a green site model
- Recommend intentions and options for ongoing evaluation and the next quarterly review scheduled for December
- To state criteria for closing the Green site and reverting to pre Covid-19 service configuration

3 Context

On 30 January the first phase of the NHS's preparation and response to Covid-19 was triggered with the declaration of a Level 4 National Incident. The definition of this being that a Covid-19 epidemic is in general circulation, with transmission high or rising exponentially. At the same time Covid19 was confirmed as a High Consequence Infectious Disease (HCID) and the UK risk level was raised from moderate to high. This triggered a national preparation and response to Covid-19 in the following four phases, beginning with the first Manage phase.

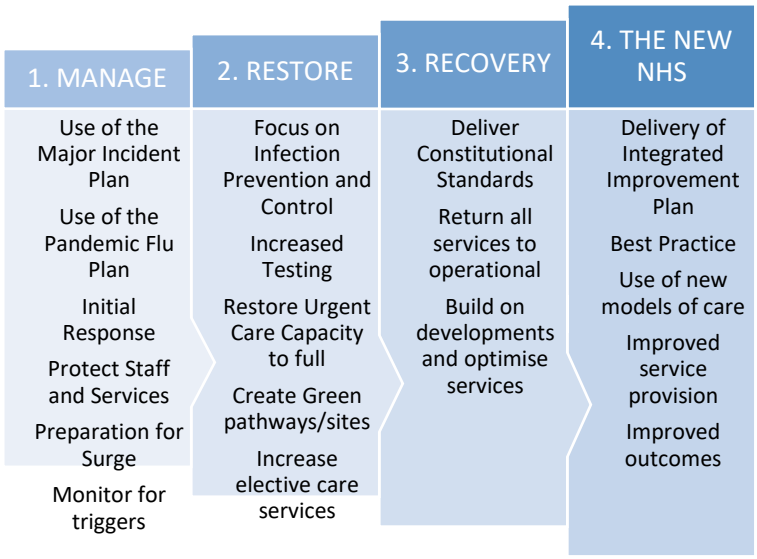
1. Manage – to 29 April
2. Restore – to 31 July 2020
3. Recovery – to 31 March 2021
4. The new NHS – 1 April 2021 onwards

It is important to recognise that at the time of developing proposals for a Green site model and the Board's subsequent consideration and decision to approve implementation the Trust was in the 'Restore Phase', requiring it to plan to restore urgent care capacity and increase elective care services through the creation of green pathways/sites.

Nationally, objectives of the response to the Level 4 National Incident were set as:

- Save Life
- Prevent Harm
- Protect the NHS

A high-level summary of each phase of the Covid-19 response is provided below:



Consequently, United Lincolnshire Hospitals NHS Trust ('ULHT') as part of the first Manage phase, quickly repurposed services, staffing and capacity to treat and care for patients with confirmed Covid-19 infection. Hospital services were reduced very quickly in order to free up capacity to manage Covid-19 cases and to reduce the risk to elective patients of going into hospitals where Covid-19 patients were being cared for. At the time clinical reports suggested the risk of death for patients contracting Covid-19 during the operative period was as high as 40%.

Large numbers of clinical staff were redeployed in response to these patients, with stringent IPC procedures established to mitigate risks. This has resulted in many appointments for cancer surgery, clinically urgent cases and urgent diagnostic testing being deferred. As a result, many more patients are now waiting for their care. Without re-establishing these services, waiting lists will continue to grow and those patients whose procedures and investigations have been delayed could suffer harm as a result. During the initial phase of the pandemic, the demand for urgent care also significantly declined, although this is now rising again, and we need to be able to continue to safely care for these patients too.

On 11 May the Trust confirmed it's Restore Phase plan (up to 31st July) as an important component of its overall Covid- 19 campaign strategy, which was presented at Trust Board in June. A further report presenting a summary review of this Restore Phase plan and progress made to date against required and intended actions was presented to, and considered by the Trust Board in July. Multiple service changes have been made at pace through this restore phase, following rigorous assessment for risk, quality and equality impact through the trust's agreed authorisation processes. The pace of this approach being focused upon providing the safest environment to deliver services to improve the health outcomes of the population served by the trust.

As national case numbers began to decline, national guidance was issued requiring all NHS organisations to develop plans to restore some essential non-Covid-19 services. The Trust's Restore phase response has been heavily focused on reducing the risk of hospital acquired Covid-19 and associated Infection Prevention and Control measures. This with the aim to create optimum levels of protection for patients and staff, drawing on a bundle of measures including social distancing, environmental enhancements, cleaning programmes, hygiene and hand washing, and test and trace. The identification and zoning of areas to support Green and Blue pathways was considered fundamental to deliver these measures and integral component of the Trust's Restore phase plan identified as the creation of a Green site. Putting in place measures to minimise hospital transmission of Covid-19 to protect patients and staff was prioritised in this stage to increase public confidence in accessing our services again.

On 5 May the Trust Board supported the establishment of Green site at Grantham for cancer and elective surgery and non-surgical procedures, supporting the setting up of 'Task and Finish' group with support from KPMG to explore proposals to restore surgical services.

On June 11th, 2020, an extraordinary public meeting of the Trust Board was held, to consider a single paper presenting detailed proposals for the temporary reconfiguration of services at Grantham as a Green site with a Blue (Covid status positive or unknown) isolated Urgent Treatment Centre. This case for change included:

- the options considered and the preferred option,
- the legal basis for the change,
- clinical leadership and governance established to oversee and enact the proposed changes.

This change would mean an increase in elective patients at Grantham hospital, including transfer of chemotherapy, cancer surgery and other surgery from across Lincolnshire onto the Grantham site.

Considerable public interest in these proposals generated a volume of questions unable to each be responded to within the time available in the meeting. Written responses were subsequently provided to each individual and every question posed.

The Trust Board approved the proposal to proceed with the temporary changes in response to the Level 4 incident response to the Covid-19 pandemic following full support and approval being received from all voting members. The timescale of the Green Site was agreed for the duration of Covid-19 up to at least 31 March 2021; recognised as a key element of the trust's Restore and Recovery phases. It was additionally agreed that the wider solution would be subject to quarterly review.

With direction and oversight provided by Gold Command, detailed plans for clinical leadership, governance arrangements, workforce and IPC protocols and procedures were established, enabling the Grantham green site to go live from 29 June. Lincolnshire County Council health scrutiny committee have voiced its concern about the changes with reference to the impact to Grantham residents requiring to access services on alternative sites.

On 19th June the UK was de-escalated to Level 3, (the definition of which being that a Covid-19 epidemic remains in general circulation). As a consequence, (in the absence of national vaccination programme) the ongoing circulation and posed threat to life should be expected for some time to come and at least the next 12 months.

On 31st July the Trust received confirmation of the beginning of Phase 3 *Recovery*. From the 1st August 2020 the NHS National Emergency level was lowered to Level 3 describing the response moving from National to regional direction. During this time Trusts have been reminded that this does not negate the rapid response required should circumstances change and the level of preparedness which must continue to be at its highest, maintaining such key functions as Incident Command Centres (ICCs) and Single Point of Contact systems (SPoC). A paper detailing the progress made within this Recovery Phase was considered by the trust board in September. The main objectives within this phase being to:

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

B. Prepare for winter demand pressures, alongside continuing vigilance in the light of further probable Covid spikes locally and possibly nationally.

C. Doing the above in a way that takes account of lessons learned during the first Covid peak; locking in beneficial changes; and explicitly tackling fundamental challenges including: support for our staff, and action on inequalities and prevention.

On 21st September, the NHS Covid Alert level was raised again to Level 4, reflecting the National picture of increasing numbers of Covid-19. The Trust currently remains in Phase 3 *Recovery,* with the CEO for NHS England confirming that whilst escalation plans are being prepared for a potential 'second wave' of Covid-19, there will be an expectation that local intentions to restore elective services will be expected to continue for as long as possible. This approach further reinforced following a letter received this week from the National Strategic Incident Director advising trusts of the importance to continue to separate Covid and non Covid pathways in order to strengthen local efforts to re-establish elective services whilst reviewing local escalation plans in anticipation of increasing hospital admissions.

4 Summary of Operating Model

The Operating Model was predicated upon 3 conditions being met, these being:

1. **Infection Prevention Control (IPC) excellence** – this to minimise hospital transmission of Covid-19 to protect patients and staff.
2. **Capacity to deliver at scale** – this to reduce risks associated with delay in treatments.
3. **Future service resilience** – this to maintain capability over an extended timescale.

A summary of the option assessment provided in the table below informed the decision to introduce a Green site for cancer surgery, urgent elective services and diagnostics, in addition to the conversion of the A&E to a UTC to maintain urgent care for the Grantham population.

Conditions	Option A – Do nothing	Option B – Green pathway	Option C – Green site
IPC excellence	*Condition not fully met*	*Condition fully met*	*Condition fully met*
Capacity to deliver at scale – theatres, staffing and estate	*Condition not met*	*Condition not fully met*	*Condition fully met*
Future service resilience	*Condition not fully met*	*Condition not fully met*	*Condition fully met*

Additionally, these three conditions required adherence to the following design principles:

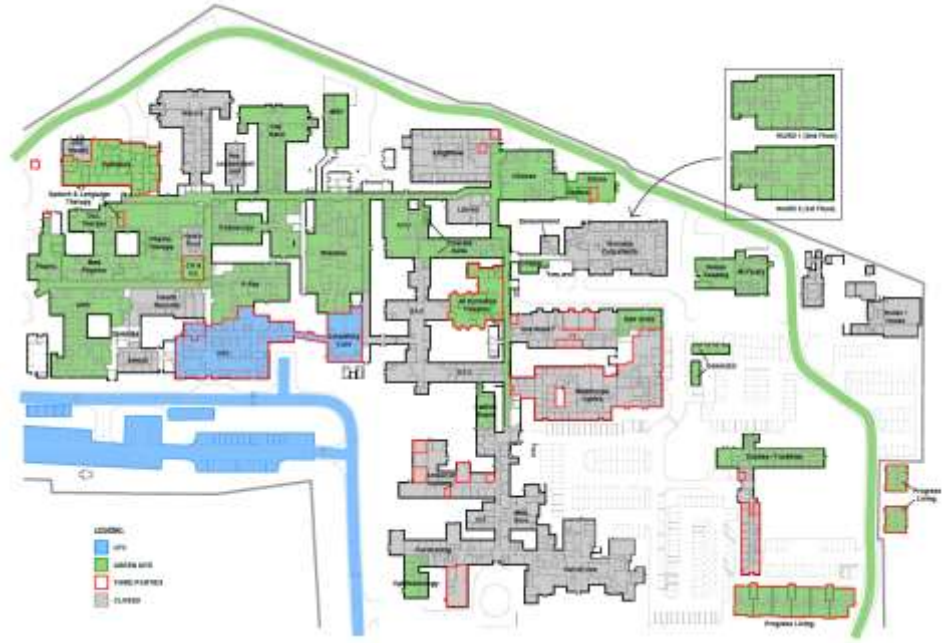
- Eliminate the risk of nosocomial infection reducing chance of contracting Covid-19 in our hospitals
- Access controlled by exemplary IPC and Personal Protective Equipment (PPE) compliance
- Conform to all guidance and standards provided within the NHS IPC Board Assurance Framework with strict adherence to the NHSE Hygiene Code.
- Adhere to a strict and rigorous regime of monitoring and surveillance for Covid-19 of our patients and staff along with reinforcing social distancing and hand hygiene guidance. This will include the use of any new testing (antibody testing is unclear at present time)
- Clinical care provided during the Restore phase will be prioritised to treat cancer patients or those requiring care that is deemed to be clinically urgent, ensuring support is in place to enable patients to comply with requirements - mental capacity, social and other factors
- Maintain consistency in staff and equipment allocation and restrict movement of staff and equipment between different sites and areas which will support minimising the risk surface contact transmission accompanied by a rigorous cleaning regime.

The model of converting a hospital site into a Green site, aimed to deliver elective and planned care in a setting that minimised the risk of cross contamination of Covid-19, with no Blue activity (unplanned or otherwise) cohabiting with Green activity i.e. Blue activity and Green activity physically separated with staff working in separate Green and Blue areas.

A summary of the detailed evaluation undertaken for the potential for each existing hospital to become a dedicated Green site is also provided below; this evidencing Grantham as the only viable option with the ability to create a large-scale surgical service, whilst having the greatest level of IPC protection to patients and staff and in such a way that provides future service resilience. Additionally, Grantham was recognised as the only site with urgent care services that could separate patients with confirmed Covid-19 status from those that are undifferentiated.

Conditions	Lincoln	Pilgrim	Grantham	Louth	Independent sector[1]
IPC excellence – protecting patients and staff	Condition fully met	Condition fully met	**Condition fully met**	Condition not fully met	Condition fully met
Capacity to deliver at scale	Condition not fully met	Condition not fully met	**Condition fully met**	Condition not fully met	Condition not fully met
Future service resilience	Condition not fully met	Condition not fully met	**Condition fully met**	Condition fully met	Condition not fully met

Translation of this evaluation into an approved site plan to implement the agreed Operating Model at Grantham is shown below:



To reduce the footfall on the site and maintain IPC principles a review was undertaken to identify the staff that could be relocated elsewhere. In total, c.600 ULHT staff and an additional 50-75 staff members from third party tenants were identified for relocation. At this time, many of these staff were already working from home or had been redeployed as part of the Manage phase of Covid-19 response. The remaining affected staff were supported in transition to work from home, from a different ULHT site or in the community as required.

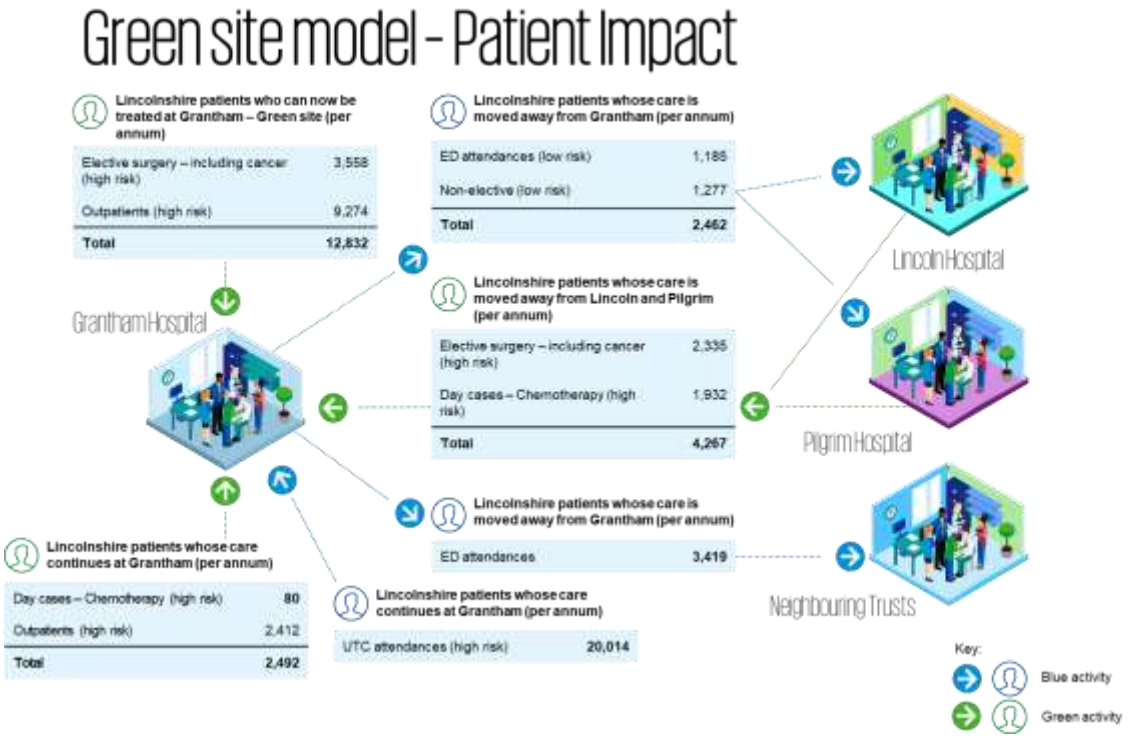
In total, the initial configuration of the Green site and Blue UTC was identified as requiring c.200 staff, with an additional c1200 badges authorising access to the site. This represented a significant reduction from the previous c3000 access passes that had been issued prior to implementation of the green site model.

A range of addition steps to be taken with the aim of protecting staff from contracting or conveying Covid-19 were agreed upon and put into place, these including:

- A defined protocol for the migration of staff between sites (especially surgical teams) to ensure no Blue to Green transfer on the same day
- Screening by wellbeing assessment including temperature check at the start and end of each shift
- A programme of random staff swabbing to screen for asymptomatic carriers – work is being undertaken to refine this approach
- Risk assessments for staff not currently in patient-facing roles due to previous risk assessment to facilitate work at IPC excellence site
- Swabbing if symptomatic or for contact tracing - adhere to the new National Test and Trace system

- Maintain the consistency in staff and equipment allocation and restrict the movement of staff and equipment between sites, accompanied by a rigorous cleaning regime that minimises the risk of contact transmission
- Maintain the advice and guidance in respect of hand washing and social distancing

The detail of the clinical model agreed can be found in **appendix 1**. This model necessitated the removal of medical admissions (and transfer to blue sites), recommissioning of 4 theatres, an increase in elective care beds and conversion of A&E to a UTC. The indicative modelling of anticipated patient flows to reflect this clinical model was presented as below:



It should be recognised that the activity levels provided in the above infographic were modelled upon assumptions known in June. Throughout the Covid-19 pandemic both emergency and planned demand for services have continued to change which effects the accuracy of the forecast and indicative activity proposed.

The clinical benefits following implementation of this clinical model were identified as:

1. Rapidly treating patients requiring cancer surgery, eradicating waiting lists within 2-3 weeks following full implementation.
2. Enabling planned elective surgery to resume and prevent further deterioration of waiting times whilst permitting the treatment of clinically urgent cases.
3. Increase urgent diagnostics to prevent further deterioration of waiting times and reduce the risk of delay in diagnosis
4. Increasing access to UTC services 24/7. Through converting 8am – 6.30pm A&E to an Urgent Treatment Centre whilst increase operating hours to become a 24/7 walk-in function.

Implementation of the agreed operational and clinical model was swiftly achieved and within 2-3 weeks of going live (29th June) all members of the recognised 'project group' responsible for development and implementation had returned full time to their primary roles, with ongoing responsibility for maintenance of the green site model being shared across the Trust's four divisions.

5 Implementation of the Clinical Model

The indicative patient flows presented in the formal proposals were based upon the initial priority to quantify and provide treatment to the most clinically urgent patients to optimise outcomes. The expectation that the acuity of these patients would likely necessitate a level of critical care support that was not currently available at Grantham further reduced the quantification of potential patients appropriate to consider transferring to the Grantham site. In this regard the indicative patient flows originally presented are a relatively small cohort of the full potential of patients whose elective care could be undertaken at Grantham.

That being the starting position, it is noted that the potential for Ophthalmology to feature within the green site model, was not realised due to the eventual prioritisation of other specialties. This decision would have further affected the indicative patient flow of activity within the original model, with the need now recognised for revision of this to take place to reflect the more complex specialty mix. Correspondingly, the decision for complex colorectal surgery to be undertaken at Grantham was taken; this in recognition of the numbers of patients with extended waiting times in this specialty. This decision similarly necessitates a revision of indicative activity to reflect the implementation of a more complex case mix of elective surgical patients.

The model's intention to move from an initial 5 day a week operating theatre to 7-day working was 75% achieved from the end of July, with the additional lists being dedicated to Orthopaedics in recognition of the long waits in this specialty and availability of clinical expertise at weekends. Operational utilisation targets for theatres should be revisited to reflect the actual and intended case mix going forward so that the opportunity for further increasing activity at Grantham within existing resources may be quantified. At this point the opportunity to further increase theatre capacity on the site should be considered as part of the trust's plans for the winter.

The model's intention for chemotherapy patients to transfer from other sites to receive treatment at Grantham has also been achieved. Standardising the measure of performance used to evaluate chemotherapy performance to agree consistent measures to develop a consistent interpretation of the impact of the change upon patients will be helpful in evaluating trust wide performance going forward.

The refurbishment of the endoscopy suite currently providing 6 day working, has also enabled the model's intention to increase diagnostic interventions for the most urgent of patients has also been significantly achieved, with the site on track to provide 7-day services from the end of October.

Standards for medical cover were planned to be reviewed in recognition of the rotation of trainees in August, with the recognition that a reduced level of clinical exposure has affected the training of medical staff within all specialties. Considerable priority is being given Nationally to mitigating these effects as a direct result of responding to Covid-19.

In reviewing the potential for returning any displaced services and teams to the Grantham site, a focus on analysing health outcomes of the wider population could assist to identify and develop services best placed at Grantham going forward. Some questions posed by Clinicians from the outset regarding the limitations of the original clinical model clearly remain, specifically regarding the decision not to include a green rehabilitation ward within the operational model from the outset. The model did commit to the establishment of in-patient rehabilitation services recognising the essential need for such services during the winter. A location for these facilities at Grantham has been identified with plans on track for these rehabilitation services to go live from 1st November. Given current challenges regarding patient flow, the number of medical beds presently closed across the sites (60 – 90) and the planning for winter underway, it is important that rehabilitation services will be provided as part of the Green site model going forward.

Despite a clear rationale developed at the time to identify which staff skills and experience were required to care for patients on the Green Site, questions continue to be raised by staff regarding the perceived inequality with which staff were identified to transfer away from the Grantham site. This has undoubtedly contributed to significant logistical and daily challenges for individuals which is viewed as having unfairly impacted upon them. Given the escalating National concerns regarding the rising transmission of Covid-19 and the expectation of the need for ongoing review and revision of services to prioritise the safety of staff and patients within the trust, the importance of developing an explicit framework for engaging authentically with all staff cannot be

underestimated. Such an approach should significantly assist in preparing staff for the way services at Grantham may continue to develop to meet the needs of the Grantham and wider Lincolnshire populations.

6 Assessment of Service Delivery

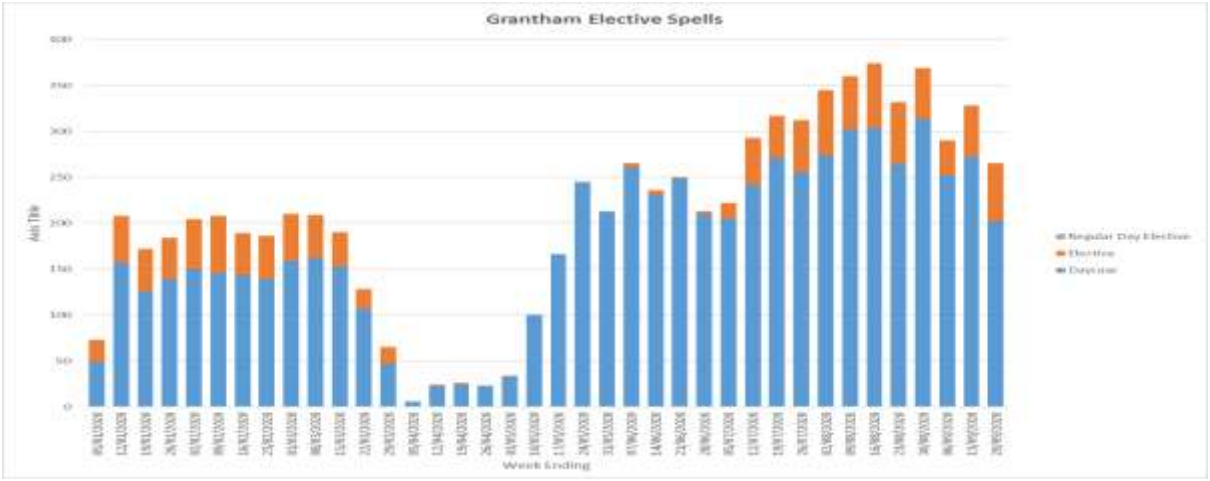
The achievement of developing the proposal for the Trust Board on 11th June and going live from 29th June, must be recognised as a significant achievement for the Trust. The pace with which aspects of this complex proposal required to be taken forward was only achieved through the significant efforts and commitment of many colleagues across corporate and operational divisions.

Most importantly the 3 strategic aims have been met to provide services that deliver:

- Infection Prevention Control (IPC) excellence
- Capacity to deliver at scale
- Future service resilience

The position that no surgical patient has contracted Covid-19 whilst in Grantham Hospital representing a kite mark for the IPC standards in place across the trust.

The graph below provides a site-wide indication of the extent to which all in patient spells (which include all activity relating to elective surgery, endoscopy and chemotherapy) have increased at Grantham. The comparison and increase from pre Covid-19 activity levels are clearly presented; with pre Covid-19 average of 196 spells/weekly and green site average of 331 spells/weekly representing a 69% increase in overall activity following implementation of the green site model.



This significant increase in elective activity has contributed to the Trust's current overall performance of recovering back to 73% of elective activity compared with pre Covid-19 performance.

Suggestions made in subsequent sections of this report anticipate ongoing routine data collection and triangulation of locally available information as well as the potential benefits for the ownership of elective performance information being focused within the responsibility of a nominated individual. Such an approach will:

- significantly strengthen both the Trust's ability to evaluate local performance going forward and
- assist in understand how the green site model continues to contribute to the Trust's operational priority to re-establish services suspended due to the pandemic.

It is to be expected within the ongoing context of a pandemic effecting service delivery that assessment of any intervention or action to extend or improve the delivery of services will continue to present considerable challenges in accurately reflecting performance within a fast-changing national context.

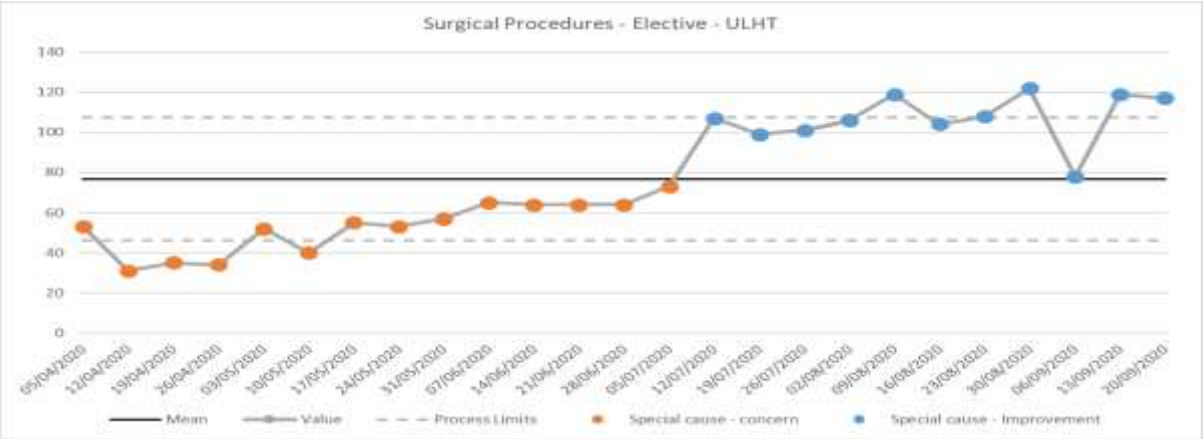
There is no doubt that establishment of a green site has resulted in several new specialties now operating from Grantham, with some indications that there may be potential for this surgical activity to increase further. Strengthening the multi-professional approach to exploring these opportunities with the benefit of improved activity information could significantly develop the trust's internal capabilities to address ongoing Covid-19 challenges as they will undoubtedly be presented in coming months.

6.1 Operational Delivery

6.11 Planned Surgical activity:

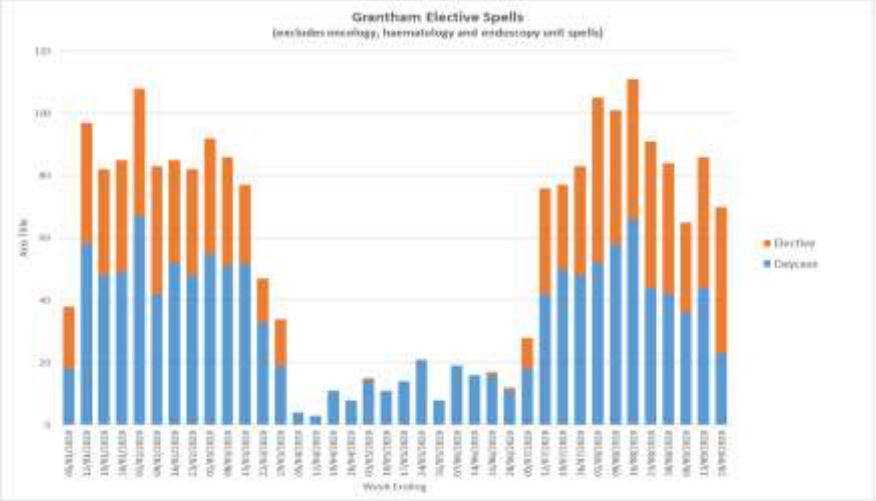
The aim of the Grantham Green Site model was primarily to enable planned surgery to resume to a level which maintained the current waiting list level, ensuring no further deterioration, (this identified as requiring 7902 cases per annum).	RAG

Total numbers of elective surgical procedures undertaken in the Trust has risen week on week (as represented in the graph below), since the end of June following implementation of the Green site model at Grantham and Green Pathways across other sites.



Specifically, the establishment of two surgical wards at Grantham with fully functioning theatres (75% of which work 7 days a week) has helped restore elective surgery for a range of specialties at Grantham. The Trust-wide run rate of elective and day case spells (the definition of the original ambition) are currently on track to hit 7061 cases, representing 90% achievement of the intended aim at this point.

Within the context of significant activity change and increase at Grantham over a short period of time, the graph below seeks to remove chemotherapy and endoscopy activity to present this data for 2020 to date, focusing purely on elective and day-case spells. This analysis represents a current average of 88 surgical cases being undertaken each week at Grantham. Whilst this is 0.2% higher than per Covid-19 levels, is explained by an 11.8% increase in inpatient elective cases offset by a 7.7% decrease in day cases. This analysis therefore suggests that the actual surgical activity undertaken at Grantham is currently operating 29% below the original indicated activity levels within the June paper, reasons for which are provided below.



The detail of surgical specialty activity undertaken at Grantham pre Covid-19 compared with current levels is presented below:

Change in Elective and Day case Spells by Discharging Specialty (excludes Endoscopy Unit)

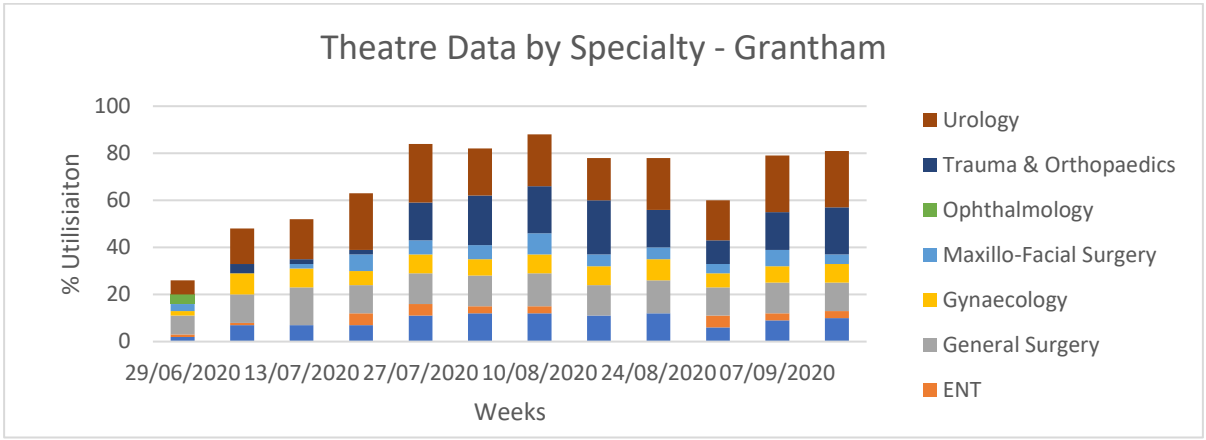
Specialty	Pre-Covid Cases (w/e 12th Jan - w/e 15th Mar)	Recent Cases (w/e 12th Jul - w/e 13th Sept)	% Change
100 - General Surgery	396	192	-52%
101 - Urology	121	259	114%
103 - Breast Surgery	31	125	303%
104 - Colorectal Surgery	8	0	-100%
110 - Orthopaedic	764	150	-80%
120 - Ear Nose & Throat	7	27	286%
130 - Ophthalmology	318	0	-100%
144 - Max Facial Surgery	40	195	388%
145 - OMF Surgery	0	1	
192 - Critical Care Med *	50	13	-74%
300 - General Medicine	24	45	88%
301 - Gastroenterology	135	2	-99%
302 - Endocrinology	1	0	-100%
303 - Haematology (Clin)	297	582	96%
320 - Cardiology	0	2	
330 - Dermatology	3	0	-100%
340 - Chest	6	0	-100%
370 - Medical Oncology	20	272	1260%
410 - Rheumatology	0	7	
430 - Care of the Elderly	6	0	-100%
502 - Gynaecology	35	99	183%
800 - Clinical Oncology	50	1190	2280%
811 – Int. Radiology	33	0	-100%
999 - Unknown	0	3	

*reflects Level 1 critical care – coding validation required

The activity levels above reflect the expected increases in specialties moved to the green site with three notable exceptions; Orthopaedics which has reduced by 80%, General Surgery by 52% and Colorectal Surgery by 100%.

For these three specialties within Orthopaedics the case mix of patients has changed significantly to protect the green site status. Operational teams are exploring the rational for other changes.

Considering the potential for theatre utilisation to be a constraint that could be impacting upon activity levels, the graph below evidences a trending increase in theatre utilisation since establishment of the green site model to date. The stepped increase in cases from the end of July marks the move to 75% 7 day working, with Orthopaedics using these sessions. The original indicative level of 25 cases per day was identified, on the premise that Ophthalmology would be undertaken on site. Currently there is an average of 10 cases per day being undertaken with the trend of increasing activity for most weeks. It would be appropriate to quantify the extent to which current activity levels may continue to improve within existing theatre resources and consider the potential options and impact of increasing local theatre capacity further. Increasing theatre capacity further so that all theatres are open 7 days a week at Grantham being the intended next step to be taken by the division.



Examination of September performance dashboard for theatres shows more sessions being used against a backdrop of a decline in cases per session. The current performance being 1.6 cases per session. The reasons for the decline in cases/list may be explained by changes to case-mix but needs to be better understood. Further exploration to identify the current constraints and opportunities to increase existing theatre utilisation will provide a sound foundation for informing alternative options currently being considered strategically and operationally by the Trust with the aim of further reducing the overall surgical waiting list to pre Covid-19 levels.

An initial review of surgical bed capacity at Grantham confirms 54 open beds for use on the site which after removing chemotherapy and oncology surgery activity from the numbers, would indicate an average of 8 additional surgery patients are being admitted overnight to the 2 wards available. This would indicate a detailed review of theatre and surgical bed utilisation is required, upon which revised targets can be based.

The graph below presents the numbers of patients waiting on the admitted patient waiting list. It shows that the increase reported from April to July would seem to have been mitigated and begun to reduce in August. This represents fewer patients now waiting for elective procedures across the Trust.

6.12 Cancer Surgical activity:

The aim of the Grantham Green Site model was to undertake in excess of 13 cancer surgery per week, to bring the trusts overall cancer surgery activity back to pre Covid-19 levels and indeed aim to exceed this level so that within 3 weeks there will be no waiting list for cancer surgery.	RAG

This aim has been significantly achieved with some aspects still requiring further clarification.

Very positively referrals to the Trust have continued to increase and have now returned to pre Covid-19 levels, as represented in the graph below. The significant drop in referrals was clearly a concern since it represented patients deciding not to attend their GP, with a corresponding potential for longer term harm.

The impact of this increasing referral rate on the Trust's overall 2 week waiting list has effectively increased this by c 500 patients since Jan 20. The most recent Cancer waiting list position regarding urgently categorised patients presented are included in the table below. This confirms that all L1 patients (those with the highest clinical urgency) have dates for surgery to be undertaken and only 7.8% of L2 patients remain awaiting confirmation of a date to be provided.

Level of urgency	Number of patients on the waiting List	Number of patients on the waiting list with TCI date	Number of patients on the waiting list requiring TCI date
Level 1 (highest)	3	3	0
Level 2	750	691	59
Level 3 (lowest)	79	66	13
Awaiting Priority Level from CBU	32	21	11
Total	864	781	83

**Please note that the above excludes those patients who have been requested for a TCI through the cell that are non-cancer, and those who have had surgery at another Trust. The information held on the MWL is only as up to date as that provided to the cell by either Cancer Services or the CBU Teams.*

Changes over recent months in data capture systems relating to cancer surgery activity have highlighted some opportunities for strengthening arrangements going forward to improve interpretation of all aspects of performance data relating to cancer services going forward.

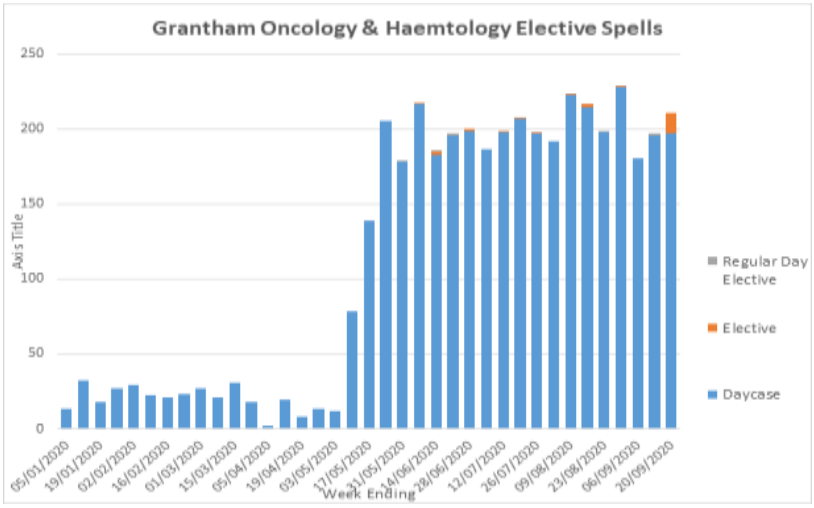
6.13 Chemotherapy activity:

The aim of the Grantham Green Site model was to continue to treat the 80 patients historically receiving chemotherapy at Grantham, whilst transferring the treatment of 1932 patients from Lincoln and Pilgrim.	RAG

The aim of the Grantham Green Site model was to restart Covid-19 Green site Chemotherapy in much larger volumes accommodating the circa 80 patients in Grantham and transferring other Chemotherapy patients from across Lincolnshire to the low risk site. 1932 patients were anticipated to receive treatment at the remodelled unit in Grantham.

This aim has been achieved in terms of the effective transfer of all patients previously receiving outpatient chemotherapy at Lincoln & Pilgrim being to Grantham. The exception to this is where patients require specialist acute inpatient care with Oncology teams that are part of an emergency spell, or where patients require multiple treatment regimes, such as Radiotherapy and the use of the Trusts Linear Accelerator (LINAC) treatments.

The graph below evidences the significant increase in chemotherapy (in episodes of care) activity undertaken at Grantham since mid-May. The timing of this increase in activity reflecting the Trust Board's endorsement of the Recovery plan for the trust and the immediate opportunities taken within Oncology to implement this plan. Some very positive feedback has been received from both patients and staff regarding this change.



6.14 Outpatient performance:

The aim of the Grantham Green Site was to increase the number of patients having a first outpatient appointment on site by 9000 per annum. This largely reflecting the potential from historical data on 1st OP appointments.	RAG

For the four weeks (17th August to 14th September) data shows a total of 2500 outpatients were seen at Grantham including 726 first appointments. Extrapolated for a year this suggests that the Trust is on-track to achieve this objective.

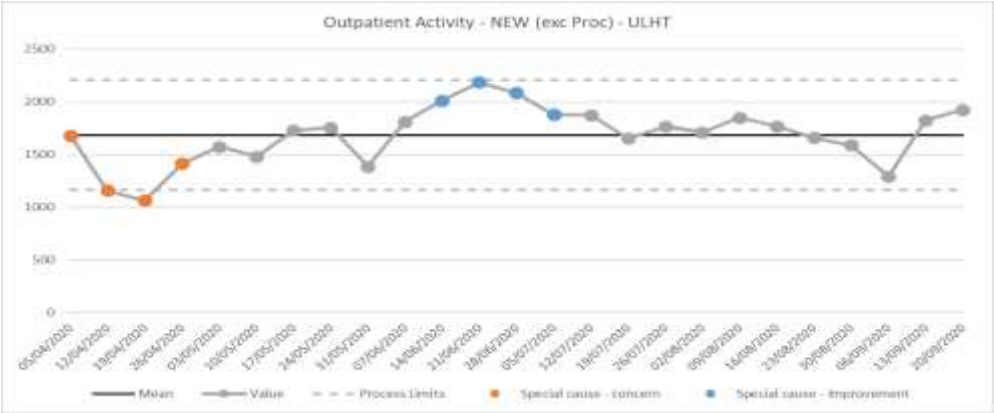
In addition to outpatient activity being run at Grantham hospital itself the introduction of the HealthCentre and Gonerby Road Health clinics have increased the number of services being offered locally in Grantham. The introduction of these new sites increases the number of face to face outpatient appointments delivered locally by a further 4500 per year. This is expected to increase with the completion of renovation works at Gonerby

Road facility, however provides a much greater spectrum of services above just those that are cancer or Green pathway; including
General Surgery,
Vascular Surgery,
Trauma and Orthopaedic,
Ophthalmology,
Dermatology and Paediatric Dermatology (some of which are provided from GP Surgeries locally)
Gastroenterology,
Clinical Physiology Tests,
Cardiology,
Neurology
As well as antenatal outpatient services.

During August 2020, 589 appointments were booked for these services although some of these were non-face to face clinics.

Recognising the impact that Covid-19 has had in accelerating the shift towards non-face to face appointments and the additional changes made to in-person services locally the Trust should reconsider how to evaluate the success, or otherwise, of the services locally. This should include inter alia agreement on a new set of KPI to evaluate success against.

The graph below shows overall 1st outpatient appointments Trust wide. The upward trend provides some assurance that activity displaced from Grantham as a consequence of the move to a different model is being delivered elsewhere.



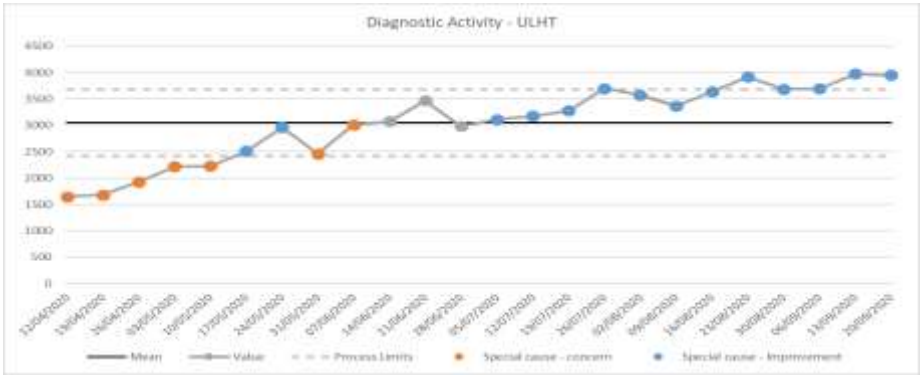
Similarly, the graph below representing the Trust's overall PBWL which quantifies the effect of Covid-19 on the increase in patients, clearly evidences the start of an improving position following approval of the Trust's Recovery plan, evidencing a c1000 patient reduction in the overall list to date. This reinforcing the importance of the Green site and Green pathways in operation across the Trust.

Harm reviews continue to be undertaken for time critical overdue patients to ensure patient safety is maintained with long waiting patients.

6.15 Urgent Diagnostic Endoscopy performance:

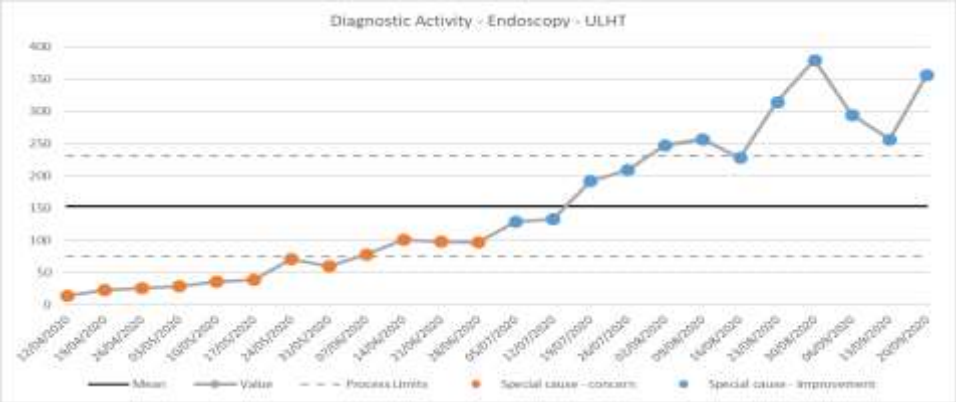
The aim of the Grantham Green Site model was to contribute to an increase in the trusts overall capacity to undertake urgent endoscopy work (June activity being 70% of normal levels). This to be achieved through the establishment of 12 hr sessions (x3 lists) 7 days a week.	

The trust wide performance regarding all diagnostic activity levels presents a context of significant increases in excess of 100% being delivered against previous years. This is the largest recovery of any trust in the Midlands and is demonstrated in the graph below.



Notwithstanding the tremendous increases in endoscopy activity since the beginning of the pandemic, the Trust's validated waiting list (as represented above) evidences a steady increase in patients referred over the last 8 weeks. This is anticipated to be a consequence of patients not presenting through the peak of Covid-19 now seeking GP assessment. For the most recent week reported a decline in waiting list numbers is reported indicating that the increased activity may be beginning to positively impact upon patient access and diagnosis.

Furthermore the graph below evidences the increase in endoscopy activity across the trust as prioritised within the Trust's Recovery plan of which Grantham increased activity is a key component. It is not possible however to definitively attribute this to the delivery of the Green site model.



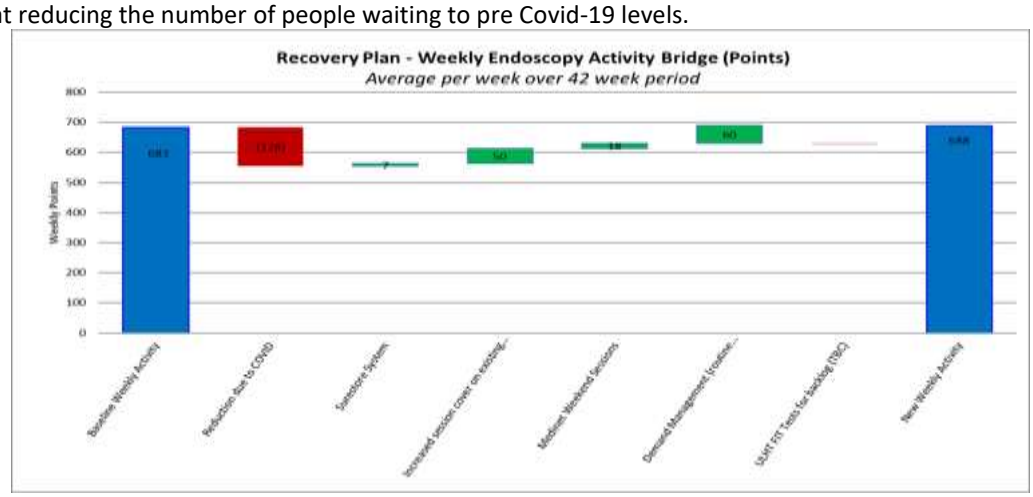
The indicative Grantham activity was predicated upon IPC standards in place at the time. It presented the potential for a maximum of 79% of available capacity to be utilised. Subsequent notification through national guidance regarding the recommended increase in IPC standards had the effect of significantly reducing the activity levels able to be achieved within given circumstances to a maximum of 48% utilisation.

Despite this the outcome being sought regarding the trust's ability to achieve urgent 2 week waits for diagnosis when cancer is suspected is now being achieved, which demonstrates that the trust's approach to increasing access to endoscopy has undoubtedly been effective through running additional lists (7 day working on alternate weeks) to off-set the in session throughput impact of augmented IPC standards. This model of working will be fully rolled out from end October 2020.

Since the reopening of the endoscopy suite, challenges with booking have also been recognised. These relate to availability of workforce to schedule bookings and some remaining safety concerns from patients resulting in cancellations. Delays experienced in receiving patient swab results have also resulted in patients being rescheduled for investigation at other sites on a 'blue pathway'. Operational teams have been focused upon resolving these issues, with no delays reported most recently due to swabbing issues.

It has been expected that the trust may receive in due course approval to implement nationally revised IPC standards which will increase potential capacity to 79%. At this point it would seem appropriate to remodel the target endoscopy activity for Grantham as part of the trust plans to further increase outcomes for cancer patients.

The graph below summarises the measures which currently form the Trust's overall endoscopy recovery plan aimed at reducing the number of people waiting to pre Covid-19 levels.



6.16 UTC performance:

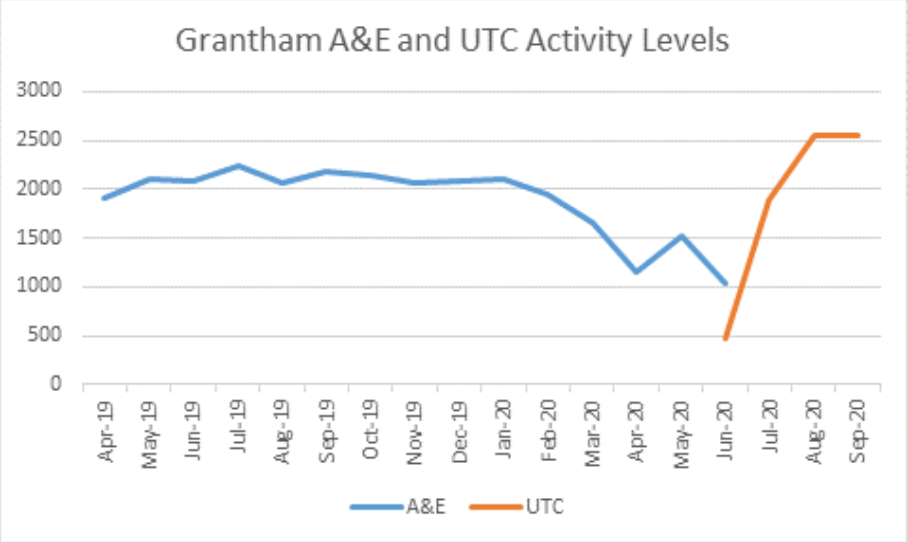
The aim of the Grantham Green Site model was to provide UTC services 24/7 to most patients who attended A&E – 20,014 attendances.	RAG

The original operational model estimated 81% of baseline levels of attendances (averaging 385 weekly) would be accommodated within the UTC. Up to mid-August, this performance was exceeded, with an average of 406 weekly attendances being recorded, representing an increase to 86% of the baseline utilising these new facilities. It is possible that the increase in hours the service was available may have impacted upon this increased performance.

Similarly, the original model anticipated that the admission rate from Grantham UTC would be 6.9% with the actual rate being recorded as 5.6%. We have been unable to quantify the proportion of patients going to other Trusts rather than an A&E within the Trust, although given the increased attendance and reduced admission rate from that projected, one might reasonably conclude that these numbers will be minimal.

Activity Levels

UTC attendance data has been overlaid against A&E activity during 2020 and is represented in the graph below. This clearly shows that attendance at UTC has continued to increase since opening, with an approximate 8% increase in patients now attending the UTC above the levels of these patients previously attending A&E on the site. This suggests that the perceived increased access to UTC services has been well received by local residents.



The Impact to Patients

In recognising the importance of fully understanding the impact of these changes for all patients an initial quantitative analysis has been undertaken on the impact to patients who may now be required to attend either Lincoln or Boston A&E. Data focusing on understanding the experience of patients who have been impacted by these changes needs to now be sought to enable further strengthening of this temporary model.

The table and graph below shows those patients with a Grantham postcode who have historically attended Lincoln A&E against current attendance. Interestingly, whilst attendance was generally below that experienced in 2019 there was a sharp increase in the month immediately following the temporary closure of the Grantham A&E and reclassification to a UTC, with numbers reducing for August. Close monitoring of these changes will be maintained.

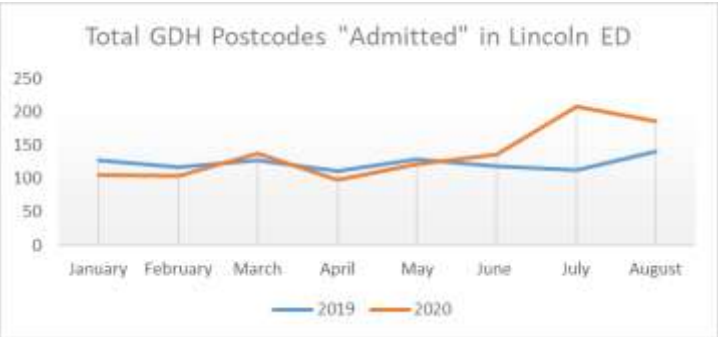
Total GDH Postcodes "Seen" in Lincoln ED

	2019	2020	Difference
January	278	259	-19
February	307	253	-54
March	291	298	+7
April	268	192	-76
May	303	251	-52
June	271	288	+17
July	292	451	+159
August	295	368	+73

Similarly, the table and graph below quantify those patients with a Grantham postcode who have historically been admitted via Lincoln A&E against current admissions. Again, whilst admissions were generally below that experienced in 2019 there was a sharp increase in the month immediately following temporary closure of the Grantham A&E and reclassification to a UTC, with numbers reducing for August. This may reflect the change to the 'stroke pathway' made in response to Covid-19 and the planned intention for Grantham patients with a suspected stroke to be assessed and treated at Lincoln, but close monitoring of these changes will be maintained.

Total GDH Postcodes "Admitted" in Lincolr

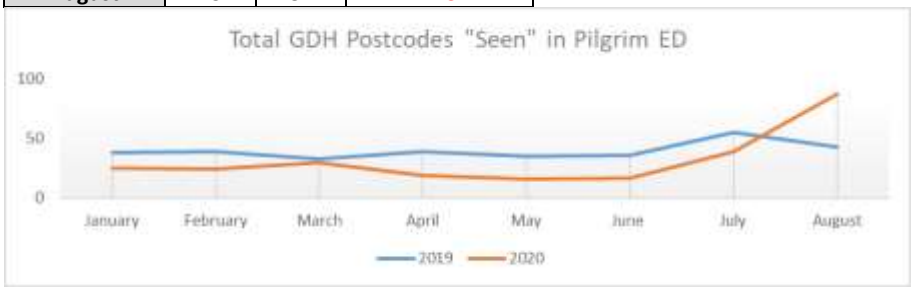
	2019	2020	Difference
January	128	105	-23
February	117	104	-13
March	128	137	+9
April	111	98	-13
May	129	121	-8
June	118	136	+18
July	113	208	+95
August	140	186	+46
Monthly Average	123	137	+14



A similar analysis of the impact of these changes for all patients who may now be required to attend Boston A&E is also presented below. The table and graph below quantify those patients with a Grantham postcode who have historically attended Boston A&E against current attendance. Interestingly whilst attendance was generally below that experienced in 2019 there have been increasing attendances since June with a sharp increase in August. Close monitoring of these changes will be maintained.

Total GDH Postcodes "Seen" in Pilgrim ED

	2019	2020	Difference
January	38	25	-13
February	39	24	-15
March	33	30	-3
April	39	19	-20
May	35	16	-19
June	36	17	-19
July	55	39	-16
August	43	87	+43



Similarly, the table and graph below quantify those patients with a Grantham postcode who have historically been admitted via Boston A&E against current admission. Again, whilst admissions have been generally below that experienced in 2019 there has been a trend of increasing admissions since May with a significant increase recorded for August which will be closely monitored.

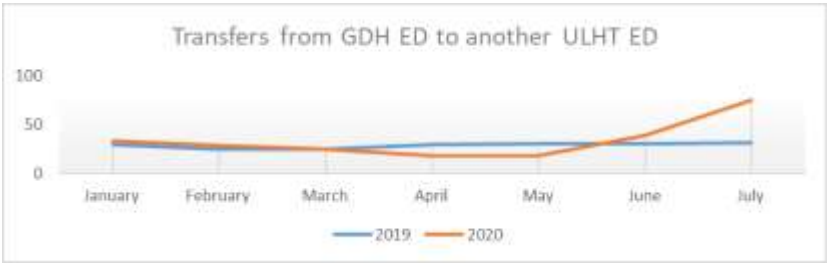
Total GDH Postcodes "Admitted" in Pilgrim ED

	2019	2020	Difference
January	15	15	**0**
February	19	16	-3
March	20	20	**0**
April	20	10	-10
May	19	9	-10
June	19	12	-7
July	27	20	-7
August	29	37	+8
Monthly Average	21	17	-4

The importance is recognised of the need to maintain the necessary data capture to continue to track and analyse the impact for all patients to inform ongoing review regarding these temporary changes.

Finally, the table and graph below quantify the number of ambulance transfers by ambulance from Grantham A&E to either Lincoln or Boston A&E. Whilst this activity has been similar for the last 2 years a significant increase in transfers required in the month following the closure of the A&E at Grantham is again noted and will require ongoing monitoring. It is noteworthy though that the combined total of all patients now going to other Trust A&E departments represents an overall increase of between only 1 – 2 patients each day.

Total Transfers from GDH ED to another ULHT ED		
	2019	2020
January	30	33
February	25	29
March	25	25
April	30	18
May	31	18
June	31	39
July	32	75



Whilst the review can confirm that the indicative activity proposed for the extended 24/7 UTC has been achieved, the initial indication of the impact upon local patients is something that the Trust will wish to monitor closely to understand fully the clinical quality, safety and experiential impact of this change. Close working with the Community Trust to ensure a comprehensive evaluation continues to inform opportunities for strengthening this temporary model and the timing and nature of any further improvements.

6.2 Quality & Safety

Systems and processes pertaining to maintaining a safe environment for all patients at Grantham are predicated upon robust IPC arrangements to maintain the site Covid-19 free. A commitment was given within the proposals for a Green site for all aspects of the IPC Board Assessment Framework (BAF) to be met. Systems are in place 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 posed by their environment and other service users. In the absence of any reported concerns regarding the safety of patients at Grantham, assurance will now be sought to evidence the consistency of systems and processes in place across Grantham to escalate and report any concerns, incidents or near misses. Currently the Trust has assessed the following aspects in detail relating to all services at Grantham:

1. The provision and maintenance of a clean and appropriate environment in managed premises that facilitates the prevention and control of infections
2. Appropriate antimicrobial in use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance
3. Provision of 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
4. 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
5. 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

6. Provision of secure adequate isolation facilities
7. Adequate access to secure laboratory support as appropriate
8. Implementation of policies designed for the individual's care and provider organisations that will help to prevent and control infections
9. Systems in place to manage the occupational health needs and obligations of staff in relation to infection

Detailed evidence has been presented to the CQC regarding the establishment and effectiveness of these standards, with confirmed regulatory satisfaction if they are assured all appropriate IPC standards are in place.

A further strategic review of IPC standards across the Trust has been undertaken as part of this review the details of which can be found in **Appendix 2**. A focused review of IPC standards at Grantham should now be undertaken as part of the developing performance management framework recommended to be developed.

6.3 Patient & Staff Experience

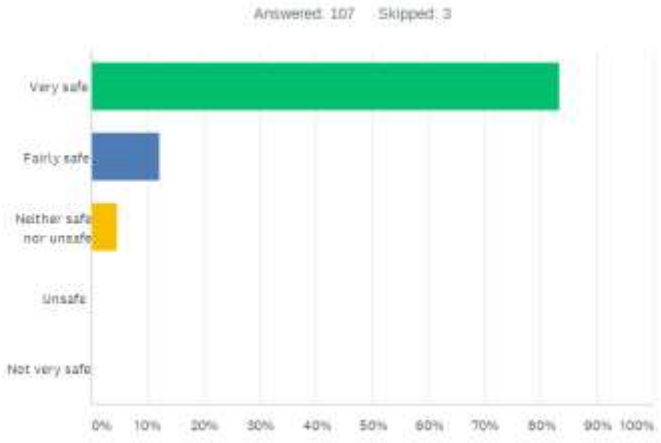
Patient Survey:

To understand the impact of the temporary service change on patients, an initial patient survey has been undertaken with 110 responses received, representing an extremely small sample of the patients treated at Grantham since June.

The findings show that most patients found it easy to access the hospital by car, primarily to receive chemotherapy. Patients reported that they had confidence in the medical, nursing and therapy care and treatments they received, and no patients indicated that they felt unsafe regarding the steps taken to manage Covid-19. Indeed, many examples were offered regarding good IPC practices observed as being in place.

Pleasingly the key question that asked patients to rate how safe the changes to IPC and pathways made them feel received excellent scores with 95% reporting feeling very or fairly safe.

Q. We have taken a number of steps to manage the risk of COVID-19 including cleaning and hygiene, social distancing, personal protective equipment and testing' How safe have these measures made you feel?



Many individual members of staff were individually recognised and praised for the positive impact they made to the individual's experience at Grantham.

> *"All staff made my visits to chemo wonderful and felt very safe all the time"*
>
> *"All staff were very kind and understanding"*

However, some specific practical suggestions were offered regarding how facilities for relatives accompanying patients could easily be improved upon, which the operational team are seeking to immediately address.

> *"A lack of access to toilet facilities for my relative whilst waiting for me to complete treatments"*
>
> *"My husband has to wait in our car for six/seven hours whilst I receive my treatment. This is not good and especially with the winter coming it is very difficult and uncomfortable for him"*

More broadly the Trust may wish to consider a more routine approach to seeking feedback from patients attending Grantham, ensuring all specialties are included, to provide a more comprehensive view of services and how any changes/improvements have been received to inform further developments.

Staff Survey:

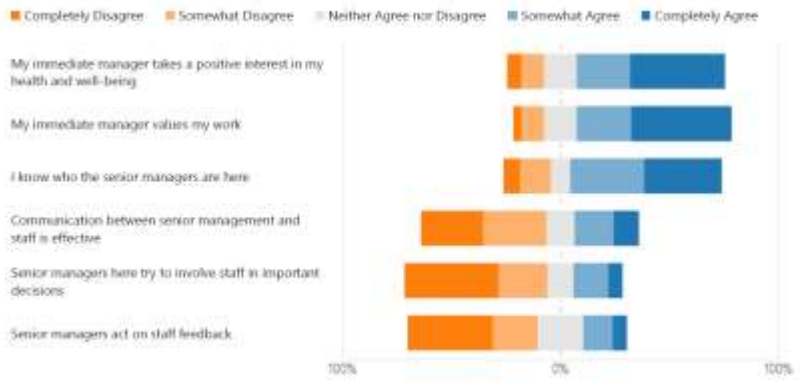
A survey of staff working on the Grantham site (not including UTC or ACU staff) has also been undertaken, with 157 responses received. This represents a 75% response rate from the staff identified within the model as being retained on site although it has been suggested that the overall number of staff currently working on the site might be nearer 600. It is noted that the number of passes issued to staff to access the site has been significantly reduced from c3000 to c1200, with the possibility that the views of staff visiting the site might also be helpful going forward to further strengthen the temporary model.

Understanding the views and differing perceptions of all staff involved in delivering services at Grantham could be very helpful in both evaluating the impact of service changes and inform options going forward. Similarly, the trust might wish to consider how one seeks to understand the experience and perspectives of those staff relocated from the Grantham site to ensure a balanced picture be developed regarding the experiences of staff to inform ongoing development and provision of services.

Notably the responses received included significant additional detailed suggestions and examples that would suggest a commendable level of commitment from local staff to further improve services at Grantham. The development of a more effective and sustainable approach to engaging with staff that have moved from or remain working on the Grantham site, would establish a more dynamic way of evaluating and developing services to be provided from Grantham going forward.

Analysis of responses received present mixed levels of confidence in the steps taken to manage risks of Covid-19 at Grantham Hospital. Specific concerns relating to the consistent application of IPC standards potentially impacting upon the safety of the environment for patients are taken seriously by the divisions with issues regarding systemic reasons for concerns appropriately escalated to the corporate team. As expected, most staff have reported as being directly affected by the changes; with workload, levels of support available, communication and effect upon mental /emotional health being identified as most significantly impacted.

Staff feedback positively recognised the extent to which immediate managers both valued and were interested in individuals' health and well-being with a clear area for improvement identified for senior managers to strengthen existing levels of engagement and communication with staff, specifically in terms of actions taken in response to feedback received. This is shown in the chart below.



The Executive team are currently actively exploring these finding with a view to determining what action is required to address these themes and the specific additional concerns and suggestions provided by staff. This including liaison with LCHS to ensure the views of UTC staff are sought and fed into the process of wider consideration. Whilst it is anticipated that many of the specific issues raised by staff can be clarified or addressed swiftly, some of the issues pertaining to the clinical model in place will necessitate wider engagement and discussion to understand fully the nature of concerns to identify the most appropriate actions to be taken. Given the consistency of themes within this local survey and wider trust surveys, it will be important to ensure that any actions taken in response to specific feedback from staff regarding Grantham are cognisant of those being developed and taken as a direct consequence of the finding from the National survey considered by the trust board in September. Oversight from the trust's Governance committee would be helpful in this regard.

Engagement with Trade Unions

Following engagement and consultation with TU s in advance of formal presentation of the Green site proposals in June, Executive representatives have continued to meet weekly with Staff Side Representatives to ensure their ongoing involvement in evaluating the implementation of the model. TU s have been asked to present the detail of their members views so that these may be considered alongside the views available from staff and patients. Specifically, the Chief Operating Officer will be meeting personally with Staff Side Representatives to discuss the final draft of the review paper intended for presentation to the Trust Board. This level of engagement will continue to ensure the full impact on staff of any changes are fully understood to inform ongoing evaluation.

Quality & Equality Impact Assessments:

Following both strategic QIA & EIA being undertaken and presented to the trust board in June to support decision making, 3 further QIAs and EIAs were additionally undertaken pertaining to services at St Barnabas, Medical services and the UTC. All assessments have a range of mitigating actions documented. A review to confirm that mitigating actions have been completed is scheduled in the next two weeks

Whilst it was recognised that considerable detailed work was undertaken at pace to support the development and subsequent approval of proposals, it was noted that all impact assessments were undertaken by the same individuals all of whom represented a corporate perspective. It is suggested that the trust now can develop its approach to reviewing decisions taken at pace, to ensure that these assessments undertaken are revisited with the benefit of divisional and clinical perspectives to strengthen both the evaluation and the identification of mitigations for identified risks. The reestablishment of a project group as an effective vehicle for achieving this would seem appropriate.

6.4 Recognition and Response to Public Concerns

Specific Concerns raised by the Public:

All individual concerns raised by parties to date to the trust board at its extraordinary meeting in June 20 have been responded to directly and in full either in the meeting at that time or in writing by the CEO. Confirmation

of these responses and a description of those answers given on the day were published on 7th July at its Board meeting held in public. These have subsequently been shared with the wider leadership team, with consideration being given to enable learning from these to influence future actions.

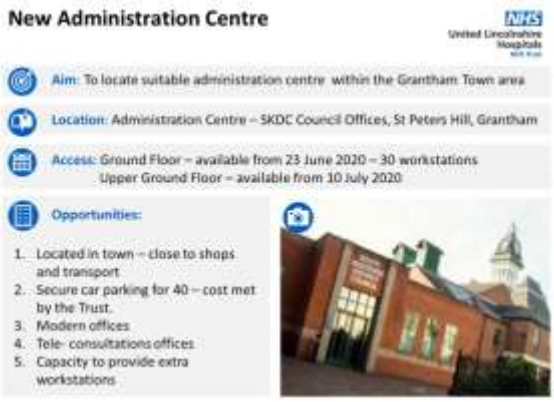
A number of these concerns raised have led to additional measures being put in place such as;

- The implementation of dedicated transport services for patients to and from Grantham Hospital via a new Patient Transport Service contract with Ambicorp Ltd. a CQC licensed independent patient transport provider.
- Maternity and Paediatric services have been restored at the Grantham Family Health Centre and additional services for the Grantham Green site itself for most vulnerable patients.
- Additional outpatient services have been restored at Clinical Assessment and Treatment Centre at Gonerby Road in Grantham reducing the need to travel to services at PHB and LCH hospitals.
- In addition to Grantham Green Site Surgical services the Independent Sector are supporting the Trust at the BMI facility in Lincoln and Ramsey in Boston.

Specific Concerns raised by Elected Representatives

Concerns have been expressed by local elected representatives that have focused upon the impact to residents requiring to travel to services to be moved from the Grantham site. The importance of these concerns has been recognised by the Trust and as previously mentioned the intended strategic development of several new sites away from the Grantham site, but within the Grantham locality have been completed and are in operation. These strategic developments reflecting the increasing choice of Lincolnshire patients to access services at Grantham in addition to operationally offering significant opportunities for increasing local access to services for Grantham residents than were originally committed to within the proposals approved in June. These developments serve to maintain the highest level of protection and IPC standards on the Green site, continue to restore services suspended during the manage phase of the epidemic and reduce both patients and staff need to transfer to other hospital sites across Lincolnshire.

These 4 new sites described below describe the main function location and timescales of when services occupied them:



6.5 Financial

A process of rapid senior decision making with analysis of risk, benefit and signed off by executive and clinical directors has been in place since the Emergency Level 4 Response nationally was confirmed on 30th January. The business case developed for the Grantham Green site model and all associated expenditure has been approved as per existing SFIs and the summary of expenditure to date is provided below:

Additional Investment Approved to Strengthen the Grantham Green Site Model 20/21

Costs	One Off	July to March	Total
Grantham Health clinic	29,080	50,862	**79,942**
SKDC Council Offices	64,280	127,155	**191,435**
Units 4,5 &6 Hill Court Estate	51,237	82,822	**134,059**
Conversion of Gonerby Health Clinic	877,060	68,801	**945,861**
Purchase of three mobile clinical trailers	25,040	18,043	**43,083**
Vine Street	2,000	56,682	**58,682**
Mobile X ray	0	0	**0**
COVID Pods	8,391	211,649	**220,040**
Total	**1,057,088**	**616,013**	**1,673,101**

Description	20/21	21/22	22/23	23/24	24/25
Total Capital	127,550	0	0	0	0
Capital Charges	6,631	13,296	13,166	12,839	12,512
Total direct Pay costs	0	0	0	0	0
Total direct Non Pay costs	1,666,470	20,332	0	0	0
Cost reductions	0	0	0	0	0
Income	0	0	0	0	0
Total Revenue	**1,673,102**	**33,627**	**13,166**	**12,839**	**12,512**

Current expenditure levels are reported as totalling £1,673,102 for 20/21, A detailed review of these costs and projections ahead is scheduled to be undertaken for next week.

7.0 Assessment of Original Decision within Current Conditions

Design Principles:

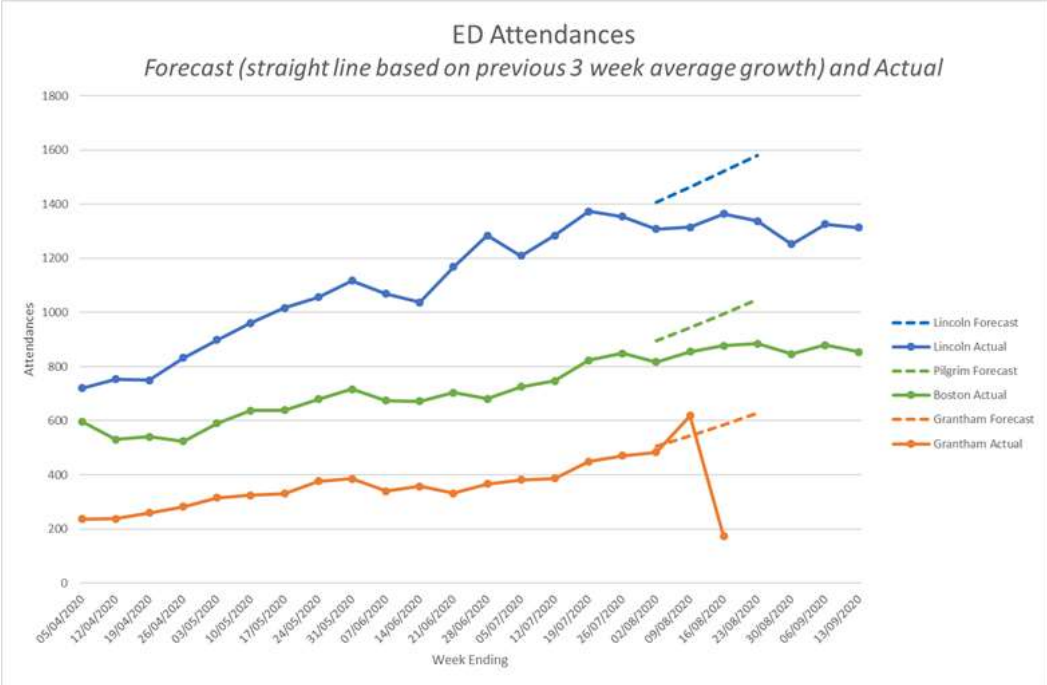
Given that the NHS Covid Alert level has recently been raised again to Level 4, reflecting the National picture of increasing numbers of Covid-19 and the trust remains in Phase 3 *Recovery* it is suggested that the 3 conditions upon which the Operating Model was predicated and indeed the design principles upon which options were evaluated remain as relevant and given the current conditions Nationally, are as important now as the time the original decision was taken.

Current transmission of Covid-19:

Currently the daily cases of Covid- 19 are rising steeply across the UK, projected as doubling every 7 days; current hospital admissions and deaths remain low. In response to this the government has introduced more stringent measures to reduce transmission with the government's chief scientific adviser and medical adviser forecasting a significant number of deaths – 200 per day by the end of October without further interventions. Given this emerging prevalence and if the National Covd-19 response phase remains at L3 – Recovery Phase, the necessity of a Green site will potentially become increasingly important to maintain and strengthen to optimise the undertaking of routine surgical and potentially medical services.

Temporary Reclassification of A&E to UTC:

The relevance of A&E attendances remains important context regarding the temporary reclassification of A&E to a UTC on the Grantham site, with ongoing monitoring of increasing activity key to assessing the ongoing appropriateness of the UTC. The graph below presents the growth in A&E attendances because of the Covid-19 epidemic. This shows that the growth rate has slowed in recent weeks to around 90% of seasonal pre-Covid levels. Please note that the Grantham UTC attendances drop then disappears due to data recording being moved to an external LCHS system. It will be important to ensure UTC activity data is available to the trust going forward to fully evaluate the impact of this temporary change and enable effective response to future A&E demand.



Existing Criteria for the Return of GDH to Pre-Covid-19 Model:

The trust has documented explicit criteria against which the original proposals in June were assessed and any question regarding the continuation of the temporary changes implemented at Grantham would be evaluated. The detail of these criteria and subsequently developed measures and trigger points to instigate formal reassessment are detailed in the next section.

8.0 Criteria, Measures and Triggers to Assess the Continuation of The Grantham Green Site Model or the Return of GDH to Pre-Covid-19 Model:

At the June 11th Extraordinary Board meeting the proposed model of care was agreed should run temporarily until 31st March 2021. Within that same proposal was a confirmation that there would be a quarterly review (this document) where the model would be evaluated against a set of criteria designed to indicate either a change to the model is required or a complete revert back to previous model should commence.
The below criteria was developed that reflects when circumstances either within the Trusts control or outside of their control would require the model to change or revert back to previous model.

The trust's original criteria to determine the return of Grantham Hospital to pre Covid-19 model are represented below:

- Regional or National Incident Override – where through the NHSE/I Command structure a request is made to revert to the pre Covid-19 model.
- Covid-19 alert level reduces to L2.
- Impact to other organisations - resulting in a request for mutual aid directly relating to the temporary model.
- Identified risks of threat to life or limb are identified with existing models of care.
- Overall waiting lists for Cancer patients reaches standards for 31 & 62 day, with all other treatments/surgeries reduced to pre Covid-19 levels.
- Winter pressures lead to activation of the surge plan – where emergency bed base, critical care demand and/or staffing requirements for critical care is not satisfied with Grantham model.

The fast changing national position regarding prevalence of Covid-19 and the introduction of tighter restrictions to reduce transmission, presents an extremely challenging and complex environment within which the trust must seek to both continue to deliver against existing priorities to restore service delivery whilst revisiting contingency plans in the event of guidance changing. Under these circumstances the criteria above remain wholly appropriate, with the importance being to strengthen current methods and mechanisms for evaluating specific aspects of performance within the context of the Trust's overall performance such that the most informed decisions may be taken by the Executive team and Trust Board in due course.

The list of criteria below has been designed in such a way that any one single would trigger the need for a change or complete revert back to previous model.

Trigger	Rationale	Measure or Indicator
○ Where Regional or National Incident Directives state this model is either incompatible with a model of care or where through the NHSE/I Command structure a request is made to revert to the pre Covid-19 model	Whilst working within emergency measures either at national Emergency planning level 3 or 4 the Trust must respond to regional or national directives.	Directive from NHSE/I either via MIDSEAST or national Command Centres/Incident Directors.
○ Where Impact on other health organisations results in a request for mutual aid directly relating to the temporary model.	Where consequences of the model have unintentional impact on other organisations to a level requiring formal mutual aid for cessation or change of the current model.	Formal Aid Request via the Local Resilience Forum.
○ Where substantial previously unidentified risk is identified with a threat to life or limb within the existing models of care.	Where new risks are identified that indicate a substantial threat to loss of life or limb that had not been identified there is a need to urgently review and potentially change/cease the current model.	Completed Risk Assessment that indicates an inability to mitigate risk through countermeasures.
○ Overall waiting lists for Cancer patients reaches levels to support 62 & 104 day treatment standards, and incomplete waiting lists reduced to pre Covid-19 standard.	Where the Trust has responded completely to the pandemic incident and restored services to levels of care within safe constitutional standards the current model should be reviewed and consideration be made to reverting back to pre-covid models.	62 day Backlog Patients <40 patients 104 day backlog <10 patients Incomplete waiting list < 37,762
○ Covid-19 alert level reduces to L2 or below	L2 Covid-19 Alert level reducing would indicate a substantial decrease in the risk of Covid-19 being acquired in the community and subsequently in hospital. This would reduce the need for such high IPC measures and would trigger a consideration of change of model or revert back to previous state.	Covid-19 Alert Level <=2
○ Activation of the Trusts Full Covid-19 Surge Plan	The impact of a subsequent wave of Covid-19 or other winter extreme demand events (including a Major Incident) could trigger the need to convert all Inpatient Capacity and re-task supporting services to Covid-19 or Urgent and Emergency Care facilities.	OPEL L4 Indicators for the system.

These 6 criteria have been designed to consider all known scenarios that should lead at first to a consideration of amendment of the model which in turn may lead to reverting back to the original pre-Covid-19 model. They are sufficiently broad to consider the full range of risks to stakeholders internally (patients) and externally (other organisations in our and out of NHS Midlands). The measures or indicators used as evidence to trigger are not greatly sophisticated in nature, but are considered to be highly visible and easy to communicate so as to easily alert the Trust to a need to consider its response differently.

The fast changing national position regarding prevalence of Covid-19 and the introduction of tighter restrictions to reduce transmission, presents an extremely challenging and complex environment within which the trust must seek to both continue to deliver against existing priorities to restore service delivery whilst revisiting contingency plans in the event of guidance changing. Under these circumstances the criteria are wholly appropriate. The National *expectation that local intentions to restore elective services will continue for as long as possible, reflects a 'window of opportunity' for the trust to continue providing services for the benefits of all patients across Lincolnshire. This approach further reinforced following a letter received this week from the National Strategic Incident Director advising trusts to continue to strengthen local efforts to re-establish elective services whilst reviewing local escalation plans in anticipation of increasing hospital admissions.*

8.1 Evaluation of Current Circumstances:

Previous sections of this report have described outcomes delivered as a result of the model of care put in place at the beginning of July 2020. In order to ascertain whether the triggers for change in model/revert back to pre Covid-19 model have been met the below table evaluates data available and provides statements of fact against each criteria.

Trigger	Current State	Has the Indicator been Triggered?
1. Where Regional or National Incident Directives state this model is either incompatible with a model of care– where through the NHSE/I Command structure a request is made to revert to the pre Covid-19 model	No directives have been received by the Trust to date suggesting incompatibility with the current temporary model. Subsequent guidance sent through MIDSEAST and from national teams support the use of Green Sites.	No
2. Where Impact on other health organisations results in a request for mutual aid directly relating to the temporary model.	No requests for mutual aid have been received. Regular reviews of patients accessing other organisations urgent care services as a result of the temporary model indicate a lesser impact than that described in the June 11th proposal.	No
3. Where substantial previously unidentified risk is identified with a threat to life or limb within the existing models of care.	No new substantial risks have been identified.	No
4. Overall waiting lists for Cancer patients reaches levels to support 62 & 104 day treatment standards, with all other waiting lists reduced to pre Covid-19 levels.	Reductions in waiting lists for cancer have occurred and all initial surgical waits have been treated or seen in alternative services. On the 24th September 2020	No

	62 day Treatment Standard backlog was at 280 against a trigger of 40 or less 104 day Treatment Standard backlog was at 42 against a trigger of 10 or less Overall waiting list levels reported 44,393 against a trigger of 37,762 or less	
5. Covid-19 alert level reduces to L2	National Covid-19 alert increased to L4 on the 22nd September 2020	No
6. Activation of the Trusts Full Surge Plan	Although the Trust has frequently increased escalation levels to OPEL 3 at LCH and PHB sites in recent weeks there have been no occasions where OPEL4 levels have been reached on a system wide basis.	No

Noting that these statements have been made about a specific position at a specific time, it is apparent that no criteria have been met that would suggest the need to substantially change the temporary model put in place or revert back to pre-Covid configurations.

9.0 Findings & Recommendations

The complex implementation of the Grantham Green site model within 2 weeks of approval was as a direct consequence of the significant efforts and commitment of many corporate and divisional colleagues which given the environmental challenges presented by Covid-19, were nothing less than outstanding.

Whilst the aims and intentions of the Green site model remain sound, the opportunity to revisit and strengthen existing arrangements for refining patient flow projections, revisiting specialty activity targets and developing the coordination and consistency by which performance is measured and reported upon is one that the Trust is recommended to take now.

Whilst there is no doubt that the services approved within the Green site model have been implemented as intended, the full effect of these changes upon staff, Grantham residents, patients, other sites and services provided by the Trust remain to be fully quantified and understood. Whilst these interdependencies may be complex, strengthening the approach to evaluation going forward as is outlined within the recommendations below will help to developing a clearer understanding that will inform both organisational and system wide decision making as the NHS continues to respond to the Covid-19 pandemic.

There is a clear opportunity for reflection on the findings from this review to benefit from the translation of the learning from the planning and implementation of the Grantham Green model by informing the approach to other developments and changes being considered by the Trust to ensure that the translation into wider organisational learning is not lost.

Decision Required:

The Trust Board is invited to approve the primary recommendation to continue with the Green site model at Grantham, recognising the review of the specialty findings presented within this paper and the prevailing context regarding Covid-19 which have been assessed against the criteria, measures and triggers detailed within the report.

In the event that approval is given to the primary recommendation, the Trust Board is additionally invited to approve 6 further recommendations pertaining specifically to the operation and implementation of the Grantham Green Site Model and 3 further Corporate recommendations that directly relate to the Green site model.

Primary Recommendation regarding the Grantham Green site model:

1. Given the Trust Board is invited 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.

Subsequent Recommendations regarding the Continuation of the Grantham Green site model:

Site Specific

2. 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

3. 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.
4. 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.
5. 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.
6. 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.
7. 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.

Corporate

8. 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.
9. Ensure any future need to redeploy staff is based upon clear corporate criteria relating to skills and need, to promote **fairness and equality**.
10. 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.

Clinical Model

IPC Excellence facility supporting a range of surgical activity including

- General Surgery
- Urology
- Breast Surgery
- Gynaecology

With smaller numbers of

- ENT
- OMF

Vascular Surgery and Paediatrics not supported in Restore at GDGH.

Casemix will vary weekly according to clinical prioritisation and be scheduled centrally in Restore.

Cohorting of specialty activity to provide speciality presence over several days to facilitate speciality cover for ward areas and support IPC excellence

A combination of day case and inpatient activity covering 2 28 bed areas, namely Ward 2 and Ward 1.

Green workforce supported by careful adherence to IPC principles and embedded culture of IPC excellence. Screening by wellbeing assessment including temperature check at start and end of each shift. Swabbing if symptomatic or for contact tracing. Programme of random staff swabbing to screen for asymptomatic carriers. Defined protocol for migration of staff between sites (especially surgical teams) to ensure no Blue to Green transfer on same day. Risk assessment for staff not currently in patient-facing roles due to previous risk assessment to facilitate work at IPC excellence site.

Medical cover provided by foundation grade doctors drawn from existing Grantham team. Existing Hospital at Night team to provide out of hours ALS cover with middle tier perioperative medical practitioner cover on call drawn from existing GS/Anaesthetic middle tier doctors. Speciality on call cover and arrangements for postoperative review of inpatients defined by individual specialities. Inpatients will require daily specialty review.

ACU functioning as 6 bed Level 1 postoperative care unit PACU (with outreach facility to support inpatient areas) Medical cover from on site anaesthetic staff (in hours) and middle tier perioperative medical practitioner cover on call drawn from existing General Surgery/Anaesthetic middle tier doctors. Defined SOP for escalation of ward patients into ACU and utilise existing SOP for transfer to L2 / L3 facility if required.

4 theatres operating 5 days a week initially with a view to 7 day working. Lists initially running from 09:00 – 18:00 (soft cap, intention to complete listed activity). Medical staffing of operating lists 8 – 18.00 to accommodate preop visits, consent etc. On call team for out-of-hours returns supported by on call non resident consultant anaesthetist and on call consultant surgeons as per agreed specialty models. Review of planned activity to ensure appropriate facilities (eg laser point), equipment (clinical engineering stream) and staffing skill mix.

Support in theatres from radiography for Urology, and occasional other use. Overnight on call radiographer required for ward / ACU (portable chest xray)
Radiology Support for breast surgery – wire guided and Sentimag machine

Histopathology function to support specimen processing from theatres

Chemical pathology function to support ward requests (including urgent out of hours), outpatient bloods and preassessment including phlebotomy

Haematology function to support ward requests, outpatient bloods and preassessment; blood bank to support elective surgery (including urgent out of hours)

Microbiology function to support ward, theatre and preassessment samples, including arrangements for urgent processing/transport of samples.

Clinical measurement function to support ward, outpatient and preassessment function with ECG.

Pharmacy function to support day case, inpatient and ACU areas and 4 theatres 5 days a week. Additional support for day case chemotherapy unit.

Preassessment function to support elective surgery including telephone assessment where possible. Includes arrangements for self isolation and swabbing (including home swabbing/CCG led swabbing).

Additional services in Green areas

Hospice	Utilises existing staffing arrangements
Day Case Chemotherapy	CSS managed; existing staffing arrangements; SOP needed for deteriorating patients
Endoscopy	CSS led; existing staffing arrangements; SOP needed for screening and for deteriorating patients
Outpatients including Emerald Suite	CSS led remote consultations and defined SOP for screening face to face attendances
Rehab Unit	Ward 6 area (following redevelopment) – therapy led facility for IPC green patients; level of nursing support to be defined. SOP to be defined for medical emergencies/deteriorating patient. Implementation later in Restore

Medical staff movement

Existing foundation tier to be reallocated to surgery (12 doctors) supporting ward work and overnight ward cover. Exception is 3 A&E F1s who will support UTC.
Model to be revisited for August rotation and numbers likely to reduce significantly
Existing Anaesthetic consultant and middle tier (14 doctors) supporting theatre activity. Anaesthetic consultant non resident on call supporting returns to theatre / PACU deterioration/transfer

Existing surgical middle tier (7 doctors) supporting theatre activity.
Anaesthetic and surgical middle tier supporting out of hours ward cover including PACU – this does not include the ST5's who support the Lincoln acute work. Workforce of 11 doctors (3 vacant posts at present)
Surgical consultants support theatre work along with visiting specialty teams. Post operative specialist cover defined by specialty.
Orthopaedic CONS and SAS reallocated to other sites / support OP activity at GKGH. Specialty to define.
Medical and speciality medical CONS, SAS, IMT and CT reallocated to other sites / support OP and endoscopy activity at GKGH. Specialties to define in conjunction with CSS.
A&E CONS and SAS support UTC model – any extra resource reallocated

Infection prevention and control board assurance framework

27th September 2020 Version 2

Infection Prevention and Control board assurance framework

1. Systems are in place 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 posed by their environment and other service users			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • infection risk is assessed at the front door and this is documented in patient notes • patients with possible or confirmed COVID-19 are not moved unless this is essential to their care or reduces the risk of transmission • compliance with the national guidance around discharge or transfer of COVID-19 positive patients • patients and staff are protected with PPE, as per the PHE national guidance	All patients are screened on admission to the organisation. Those who are suspected COVID-19 are cared for in dedicated wards Patients with suspected or confirmed COVID-19 are placed on dedicated wards or placed in isolation room on other wards if deemed clinically necessary The Trust has been consistent in following national guidance on discharges and has supported social care discharges with a supply of PPE for 72 hours The Trust has followed PHE national guidance throughout the pandemic	Swabbing not a perfect method of screening Asymptomatic cases have been detected Some initial gaps in notifying discharged patients with swab results There have been occasions where supplies have been running low.	The Trust allows for other diagnostic evidence such as CT or X-ray and clinical picture to be considered pending re-testing If an asymptomatic case is detected, close monitoring of contacts is undertaken System now in place with Local Authority Public Health to notify post discharge patients of results The Trust has sufficient supplies of all types of PPE and is building alternative and compliant PPE for future demand

• national IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way • changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted • risks are reflected in risk registers and the Board Assurance Framework where appropriate • robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	The Trust has subscribed to automated updates and has notified incident commanders at daily briefings with relevant updates cascaded through SBAR communication tool and live webinars Changes to PHE guidance are discussed with strategic commanders and any necessary adjustments or communications are agreed through daily meetings. The Trust BAF and risk register have been updated to reflect the current issues and signed off at subcommittee and board External additional support for non-COVID-19 IPC activity has been sourced by the DIPC.	This work is part of an ongoing refresh piece of all IPC functions & compliance with the hygiene code, currently assurance is limited	IPCT continue to monitor and manage HCAI cases including RCA investigations for alert organisms. Refreshed IPC group in place. Terms of reference approved and will be ratified by Quality & Governance Committee on 19 May 2020. Strengthened reporting arrangements in place
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			

• designated teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas	Designated cohorting and isolation areas with specifically allocated teams to reduce the risk of transmission These teams are further supported by IPCNs QM Clin Ed		
• designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas.	All relevant housekeeping staff are trained to work in these areas. training sessions are recorded		
• decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance	In conjunction with IPC areas when identified, are cleaned in line with PHE guidance. Chlor Clean and HPV fogging	Historically there was no deep clean process in use Rolling programme in situ across all sites to undertake deep cleaning as wards become empty	New process for deep clean currently being implemented with a defined deep clean schedule and accompanying SOP
• increased frequency of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance	Increased cleaning is in place across all sites/areas during this pandemic in line with the Deep cleaning protocol		New deep clean process now includes hydrogen peroxide vaporisation (HPV) and staff have been trained to use it appropriately
	All Linen is treated as infectious and is managed using soluble laundry bags double bagged in a clear outer sack to be transported to the laundry. It is then		To increase collection from designated areas and

• linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken • single use items are used where possible and according to Single Use Policy • reusable equipment is appropriately decontaminated in line with local and PHE and other national policy	laundered as infectious laundry by the 3rd party laundry service	Infectious linen builds up in COVID-19 ward areas Currently No decontamination lead appointed within the Trust	remove to areas to await collection by 3rd party IP Team have written and updated cleaning and decontamination of medical equipment at ward level and have produced guidance at a glance to assist staff to clean and decontaminate equipment at ward level
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and process are in place to ensure: • arrangements around antimicrobial stewardship are maintained • mandatory reporting requirements are adhered to	Ongoing and strengthened accessibility to Antimicrobial Pharmacists for advice on antibiotics and infection management for all staff including junior doctors 7 day working PGME and pharmacy reminders, newsletters, tweets, very good uptake of this availability.	ASSG meeting cancelled in April as rooms bookings were over-ruled for COVID cells and other organisational purposes without options. ASSG held virtually in May. Productive but not quorate. Nothing to sign off but have progressed some actions	Direct contact from persons requiring ASSG input for antimicrobial stewardship, encouraged by request for virtual returns as enquired if anyone in group

and boards continue to maintain oversight		and had opportunity for updates.	
	C.Diff walk arounds halted, but have been taken over by phone calls to discuss patient where required with the lead consultant.		
	RCAs being held at Lincoln for all C.diff cases have antimicrobial input	Not got same assurance for PHB and GDH New RCA documentation and process launched across all sites including DDIPC /DIPC and Multi-disciplinary Rapid Review Group	New Antimicrobial Pharmacist at PHB will be assigned to pick these sites up for RCA input virtually with support of existing antimicrobial pharmacists if needed Specific training to be launched for new RCA process for senior management teams to enhance knowledge and understanding of process
	Antimicrobial stewardship and requests for advice. Virtual platforms used more frequently by pharmacists seeking advice on the wards – mobile, office line, skype, teams, whatsapp groups. Includes frequent requests for advice from Rowlands Outpatient Pharmacists. Comms sent out re availability over mon-sun have had good response and uptake.		
	PII audit(s) still prioritised and completed. Virtual communications with clinical teams and very good response. Confident no gaps in this assurance		
	Repeat PII audit planned and will be prioritised despite pressures, with ward pharmacist involvement	Unable to complete PII investigation with Ribotyping, would be very helpful in drawing further conclusion	

	Non-essential (or non-mandatory) Antimicrobial Stewardship audits halted to avoid risk to patient safety due to inaccessibility to patient medical notes and to reduce unnecessary footfall on wards. Junior doctor projects registered with Clin Governance largely concluded, some have actions of final report remaining, which will be completed once pressures are manageable.	and assurance for antibiotic prescribing assessment	
	Ongoing contribution in virtual DTC, working to sign off guidelines related to antimicrobials, providing input in developing safe and effective documents, with feedback mechanisms. Rapid updates sent out around COVID and antimicrobial stewardship – evidences PGME emails, newsletter and pharmacy advice	Usually would be captured in team brief and educational update sessions	Provided updates by email instead. Working on further means of communicating these to increase awareness Sent updates to PGME and all pharmacy staff for sharing with all relevant staff
	Commenced work on an antimicrobial app procured by pharmacy, and being led by Antimicrobial Pharmacy team using STP funds. Collaborative effort captured in the 'long term plan' to improve AMS and support organisations across the patch. Will help with C.diff and ESBL bacteraemia rates related to correct antimicrobial use – governance process to be finalised via DTC before release/launch	COVID priorities have slowed antimicrobial team on antimicrobial guideline work COVID interruption of DTC and PACEF access pathways may impact on governance sign off, but will	Specific resource funded via SPT has been ring-fenced for populating the microguide app, pending governance sign-off, using existing Trustwide guidelines New antimicrobial pharmacist started Mid May will be part of effort to

	Review of paediatric antibiotic guidelines out of date by 5 years. Commenced work on this but halted by COVID	be pursued as virtual set up is formalised for these committees	prioritise this work on guideline review
	Review of adult antibiotic guidelines due this year and requires some updates to bring in line with NICE	Will need to secure microbiologist review and Pathlinks sign off	Antibiotic guideline review will also address some of the feedback from end-users where clarity was requested
	Surveillance continues		
		Extrapolation against occupied bed days and admissions may be skewed on system used for surveillance	Using various means and parameters for extrapolation to ensure good level of confidence in surveillance and trends identified
	RECOVERY trial input including screening patients and advising on antimicrobial choices that have been made, next steps etc. Commas sent out via Trust, pharmacy, and STP		
	Follow up of patients with support of ward pharmacists, including complex patients on microbiology radar		
		Educational sessions for pharmacy teams halted, and will need to be re-developed depending on means of delivering them amid social distancing	All antimicrobial advice requests include educational aspect on rationale behind this advice and is acknowledged as being very helpful. Evidence of pharmacy colleagues applying this rational in their daily work, as notable difference in those who request advice frequently

	OPAT of patients where feasible	Some issues with premature and error in handover of patients amidst COVID rotas which could have impacted patient outcomes, and have required safety mechanisms to be used.	Tightened OPAT criteria to reduce risk of recurrence, at expense of delays to OPAT but important for patient safety

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

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
Systems and processes are in place to ensure: • implementation of national guidance on visiting patients in a care setting	In line with national recommendations, the Trust suspended visiting with controlled exceptions i.e. end of life visiting	Some issues remain on rules for visitors bringing in patient possessions	The Trust has developed a protocol for acceptance of patient possessions
• areas in which suspected or confirmed COVID-19 patients are where possible being treated in areas clearly marked with appropriate signage and have restricted access	Dedicated wards have been in use for both suspected and confirmed COVID-19 patients. The Trust has a place based approach to PPE precautions so all clinical areas take the same precautions regardless of the COVID-19 status of any patient		A series of laminated door cards are in use for identification of isolation and staff considerations when entering and leaving the rooms alongside PHE COVID-19 relevant Posters distributed through the Communication team
• information and guidance on COVID-19 is available on all Trust websites with easy read versions	There is a link on the Trust website front page taking the user to the national NHS COVID-19 page.		
		Initial gaps in communication were identified both for	

• infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	The status (known at time of transfer) of each patient is communicated to the receiving organisation. This includes when swab results are pending.	discharge home and to social care	Local Authority Public Health now communicate results to discharged patients. Discharge protocol in place
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			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms to minimise the risk of cross-infection	Each ED has a designated streaming process for patients with suspected COVID-19.		
• patients with suspected COVID-19 are tested promptly	All patients admitted to ULHT are swabbed on admission.	Some patients have tested positive but have been asymptomatic	Swab turnaround times are less than 24hrs meaning patients can be quickly isolated
• patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested	The Trust follows national guidance in relation to the management of patients who may have either a diagnostic or clinical presentation consistent with COVID-19. In	Atypical presentations can cause delays in diagnosis	This has now been largely mitigated by the inclusive testing of all admitted patients

• patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	these cases, patients are isolated and re-swabbed Patients attending for planned care appointments are requested to shield for 7 days prior to appointment. The patient is then swabbed 48hrs prior to the planned intervention. If the patient is positive or has symptoms consistent with COVID-19, they will be deferred and a new appointment made.	Some anecdotal evidence from a nearby Trust identified that some patients became symptomatic shortly after their procedure meaning they were likely positive during their appointment	All reasonable precautions are in place and are in line with national guidance
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			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • all staff (clinical and non-clinical) have appropriate training, in line with latest PHE and other guidance, to ensure their personal safety and working environment is safe	The Trust uses the published videos and posters provided by PHE to ensure that PPE is correctly used. There is a continuous programme of fit testing in all Divisions to ensure that staff can use all FFP3 mask types issued.	There is no control over the type of PPE received by the Trust from NHS Supply Chain including FFP3 masks. This means some risks exist of having sufficiently fit tested staff on a given mask type	The Trust is procuring reusable respirator masks that can be issued to individuals (400 + 23 Hoods). This will negate the need for high volume repeated fit testing
• all staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely don and doff it	All staff who require fit testing attend training. The Trust uses the PHE videos and posters to assist with training relating to selection, donning and doffing of PPE	High FFP3 fit test failure rate in some areas. Lack of choice with masks further restricting fit tested staff available for a given shift	The Trust has purchased 2 quantitative fit testing kits. These kits can confirm a fit test pass or fail without the reliance on the human factor to smell/taste the fit test solutions

• a record of staff training is maintained • appropriate arrangements are in place that any reuse of PPE in line with the CAS alert is properly monitored and managed • any incidents relating to the re-use of PPE are monitored and appropriate action taken	Staff fit testing records are held by Divisions and recorded on Health Roster While arrangements are in place (the published PHE guidance), the Trust has not yet introduced the reusing of PPE The Trust is currently not reusing PPE however if needed, it would follow PHE published guidelines	Health Roster does not include medical staff.	Evidence of fit trained staff held by clinical areas
• adherence to PHE national guidance on the use of PPE is regularly audited • staff regularly undertake hand hygiene and observe standard infection control precautions • staff understand the requirements for uniform laundering where this is not provided for on site • all staff understand the symptoms of COVID-19 and take appropriate action in line with PHE and other national	The Trust has consistently abided by the national PHE PPE guidelines and daily reports on PPE usage are supplied to the COVID-19 Tactical Cell The Trust has employed Personal Safety Champions (PSC) to visit all areas to ensure staff are adhering to hand hygiene, PPE, cleanliness and social distancing. Reports are provided daily The Trust has provided soluble red laundry bags to all staff who take uniform home to support safe laundering practices. Staff self-isolate and contact Occupational Health if they experience any symptoms consistent with COVID-19. The Occupational Health team also support national guidance in relation to	There is still evidence of inappropriate PPE use however this has significantly reduced The PSC team work across all sites however out of hours is not fully covered. Outbreak management of staff following on from contact both at work and socially requiring screening and isolation	Personal Safety Champions provide reports on challenges around inappropriate PPE usage and provide immediate training in the work place. Infection Prevention has a dedicated hand hygiene audit system in place completed and submitted by each ward/department across the Trust relating to the WHO 5 moments of hand Hygiene IPTeam have been undertaking regular weekly support visits to ward areas reviewing social distancing, PPE, Hand hygiene, staff social areas

guidance if they or a member of their household display any of the symptoms.	symptomatic household contacts and support staff isolation.		Outbreak management plan and working and supporting teams including occupational health in a more collaborative manner sharing information and communicating on a wider level
7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate	Dedicated suspected or confirmed pathways have been established. This starts at ED and is facilitated throughout the Patient stay.		
• areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance	Designated suspected and confirmed COVID-19 wards have been identified. If a Patient needs care on their base ward, suitable isolation facilities are required.	Many clinical areas are in need of refurbishment	Processes have been agreed (awaiting business case) for the complete refurbishment of 3 wards and environmental upgrades of a further 12 wards across the Trust
• patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	Patients identified with an alert organism or resistant organism are managed as per Trust policy.	Review of alert organism and Gram –ve BSI plans are in progress but not complete	External support for review of IPC function has been sourced by DIPC
8. Secure adequate access to laboratory support as appropriate			

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
There are systems and processes in place to ensure: • testing is undertaken by competent and trained individuals	Molecular testing is undertaken within the microbiology section of Path Links laboratories which have UKAS accreditation and which are applying for an extension to scope for COVID-19 testing as part of the regional network. HCPC registered BMS staff are undertaking and overseeing the testing. Full validation and verification has been undertaken, and V&V documents, SOPs, training records and manufacturers' information documents are available on request**.**		
• patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance	PHE guidance is used as the framework for testing, although some locally arranged additional testing has been taking place. NHSE is co-ordinating across the MidE2 network. Current turnaround time is 13-18 hours from receipt of samples.		
• screening for other potential infections takes place	Demand management has been implemented according to national guidance, and according to the attached letter. Samples of limited clinical value are not being processed, but CPE screening and MRSA screening from high risk contexts is ongoing. We are reviewing the situation in light of "business as usual"		

	guidance, balanced with the additional workforce pressures and demand upon the laboratory.		
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure that: • staff are supported in adhering to all IPC policies, including those for other alert organisms • any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff • all clinical waste related to confirmed or suspected COVID-19 cases is handled, stored and managed in	The Trust provides daily updates (SBAR) and the Exec team host Facebook Live events to provide advice and information to staff. The Trust has also deployed Personal Safety Champions who visit all areas on all sites to ensure there is good practice on hand hygiene, PPE use, cleanliness and social distancing. The IPC team continue to support wards and departments with regular visits to ensure that non-COVID-19 infections are properly managed. The Trust has subscribed to the automated PHE update system and once notifications are received they are reviewed and escalated to the DIPC and COVID-19 Gold command. Any necessary actions or adjustments are communicated as soon as practicably possible From the outset, the Trust has followed national PHE guidance on waste segregation. This is also in line with the national specification HTM 07-01 (Management of Healthcare Waste)	IPC policies need review to support staff. The Trust annual IPC plan and structure is in need of a review.	The DIPC has sourced an external support to review and refresh the Trust IPC policies. Systems and processes New Policies are being uploaded to the IPC intranet pages along with new innovation of Guidance at a glance to support salient bullet points as a reference for staff with more in depth advice contained in the policy The IPC and Procurement teams have worked to source alternative types of PPE (masks and gowns) that meet the same or better PHE standards. This has meant that stocks are more manageable.

accordance with current national guidance • PPE stock is appropriately stored and accessible to staff who require it	PPE is stored centrally and controlled by the Trust procurement teams. There is a PPE 'hotline' so staff can access PPE stocks at short notice. A daily PPE stock report is produced which includes a tracker for each line item stating the number of days stock available.		

		There have been occasions when stocks of PPE have	

		decreased to dangerous levels	
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Appropriate systems and processes are in place to ensure: • staff in 'at-risk' groups are identified and managed appropriately including ensuring their physical and psychological wellbeing is supported • staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained • staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing • staff that test positive have adequate information and support to aid their recovery and return to work.	As a Trust we are proactive in recognizing the risk to our staff of Covid19 and provide an action plan that is supportive of their physiological and mental health needs at this time. Individual managers are aware of the risk to our staff and provide time for conversation surrounding the anxieties this may cause for some staff signposting for additional support as required, seeking the advice from Occupational Health, where appropriate the counselling service and wellbeing service offered by the Trust. This includes BAME staff. All staff absence is recoded and on two data bases. All staff who are self-isolating will be contacted by their line manager OH and HR also Maintain contact with individuals considered at greater risk. All staff are offered a swab test. Priority is given to staff and Household members isolating for 10 and 14 days.	Staff testing through national testing centres is difficult and appts and timeliness of results is poor	Staff are tested through in house NHS testing Labs commissioned for patient services managed by Occ/Health

	All staff are called personally by a Nurse from Occupational Health to support them on having a confirmed positive test. They are offered support through wellbeing and counselling		

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Report to:	Trust Board
Title of report:	Quality Governance Committee Assurance Report to Board
Date of meeting:	22nd September 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 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
	Lack of Assurance in respect of SO 1a Issue: Deliver harm free care **Incident Management Report including SI Never Events** The Committee noted that incident reporting remained in line with the national average and reporting was presented in further detail. The number of open patient incidents had increased over then month and 88% of actions remain open however a significant amount of work to increase the pace on actions was underway. The Committee were advised that the Never Event that had occurred in July was identified as having been reported in August due to the incident occurring so late in the month. The Committee noted the 1631 overdue actions arising from incident investigations and further information would be provided to the Committee through KPIs. A review of the level of risk on the register regarding patient safety regulations and standards was required and a number of open actions would require work to be undertaken in order for them to be closed. The Patient Safety Group were working through the recommendations within the report. A training need had been identified within the divisions in order to support and address the number of open actions, this would ensure greater sight and transparency of issues.

	Never Event Report The Committee were pleased to receive the report demonstrating an increased level of detail and noted that the number of outstanding actions had been reduced. Work was underway in relation to safety culture and improvements were starting to be seen. A key element of this would be observation and human factor issues. The Committee were advised that the Theatre Safety Group had been established and were conducting observations which were consistent with the feedback from the Compliance Team in January, this would be fed back to the Committee. Action requested by the Committee: The Committee requested an overview paper regarding the safety culture work which included timelines **Mortality and Learning from deaths** The Committee received the mortality data noting that the impact of Covid-19 had made the data difficult to interpret. It was positive to see an improvement in SHMI but there had been an increase in crude mortality and HSRM due to Covid-19. The Committee noted the improvement of medical examiner screening toward 90% however key issues remained within mortality. There would be a need to provide focus in order to improve the experience and effectiveness of care patients receive. **Harm Review process – including ethnicity** The Committee received the thematic review noting that the Trust had had a relatively small number of patients with Covid-19 compared to other regions with higher figures. The review had included ethnicity as requested previously by the Committee and it was noted that due to the population of the county having a smaller BAME community, mortality had been no different for ethnic groups. **Safeguarding Assurance Report** The Committee noted that there was a focus on safeguarding training plans and that the terms of reference for the group had been reviewed. The group proposed to change its name in order to provide better oversight. The Committee wished to understand the requirement of the group as either an operational or assurance group in order to approve the terms of reference. The Committee received the Safeguarding Annual Report. The report reflected that there had been great work over the past 12 months and

	this had been done with a limited resource. The Committee approved the annual report for onward submission to the Board. **Infection Prevention and Control Assurance Report** The Committee received assurance that water flushing continued across the Trust and the compliance remained the same as the previous month. The Committee were notified that there had been a non-clinical outbreak of Covid-19 among staff and an outbreak process was being undertaken. **Nursing, Midwifery and Allied Health Professional Forum Assurance Report** The Nursing and Midwifery draft framework had been signed off through all nursing and midwifery routes. This provided the answer to what outstanding care looked like and how it was known that this was being delivered. 4 themes had been identified from staff feedback and included within the framework. This would provide a direction of travel for nursing and midwifery staff for the coming 2 years. The Committee strongly supported the improvement and innovation and welcomed the framework. **Clinical Effectiveness Group Assurance Report** The report to the Committee described areas of good practice and concern. Good compliance with VTE was reported however there were a number of Serious Incidents relating to VTE. This suggested that there was good compliance with reporting but further work was required to address actions. Concern was noted regarding the lung cancer audit where the Trust were below the national standard. This would be revisited at the next meeting of the group. The first Do No Harm report had been received and the group would review this in relation to medical devices and report through to the Committee. The Committee raised concern regarding divisional representation at the group noting that there needed to be a clear approach to the groups reporting to the Committee. **Patient Safety Group Assurance Report** The Committee received the patient safety group upward reporting noting the assurance from the nutritional group in relation to NG and NJ bundles and training programmes being rolled out. Thematic reviews had commenced with insulin and diabetics the first to

	be undertaken. The Committee were advised that complaints reported to the group and there continued to be ongoing issues regarding staff attitude and behaviour. The Complaints Manager would work with Organisational Development in order to address the theme. The group would now be inviting divisions to attend the meeting when themes were identified in order to be able to identify how these will be actioned. The Committee noted concern relating to IR(ME)R licence expiries for practitioners and whilst there had been no harm to patients these were reportable to the CQC. The Committee were assured that action was being taken to address the issue however raised concern that there may be other lapses in licencing that had not been identified. The Chief Operating Officer as Chair of the Radiation Protection Group was taking action to review licencing.
	Lack of Assurance in respect of SO 1b Issue: Improve patient experience **Patient Experience Group Assurance Report** The Committee received the assurance report noting that this did not provide the expected level of assurance. The Committee agreed to defer the report along with the terms of reference for the patient panel and patient experience group. The Committee considered the new approach to patient stories within the Trust. The proposal was for patient stories was to ensure there was a clear understanding of the issue, action and follow up with the patient. This was proposed to be managed through the medium of video recording as a way in which to build a library of patient stories. There was a need to focus wider than complaints as a route for patient stories and these also needed to focus on staff. The Committee were keen to retain the Q&A aspect of patient stories in order that Board members could react and respond to the story that had been heard. The Committee supported the proposed approach to patient stories and support from the Communications team would be sought.
	Assurance in respect of other areas: **Family Health Division and Paediatric Assessment Unit** The Committee received a presentation from the Family Health Division Triumvirate in order to appraise the Committee of the current position and to present the progress of the division following a cultural shift. There is significant clinical support for the Paediatric Assessment Model and it was anticipated that there would be a move to recruit 2 further

	substantive consultants. There had been an indication for Health Education England that tier 1 trainees would return to Pilgrim Hospital. The proposed model presented to the Committee was for short stay with discharge within 24 hours and a move to day case surgery with a 24 hour observation opportunity that would sit alongside a clear criteria. This would mean that patients would be discharged within a maximum of 48 hours. The division had engaged with stakeholders and the local campaign group in relation to the new model and whilst there would not be a move away from the PAU model this would be flexed with a longer term plan developed. Lincoln PAU would now be developed and there was consultant buy in however a senior decision makers would need to move to 7 day working. The division hoped to have something in place for the winter period with a PAU running 5 days per week from 1st October with a view to moving to 7 day working. A further paper describing the patient benefits and changes over the past 6 months would be developed and reported back to the Committee prior to reporting to the Board. The Committee supported the onward development of the model and reporting through appropriate governance processes. The Committee also received an update on Maternity CNST noting the expected re-launch in October following a pause due to Covid-19. The Committee wanted to consider this in more detail, this would be received back to the Committee in October. **Maternity Dashboard** The Committee received the maternity dashboard noting the rise in the Trusts C-section rate, it was noted however that this was not outside of national parameters based on benchmark data from 2017/18. A monthly review of C-section and induction rates was undertaken and had increased recently, mostly due to the increase in mothers with diabetes. Work on the management of post-partum haemorrhage in theatres was in place and it was hoped that this would have a positive impact on the report rates. The Committee requested that SPC charts be included with the data in order that trends could be viewed alongside data however it was clear from the reporting received that issues were being monitored and managed by the division. The Committee received an update in relation to the Healthcare Safety

	Investigation Branch (HSIB) and advised that intelligent oscillating partogram training was in place to address the issues identified. Draft copies of the reports from HSIB were awaited. The recent inquest was also discussed and actions are being taken by the division, it was intended that the Medical Director and Director of Nursing would be engaged to consider further actions required. **Referred item from Board Committee** The Committee discussed the referral from the Finance, Performance and Estates Committee to review liver biopsy's. The Committee noted that these were being reviewed through the appropriate processes and would be reported to the Committee via the Patient Safety Group in October. **Committee Performance Dashboard** The Committee noted that Falls and Pressure Ulcer panels were providing scrutiny and quality review meetings would commence from November. Discussion was held regarding a move from month specific narrative to trend narrative with the Committee being advised that work was underway to review the KPIs and ensure these were aligned to the IPR, IIP and CQC. **Medicines Management Internal Audit Progress Report and Plan** The Committee received the updated plan including milestones. It was noted that this would rely on upward reports from the Medicines Quality Group to provide assurance on the progress of actions. The Medicines Quality Group had now recommenced and the Committee looked forward to receiving reports and seeing movement against the actions. **CQC Update** The Committee noted that work was underway to ensure that the Trust was prepared for an inspection at any time. Work was ongoing with the Divisions to conduct confirm and challenge meetings. Progress appeared to have slowed with the action plan but the Committee were reassured that this was due to the realignment of the action plan. **Clinical Governance Review** The Committee received the clinical governance review commissioned by the Director of Nursing which would be discussed by the Executive Leadership Team. The review provided some clear immediate short and long term actions to move to an improved positon. Work was underway to pull the recommendations in to an action plan and the Committee noted that this would build on what was already in place within the organisation.

	The Committee will further consider the report, bringing back to the October Committee, prior to making recommendations to itself and any referrals to other Committees and the Board. **Update NHSI Committee/Group Actions** The Committee reviewed the NHSI Committee/Group actions noting that this should be reviewed in the context of the clinical governance review and ensure that maintenance of the actions and continual review was in place via the Committee terms of reference and work programme to ensure sustained improvement.
Issues where assurance remains outstanding for escalation to the Board	None
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 noting the new report format which provided greater assurance. There was confidence that risks were being reviewed however there did not appear to be movement of the ratings. Work was underway with the clinical governance team to move forward updates on the risk register and a focus would be provided to ensure accurate actions and mitigations were captured. The Committee accepted the risks reflected those discussed in the Committee.
Matters identified which Committee recommend are escalated to SRR/BAF	None
Committee position on assurance of strategic risk areas that align to committee	The Committee considered the reports which it had received which provided assurances against the strategic risks to strategic objectives.
Areas identified to visit in dept walk rounds	No areas identified.

Attendance Summary for rolling 12 month period

Voting Members	O	N	D	J	F	M	A	M	J	J	A	S
Elizabeth Libiszewski Non-Executive Director	X	X	X	X	A	X	X	X	X	X	X	X
Chris Gibson Non-Executive Director	X	A	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
Michelle Rhodes/ Victoria Bagshaw Director of Nursing	X	X	X	X	X							
Simon Evans Chief Operating Officer									X	X	A	X

X in attendance A apologies given D deputy attended

Meeting	*Trust Board*
Date of Meeting	*Tuesday 6th October 2020*
Item Number	
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 & Patient Safety Group (September 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	
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)*
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 number of open patient incidents on Datix as of 4th September 2020 was 1,670 (up by 158 since last month)
- This number of open patient incidents has been increasing over the past 3 months, since the backlog was cleared, as only around 65% of investigations are being completed within 4 weeks of being reported
- 58% of open patient incidents are overdue
- 17 Serious Incidents were declared in August, including 1 Never Event, which means that there are now 54 on-going and 32 awaiting CCG review and approval following submission of completed investigation reports
- 2 independent SI investigations (both occurring within Maternity) are currently being investigated by the HSIB
- As of 4th September 2020 there were 1,631 overdue actions arising from incident investigations recorded on Datix
- As of 15th September 2020 there were 41 open actions relating to Never Events, of which 38 were overdue; further details are included in a separate report to QGC
- Recent Divisional Investigations are being prioritised, with a thematic review of older incidents to identify scope for potential learning
- A report on the implications of the new national Patient Safety Incident Response Framework (PSIRF) and a gap analysis against current ULHT policy and procedure is being undertaken and will be reported to the Patient Safety Group in October

1. Purpose

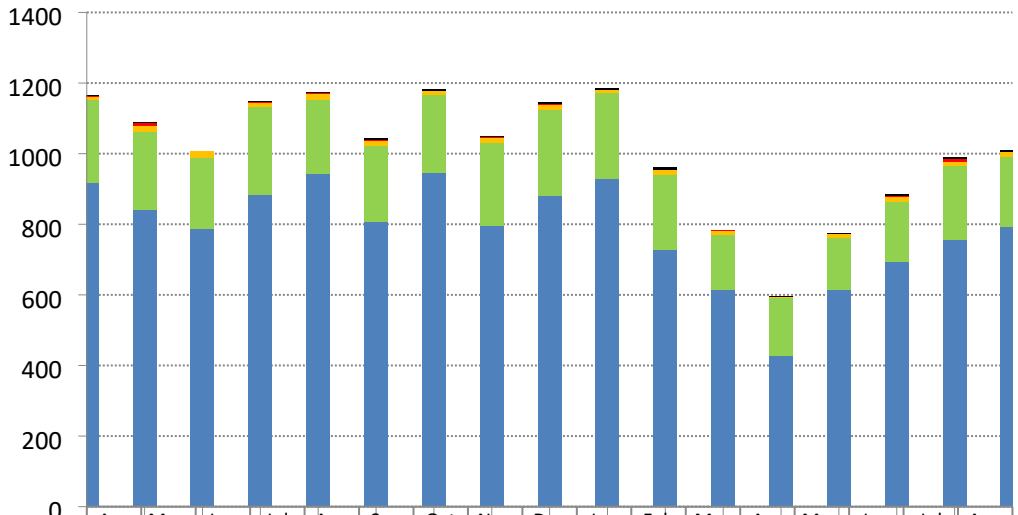
1.1 The purpose of this report is to enable the Trust Board to review the effectiveness of the Trust's incident management policy and procedures (including the management of Never Events and other Serious Incidents).

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 incident investigations

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
5 - Death	1	2	0	2	1	4	3	2	3	4	8	0	1	1	3	4	4
4 - Severe Harm	2	8	0	4	2	2	1	3	1	1	0	1	0	0	4	6	0
3 - Moderate Harm	11	15	19	11	17	16	12	15	15	8	12	11	4	12	13	12	14
2 - Low Harm	235	223	201	247	211	213	220	234	244	243	214	157	162	147	171	212	200
1 - No harm	916	840	788	885	942	808	947	796	881	929	727	614	429	615	693	755	792

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 incidents reported each month of the 2020/21 financial year to August is 850. 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 78% of incidents reported by the Trust resulted in no harm; 20% in low harm; and less than 2% in moderate harm, severe harm or death. This is also in line with the national average.

3.5 **Table 1** shows a breakdown of the 1,670 open patient safety incident investigations (as of 4th September 2020) by division and Clinical Business Unit (CBU) or corporate department, and the change since last month's report (on 4th August 2020):

Division & CBU	Open patient incidents	Change
Medicine Division	**754**	**+72**
Urgent & Emergency Care CBU	481	+82
Specialty Medicine CBU	223	-18
Cardiovascular CBU	55	+13
Surgery Division	**358**	**+38**
Surgery CBU	113	-5
Theatres & Critical Care CBU	132	+43
Urology, Trauma & Orthopaedics and Ophthalmology CBU	113	-
Family Health Division	**176**	**+14**
Women's Health and Breast CBU	137	+5
Children & Young Persons CBU	39	+9
Clinical Support Services Division	**338**	**+18**
Diagnostics CBU	86	+3
Outpatients CBU	75	+10
Cancer Services CBU	61	-16
Pharmacy CBU	47	+5
Therapies & Rehabilitation CBU	6	+2
Pathology (Path Links)	57	+14
Corporate Services	**44**	**+5**
Operations	14	-
Estates & Facilities	11	-1
Nursing Directorate	10	+3
Medical Directorate	6	+1

Division & CBU	Open patient incidents	Change
Finance & Digital	2	+1
HR & OD	1	+1
Total	**1670**	**+158**

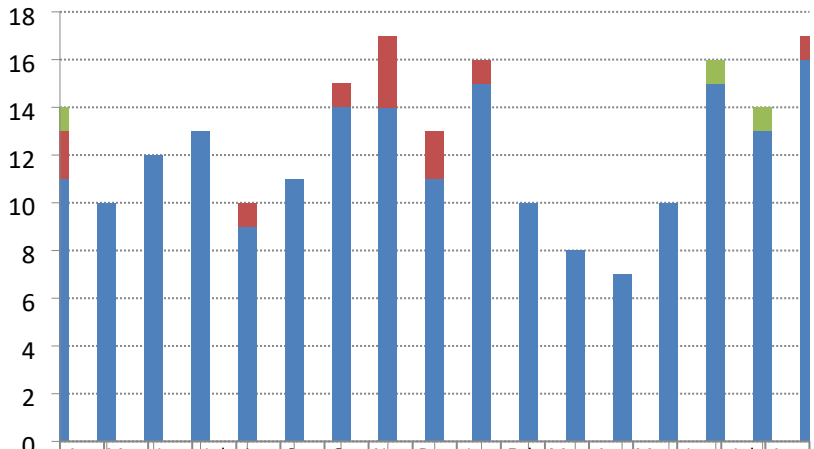
3.6 This represents an increase of 320 open patient incidents in the last 2 months, showing that the current approach to reviewing incidents in a timely manner is not sufficiently effective. Unless action is taken urgently to address this issue, the number of open incidents will continue to rise and the risk of potentially serious patient safety concerns not being responded to will also increase.

3.7 Of these open patient incidents, 58% were reported on Datix prior to the start of August 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 54% overdue last month. 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	% overdue
Clinical Support Services	230	68%
Corporate	36	80%
Medicine	413	55%
Surgery	219	61%
Family Health	78	44%
TOTAL	**976**	**58%**

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
Independent Serious Incident investigation (StEIS)	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0
Never Event Serious Incident (StEIS)	2	0	0	0	1	0	1	3	2	1	0	0	0	0	0	0	1
Serious Incident (StEIS)	11	10	12	13	9	11	14	14	11	15	10	8	7	10	15	13	16

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 17 Serious Incidents, including 1 Never Event, in August 2020. This was the first Never Event to be declared in the 2020/21 financial year to date. It concerned the retention of a guidewire following placement of a naso-gastric tube and is currently under investigation.

4.4 There were 10 Never Events declared by the Trust in 2019/20. **Table 3** shows a summary of all Never Events declared by the Trust in 2019/20 and 2020/21 (to the end of August 2020):

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 17 months 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 Incidents (StEIS) open	Change (this month)	Complete, awaiting CCG approval
Medicine	29	+3	21
Surgery	16	+2	6
Family Health	7	-1	1
Clinical Support Services	3	-	4
TOTAL	**54**	**+3**	**32**

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. It should also be noted that during the earlier stages of the Covid-19 pandemic response the Trust agreed CCG the following changes to the standard 60 working day deadline for completing Serious Incident investigations:

- 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. Improvement actions

5.1 As of 4th September 2020 there were 1,631 overdue actions arising from incident investigations recorded on Datix (these are actions with a due date up to and including August 2020), an increase of 31 since the previous month. This is out of a total of 1,855 open actions arising from incidents (a reduction of 11 compared with the previous month). This means that 88% of agreed actions are currently overdue (up from 86% last month).

5.2 **Table 5** shows a breakdown of all open actions from incidents, by division and CBU:

Division & CBU	Total	Overdue
Medicine Division	**1149**	**998**
Cardiovascular CBU	95	84
Specialty Medicine CBU	478	412
Urgent & Emergency Care CBU	576	502
Surgery Division	**318**	**280**
Surgery CBU	150	126
Theatres & Critical Care CBU	15	12
Urology, Trauma & Orthopaedics and Ophthalmology CBU	153	142
Family Health Division	**153**	**147**
Children & Young Persons CBU	31	31
Women's Health and Breast CBU	123	116
Clinical Support Services Division	**110**	**91**
Cancer Services CBU	77	63
Diagnostics CBU	21	21
Outpatients CBU	6	2
Pharmacy CBU	2	2
Therapies & Rehabilitation CBU	3	3
Pathology (Path Links)	1	0
Corporate Services	**124**	**115**
Digital (ICT)	1	1

Division & CBU	Total	Overdue
Estates & Facilities	9	8
Human Resources & Organisation Development	2	2
Nursing Directorate	1	0
Operations	111	104
TOTAL	**1855**	**1631**

5.3 There are 41 open actions relating to Never Events as of 15th September 2020, of which 38 were overdue (compared with 127 out of 132 that were overdue last month). Detailed analysis of Never Events and their management is included in a separate report to the Committee.

6. Divisional Investigations

6.1 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.

6.2 **Table 6** shows the number of open Divisional Investigations by division (as of 4th August 2020):

Division	Divisional investigations open	Change (this month)	Complete, awaiting approval
Medicine	16	-8	9
Surgery	5	-2	5
Family Health	2	+1	0
Clinical Support Services	1	-	2
Total	**24**	**-9**	**16**

6.3 The number of open Divisional Investigations has been steadily reducing over the past 6 months. There remain 19 that are overdue (the Trust's Incident Management Policy states that Divisional Investigations should be completed within 8 weeks of the decision to set the level of investigation) which is an improvement of 8 on the previous month.

6.4 Clinical Governance support for Divisional Investigations is being provided for recent incidents, as they represent the greatest likelihood of identifying potential learning. A thematic approach is being undertaken of older incidents, to determine whether a full investigation is still required or if there have been other similar investigations since they were reported which may supersede the requirement for a full investigation.

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). There is one mitigating action planned in relation to incident management, specifically to address the volume of Never Events declared in 2019/20. This action should be reviewed in light of recent learning from Never Event investigations and compliance audits.

7.2 Based on the current rate at which the volume of open incident investigations is increasing, there is an increasing risk that the Trust may be found to be non-compliant with national requirements and expectations regarding incident management. Work to reduce this risk is underway, addressing recommendations made in the recent review of clinical governance commissioned by the Director of Nursing.

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. A report on the implications of the new PSIRF and a gap analysis against current ULHT policy and procedure is being undertaken and will report to the Patient Safety Group in October.

8. Conclusions & recommendations

8.1 The following recommendations were made to the Patient Safety Group and accepted:

- To review the current risk mitigation plan regarding the frequency of Never Events, in light of recent learning and update Risk ID 4043
- To develop a mitigation plan to address the increase in volume of open patient safety incidents, and record this on the risk register under Risk ID 4043
- To develop a mitigation plan to address the volume of overdue improvement actions arising from patient safety incidents, and record this on the risk register under Risk ID 4043

8.2 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 the Trust's incident management arrangements have been made within the report from that review and will inform the mitigation plan.

8.3. 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.

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Meeting	*Trust Board (Private)*
Date of Meeting	*Tuesday, 6 October 2020*
Item Number	*TBC*
Impending CQC Inspection: Communications Plan	
Accountable Director	*Dr Karen Dunderdale, Director of Nursing*
Presented by	*Dr Karen Dunderdale, Director of Nursing*
Author(s)	*Angie Davies, Deputy Director of Nursing and Anna Richards, Associate Director of Communications & Engagement*
Report previously considered at	*Executive Leadership Team Friday, 25 September 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	*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	*Significant*

Recommendations/ Decision Required	*The Trust Board is asked to:*
	• *note the Communications Plan & Staff Guide: 'Preparing for a CQC inspection: what it means for me':*
	• *provide any comments or amendments;*
	• *agree the need for any additional actions at this stage*

Executive Summary

Background & Introduction

Whilst the date and format is not yet known, the Trust is expecting its next Care Quality Commission (CQC) inspection before the end of the 2020 calendar year. Work is continuing in response to the 'must do' and 'should do' actions within the 2019 inspection report with delivery of those improvements captured as one of the priorities within the Trust's 2020 – 2025 Integrated Improvement Plan (IIP) ensuring a more holistic, consistent and sustained approach to improvement.

The CQC Divisional 'Confirm and Challenge' sessions currently being held, are helping to provide a greater understanding and assurance in respect of progress with the 'must do' and 'should do' actions at Divisional level. Progress continues to be reported up to the Trust Board through the Quality Governance Committee.

Communication to Staff & Other Stakeholders About the Inspection

As part of the preparations for the 2020 CQC inspection, a Communications Plan has been prepared and is **attached**. The plan outlines the communications, briefings and other events & initiatives which are planned in the lead up to the inspection including:

- the issue of a 'guide' for staff and managers - *'Preparing for a CQC inspection: what it means for me'*, on what to expect during the inspection **(attached)**; and

- the development of the *'Time to Shine'* initiative, which describes how staff can showcase the improvements made in their areas.

The Communications Plan is intended to ensure the Trust and its staff:

- are fully prepared for the inspection;
- know what will happen and the types of questions they may be asked; and
- are able to talk about the improvements made and positive stories as well as the challenges which remain and the work which is happening to address them.

The Communication Plan and Staff Guide have been received and endorsed by ELT.

Communications plan – CQC preparation 2020

1. Aims and objectives

The aim is to ensure that our staff are informed of and are fully prepared for the next CQC inspection and are able to talk about the improvements made within their own areas and the wider Trust as well as the challenges which remain and the work which is happening to address them.

Objectives of the communications plan are:

- To ensure that staff know the process of CQC inspection and their part in it.
- To further raise awareness amongst staff and other stakeholders of the work the whole Trust is doing to deliver improvements in focused areas as part of the Integrated Improvement Plan (IIP)
- To create a sense of positive momentum, to ensure staff are able to describe and demonstrate the journey the Trust is taking.
- To ensure that staff can describe how they 'live' the Trust's values and behaviours in their working life.
- To facilitate staff discussions on progress and shared learning.
- To encourage staff to share positive messages as well as the challenges which remains and the actions being taken and be advocates of the Trust.
- To support managers in sharing and cascading consistent Trust-wide information so that staff feel engaged.

This is not only about being prepared ahead of a CQC inspection, but helping our staff to articulate successes and what they are proud of every day.

2. Key audiences

For the purposes of this plan, our staff are our audience, at all levels and in all disciplines.

Some of the communications channels and approaches outlined below will be more appropriate for some staff groups than others, but to reach our end goal we need to ensure that every member of ULHT staff is a part of this change.

3. Key messages

- Now is the time for us to show how far we have come on our improvement journey, as part of the Integrated Improvement Plan (IIP).
- CQC inspections are just a part of that process- and we want you to be fully prepared when that time comes.
- Staff need to be able to showcase their good work, strengths and achievements and the improvements that have been made. This includes being able to describe how the demonstrates our Trust values.

- Staff also need to demonstrate that we know where our improvement areas are and what we are doing about them.
- Everyone needs to know how we gain feedback about the care we provide, how we learn and share lessons to make changes for the better for the people who use our services

4. Proposal

To prepare us for an inspection, the comms team will liaise with the NHS comms network to develop ideas for positive ways to inform and engage staff around the CQC process.

All comms activity will be coordinated jointly through the Trust corporate communications team and the lead nursing team. All messaging will be in the Trust brand and will incorporate reference to the IIP and Trust values wherever possible.

Key comms and staff engagement actions to be taken include:

Guide for staff

Development of a guide to be used by all staff and teams in preparing for any up-coming CQC inspection.

This guide is designed to support individuals and teams to feel confident and prepared for forthcoming CQC inspections and will include:

- Outline the CQC's approach to inspection
- Explain the five key questions the CQC will ask
- Provide prompts on how best to prepare
- Provide contacts for further support and additional information

Provide a reminder of ULHT's strategic direction & objectives, its values and improvement approach

A summary (business card-sized) version can also be produced and issued to each staff member as a handy ready-reference.

Details of how both documents will be shared is in the full action plan.

Senior leaders forums

Meetings will be scheduled with senior leaders (e.g. ELT members and divisional and corporate leads), briefing them on the inspection process using a series of slides inspired by the staff guide.

The aim of these sessions is to inspire and enable them to cascade the information among their teams.

Staff forums

A series of events for staff at all levels, led by executive team members, briefing them on the inspection process. These will use a series of slides inspired by the staff guide and will also include a short Q&A opportunity for participants.

The aim of these sessions is to inspire and encourage staff to recognise what they are doing well and helping them to describe it. These sessions will have a focus on helping staff think about how they:

- Showcase their good work, strengths and achievements and the improvements that have been made.
- Demonstrate that we know where our improvement areas are and what we are doing about them.
- Demonstrate how we gain feedback about the care we provide, how we learn and share lessons to make changes for the better for the people who use our services.

These could be held either in person (COVID restrictions permitting) or virtually via Microsoft Teams.

To be scheduled at varied times and dates to ensure accessibility for staff across all sites and disciplines.

Sharing and learning folders

Creation of locally-held folders that can be used to collate information for each area, such as recent complaints, serious incidents and improvement actions taken. This can also contain a copy of the staff guide and can be used to house other relevant messaging that is issued.

It is proposed that a ‘dummy’ folder is created, containing examples of what could be included and how they should be used in practice on the wards, with responsibility for establishing them on each ward sitting with the ward leader.

Our Time to Shine

One of the key things we need to do is encourage our staff to recognise where they are doing things well and help them to find a way to articulate that.

Recognising that there needs to be some local ownership of this process, messaging will be shared encouraging each ward and department area to think about how they do that for themselves, but providing them with examples and suggestions for how that could be done.

The ‘Our Time to Shine’ graphic has been created, in the Trust brand, which could be re-created and used by wards and departments in recognising and then displaying what they are proud of. This can be used alongside a prompt document start the discussion.

In addition, ideas and best practice that other wards have already developed can be shared in the comms messaging to inspire areas, including e.g. Carlton/Coleby’s ‘Tree of Success’ and Burton Ward’s ‘Going for Gold’

Intranet presence

There is already a CQC page on the ULHT intranet, but this will be updated and developed to become the ‘go-to’ place for all CQC-related information. This can include (but is not limited to):

- CQC staff guide
- FAQs
- Dates and links for staff events

CQC preparation 2020 - comms action plan

Communications channels to be used and frequency are:

- Weekly roundup - CQC message included every other week.
- One-off all staff emails - as required
- CEO weekly blog - CQC mentioned monthly.
- DoN weekly blog - CQC mentioned weekly
- Intranet - updated as required.
- Intranet scroller - used on a rolling basis throughout
- Screensavers - used on a rolling basis throughout.
- Posters - as required
- ULHTogether - CQC mentioned weekly.
- Weekly ELT Live broadcasts- CQC mentioned weekly.

Action	Who	When	Progress
Development of staff guide	Comms	24/09/2020	
Staff guide feedback and signoff	CQC group	18/09/20	
Preparation and signoff of messaging around Time to Shine	Comms	16/09/2020	
Circulation of Time to Shine messaging on all internal comms channels	Comms	From 21/09/2020	
Booking of staff forums	CQC team	From 21/09/20	
Creation of ‘dummy’ sharing and learning folder	Comms/ nursing team	From 21/09/2020	
Staff guide to ELT for comment	DoN/Comms	25/09/2020	

Advertising of staff forums on all internal comms channels	Comms	From 28/09/2020	
Circulation of sharing and learning folders and briefing ward leaders on their use	Nursing team	From 06/10/2020	
Staff guide to Trust Board for comment	DoN	06/10/2020	
Production of slides for staff briefings- based on content of staff guide	Comms	w/b 06/10/2020	
Creation of intranet area containing staff guide, FAQs and any useful documentation	Comms	09/10/2020	
Digital version of staff guide circulated- shared on all comms channels	Comms	09/10/2020	
Hard copy staff guide printed and distributed	Comms	w/b 12/10/2020	
Staff forums take place	ELT members, supported by comms and CQC team	From 12/10/2020	
Sharing staff guide in all comms channels- starting with all-staff one off email which includes introduction to our new processes	Comms	From 12/10/20	
ELT Live around CQC to launch guide	Comms/ELT	12/10/2020	

Preparing for a CQC inspection

What it means for me - a guide for all staff

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Introduction

This guide is designed to support you and your teams to feel confident and prepared for a Care Quality Commission (CQC) inspection.

The Care Quality Commission (CQC) is the independent regulator of all health and social care services in England. All of the services we provide as an NHS Trust must be registered with the CQC and we must meet certain quality standards in order to maintain this registration. The CQC use a range of mechanisms to monitor how well care is being provided including through announced and unannounced inspection visits.

The CQC can undertake one of three types of inspection: scheduled, themed or responsive inspections. The CQC are due to visit ULHT to carry out a comprehensive scheduled inspection of services during 2020. The Trust will be notified of the inspection dates but the CQC may also carry out some unannounced inspections either before or after the announced inspection which can occur at any time and could very well be out-of-hours or over the weekend.

The CQC inspection is a professional assessment of the quality of our services. It is also our chance to share what is really positive about the Trust and the improvements we have made and continue to make. We also have to be open and honest about the challenges we face, and what we are doing to address them.

The inspection will be carried out by a mixture of inspectors, healthcare professionals and experts by experience who will assess using five domains that define the key areas of quality and safety, which every Trust should meet. These domains are: **safe, effective, caring, responsive and well-led.**

More information on these five domains is provided later in this guide.

The 2020 inspection gives us an opportunity to improve on our overall rating of 'requires improvement', as we are now further on down our journey of improvement. It also gives our services a chance to improve on their previous ratings, as we know lots of excellent work has taken place in recent months across the Trust.

Fundamentally, we need to remember that although we've been continually improving, we have excellent services with many examples of best practice and outstanding work and this is our chance to showcase our achievements.

Preparing for our CQC inspection

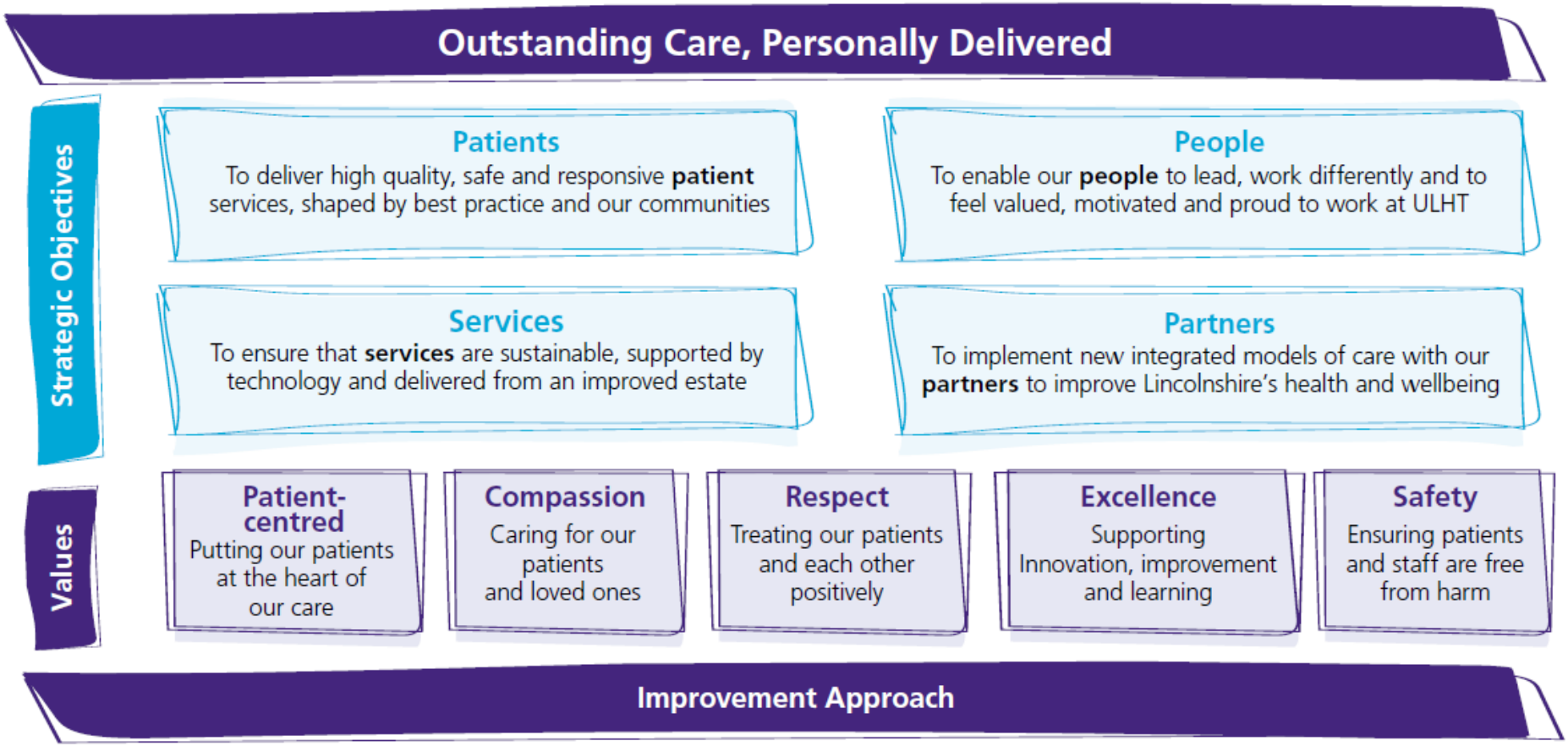
This guide will:

- **Help you to understand the CQC's approach to inspection**
- **Explain the five domains the CQC will assess and list some of the questions we can expect the CQC to ask us under each of the inspection domains – these are known as the Key Lines of Enquiry (KLOEs)**
- **Suggest how you can prepare**
- **Provide you with contacts for further support and additional information**
- **Provide a helpful reminder of our strategic direction, objectives and values**

Reading this handbook should not only assist in preparing you for a CQC inspection, but also offer best practice points for life beyond the CQC visit and business as usual.

Information about our Trust

Our strategic framework 2020-2025 provides our future direction



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Our Trust Board

Chair
Elaine Baylis

Chief Executive
Andrew Morgan

Director of Improvement and Integration and Deputy CEO
Mark Brassington

Director of Nursing
Dr Karen Dunderdale

Chief Operating Officer
Simon Evans

Director of People and Organisational Development
Martin Rayson

Director of Finance and Digital
Paul Matthew

Medical Director
Dr Neill Hepburn

Non-executive Director
Liz Libiszewski

Non-executive Director
Gill Ponder

Non-executive Director
Geoff Hayward

Non-executive Director
Sarah Dunnett

Non-executive Director
Dr Christopher Gibson

Our approach

Supporting people to live well

The people who use our services expect us to:

- Put their needs first at all times
- Be **aware** and **take ownership** - if you know of or notice any issues, address these as soon as possible by raising them with your line manager or through the appropriate processes
- **Be honest, polite, helpful** and **welcoming** - answer any questions you can to the best of your ability and if you are not sure ask a colleague for help
- Be **proud** and **positive** - celebrate the excellent work you do by talking about how your service makes a real difference
- Be **prompt** and **responsive** - if an issue is raised, rectify it as soon as you can or, where this is not possible, log it and report it to your line manager

CQC inspections are our opportunity to:

- Showcase our good work, our strengths and achievements and the improvements we have made
- Demonstrate that we know where our improvement areas are and what we are doing about them
- Demonstrate how we gain feedback about the care we provide, how we learn and share lessons to make changes for the better for the people who use our services

We know that our services are not always perfect. We need to be able to tell the story of what we are doing well, where we are making improvements and where our services are aiming to be.

What will happen during the inspection?

Usually, the Care Quality Commission (CQC) send inspectors to ULHT to review all of our services. The inspectors usually operate in small teams over the period of a week. The teams will inspect all inpatient areas and a sample of other services - these will be determined by the inspectors during the week.

The inspectors will represent a wide variety of disciplines and specialities. They will be well-informed and briefed in detail about our services. We will have provided a lot of information to the CQC in advance of the inspection to help them assess our services.

During the inspection, the CQC inspectors will want to:

- **Talk to staff** (all grades and disciplines) about the Trust, the services we provide, the improvements we have made and the challenges we face.
- **Observe care** and **talk to people receiving care** as well as their carers and family members.
- Review clinical records and corporate information*.
- Carry out **'pathway tracking'** (following a patient's route through the service and get their views on it).
- Look at **specific areas** of the services we provide e.g. how we store medicines and may ask to be shown information such as training records.

The inspection will be focused on the following areas:

- Urgent and emergency care
- Medical care (including older people's care)
- Surgery
- Critical care
- Maternity and gynaecology
- Services for children and young people
- End of life care
- Outpatients and diagnostic imaging
- Community health services for children, young people and families

The CQC may distribute cards/comments boxes around the Trust and they may host focus groups with staff, people using our services, carers, family members and other stakeholders to gather a wide range of feedback.

*[*Under the Health & Social Care Act 2008, the CQC have the right to request and review patient records so there should be no concern about providing access.]*

Now is Our Time to Shine

When talking to the CQC inspectors, it is so important that you take the opportunity to tell the story of your success. We all need to recognise and highlight our achievements and take Our Time to Shine.

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The five key questions

The CQC will focus their inspection around five questions about the quality of our services, based on what matters most to people and on the five domains described above.

When telling your story always have these five questions in mind:

Is it safe?

People are protected from abuse and avoidable harm.

Is it effective?

People's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Is it caring?

Staff involve and treat people with compassion, kindness, dignity and respect.

Is it responsive?

Services are organised so they meet people's needs.

Is it well-led?

The leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

To understand these five key questions further and for practical prompts in preparation, see *Appendix A.*

How can I best prepare?

There is a lot you can do to ensure you are prepared for the CQC's visit. These are things you already do and know.

- **Keep informed:** Please engage in supportive preparation activities, talk to your team/manager. Read our CEO and Director of Nursing weekly emails, our weekly Roundup emails and keep an eye on the ULHTogether Facebook page for updates, as well as listening in to our weekly ELT Live sessions.

  We will also be sending out regular information pages (information here can be printed out for your ward information folders) and continually updating the pages on the intranet providing details of the CQC inspection. You can also talk to your team/manager.
- **Review Appendix A:** This will give you a good overview of the five key questions and useful prompts for you to consider personally and as a team.
- **Share best practice and learning with colleagues:** Be proactive in sharing approaches that could benefit other areas.
- **Practice telling your service's achievements and 'story':** Be clear, open and honest about what you do, focusing on what you do at present and plans for the future.
- **Familiarise** yourself with where your team's documentation is held e.g. staff rotas, policies, procedures and protocols, information leaflets, close observation monitoring sheets, staff supervision recording systems, mandatory training, environmental risk assessments, business continuity plans, health and safety risk assessments, risk registers etc.
- **Familiarise** yourself with Trust systems and processes and, if you are uncertain about where to find information, ask your line manager.

General housekeeping for everyone, all of the time:

- Wear your **ID badge** at all times
- Review **notice boards** to ensure all of the content is clear and up to date
- **Check information leaflet stands** are still current and stocked - the CQC may ask you about information that is displayed
- Ensure **alcohol hand gel** is available and use it on entering premises and units.
- Make sure all areas are **clean, tidy and free from clutter**
- Make sure your **appraisal** and **mandatory training is up to date** including **safeguarding training**
- **Replace or remove** broken furniture. For items no longer used - contact estates for help with disposal
- Ensure staff have **completed their induction**
- Know how to find **Trust policies** on the intranet and be aware of the content of those pertinent to your role.
- Make sure the outside environment is **safe, welcoming, clean** and **tidy,** including any gardens, court yards or pathways. Contact estates for help if required
- Ensure your **clinical records are up to date.**
- Ensure that **records and identifiable information are kept safe and secure** at all times to maintain **confidentiality**
- Know how you would report an incident or **raise a concern,** for example a patient safety incident or safeguarding concern, and how you would contact our Freedom to Speak Up Guardian if you needed to - on 01522 573988 or email freedomtospeakguardian@ulh.nhs.uk
- Recognise and discuss as a team your **service strengths** and **less strong areas** and know what is being done to make improvements
- Know how **lessons are shared** and **learned** in your team, for example from complaints and incidents.

Improvements we've made since the last CQC inspection

Improving our Hospital Standardised Mortality Ratio (HSMR)

ULHT was one of 14 Trusts identified in the national Keogh Review in 2013 as having a high HSMR. The expected value was 100 and for ULHT it was 113. To reduce our HSMR and achieve our pledge of eradicating preventable deaths, we developed and implemented a wide ranging programme of work with strong clinical leadership.

Our HSMR has now been consistently below 100 since September 2018, placing us in the top 28% of Trusts nationally. This means we have become a safer organisation.

Reconfiguration of trauma and orthopaedic services

Working with the Getting It Right First Time team we implemented the 'hot' (trauma) and 'cold' (elective) site reconfiguration model for trauma and orthopaedics. The aim of the trial was to ensure a better patient and staff experience for elective and trauma care.

During this trial orthopaedics has reduced their waiting times significantly and over 90% of patients are now receiving their care within 18 weeks, more patients receive their surgery on the planned day (reduced cancellations) and length of stay has been reduced.

Medical recruitment across the Emergency Departments

For many years we have struggled to recruit sufficient staff for us to maintain safe rotas across our three Emergency Departments (ED). At the beginning of 2018/19 50% of our medical posts across our EDs were vacant.

During 2018 we were able to secure significant clinical support to strengthen our recruitment efforts which resulted in:

- Improved clinical leadership through the appointment of a Trust wide clinical lead, and site based deputy clinical leads.
- Appointment of 14 whole time equivalent (WTE) consultants
- Appointment of 24 WTE middle grades

The Improvement Academy

We have a new Improvement Academy where you can get help with improvement work in your area:

- **Karen Sleigh** is our Assistant Director of Improvement and if you would like support from the Improvement Academy Team please e-mail Improvement@ULH.nhs.uk with your request.

- If you are starting out on your improvement journey our **foundation workshops** will provide individuals or teams with basic improvement knowledge and skills. These workshops introduce problem solving tools and techniques to apply to routine daily issues and concerns. These include:

  Outstanding Care Improvement System (OCIS): A five-month programme, each month involves a one-day training workshop followed by three coaching sessions, designed to introduce and embed ward improvement huddles. It will help teams to introduce improvement into daily routines and behaviours using tools and techniques to problem solve.
  Quality Improvement (QI) Shared Decision Making: One-day interactive workshop introducing tools and techniques for making improvements with follow-up coaching support if required.
  Human Factors: One-day situational awareness workshop to encourage individuals and teams to be more aware of their environment, safety culture and team work. It recommends simple solutions to avoid human error.

- If you have basic improvement skills and would like to continue learning, our **intermediate workshops** will provide a more detailed level of improvement skills for individuals and teams to apply to larger or more complex improvements. These include:

  Quality Service Improvement and Redesign – Virtual (QSIR V): 18-week virtual programme (using Microsoft Teams) including 8 one-hour virtual improvement sessions supported by 8 one-hour QSIR Virtual Cafes (optional) and 2 one-hour Virtual Action Learning Sets (optional) to support individuals or teams to take an improvement initiative from idea to implementation with peer support.
  Quality Improvement Programme (QI): 3 half-day workshops to support individuals or bespoke sessions for teams to develop and practice improvement tools and techniques with additional coaching if required.
  Project Management: One-day introduction for those with an interest in understanding the fundamental of project management.

- If you are already an improvement enthusiast and want continuous improvement learning, our **Practitioner Workshops** offer the opportunity to gain an advanced level of improvement expertise to apply to complex improvement initiatives.

  QSIR Practitioner (QSIR P – 30 CPD points): 5-month programme with one-day workshop each month to build advanced improvement knowledge and skills. Due to COVID restrictions, these workshops will now restart in 2021.

If a CQC inspector arrives in your area

When the CQC arrive, please:

- **Welcome the inspecting team** and ask to see their identification badges. Do not allow anyone access without the proper authorisation/ identification
- Sign them in and ensure the most **senior member of your team is called** to meet and accompany the inspecting team, to introduce them to the service area and facilitate their visit. Orientation to the area should include safety and facilities, including handwashing

Having welcomed the inspectors:

- **Notify your manager and ask them to inform the Chief Executive's PA of the CQC's arrival with your team on ext 573977.**
- **Out of hours please call the Site Duty Manager.**

Engaging with the inspection team:

- Remember, **patient care comes first** – the inspectors will know this. If you are busy supporting patients, let the inspector know that you will be with him/her as soon as you are free so that care is not disrupted and give a specific time wherever possible
- Inspectors can have access to clinical notes and other information and records but should **not** take them away or make photocopies. If copies of records or other information is required, this will be requested by the CQC through the central team responsible for co-ordinating the arrangements for the inspection

When an inspector wants to talk to you:

- Be **open** and **honest**, and as helpful as you can
- Be **proud** and **positive** and **celebrate** the **excellent** work you do by talking about how your service makes a **real difference** and meets people's individual needs in partnership with them, their families and carers
- **Keep conversations away from public areas** to avoid disruption and to maintain confidentiality
- **Encourage service user/carer participation** in the chat where appropriate/possible
- Respect people's privacy and dignity: **always check with people first** if the inspectors want to observe your interactions with them
- Be mindful of where you **know improvements are needed and share how we are responding to these**
- **In preparing,** make sure you know both your service's **achievements** and where improvements are taking place before the visit, and have **evidence** to demonstrate these. If an issue is raised, outline our plans to improve in this area
- If you don't understand the question or don't know the answer, **don't panic** - ask for clarification or state where you will go for the information and get back to them

If the inspecting team identify an issue:

- We need to act **promptly** and **responsively**
- Where issues are raised, these need to be **logged** by the ward/department manager and escalated. Issues raised need to be fed back by the ward/department manager to the service manager, matron, Divisional triumvirate and also emailed to the CQC compliance team directly after the visit.
- Issues should be **rectified** before the inspection team leave, or where possible before the inspection week is complete. Where this isn't possible, the Trust will need to be able to advise the CQC when this action will be complete.

Appendix A Key Lines of Enquiry

SAFE- People are protected from abuse and avoidable harm

Incident reporting and lessons learned

- Do I know how to report an incident, near miss or allegation of abuse?
- Does my team discuss incidents, complaints and patient feedback and how we can learn from them?
- Can I identify any changes to practice as a result of an incident, complaint or patient feedback?
- Do I ensure I ask if I have not received feedback from an incident I have reported?
- Do I understand the various methods in which feedback on incidents and lessons learned is provided within the Trust (team meetings, staff updates, newsletters, quality and safety days)?
- Do I, or does someone within my team, receive and act on safety alerts, recalls, enquiries, investigations or reviews?
- Is data from audit reports, safety incidents and patient feedback (complaints, survey etc) discussed at our local team meetings, with lessons learned shared with colleagues and improvement actions decided and acted upon. Can I think of some examples?

Medicines management

- Do I ensure drug fridges have a daily temperature recorded and actioned appropriately?
- Do I know what procedure to follow for controlled drugs?
- Do I ensure my team's records confirm that stock checks of controlled drugs are carried out once a day?
- Do I know what to do if a patient has an adverse reaction to a medicine?
- Do I know how to obtain advice on medicines?
- Do I always check a person's allergy status ensure all patients have their allergy status documented in the records?
- Can I describe the process for ensuring patients' medicines are reconciled in line with current national guidance when transferring between locations or changing levels of care?
- Can I describe the process for ensuring patients are receiving appropriate therapeutic drug and physical health monitoring with appropriate follow-up in accordance with current national guidance or evidence?

Medical devices

- Do I always check that medical devices I use are up to date with their maintenance before use? Are they decontaminated before and after use?
- Do I understand what a single use device is?
- Am I trained in all medical devices that I use?
- Do I know where I can access resuscitation equipment?

Infection prevention

- Do I always follow hand hygiene procedure according to the WHO 5 moments for hand hygiene?
- Do I ensure equipment is cleaned and stored correctly with appropriate labels, signed and dated after use?
- Am I aware of and complying with PPE guidelines (particularly the use of gloves)?
- Do I ensure alcohol hand rub is available and accessible at the point of care?
- Are you aware of your team's performance against infection prevention audits?
- Is my infection control mandatory

training up to date?
-
- Do I know who to contact for advice on infection prevention and control?

Staffing

- Am I aware of nursing/midwifery “red flag” events?
- Are people kept safe in my team/on my ward because we maintain safe staffing levels and have effective handovers?
- Do I ensure bank/agency staff/locums have been inducted before starting work?
- Do I display daily staffing levels (actual and planned)?
- Do I know how and when to escalate staffing concerns when it compromises patient care?

Business continuity and emergency planning

- Would I know what to do in the event of an emergency or major incident?
- Am I familiar with my team’s business continuity plans?
- Am I familiar with any changes in the way we work during COVID-19 and understand why we needed to make these changes?

Falls

- Have my patients had a falls risk assessment if deemed appropriate and a completed action plan?

Safeguarding

- Do I know what to do if I have any concerns about my patients’ safety within my team?
- Do I know who to contact if I have a concern about an adult or a child?
- Do I know how to respond to any signs of, or allegation, of abuse?
- Am I familiar with the safeguarding procedures and processes relevant to my role?
- Am I up-to-date with my safeguarding training?
- Do I understand the role of the chaperone/escort?

Dementia/mental health/learning disability

- Am I aware of the pain assessment tool for patients with a cognitive impairment and can I use it appropriately?
- Do I ensure patients/clients with a diagnosis of dementia have a person-centred care plan and associated documentation?
- Have I completed dementia awareness training?
- Do I know how to access specialist mental health advice and support?
- Do I ensure patients with a learning disability have a Reasonable Adjustment Care Plan completed?
- Am I able to test for capacity (under the Mental Capacity Act) and do I understand DoLS (Deprivation of Liberty Safeguards)?
- If a person lacks capacity ,do I know how to ensure their best interests are assessed and recorded?
- Do I ensure best interest meetings are held when a patient may lack capacity to make a significant decision in order to develop the most appropriate care plan for the patient?
- Do I understand my role relating to Mental Capacity Act and DOLS (Deprivation of Liberty Safeguards), and have I completed the training?

EFFECTIVE- People’s care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence

Audit and evidence – guidance and standards

- Am I aware of new NICE guidance/evidence based practice relevant to my role?

- Do I participate in or am I made aware of local/national audits and am I involved in activities to monitor people's outcomes?
- Can I explain the outcome of various audits that take place in my service e.g. Safety Thermometer, clinical audit, infection prevention audit etc.?
- Do I undertake the necessary risk assessments, keep them current and reflect them in care and treatment plans?

Consent to care and treatment

- Do I know when to obtain written consent?
- Do I know when I can take verbal or implied consent?
- Do I know how to document and keep records of consent?
- Do I provide information about all the benefits and risks, to enable valid consent to be obtained?
- Do I know how to assess the mental capacity of patients?
- Do I make appropriate arrangements for patients/clients who lack capacity to make their own decisions about care and treatment?
- Am I able to describe what patients are told about seeking further help and advice if their condition deteriorates?

Pain management

- Do I make sure all patients have a pain assessment recorded if applicable?
- Do I help patients to manage their pain in a timely manner and monitor its effectiveness?
- Do my patients have a pain care plan?
- Do I know when and how to contact and involve the pain team

Staff skills, knowledge and experience

- Did I receive a local induction when I began this role?
- Have I had an appraisal in the past 12 months?
- Am I up-to-date with my mandatory training?
- Have all my competencies been assessed and signed off this year?
- Do I maintain my personal knowledge by attending training/study sessions/conferences or reading guidance and journals?
- Do I undertake all necessary risk assessments?
- Do we ensure that our services aimed at children and young people are accessible and relevant to new forms of communication?
- Are we available to young people when they require help and advice?

Acute illness

- Am I up to date with my resuscitation training?
- Do I know how to record National Early Warning Scores (NEWS) and know how/when to escalate concerns?
- Do I understand the SEPSIS bundle and the actions I need to take and how/when to escalate?
- Do I feel comfortable discussing RESPECT and DNACPR decisions?
- Has my resuscitation trolley/defibrillator been checked today?
- Do I make sure that patients' fluid balance is monitored and managed?

Food and hydration

- Have my patients had the MUST assessment completed and a completed action plan if at risk?
- Do I make sure that patients' nutrition and hydration needs are met?
- Are fluid and food charts completed if applicable?
- Do I know where to obtain further guidance for my patients if they require extra nutritional support?
- Have my patients been helped to make their own food choices?
- Do I offer my patients hand wipes before eating a meal?

Tissue viability

- Have my patients had a pressure area risk assessment recorded and a completed action plan if the patient is at risk?
- Do I know where and how to obtain pressure relieving equipment?
- Do I know who to contact or find information if I need advice and support on tissue viability?
- Do I know when and how to report if my patient suffers harm from a pressure ulcer?
- Have I given my patient a pressure ulcer information leaflet?

CARING - The service involves and treats people with compassion, kindness, dignity and respect

Dignity, respect and compassion

- Do I always respect the privacy and dignity of patients?
- Do I always call patients by their preferred name and document this in their notes?
- Do I help patients who need assistance with washing, dressing, eating and continence care?
- Do I respond in a timely way to call bells, calls from families and patients?
- Do I always introduce myself to my patients?
- Do I always wear my name badge?
- Do I always consider a patient's personal, cultural and religious needs?
- Do I always respect patients' confidentiality, verbally and in written records?
- Do I report any episodes of disrespectful, discriminatory or abusive behaviour towards patients?
- Do I offer additional support for those patients that require interpreters, specialist advice or advocates?
- Do I offer patients a shower?
- If the patient is bed bound, do I offer a full bed bath including hair washing?
- Do I ensure male patients have been shaved or have been offered assistance to shave (if appropriate)?
- Do I offer patients assistance with mouth care and to brush their teeth/clean dentures?
- Do I offer patients assistance to clean their hand and toe nails if applicable?
- If patients have dry skin, do I offer assistance to moisturise their dry area?
- Do I encourage my patients to wear their own clothes to maintain their identity and dignity?

Involvement of patients and those close to them

- Do I always give my services contact details to patients?
- Do I always involve patients, their families and carers when developing their care plans?
- Do I always involve patients, their families and carers in decisions about their care? (No decision about me without me)
- Do I know how to obtain an advocate if a patient needs one?
- Do I know how to access translation services?
- Am I always considerate and respectful in my interactions with patients and their families?
- Am I confident supporting people to cope emotionally with their care and treatment?
- Do I promote self-care, self-management and independence?
- Do I demonstrate the Trust value-based behaviours?
- Do I ensure that patients are assured that information about them is treated confidentially in a way that complies with the Data Protection Act and ensure that my service supports people to make and review choices about sharing their information?
- Does my ward/department receive, continuously review and act upon feedback from patients and their families?

RESPONSIVE - Services are organised so that they meet people's needs

Timely access

- If I have to cancel an appointment do I always explain why?
- If appointments are cancelled do I rearrange as soon as possible and prioritise patients according to their needs?
- Do I make sure that when patients are transferred or discharged they are given sufficient information and support?

Concerns and complaints

- Do I know what to do if a patient wishes to make a complaint?
- Do I discuss complaints and concerns at team meetings in an open and honest way?
- Do I give patients a complaints leaflet and is this information displayed?
- Do I deal with a concern as soon as I know about it?
- Do I ensure that people who raise concerns or complaints are protected from discrimination, harassment or disadvantage?
- Do I encourage people to feedback their experiences of the service and provide means to do this e.g. Friends and Family Test?
- Do I know what people are feeding back about the service ,and do I act on person/carer feedback?
- Do I know what improvements are being made?

Discharge

- Do I make sure that when patients are transferred or discharged from or to services, their families/carers are involved?
- Do my patients have an estimated date of discharge (EDD) documented in the notes?
- Is my patient aware of their estimated discharge date?
- Are people kept in hospital for the minimum amount of time needed?

End of life care

- Am I aware of the need to produce an individualised plan of care for patients in their last hours/days of life and those close to them?
- Am I competent in initiating an end of life care plan and setting up a syringe driver for symptom control?
- Do I know where to find the prognostic indicator guide and how to access palliative care?
- Do I know the process for initiating and coordinating a rapid discharge for patients in their last week of life?
- Do I know what bereavement support is available to relatives?
- Do I have a knowledge of the medications required for symptom control for end of life care?
- Have I attended any EOLC training sessions?

WELL-LED - Leadership, management and governance of the organisation assures the delivery of high quality person-centred care, supports learning and innovation, and promotes an open and fair culture

Vision and strategy

- Do I know what the Trust's visions and values are?
- Am I familiar with the clinical strategy for the Trust and for my service?
- Do know about the Trust's Integrated Improvement Plan?
- What action is taken to address behaviors and performance that is inconsistent with the vision and values?

Clear responsibilities

- Have I agreed my personal objectives with my manager?
- Do I know what the current risks are for my team and services?
- Do I know what “Duty of Candour” means?

Leadership and culture

- Do I attend regular team meetings?
- Do I receive and read team meeting minutes?
- Am I compliant with the Trust uniform dress code policy?

Governance and improvement

- Do I know what risks are currently relevant to the department I work in?
- Do I review all open risk assessments relevant to me on the risk register and implement all actions?
- Do I know who to ask about risk assessments if I don’t have access to the risk register?
- Do I discuss all action plans, review risks and lessons learned at my team meetings?
- Do I know how to raise concerns about risks, poor practice and adverse events?
- Am I familiar with the Trust’s Freedom to Speak Up Guardian and the Speak up-Raising your concerns policy?
- Do I carry out risk assessments, implement actions, document patient notes and review appropriately?
- Do I take part in clinical audits, share lessons learned and change practice as a result?
- Do I take part in daily safety huddles to identify current risks and share learning with other members of my team?

Contact details

For any enquiries, please contact your line manager in the first instance.

For quality enquiries, please contact quality.matrons@ulh.nhs.uk

For general CQC enquiries please contact communications@ulh.nhs.uk

We would like to thank all our staff for their support and participation in our CQC inspection.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*6 October 2020*
Item Number	*Item number allocated by admin*
Safeguarding Annual Report	
Accountable Director	*Karen Dunderdale, Director of Nursing*
Presented by	*Karen Dunderdale, Director of Nursing*
Author(s)	*Craig Ferris* *Deputy Director of Safeguarding*
Report previously considered at	*Quality Governance Committee* *22 September 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	*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	*X*
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	*Moderate*

Recommendations/ Decision Required	• *For approval by the Board*

NHS
United Lincolnshire Hospitals
NHS Trust

Safeguarding and Mental Capacity

Annual Report 2019-2020

OUTSTANDING CARE
personally DELIVERED


Safeguarding
Domestic Abuse
Adults
DoLS
PREVENT
Think Family
Children and Young People
Mental Capacity
Learning Disability
Slavery and Trafficking
Mental Health
Corporate Parenting
County LInes
FGM

Contents

Foreword

As the Executive Lead for Safeguarding, I am pleased to introduce United Lincolnshire Hospitals NHS Trust's Safeguarding and Mental Capacity Annual Report for 2019/20. Over the past year, the Trust has continued to deliver quality and compassionate care and treatment across the communities in which we provide inpatient, community and emergency services.

In October 2019 the Care Quality Commission (CQC) published its re-inspection findings. The Trust received an overall rating of 'requires improvement' with 'good' across both Grantham and District Hospital and County Hospital, Louth. I am proud that across our wide-ranging services, patients consistently found our staff to be caring, and said that they were treated with dignity, respect and kindness.

As an NHS Trust, we continue to drive forward improvements in care and treatment against an integrated quality and safety improvement plan. We aspire to provide care of the highest quality in collaboration with everyone who uses and delivers our services. To achieve this, we need to think differently, be innovative and creative and give people the skills they need to lead and embed change. Everything we do involves and prioritises our patients, and their families and carers.

Safeguarding these people and their rights is the thread that runs through all that we do as a Trust. This report highlights how we achieve this and sets out our commitment to the coming years' Safeguarding agenda.

The Trust's Board of Directors is committed to continuing to find ways to provide time and resources to Safeguarding and to ensure that people accessing Trust services are safe and protected from abuse. The Trust's Safeguarding Statement of Intent for 2020/21 is published on our website.

The Trust has specialist Safeguarding and Mental Capacity staff who lead on and embed the practice of protecting adults and children from abuse, neglect, modern slavery, domestic abuse and radicalisation. They work tirelessly to ensure that our frontline staff have the required skills and knowledge to protect people, uphold their human rights and assess capacity.

I would like to thank our committed and caring frontline staff, volunteers and Safeguarding team for their dedication in working alongside and providing protection, guidance and support to people whose circumstances make them vulnerable to abuse, neglect or radicalisation.

Dr Karen Dunderdale
Director of Nursing and Executive Lead for Safeguarding

Safeguarding in a challenging landscape

At a time of ongoing change and financial constraint in the NHS, the need to safeguard those who are most vulnerable in our society has never been so visible and tangible. Throughout recent years, there have been high-profile media cases of Celebrities and Healthcare Professionals who have abused vulnerable children and adults; radicalisation of young people in our society, leading to extremist views and acts; evidence of Exploitation, including County Lines, Trafficking and Slavery and a significant increase in allegations and prosecutions relating to abuse and neglect against those working in public and Professional roles.

How does an NHS Trust manage the conflicting situations of financial restriction versus the need to develop and to ensure that its patients are provided with high quality care and treatment and whilst being Safeguarded against a growing number of risks?

United Lincolnshire Hospitals NHS Trust's Board of Directors, Safeguarding Leads and Managers are committed to ensuring that Safeguarding and the assessment of Mental Capacity of patients is given the highest priority in all that the Trust does. Many people accessing the Trust's services have experienced abuse or neglect at some point in their lives. On average, one in four women and one in six men in Lincolnshire will have experienced domestic abuse. By asking direct questions and establishing where abuse has caused harm through physical injury or emotional distress, the Trust's Clinicians can assist patients to recognise the impact of different types of abuse. They can then work with them to identify the abuse, report concerns and signpost them for safeguarding and therapeutic intervention, to protect them and promote recovery from the negative impact of living with abuse.

The Trust's Clinicians are trained, to a high standard, to recognise signs and symptoms of abuse in children and adults; including domestic abuse, child sexual and criminal exploitation, radicalisation, Modern Slavery, Female Genital Mutilation, Honour-based Violence and Forced Marriage. Clinicians are supported to access appropriate guidance and protection for those currently experiencing abuse. They also work closely with other agencies, such as Lincolnshire Police's Protecting Vulnerable Persons Unit and Lincolnshire County Council's Safeguarding Adult & Safeguarding Children Teams, to protect and historical abuse, where others remain at risk or where the person wishes to formally report abusive and criminal acts against them.

The Trust continues to endeavour to make Safeguarding part of its core business, embedding systems and processes to support patients and their families to feel safe and protected.

In 2019 the CQC found that staff were aware of what to do should a patient raise a Safeguarding concern. The work is emotional and at times places additional pressure on the trust however it is a challenge that the Trust is embracing and has committed its NHS resource to work to reduce abuse and violence in our communities.

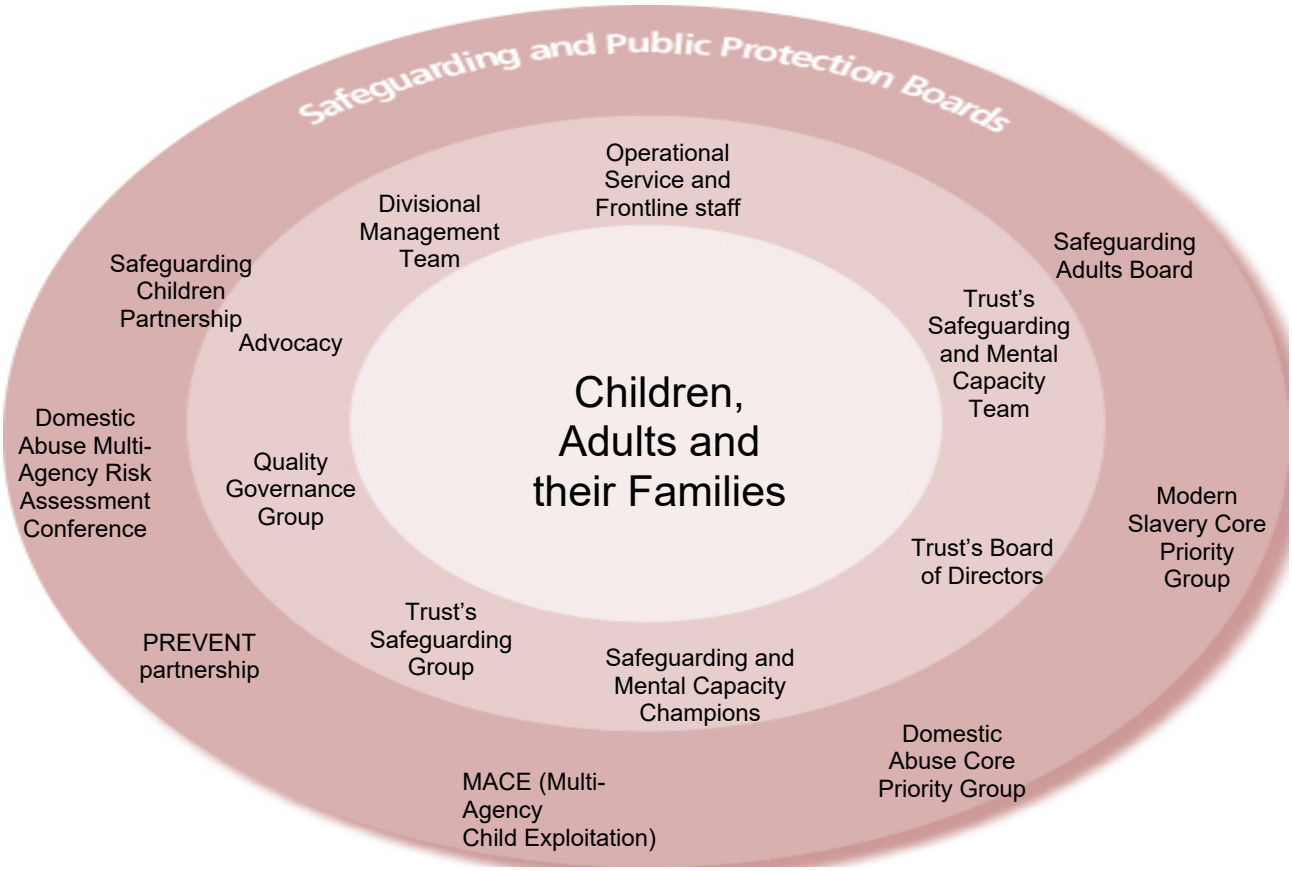
It is a challenging time for NHS Trusts, but by using existing resources to safeguard effectively those for whom we care, we can work to improve physical and psychological wellbeing, recovery from injury, reduce reliance on drugs and alcohol and improve the future of our society as a whole.

Trust Safeguarding and Mental Capacity Team

Our Safeguarding and Mental Capacity Team is integral to our membership and engagement with Lincolnshire's Safeguarding Children Partnership, Safeguarding Adult Board, Domestic Abuse Core Priority Group, Modern Slavery Core Priority Group and Prevent Partnership. The Team proactively engages in multi-Agency working to enhance relationships, develop strategies and strengthen processes required to ensure that the people who receive Trust services and the communities in which we work are safeguarded from abuse and that early help and appropriate interventions are available to all.

Internally, the Trust's Safeguarding and Mental Capacity Leads and their staff work with the Trust's Safeguarding Group (chaired by the Executive Lead for Safeguarding) to ensure that safeguarding is embedded within all Trust policies, procedures and services, and that all Trust staff have the required training and knowledge. The Safeguarding and Mental Capacity Team provides frontline clinicians with additional advice and guidance and support in managing complex and high-risk situations. They also act as an escalation point for situations that require resolution and senior level intervention to improve outcomes for patients and their families.

The Team also oversees the development, additional training and specialist supervision of 200+ Safeguarding and Mental Capacity Champions that work to embed practice directly in the frontline of service delivery.



Achievements
April 2019 – March 2020

- Member of Lincolnshire's new MACE (Multi-Agency Child Exploitation) model for child exploitation
- Member of Lincolnshire's new Modern Slavery Core Priority Group
- Member of the Lincolnshire Safeguarding Adults Board (LSAB) Partnership Board and Review and Learning sub-groups
- Supported transition of the Lincolnshire Safeguarding Children Partnership's (LSCP) new Local Safeguarding Arrangements
- Work alongside the University of Lincoln on Safeguarding allegations and fitness to practice
- Delivered bespoke training for Health and Social Care students at the University of Lincoln
- Assessed 46 victims of domestic abuse as being at high risk and referred to Multi-Agency Risk Assessment Conferencing

- Improved standards relating to where medication is used to restrain a patient (chemical)
- Improvement in the application of Chaperone Policy for Adults and Children Trust-wide
- Full compliance with Savile and Bradbury report recommendations for NHS Trusts
- Trained staff and significantly increased awareness and referrals to Multi Agency Public Protection Arrangements and Potentially Dangerous Person processes
- Reviewed and revised best practice standards relating to the identification, risk assessment and care planning for children who cared for in A&E, Theatres and non-Children's Specific areas

- Made new Case Law in relation to a Court of Protection Case within the Maternity service
- Published a guideline for pregnant women and new mothers who have a learning disability/difficulty or Autism
- Midwives identified and referred 223 unborn/new-born babies to Children's Social Care due to risk of harm.
- Worked with Trust staff to understand and improve the identification of information which indicates risk of, or actual, abuse and embedded the practice and concept of professional curiosity
- Participated in audits with Safeguarding Boards for Making Safeguarding Personal; Child Exploitation; Cases considered, by Social Care, for No Further Action; Quality Assurance of Child Protection Reports; Agencies' use of Translation Services
- Continuation of Safeguarding and Mental Capacity and Domestic Abuse Trust-wide records, compliance and benchmarking audits
- Led on Multi-Agency incident reviews, Serious Case Reviews, Serious Adults Reviews and Domestic Homicide Reviews
- Sponsorship of two hospital IDVAs (Independent Domestic Violence Advisors) in line with national recommendations cited within 'A Cry for Health'
- Identification and Planning for the Safeguarding elements of the Integrated Quality and Safety Improvement plan.
- Provision of pre-Court support for staff required to attend Family Court processes.
- Developed Masterclasses for small groups of staff on developing MCA practice and skill, using case studies for analysis and reflection.
- Preparing the Organisation for the proposed introduction of the Liberty Protection Safeguards
- Participated in multi-Agency information-sharing, risk assessment and development formulation across Lincolnshire
- Provided individualised support to staff members experiencing domestic abuse and stalking
- Developed an 'Examples of Excellence' section within the Safeguarding Lessons Learned Newsletter, in order to recognise those frontline staff members who went above and beyond to safeguard our patients
- Supported the development of Divisional Operational Safeguarding Meetings to support and empower staff in discharging their Safeguarding responsibilities
- Continuation of a training programme for 'hidden child' areas
- Shortlisted for ULHT Staff Awards
- Improved information sharing processes in relation to identification individuals known to MAPPA processes
- Continued compliance with PREVENT (Preventing radicalisation) delivery plan
- Domestic Abuse compliance assed to the Risk Register
- Review and updating of Safeguarding section of the Trust Intranet.
- Review of all training programmes for April 2021
- Continued review and updating of Safeguarding (and associated) Policies and procedures
- Participated in locally driven Multi-Agency Fire Death Reviews.

Safeguarding and Mental Capacity Champions

The Trust has developed a refreshed Safeguarding Champions Network, aimed to be a driving force behind the number of patients effectively safeguarded by Trust employees and volunteers. This group of 200+ staff has a true commitment and passion to engage in the Safeguarding and Human Rights agenda. This is proving to be an effective way of distributing specialist skill and knowledge to all frontline staff working across the Trust's four divisions and their respective departments and wards.

The Trust's Safeguarding and Mental Capacity Leads have supported a network of Safeguarding Champions to develop additional knowledge and skills and to enable them to provide their colleagues with general guidance and support; thus ensuring that the Safeguarding and Mental Capacity agendas are embedded across the entire Organisation. This year the Champions have received additional training (from external partners) focused on:

- Domestic abuse and the role of the IDVA (Independent Domestic Violence Advisor)
- Addaction and Young Addaction
- Young Carers and Carers First
- Hospital Housing Link Workers
- Mental Capacity care planning
- Domestic Violence Disclosure Scheme (DVDS)

Safeguarding Supervision sessions for Champions and Staff

The Safeguarding Team has supervised several of our attending Champions over the last year as well as providing targeted Supervision to teams working with complex cases or for teams that work with high risk individuals. Ad-hoc advice has also been provided to staff to support them to risk assess and manage concerns arising with their patients, as necessary.

Safeguarding Assurance - Reviews, inspections and Lessons Learned

Statutory Safeguarding Board compliance

The Trust's Safeguarding and Mental Capacity Team attends the majority of the Safeguarding Board/Partnership Operational Safeguarding meetings for children, adults, Domestic Abuse, Modern Slavery and PREVENT.

In 2017 the Trust was inspected/audited against its compliance with Section 11, Children Act 2004. This is an in-depth review of the Trust's processes and policies, in order to evidence that it has robust arrangements in place that ensure that children are safeguarded, and their welfare promoted. Lincolnshire's Safeguarding Children Board found the Trust to be fully compliant. Re-assessment will occur during 2020. The Trust can also demonstrate its full compliance with the Safeguarding Adult Board Assurance Framework (LAF), Lincolnshire's PREVENT Strategy and partial compliance with the Domestic Abuse Charter.

Statutory Safeguarding Reviews

During the 12-month period under review, the Trust has been involved in two new Domestic Homicide Reviews, and two new Child Serious Case Reviews. These have not been published at the time of reporting; however, identified learning has been actioned; particularly in relation to:

- The appropriate use of translation services
- Exercising Professional Curiosity
- Consideration of the need to undertake Early Help Assessments (EHAs) for multiple pregnancies.

There have been two Safeguarding Adult Reviews (SARs) published. One which identified a care home's neglect of an elderly lady, and the other a response to a high-profile Modern-Day Slavery case, which identified physical and psychological abuse of the victims, some of whom were identified as Trust patients. The Trust had already completed several actions, during the period when the review was underway. In addition, the Trust identified actions related to:

- The appropriate use of translation services
- Exercising Professional Curiosity and appropriate escalation of concerns
- Reiteration of the need for signposting/referral of patients to support services – with relevant information contained within a 'resources' section on the safeguarding intranet site.

Themes identified, lessons learned, and ULHT-specific action plans are circulated to Divisional Teams leads via the Safeguarding Group, with published reports being included for wider staff reading

Inspections

In 2019, the Trust was comprehensively re-inspected by the Care Quality Commission (CQC) across all four of its hospital sites. They continued to note some good and effective safeguarding practice and processes, such as:

"*Correct levels of training for relevant staff*"

"Urgent and emergency care staff ….." had a good knowledge and awareness of abuse and knew the reporting procedure if they had concerns."

"Staff understood their roles and responsibilities under the Mental Health Act 1983, and the Mental Capacity Act 2005."

"Outpatient Staff understood their roles and responsibilities regarding safeguarding vulnerable adults and children.

"Qualified nursing staff had received appropriate levels of safeguarding training and could tell us about examples where they had identified and raised concerns."

"Urgent, emergency care and surgical staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to access support for patients experiencing mental ill health and those who lacked the capacity to make decisions about their care."

"The Safeguarding Team had delivered Mental Capacity Act (2005) and Deprivation of Liberty Safeguarding training to ward-based teams following feedback staff found the processes confusing."

"There were effective systems to safeguard women and their babies from harm. Women identified as high risk were offered enhanced care by specialist midwives".

However, the CQC identified areas of improvement in:

Training compliance across Safeguarding and Mental Capacity.

"The Trust must ensure all clinical and non-clinical staff receive the appropriate level of safeguarding children training: as directed in the Intercollegiate guidance: Safeguarding Children and Young People: Roles and Competencies for Health Care Staff (March 2014)."

"The Trust should ensure mandatory training is completed by medical staff in line with trust policy, in particular, mental capacity and deprivation of liberty safeguarding training. Possible breach of regulation 18(2)"

"Medical staff did not meet the trust target for mental capacity training". Nursing and medical staff knowledge of mental capacity issues was not up to date. The trust did not meet the trust target for Mental Capacity Act training completion.".

Documentation of Mental Capacity Act & Deprivation of Liberty Safeguards.

"not all Deprivation of Liberty Safeguards were reviewed in a timely manner."

Availability of Supervision for Named Nurse and relevant Nursing Teams

"The Trust should ensure children's safeguarding lead is in receipt of regular one to one safeguarding supervision."

"The Trust should ensure staff are in receipt of regular group supervision. Possible breach of regulation 13(1)(2)".

Safeguarding Compliance within Children's Services

"The Trust should ensure that they have robust procedures and processes that make sure that people are protected. Safeguarding must have the right level of scrutiny and oversight with overall responsibility held by the board".

"The Trust should ensure there is a medical lead for safeguarding. Possible breach of regulation 13(1)(2)"

Lessons Learned Newsletter

The Trust's Safeguarding and Mental Capacity Team publishes a bi-monthly lesson learned Newsletter. In 2019-20 the Safeguarding Team wrote lessons from internal and statutory Safeguarding Reviews relating to:

- The need to document those in attendance with patients when attending appointments (both name and relationship)
- Recognition of the impact of mental ill health on domestic abuse and vice versa
- Recognition of the impact of caring responsibilities
- Recognition of coercive control
- The need to use Mental Capacity care plans and Deprivation of Liberty (DoLS) scoping tools

- The need to signpost patients to relevant support services
- The need for appropriate and timely escalation of concerns
- The need to convene discharge planning meetings for children with complex care needs and/or safeguarding concerns (and to challenge and escalate if requests are declined)
- Professional curiosity and use of language to disclose abuse such as ‘coercion and control’, ‘sexual abuse’ and ‘domestic abuse’
- The need to recognise the power of language within documentation and when speaking with patients
- The need to adhere to Domestic Abuse Protocols and to ascertain the name of an assailant when a patient attends following an assault
- The need to access official Trust Translations services when managing potential safeguarding, domestic abuse or complex care concerns.
- Marks and bruises on non-mobile babies should always be referred to children’s services
- Safeguarding duty in relation to patients who have Professional roles and responsibilities
- Recognition and management of patients exploited via County Lines
- Domestic Violence Disclosure Scheme (DVDS)
- Recognition and management of Child to Parent/Carer Abuse
- The need to complete the ‘free text’ box for A&E admissions to ensure effective information-sharing with GPs
- Child Death Overview Process
- LSCP Policy and Procedure Manual, raising awareness of the various Policies available (e.g. Mobile Families)

The Year ahead: April 2020 – March 2021

Our Safeguarding and Mental Capacity Team's objectives include:

- Further embedding Mental Capacity Act (MCA) and NICE guidance
- Evidence-gathering and uploading to support Section 11 compliance submission
- Supporting the Trust in its management of the COVID-19 pandemic
- Implement new Liberty Protection Safeguards (LPS) Framework and processes (once published)
- Continue to provide individualised support to all staff who experience domestic abuse and stalking
- Continued support for the Divisional Safeguarding Model to support and empower frontline staff in the management of safeguarding their patients
- Continuation of safeguarding training offer, with proposal to amend safeguarding children's training offer in line with LSCP six-year pathway
- Continuation of training programme for 'hidden child' areas
- Continuation of safeguarding supervision offer – with plans to support safeguarding supervision training for Managers/Matrons
- Continuation of the Domestic Abuse audit to monitor compliance with Domestic Homicide Review (DHR) recommendations; continuation of quarterly compliance audits
- Delivery of a Masterclass to support staff in maintaining patient safety in the context of Domestic Abuse

- Continuation of the Translation Services audit within Midwifery Services
- Review of the pre-birth protocol
- Development of a training programme to support staff members who are required to participate in Family Court processes
- Review of all training programmes for April 2021
- CP-IS (Child Protection Information Sharing) Audit to monitor compliance with the Trust's CP-IS processes
- Completion of the various Safeguarding projects identified within the Trust's Integrated Improvement Plan.
- Review the capacity of the safeguarding team to ensure it is able to meet its future challenges

Our Safeguarding vision

ULHT firmly believes that a whole-organisational approach is required to safeguard and promote the welfare of children, young people and vulnerable adults using Trust services.

ULHT very much emphasises that Safeguarding is everyone's business, whether they provide direct patient care or not and irrespective of seniority. This will require Safeguarding Governance and practices to be embedded across all Divisions and Services provided by the Trust, and in every aspect of the Trust's work.

There will be robust Governance arrangements around the Safeguarding agenda and all staff working within United Lincolnshire Hospitals NHS Trust will be able to discharge their Statutory responsibilities within their Professional boundaries through developing a workforce who are competent, confident and empowered to speak up and take action when they see or suspect safeguarding issues.

Shared learning will enhance and shape service provision.

ULHT fully supports the 'Making Safeguarding Personal' Agenda within Safeguarding and plans to do this through building supportive internal processes and pathways that enable the needs of patients to be met in a dignified manner, which also includes responses to incidents and concerns.

The patient and carer's experience will also be enhanced by the provision of effective Partnership working with other Agencies, which will aid seamless service provision.

ULHT is committed to maintaining patients' right to be safe and is aware that professional inter-Agency working is critical to ensure that patients receive seamless care.

Safeguarding and Mental Capacity Act Team
September 2020

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*6 October 2020*
Item Number	*Item number allocated by admin*
Nurse Establishment Review	
Accountable Director	*Karen Dunderdale*
Presented by	*Karen Dunderdale* *Director of Nursing*
Author(s)	*Karen Dunderdale, Director of Nursing* *Simon Evans, Chief Operating Officer* *Paul Matthews, Director of Finance*
Report previously considered at	*ELT* *1 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	*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	
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	*Significant*

Recommendations/ Decision Required	• *Approve Establishment*

Executive Summary

A comprehensive Nurse Establishment Review was undertaken in August 2020 for all 4 Divisions to enable the Director of Nursing to be assured that the current nurse establishments were appropriate for the Trust in light of the development of the Nursing Workforce Transformation Group and to ensure that the nursing establishments and shift arrangements delivered the optimum balance of care quality and efficient use of resources in the context of the recent COVID-19 pandemic.

The paper sets out the methodology for the reviews, the outcomes and the next steps.

Nurse Establishment Review

1: Nursing Review Process:

The Nurse Establishment Review set out in August 2020 to take forward a comprehensive review of ward nursing levels for two reasons:

1) To enable the new director of nursing to satisfy herself that the current nurse establishments were appropriate for the Trust in light of the development of the recent Nursing Workforce Transformation Group.
2) A comprehensively review of establishments to ensure that nursing establishments and shift arrangements delivered the optimum balance of care quality and efficient use of resources in the context of the recent COVID-19 pandemic.

This paper sets out a review for the divisions of Medicine, Surgery & Critical Care, Clinical Support Services and Family Health, reflecting the core bed base.

2. Medical In-Patient Wards – Reviewed:

This review element covers the following areas on the Pilgrim Hospital site:

- Integrated Assessment Centre
- Acute Cardiac Unit
- AMSS
- Stroke Unit
- Ward 6A
- Ward 6B
- Ward 7B (Respiratory)
- Ward 8A

The review covers the following areas on the Lincoln County site:

- Scampton
- Lancaster
- Burton
- Navenby
- Digby(Dixon)
- Carlton Coleby
- Stroke Unit
- Johnson
- Frailty Assessment Unit
- MEAU

FAU – This ward was reviewed with a core bed base of 19 beds. A separate business case would be required to increase beds in the ward due the risks associated with social distancing and the associated patient safety risks.

MEAU – The ward was reviewed with a core bed base of 50 beds which is an increase of 10 beds from any previous establishment reviews due to the ward operating consistently at 50 bed capacity.

The Emergency Departments on each site will be subject to separate reviews during October 2020 in line with ECIST modelling.

3. **Surgical In-Patient Wards – Reviewed:**

This review covered the following areas on the Pilgrim Hospital site:

- Ward 9A
- Day Case
- Ward 5A
- Ward 5B
- ICU

The review covers the following areas on the Lincoln County site:

- Greetwell
- Clayton
- Hatton
- Neustadt Welton
- SEAU
- Shuttleworth
- ICU
- SAL

Theatres – although theatres were reviewed their establishment remains the same in light of a comprehensive establishment review in 2019

Bevan establishment remains the same as the staff and beds have been dispersed to other wards as part of the COVID plan

The ICU at LCH is commissioned for a 10 level 2 beds and 6 level 3 beds. In order to provide flexibility into the establishment a proportion of the budget has been identified for reinvestment for bank or agency. This is shown as an initial saving which is offered back into the budget for temporary workforce needs. This establishment will be reviewed on a monthly basis to ensure the templates reflect the patient needs and educational requirements of the staff.

4. **Clinical Support Services Wards – Reviewed:**

- Waddington
- Ashby
- Bostonian (previously 7A)

5 **Family Services Wards – Reviewed**:

- Neonatal units at LCH and PBH

Birthrate Plus has been commissioned to review our maternity establishments although for the purposes of this review both Nettleham and M1 have agreed to the supernumerary and supervisory time for the ward leader detailed below.

A specific review of the paediatric wards will be undertaken as part of a wider paper to the Board regarding the interim paediatric service configuration.

6 **Methodology**

Each establishment review was undertaken with the ward leader, matron, divisional nurse, supported by finance colleagues and the deputy director of nursing who leads on

workforce. An objective approach using evidence was taken to ensure consistency of approach and robustness of outcome which stands up to scrutiny.

Wards completed data on a daily basis as part of the Safer Nursing Care Tool to take into account acuity, dependency and complexity of care in order to ensure the nursing levels are optimised for workloads in each area.

Establishments have been reviewed using the Trust's long day and long night shift pattern and where appropriate 1 short shift pattern to create flexibility in the rota.

Shift patterns with appropriate staff numbers have been collated using an objective evidence based establishment setting tool, which is configured to create both an establishment and budget for any given shift pattern. The model uses the following assumptions:

- Shift patterns as identified for each ward area
- Leave cover arrangements based upon standard leave entitlements (33 + 8 B/H)
- Training cover set to 8 days per WTE per year
- Sickness absence cover set at 3.65% sickness rate (bank cover)

The calculated establishments include all nursing but exclude ward support functions and ward administration. They do include supernumerary nurse management time tied directly to the ward establishment. This has been apportioned to a 60:40 split reflecting 3 days supernumerary and 2 days clinical supervisory, therefore, legitimising actual practice and in line with the Ward Leaders handbook.

In addition, the review assumed a default position of two registered nurses on night shift as a minimum. The weighting of 0.25 WTE was offered per side room for each ward taking into account the geographical footprint of the ward and potential to have a reduced line of sight when in the side rooms. Donning and doffing was a consideration and additional hours were aligned to those areas who have a requirement to care for high risk patient where this practice would occur.

Each ward was reviewed with regard to the nursing workforce plan to incorporate Nursing Associates and extended clinical placements for student nurses. A separate workforce plan will be developed to reflect this outcome.

7. Outcome of the Review:

Appendix 1 summaries the outcome for each ward based on the core number of beds, occupancy and acuity of patients.

Roster plan appendices, with the detailed calculations for each area, including the occupancy rate assumptions and acuity rate underlying all establishment calculations, are available separately.

Table 1 below provides high level information regarding the WTE, cost and variance

Table 1

Division	Ward	New Establishment WTE	New Establishment £	Bank WTE	Band £	Total New WTE	Total New £	Budget WTE	Budget £	Impact WTE	Impact £
Medicine	Integrated_Assessment_Centre	41.07	1,651,600	0.00	0	**41.07**	**1,651,600**	39.79	1,596,800	1.28	54,800
Medicine	Acute_Medical_Short_Stay_Unit	62.54	2,384,100	0.00	42,700	**62.54**	**2,426,800**	56.88	2,245,800	5.66	181,000
Medicine	Acute_Cardiac_Unit	24.38	906,400	0.00	5,500	**24.38**	**911,900**	26.62	1,035,900	-2.24	-124,000
Medicine	Pilgrim_Stroke_Unit	32.38	1,234,300	0.00	0	**32.38**	**1,234,300**	38.50	1,486,000	-6.12	-251,700
Medicine	Ward_6A	39.47	1,454,900	0.00	0	**39.47**	**1,454,900**	42.62	1,582,300	-3.15	-127,400
Medicine	Ward_6B	39.47	1,469,700	0.00	0	**39.47**	**1,469,700**	42.62	1,597,600	-3.15	-127,900
Medicine	Ward_7B_Respiratory	41.07	1,548,800	0.00	0	**41.07**	**1,548,800**	41.62	1,564,300	-0.55	-15,500
Medicine	Ward_8A	43.82	1,654,000	0.00	0	**43.82**	**1,654,000**	44.22	1,670,900	-0.40	-16,900
Medicine	Scampton_Ward_Old_Hatton	28.04	1,027,500	0.00	0	**28.04**	**1,027,500**	28.44	1,043,800	-0.40	-16,300
Medicine	Lancaster_Ward	28.04	1,044,000	0.00	0	**28.04**	**1,044,000**	28.44	1,060,700	-0.40	-16,700
Medicine	Dixon_Ward	41.07	1,561,900	0.00	0	**41.07**	**1,561,900**	35.76	1,349,600	5.31	212,300
Medicine	Navenby_Respiratory	34.67	1,152,100	2.40	89,900	**37.07**	**1,242,000**	38.96	1,279,900	-1.89	-37,900
Medicine	Frailty_Assessment_Unit	28.04	1,053,200	0.00	0	**28.04**	**1,053,200**	31.52	1,171,000	-3.48	-117,800
Medicine	Burton_Ward	30.00	1,116,000	0.00	0	**30.00**	**1,116,000**	28.44	1,071,100	1.56	44,900
Medicine	Carlton_Coleby_Diabetes	38.56	1,208,000	0.00	0	**38.56**	**1,208,000**	29.36	947,600	9.20	260,400
Medicine	Lincoln_Stroke_Unit	47.02	1,804,400	0.00	0	**47.02**	**1,804,400**	44.22	1,729,100	2.80	75,300
Medicine	Johnson_Ward	65.61	2,669,200	0.00	0	**65.61**	**2,669,200**	64.43	2,650,500	1.18	18,700
Medicine	Lin_Emergency_Assessment_Unit	77.89	3,059,800	0.00	0	**77.89**	**3,059,800**	71.28	2,833,300	6.61	226,500
Surgery	Ward_9A	39.24	1,451,800	0.00	0	**39.24**	**1,451,800**	36.44	1,354,500	2.80	97,300
Surgery	Ward_5A	41.76	1,598,200	0.00	0	**41.76**	**1,598,200**	38.39	1,496,100	3.37	102,100
Surgery	Ward_5B	36.50	1,371,800	0.00	0	**36.50**	**1,371,800**	36.90	1,378,800	-0.40	-7,000
Surgery	Day	19.12	617,400	0.00	0	**19.12**	**617,400**	23.45	766,500	-4.33	-149,100
Surgery	Bevan	0.00	0	0.00	0	**0.00**	**0**	20.44	793,500	-20.44	-793,500
Surgery	ICU_PHB	48.88	2,283,500	0.00	0	**48.88**	**2,283,500**	53.85	2,497,400	-4.97	-213,900
Surgery	ICU_L1	0.00	0	0.00	0	**0.00**	**0**	4.70	154,800	-4.70	-154,800
Surgery	Greetwell_Ward	35.58	1,331,300	0.00	0	**35.58**	**1,331,300**	32.50	1,229,000	3.08	102,300
Surgery	Clayton_Ward	33.30	1,286,100	0.00	0	**33.30**	**1,286,100**	30.98	1,213,300	2.32	72,800
Surgery	Hatton_Ward	33.07	1,345,300	0.00	0	**33.07**	**1,345,300**	42.51	1,699,800	-9.44	-354,500
Surgery	Neustadt_Welton	55.48	2,149,200	0.00	0	**55.48**	**2,149,200**	38.62	1,500,100	16.86	649,100
Surgery	SEAU	40.39	1,609,000	0.00	0	**40.39**	**1,609,000**	39.77	1,612,100	0.62	-3,100
Surgery	Shuttleworth_Ward	41.76	1,569,800	0.00	0	**41.76**	**1,569,800**	42.60	1,620,100	-0.84	-50,300
Surgery	ICU_Lincoln	65.33	2,936,200	0.00	0	**65.33**	**2,936,200**	80.36	3,531,000	-15.03	-594,800
Surgery	SAL	18.27	602,100	0.00	0	**18.27**	**602,100**	15.40	517,400	2.87	84,700
Family Health	Nettleham_Ward	36.73	1,561,100	0.00	0	**36.73**	**1,561,100**	36.96	1,576,000	-0.23	-14,900
Family Health	Ward_M1_Maternity	21.96	1,014,500	0.00	18,600	**21.96**	**1,033,100**	22.36	1,055,600	-0.40	-22,500
Family Health	Branston_Ward	17.29	660,000	0.00	0	**17.29**	**660,000**	21.39	819,300	-4.10	-159,300
Family Health	Ward_1B_Womens_Health	16.38	612,800	0.00	0	**16.38**	**612,800**	15.33	592,800	1.05	20,000
Family Health	Neonatal_Services	46.87	1,907,600	0.00	0	**46.87**	**1,907,600**	46.81	1,907,400	0.06	200
Family Health	SCBU	24.27	1,007,700	0.00	0	**24.27**	**1,007,700**	24.68	1,024,200	-0.41	-16,500
CSS	Waddington	41.30	1,533,800	0.00	0	**41.30**	**1,533,800**	42.21	1,634,800	-0.91	-101,000
CSS	Ashby	28.27	1,093,400	0.00	0	**28.27**	**1,093,400**	28.88	1,121,400	-0.61	-28,000
CSS	Bostonian	33.76	1,260,400	0.00	0	**33.76**	**1,260,400**	27.80	1,076,300	5.96	184,100
TOTAL		**1,518.65**	**58,802,900**	**2.40**	**156,700**	**1,521.05**	**58,959,600**	**1,537.05**	**60,088,400**	**-16.00**	**-1,128,800**
TOTAL EXCLUDING LINCOLN ICU		**1,453.32**	**55,866,700**	**2.40**	**156,700**	**1,455.72**	**56,023,400**	**1,456.69**	**56,557,400**	**-0.97**	**-534,000**

7. Workforce Changes:

The establishment requirement set by this review process will be compared to the current staffing in post with the following actions to take place to re-align/recruit staffing where there are gaps following the review.

Recruitment actions will include:

- Implement recruitment in accordance with the Trust Recruitment Strategy
- Cohort recruitment and establishment of talent pools
- Support our HCAs to nursing associate or RN training and backfill with an apprentice provision yet to be worked up
- Support placement of Return to Practice Nurse
- Continue to actively recruit through local and national recruitment drives
- Review competencies and skills to determine new and emerging roles
- Develop a Nursing Workforce plan in line with new roles

8. Implementation Plan:

The implementation plan will include the following elements:

Action: Implement roster plan changes within e-rostering system
Date: November 2020

9. Next steps:

- Implementation of the establishments in line with the implementation plan
- Undertake a skill mix review in 6 months
- Feed the output of the establishment reviews into the Nursing workforce work-stream to ensure agency controls continue to be in place
- Plan for the introduction of Nursing Associates into the establishments in line with the workforce plan
- Work through the financial impact of any identified ward inefficiencies

Dr Karen Dunderdale, Director of Nursing
Simon Evans, Chief Operating Officer
Paul Mathews, Director of Finance

October 2020

APPENDIX 1 - NURSING ESTABLISHMENT CONFIRM AND CHALLENGE SUMMARY

	Ward	No. of Beds	Bed Occ.	Acuity	Shift	Current Skill mix RN	Current Skill mix HCA	Existing establishments RN	Existing establishments CSW	Existing establishments Overall	Nursing team proposed RN	Nursing team proposed HCA	WTE Required for Proposed Nursing RN	WTE Required for Proposed Nursing CSW	WTE Required for Proposed Nursing TOTAL
Lincoln	Ashby	18	100%	2	Long Day	3	2	15.90	12.98	28.88	3	2	15.23	13.03	28.26
					Long night	2	3				2	3			
	Burton	20	100%	2	Long Day	3	3	14.72	13.72	28.44	3	4	14.32	15.68	30.00
					Long night	2	2				2	2			
	Carlton Coleby	28	95%	3	Long Day	4	4	17.24	12.12	29.36	4	3	19.58	18.98	38.56
					Long night	3	2				3	3			
	Clayton	27	95%	2	Long Day	4	3	19.46	11.52	30.98	4	3	19.58	13.72	33.30
					Long night	3	2				3	2			
	Digby / Dixon	28	100%	3a	Long Day	4	4	20.44	15.32	35.76	5	3	24.84	16.23	41.07
					Long night	3	2				4	3			
	FAU	19	100%	3	Long Day	4	3	15.52	16.00	31.52	3	3	14.32	13.72	28.04
					Long night	3	2				2	2			
	Greetwell	28	95%	2	Long Day	4	3	20.38	12.12	32.50	4	3	20.95	14.63	35.58
					Long night	3	2				3	2			
	Hatton	22	95%	3a	Long Day	5	3	27.76	14.75	42.51	4	2	22.09	10.98	33.07
					Long night	5	2				4	2			
	ICU	16	79%	7	Long Day	13	1	72.37	7.99	80.36	11	1	60.08	5.26	65.33
					Long night	13	1				11	1			
	Johnson	44	90%	5	Long Day	9	4	47.96	16.46	64.43	9	4	46.63	18.98	65.61
					Long night	8	2				8	3			
	Stroke	27	90%	4a	Long Day	5	4	28.90	15.32	44.22	6	4	28.04	18.98	47.02
					Long night	4	2				4	3			
	MEAU	50	100%	4a	Long Day	9	5	49.33	21.95	71.28	10	5	51.13	26.75	77.88
					Long night	6	4				9	5			
	Navenby	23	90%	4	Long Day	4	3	22.50	16.46	38.96	4	3	23.35	13.72	37.07
					Long night	4	2				4	2			
	N/Welton	28	90%	4a	Long Day	7	5	22.38	16.24	38.62	7	5	33.30	22.18	55.48
					Long night	5	3				5	3			
	Scampton	20	100%	1	Long Day	3	3	14.72	13.72	28.44	3	3	14.32	13.72	28.04
					Long night	2	2				2	2			
	SAL	16	33%	3	Long Day	3	2	11.32	4.08	15.40	3	2	12.91	5.36	18.27
					Long night	2	0				2	0			
	SEAU	20	95%	4a	Long Day	5	3	26.05	13.72	39.77	5	2	24.38	16.01	40.39
					Long night	4	2				4	2			
	Lancaster	20	100%	1	Long Day	3	2	14.72	13.72	28.44	3	3	14.32	13.72	28.04
					Long night	3	2				2	2			
	Shuttleworth	28	95%	3a	Long Day	5	4	27.28	15.32	42.60	5	4	24.84	16.92	41.76
					Long night	4	2				4	2			
	Waddington	26	100%	4	Long Day	5	3	30.84	11.37	42.21	5	3	24.15	17.15	41.30
					Long night	4	1				3	3			
Pilgrim	ACU	16	95%	3	Long Day	4	2	19.52	7.10	26.62	3	2	13.86	10.52	24.38
					Long night	3	1				2	2			
	AMSS	48	90%	3a	Long Day	7	6	34.93	21.95	56.88	7	6	35.56	26.98	62.54
					Long night	6	4				6	4			
	Day Ward	12	16%	3	Long Day	2	1	15.20	8.25	23.45	2	1	11.12	8.00	19.12
					Long night	2	1				2	1			
	IAC	24	90%	3	Long Day	5	3	23.55	16.24	39.79	5	3	24.84	16.23	41.07
					Long night	5	3				4	3			
	ICU	9	91%	7	Long Day	8	2	48.39	5.46	53.85	8	3	44.07	4.80	48.87
					Long night	8	1				8	0			
	ICU Level 1							2.35	2.35	4.70	0	0	0.00	0.00	0.00
											0	0			
	Stroke	24	90%	3	Long Day	4	4	25.24	13.26	38.50	4	3	19.12	13.26	32.38
					Long night	3	2				3	2			
	Bostonian/ 7A	18	90%	2	Long Day	4	3	19.20	8.60	27.80	4	3	20.04	13.72	33.76
					Long night	3	2				3	2			
	Bevan	12			Long Day	2	1	14.72	5.72	20.44	0	0	0.00	0.00	0.00
					Long night	2	1				0	0			
	5A	29	100%	3a	Long Day	5	4	23.07	15.32	38.39	5	4	22.78	18.98	41.76
					Long night	3	2				3	3			
	5B	25	80%	3	Long Day	5	3	22.18	14.72	36.90	5	2	22.78	13.72	36.50
					Long night	3	2				3	2			
	6A	28	92%	3	Long Day	5	4	23.18	19.44	42.62	4	4	20.04	19.44	39.48
					Long night	3	3				3	3			
	6B	28	95%	3	Long Day	5	4	23.18	19.44	42.62	4	4	20.04	19.44	39.48
					Long night	3	3				3	3			
	7B	25	98%	3a	Long Day	5	4	24.70	16.92	41.62	5	3	24.84	16.23	41.07
					Long night	4	2				4	3			
	8A	29	100%	3a	Long Day	5	4	25.24	18.98	44.22	5	4	24.84	18.98	43.82
					Long night	4	3				4	3			
	9A	32	90%	3	Long Day	5	4	21.58	14.86	36.44	5	4	22.78	16.46	39.24
					Long night	3	2				3	2			
Family Health	Branston	18	30%	2	Long Day	2	1	15.07	6.32	21.39	2	1	11.58	5.72	17.29
					Long night	2	1				2	1			
	1B	12	50%	3	Long Day	3	2	11.56	3.77	15.33	2	1	11.12	5.26	16.38
					Long night	2	1				2	1			
	Neonatal Services	21	30%	4	Long day	6	2	34.01	12.80	46.81	6	2	33.61	13.26	46.87
					Long night	6	2				6	2			
	Nettleham	30	80%		Long day	5	2	22.95	14.01	36.96	5	2	22.55	14.18	36.73
					Long night	3	2				3	2			
	Ward M1 Maternity	15	80%		Long day	3	2	14.36	8.00	22.36	3	2	13.96	8.00	21.96
					Long night	2	1				2	1			
	SCBU	12	50%	2	Long day	3	2	17.24	7.44	24.68	3	2	16.84	7.44	24.27
					Long night	3	1				3	1			
TOTAL WARD BASED ESTABLISHMENT (EXCLUDING ENHANCEMENT & SUPERNUMERY POSTS)								1,001.21	535.83	1,537.05			944.72	576.33	1,521.05
MOVEMENT FROM CURRENT BASELINE ESTABLISHMENTS													56.49	(40.50)	16.00 0.01

SUMMARY

1. Utilisation of the SNCT tool and professional adjustments (largely for side rooms, donning & doffing & the role of the ward leader) results in a reduction in RN's of 56.49 wte and CSW's increased by 40.5 CSW from existing baseline establishment over the wards that have been assessed
2. The above table includes the addition of 0.6WTE sister/ charge nurse for each area who will operate supernumeray and is funded in addition to the wte's quoted within the above establishment review
3. Board can therefore take assurance the current establishment for ward based care matches SNCT required levels and includes professional judgement adjustments therefore offers safe care levels when fully established

Report to:	Trust Board
Title of report:	People and OD Committee Assurance Report to Board
Date of meeting:	16th September 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** **Workforce Strategy Group** The Committee received an upward report from the group noting that further updates would not be received, assurance would be provided through the Committee Performance Dashboard, this would also provide assurance against the Board Assurance Framework. The Workforce Strategy Group would review and provide assurance to the Committee on the dashboard, highlighting areas of concern. A 4 weekly cycle of meetings had been scheduled which would provide focus to the NHS People Plan. The Committee were advised that the current suite of KPIs were not comprehensive and did not cover all issues and concerns. Work was ongoing to develop the suite of metrics. The Committee approved the terms of reference and work programme for the group.

	Pulse Survey Feedback The Committee received the first set of feedback from the Pulse Survey noting that 900 staff had responded. This had provided useful feedback about how staff felt compared with other Trusts. The Committee were advised that the fortnightly frequency of the surveys would reduce to monthly and data received would provide a trend. The importance of support from line managers was noted and it was recognised that whilst local wellbeing support phone lines were in place these were not being accessed by staff. The Committee welcomed the report and were pleased that regular reports would be received. **Safe Staffing** The Committee noted that there continued to be a static use of bank staff with a slight decrease in agency usage. This reflected the check and challenge now in place regarding baseline roster creation. It was anticipated that vacancy as a top reason for the use of agency would reduce due to the arrival of international nurses and newly qualified nurses to the Trust. More structured use of higher rate agency was being seen and this was being planned and approved at Executive level, providing grip and control. The Committee were pleased to note that the establishment reviews had been completed and were due to be presented to the Board in October. Consideration was being given to a medical workforce transformation programme, discussion would take place with the Trust Leadership Team regarding the construct of the medical workforce. Progress would be reported to the Committee. Clarity on the 95% fill rate in order to understand how this would be managed in smaller teams. The Committee were advised that fill rate

	was considered over 1 month, gaps that could be absorbed i.e sickness were considered through roster planning.
	Assurance in respect of SO 2b **Issue: Making ULHT the best place to work** **Bullying, violence and harassment update** The Committee were advised that this had been aligned under the values and behaviours project initiation document within the Integrated Improvement Plan. Activity had been adapted in response to the pandemic and it was recognised that there has been a lot of emotional growth in the Trust over the manage phase. Elements of the bullying and harassment workshops had been moved to virtual workshops to support staff to access these and there had been a re-emphasis on the building respectful teams challenges. Consideration was being given to the alignment and integration of the workshops with cultural inclusion training in order that these could be jointly delivered. The Committee noted that this was an iterative approach with some specific and bespoke aspects being delivered to support teams and managers. Action requested by the Committee: The Committee requested that future reports contained detail of the effectiveness of the programmes and the progress and impact being seen in those teams/areas of concern. **Employee relations update** The Committee noted that there had been a national agreement to put activity on hold. During this time there had been a significant increase in relation to grievances, poor behaviour and fraud. It was noted that the Trust were unable to know which staff had been referred to a medical body and work was being undertaken in order to ensure the Committee were sighted on the numbers of staff referred. The Committee were pleased to note that the Trust had successfully defended the last 7 employment tribunals. This demonstrated that the

	Trust was now more willing to defend itself and that there was improved process and decision making in place with policies and procedures being followed by managers. This provided assurance of the robustness of practice.
	Assurance in respect of SO4c **Issues: To become a University Hospitals Teaching Trust** **University Hospitals Teaching Trust update** The Committee received an update on the position of the Trusts desire to move to a University Hospitals Teaching Trust and were advised that groundworks on the project would need to commence as soon as possible. The Committee agreed that this was an exciting opportunity for the Trust however there needed to be a clear timetable in place of actions to be taken in order that assurance could be received. The Committee noted that there needed to be a wider inclusion of staff groups within the plans to ensure that this supported multidisciplinary teams, inclusive of the nursing workforce and allied health professionals. Action requested by the Committee: The Committee requested that an outline plan and timelines be reported to the November Committee followed by quarterly updates on progress. **Medical School update** The Committee raised concern regarding timescales and ensuring due process was followed in order that the medical school could be opened in February 2022. Further work would be required on the capital element of the plan in order that this could be realised. To date 1 professorial post had been appointed to with 2 further posts requiring appointments. Consideration to alternative appointments, including job shares, were underway in order to attract candidates. The Committee noted the need to develop an audit programme to demonstrate how the divisions would be able to support Junior Doctors

	from the medical school. The Committee noted that the plan for the medical school needed to be in place and timescales would be included to identify critical elements.
	Assurance in respect of other areas: **Board Assurance Framework** The Committee considered the Board Assurance Framework noting the assurance ratings provided. The Committee requested that the narrative in relation to objective 4c be strengthened. As the narrative and reports provided to the Committee did not provide the required level of assurance objective 4c was moved to a red assurance rating. **Committee Performance Dashboard** The Committee received an updated report which contained more information than had previously been received. An overview of the levels of assurance against work streams had been provided. The Committee were advised that the area of focus for the month had been appraisals and wellbeing conversations had commenced with staff in line with the NHS People Plan. The Committee noted concern regarding safeguarding level 3 training and were provided with assurance that the appointment to the Deputy Director of Safeguarding role had resulted in focus being provided. The Committee raised concerns about the pressures and wellbeing of staff in the organisation and concerns regarding any potential impact of a second wave of Covid-19.
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. The use of relevant data to support the level of risk and assessment would provide a robust and defensible position for risk
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	**S**	**N**	**D**	**J**	**F**	**M**	**A**	**M**	**J**	**J**	**A**	**S**
Geoff Hayward (Chair)	X	X	X	X	A	A	No meetings held due to Covid-19			X	X	X
Sarah Dunnett	X	X	A	X	X	X				X	X	X
Non-Voting Members												
Martin Rayson	X	X	X	X	X	X				X	X	X
Matthew Dolling	A	A										
Debrah Bates												
Simon Evans	X	X	A	A	A	D				X	D	D
Victoria Bagshaw	X	X	X	X	X							
Karen Dunderdale						A				X	X	X

Report to:	Trust Board
Title of report:	Finance, Performance and Estates Committee Assurance Report to Board
Date of meeting:	24 September 2020
Chairperson:	Gill Ponder, Non-Executive Director
Author:	Karen Willey, 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 Estates, Infrastructure and Environment Group** The Committee received the upward report noting that future reports would be structured to ensure all statutory requirements were covered. This would ensure the Committee were better sighted on all the issues outstanding across the Trust. The Committee would continue to receive updates in relation to water flushing with a focus on the capital spend and associated risks. The quality of water would be monitored through the Infection Prevention and Control Group and upward reported to the Quality Governance Committee. Planned investment in 2020/21 would alleviate some of the historical issues. Concern was raised by the Committee regarding the low completion of core learning within the Estates Team. The Committee were advised that due to the nature of the work undertaken within the team, staff did not routinely have access to IT equipment. Drop-in sessions and additional IT equipment were being provided to support staff to complete online training. **Issue: Assurance/Exception Report Fire** The Committee received further information in relation to the fire call point being deactivated at Pilgrim Hospital and were assured that appropriate action had been taken.

	The Committee received an update in respect of the completion of the capital fire compliance works noting that there had been some delay due to the impact of Covid-19. The Trust were seeking to increase the speed of delivery. The Committee were advised that an Authorising Engineer for Fire had been appointed to provide a new perspective within the Trust. The appointment would see an assessment of the Estates team structure to deliver the necessary improvements to be fully compliant with Fire Safety The Trust were looking to increase capital project manager capacity in order that capital works could be delivered appropriately. It was expected that there would be a rapid increase in pace to deliver the fire recovery plan and dialogue was taking place with Lincolnshire Fire and 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 5 driven by the financial regime in place. The Committee noted that the requested top up had reduced in August to £1.4m demonstrating that the cost base was beginning to reduce as the non-recurrent costs of responding to Covid-19 came to an end. As further activity was undertaken to recover activity levels in the Trust the marginal cost base would increase. Non-pay costs were increasing in line with activity increased to £29.4m on PBR in August, up on £21.2m in April. The Trust had achieved year to date delivery of CIP at £3.1m demonstrating that a focus has not been lost and progress was being made. Delivery was being well received by regional finance colleagues as there had not been a requirement on delivery in the first 6 months of the year. Revised capital funding levels were reported as £45.2m and the Committee received a breakdown of funding for areas across the Trust. The Committee were advised that the delivery of the capital programme would not be greatly impacted if a second wave of Covid-19 was experienced. This was due to the programme being procurement heavy against impact light schemes, this would mean work could be carried out without the need to move large numbers of wards. The Committee received the CRIG Upward Report for information.

	Issue: Use of resources The Committee received the report and requested that this was developed into a programme of work allowing progress to be reported to the Committee.
	Lack of Assurance in respect of SO 3c Enhanced Data and Digital Capability **Issue: Assurance/Exception Report Digital Group** The Committee received the report noting the technical risk associated with unpatched computers and servers. The Committee were advised this was a national issue and NHS Digital were supporting progress towards a solution. In the meantime, the risk was being mitigated by the use of network segregation. The Committee acknowledged the size and complexity of the e-health record transformation programme noting that this was critical to the future aspirations of the Trust. Concern was raised by the Committee in relation to the lack of clinical engagement. The Committee were advised that the Director of Finance and Digital was undertaking a refresh of the programme including appointing a Chief Clinical Information Officer and a Chief Nursing Information Officer to ensure clinical engagement was at the forefront of the programme. Wider work with the system was required in order to ensure that the use of the shared care record was delivered effectively and a Chief Information Officer to the system had been appointed. A tender process would be required in order to identify a suitable system for the Trust. The e-Prescribing system had been delayed due to Covid-19 and the Trust were working with the supplier to identify a start date. Funding was in place to appoint to the project clinical posts which would drive the project forward. The Committee were pleased with the level of assurance received by the report even though some areas of concern remained.
	Assurance in respect of other areas: **Committee Annual Report 2019/20** The Committee received the updated annual report and requested the addition of further achievements. **Integrated Performance Report** The Committee were advised that there was an expectation of a positive move in agency costs due to recruitment to specific roles within the Trust. However high-level agency use had been agreed to support the bronze model in the emergency departments which would form a substantial part of the medical agency costs.

	Due to the potential second wave of Covid-19 and the continuation of services there may be a need to increase agency usage as the workforce would not be able to move as in wave 1. The Committee raised concern that with the appointment of staff there had been no reduction in agency spend. The nursing workforce was being addressed through the establishment review and nursing transformation programme and the Trust were keen to establish a similar programme for medical staff. Planning for phase 3 of the Covid-19 response would result in a revision of job plans. 4-hour emergency department performance was being managed and the Committee noted that footfall would continue to be seen if the country did not experience a further lockdown. Attendances would need to be managed if an increase in Covid-19 was seen and plans developed had assumed there would not be a reduction in demand. Grantham Green Site would support and offer a degree of protection to the emergency departments at Lincoln and Pilgrim as a full range of services on the blue sites could be offered. The Committee noted that 62-day cancer screening was reported as 0% but were assured that this was being recovered and a substantial increase was expected in the next reporting period. **Committee Performance Dashboard** The Committee received the dashboard noting that there continued to be a focus on clearing patient backlogs. The Trust however remained one of the best performers of 52 week wait delays in the region. The Committee were advised that the Trust were offering advice to other Trusts on how to manage the backlogs. This had been a complex risk based approached using national scoring mechanisms to identify priority patients with the application of clinical capacity and expertise on individual cases. The Committee noted that there did not appear to be an improvement in relation to diagnostics however were advised that this was due to reporting and the inclusion of a number of diagnostic services. There had been improvements seen in a number of individual services but not all. It was noted however that whilst the overall trend was not showing an improvement, endoscopy waiting times had reduced to below 14 days for the most acute patients. This represented the greatest rate of recovery in The Midlands. Diagnostic services, whilst part of the overall recovery plan, were not likely to significantly recover in the near future. This was expected to

	remain low as diagnostic services were provided to acute high-risk patients first before the backlog was addressed. **Performance Review Meeting upward report** The Committee noted the improved report received that identified the key issues from the divisions. The report would be further developed in order that assurances could be provided. The Committee noted the intention for the report to be presented to each of the Board Committees however there was a need to determine how the reporting would be effectively achieved. The Committee noted the continued fragility of the stroke service and that this continued to be delivered from a single site with input still being provided from NHS England. **Urgent Care Report** The Committee received the report noting the difficulties in the increased length of stay as there was a move back to normal ways of working. At the start of the response to Covid-19 improvements had been seen but these had not been sustained. The Committee were advised that a reduction in performance during September was forecast due to an impact on staffing levels and a knock-on consequence of flow and discharge difficulties. Results of swabbing of patients prior to discharge to care homes had also caused delay to discharges. To enable the Trust to continue to improve the safe provision of urgent care services, support was required from the wider system. It was hoped that 'talk before you walk' and 111 would help to alleviate some of the pressures during the winter period. **Integrated Improvement Plan Report** The Committee received the report noting the scale of the programmes detailed. The Committee requested inclusion of a link between delivery of activities in the improvement plan and the results and outcomes delivered as a consequence of completing those activities. In the light of a possible increase in Covid-19 cases, the Committee suggested that consideration was given to prioritising work in the 70 work streams for the remainder of the year, to avoid diluting the impact in key areas.
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 noting the new format and triangulation of risk
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 with the addition of Covid-19.
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	O	N	D	J	F	M	A	M	J	J	A	S
Gill Ponder, Non-Exec Director	X	X	X	A	X	X	No meetings held due to Covid-19			X	X	X
Geoff Hayward, Non-Exec Director	X	X	X	X	X	X				X	X	X
Chris Gibson, Non-Exec Director	X	A	X	X	A	X				X	X	X
Director of Finance & Digital	D	X	D	X	X	X				X	X	X
Chief Operating Officer	D	X	X	X	D	A				A	D	X
Director of Estates & Facilities	X	D	X	D	X							
Director of Improvement & Integration												A

X in attendance A apologies given D deputy attended

Provider Collaboration Review

Lincolnshire STP

***Michelle Dunna**, Inspection Manager*

Provider Collaboration Reviews

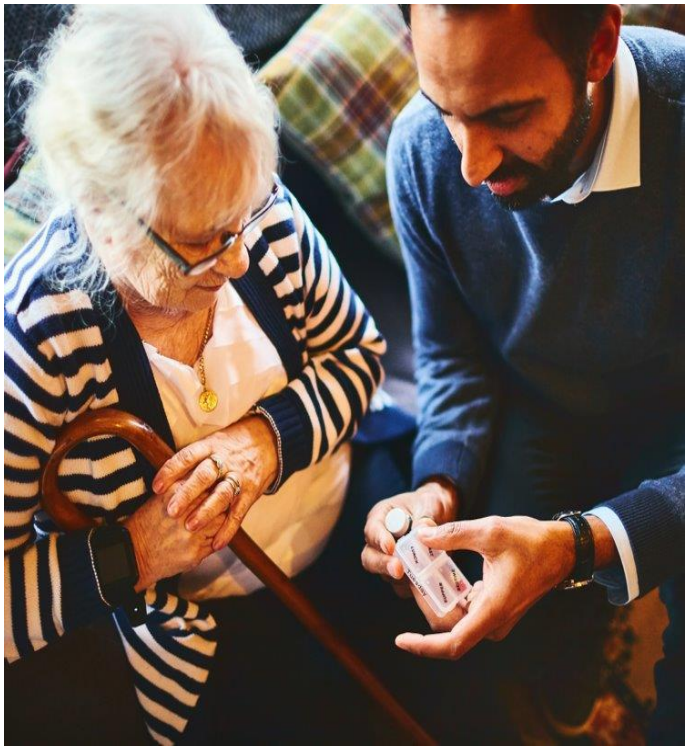
How have providers worked collaboratively in a system in response to the COVID-19 pandemic?

The Scope

- The journey for people over the age of 65 with/without COVID-19 across health and social care providers, including the independent sector, local authorities and NHS providers.

- The objective is to support providers across systems by sharing learning on the COVID 19 period and on how providers are preparing to re-establish services and pathways in local areas.

The outputs



- Feedback for each local System
- Insight report – September
- Final report – Chapter in state of care report October 2020.

Key Lines of Enquiry

- How have providers collaborated to ensure that people moving through health and care services have been seen safely in the right place, at the right time, by the right person?
- Was there a shared plan and system wide governance and leadership during the COVID -19 period?
- Was there a plan for ensuring the safety of staff, and sufficient health and care skills across the health and care interface during the COVID -19 period?
- What impact have digital solutions and technology had on providers and services during the COVID -19 period?

How we carried out this Review

- We carried out this review at pace during the week of 27 July 2020.
- We spoke with a range of health and social care staff, senior managers and executive leaders.
- We carried out 26 interviews with groups of people such as Primary Care Networks, providers of adult social care and providers of NHS funded care.
- This review focused on the Local Authority area of Lincolnshire, the geographical footprint of which, is consistent with the Lincolnshire sustainability and transformation partnership (STP).
- The review did not assess the role that commissioning plays within the system as we do not have the legal powers to comment on the commissioning of services.

Lincolnshire in Context

The following organisations are part of Lincolnshire STP:

- NHS Lincolnshire CCG
- Lincolnshire County Council
- United Lincolnshire Hospitals NHS Trust
- Lincolnshire Community Health Services NHS Trust
- Lincolnshire Partnership NHS Foundation Trust
- East Midlands Ambulance Service NHS Trust
- LinCA
- Lincolnshire VET

Lincolnshire in Context

- Lincolnshire STP has many areas with a medium or high proportion of older people. This is the case for most of the system, with the exception of Lincoln which has some of the lowest proportions of people aged over 65.
- There is big variation in the deprivation of areas across Lincolnshire STP. There are areas of very high deprivation on the coastline around Skegness and further north towards North East Lincolnshire LA. The further west in the STP the lower the levels of deprivation with the exception of small pockets of high deprivation in Gainsborough, Lincoln, Grantham and Sleaford.
- There are low numbers of BAME populations across the whole of the system.
- Lincolnshire's age standardised rate of Covid 19 diagnosis was less than half the national rate. The area has the 12th lowest rate of all the local authorities in England.
- The number of lab confirmed cases in Lincolnshire peaked during week ending 11 April at 176.
- Lincolnshire had a fairly late peak compared to other areas, in Weeks 21 and 22 (late May).

Key Findings – How have providers collaborated to ensure that people moving through health and care services have been seen safely in the right place, at the right time, by the right person?

What we heard went well:

- **Joint working across the STP** was led and coordinated through a local resilience forum (LRF) and comprehensive cell structure, which included representation from a broad range of stakeholders.
- The Lincolnshire system made a joint **decision to only discharge patients to care homes once a COVID-19 status was known.** System leaders believed this significantly contributed to COVID mortality being lower in Lincolnshire than the England average.
- Lincolnshire had a large problem with PPE during early April. A 'PPE cell' quickly resolved this, enabling a single approach and ensuring PPE supplies could be accessed by all providers. **Mutual aid across the system also ensured PPE availability** where it was needed most.
- The **Lincolnshire Care** Association (LinCA) was an active part of the STP and played a vital role during the pandemic by representing and supporting providers within the independent and voluntary sector.
- There was **good oversight of the needs of the population** with recognition of health inequalities in those areas of deprivation across Lincolnshire STP. **Partnership working** across the health and social care footprint connected residents with local support networks and mechanisms.

Key Findings – How have providers collaborated to ensure that people moving through health and care services have been seen safely in the right place, at the right time, by the right person?

- **There was a well-established third/voluntary sector, providing support services.** The wellbeing service identified those people who were vulnerable. Over three months, 17,000 people who were shielding were contacted. The wellbeing service also coordinated the volunteer service, these efforts resulted in; 1000 requests dealt with over the phone, 17000 contacts made, dealt with 936 requests for support, and more than 300 referrals to the British Red cross for urgent support for example, food parcels.
- **Urgent dental centres worked closely with community dental services** to ensure where someone was over 65 and required a site visit they were directed to the right service and seen at the start or end of the day to reduce contact as much as possible.
- **Support during COVID-19 was focussed on two groups** within the population; clinically vulnerable (shielding) and vulnerable. Through a process of RAG rating, the system were able to identify the most vulnerable from these two groups and prioritise care accordingly.
- **Pathways and services were redesigned** to manage people with COVID and non-COVID illness. These included for example, implementation of blue (COVID) and green (non-COVID) sites across the acute and primary care sectors.

Key Findings – How have providers collaborated to ensure that people moving through health and care services have been seen safely in the right place, at the right time, by the right person?

- **There was an overwhelming commitment across the system to reduce the burden on urgent and emergency services within the acute trust.** The Clinical Assessment Service (CAS) was instrumental in preventing hospital admissions and/or arranging additional home care support, with 70% of NHS111 calls transferred to the CAS. In addition, the care home sector were given direct access to CAS.
- **Advice and guidance was available 24/7 for those staff caring for people who were palliative and/or end of life.** In addition, seven day working, integrated pathways for COVID-19 patients at end of life and improved demand monitoring enabled fast-track access to domiciliary care and other care networks.
- **Medicines arrangements were in place to support vulnerable people**. For example, close working with primary care colleagues to help identify an accurate list of patients who needed to shield and remote prescribing clinics which helped avoid the need for patients to access their GPs for certain medicines during the pandemic.
- **A weekly survey** was carried out for 10 weeks during the COVID-19 lockdown period to understand how people had accessed health and social care services during this time.

Key Findings – Was there a shared plan and system wide governance and leadership during the COVID -19 period?

What we heard went well:

- In the early phase there was a **rapid development of command and control** and strategic cell structure with the focus very much on finding solutions at pace.
- There was **daily situation reporting** (SITREP) on staff and patient incidents and disease prevalence. In addition, an Early Warning Dashboard monitored a range of COVID-19 indicators as potential early warning triggers, including for example, NHS Pathways triages through NHS 111 and 111 online, staff sickness, patients admitted or newly diagnosed with COVID-19 to United Lincolnshire Hospitals NHS Trust (ULHT), confirmed COVID-19 patients occupying beds at ULHT hospitals and oversight of PPE stock levels and availability.
- Across the system **there was good support from local dental councils (LDC) and networks (LDN)** to set up urgent dental centres. The geographical location of an urgent dental centre was taken in to account and factors such as age, deprivation and rurality were considered. The locations chosen prevented as much travel as possible. One site was established specifically for shielding, vulnerable and people over 65.
- **Providers were involved in systemwide and national discussions about stocks of medicines**, so that they would be able to help with supplies both locally and to other systems if it were required.

Key Findings – Was there a shared plan and system wide governance and leadership during the COVID -19 period?

- All cells had **empowered representation** from every organisation. Agreements and learning from cells was escalated up and down through the command structure to ensure rapid learning at the height of the crisis. A revised strategic cell structure incorporating the new ways of system working was to continue as the system moved into the recovery and restoration phase.
- **Monthly slide decks on learning** was compiled and presented to the board of directors, governors, system CEOs, regional alliance and health scrutiny committee for Lincolnshire.
- **Quality Impact Assessments** were consistently used across services where changes to service delivery had taken place and to inform services restarting.
- The system had taken the lessons of the more **flexible, agile and responsive** working during COVID and was redesigning its governance structures to emulate this good practice going forward. For example, the use of digital technology, home working, flexible working arrangements and quick decision making.
- As services were to reopen as part of the recovery and restoration phase, the system encouraged people to access help and advice needed in a simple, safe and convenient way in order to provide an alternative to accessing urgent and emergency services. The **'talk before you walk'** initiative offered four different ways for the public to access medical services they required.

Key Findings – Was there a strategy for ensuring the safety of staff and sufficient health and care skills across the health and care interface?

What we heard went well:

- **Oversight of staffing across health and social care** was managed through a 'workforce' cell with outputs for example, sickness absence, shielding, testing and staff relocation discussed at a daily chief executive call.
- Wherever possible, staff were redeployed to enable them to continue working despite shielding. For example, staff were able to provide virtual clinical triage services.
- Staff had access to a 24/7 **mental health hotline** to receive support and advice for the pressures they had faced.
- **Staff testing was described as an "easy process"** and staff were able to book their own tests.
- **Support across adult social care through weekly registered manager meetings** gave staff the opportunity to share best practice and any concerns. Outputs from these meetings enabled information to be shared with commissioners.
- **Additional training for staff across the STP** was provided and was instrumental in ensuring for example, where staff had been redeployed they had the necessary skills to equip them for their alternative role.

Key Findings – Was there a strategy for ensuring the safety of staff and sufficient health and care skills across the health and care interface?

- **Risk assessments were undertaken in response to specific staff groups**. For example, BAME staff, pregnant women and people with long term health conditions.
- Providers acknowledged the lack of national guidance around the return to work of shielded staff. At the time of our review discussions remained ongoing with no set strategy for this group of staff.

Key Findings – What impact have digital solutions and technology had on providers and services during the COVID -19 period?

What we heard went well:

- **The digital agenda advanced at pace** with virtual GP and outpatient consultations and advice through the use of electronic applications such as Q health, askmyGP and Project ECHO.
- Video conferencing worked well to **establish local relationships** and ensure any problems could be raised and addressed quickly and learning could be shared across the system. This was also used to provide training to staff in for example, infection prevention and control including donning and doffing of PPE and oral health.
- **Multidisciplinary and multi-agency meetings were facilitated rapidly** through the use of Microsoft TEAMs.
- **Whzan Digital Health technology had been introduced to a number of care homes** during the COVID pandemic with a full roll out to all care homes expected by the end of August 2020. Care homes were supplied with a digital health kit, including blood pressure monitor, pulse oximeter, and a thermometer enabling vulnerable residents to be closely monitored and give staff the reassurance to act on situations quickly if symptoms changed. Findings were shared with other professionals such as paramedics or GPs when needed.

Key Findings – What impact have digital solutions and technology had on providers and services during the COVID -19 period?

- **Wider sharing of access to SystemOne** enabled providers across sectors to view individual patient records and share treatment plans.
- Use of social media and public broadcasting enabled the system to inform the public of critical information. Besides **informing the public** about COVID-19 and where to seek help, they were also able to keep the public updated on any changes to service delivery.
- In appreciation of those **vulnerable people** where access to digital technology was limited and/or areas of deprivation, offices were provided where people could access IT equipment to enable virtual appointments.
- The digital work was considered to be a **great success in mental health**. There was previously a reluctance to move to digital consultations for mental health patients as it was believed that seeing someone in person was part of the therapy, but since COVID-19 this has been well received. In some cases it had helped those with social anxiety, i.e. being able to see someone from the comfort of their own home.

Future Focus

- It was recognised across the system that the volume and frequency of guidance from national government was challenging to manage and adapt to at times.
- Relationships with some third sector organisations, fostered pre-COVID through the STP, had not been used to their advantage during the pandemic.
- There appeared to be more than one part of the system identifying those shielding and vulnerable adults which suggested the system may not have had complete oversight. There were small numbers of individuals who felt they had not been identified as either clinically vulnerable or vulnerable and some providers felt shielding information had not always been shared across the system as a whole.
- A small number of people felt, in the early stages of the pandemic, access to primary medical services (GPs) “seemed like it had shut down”.
- One stakeholder told us they were not aware of a shared strategic approach and did not feel that all services met the needs of the population during the COVID-19 pandemic.
- Some staff were unaware of mobile testing sites.
- In the first 10-week COVID-19 survey many comments revealed patients feeling left in the dark with regards to their non COVID-19 related treatment and appointments.

Integrated Working

"We were in this together"

"LinCA, the voice of social care"

"The care workforce has been excellent and invaluable in their response"

Integrated Working

"Key workers going the extra mile to keep people safe and well"

"Talk before you walk!"

"We all knew what our job was; to protect people from harm and save lives"

Reflections

- Lincolnshire was later than a lot of the country to register diagnoses (both in the community and in care homes). This extra time allowed the system to focus on national messages, monitor activity elsewhere and apply learning to their own system.

- Most people we spoke with commented on the overwhelming support provided across the LRF with regards to mutual aid. We heard many examples where resources and services had been shared. For example, PPE, IT equipment, staff and clinical areas.

- Honorary contracts and MoU enabled staff to move between organisations seamlessly where required.

Reflections

- Restoration of essential NHS non-COVID services brought about a green (COVID-free) site at Grantham Hospital. The conversion of Grantham ED to an UTC afforded the option of having completely green diagnostics and inpatient services on the rest of the site to deal with elective activity.

- There was a shared sense and ownership of risk across the system; the patient belonged to everyone not just one part of the system.

- Providers worked closely with third sector organisations to provide community support. For example, with meal provision, meal preparation and shopping.

Reflections

- There was an overwhelming sense of satisfaction across the STP, with high levels of support and low bureaucracy across the system enabling changes to be implemented at pace.

- Pre-COVID, Lincolnshire STP had already re-established collaborative working across health and social care. The COVID-19 period accelerated this partnership working with effective communication across all sectors and agreed STP priorities for both during and post-COVID.

- Outputs from this review suggest the STP has an effective platform to progress to ICS status from 2021.

Your questions please

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*ULHT BOARD MEETING*
Date of Meeting	*6th October 2020*
Item Number	*Item 11.2*
System Social Marketing Campaign	
Accountable Director	*Andrew Morgan CEO*
Presented by	*Charley Blyth* *Director of communications and engagement, Lincs NHS*
Author(s)	*Charley Blyth* *Director of communications and engagement, Lincs NHS*
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	
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	*X*
4a Establish new evidence based models of care	
4b Advancing professional practice with partners	*X*
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	*N/A*

Recommendations/ Decision Required	To support and provide general feedback on the campaign, including: • Does it incorporate acute health care requirements adequately in the five key acts? • Are there any key considerations the board would like to be incorporated into the final development of the campaign? (accepting that the ongoing refinement requires feedback that is less about the detail, more about the direction/ broad messages etc)

Executive Summary

This report is intended to:

- Familiarise with the systemic 'social marketing' campaign, developed in response to request by all four Lincolnshire CEOs
- Outline progress to date and invite advice and comment as we enter the finalisation stage of the campaign creation

Following a discussion at the CEO meeting 03/06/20 regarding the wish to retain the public behaviour change occurring during coronavirus (use of telephony and digital, less reliance on A&E etc), system communications colleagues were collectively briefed to produce a 'marketing' campaign to encourage continuation. It was agreed that this would be delivered via a third party due to capacity concerns.

The resulting proposal, to engage a social marketing (behavioural change) specialist agency, was agreed by CEOs, and a work programme of data analysis and strategic and concept development was re-presented to the CEOs via the attached report on 19/08/20. General approach and direction was supported, with enhancements and refinements were suggested. Please note, these refinements continue to be developed, and will also incorporate feedback from this board. This paper is therefore a working document, incorporating 'draft' creative concepts and a number of 'next steps' and improvements are already in progress to refine the five acts (though the core acts have been supported to date and can therefore be assessed on that basis).

To date, this has been reviewed at the NHS comms and engagement cell meetings, CEO meetings and CCG Executive, and the campaign was welcomed by Lincolnshire's HSC in September (no papers presented). In line with CEO request, it will be shared with all provider boards and the commissioner board. It is also scheduled to be considered at the People Board, LMC, and the system Clinical Forum, as well as JWEG, all with the intention of inviting specialist comment, and encouraging full system ownership and support.

The principles we have worked to throughout the development of this campaign are:

- Do a few things well, hence limiting to 5 key acts in this phase
- Clear, precise behavioural change requests to help the public adhere
- Alignment with national/ local NHS and PHE campaigns to avoid conflicting and confusing messaging
- Simple, consistent messages, across the NHS, and our partners in Lincolnshire as a whole. We all share an audience of 780k, delivering our messages in a united and recognisable way, across all of our 'owned' platforms and touchpoints will aid familiarity and understanding. We have already agreed the principle of 'lending' this campaign to Active Lincs and Lincs' public health colleagues to help us deliver part of the prevention 'ask'. It is intended that upon the NHS system being content with the campaign, it will be shared to LRF partners, to be used as an 'umbrella' campaign across the county.

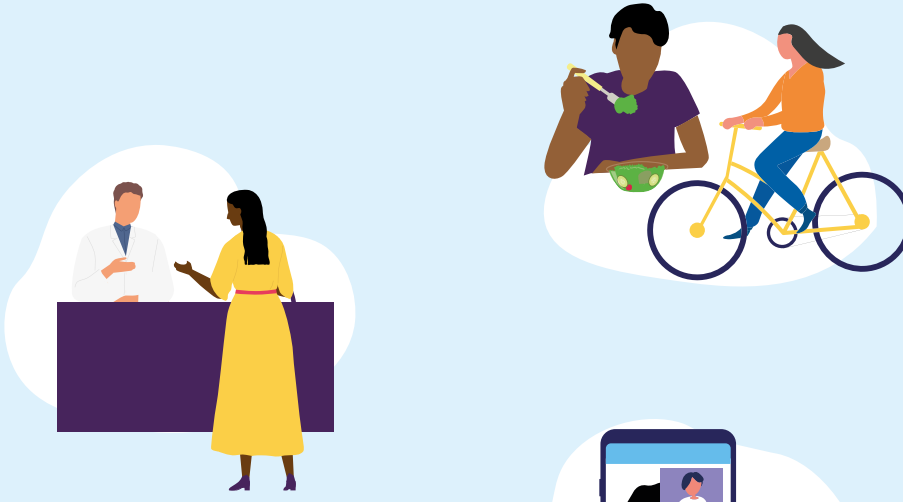
In conjunction with the core public communications arm of the campaign, additional supporting elements include:

- Staff communications – aligned and supportive ‘spokespeople’ across all staff will be prioritised and critical in the success of this project (full system inc GPs)
- Staff OD – mirroring the behavioural change requirement, HEE funding has been secured in order to ensure this campaign supports Lincolnshire’s People Plan delivery (Working Differently), with the oversight of the system workforce cell/ people team

NHS Lincolnshire

Let's do this together.

#LincsTogether



Campaign Guide

Let's do this together

2020-21

Introduction

The COVID-19 Pandemic has led to several changes in behaviour. Some are positive behavioural changes that have the potential to be sustained long-term and help the NHS [and partners] to be strong and stable in the short and long term.

The NHS [and partners] in Lincolnshire have come together to drive forward a campaign to encourage and inspire residents to sustain some of the positive behaviours demonstrated by the public during the pandemic. Following research, we have identified and agreed five positive behaviours that can make a real difference to our NHS and to the people and communities we serve:

1. Looking after yourself, eating healthy food and getting active
2. Visiting a pharmacist before a GP
3. Maintaining routine appointments
4. Asking for a telephone or video appointment
5. Calling or visiting 111 online before attending an urgent treatment centre or A+E.

These five actions have been collectively called “The 5 acts”. The idea is to ask Lincolnshire residents to support the NHS by adopting these behaviours. We have a unique opportunity to capitalise on the current positive sentiment, support and general good feeling towards our NHS and we want to strike now at a time when change is afoot and people are receptive to our message and call to action.

But it is not just the NHS that will benefit if the public adopt these five acts. Partners and the community at large will benefit, and although we, representing your NHS are focused on these five acts we have created a brand that can be used by the wider Lincolnshire Community as a movement towards change and sustainability. “Let’s do this together” promotes a will and recognition to work collectively to make positive change happen and we encourage our friends and partners to join us. It is by working together that we can make Lincolnshire a thriving and special place to work and live long, happy and healthy lives.

Maz Fosh
Chief Executive, NHS Lincolnshire Community Health Services

Brendan Hayes
Chief Executive, Lincolnshire Partnership NHS Foundation Trust

Andrew Morgan
Chief Executive, United Lincolnshire Hospitals NHS Trust

John Turner
Chief Executive, NHS Lincolnshire Clinical Commissioning Group

Key insights

Following a thorough review of NHS data [covering the last 12 months] including but not limited to; outpatient hospital appointments, A+E attendance, GP attendance & use of online and telephone appointments, key insights have emerged. These key insights have helped to shape the strategy and the ideas you will see in this document.

Data Insights:

- In general practice, people are less likely to attend their GP when the appointment is made one day prior compared to making the appointment and attending on the same day. This behaviour suggests that residents may be unwilling to wait and seek medical attention elsewhere or that their issue can be resolved outside of general practice. This and a higher demand for a specific appointment type suggests people want their appointments to be on their terms.

- The number of people using A&E [walking-in] varies significantly depending on where you live. There are people in some areas accessing healthcare in large numbers and disproportionately to the rest of the Lincolnshire population.

- A&E is a 24/7 offer, yet most people are using A&E in 'school hours' which suggests either most emergencies occur during the week in daylight hours or that it is not an emergency at all.

- The use of GP practice varies across Lincolnshire - some saw greater use during the lockdown months, whilst other practices saw very little use.

- There is low take-up of telemedical appointments across the board for outpatient hospital appointments, despite the fact that patients are more likely to be seen using this method - especially in the middle of a pandemic. This suggests that they are initially less appealing to people but are actually more accessible.

- There seems to be a greater buy-in for telemedical mental health than telemedical physical health appointments. This indicates that people with physical ailments feel they need to be LOOKED at by a doctor.

- Lincolnshire is physically inactive - according to the annual Active Lives Survey. Lincolnshire is at the bottom of the England-wide survey.

- Obesity levels are above the national average in some areas of the county - in some areas at dangerously high levels.

Behavioural insights

This campaign will apply behavioural science to increase effectiveness. Using the EAST[1] framework, we will do the following:

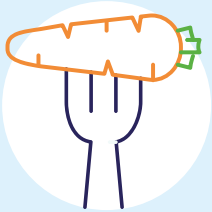
- Communicate simple, but consistent and repetitive messages
- Help reduce the hassle factor
- Harness defaults
- Attract attention
- Leverage ‘new’ norms
- Use social networks
- Encourage commitments
- Prompt people when receptive
- Present the immediate costs and benefits.

We will also pay close attention to ‘who’ delivers our messages – working carefully to ensure the right messenger is delivering the right message at the right time. We will also apply some ‘urgency’ tactics – because it is very important people act now – for their NHS but also for their own personal and family health and wellbeing.

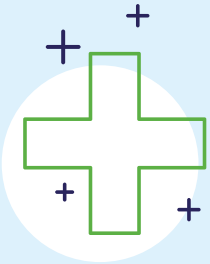
[1]https://www.bi.team/publications/east-four-simple-ways-to-apply-behavioural-insights/

Campaign goal

Our overall campaign goal is to encourage the Lincolnshire public to adopt the '5 acts' so eventually they become a default behaviour and 'norm' that won't require 'nudging' or reminders.



1. Eat healthy and move more



2. Pharmacy before GP

3. Make and maintain your appointments

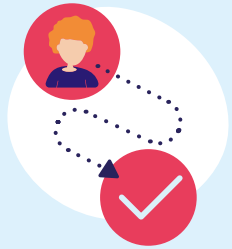
4. Ask for a phone or video appointment

5. 111 before A&E

We will measure success by reviewing:

- The year-on-year increase/decrease in GP appointments delivered online and via telephone
- The year-on-year increase/decrease in A&E walk-ins
- The year-on-year increase/decrease in mental health appointments delivered online and via telephone
- The year-on-year increase/decrease in acute consultations delivered online and via telephone
- Improved obesity and physical activity rates in Lincolnshire.

Campaign strategy



The strategy is to deliver the 5 acts consistently and repetitively over the next 12 months so residents are aware, and are 'by default' doing one or more of the 5 acts.

To try and default behaviour to our preferred behaviours it is important that we remain consistent and repetitive. We want Lincolnshire residents to see our messages at least 9 times in the next six months and act on that message.

Our strategy is focused on creating a 'new norm' for accessing the NHS. Entrenched behaviours exist, so it is important to sustain this campaign over a long period - beyond the initial six months. We want to be effective in how we communicate these 5 acts so our campaign strategy is collaborative, promoting 'togetherness' and team effort, as well as highlighting the capability of residents to make the change.

We will use positive language, being clear about the ask, leaving no room for ambiguity or confusion. We feel that highlighting the positive behaviours and changes the public have already done such as embracing technology and looking after their elders will help people to feel that they can 'do it' – because they have already made positive changes throughout this pandemic.

Tone of voice

The tone of voice for the campaign is friendly, motivational and supportive.

We have used language which inspires action in the public while being encouraging and positive in its proposal. The 5 acts are always clear, consistent and concise, but should never seem accusation or too authoritative. We want to maintain a positive tone, which still shows appreciation for the support which the public have offered so creates a sense of community - we're all one big team 'Let's do this together'.

Words we like

"Together "
"Support "
"Your NHS "
"Our NHS "
"We"
"Now"
"Keep it up"
"Mastered "
"Cared"
"Adapted"
"Committed"
"Skills"
"Ask"
"You can"
"We can"

Words we don't like

"The NHS"
"Protect the NHS"
"Not enough"
"Stop"
"Don't"
"Can't"

Eat healthy and move more

This is a very important act, but is not as defined as the other four acts and cannot be 'defaulted' without helping people with the "how". Working with our partners Active Lincolnshire and the public health team at Lincolnshire County Council, we will promote positive behavioural changes that support people to eat healthy and become more physically active. A sample of the types of messages could include:

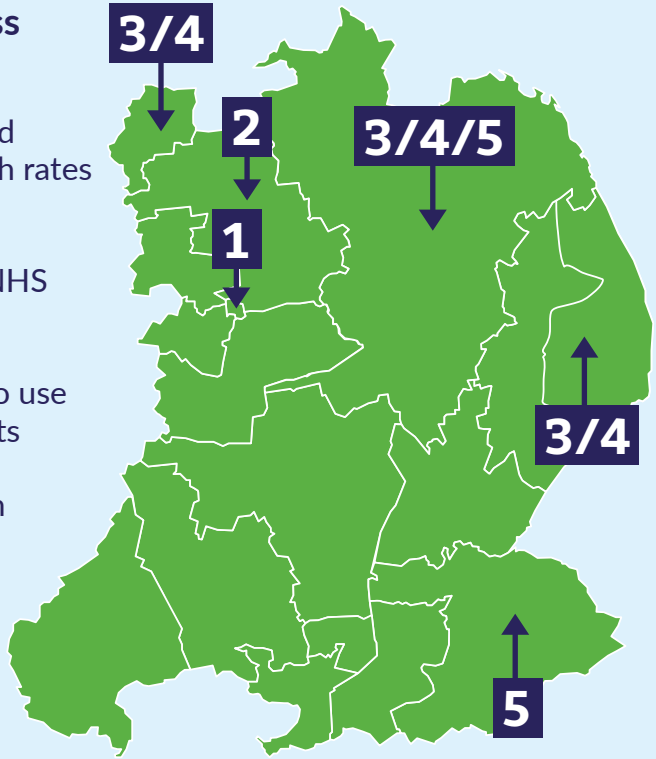
1. Aim to move vigorously for 150 minutes per week (30 minutes, 5 days a week)
2. Spend less time sitting or lying down – get up and move around more. Why not set your watch or phone to 'nudge' you when you have been sitting down for more than 30 minutes
3. Try to reach 10,000 steps per day
4. Try the Couch to 5K app
5. Eat at least 5 portions of fruit and veg a day
6. Drink plenty of water (6-8 glasses a day) if you can't drink water alone, opt for a sugar free cordial
7. Ditch fizzy drinks – even the diet ones. Switch to fizzy water if you need fizz in your life
8. Have at least two alcohol free days to allow your liver to repair itself
9. Have milk and dairy for sources of calcium or protein or try an non-dairy alternative like Soya
10. Ditch the white bread and pasta! Eat more fibre by choosing wholegrain or wholemeal varieties of bread, pasta, rice, etc.

Target audience

The target audience for this campaign is all residents in Lincolnshire, with enhanced efforts and activity up-weighted in areas that would benefit from greater intervention. We have identified these areas or people through data analysis and research.

We intend to do the following across the **whole** of Lincolnshire:

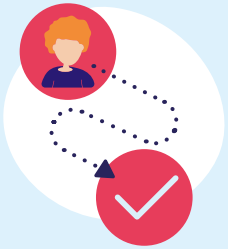
- Target parents of children aged 0–4 and young people aged 20–24 for their high rates of A&E walk-ins
- Target females for their higher use of NHS services
- Encourage adults aged 18 and above to use telemedical mental health appointments
- Discourage unnecessary use of A&E on Mondays and in working hours across Lincolnshire.



We have also identified areas where greater intervention is needed and we intend to 'upweight' efforts in these areas:

1. Encourage uptake of [telemedical] mental health services in Lincoln
2. Promote IMP PCN's use of telemedical services - to inspire others
3. Discourage A&E walk-ins in the First Coastal, Trent Care and East Lindsey PCN areas
4. Target and discourage consistently high use of services by people in the First Coastal, East Lindsey and Trent Care PCN areas
5. Promote physical activity and better physical health and wellbeing in East Lindsey and Boston.

Campaign customer journey



Offline public campaign

Online digital campaign

Print
- Leaflets
- Posters
- Outdoor advertising
- Patient communications

Paid
- Facebook
- Instagram
- SMS

Organic
- NHS channels
- Stakeholder channels

Earned
- Staff campaign
- Influencers
- Media

Website
(Landing page)

Actions on website
www.nhs.uk/5acts

Find out more links

- **Active Lincolnshire**
- **One You Lincolnshire**

5 behaviours

1. **Eat healthy and move more**
2. **Pharmacy before GP**
3. **Make and maintain your appointments**
4. **Ask for a phone or video appointment**
5. **111 before A&E**

Campaign Plan

A range of assets have been produced to allow for the successful execution of this multi-channel campaign. The campaign will run on digital channels and will embrace print to allow for maximum reach to this broad audience – residents in Lincolnshire.

Activities will be put in place to up-weight marketing to specific target groups as already mentioned.

Activity over the winter will include:

- Paid social media advertising running at different times with tailored messaging and creative to reach different audiences in line with the insights
- Organic social media activity to reach established audiences
- Development of creative to include a combination of images, and animated GIFs to engage audience groups
- Distribution of print material to GP surgery's, hospitals and treatment centres across the county
- Distribution of roller banners to NHS waiting rooms in targeted locations
- Distribution of assets to staff and stakeholders – Digital screen images for use in waiting rooms and other public places, screen savers, email signatures, letter templates
- Outdoor advertising in targeted locations including floor stickers in key locations to prime people and nudge them in the right direction
- Press engagement activities - we want to engage local media in the campaign to increase the reach and support for the campaign. PR activities will include engaging magazines, newspapers and other local media to communicate the campaign.

This activity covers the first six months of this campaign and a second version of this document will be released in Spring 2021 setting out the plan for a further roll out into the summer and winter months of 2021.

		October's weeks				November's weeks				December's weeks				
Owned	Organic social media posting across all platforms (Including images, stories, carousels and GIFs)													3 Month campaign review
	Distribution of assets to stakeholders - GP & waiting room digital screens, email signatures, screensavers													
	Communication of campaign and messaging on staff channels (Including weekly emails, private social media channels & Intranet)													
Earned	Media relations & press engagement													
	Social Engagement													
	Distribution of social assets to partner organisations													
	Staff 'ambassador' engagement													
	Community influencers													
Paid	Social Media advertising													
	Text messages to patients from GP systems													
	Local publications digital advertising - banner adverts													
	Poster, banner and outdoor print distribution to targeted patient facing NHS premises													
Evaluation	Data collected													
	Data analysis and reporting													
	Social media listening													

		January's weeks				February's weeks				March's weeks			
Owned	Organic social media posting across all platforms (Including images, stories, carousels and GIFs)												
	Distribution of assets to stakeholders - GP & waiting room digital screens, email signatures, screensavers												
	Communication of campaign and messaging on staff channels (Including weekly emails, private social media channels & Intranet)												
Earned	Media relations & press engagement												
	Social Engagement												
	Distribution of social assets to partner organisations												
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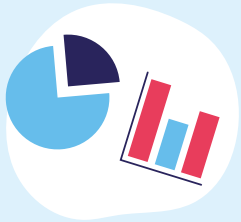
	Local publications digital advertising - banner adverts												
	Poster, banner and outdoor print distribution to targeted patient facing NHS premises												
Evaluation	Data collected												
	Data analysis and reporting												
	Social media listening												

Campaign Metrics



	Pre-COVID monthly average (Oct 19 – Mar 20)	COVID monthly average (Apr – Jul 20)	% increase/decrease	Target for Q3/Q4
Telemedicine – outpatient hospital appointments	5,661	30,402	+436%	+5% on pre-COVID levels
In-person – outpatient hospital appointments	105,319	58,041	-44.89%	No more than +5% on COVID average
Telemedicine – primary care (AskMyGP appointments resolved by video/phone)	5,159	28,181	+446.2%	+5% on pre-COVID levels
In-person – primary care (AskMyGP appointments resolved by visit/face to face)	5,667	3,366	-40.6%	No more than +5% on COVID average
A&E walk-ins	18,198	*	TBC	TBC
Telemedicine – mental health	*	1,043	TBC	TBC – E.G Sustain [+ or – 2%] Increase mental health telemedical appointments by 5%

	Pre-campaign position	At January 2021	At July 2021
Reach [Facebook]	ORGANIC AVERAGE MONTHLY REACH across NHS system [Note: during COVID 6/4/20-3/5/20] 507,021 based on 524 posts [967 people per post]	+10%	Maintain monthly average reach with same level of investment
Impressions [Twitter]	ORGANIC AVERAGE MONTHLY REACH across NHS system [Note: during COVID6/4/20-3/5/20] 607,311 based on 1090 tweets [557 people per tweet]	Sustain	Maintain monthly average impressions with same level of investment
Impressions [Facebook]	0	1 million by January 2021	2 million by July 2021 with same budget
Website visits	AVERAGE PER MONTH [01/08/2019-31/07/2020] LCHS: 46,855 STP/CCG: 5,367 LPFT: 51,646 ULHT: unknown	+5%	Sustain monthly +5% or adjust at January 2021
Engagement [Likes, comments, shares, retweets, clicks, views, plays]	ORGANIC AVERAGE [Note: during COVID 6/4/20-3/5/20] Twitter: 11,572 based on 1090 tweets [10.6 actions per tweet] Facebook: 74,586 based on 524 posts [142.3 actions]	+5%	Sustain monthly +5% or adjust at January 2021

Campaign Creative

The people of Lincolnshire have been doing a great job at adapting to life during the pandemic as well as changing their behaviour to help the NHS. This campaign aims to acknowledge the audience and their positive behavioural changes, asking them to keep it up and do 5 acts to support the NHS.

The campaign does this through simple, understandable illustrations reflecting the journey that they have taken during the pandemic, and how their willingness to change and adapt can now be used to carry out the 5 acts.

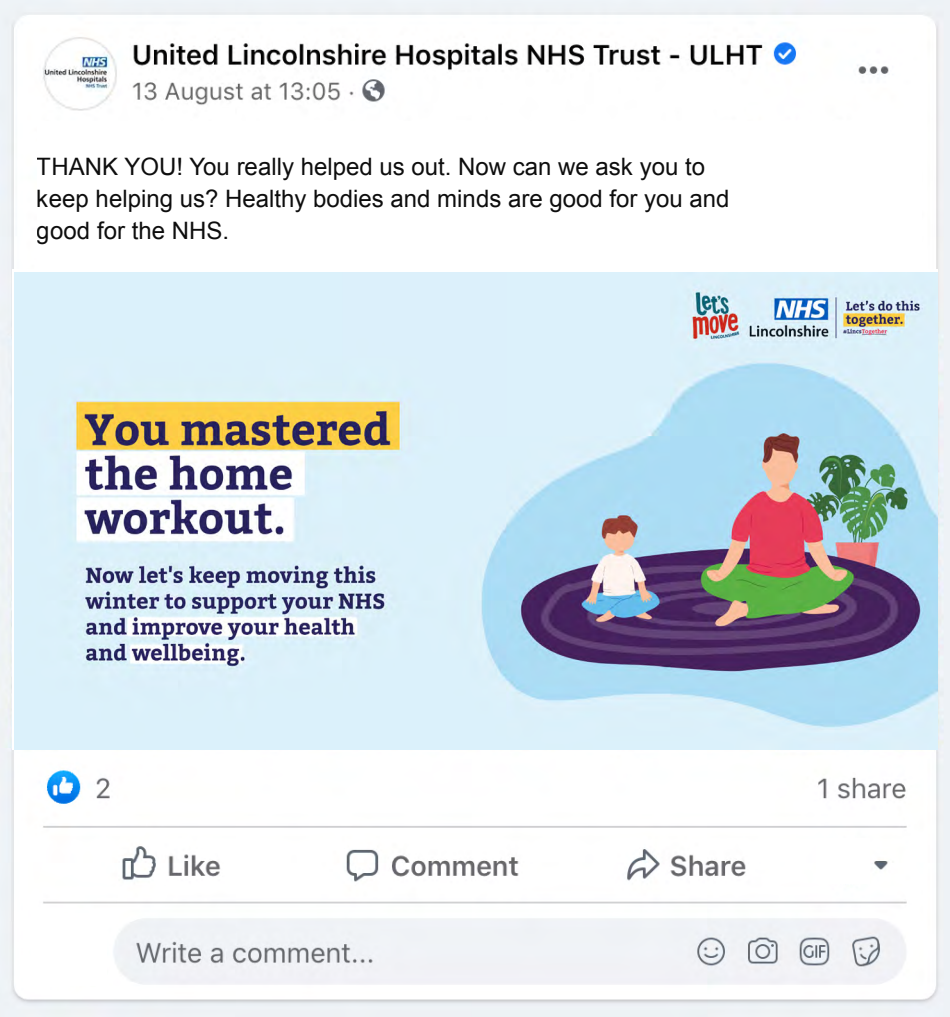
The campaign can work in many ways, as it uses a logo lock-up which unites different partner organisations across Lincolnshire with one core aim, of working together to support the NHS in Lincolnshire.

The NHS logo

Lock-up examples

Social media

1: Eat healthy and move more



The campaign will deliver our messages in a range of formats to optimize reach on social including carousel ads, GIFs and graphics that will 'scroll stop' and grab attention.

The posts thank the audience, and ask them to keep it up and continue this positive change to further support the NHS and keep themselves active and healthy.

In this example, we focus on staying active and eating healthily. Everyone was forced to work out in their homes during the pandemic and make the most of their one hour of exercise outdoors, so we are asking that they keep it up and keep moving.

Social media

1: Eat healthy and move more

Social media

2: Pharmacy before GP

These social media posts focus on the second act which is encouraging the audience to continue to visit their pharmacy before their GP.

Social media

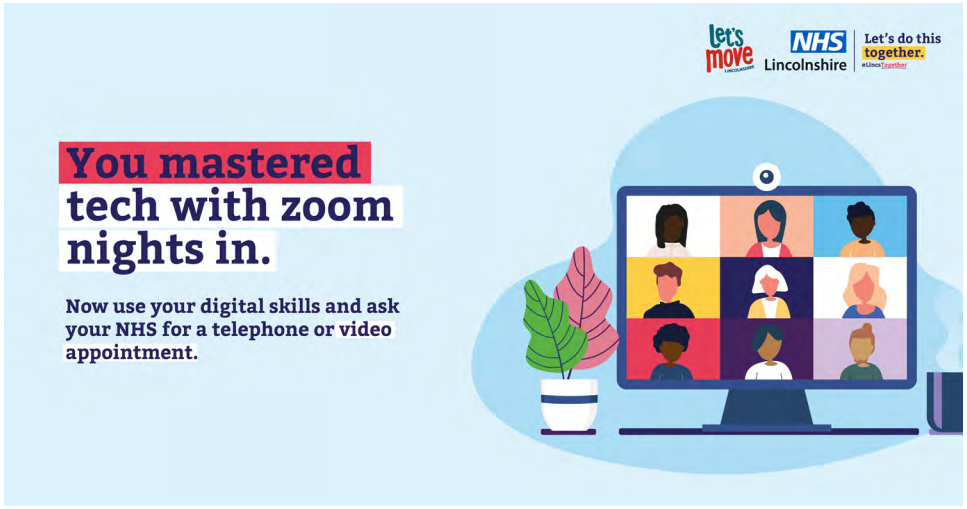
3: Make and maintain your appointments

These social media posts focus on the third act which encourages the audience to maintain their routine appointments, which they have avoided due to the pandemic. People are now coming out of lockdown and trying to get back to 'normal' as best they can, by going to the hairdressers and rebooking MOTs. These posts take those behaviours and encourage people to treat routine appointments in the same way.

Social media

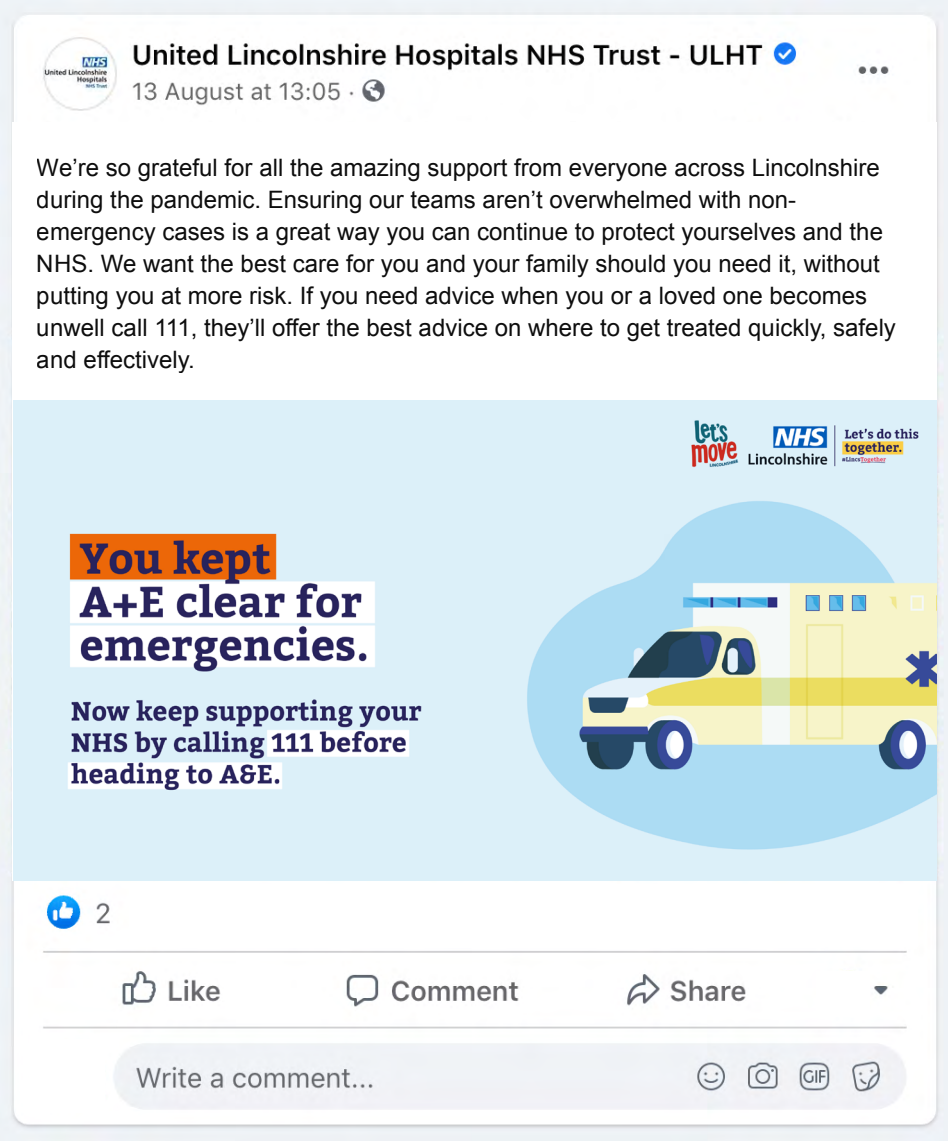
4: Ask for phone or video appointments

These posts focus on the fourth act which encourages the audience to ask for a phone or video appointment. Throughout the pandemic people have adapted to new ways of using digital technology for a number of behaviours such as connecting with friends and family, ordering groceries and entertainment. Due to this, we have all gained new digital skills which can be used to support our NHS including requesting a phone or video appointment.



Social media

5: 111 before A&E

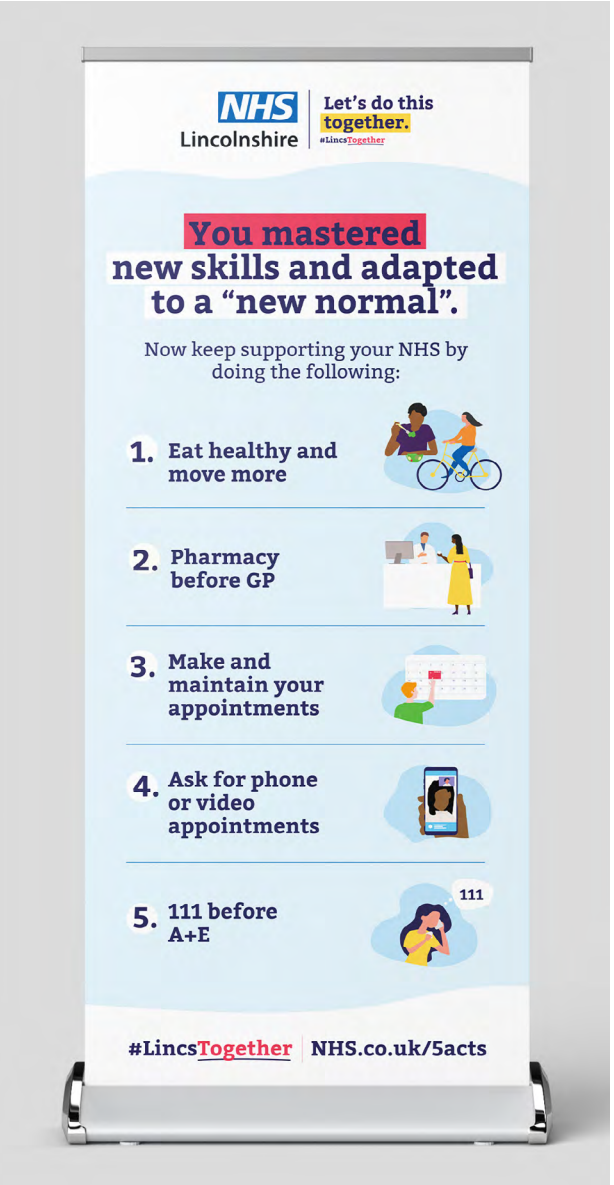


These social media posts focus on the fifth act of calling 111 instead of heading straight to A+E. The public did a fantastic job of keeping A+E clear for those who needed it most during the lockdown months, and sought the right support via 111 instead. This post asks the audience to maintain this behaviour by always calling 111 before going straight to A+E.

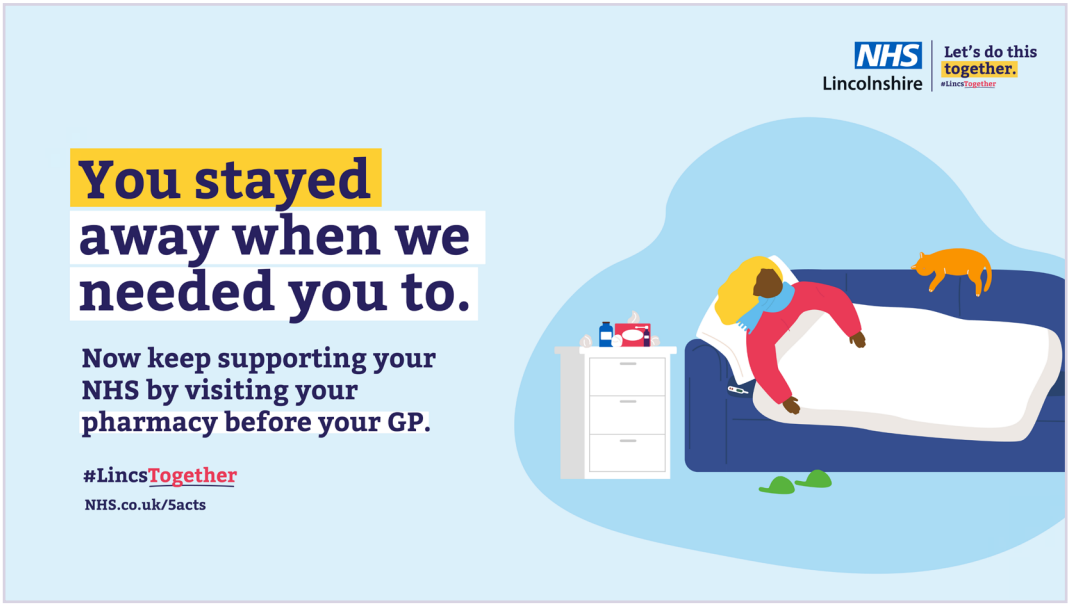
Roller banners

Roller banners will be used to explain all of the 5 acts to the audience. These can be placed in GP/clinical waiting areas, where the audience is primed to receive advice about their health and wellbeing. The roller banners will educate the audience in a situation where they are likely to think about their actions and the consequences, such as reflecting on whether they should really be there, or could they have requested a phone or video appointment, or visited a pharmacy instead?

These roller banners aim reinforce the campaign messaging by educating but also encouraging the audience to consider the new skills they have gained and how well they have adapted throughout the pandemic. It tells them they can do it - because they have changed and adapted.



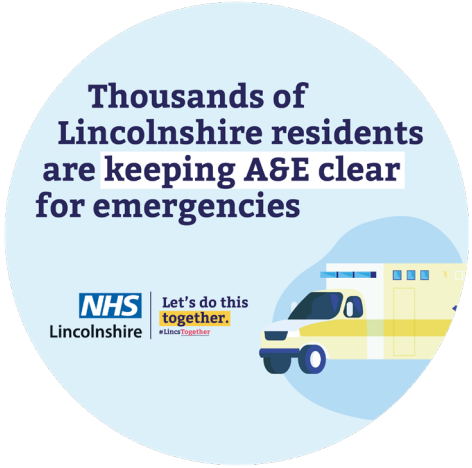
Digital GP screens



GP screens can be used where the audience is already primed to receive information about their health and wellbeing. These messages focus on making the audience reconsider their decisions.

Floor stickers

We will be using salient tactics to attract attention at times and places that are likely to default attitudes and behaviours - including using floor stickers to direct people to our desired behaviours. This is an example of outdoor floor stickers for use at the entrance to A&E and carpark pay and display machines [or in the nearby vicinity].

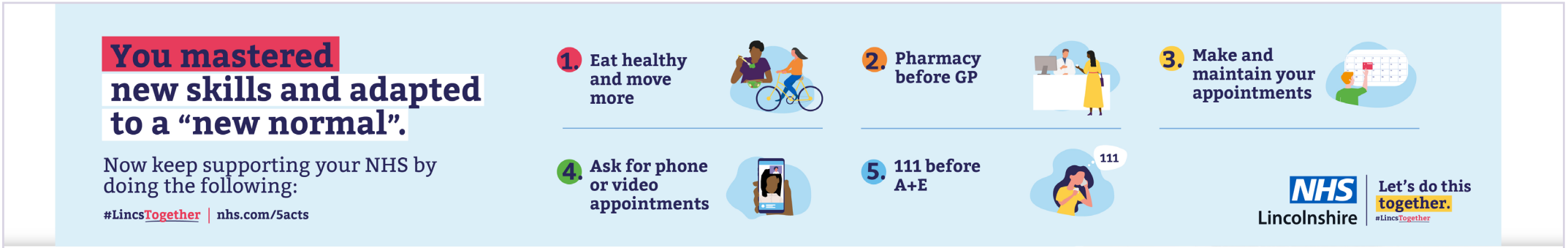


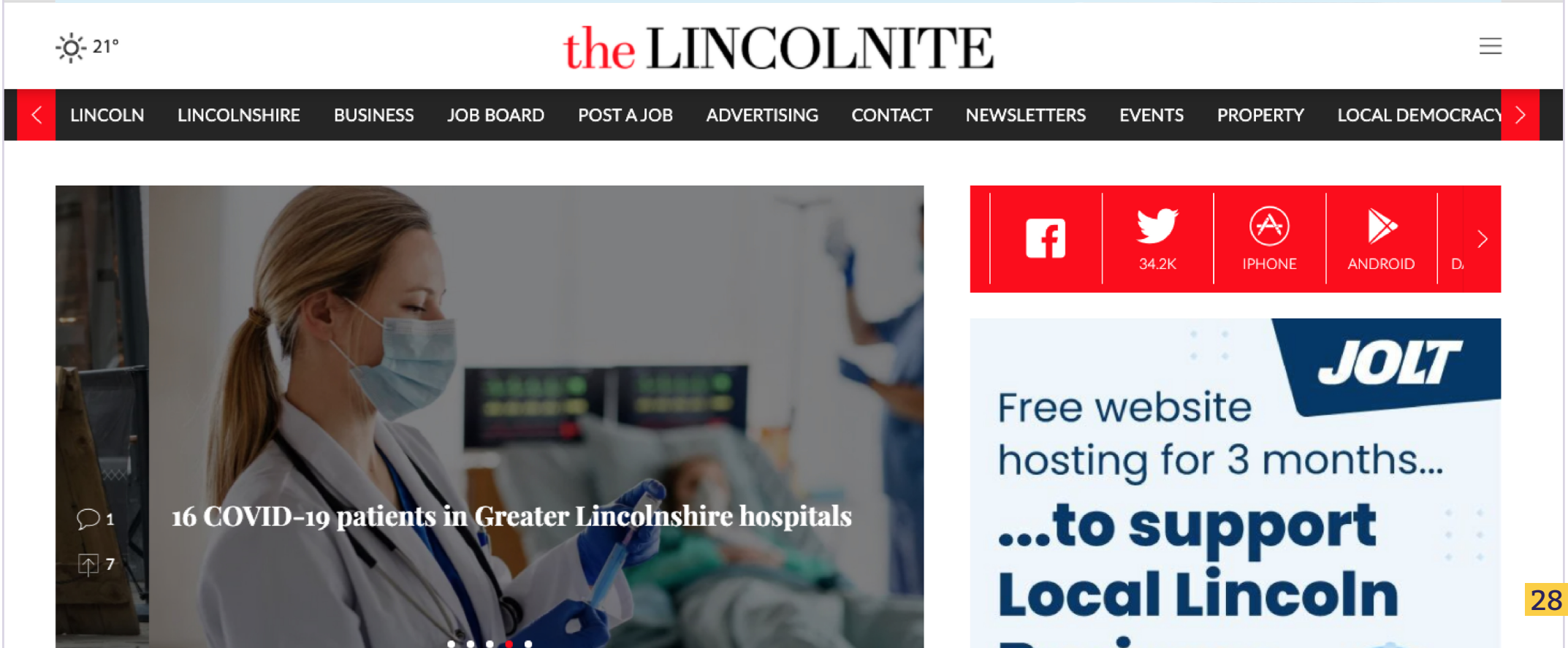
Posters

Posters can be used in places where the audience are primed to receive information. These posters follow the consistent campaign message and ask the audience to follow the 5 acts in a clear way.

Digital advertising

Digital advertising is a great way to get the campaign messaging across to our audience. By using a news outlet which is Lincolnshire based, we will reach a wide audience with our key messages. We also aim to utilise moving images where possible, in order to make these fun and engaging. This will also reach members of the audience who may not use social media, but still spend time online.

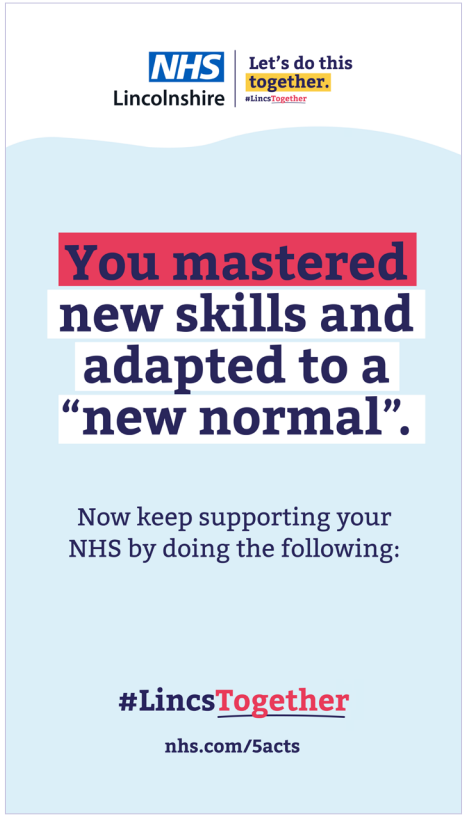




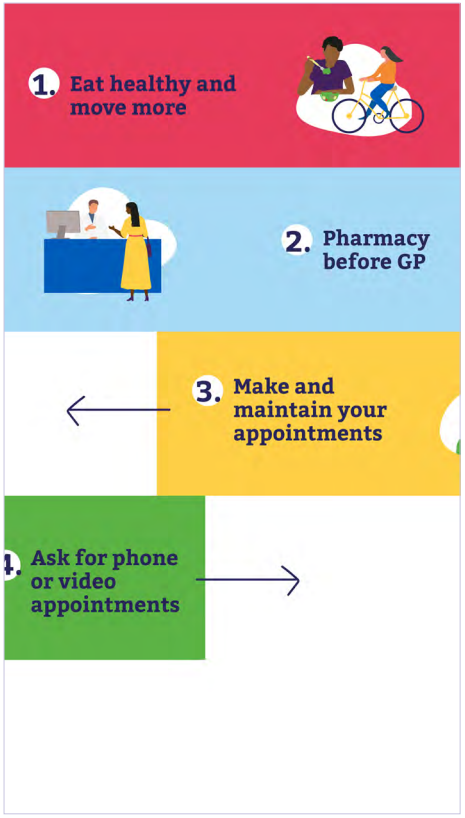
Email signatures

Email signatures are a great way for staff and partners to support the campaign and spread awareness. By encouraging stakeholders and staff to use these assets, it creates a sense of community and lead to norming and social proof.

Instagram stories



Example animation:

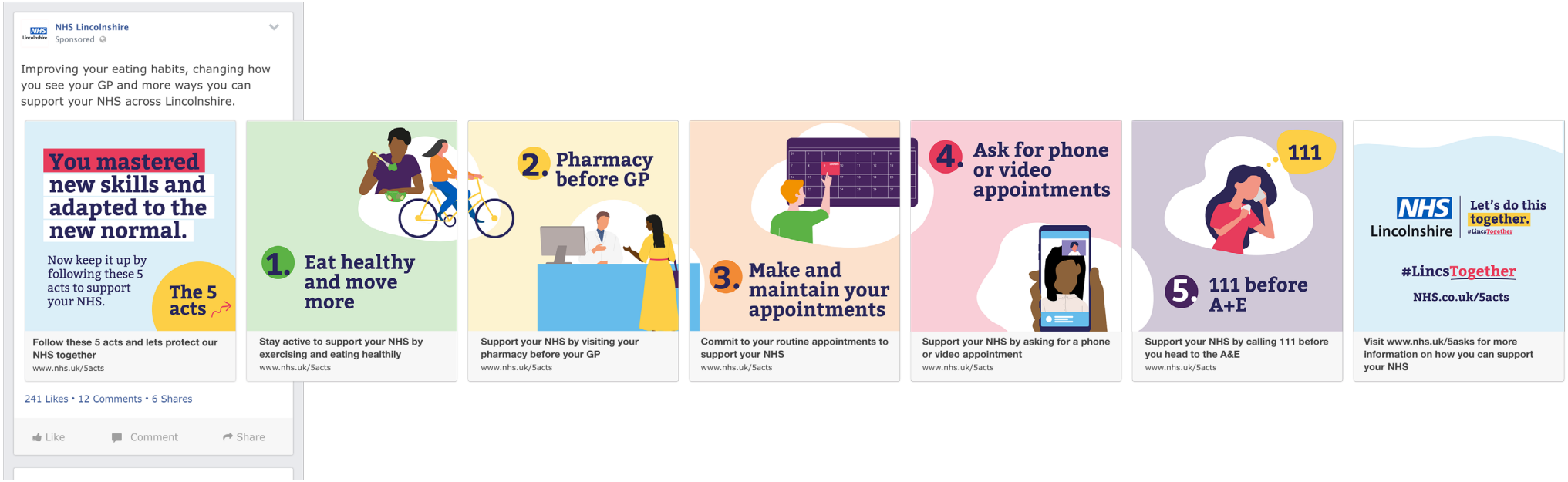


Instagram stories is a great way to catch your audiences attention. This approach follows the key campaign message and also educates the audience on the 5 acts using engaging, colourful animations that will capture attention.

We are also proposing some Instagram stickers which allow the public and businesses to use them on their on stories, spreading awareness of the campaign.

Stickers

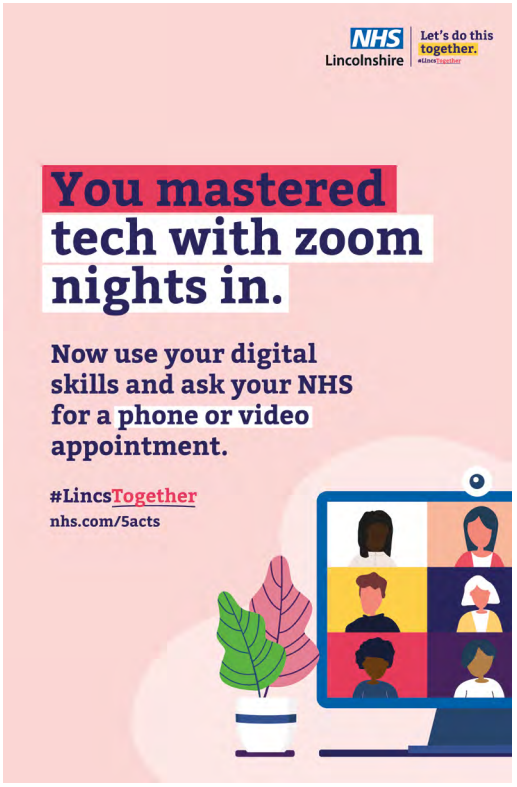
Carousel



Facebook carousels are a great way to engage with your audience as the scroll function is more interactive. The user can scroll through and learn about the 5 acts whilst also being able to click through and read more if they would like to.

Outdoor media

We are proposing to run a series of outdoor ad placements on digital bus shelters over the course of the campaign. The locations will be targeted to those areas where upweighted efforts are needed, with messaging tailored to the objectives within those areas.



Move more creative - social media

We mentioned earlier that it is important to help people with the 'how' when asking them to eat healthy and become more active. A suite of creative assets will be designed in partnership with our partners to help people with this important behaviour. Here is a sample.

Social Change UK

Research and marketing that matters

London.

The Gridiron Building, 1
Pancras Square,
London,
N1C 4AG

Phone: 020 7186 1980

Lincoln.

First Floor,
29 - 31 Mint Street,
Lincoln,
LN1 1UB

Phone: 01522 77 50 60

www.social-change.co.uk

A campaign designed for NHS Lincolnshire [2020]

Meeting	Trust Board
Date of Meeting	6th October 2020
Item Number	
Integrated Performance Report for August 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

Never Events

There has been one Never Event declared for August 2020, Retained foreign object post procedure. The incident involved a nasogastric tube guide wire that was left in place post-procedure. The incident has been reported in accordance with the Serious Incident Framework and is currently under investigation. This is the first reported Never Event for this financial year. An update report will be presented at August QGC.

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 majority of SI investigations continue to be carried out by the temporary SI Team within Clinical Governance. It should also be noted that during the Covid-19 pandemic response the CCG was not enforcing the standard 60 working day deadlines specified for completing SI investigations, therefore no SI investigations have been overdue so far this financial year. These deadlines will be applied for new SIs declared from September 2020 onwards.

Mortality

1.SHMI

Although SHMI is above the 100 target at 107.56 based on the most recent period available (March 2019 to March 2020), it has further decreased from the previous reporting period and is now '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 94.87 and the exception report details the work being undertaken with system partners to reduce mortality within 30 days of discharge.

2.Crude Mortality

The Trusts crude mortality in August 2020, has increased to 2.07% (up 0.3% from July 2020). The crude mortality rate for Lincoln (2.18%) and Pilgrim (3.17%) has increased over the benchmark for August. Rolling 12-months (September 2019 to August 2020) has increased by 0.05% to 2.23% from the last reporting period. The Trusts mortality increased during the COVID-19 pandemic; however, during August the Trust is still seeing a reduced level of admissions prior to COVID-19. When comparing August 2019 and August 2020 there are 3,161 less admission spells.

3.HSMR

HSMR for the financial year is showing above the expected at 100.88 for the Trust and Lincoln and Pilgrim sites. However, due to the COVID-19 pandemic this was to be expected.

eDD within 24 hours

The Trusts compliance of sending eDDs within 24 hours for August 2020 was 93.2% and an improvement from the previous month. Compliance for eDDs sent anytime in August was 96.9%. There were 104 eDDs not sent out of the 5,482 discharges from the Trust.

Sepsis

Screening Bundle Compliance (Paediatric ED)

Compliance for Children's sepsis screening in ED has fallen just short of the 90% standard achieving 88% for August. The harm reviews undertaken for those children who did not receive a screen have revealed no harms or concerns. Targeted harm reviews continue by ward leads and the sepsis practitioners to identify and address areas of and reasons for non- compliance or common themes.

Duty of Candour

There were 17 notifiable incidents for July 2020. 14 incidents were compliant for initial notification in person (82%); 12 were compliant for written follow-up (71%). In month monitoring and reminders to both individuals and divisional teams continues and a review of compliance at the Patient Safety Group with divisional representatives to discuss performance and actions needed has been introduced. From September 2020 the Risk & Incident Team will be responsible for providing direct support with the completion of written follow-up letters for divisions, where the initial notification in person has been provided by the clinical team.

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 June-July where data is available reflects the Restore phase where services were being reinstated, but not recovered. 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 July was 78.46%, against a trajectory of (70.92%), achieved despite a fourth month of increased ED attendances (9.1% higher than July). The Trust is performing above the pre-Covid-19 target trajectory and has done for the last four months. Performance remains stronger than 2019 levels at 8% better position. Whilst A&E triage performance deteriorated slightly compared to July 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 August there were 194 >59-minute ambulance handover delays across the Trust, a deterioration from July's position of 81, reflecting the second month of conveyance numbers returning to above trajectory levels since the pandemic started. 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 July was 47.33%. The Trust reported 149 incomplete 52 week breaches for June 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 in line with recovery plans and implementation.

Waiting Lists

In a similar way to RTT performance waiting list size has increased from June into July with the total waiting list increasing by 2725 to 42,306. 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 figure 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 July has deteriorated slightly compared with June. However with Restoration of Endoscopy and Imaging capacity, currently modelling demonstrates a strong recovery against key Recovery Targets (CT and MRI). There are plans to extend the hire of the mobile MRI to support continued improvement through the Recovery Phase, 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

July Cancer 62 Day Classic performance was maintained, with performance at 75.0%, a slight improvement of 0.5% on the previous month. 2 Week Wait performance was 98.7% (against a 93% target) which marks a further improvement and Trust's best performance since October 2017 against this standard.

Backlog number of patients waiting more than 62 and 104 days remains a priority and is part of Covid-19 Recovery phases. August has shown a reduction in both, with sharp reductions in 104+ numbers. As of 10th Sept there remained 50 patients waiting over 104 days down from a peak of 163 in mid-July. 31 day 1st treatment was 92.4% against a target of 96% and was predominantly affected by a nigh number of patients who were unfit or unwilling to engage with the NHS at this time.

A new pre diagnosis CNS post has been agreed and appointed to to support patients to attend and have treatments. Screening has significantly improved from 12.9 to 25.4% in July, however remains well below the target, affected by the cessation of surgery during Covid-19. Clearance of the back log remains a priority as access to surgery improves. This backlog reduction and improvement in waiting times will initially have a very significant impact on 62day performance which calculates treated patients waiting times. Therefore in August and September 62day classic performance standard particularly will reduce.

Workforce

Agency & Turnover

M5 Pay is adverse to plan, with much of this resulting from direct COVID expenditure. However, there is a notable variance in substantive fte to plan YTD driven by reduced turnover and stronger than planned recruitment. Whilst this is on the whole positive, a lack of a corresponding reduction in bank and agency staffing costs presents a risk.

The Nursing Transformation Programme continues to explore and implement initiatives to reduce nurse agency spend (e.g. incentivising use of bank). We are creating a Medical Transformation Programme to focus on the drivers of agency spend and fundamentally the medical capacity we need to deliver activity; how can we adopt new roles and reduce the medical establishment and understand how to use the medical capacity we have more efficiently.

Vacancies

Whole Trust vacancy rate increased slightly in M5. This follows four months of improvement from April to July. The increase is largely driven by a sharp increase in the medical vacancy rate during August. This in part due to an anomaly in the July data, where we had an overlap in the rotation of junior doctors and the rate of 13% for medical staff was understated. This is corrected in August, but alongside that we have seen an increase in vacancies for trainees (20fte) and career grades (23.5fte). However, the establishment for both has increased by 13fte and 19fte respectively.

The nursing vacancy rate is better than plan YTD with stronger than anticipated recruitment despite delays to international starts. 9 international nursing recruits have started in September and further 25 are expected in October.

Sickness Absence

Absence rate has been significantly affected by COVID related absence. The monthly rate rose to 5.48% in May, but is now back down to 4.76% (around the same level as in late summer 2019). This reduction reflects the lower level of COVID in the community (recognising this may change) and the work to bring those shielding back to work. The rolling 12-monthly average does remain above 5%. We started in August to roll out the new Absence Management System and this will enable greater control to be exercised over sickness.

Appraisals

The AfC staff appraisal rate remains low and core learning compliance has dropped to below 90%, both due to the distraction of COVID. We are focusing on appraisal in particular and requiring all managers, where an appraisal is outstanding, to advise when it will be undertaken. All staff will also have a well-being conversation, which is an expectation in the NHS People Plan.

Employee Relations

The number of unresolved Employee relations cases has increased to 94 (excluding appeals). A backlog has been created through COVID, which the ER team are seeking to manage through process as quickly as possible. Their ability to do so will be dependent upon the availability of managers in a very busy time and TU representatives.

Paul Matthew
Director of Finance & Digital
September 2020

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

PERFORMANCE OVERVIEW

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	Jun-20	Jul-20	Aug-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	6	7	33		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	0.04	0.06				
	E. coli bacteraemia cases counts and 12-month rolling rates, per 1000 bed days formula	Safe	Patients	Director of Nursing	TBC	0.13	0.04	0.18	0.08				
	Never Events	Safe	Patients	Medical Director	0	0	0	1	1		F		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	1	3	3	8		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	3	9	7	26				
	Summary Hospital Mortality Indicator (SHMI) (rolling year data 6 month time lag)	Effective	Patients	Medical Director	100	109.73	108.42	107.56	109.06		F		
	Hospital Standardised Mortality Ratio - HSMR (rolling year data 3 month time lag)	Effective	Patients	Medical Director	100	95.50	95.73	100.90	96.39		F	A	
	Sepsis screening (bundle) compliance for inpatients (adult)	Safe	Patients	Director of Nursing	90%	80.90%	86.50%	91.20%	86.16%		P		
	Sepsis screening (bundle) compliance for inpatients (child)	Safe	Patients	Director of Nursing	90%	86.10%	86.30%	93.30%	87.94%		P		
	IVAB within 1 hour for sepsis for inpatients (adult)	Safe	Patients	Director of Nursing	90%	87.40%	94.00%	92.60%	92.72%		P		
	IVAB within 1 hour for sepsis for inpatients (child)	Safe	Patients	Director of Nursing	90%	60.00%	90.00%	100.00%	84.38%		P		

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

PERFORMANCE OVERVIEW

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	Jun-20	Jul-20	Aug-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%	92.50%	94.11%	91.70%	92.76%		P	A	
	Sepsis screening (bundle) compliance in A&E (child)	Safe	Patients	Director of Nursing	90%	98.40%	100.00%	88.10%	91.36%		F	A	
	IVAB within 1 hour for sepsis in A&E (adult)	Safe	Patients	Director of Nursing	90%	95.70%	97.30%	97.50%	96.36%		P		
	IVAB within 1 hour for sepsis in A&E (child)	Safe	Patients	Director of Nursing	90%	100.00%	100.00%	100.00%	100.00%		P	A	
	Rate of stillbirth per 1000 births	Safe	Patients	Director of Nursing	4.20	1.72	2.59	2.39	2.11		P	B	
	Number of Serious Incidents (including never events) reported on StEIS	Safe	Patients	Medical Director	14	16	14	17	64		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	0.08	0.15	0.18	0.16		P		Timeliness, Completeness, Validation, Process
	Reported medication incidents per 1000 occupied bed days	Safe	Patients	Medical Director	4.3	4.68	5.10	6.26	5.06		P	B	
	Medication incidents reported as causing harm (low /moderate /severe / death)	Safe	Patients	Medical Director	10.7%	19.80%	12.60%	10.40%	13.58%		P		
	Potential under reporting of patient safety incidents / Reported incidents (all harms) per 1,000 bed days	Safe	Patients	Medical Director	30	38.20	37.80	36.86	37.02		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%	89.00%	93.00%	92.20%		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%	97.90%	98.30%	98.10%	97.03%		P		
	eDD issued within 24 hours	Effective	Patients	Medical Director	95%	95.30%	90.00%	93.20%	94.02%		F		

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

PERFORMANCE OVERVIEW

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	Jun-20	Jul-20	Aug-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%	88.16%	88.95%	88.96%	88.91%		F		
	Number of Vacancies	Well-Led	People	Director of HR & OD	12%	12.20%	11.88%	12.74%	12.53%		F	L	
	Sickness Absence	Well-Led	People	Director of HR & OD	4.5%	5.08%	5.07%	5.02%	5.02%		F	A	
	Staff Turnover	Well-Led	People	Director of HR & OD	12%	10.62%	10.80%	10.73%	10.92%		P		
	Staff Appraisals	Well-Led	People	Director of HR & OD	90%	68.27%	68.52%	70.86%	69.48%		F		
					£'000	£'000	£'000	£'000	£'000				
	Agency Spend	Well-Led	People	Director of HR & OD	TBC	-£3,743	-£3,674	-£3,060	-£16,755		F		
Improve Patient Experience	Mixed Sex Accommodation breaches	Caring	Patients	Director of Nursing	0	0	0	0	0		P		Reviewed: 12.06.20 Data available at: Specialty level Timeliness Completeness Validation Process
	% Triage Data Not Recorded	Effective	Patients	Chief Operating Officer	0%	0.13%	0.15%	0.82%	0.30%		F		
	Duty of Candour compliance - Verbal	Safe	Patients	Medical Director	100%	86.00%	82.00%		86.75%		F		
	Duty of Candour compliance - Written	Responsive	Patients	Medical Director	100%	76.00%	71.00%		76.75%		F		

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

PERFORMANCE OVERVIEW

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	Jun-20	Jul-20	Aug-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	70.92%	88.15%	82.37%	78.46%	85.39%	69.32%	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%	96.01%	93.03%	86.12%	93.12%	88.50%	F		
	52 Week Waiters	Responsive	Services	Chief Operating Officer	0	34	149		217	0	F		
	18 week incompletes	Responsive	Services	Chief Operating Officer	84.1%	54.08%	47.33%		58.98%	84.10%	F		
	Waiting List Size	Responsive	Services	Chief Operating Officer	37,762	39,581	42,306		n/a	n/a	F		
	62 day classic	Responsive	Services	Chief Operating Officer	85.4%	74.52%	75.00%		70.65%	85.39%	F		
	2 week wait suspect	Responsive	Services	Chief Operating Officer	93.0%	94.08%	98.74%		92.50%	93.00%	P		
	2 week wait breast symptomatic	Responsive	Services	Chief Operating Officer	93.0%	84.48%	74.15%		80.43%	93.00%	F		
	31 day first treatment	Responsive	Services	Chief Operating Officer	96.0%	96.11%	92.37%		95.54%	96.00%	F		
	31 day subsequent drug treatments	Responsive	Services	Chief Operating Officer	98.0%	95.24%	98.25%		97.99%	98.00%	P		
	31 day subsequent surgery treatments	Responsive	Services	Chief Operating Officer	94.0%	88.89%	90.38%		87.78%	94.00%	F		
	31 day subsequent radiotherapy treatments	Responsive	Services	Chief Operating Officer	94.0%	89.89%	94.74%		94.69%	94.00%	P		
	62 day screening	Responsive	Services	Chief Operating Officer	90.0%	12.50%	0.00%		23.44%	90.00%	F		

OUTSTANDING CARE personally DELIVERED

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5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	Jun-20	Jul-20	Aug-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%	80.92%	79.87%		79.45%	85.00%	F		
	Diagnostics achieved	Responsive	Services	Chief Operating Officer	99.0%	53.96%	57.89%	52.81%	49.46%	99.00%	F	?	
	Cancelled Operations on the day (non clinical)	Responsive	Services	Chief Operating Officer	0.8%	0.54%			1.33%	0.80%	P	L	
	Not treated within 28 days. (Breach)	Responsive	Services	Chief Operating Officer	0	1			56	0	F		
	#NOF 48 hrs	Responsive	Services	Chief Operating Officer	90%	84.21%	90.63%	90.63%	87.08%	90%	P		
	#NOF 36 hrs	Responsive	Services	Chief Operating Officer	TBC	70.18%	78.13%	78.13%	73.29%				
	EMAS Conveyances to ULHT	Responsive	Services	Chief Operating Officer	4,657	4,218	4,700	4,688	4,344	4,657	F		
	EMAS Conveyances Delayed >59 mins	Responsive	Services	Chief Operating Officer	0	49	81	194	83	0	F		
	104+ Day Waiters	Responsive	Services	Chief Operating Officer	5	137	116	70	393	25	F	?	
	Average LoS - Elective (not including Daycase)	Effective	Services	Chief Operating Officer	2.80	2.57	3.38	2.19	2.97	2.80	P		
	Average LoS - Non Elective	Effective	Services	Chief Operating Officer	4.50	3.98	4.37	4.35	3.98	4.5	P		
	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	19,106	19,789	21,853	19,398	4,524	F	H	
	Outpatients seen within 15 minutes of appointment	Effective	Services	Chief Operating Officer	70.0%	38.0%	33.3%	41.9%	37.00%	70.00%	F		
	% discharged within 24hrs of PDD	Effective	Services	Chief Operating Officer	45.0%	36.0%	34.8%	36.2%	36.59%	45.00%	F		

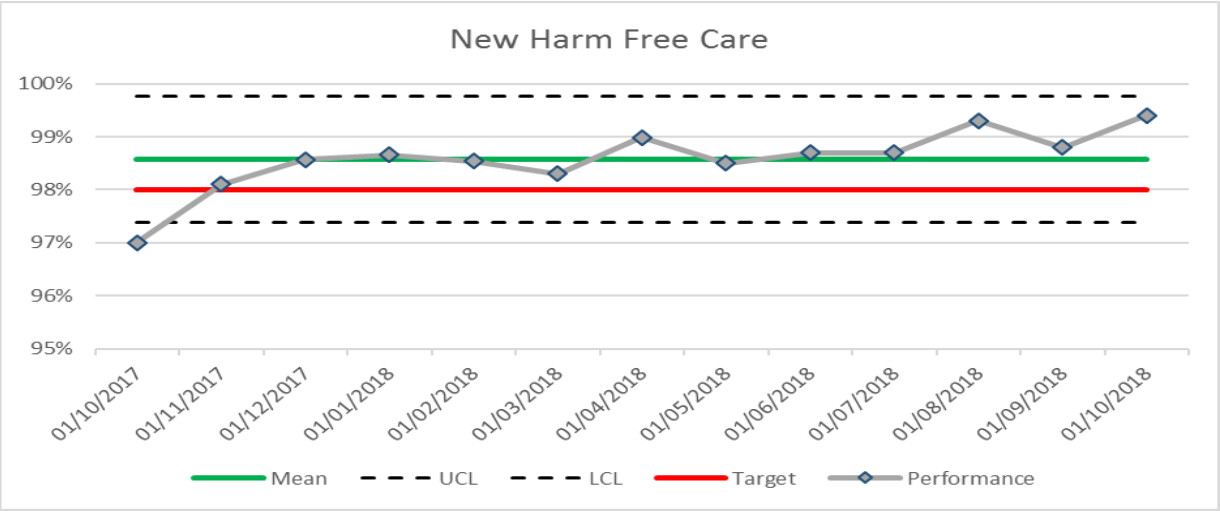
STATISTICAL PROCESS CONTROL CHARTS

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:



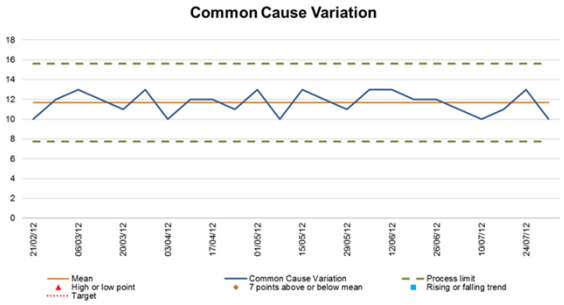
Normal variations in performance across time can occur randomly- without a direct cause, and should not be treated as a concern, or a sign of improvement, and is unlikely to require investigation unless one of the patterns defined below applies.

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

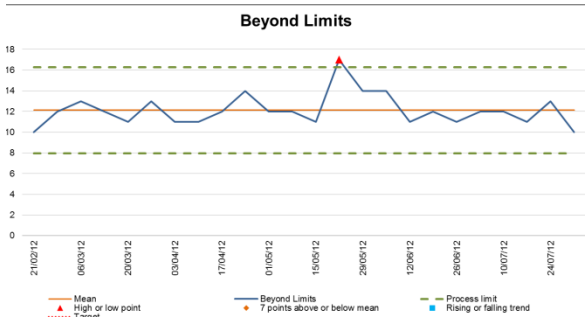
- Normal variation – (common cause) fluctuations in data points that sit between the upper and lower control limits
- Extreme values – (special cause) any value on the line graph that falls outside of the control limits. These are very unlikely to occur and where they do, it is likely a reason or handful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

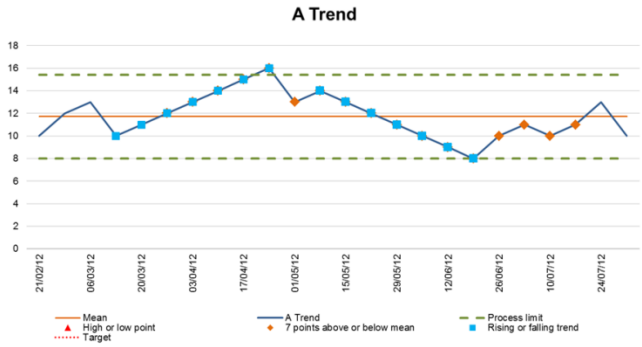


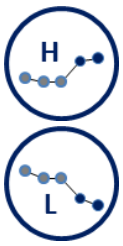
Extreme Values



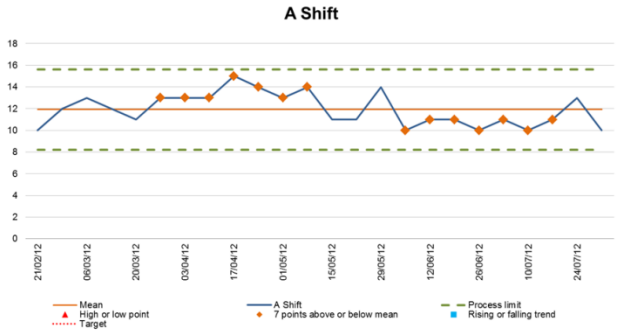
There is no Icon for this scenario.

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

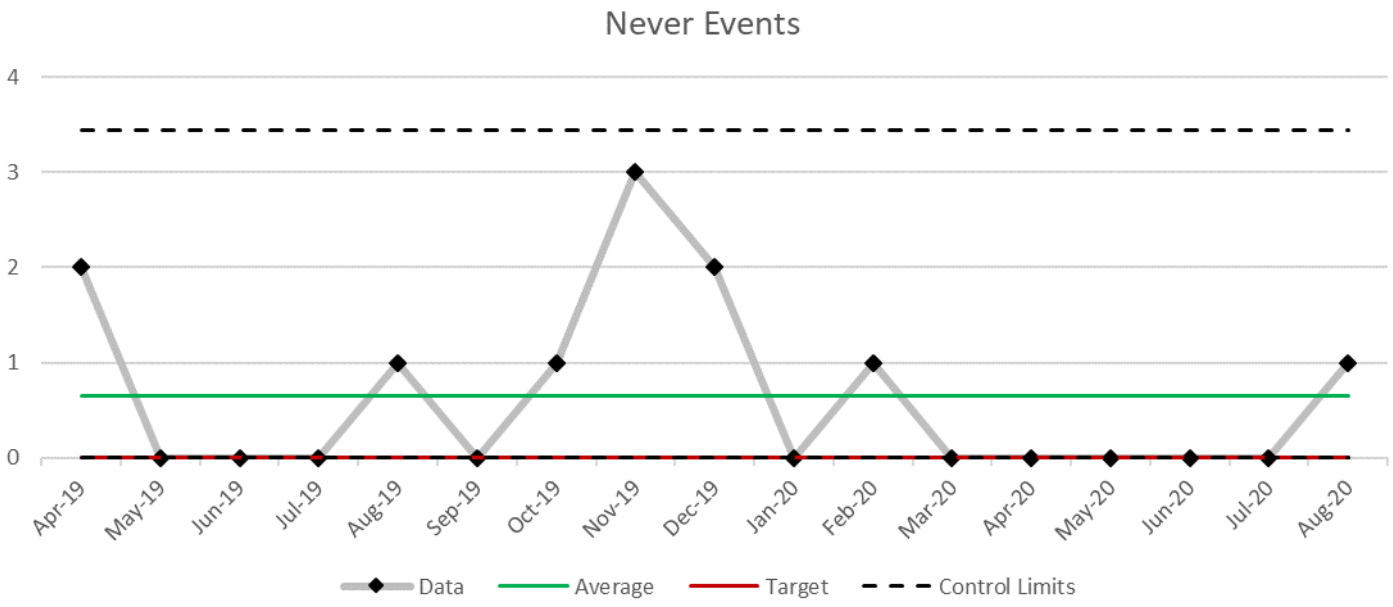
Where the target has been missed for at least 3 of the most recent data points in a row, or in a string of 7 of the most recent data points, at least 5 out of the 7 data points have missed.

DELIVER HARM FREE CARE – NEVER EVENTS

Executive Lead: Medical Director

CQC Domain: Safe

Strategic Objective: Patients



Challenges / Successes:

- The Trust declared 1 Never Event in August 2020; the incident actually occurred in July.
- The incident involved a nasogastric tube guide wire that was left in place post-procedure.

Actions in place to recover:

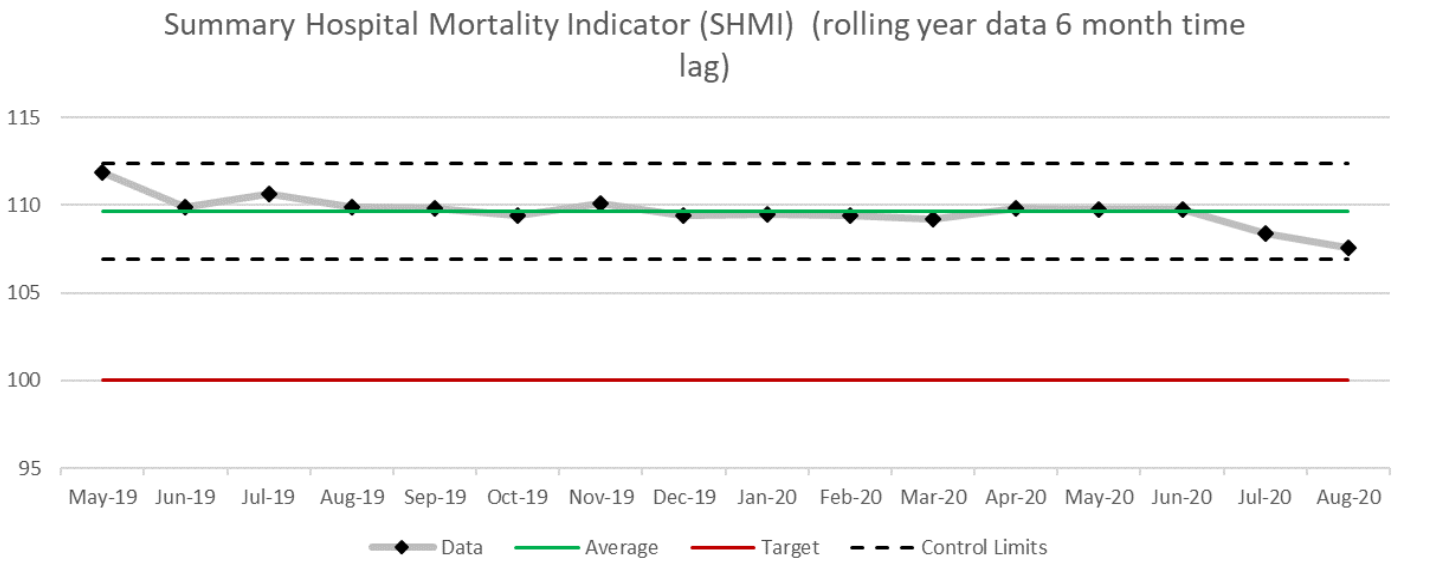
- A Serious Incident investigation is underway.
- The Trust's NG tube policy has been reviewed and updated to make it clear that the guidewire must be removed.
- The occurrence of Never Events is recorded on the patient safety risk register with an action plan in progress; this action plan will now be reviewed in light of learning from the most recent incident.

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 107.56, another decrease 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 94.87 and is below threshold limits.

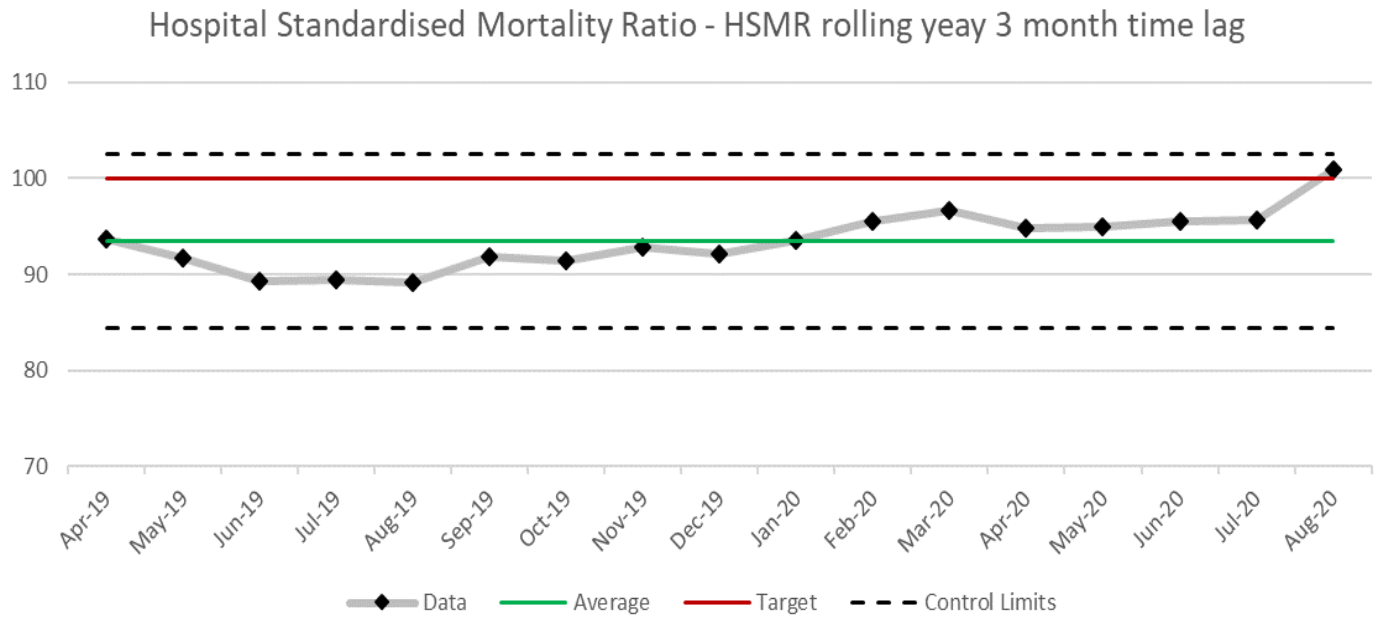
Alerts: Pneumonia is currently alerting.

DELIVER HARM FREE CARE – MORTALITY HSMR

Executive Lead: Medical Director

CQC Domain: Effective

Strategic Objective: Patients



Challenges/Successes

ULHT's HSMR is at 100.88, which is within expected limits.

Lincoln site is outside the expected limits at 110.24 for the rolling year; with 93 more deaths than predicted (1009 Observed: 916 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:

Leukaemia: alerting for the seventh month at Pilgrim and second month at Trust level (6.64 expected deaths compared to 15 deaths). Case notes and coding have been reviewed.

Septicaemia (except in labour): alerting for the third month at Lincoln (145.38 expected deaths compared to 172 deaths). Case notes currently being reviewed

Intestinal obstruction without hernia: alerting for the first month at Lincoln (14.71 expected deaths compared to 24 deaths).

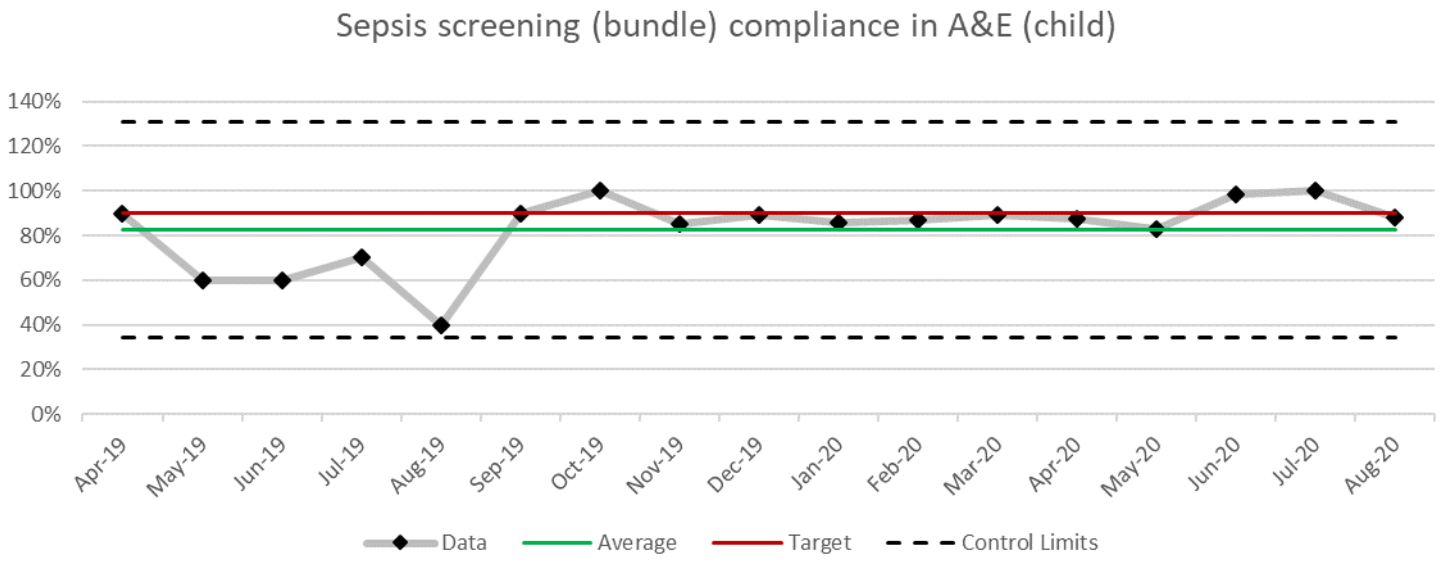
Non-infectious gastroenteritis: alerting for the third month at Pilgrim (0.83 expected deaths compared to 4 deaths). Case notes have been requested to review coding.

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 just short of the 90% standard achieving 88% for August. The harm reviews undertaken for those children who did not receive a screen have revealed no harms or concerns.

Actions in place to recover:

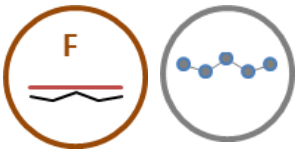
The designated paediatric Resuscitation and Sepsis Practitioner has successfully piloted an engagement project at one site where the Paediatric and ED staff meet monthly to share experiences and knowledge and this is bolstered by a quarterly education forum that covers sepsis as part of the programme. This will be rolled out to all sites by next month and will augment the support provided by the Sepsis Practitioners through their regular visits.

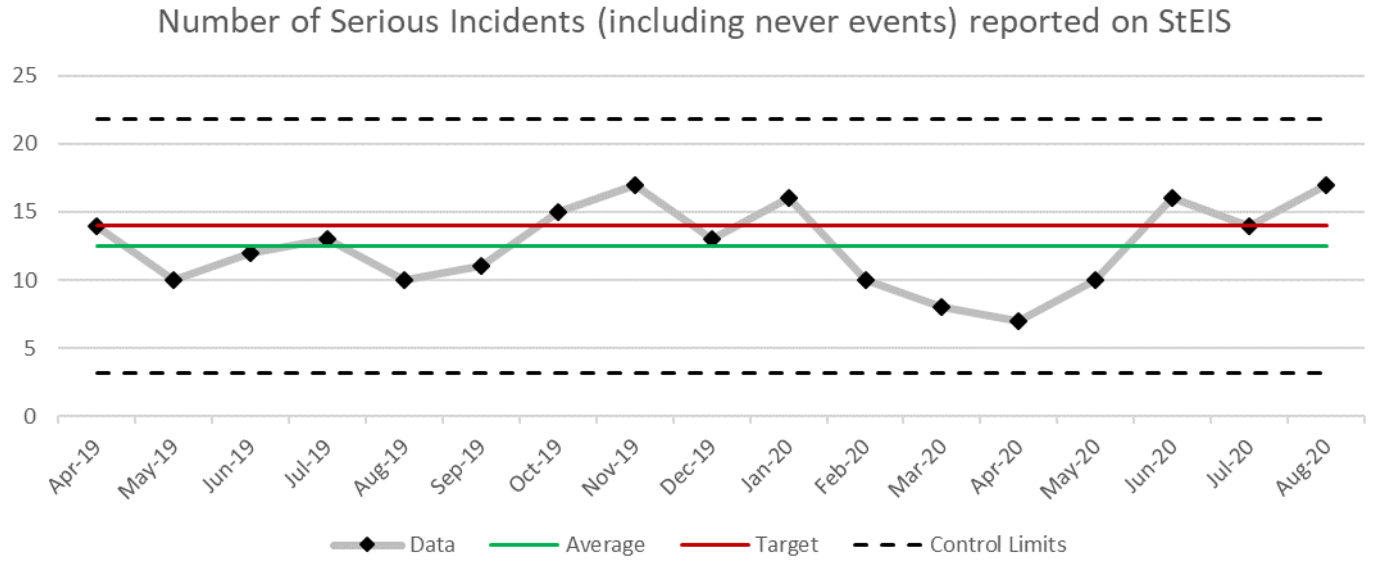
DELIVER HARM FREE CARE – SERIOUS INCIDENTS ON StEIS

Executive Lead: Medical Director

CQC Domain: Safe

Strategic Objective: Patients





Challenges / Successes:

- The Trust declared 17 Serious Incidents in August 2020, which is above the monthly average of 12 for the 2019/20 financial year.
- Of those 17 incidents, 4 were patient falls (in 4 different ward locations).

Actions in place to recover:

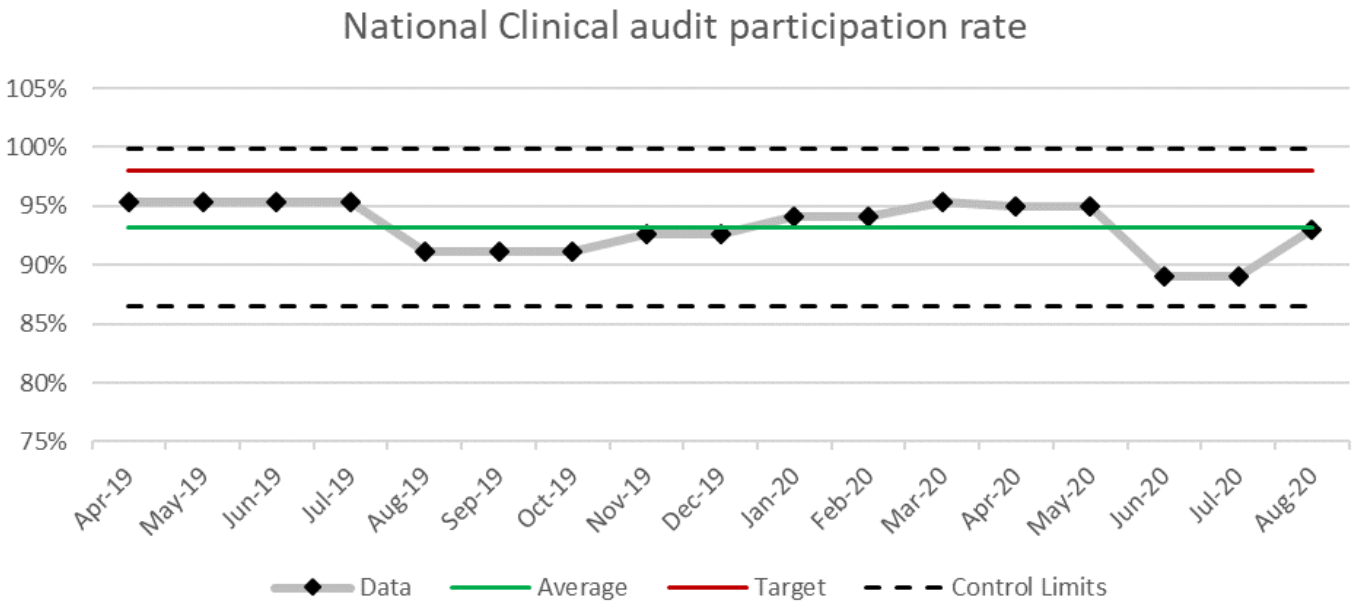
- A Trust-wide patient falls action plan is being developed, based on learning from incident investigations recently completed.
- A review of the Trust's current Serious Incident processes is planned for quarter 3; this review will also take account of the planned introduction of a new national Patient Safety Incident Response Framework (PSIRF), which is currently being trialled in a small number of trusts.

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 93% for the month of August 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

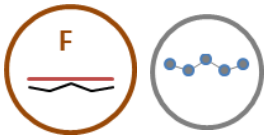
- Procedures now taking place this should improve participation submissions with the Green site restoration phase.

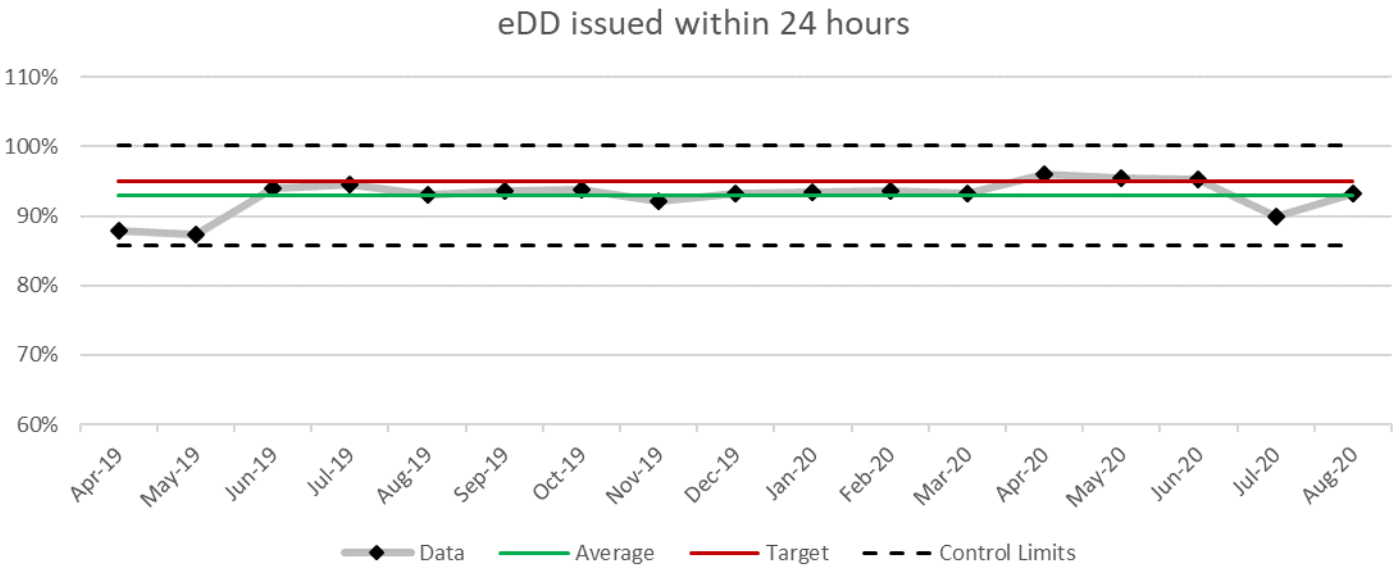
DELIVER HARM FREE CARE – eDD ISSUED WITHIN 24 HOURS

Executive Lead: Medical Director

CQC Domain: Effective

Strategic Objective: Patients





Challenges/Successes

The Trusts compliance of sending eDDs within 24 hours for August 2020 was 93.2%. Compliance for eDDs sent anytime in August was 96.9%. There were 104 eDDs not sent out of the 5,482 discharges from the Trust.

Actions in place to recover:

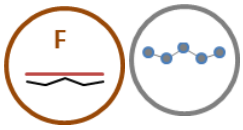
The Divisions receive monthly eDD compliance reports on their performance and their compliance will be included within the PRM going forward. The Deputy Medical Director has sent a letter to all Consultants informing them of the importance of completing eDDs prior to discharging their patients and that they will be held to account for their compliance.

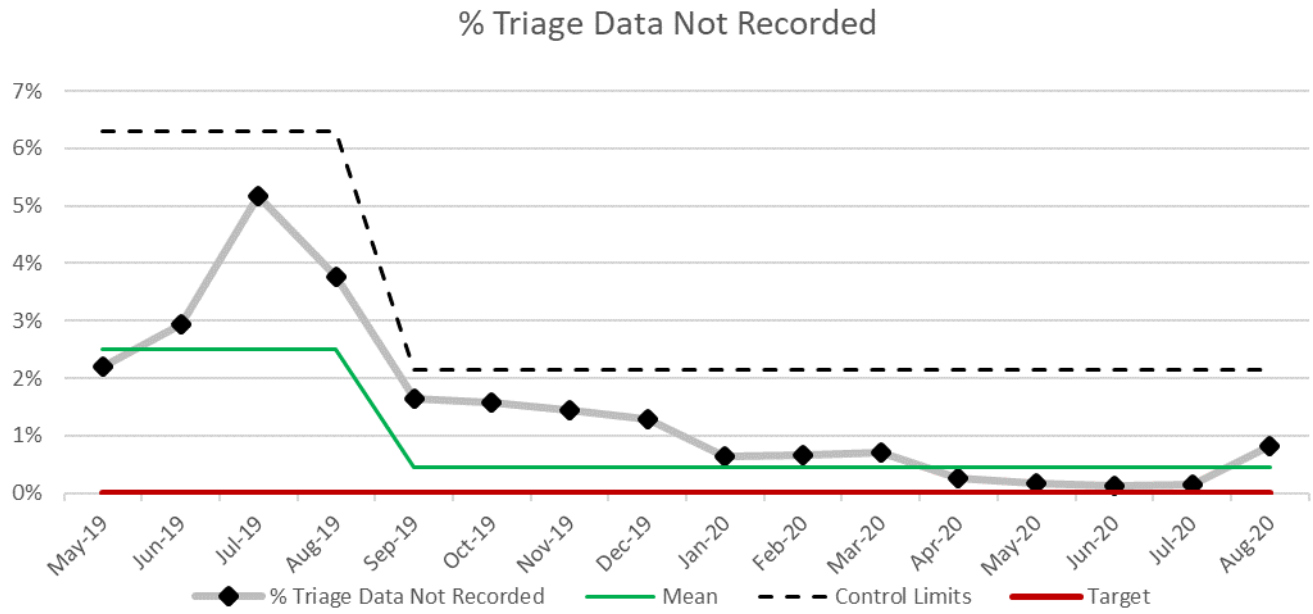
IMPROVE PATIENT EXPERIENCE – % TRIAGE DATA NOT RECORDED

Executive Lead: Chief Operating Officer

CQC Domain: Effective

Strategic Objective: Patients





Challenges/Successes

- August demonstrated a 0.67% negative variation in performance compared with July but 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. This proved problematic in August especially overnight and it is noted that Lincoln County experienced the greatest degree of non-compliance with recording.
- Some short notice sickness and agency cancellation has resulted in the inability to provide two triage streams at peak times of attendances.

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.
- The Divisional UEC Operational Leads (DGM and Lead Nurse) continually feedback performance to the clinical teams and address non-adherence to process and seeks rectification measures.
- Additional training is being sourced.

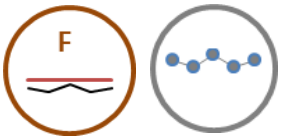
Triage time is a key patient safety performance indicator and forms an essential part of the department huddles. Overview, scrutiny and challenge continues to be provided through the 3 daily Capacity and Performance Meetings and support.

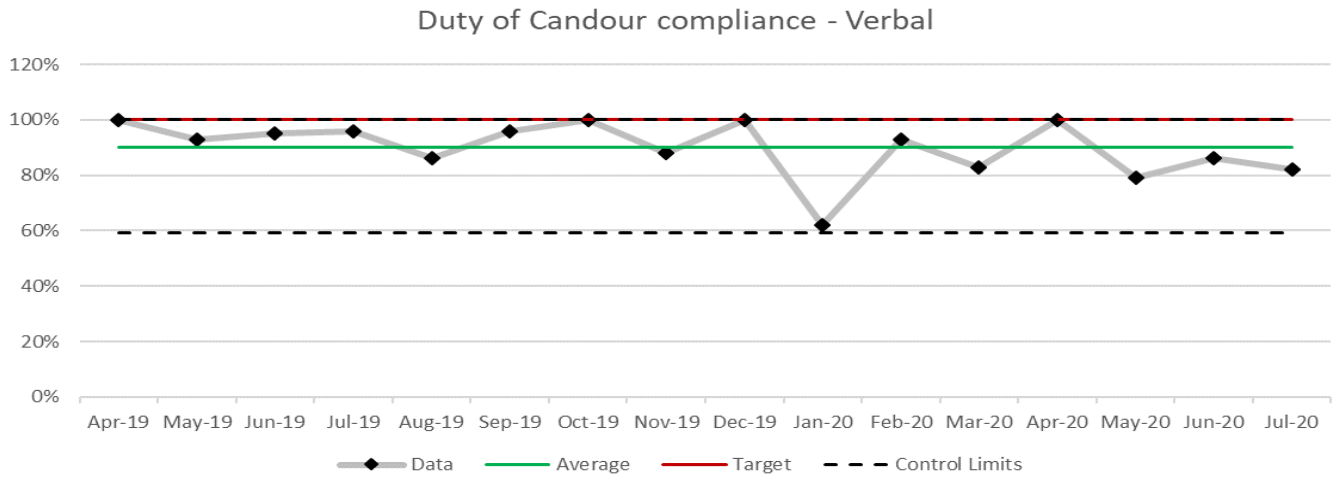
IMPROVE PATIENT EXPERIENCE – DUTY OF CANDOUR

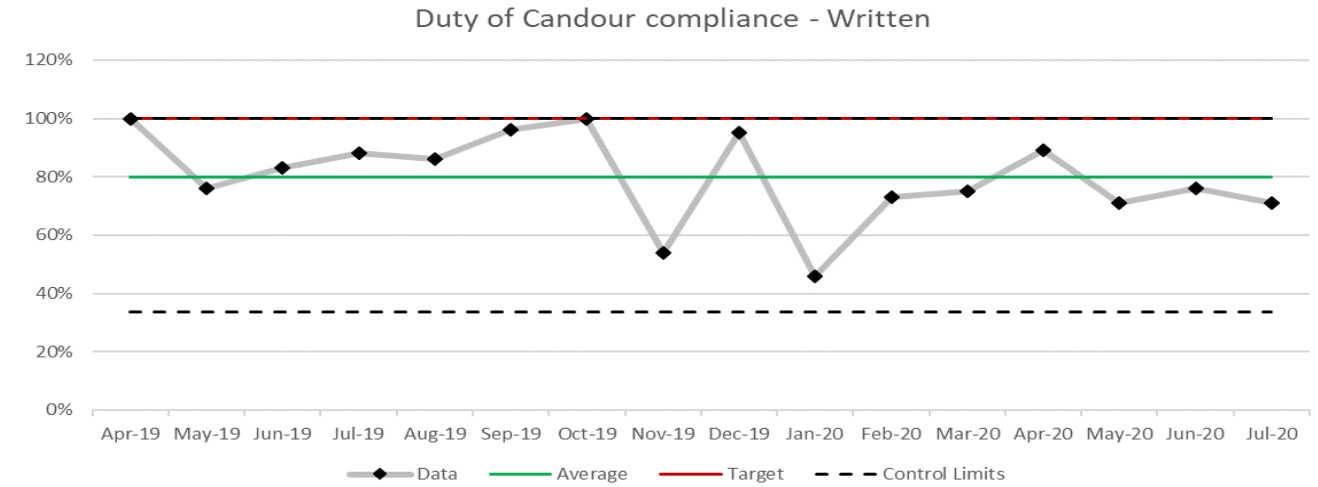
Executive Lead: Medical Director

CQC Domain: Safe/Responsive

Strategic Objective: Patients







Challenges/Successes

- There were 17 notifiable incidents requiring Duty of Candour in July 2020.
- 14 incidents were compliant for initial notification in person (82%); 12 were compliant for written follow-up (71%).
- The non-compliant incidents were in Surgery CBU; Cardiovascular CBU; Urgent & Emergency Care CBU; and Diagnostics CBU.

Actions in place to recover:

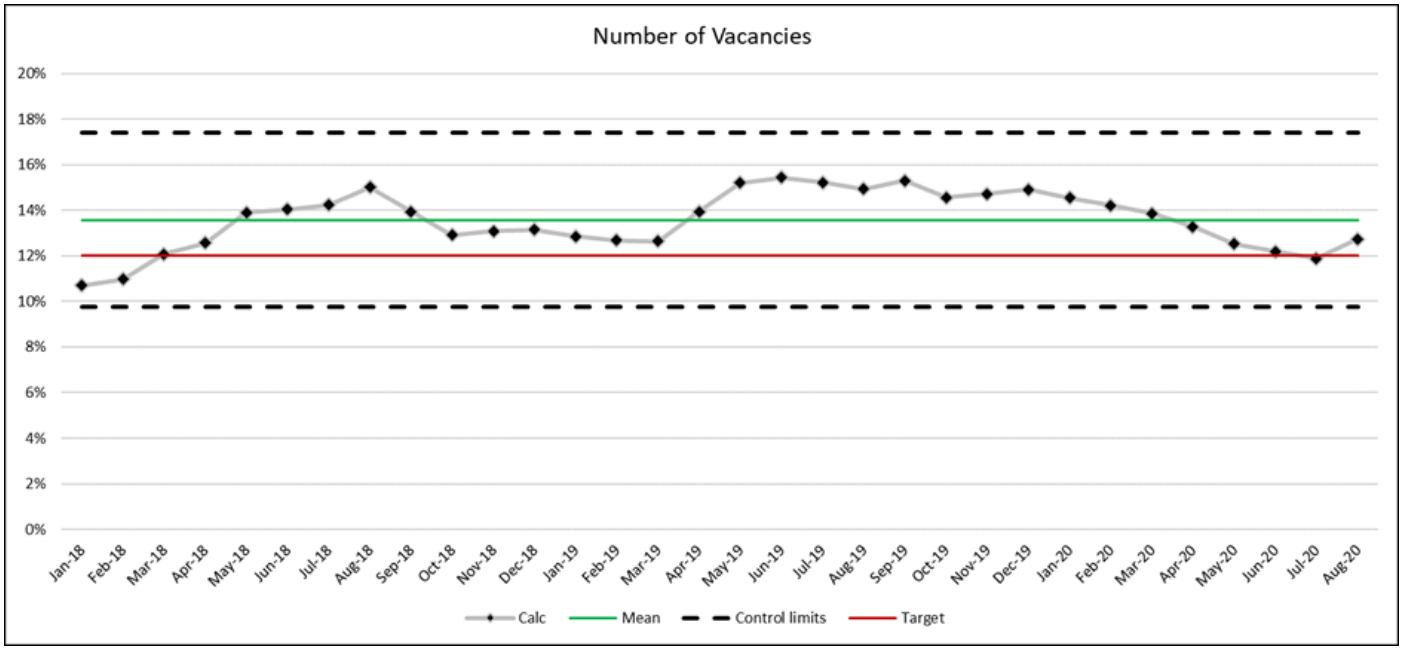
- Issues with Duty of Candour compliance are raised with the divisional representatives at the monthly Patient Safety Group (PSG).
- From September 2020 the Risk & Incident Team will be responsible for providing direct support to the completion of written follow-up letters to divisions, where the initial notification in person has been provided by the clinical team.
- Trust-wide communications will be sent out in September to highlight the importance of Duty of Candour and the requirements for compliance.

A MODERN AND PROGRESSIVE WORKFORCE – VACANCY RATES

Executive Lead: Director of HR & OD

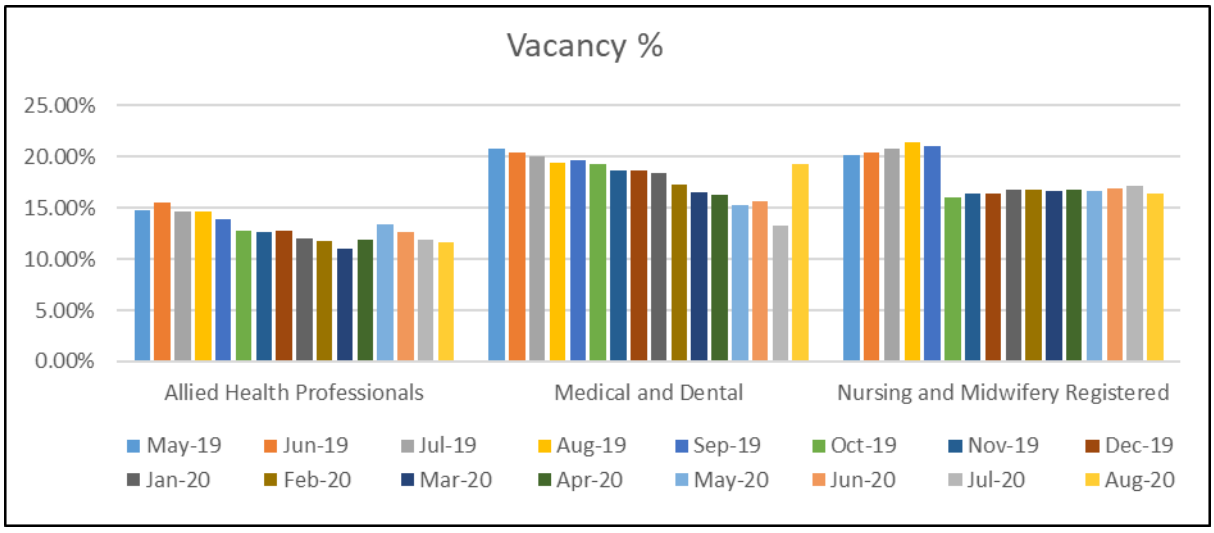
CQC Domain: Well-Led

Strategic Objective: People



Challenges/Successes

In July the vacancy rate had reduced to 11.88% this was due to the overlap of the Trainee F1 doctors as part of the doctors rotation. The Trust vacancy rate has risen in August by 0.86%, which aligns more accurately with the monthly vacancy rates.



Staff Group	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20
Allied Health Professionals	13.94%	12.76%	12.68%	12.82%	12.00%	11.71%	11.02%	11.93%	13.33%	12.66%	11.90%	11.66%
Medical and Dental	19.60%	19.24%	18.64%	18.62%	18.43%	17.31%	16.58%	16.27%	15.31%	15.66%	13.21%	19.28%
Nursing and Midwifery Registered	21.04%	16.06%	16.40%	16.40%	16.74%	16.82%	16.67%	16.75%	16.69%	16.87%	17.08%	16.36%

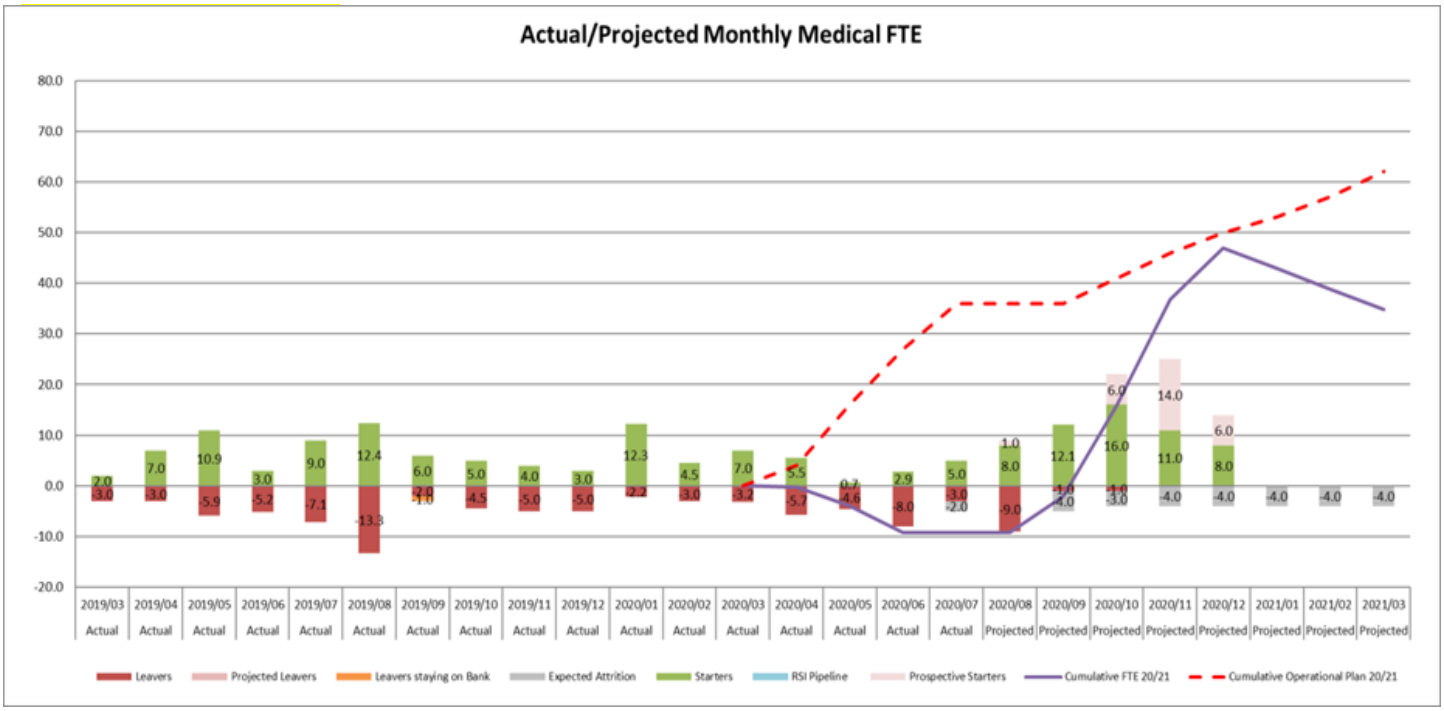
Medical Staff Vacancy Rate

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.

The reduction in the vacancy rate in July, particularly driven by the reduction in the medical rate is noted above. This was in part due to the overlap in trainee rotations in July. However there has also been an increase in medical vacancies in August.
There are 23.58 FTE more vacancies between Jun and Aug for Career Grades. However of this 19.22 FTE was the result of an establishment increase.
Similarly there are 19.96 FTE more vacancies between Jun and Aug for Trainee Grades, however the establishment was increased by 12.98 FTE.

ICU Consultants

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 24 Aug 20

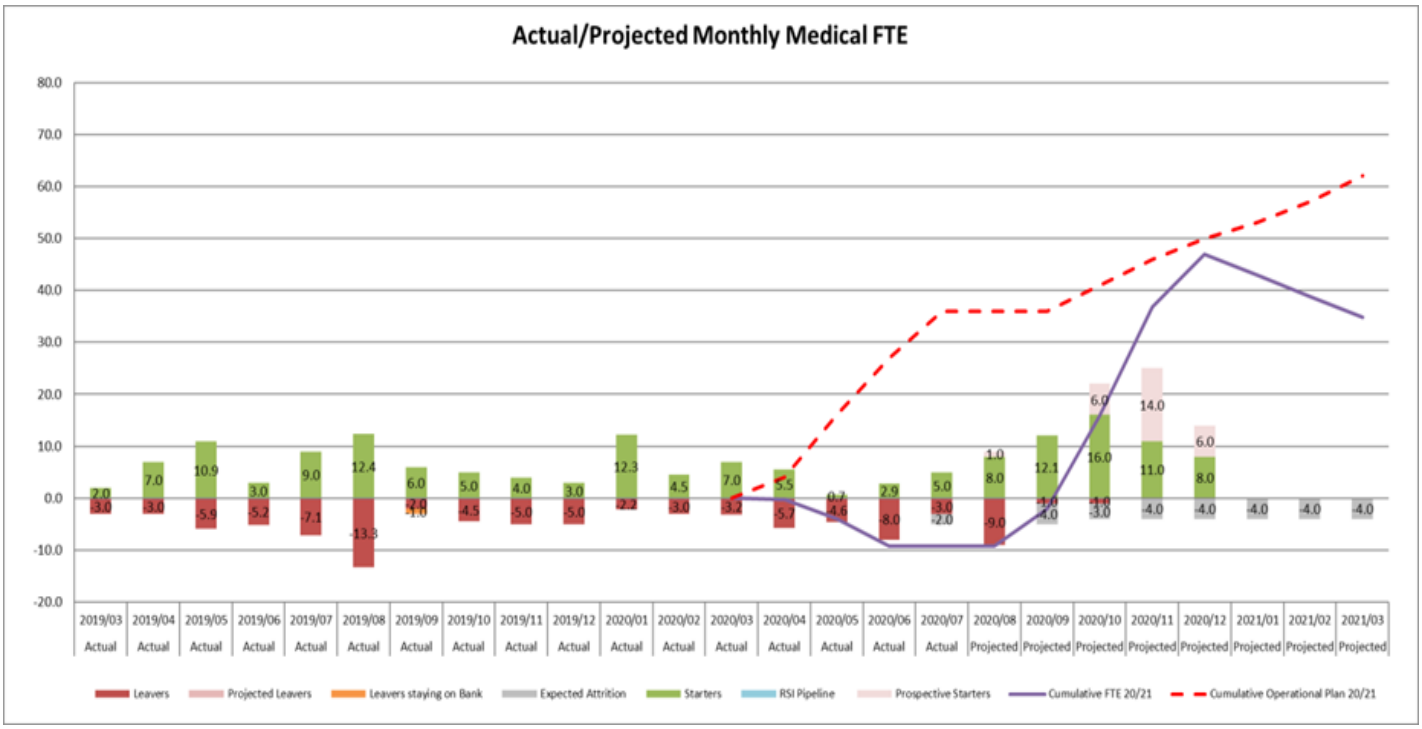
Nursing Vacancy Rate

Improvement in the vacancy rate for nursing also continues with a 5.1 percentage point improvement over the last twelve months, with a 3.3% improvement in annual turnover a much stronger contributory factor and remains ahead of 2020/21 Operational Plan (red dotted line), resulting from reduced turnover and stronger than planned domestic recruitment.

International Nursing

Given the initial delays due to covid, the first cohort of nurses arrive in September (12 in total) and will begin quarantining for 14 days prior to starting in the Trust. At present 2 have arrived with a further 4 having flights booked for the 8/09/20. The remaining 6 are awaiting Visa offices to open and flights to be booked. They may be spill over into October.

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).

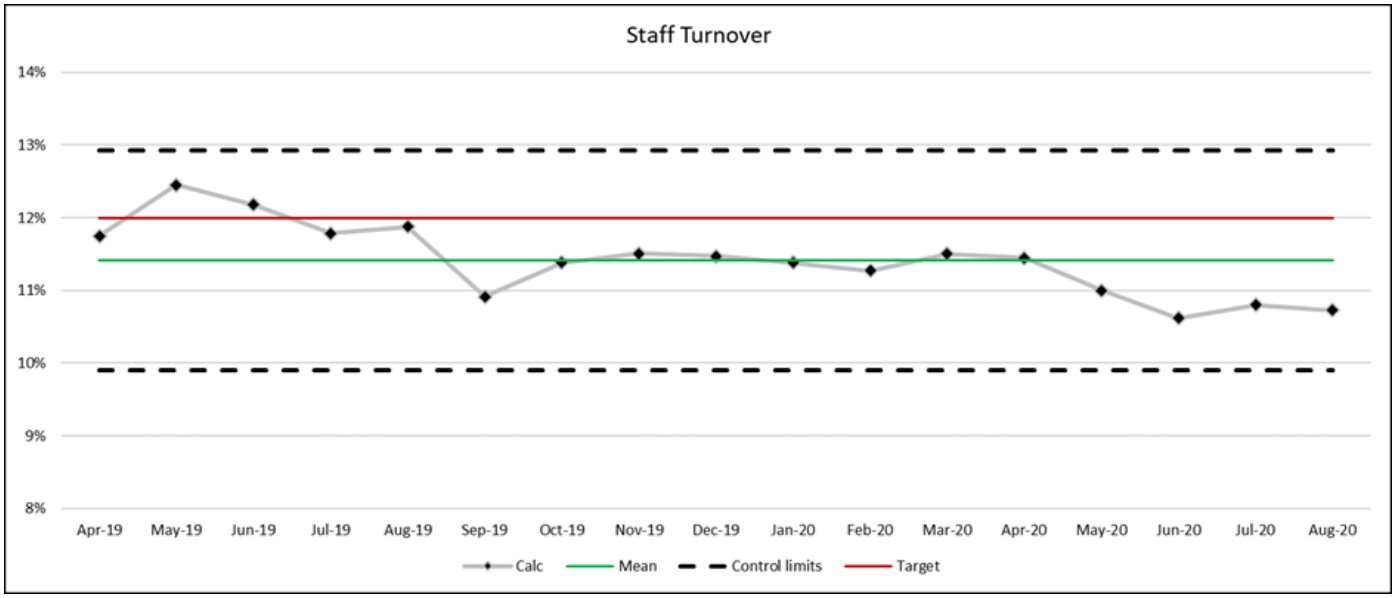


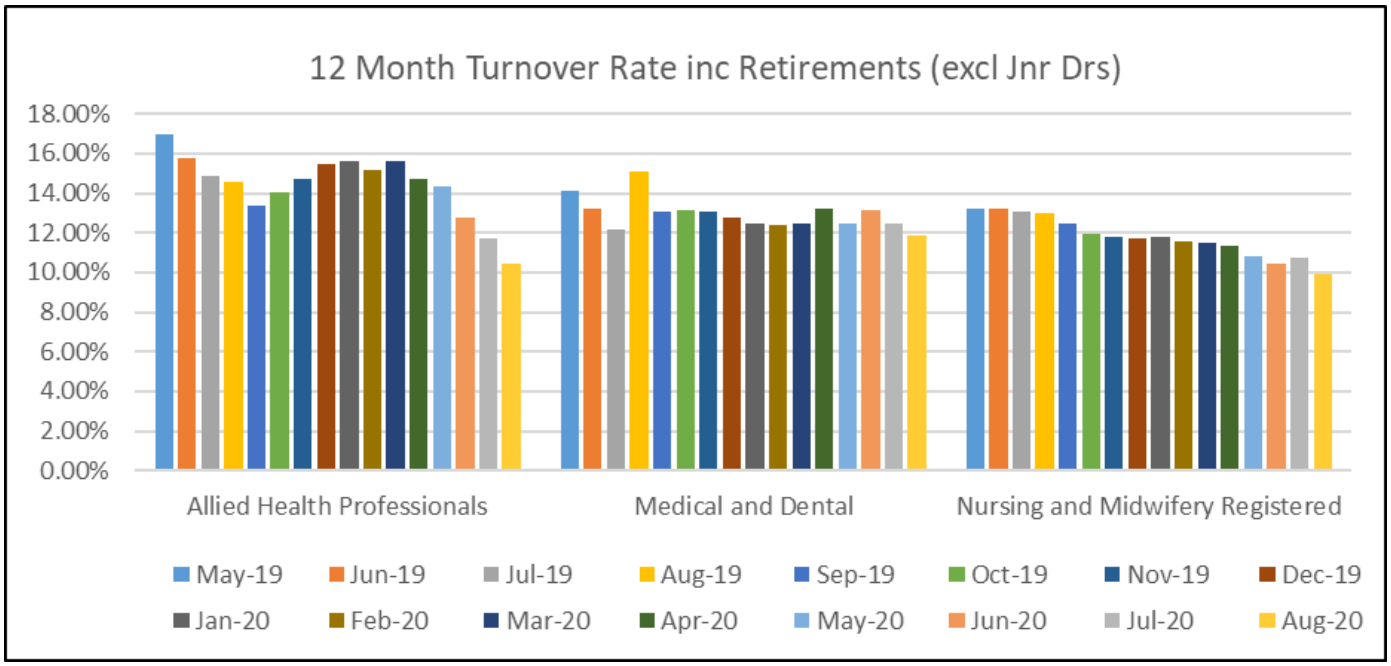
A MODERN AND PROGRESSIVE WORKFORCE – VOLUNTARY TURNOVER

Executive Lead: Director of HR & OD

CQC Domain: Well-Led

Strategic Objective: People





Staff Group	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20
Allied Health Professionals	13.36%	14.02%	14.69%	15.46%	15.60%	15.16%	15.64%	14.73%	14.37%	12.79%	11.74%	10.43%
Medical and Dental	13.07%	13.11%	13.04%	12.78%	12.46%	12.36%	12.44%	13.21%	12.49%	13.14%	12.49%	11.87%
Nursing and Midwifery Registered	12.43%	11.96%	11.81%	11.70%	11.82%	11.56%	11.50%	11.32%	10.80%	10.42%	10.71%	9.93%

Challenges/Successes

Longer-term trends for turnover remain positive, with the nursing rate close to national median rates. AHP turnover rate has reduced in the last 4 consecutive months and vacancy rate is remains below 12%.

Vacancy Rate / Turnover – Assurance, Actions In Place To Improve and Risks

For Assurance

- 12 month trend of improvement in KPIs
- Continued strong pipeline for Consultant and SAS recruitment
- 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).
- High number of AACs planned for 20/21 with an increasing standard on the bar to be met for appointment as a ULHT consultant.
- JustR, digital recruitment specialists, engaged to support a 6 months campaign to recruit ICU consultants, currently 4 vacancies which despite continual efforts we have been unable to recruit to.
- 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 planned
- Strong engagement with student nurses and guaranteed employment offers
- International radiographers landed.
- Positive HCSW recruitment campaign with now minimal vacancies.
- Recruitment times have reduced from around 90 days, to around 60 days

Further Improvement

- Increased focus on staff engagement to reduce turnover. We are now looking at different initiatives for identified staff groups – Nursing, AHP's and Doctors.
- Retention now also a part of the IIP through the recruitment and retention PID.
- 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

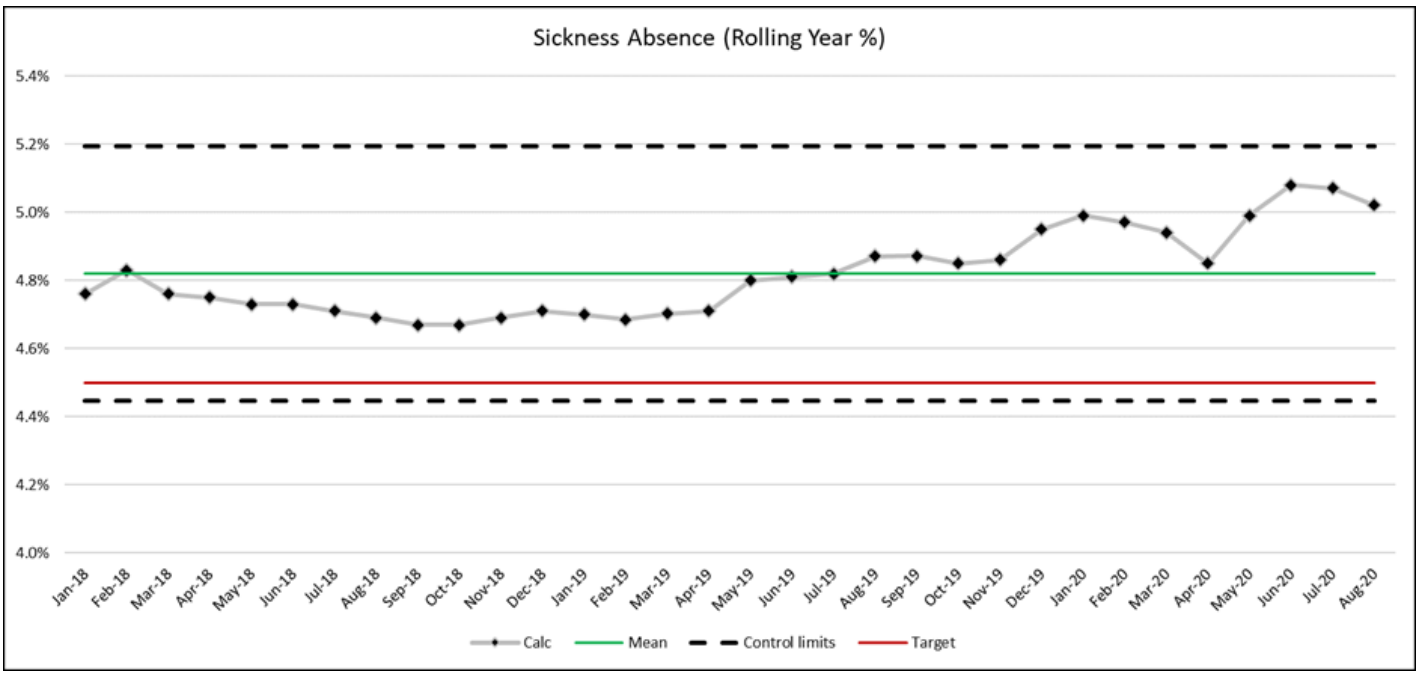
- Continued delay in international starts due to COVID and increased risk of attrition of international recruits from offer to start
- Divisional timely processing of known leavers and lost opportunity for early planning of local intelligence of anticipated staff moves.
- Translation of improvement in 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.

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 is 5.0%, a decrease of 0.1% from the previous month.

Sickness Absence – Assurance, Actions In Place To Improve and Risks

Points for Assurance

- The number of staff absent due to COVID reasons remains minimal.
- Work continues with line managers in order to ensure data is accurate as reflected in ESR and Healthroster.
- All Line Managers have been contacted to arrange any formal sickness meetings that may have not taken place during the COVID pandemic.
- We are continuing to hold meetings via Microsoft Teams and face to face ensuring we continue to support social distancing whilst maintaining momentum in completing meetings to avoid any further delays.
- The ER Team will continue to contact those employees who are showing new symptoms and are in quarantine following foreign travel and provide support to managers.
- Meetings postponed due to the national union agreement have now taken place or are booked in to be completed.
- We have completed 5 Capability Hearings due to Ill Health postponed due to COVID across August.

Actions being taken to improve performance

- We have four new Assistant Advisors joining the Team across September to provide further support to the Team Divisions in managing absence.
- There are currently 93 open sickness cases relating to Stress and Anxiety. The ER team continue to support Line Managers to contact those people to offer them support, to ensure all health and wellbeing avenues are being explored fully.
- The ER Team continue to focus on setting up a number of formal hearings for Disciplinary, Capability, Grievance and Appeal which may be impacting upon absence.
- The majority of staff who were shielding have now returned to work. We currently have 5 staff members that remain shielding due to severe underlying health conditions as advised by Occupational Health.
- 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.

Update on the Attendance Management System

- Since go live (in Corporate Services) on the 3rd August, there has been 10 existing long term sickness cases that have transferred across to the new system and there has been 28 new short term absences recorded and being managed through the system from the initial trance of 427 staff.
- There is ongoing preparation to maintain the momentum in rolling out the new system for the next tranche, ICT, to go live by the 1st October, Outpatients and Estates and Facilities to both go live by the 2nd November. The system will then be rolled out across the remaining clinical teams in the remainder of this year followed by the Medics in early January 2021.
- The ER team continue to contact managers who have not been completing their call backs to ensure that the trust has full engagement with the system and the absence management process as per our policy.
- The ER Advisors continue to support line managers with the implementation of the new Attendance Management System to manage attendance effectively.

Risks

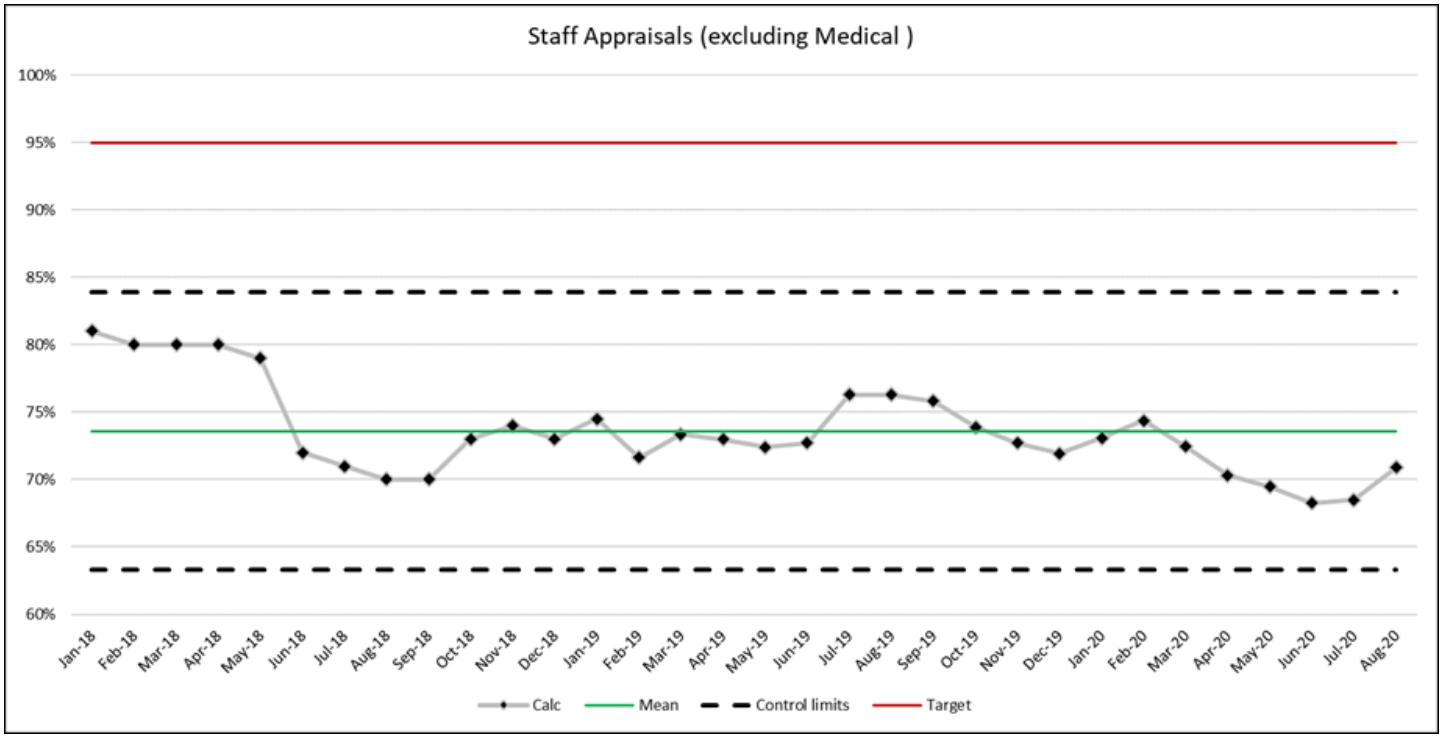
- A second spike of COVID, alongside annual leave and winter pressures.
- The lack of accurate or timely recording by managers.
- Risk of absence management processes not being completed in a timely manner as per policy due to the number of redeployed staff including managers moving around the Trust.

A MODERN AND PROGRESSIVE WORKFORCE – APPRAISALS

Executive Lead: Director of HR & OD

CQC Domain: Well-Led

Strategic Objective: People



Appraisal – Assurance, Actions In Place To Improve and Risks

Points for assurance

- E&F – OD work has been initiated to identify and address the underpinning issues within E&F and where these impact on appraisal quality and completions.
- Trustwide – Appraisals continue to be a focus of attention.
- Surgery – rates have increased again this month, but are still below the target at 84%. Remains an area of consistent scrutiny within the division and plans for completion of appraisal are discussed with CBU's at the monthly CBU PRM meetings.

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.
- 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

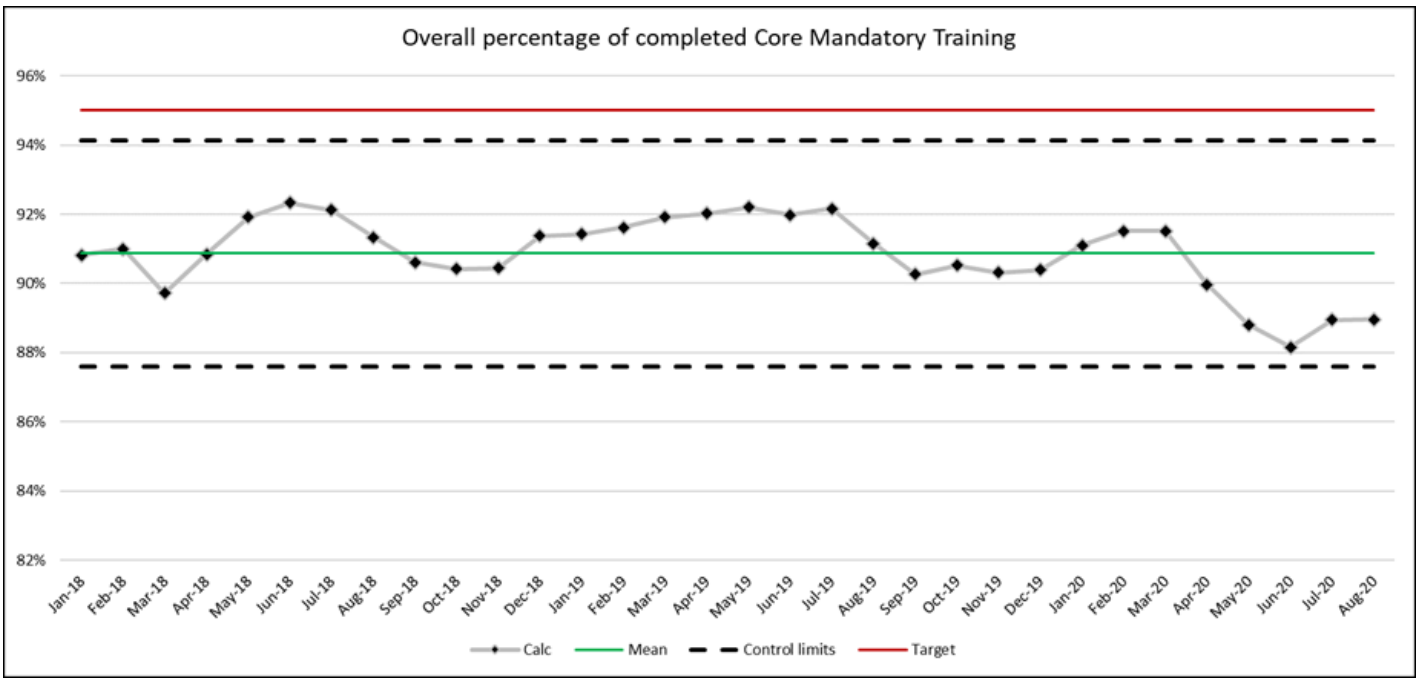
- Appraisal rates continue to fall due to a second surge and/or winter pressures

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 showed a consistent pattern around 90% compliance through to the start of COVID. Data from Lincolnshire Partnership Foundation Trust (LPFT) and Lincolnshire Community Health Services (LCHS) show that their compliance rates are in the same overall range.

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

Continued focus on IG training compliance to enable the Trust to achieve accreditation.

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 packages
- 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 are looking at 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

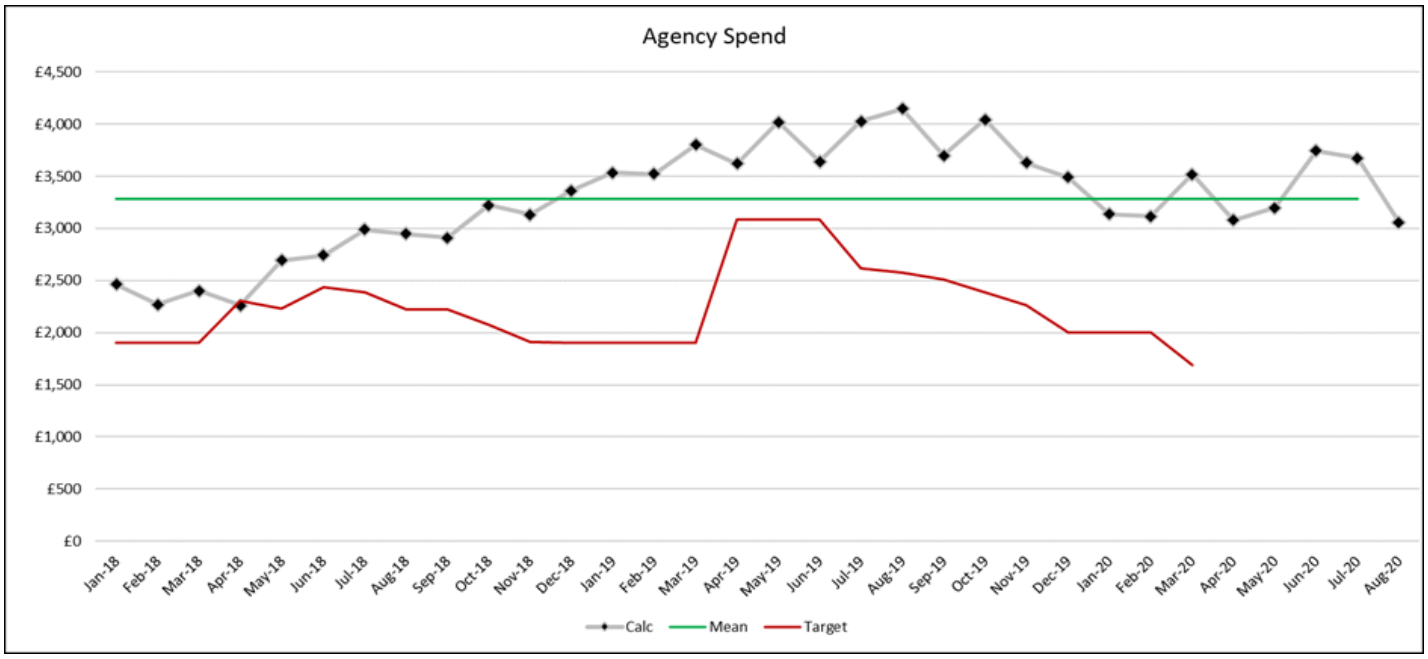
- Managers not releasing staff to undertake training as part of the restoration/recovery phase
- Failure of social distancing in classroom setting leading to potential social isolation requirement for larger numbers of staff, as occurred recently at Hillingdon Hospital.
- A second spike in Coronavirus
- 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

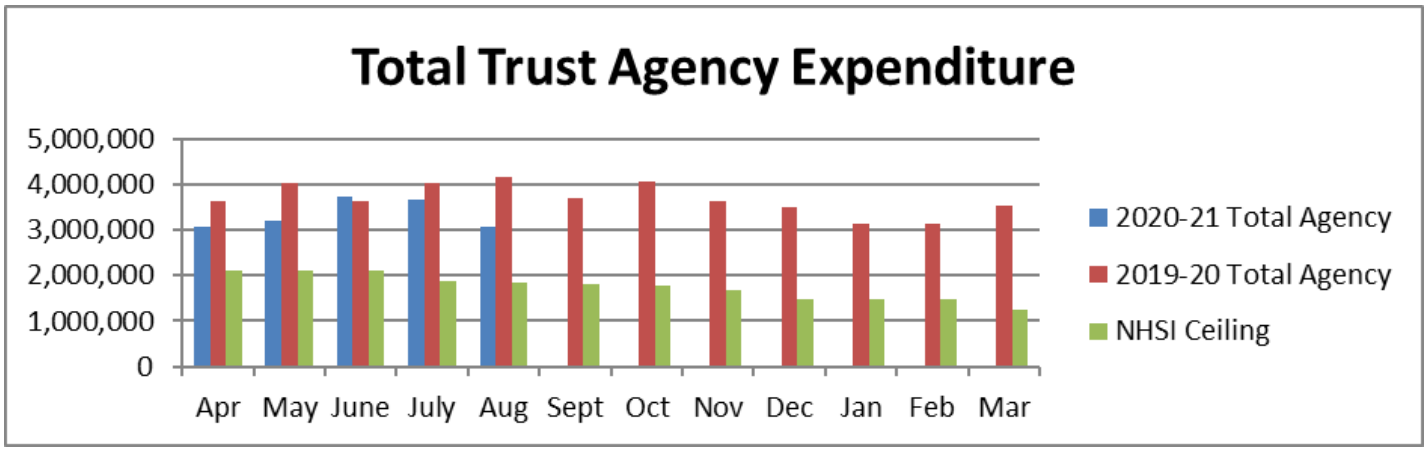
Strategic Objective: People



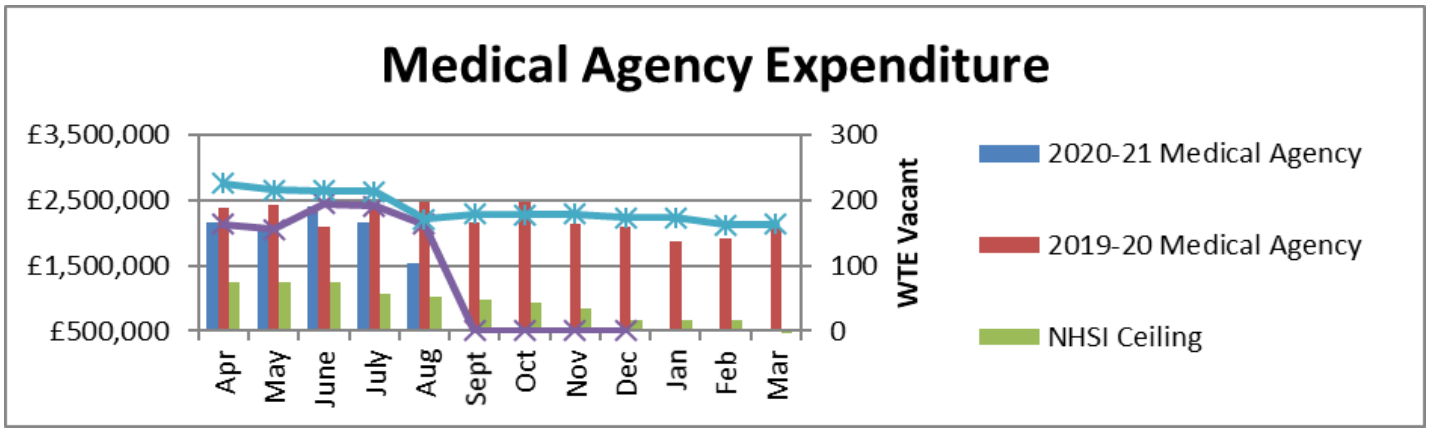
Challenges/Successes

Pay is £11.2M adverse to plan, including £4.9m of additional pay costs related to Covid and £3.9m of notional expenditure in relation to additional employers' pension contributions, which NHS England did not take into account when setting the block payment.

However, there is notable adverse variance in substantive staffing which is being driven by a marked difference in actual substantive staff in post to plan at M5. Whilst we have seen successes over a number of months in terms of medical recruitment in particular, there is not a corresponding reduction in bank and agency staffing costs and this presents an on-going risk.



The monthly run rate for total agency spend in July (M4) was just below 19/20 levels, but is significantly below in August (M5). We are of course well above the NHSE/I ceiling.



The Requested shifts were down from July's 4730 to 3712 and the agency booked hours were down from 28,519 to 19,698 in August. This is a significant reduction in agency hours and correlates with the reduction in agency spend and increased bank usage. The agency spend in august reduced to circa £1,794,087 (pre finance adjustments) from £2,393,198 in July. This is the lowest agency spend since June 2018.

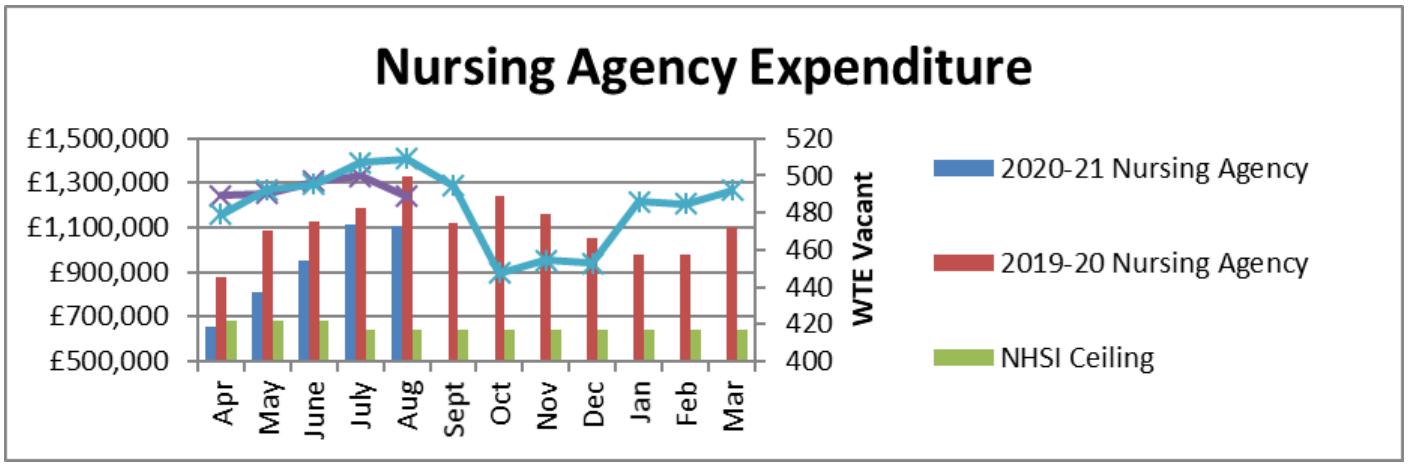
Agency bookings account for 61.5% of August's total with the remaining being split with 36.4% from internal bank and 2.1% from Regional bank, this growth in bank usage has taken our bank ratios to the highest they have been in at least 18 months.

Regional bank also continued to book and have now booked an overall 2,428 hours since the beginning of April 20

The positive work on commissions control continues in August with a further £7,394.30 savings. In the last 12 months we have saved £125,980 in commissions alone.

DE savings for the month of August were at £321,700 taking the last 12 months total to £4.34million. The DE efficiency was at 100% with only no shifts being VAT applicable, This is the first time since the DE model was introduced that we have hit 100%

We have no off framework bookings at present.



Pay Costs – Assurance, Actions In Place To Improve and Risks

For Assurance

- Divisional MI information for medical agency is to a high standard and is increasingly being used.
- Monthly medical agency spend in August was the lowest monthly figure since June 2018
- Nursing agency costs were controlled during lower bed occupancy levels.
- Trend of reducing off-framework nursing agency use.
- The Director of Nursing has commissioned a refreshed forum for transforming the nursing workforce with an early focus on nursing agency use and cost.
- Scientific, AHP and other agency costs continue on downward trend.

Further Improvement

- We still spend significantly above the NHSE/I monthly ceiling**.**
- Recruitment Improvement – see Vacancy Rate Section.
- Medical agency master vend currently undergoing collaborative procurement and will further support the positive work on contractual commission levels.
- Plan to move to single position numbers in ESR to further support triangulation of associated agency costs with vacant posts.
- Capitalising on benefits of managed and collaborative Medical Bank.
- A number nursing agency improvement work streams are in train including enhanced divisional MI, new SoP for Agency use, full review of rostering practice, review of overtime and bank, increasing lower tier framework nurse agency volumes to further reduce reliance on off frame work agency use and longer term temporary nursing staffing plans in place to avoid higher premiums of shorter lead time requests.

Risks

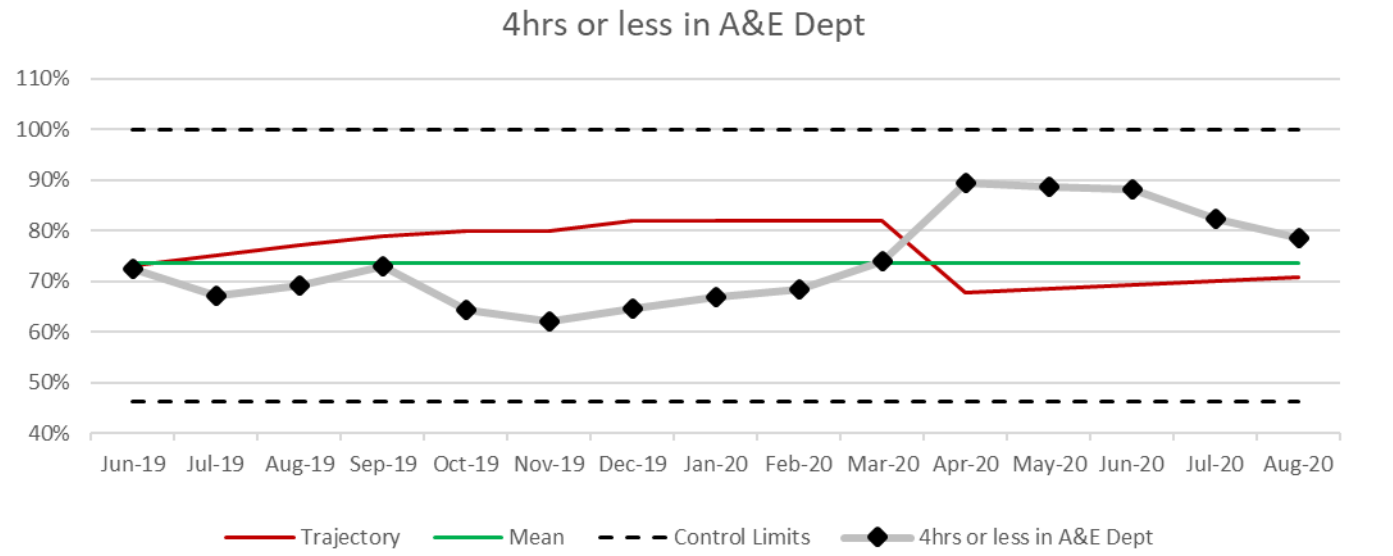
- Continued delay in international starts due to COVID.
- Direct COVID activity and expenditure is continued.
- Current run rate will breach NHSE/I cap by greater than 150% limiting UoR Assessment Rating

IMPROVE CLINICAL OUTCOMES – A&E 4 HOUR WAIT

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services



Challenges/Successes

- The Urgent Care Centres and Emergency Departments attendances continued to increase throughout August.
- Following the transition of Grantham from an Emergency Department to a 24 hours Urgent Care Treatment Centre, attendances have continued to increase. August treated 2591 compared to 1887 in July. This represents an increase of 704 attendances, which equates to a 27.18% increase. The GDH increase needs to be seen within the context extended opening hours.
- The change in status at Grantham has led to a worsening performance with type 1 activity.
- August ED type 1 and streaming was 16,797 attendances verses 15,269 in July. This represents a 9.1% increase. By site LCH experienced a 5.16% increase in attendances, PHB saw an increase of 6.66%. August overall outturn for A&E type 1 and primary care streaming delivered 78.46% against an agreed trajectory of 70.92%.
- This demonstrates a further deterioration in performance. 3.91% compared with July outturn, although this is still an improvement against trajectory of 7.54%.
- By site, for August, LCH delivered 72.24%, an 4.56% deterioration on July's performance, PHB delivered 78.86%, a deterioration of 5.55%. GDH achieved 97.61% which was a deterioration of 1.54% compared to July. This includes type 1 and type 3.
- The highest days of delivery by the Emergency Departments only was 1st August when PHB delivered 86.84% and when LCH achieved 81.31%. The performance uplift from the UTCs was 5.14% at PHB (91.98%) and 6.46% at LCH (87.77%). Conversely, the lowest day of delivery for both Emergency Departments was 22nd August, when LCH only achieved 46.52% and PHB only achieved 44.12%. The performance uplift from the UTCs activity was 19.26% (63.38%) and 18.88% (65.40%) respectively.
- Streaming at PHB experienced a slight improvement in performance, 94.80% in August compared to 92.10% in July
- The deterioration should also be seen in the context of increased non-elective admissions and reduced discharges thus leading to a reduced available bed base.

Actions in place to recover:

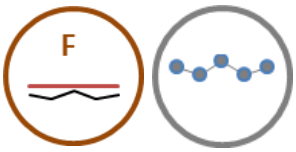
- Those process improvements, not affected by volume, have been reflected in the Restore phase of COVID management and where identified as more transformational, they have been further developed through a re-energised local improvement and delivery structure and feature heavily within phase 3 - Recovery.
- 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.
- Work is in train to ensure that out of hours staffing is fit for purpose. This work is focusing on staffing numbers, skill sets and behaviours.
- As part of recovery, a bid for NHSe/i capital monies was submitted and approval to proceed obtained. This will see an increased ED footprint and the extension of primary care streaming at both LCH and PHB.

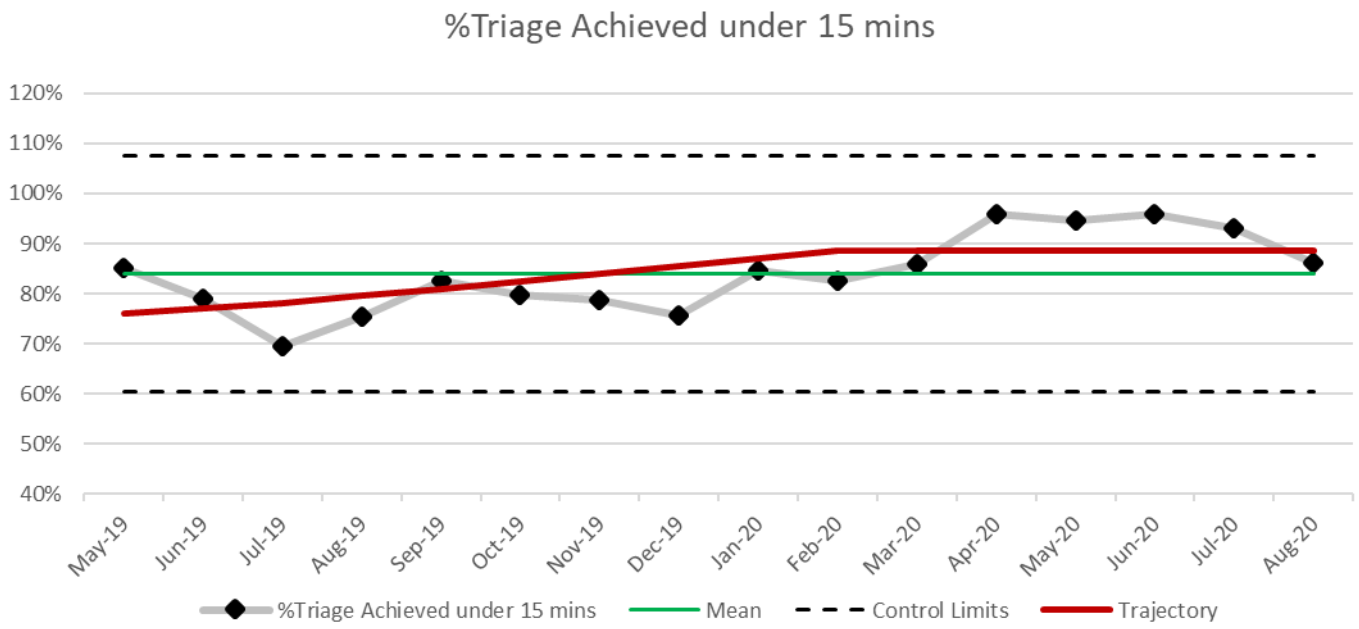
IMPROVE CLINICAL OUTCOMES – %TRIAGE ACHIEVED UNDER 15

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services





Challenges/Successes

- Triage under 15 minutes deteriorated again in August by 6.91%. 86.12% in August verses 93.03% in July. The balance between managing the blue pathway and green pathway continues to be problematic, especially at times of increased volume of patients in the departments
- Sickness has led to occasional gaps in maintaining the second triage stream.
- Measures are in place to ensure this key metric continues to achieve its improvement trajectory toward 100%.
- This metric is also 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:

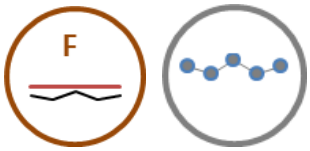
- With a return to Pre-COVID19 levels of attendances, the focus must remain on achievement. This will be monitored and actioned locally by the newly appointed band 8a ED Performance Managers and the recent appointments of 2 x 8a Clinical Leads (Nursing).
- Clear action and recovery plans are scrutinised at the three times daily Performance and Capacity Meetings including any staffing deficits that may impact on the ability to maintain a second triage stream both in and out of hours.
- Any gaps are escalated immediately to the Deputy Divisional Nurse, Urgent and Emergency to resolve and restore.

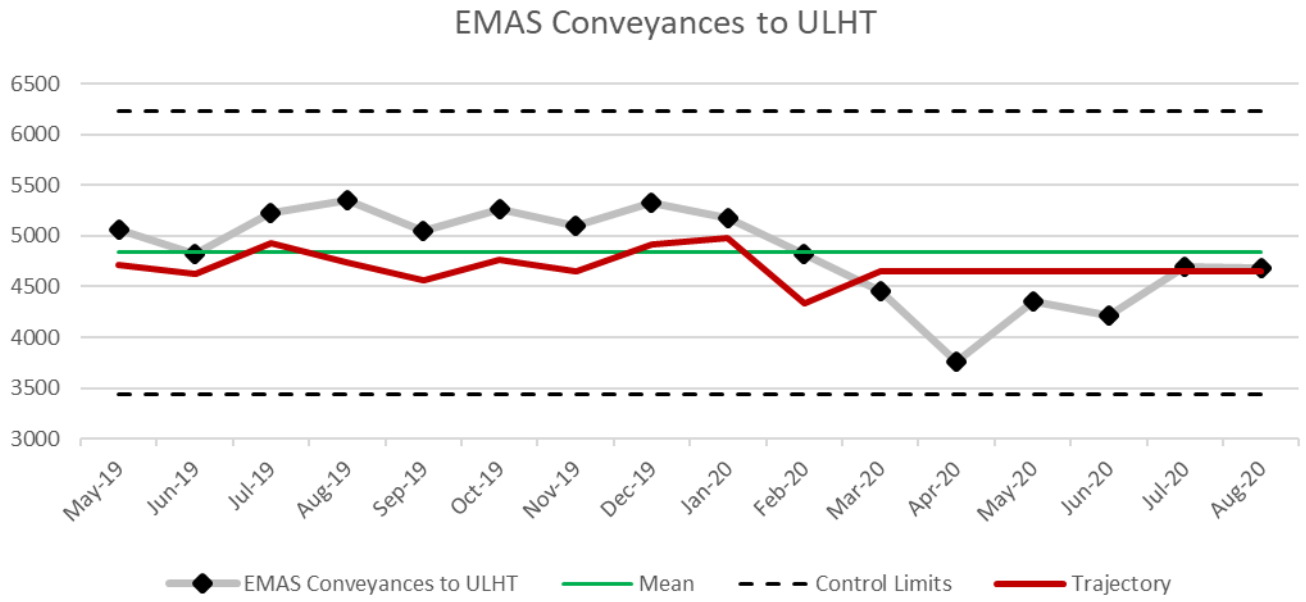
IMPROVE CLINICAL OUTCOMES – AMBULANCE CONVEYANCES

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services





Challenges/Successes

- Ambulance conveyances for August were 4688 compared to 4700 in June. This represents a 0.26% reduction in conveyances across all sites.
- By site, LCH conveyances were 2735 in August compared with 2835 in July, a 3.53% decrease, PHB was 1910 in August compared with 1821 in July, a 4.66% increase. The increase at PHB and the corresponding decrease at LCH is as a result of the load share process put in place to reduce the burden on LCH as a result of the temporary changes made to GDH. GDH continued to experience a reduction in conveyance 43 in August compared to 44 in July.
- The number of conveyances to LCH are at pre-covid levels but the conveyances to PHB are still 9% below the numbers experienced pre-covid.
- The continued challenge, as we move from restore and into recovery, whilst maintaining the segregated pathways, will be managing our overall conveyances. We are working with the System to reduce our overall attendances and conveyances by ensuring all admission avoidance pathways are robust and communicated clearly. More work is needed to clarify the benefit of EMAS introducing 'Hear and Treat' and 'See and Treat'.

Actions in place to recover

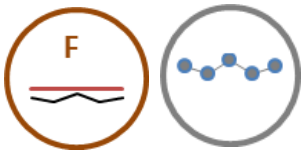
- Restore and Recovery plans being put in place by the Trust for urgent and emergency care (UEC) include patients being appropriately clinically managed through alternative streams to avoid large numbers of patients in the emergency department leading to possible delays in handover.
- An increase to 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 Trusts UEC Restore and Recovery plan is the understanding and transparency of the Restore and the Recovery plans being developed and agreed by our partners in EMAS, LPFT, ASC and LCHS and how these plans reduce the burden placed upon the Acute Trust.

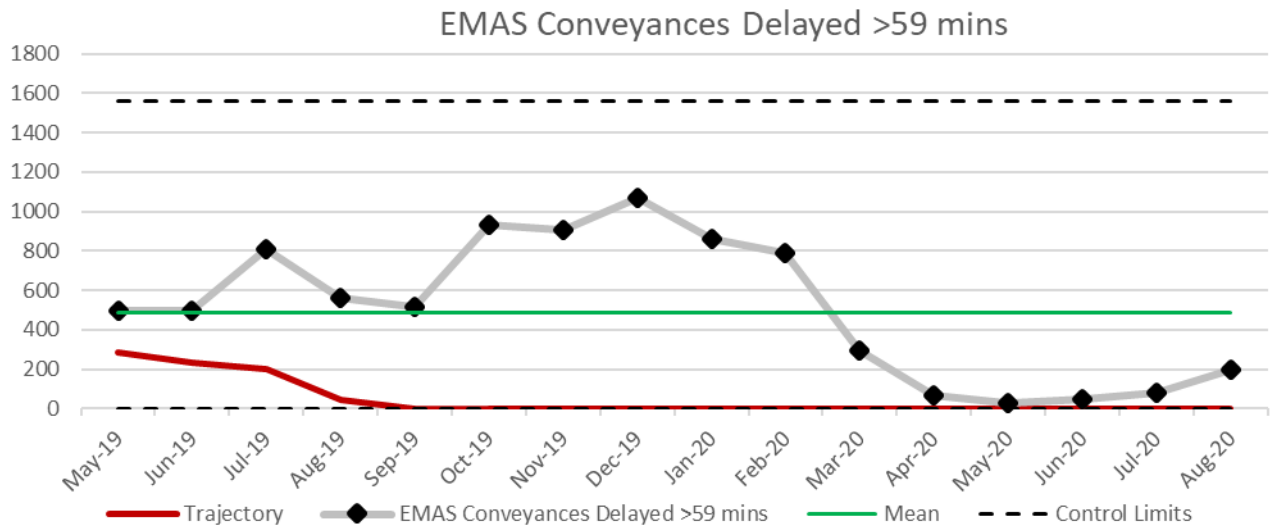
IMPROVE CLINICAL OUTCOMES – AMBULANCE HANDOVER >59

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services





Challenges/Successes

- During August there were 194>59-minute ambulance handover delays. This is an increase of 113 compared to July. This represents a 57.22% increase in >59-minute ambulance handover delays. A focus has been applied to understanding this. NHSe/i are supporting with improvement strategies.
- LCH had 141>59-minute ambulance conveyances in August compared with 63 in July. This represents a 55.32% increase in August compared to July. PHB had 52>59-minute ambulance conveyances in August compared with 18 in July. This represents a 65.39% 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 and the pattern of conveyance.

Actions in place to recover

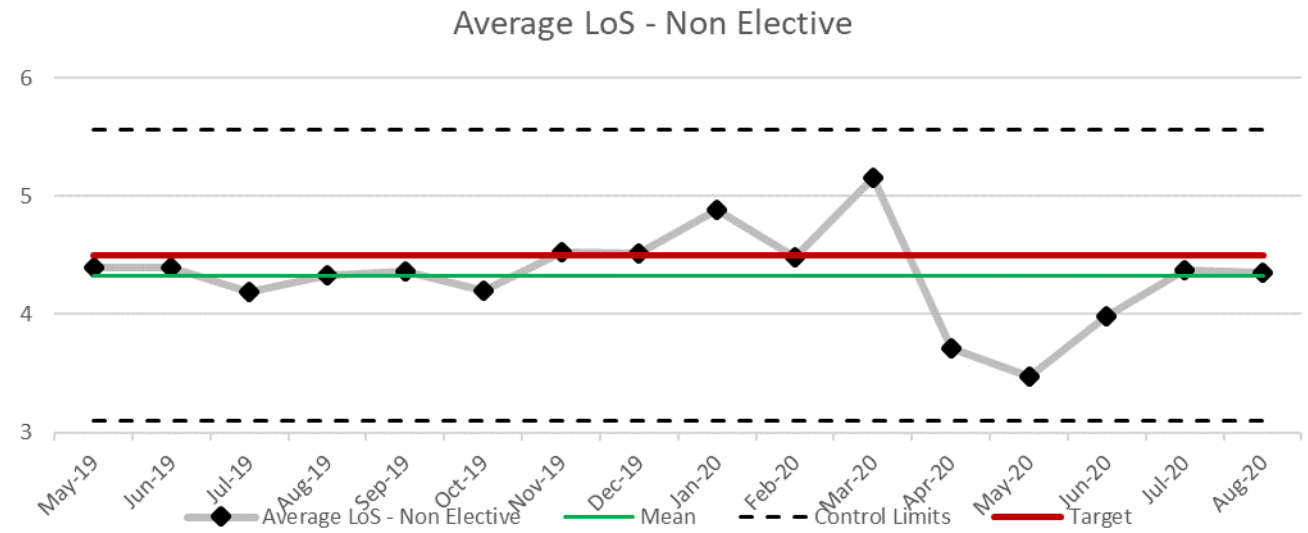
- RAT has been reinstated as well as maintaining a level of segregation for suspected COVID patients.
- A capital bid of £2m for PHB and a bid of £15m for LCH to increase the footprint of both the Emergency Departments (LCH and PHB) were submitted via NHSe/i to the Department of Health and have been approved. The focus of these bids were to allow an increased ability to respond to the timely and safe Ambulance handovers and improve outward flow from the Emergency Departments
- Work continues within the System to reduce the overall ambulance conveyances to ULHT through implementing robust alternative pathways. The webinar that took place on 12th August hosted by NHSe/i had 120 representatives from EMAS as well as Senior Leaders from within the Lincolnshire system.

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 slight improvement during August, delivering 4.35 ALOS compared to 4.37 compared in July. This represents a positive variation of 0.02 days.
- During August the numbers of patients with a LLOS decreased from 82 in July to 81 in August. A reduction of 1 patient.
- The work of the system wide discharge cell continues to address inequalities in access for both Community care and adult social care. ULHT now has a substantive senior leader within this structure. This post ensures robust relationships and positive outcomes both for our patients and Teams.
- 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.
- Non elective admissions increased slightly in August by 3.92%. 3016 in August compared to 2898 in July. We are still below pre-covid levels. An August 2019 elective comparison to August 2020 shows a 16.23% decrease in non-elective admissions. 3600 NELA in August 2019 verses 3016 in August 2020.
- G&A core bed availability within ULHT has reached its tolerance at PHB and LCH. Escalation beds are now in use consistently.

Actions in place to recover

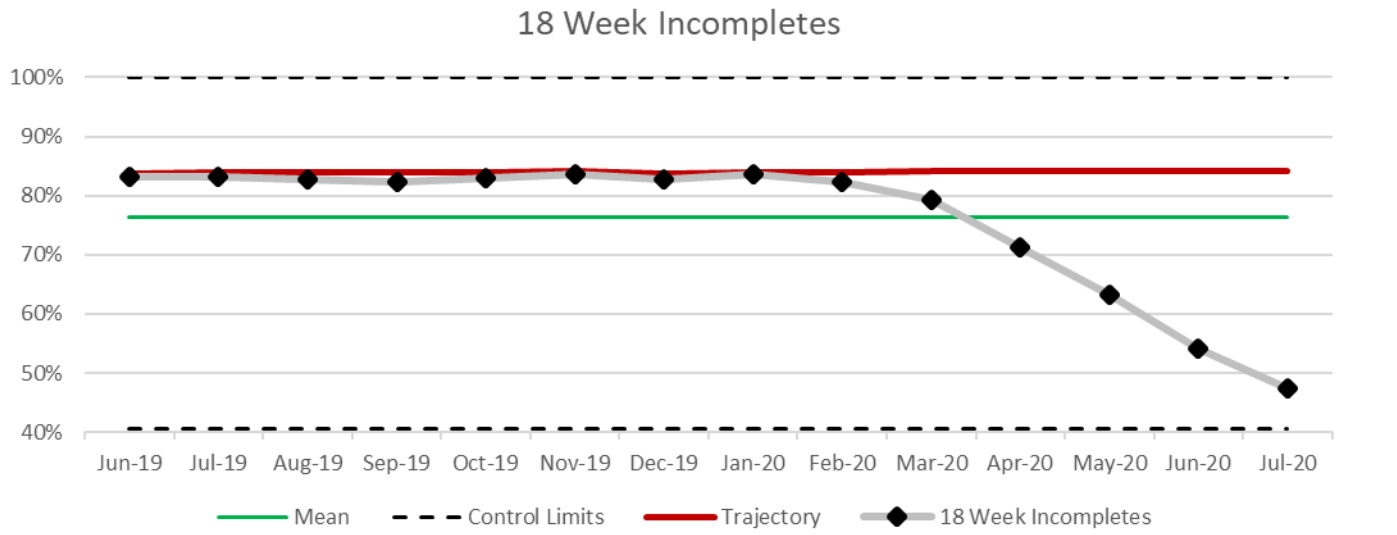
- Multi-agency discharge meetings continue take place daily, seven days a week. Line by line reviews take place against each patient on pathway 1,2 and 3. Discharge plans are scrutinised. Clear expectations are agreed within the System to protect agreed discharge plans.
- Weekly multi-agency long length of stay meetings for each hospital site in place to support more complex patients through their discharge pathway.
- Patient swabbing agreement has been reviewed to allow more flexibility in terms of valid swab result timescales to reduce >72-hour delays to discharge.
- System wide discussion and agreement has been reached to secure the multi-agency Discharge Cell continues through restore and recovery and ULHT have substantively appointed a senior leader to fulfil this role.
- More work is required in respect of pathway zero. This work will be led by the Deputy Chief Operating Officer for Urgent Care in collaboration with the Divisional Clinical Business Units.

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.

July saw RTT performance of 47.33%, -6.75% worse than June.

Maxillo-Facial Surgery, Orthodontics and Oral Surgery is the lowest performing specialty, from 28.95% last month to 20.63% (-8.31%). Neurology has deteriorated this month with a 5.97% decrease from 51.33% last month to 45.36% in July.

The five specialties with the highest number of 18 week breaches at the end of the month were:

- Ophthalmology - 4017 (Increased by 869)
- ENT - 2312 (Increased by 473)
- Trauma & Orthopaedics - 2221 (Increased by 756)
- Maxillo-Facial Surgery + Orthodontics + Oral Surgery - 2100 (Increased by 220)
- Gastroenterology - 1597 (Increased by 35)

Actions in place to recover:

As detailed above, performance across all specialties continues to decline. Ophthalmology, ENT and Trauma & Orthopaedics have seen the largest decrease in performance.

The re-introduction of routine elective work for both admitted and non-admitted is now being progressed in line with recovery plans.

One of the largest detrimental impacts on General Surgery and Gastroenterology performance is the standing down of the Endoscopy service for routine patients. The Endoscopy service re-opened on 6th July, with the exception of services at Louth, which is scheduled to re-open on 7th September, and is

currently working on the backlog of Cancer patients. It is anticipated that Cancer performance will be recovered to pre Covid levels by the end of November. Endoscopy has already cleared its backlog of 62+ and 104+ patients and is now booking live.

Specialties achieving the 18 week standard for July were:

- Medical Oncology 100%

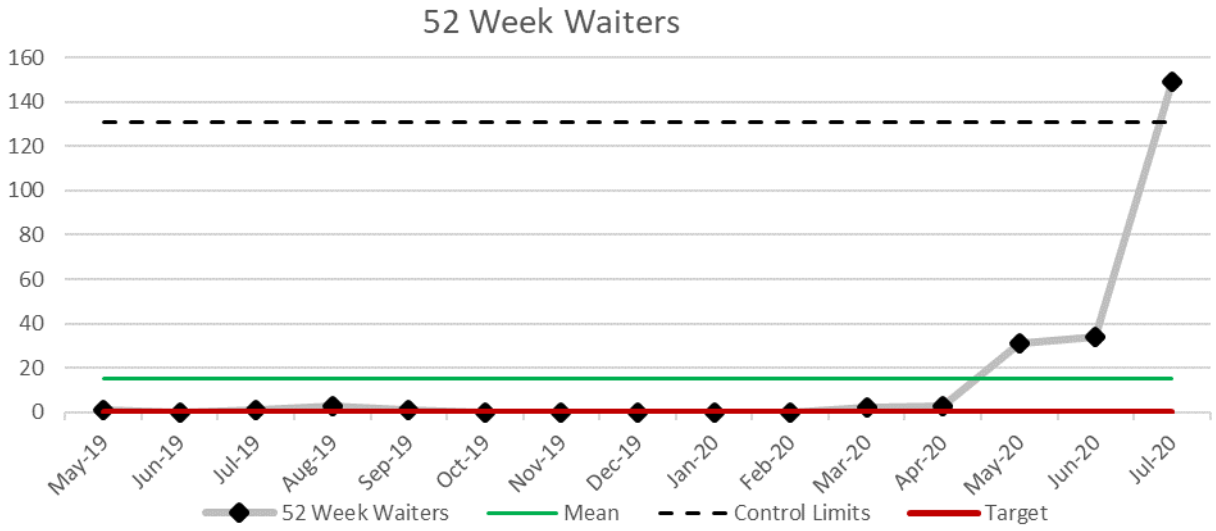
This is due to the continuation of Cancer services throughout the pandemic.

IMPROVE CLINICAL OUTCOMES – 52 WEEK WAITERS

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services



Challenges/Successes

The Trust reported one hundred and forty-nine incomplete 52 week breaches for July end of month.

Covid Capacity	139
Capacity	1
Delay in Process	3
Incorrect data entry	5
Prior Approval	1

Root cause analysis 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.

Due to the COVID19 pandemic necessitating the standing down of routine services, and also the reduction in capacity due to social distancing as services have started to recommence, it is anticipated that there will be an increased number of breaches declared each month.

Actions in place to recover

Work is continuing within services for Cancer and Urgent patients.
Recovery plans continue to be discussed and revised; accounting for a changing environment.
Divisions are reviewing pathways to look at ways to enable provision of routine services.
Across the Trust outpatient services continue to use all available media to consult with patients.

Data for July is below.

Start W/c	29/06/2020
End before W/c	03/08/2020

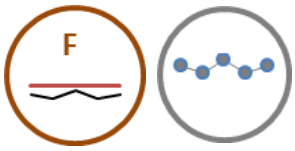
Average Appointments per week (all media)	9316.4	
Face to Face	4536.2	49%
Telephone	4677.4	50%
Telemedicine (Video)	102.8	1%

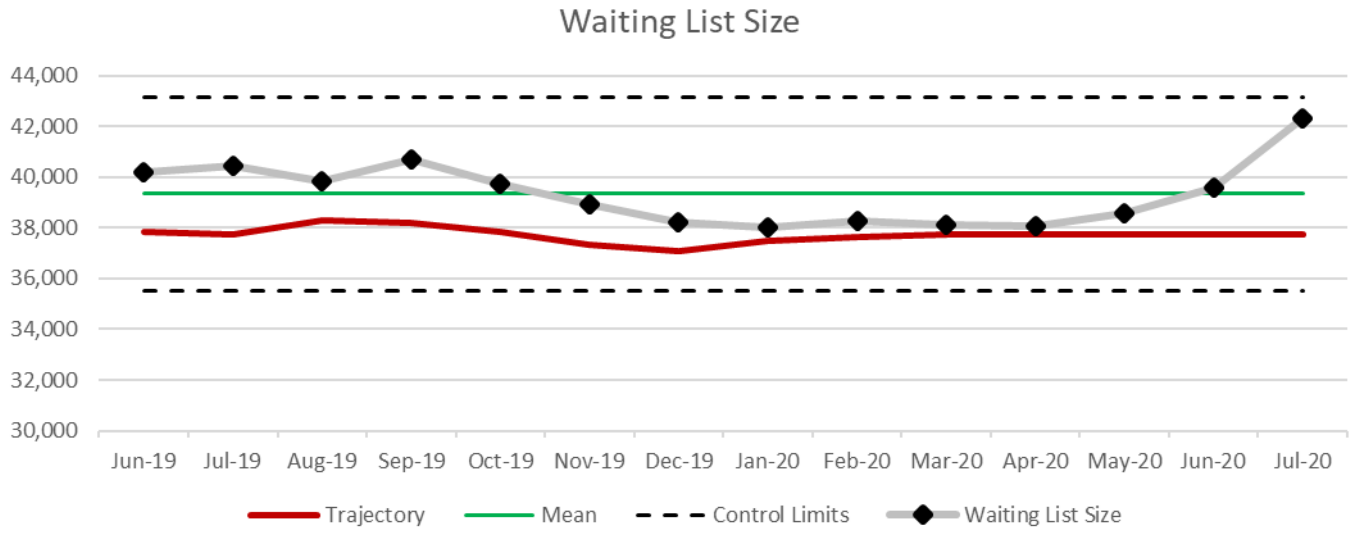
IMPROVE CLINICAL OUTCOMES – WAITING LIST SIZE

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services





Challenges/Successes

Overall waiting list size has increased from June, with July total waiting list increasing by 2725 to 42,306. The incompletes position for July is now approx. 3274 more than the March 2018 (39,032) target.

The top five specialties showing an increase in total incomplete waiting list size from June are:

- Trauma & Orthopaedics + 450
- Ophthalmology + 348
- ENT + 277
- Dermatology + 268
- General Surgery + 259

The five specialties showing the biggest decrease in total incomplete waiting list size from June are:

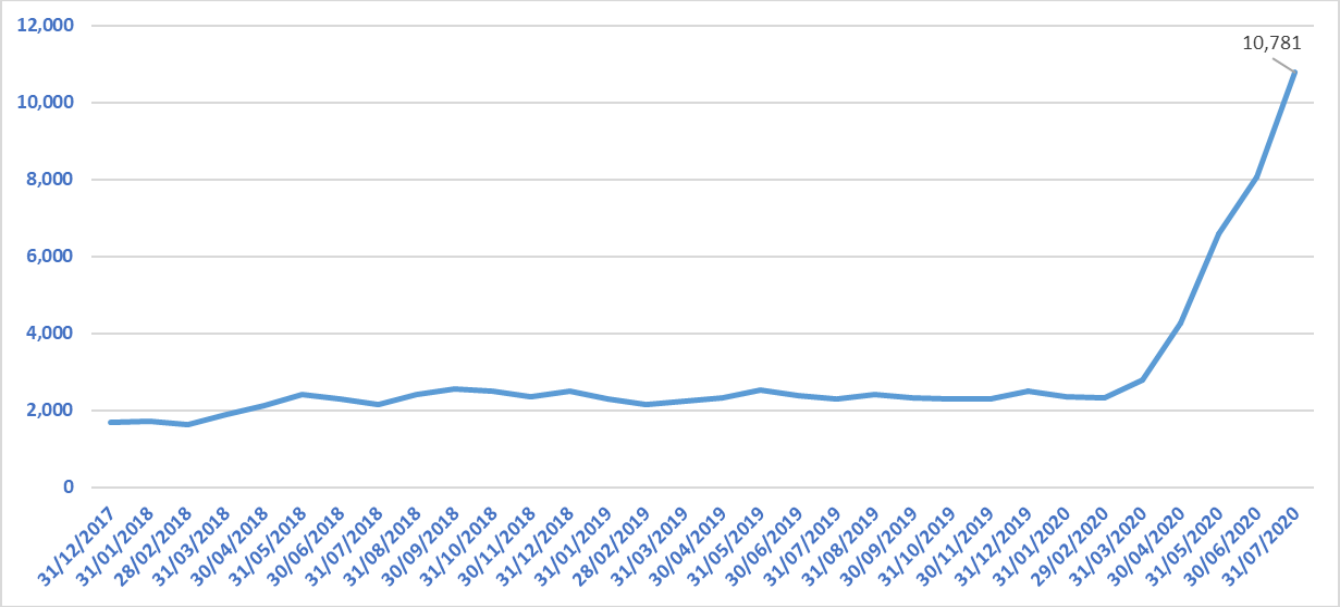
- Paediatrics - 40
- Transient Ischaemic Attack - 28
- Paediatric Cardiology - 13
- Endocrinology – 12
- Diabetic Medicine - 11

Actions in place to recover

The longest waiting patients are tracked and discussed at the weekly PTL meeting. June to July saw an increase of patients waiting over 40 weeks, +655, with Ophthalmology (+132) showing the largest increase. Five specialties reduced their position compared to last month, with Gastroenterology showing the best improvement of -11 patients from last month.

The chart below shows progress up to 31st July, with an increase of 2724 patients from June. The largest increase was seen in Ophthalmology, +706. The largest decrease of -17, being in Endocrinology.

Total Number of Incomplete Patient Pathways at 26 Weeks and Above for ULHT by Month

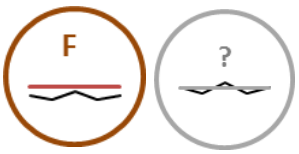


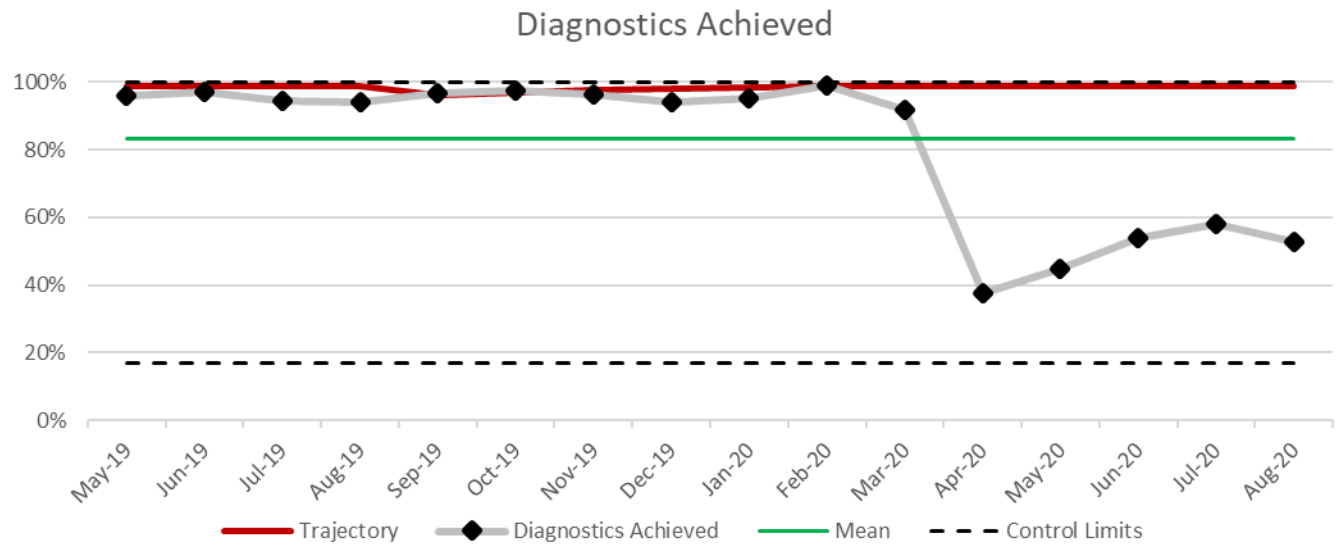
IMPROVE CLINICAL OUTCOMES – DIAGNOSTICS

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services





Challenges/Successes:

August performance was 52.81% which was a slight deterioration on July 57.89%

Actions in place to recover:

Endoscopy is undertaking a recovery project where we are looking to maximise all available capacity as well as utilising outsourcing for 12 weeks and weekend working. This will allow endoscopy to be at 100% of pre Covid capacity by October. As the new guidelines for IPC relating to endoscopy procedures will not come into effect until October November due to booking restraint, we will see an additional improvement on our backlog as a step change around that time.

Audiology are in negotiation with Specsavers in securing capacity within their shop to see patients that would normally be seen by United Lincolnshire hospitals, this will massively reduce the backlog within audiology if Specsavers are able to support us. Concerns have been raised as ENT are separating out the Audiology requests from the joint clinics for paeds and making them into separate diagnostics requests. This would now be under the DM01 as before ENT patients did not come under the DM01. Before validation this could add 1000 patients to the DM01.

CT although very close to pre Covid capacity we have had additional demand from the conversion of colonoscopy is to CTCs , this work will be picked up by the Grantham CT scanner (green site). Additional mobile CTs are in place to deal with cancer and outpatient demand. We are still having difficulties in some people attending their appointment. We have a backlog of cardiac patients which we are working on with Cardiology and Radiology to come up with capacity.

MRI although very close to pre Covid capacity 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.

Neurophysiology have been working at 50% staffing due to vacancy, 1 post was filled pre Covid but was unable to arrive due to the pandemic. Both posts are now filled and 1 member of staff is now isolating and will be joining the team next week. A locum has also started this week so capacity will be greatly improved going forward into September.

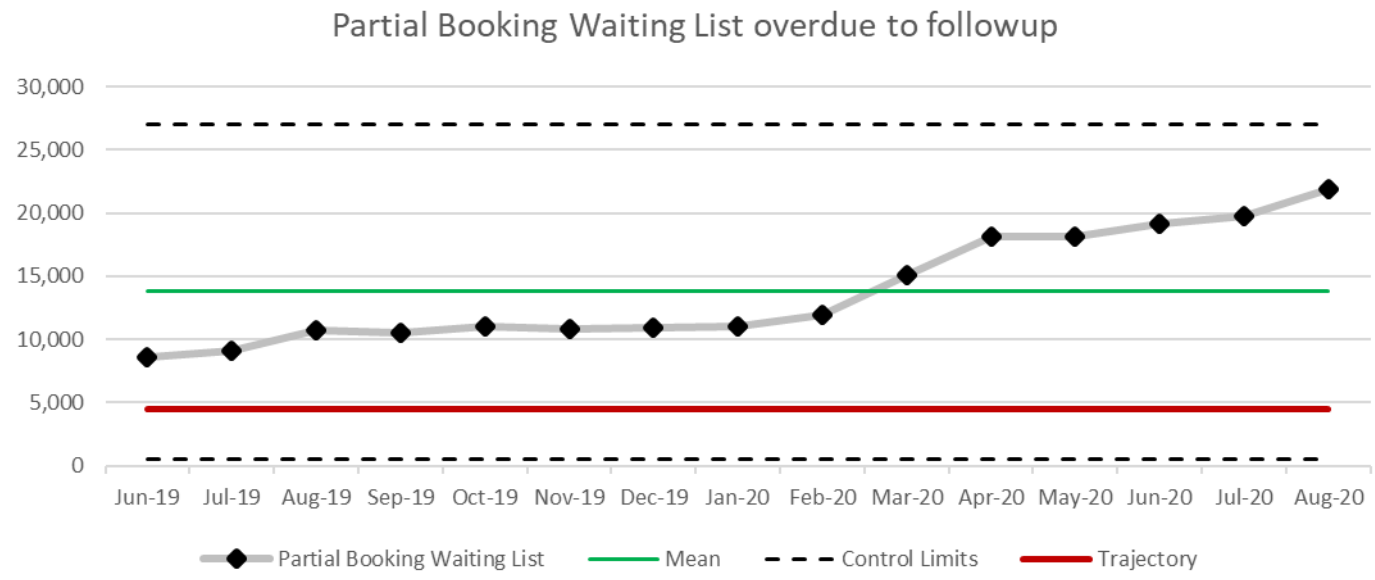
The Operational Manager has been asked to lead on making plans for Audiology, Neurophysiology and Urodynamics looking at what is needed to get to pre Covid capacity and then what is needed to reduce the backlog. We are looking at outsourcing and new ways of working.

IMPROVE CLINICAL OUTCOMES – PARTIAL BOOKING WAITING

Executive Lead: Chief Operating Officer

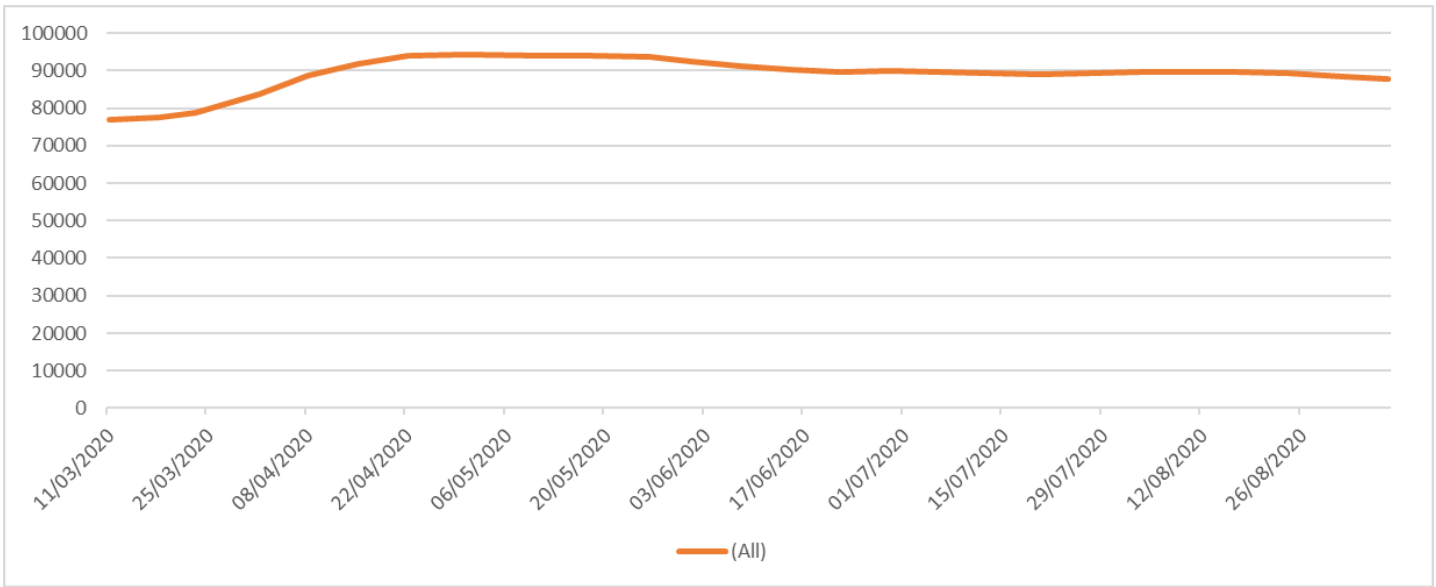
CQC Domain: Responsive

Strategic Objective: Services



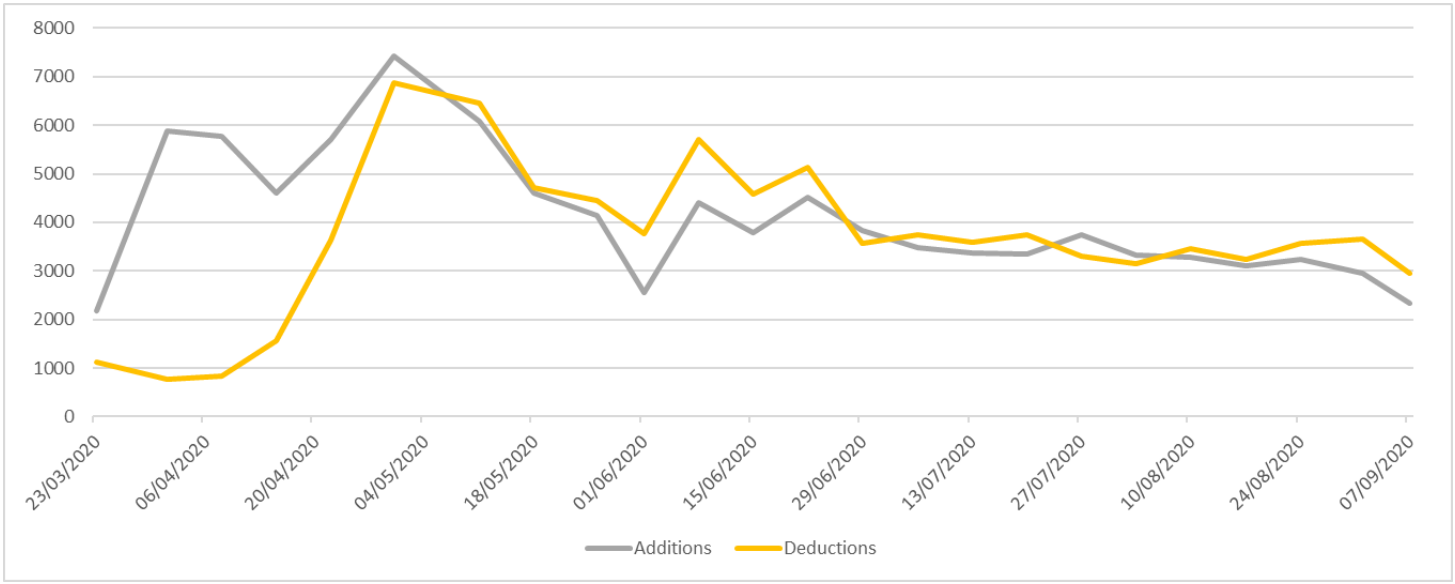
Challenges/Successes:

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 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 been asked to submit their plans to increase activity back to last year's activity levels within outpatients. The actions are challenged at a weekly PBWL review meeting. We are monitoring and challenging at these meetings to ensure deductions are outrunning additions, leading to the reduction in overall waiting list size.

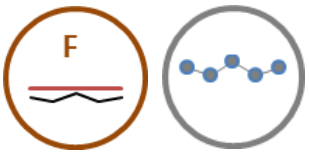


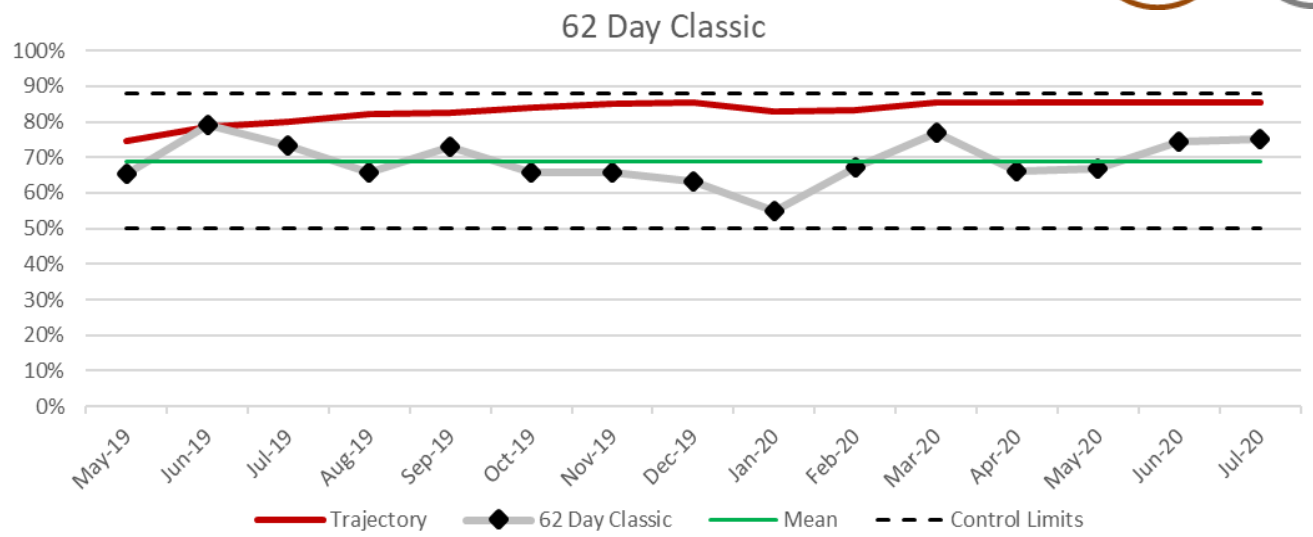
IMPROVE CLINICAL OUTCOMES – CANCER 62 DAY

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services





Challenges/Successes

In July we maintained (+0.5%) our 62 Day Classic performance compared to June, at 75.0% and putting us just below the national average (78.4%)

Early indications are that our August 62 Day Classic performance will be circa 70%.

The impact of COVID-19 on our cancer pathways remains visible though the number of patients over day 62 and 104 is steadily reducing. Since 22 July the 62 day backlog has reduced from 441 patients down to 293 as of 10 September, with a trajectory to return to our pre-COVID levels of below 100 patients by the end of November.

The Trust also met the NHSE/I requirement that all patients waiting 104 days and over to be seen by the 21st August 2020 and that the number of patients waiting over 62 days should be reduced by 20% by that date.

Actions in place to recover:

Meetings are held three times a week, to review all patients over 104 days, led by the CSS Managing Director and attended by senior Divisional staff. The cohort of patients being discussed in these meetings is being extended to include patients those in the 50 – 62 day range as well, so that the chance of them reaching 104 is minimised.

The Grantham Green Site is running 4 theatres for 5 days a week with a view to increasing this to 6-7 days; Lincoln is working with 2 theatre lists per day for 5 days a week and Pilgrim with 1 theatre lists per day, 5 days per week.

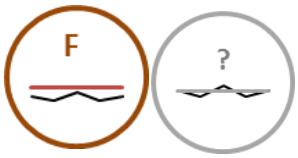
The Endoscopy Units have cleared their 62/104 backlogs and are now live booking cancer patients.

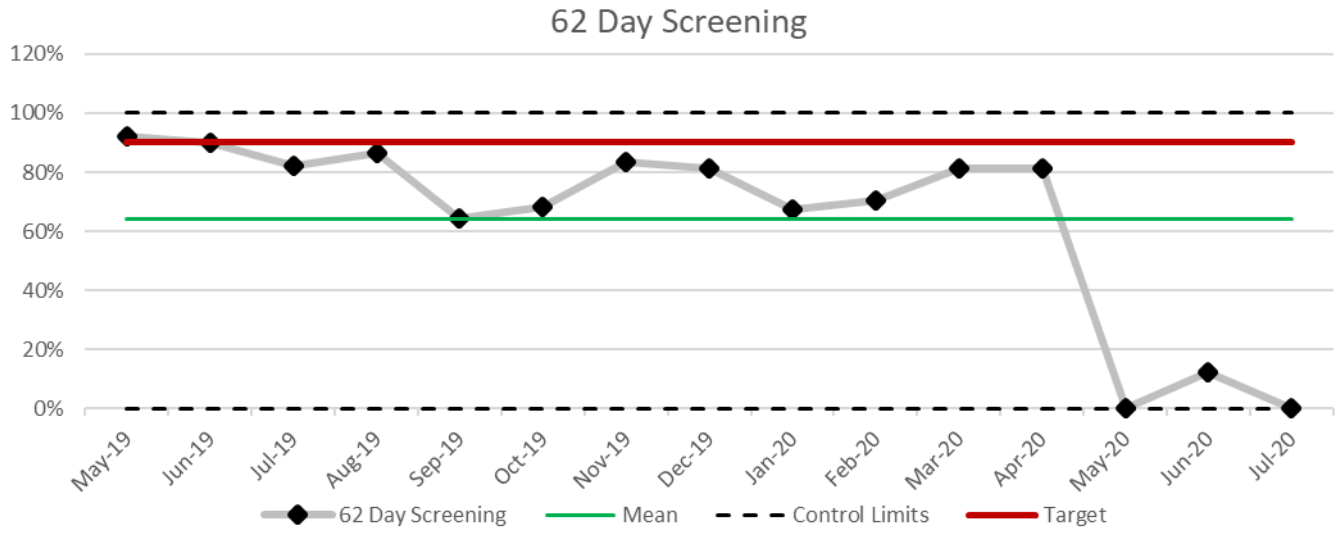
IMPROVE CLINICAL OUTCOMES – CANCER 62 DAY SCREENING

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services





Challenges/Successes:

The failure of the 62 Day Screening standard is due to surgery being the main treatment modality for this group of patients and therefore heavily impacted by the stopping of surgery during COVID-19 and later capacity restrictions. This standard's average national performance, which is usually 80-90%, dropped to 12.9% in June and only at 25.4% in July. This poor performance is expected to continue as the backlog is cleared and awaiting the Screening services to recommence fully.

Actions in place to recover:

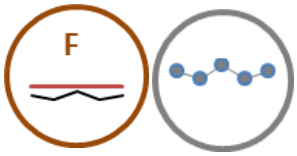
Review of theatre capacity to ensure sufficient to meet backlog demand.

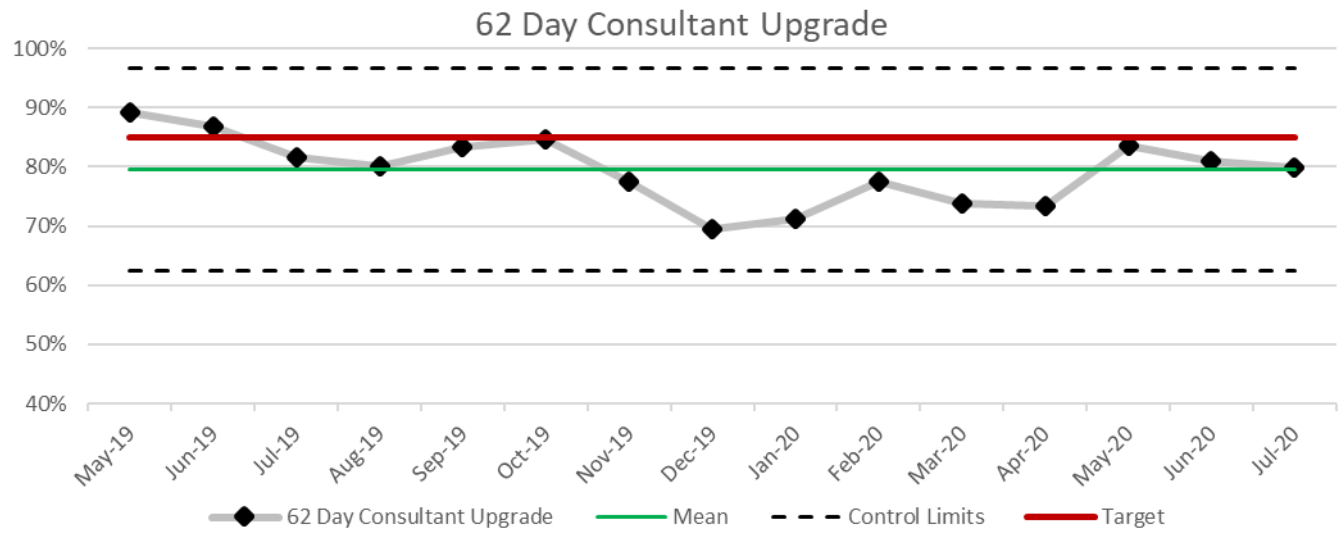
IMPROVE CLINICAL OUTCOMES – CANCER 62 DAY UPGRADE

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services





Challenges/Successes

The national CWT upload and reporting system had significant changes made prior to the July upload and an error has been found in the way the national system has calculated waits for Upgrade patients, in one instance seemingly adding 655 day on to a patient's wait. We are waiting to see if this will materially change our performance, though expectation is not as this standard has been impacted by the same causes that affected our 62 Day Classic standard (mainly diagnostic and theatre capacity)

Actions in place to recover:

In anticipation of the new, national, single 62 Day standard (incorporating the current three 62 Day standards), this cohort is now included as part of the weekly Cancer PTL review meeting with the Divisions.

The Grantham Green Site is running 4 theatres for 5 days a week with a view to increasing this to 6-7 days; Lincoln is working with 2 theatre lists per day for 5 days a week and Pilgrim with 1 theatre lists per day, 5 days per week.

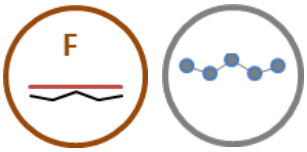
The Endoscopy Units have cleared their 62/104 backlogs and are now live booking cancer patients.

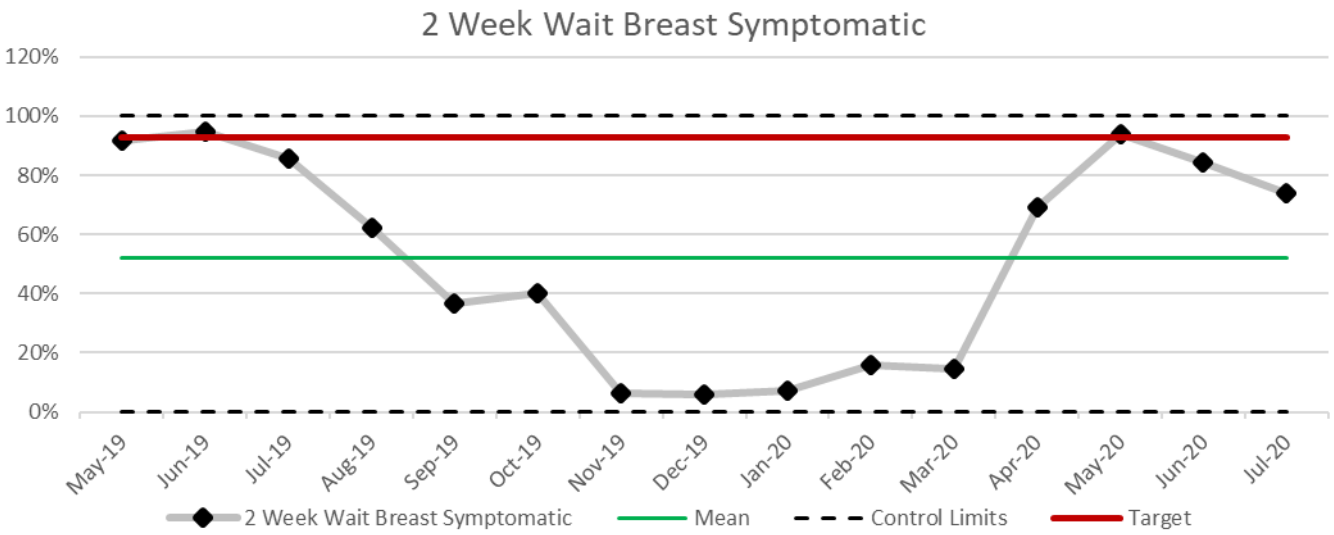
IMPROVE CLINICAL OUTCOMES – CANCER 2 WEEK WAIT

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 Lung and Upper GI, both due to the consequences of the impact of COVID.

Actions in place to recover:

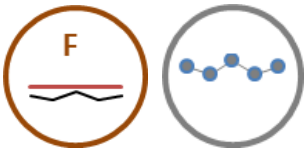
Review of Imaging services (including Breast Radiology provision) have been undertaken by Meridion and the Trust is being supported in taking the findings forward through NHSE management assistance.

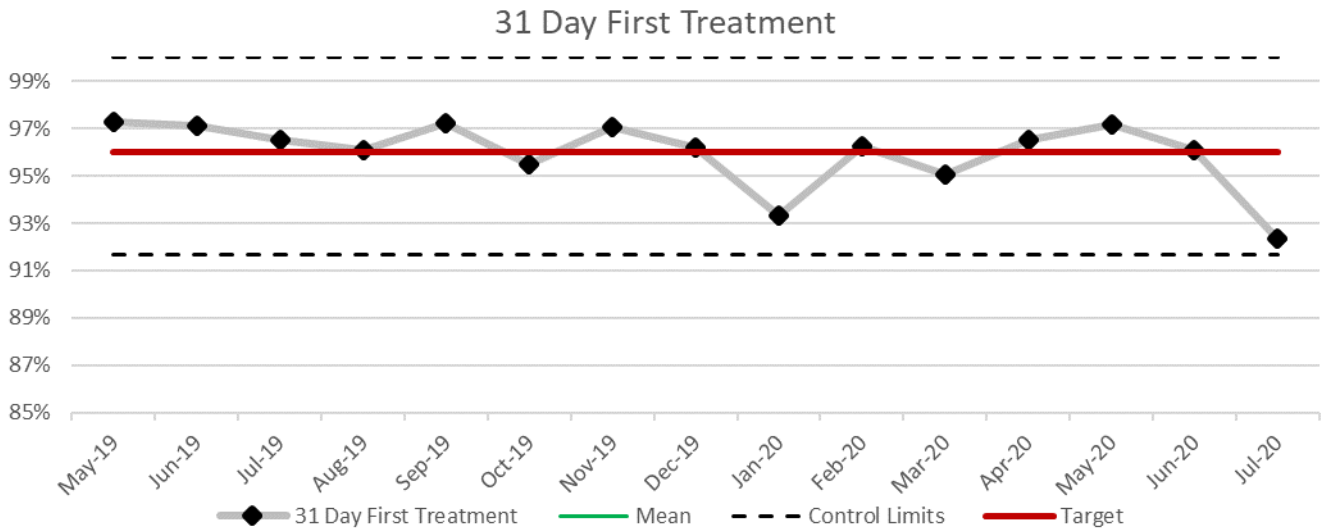
IMPROVE CLINICAL OUTCOMES – CANCER 31 DAY FIRST

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services





Challenges/Successes

The failure of the 31 Day First standard was due to surgical capacity, primarily for Breast patients, as well as a high number of patients who were either unwell/unfit or were reluctant to engage with the NHS.

Actions in place to recover:

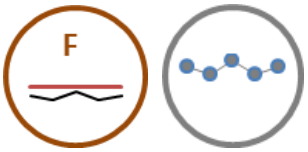
A new post of Pre-Diagnosis CNS has been filled and they have been having significant success in supporting patients to attend appointments and have treatments. This has involved considerable dialogue with GPs to ensure that a holistic approach is taken in assisting these patients. There will also be a review of theatre capacity to ensure sufficient to meet Specialty demand.

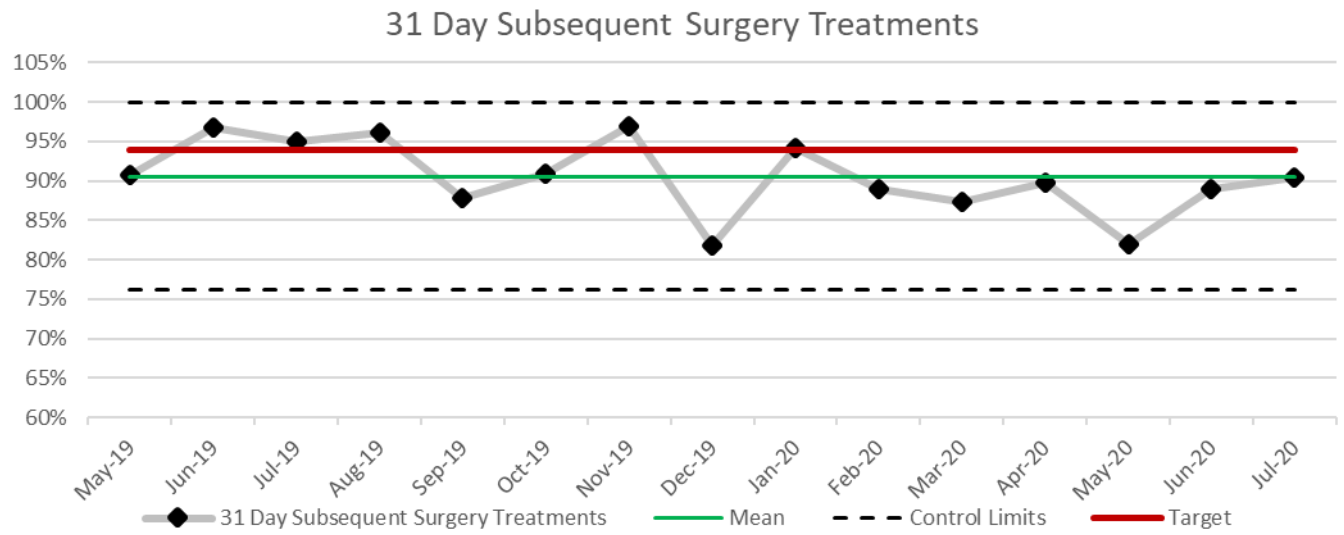
IMPROVE CLINICAL OUTCOMES – CANCER 31 DAY SUB SURGERY

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services





Challenges/Successes

The 31 Day Subsequent standards were missed primarily due to the impact of COVID: the reduction in capacity and patient reluctance to attend hospitals.

Actions in place to recover:

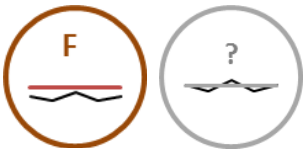
Although all theatre activity initially stopped in the run-up to COVID-19, the Grantham Green Site is running 4 theatres for 5 days a week with a view to increasing this to 6-7 days; Lincoln is working with 2 theatre lists per day for 5 days a week and Pilgrim with 1 theatre lists per day, 5 days per week.

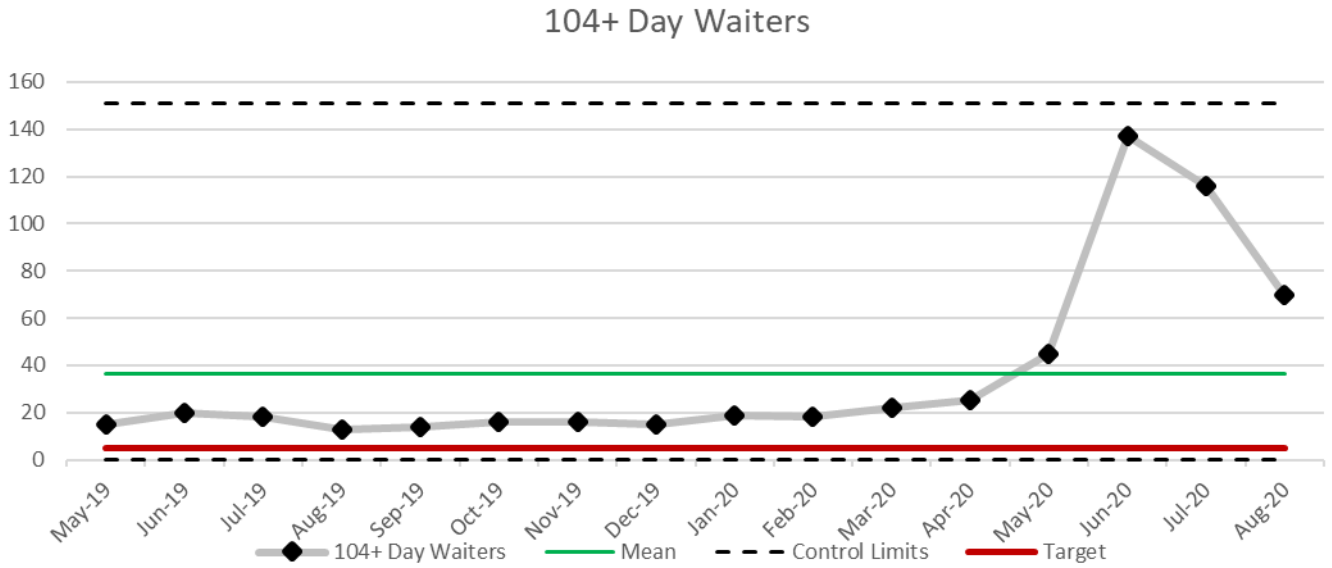
IMPROVE CLINICAL OUTCOMES – CANCER 104+ DAY WAITERS

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 10th September there remain 50 patients waiting over 104 days, significantly down from the highpoint of 163 patients in mid-July. Of these patients 70% are on a Colorectal pathway, with half awaiting a diagnostic procedure.

Actions in place to recover:

The Trust met the NHSE/I requirement that all patients waiting 104 days and over to be seen by the 21st August 2020 and that the number of patients waiting over 62 days should be reduced by 20% by that date.

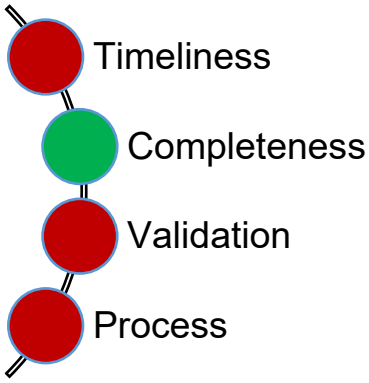
Meetings are held three times a week, to review all patients over 104 days, led by the CSS Managing Director and attended by senior Divisional staff. The cohort of patients being discussed in these meetings is being extended to include patients those in the 50 – 62 day range as well, so that the chance of them reaching 104 is minimised.

There is a weekly review of all patients over 104 days with the Cancer Lead Clinician.

The Grantham Green Site is now running 4 theatres for 5 days a week with a view to increasing this to 6-7 days; Lincoln is working with 2 theatre lists per day for 5 days a week and Pilgrim with 1 theatre lists per day, 5 days per week.

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 6th October 2020*
Item Number	*Item number allocated by admin*
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

- 40 out of 82 risks recorded on the Trust's Strategic Risk Register are currently rated as Very high or High (49% of the total); this is an increase of 1 since last month
- The increased risk relates to the safe use of medical devices and equipment and in particular, the lack of a centralised equipment training record
- Evaluating the current level of risk of harm in relation to the Covid-19 pandemic is challenging due the high degree of uncertainty – at present it is recorded as Very high risk (25)
- The management of emergency demand remains a Very high risk (20), with plans in progress to re-develop Emergency Departments at Lincoln County and Pilgrim hospitals
- The management of finances and delivery of cost improvement plans remain Very high risks (20) due to the need to implement robust and sustainable controls
- There are also Very high risks (20) in relation to workforce capacity, capability and morale; these are Year 1 priorities in the Integrated Improvement Plan (IIP)

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

Introduction

4.1 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

4.2 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.

4.3 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.

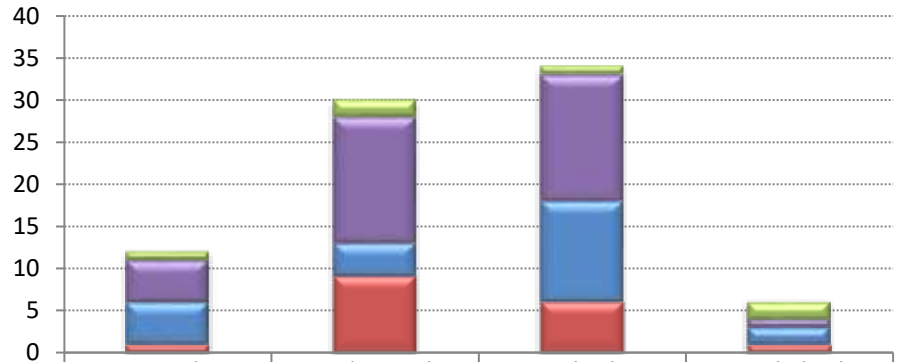
4.4 Strategic and operational risk registers consist of two types of risk:

- 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

4.5 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.

Strategic Risk Profile

4.6 **Chart 1** shows the number of strategic risks by risk type and current risk rating (taking account of existing controls):



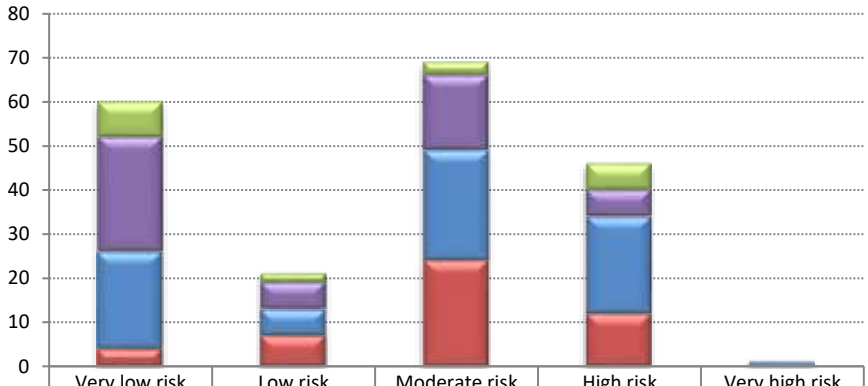
	Low risk	Moderate risk	High risk	Very high risk
Finances	1	2	1	2
Reputation / compliance	5	15	15	1
Service disruption	5	4	12	2
Harm (physical or psychological)	1	9	6	1

4.7 40 out of 82 strategic risks recorded on Datix are currently rated as Very high or High (49% of the total). This an increase of 1 (+1%) from last month.

4.8 A summary of all risks currently recorded on the Strategic Risk Register is attached as **Appendix I.**

Operational Risk Profile

4.9 **Chart 2** shows the number of operational (divisional business unit) risks by current (residual) risk rating:



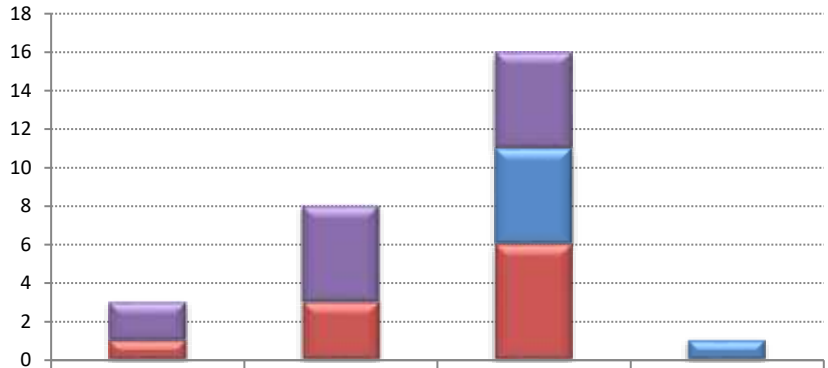
	Very low risk	Low risk	Moderate risk	High risk	Very high risk
Finances	8	2	3	6	0
Reputation / compliance	26	6	17	6	0
Service disruption	22	6	25	22	1
Harm (physical or psychological)	4	7	24	12	0

4.10 Of the 197 risks recorded on divisional business unit risk registers, 47 (23%) are currently rated as High or Very high. There have been some changes in risk ratings between Low and Moderate risk this month, but no changes to the ratings of High or Very high risks. A summary of current High and Very high operational risks is attached as **Appendix II.**

Quality & Safety Risk Profile

4.11 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 now operating with a full agenda. Most lead groups have also continued to meet wherever possible.

4.12 **Chart 3** shows a breakdown of these 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

4.13 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). 1 risk has increased in rating from Moderate risk (8) to High risk (12) since last month's report:

Risk title (ID)	Safe use of medical devices & equipment (4353)		
Current risk rating	High (12)	**Risk lead**	Andrew Simpson
Lead group	Patient Safety Group / Medical Device Safety Group		

Key Risk Indicators (KRIs):

- Patient safety incidents involving the use of medical devices (faulty equipment; user competence issues) – the number of incidents resulting in harm in 2020/21 is comparable to 2019/20
- Medical device training records – centralised data is not currently available

Gaps in control & mitigating actions:

- Inconsistent, localised management approach to recording of medical device user training – development of a centralised medical device user training database

4.14 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 – these had reduced to 0 but have recently started to increase again
- Number of patients in intensive care due to Covid-19 – these have reduced since the peak of the pandemic
- Number and severity of patient safety incidents linked to the Trust's Covid-19 response – the number and severity of incidents have reduced significantly since July 2020

Gaps in control & mitigating actions:

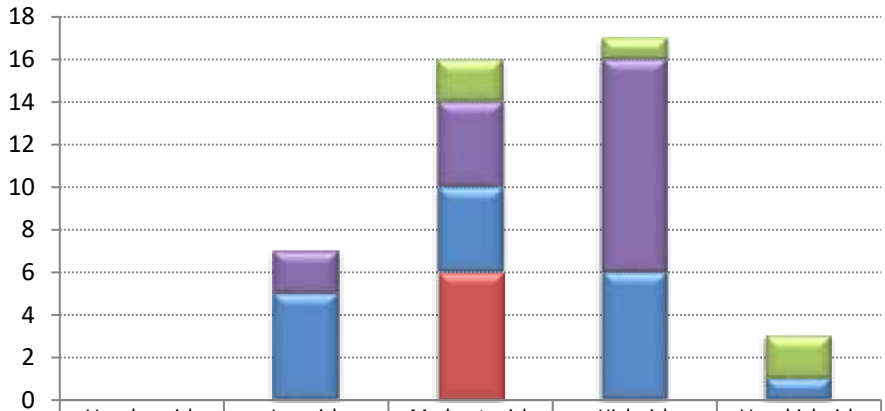
- Lack of an approved vaccine and limited effective treatment options available; the Trust has enacted the agreed national response plan, including the use of PPE and social distancing measures, and has been reintroducing suspended services since Covid-19 demand has reduced
- There remains a high degree of uncertainty over the potential for a second wave and the scale of its impact, along with the threat from regular winter pressures and the impact on staff wellbeing from dealing with the pandemic both professionally and personally

4.15 Of the 62 operational quality and safety risks recorded on business unit risk registers, 14 (23% of the total) are currently rated as High risk (12-16). This is unchanged from last month's report.

Finance, performance and estates risk profile

4.16 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.

4.17 **Chart 4** shows a breakdown of the 43 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

4.18 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 is unchanged from last month's report.

4.19 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 with an improving trajectory
- Bed occupancy rates have continued to return towards pre-Covid levels
- Ambulance handover times – the number of delays of more than 59 minutes was above trajectory in August
- Incidents relating to delayed diagnosis & treatment in A&E – the proportion of incidents resulting in significant harm so far in 2020/21 is comparable to 2019/20

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 – whilst providers are currently being funded to break-even, it remains important that the Trust understands where it is against its original plans and continues to build budgetary control as a discipline
- Year-end financial forecasts – the high level financial forecast for 2020/21 is based upon a break-even position

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 – by comparison with Month 4, the Year to Date Variance to plan increased by £438k to £2.786m in Month 5
- Risks to the delivery of planned cost reduction schemes

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
- Utilisation of additional external resource to support delivery.

4.20 Of the 109 operational finance, performance and estates risks recorded on business unit risk registers, 24 (22% of the total) are currently rated as Very high risk (20-25) or High risk (12-16). The 1 Very high risk is as follows:

Risk title (ID)	Availability of essential equipment & supplies (Diagnostics CBU) (4426)		
Current risk rating	Very high (20)	**Risk lead**	Ian Fulloway
Lead group	CSS Division Clinical Cabinet		

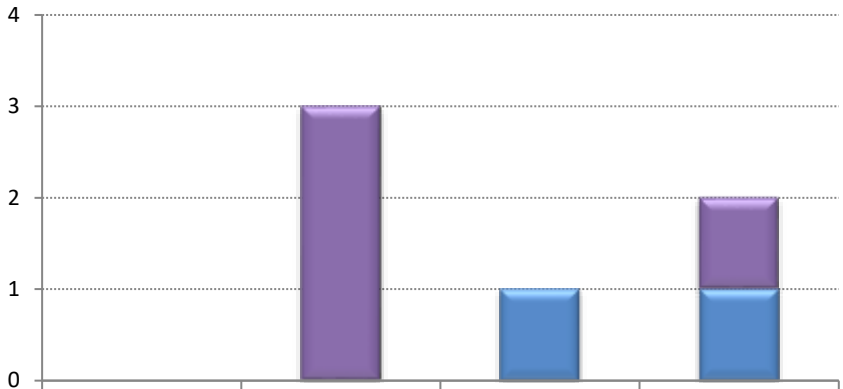
Gaps in control & mitigating actions:

- Replacement of endoscopes; ultrasound equipment; image intensifiers; CT scanners; interventional radiology machines; OPT units and Spalding and Louth
- Upgrade the medical air supply to Endoscopy at Lincoln Hospital to a duplex system
- Potential impact of Brexit on supply of radiopharmaceuticals & condition of aseptic cabinets affecting manufacture at Lincoln and Grantham hospitals

People & organisational development risk profile

4.21 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.

4.22 **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
Finances	0	0	0	0
Reputation / compliance	0	3	0	1
Service disruption	0	0	1	1
Harm (physical or psychological)	0	0	0	0

4.23 Of the 6 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.

4.24 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 declining, although significant hotspots remain
- Sickness absence rates – sickness rates have been 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
- Nursing and medical vacancy rates have reduced over the last three months
- 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

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 feel informed (+0.6 vs NHS overall); 63% feel confident in local leaders (equal to NHS overall); 61% feel supported (-5.7 vs NHS overall); 59% have a work-life balance (-2.5 vs NHS overall)
- NHS National Staff Survey (NSS) results – 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:

- Some improvement in the results of the 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
- 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

4.25 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). Tis 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)

Strategic communication and engagement risks

4.26 The following 3 strategic risks do not currently fit within any of the assurance committee risk profiles:

- Public consultation and engagement (rated Moderate risk)
- Internal corporate communications (rated Moderate risk)

- Adverse media or social media coverage (rated Low risk)

4.27 These risks are all unchanged since the last report.

5. Conclusions & recommendations

5.1 The relatively static nature of the Trust's strategic and operational risk profiles indicates that actions taken to mitigate these risks over the past 12 months have not reduced the extent of risk exposure to any measurable degree. Equally, the level of risk does not appear to have increased noticeably during the same period.

5.2 The use of Key Risk Indicators (KRIs) to evaluate risk exposure is now being introduced, to provide a more objective means of assessing risks through the utilisation of existing metrics and the further development of additional metrics where necessary. It is planned for regular review of divisional risk registers to be included within future Performance Review Meetings (PRMs), in which divisions will be required to provide evidence of actions being taken to mitigate their most significant risks and also the effectiveness of those actions.

5.3 It is recognised that there has been limited risk management training available within the Trust in recent years. Developing management skills in risk assessment using available data and the implementation of effective risk mitigation plans is a key focus of a risk and incident training needs analysis that the Clinical Governance team are working on with divisions and corporate departments. This will support the establishment of a comprehensive, role-based risk and incident training programme, which is a work-stream within the Integrated Improvement Plan (IIP).

5.4 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
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
4439	Industrial action	Corporate	Service disruption	4	Low risk

ID	Title	Division	Risk Type	Rating (current)	Risk level (current)
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	20	Very high risk
4193	Health, safety & security of staff, patients and visitors (Surgery CBU)	Surgery	Harm (physical or psychological)	15	High risk
4340	Workforce capacity & capability (Cancer Services CBU)	Clinical Support Services	Service disruption	15	High risk
4194	Delayed patient diagnosis or treatment (Surgery CBU)	Surgery	Harm (physical or psychological)	12	High risk
4196	Workforce capacity & capability (Surgery CBU)	Surgery	Service disruption	12	High risk
4201	Compliance with regulations & standards (Surgery CBU)	Surgery	Reputation / compliance	12	High risk
4262	Availability of essential equipment & supplies (Urology, T&O and Ophthalmology CBU)	Surgery	Service disruption	12	High risk
4287	Access to essential areas of the estate (Therapies & Rehabilitation)	Clinical Support Services	Service disruption	12	High risk
4289	Exceeding annual budget (Therapies & Rehabilitation)	Clinical Support Services	Finances	12	High risk
4297	Workforce capacity & capability (Therapies & Rehabilitation)	Clinical Support Services	Service disruption	12	High risk
4302	Workforce capacity & capability (Specialty Medicine CBU)	Medicine	Service disruption	12	High risk
4303	Safety & effectiveness of patient care (Specialty Medicine CBU)	Medicine	Harm (physical or psychological)	12	High risk
4304	Health, safety & security of staff, patients and visitors (Specialty Medicine CBU)	Medicine	Harm (physical or psychological)	12	High risk
4305	Exceeding annual budget (Specialty Medicine CBU)	Medicine	Finances	12	High risk
4311	Access to essential areas of the estate (Specialty Medicine CBU)	Medicine	Service disruption	12	High risk
4315	Delayed patient diagnosis or treatment (Cardiovascular CBU)	Medicine	Harm (physical or psychological)	12	High risk
4317	Exceeding annual budget (Cardiovascular CBU)	Medicine	Finances	12	High risk

ID	Title	Division	Risk Type	Rating (current)	Risk level (current)
4320	Workforce capacity & capability (Cardiovascular CBU)	Medicine	Service disruption	12	High risk
4322	Safety & effectiveness of patient care (Cardiovascular CBU)	Medicine	Harm (physical or psychological)	12	High risk
4324	Access to essential areas of the estate (Cardiovascular CBU)	Medicine	Service disruption	12	High risk
4327	Delayed patient diagnosis or treatment (Urgent & Emergency Care CBU)	Medicine	Harm (physical or psychological)	12	High risk
4328	Quality of patient experience (Urgent & Emergency Care CBU)	Medicine	Reputation / compliance	12	High risk
4331	Exceeding annual budget (Urgent & Emergency Care CBU)	Medicine	Finances	12	High risk
4333	Delayed patient discharge or transfer of care (Urgent & Emergency Care CBU)	Medicine	Reputation / compliance	12	High risk
4334	Access to essential areas of the estate (Urgent & Emergency Care CBU)	Medicine	Service disruption	12	High risk
4335	Compliance with regulations & standards (Urgent & Emergency Care CBU)	Medicine	Reputation / compliance	12	High risk
4372	Compliance with regulations & standards (Outpatient Services)	Clinical Support Services	Reputation / compliance	12	High risk
4391	Health, safety & security of staff, patients and visitors (Estates & Facilities)	Corporate	Harm (physical or psychological)	12	High risk
4392	Availability of essential equipment & supplies (Estates & Facilities)	Corporate	Service disruption	12	High risk
4394	Access to essential areas of the estate (maintained by Estates & Facilities)	Corporate	Service disruption	12	High risk
4396	Exceeding annual budget (Estates & Facilities)	Corporate	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
4415	Exceeding annual budget (Children & Young Persons CBU)	Family Health	Finances	12	High risk
4416	Delayed patient diagnosis or treatment (Children & Young Persons CBU)	Family Health	Harm (physical or psychological)	12	High risk
4420	Workforce capacity & capability (Children & Young Persons CBU)	Family Health	Service disruption	12	High risk
4425	Workforce capacity & capability (Diagnostics CBU)	Clinical Support Services	Service disruption	12	High risk

ID	Title	Division	Risk Type	Rating (current)	Risk level (current)
4116	Availability of essential equipment & supplies (TACC CBU)	Surgery	Service disruption	12	High risk
4168	Availability of essential equipment & supplies (Pharmacy)	Clinical Support Services	Service disruption	12	High risk
4169	Availability of essential information (Pharmacy)	Clinical Support Services	Service disruption	12	High risk
4170	Workforce capacity & capability (Pharmacy)	Clinical Support Services	Service disruption	12	High risk
4191	Availability of essential equipment & supplies (Surgery CBU)	Surgery	Service disruption	12	High risk
4429	Availability of essential information (Diagnostics CBU)	Clinical Support Services	Service disruption	12	High risk
4435	Access to essential areas of the estate (Diagnostics CBU)	Clinical Support Services	Service disruption	12	High risk
4452	Compliance with regulations & standards (Women's Health & Breast Services CBU)	Family Health	Reputation / compliance	12	High risk
4460	Workforce capacity & capability (Women's Health & Breast Services CBU)	Family Health	Service disruption	12	High risk
4461	Safety & effectiveness of patient care (Women's Health & Breast Services CBU)	Family Health	Harm (physical or psychological)	12	High risk
4565	Safety impact during the Covid-19 pandemic response (TACC CBU)	Surgery	Harm (physical or psychological)	12	High risk

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*6 October 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 September.

A number of updates were requested by the Committees which will be made and presented for Committee consideration at their meetings in October.

Further work will be undertaken in order to better align links in the risk register to the BAF and reflect the updates made to objective 1.

Assurance ratings have been provided for all objectives and have been confirmed by the Committees. The Board should note that Objective 4c has reduced from an amber rating to red due to the People and Organisational Development Committee not receiving sufficient assurances to maintain the amber rating.

The following assurance ratings have been identified:

Objective		Rating at start of 2020/21	Previous month (August)	Assurance Rating (September)
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	R
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 - September 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	If the Trust manage safely and effectively the care of patients due to staffing capacity and capability and estate and equipment constraints If the Trust is unable to manage the backlog of patients who require time critical treatments recovering from the COVID response	4558	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 Continued review and monitoring of HSMR and SHMI by QGC CQC actions monitored through QGC meeting during Covid 19 streamlined governance arrangements IPC Team part of Trust Covid response National guidance followed on PPE/ Infection Prevention methods Pandemic Flu Plan initiated 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	Control gaps identified and reported through to Gold Command Structure. Reviews of the Incident Management Structure are Conducted at the end of each phase and include any gaps in controls. Audits of changes are carried out internally and externally as part of NHSE change processes. Tracking learning actions from incidents and reviews	Trust Wide Accreditation Programme 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 Monitoring nosocomial infection rates National Clinical Audits Dr Foster alerts	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	If the Trust is unable to manage safely and effectively the care of patients presenting with severe symptoms of covid 19 caused by the absence of an effective treatment, issues with availability of equipment (including PPE) or the required staffing capacity to manage the level of demand	4558	CQC Safe	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 Covid 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	Control gaps identified and reported through to Gold Command Structure. Reviews of the Incident Management Structure are Conducted at the end of each phase and include any gaps in controls. Audits of changes are carried out internally and externally as part of NHSE change processes.	Getting real time patient and carer feedback Hold 6 listening events Thematic reviews of complaints and compliments User involvement numbers National patient surveys Number of locally implemented changes as a result of patient feedback	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	If the Trust manage safely and effectively the care of patients due to staffing capacity and capability and estate and equipment constraints If the Trust is unable to manage the backlog of patients who require time critical treatments recovering from the COVID response	4558	CQC Safe 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 Covid 19 streamlined governance arrangements Pandemic Flu Plan initiated	Control gaps identified and reported through to Gold Command Structure. Monitoring incident reports and investigations	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	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	Declared as a level 4 incident throughout the UK. NHSE to coordinate NHS response. Major incident (Gold Command Structure) 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. During August we will re-establish the Workforce Strategy Group, who will oversee delivery of the People workstreams of the IIP and 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	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	Covid Command and decision making structure alongside Board agreed lean governance arrangements have been in place during the COVID incident. During August we will re-establish the Workforce Strategy Group, who will oversee delivery of the People workstreams of the IIP and 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.	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			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
						Rounds Embed Freedom to Speak Up and Guardian of safe Working Celebrate year of the Nurse/Midwife	ELT Live sessions on Facebook and Teams		Lincolnshire System Workforce Plan Use of NHSI Covid pulse survey				
2c	Well led services	Chief Executive	Specific projects paused during Covid 19 response		CQC Well Led	Review of executive portfolios Simplify Trust strategic framework Embedding Divisional Governance structures to operate as one team Delivery of risk management training programmes Review and strengthening of the performance management & accountability framework Development and delivery of Board development programme Implementing a Shared Decision making framework Implementing a robust policy management system Ensure system alignment with improvement activity	Review of Executive Portfolios Complete On hold Covid command structure in place On hold On hold Board Development sessions on hold due to covid Covid command structure in place PID in place. Paper to ELT w/c 29 June 2020	Covid Command and decision making structure alongside Board agreed lean governance arrangements	Third party assessment of well led domains Internal Audit assessments Completeness of risk registers Annual Governance Statement Number of Shared decision making councils in place Numbers of in date policies	No assurance received Head of Internal Audit Opinion received showing improved position on previous year Annual Governance Statement - Completed.	No assurance received on policies. Escalated from Quality Governance Committees paper to ELT w/c 29 June, escalation and rapid review of actions and blockers.	Audit 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
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 - in progress 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	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. B16	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
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:

R — Effective controls may not be in place and/or appropriate assurances are not available to the Board

A — Effective controls are thought to be in place but assurances are uncertain and/or possibly insufficient

G — Effective controls are definitely in place and Board are satisfied that appropriate assurances are available

OUTSTANDING CARE
personally DELIVERED

NHS
United Lincolnshire Hospitals
NHS Trust

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										
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													