Bundle Trust Board Meeting in Public Session 2 June 2020

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

1	Introduction, Welcome, Chair's Opening Remarks and Health and Safety *Chair*
2	Public Questions *Chair*
3	Apologies for Absence *Chair*
4	Declarations of Interest *Chair*
5	Minutes of the meeting held on 5th May 2020 *Chair* Item 5 Public Board Minutes May 2020.docx
6	Matters arising from the previous meeting/action log *Chair* Item 6 Public Action log May 2020.docx
7	Chief Executive Horizon Scan Including STP *Chief Executive*
8	Objective 1a Deliver Harm Free Care
8.1	Covid 19 Update *Chief Operating Officer* Item 8.1 Covid-19 Restore Phase June 2020.docx
8.2	Assurance and Risk Report from the Quality Governance Committee *QGC Chair* Item 10 QGC Upward report May 2020.doc
9	Objective 2a A Modern and Progressive Workforce
9.1	Protecting and Supporting BAME Patients and Staff through Covid 19 *Director of Improvement and Integration/ Deputy Chief Executive* Item 9.1 Supporting BAME Staff front cover.docx Item 9.1 Supporting BAME Staff.pptx
10	Objective 3b Efficient Use of Resources
10.1	Finance Report Item 10.1 Finance Report 1920 M12.docx
11	Integrated Performance Report *Director of Finance and Digital* Item 11 Integrated Performance Report - Trust Board.pdf
12	Risk Management Report *Medical Director* Item 12 Strategic Risk Report - June 2020.pdf
13	Board Assurance Framework *Trust Secretary* Item 13 BAF 2020-21 Front Cover.docx Item 13 BAF 2020-2021 v260520.xlsx
14	Any Other Notified Items of Urgent Business
15	The next meeting will be held on Tuesday 7th July 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.

Agenda Item 5

NHS
United Lincolnshire Hospitals
NHS Trust

Minutes of the Trust Board Meeting

Held on 5 May 2020

Via MS Teams Live Stream

Present

Voting Members:
Mrs Elaine Baylis, Chair
Dr Chris Gibson, Non-Executive Director
Mrs Sarah Dunnett, Non-Executive Director
Dr Karen Dunderdale, Director of Nursing
Mr Paul Matthew, Director of Finance and Digital
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

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

In attendance:
Mrs Jayne Warner, Trust Secretary
Mrs Karen Willey, Deputy Trust Secretary (Minutes)
Mrs Anna Richards, Associate Director of Communications
Ms Cathy Geddes, Improvement Director, NHS Improvement
Dr Maria Prior, Healthwatch Representative

Apologies
Mr Geoff Hayward, Non-Executive Director

441/20	**Item 1 Introduction** The Chair welcomed members to the meeting of the Trust Board being held in public session noting that in line with Covid-19 guidance and in the interest of protecting patients and staff the meeting was not open for the public to attend in person.
442/20	Instead the meeting was being live streamed to the public for the first time to maintain openness and transparency through the pandemic. A streamlined agenda was being discussed to allow Board members to focus on key issues relating to the national incident.
443/20	The Chair took a moment to reflect with the Board on the sad loss of a member of the United Lincolnshire Hospitals NHS Trust family. Anujkumar Kuttikottu Pavithran, a member of nursing staff at Pilgrim Hospital, Boston had died from Covid-19. Kumar as he was known to colleagues was a much loved and well respected member of the team.
444/20	The members of the Trust Board offered their condolences to Kumar's family and joined in a minutes silence in respect of his life and service to the NHS. *The Board observed a minute silence*

445/20	The Chair moved to questions from members of the public. **Item 2 Public Questions** **Q1 from Jody Clarke** **In the board papers, it talks about Phase 4 - The New NHS. Can you please tell me what that means for Grantham Hospital? Especially our A&E situation? Is it still awaiting the formal public consultation or will changes be made due to the Covid-19 outbreak?** The Chief Operating Officer responded: Phase 4 would be discussed in further detail on the agenda however in terms of the response being made and changes between now and phase 4 these were limited to the response to Covid-19. Phase 4 discusses what the future may look like and as could be expected at this stage there would be more to learn about Covid-19 and the measures that need to be put in place to respond. The Trust were looking to work on the development of green site and service responses ahead of phase 4.
446/20	**Item 3 Apologies for Absence** Apologies were received from Geoff Hayward, Non-Executive Director
447/20	**Item 4 Declarations of Interest** There were no declarations of interest which had not previously been declared.
448/20	**Item 5 Minutes of the meeting held on 3rd March 2020 for accuracy** The minutes of the meeting held on 7th April 2020 were agreed as a true and accurate record.
449/20	**Item 6 Matters arising from the previous meeting/action log** The Chair noted that there were a number of deferred actions that would be addressed post Covid-19. 410/20 – Covid-19 – Proposal to be developed and reported to the Quality Governance Committee regarding Quality Impact Assessments – captured in the Committee upward report. 427/20 & 429/20 – Risk Management Report – Develop and capture oversight by Gold Command to ensure audit trail and existing risks to be updated in response to the impact of Covid-19 – Agenda item 436/20 – Board Assurance Framework 2020/21 – Develop a streamlined BAF including a separate Covid-19 objective - complete 437/20 – Board Assurance Framework 2019/20 – Circulate 2019/20 BAF to Committee Chairs for review prior to final sign off by Board – Complete
450/20 451/20	**Item 7 Chief Executive Verbal Briefing** The Chief Executive provided a verbal update to the Board noting that the level 4 national incident remained however there was a move towards the next stage of the response.

452/20	The Chief Executive thanked staff, both frontline and those in support functions for the efforts being made in the stressful and unprecedented times. There had been an increase in engagement and listening to staff through this period. Any beneficial changes made during Covid-19 would need to be locked in by the Trust.
453/20	Thanks were expressed to the public and local communities for the huge practical and emotional support that was being offered to the NHS. These expressions of support, including the Clap for Carers on a Thursday evening were having a big impact on colleagues.
454/20	As the Trust moved to the next phase of the response to Covid-19 the Trust would reintroduce some services but also focus on those activities that had to be paused due to social distancing, including the Integrated Improvement Plan (IIP) and staff engagement work. Alongside continuing to move focus back to the IIP the Trust would not lose sight of the need to manage public finances well.
455/20	The government had been clear that finances should not be a constraint on managing Covid-19. The resource was being managed carefully in the public interest and the Trust were also managing the general finances during the challenging time.
456/20	The Chair noted that it was reassuring to hear that the Trust had not lost sight of the IIP, due to the effort put in to producing the plan. The Board remained fully committed to taking this forward however it would be affected by the response to Covid-19. The Chair was also reassured to hear that finances were being managed efficiently and noted that there would be a need for a detailed review of the financial position. The Trust Board: • **Received the update**
457/20	**Item 8 COVID-19** The Chief Operating Officer presented the report to update the Board with regards to the response to COVID-19.
458/20	The Board were reminded that the level 4 incident reminded in place and that the Trust had been asked to maintain the command and control approach through the next phase of the response. Until advised otherwise by NHS England the Trust would continue to manage Covid-19 as an incident.
459/20	Continuing to manage Covid-19 as an incident would allow the Trust to deploy changes effectively and efficiently whilst maintaining the focus to save lives and to protect staff, patients and services.
460/20	Lincolnshire had been fortunate that the level of Covid-19 demand had not reached the levels suggested through NHSE modelling, there had been the expectation of a greater surge than seen. Some factors may be due to geography however it had shown the response of the Lincolnshire population who had been socially distancing and following national guidelines.
461/20	As a result of the lower impact the Trust had been able to test surge plans and those actions that needed to be put in place should a subsequent surge be seen in the coming months. The plan had been tested and the Trust were well placed to respond should a subsequent surge be seen.

462/20	It was noted that some of the issues regarding personal protective equipment (PPE) had been discussed nationally. The Trust had managed well in both the way PPE was being used but also the level of stores and supply. This had not been without challenge and teams had been working hard to ensure there was both the correct equipment and it was used in the correct manner. There had been no episodes where PPE had run out but levels had been low enough that the Trust had used some of the national drop services.
463/20	There had been media interest and concern regarding PPE and the Trust had responded by ensuring that staff were communicated with regarding supplies and providing reassurance to teams that there was not an issue with availability. Communications would continue with staff through weekly Facebook live and MS Teams events where staff were encouraged to ask questions of those in the command centre.
464/20	Testing had recently increased nationally both in volume of capacity and the breadth of those eligible for testing. There had been a benefit of the increased capacity from NHS laboratories and also the services set up regionally by the Clinical Commissioning Groups with support from the military.
465/20	The overall plan for responding to the pandemic had been broken down in to four stages, these were manage, restore, recover and new NHS ways. It is believed that there had been a move beyond the manage stage and the paper described all the measures that had been discussed in respect of changing the form of the organisation in order to change quickly using command and control to respond.
466/20	The use of command and control had enabled the Trust to change some services and to respond to other challenges such as increased staff sickness. The Trust had responded well during the manage phase and was now prepared to move forward.
467/20	Within the manage phase the focus had been on the protection of the workforce, measures were in place to support Black, Asian and Minority Ethnic (BAME) staff due to the potential greater impact the virus could have on them. Risk assessments and approaches to work with those members of the organisation who may be at greater risk had been put in place with adjustments being made to protect staff.
468/20	The Trust were now working in the restore phase. The phrase did not articulate the focus of the work, this was not about putting services back to the way they were previously but about putting in place capabilities to deliver services potentially in a different form. There would be a focus on additional capacity in urgent care as patients started to present in greater numbers and an increase in admissions was seen due to changes to lockdown and public behaviour.
469/20	The Trust would also put in capacity to increase the cancer response and maximise services to treat patients more quickly, there would be a need to ensure safe care continued to be offered.
470//20	The third phase, recovery, would be a longer piece of work that would move beyond restoration in order to address non-urgent elective services and switch on more screening type services that had not been addressed in the restoration phase. This would move the Trust back to constitutional standards and national waiting times.
471/20	Currently the new NHS phase was not well defined however the Trust would want to ensure that the positive changes that had been made were embedded where it was felt that these were leading to a significant improvement in patient care.

472/20	The Chair advised that questions had been received from Dr Maria Prior, Healthwatch representative and Mr Hayward, Non-Executive Director.
473/20	Dr Prior, through the Chair, asked how patients being invited for surgery and investigations would be communicated with regarding safety in order to encourage attendance.
474/20	The Chief Operating Officer noted that the Trust were following nationally prescribed measures that would be taken before bringing in potentially vulnerable patients. This would involve a questionnaire and discussion of risk factors before appointments were offered. As part of pre-operative screening this would involve a test to ensure patients were Covid-19 negative. There may be other measures that needed to be put in place however a suite of measures were being put in place for all patients.
475/20	Communications would be both from the Trust and nationally, the national message would continue to be that Trusts were still there to care for people that require care and from a cancer perspective, the Trust were keen to see people promptly and encourage patients to come in to hospital if they need treatment.
476/20	The Trust were locally targeting those patients who may have been waiting for some time in order to provide assurance that a safe environment could be provided to care for them. This would continue on a one to one basis for some time until national confidence was built with patients to attend hospitals for treatment.
477/20	Dr Prior, through the Chair, noted that patients requiring cancer and planned surgery would have access to Covid-19 testing prior to surgery and asked if this would be a standard pre-operative procedure in planned cases as pre-admission for the foreseeable future.
478/20	The Chief Operating Officer confirmed that there would be some form of testing and screening would be a feature of all elective care at the Trust.
479/20	Mrs Libiszewski noted that the SBAR had shown a slight increase in positive patients in the Trust and asked if this was considered a concern given the potential easing of lockdown following the government announcement due to me made on 10th May.
480/20	The Chief Operating Officer acknowledged that there had been an increase in positive patients and that the Trust were tracking positive cases along with a suite of activity as part of the command and operation centres. The increase was manageable within the threshold and a series of triggers were in place to respond to a surge should there be one. The Trust remained behind the national curve but this would continue to be tracked.
481/20	Confirmation was sought by Mrs Libiszewski that the Trust had not moved away from the 1:1 ratio of staffing for level 3 patients. Confirmation was provided that there had not been a move away from the 1:1 ratio for level 3 patients. This had been managed through the surge plan and the Trust had not gone above 60-70% of capacity.
482/20	Mrs Libiszewski asked if the Trust were swabbing all patients and knowing the outcome prior to discharging to care homes or the community.
483/20	The Chief Operating Officer noted that swabbing of patients was now a prerequisite to discharge. The Trust needed to ensure that patients continued to be discharged who were Covid-19 positive, whilst this posed a challenges in the community the Trust needed to maintain capacity and the ability to treat acutely unwell patients. There would be a focus on discharge through the restore phase.

484/20	Mrs Dunnett noted that there had been information in the media regarding research and asked if the Trust were involved in research trials.
485/20	The Medical Director advised that the Trust were actively involved in a research study for treatment as well as a genomic study. The treatment study was being well recruited to and the genomic study was looking at patient outcomes and it was hoped that there would be the identification of some of the triggers that made people more susceptible.
486/20	Mrs Dunnett asked what measures had been put in place to support contact between patients and families due to visitors not being allowed on site.
487/20	The Chief Operating Officer recognised the limitation on visiting had been difficult for patients and families that did not have contact and support whilst they were unwell. A number of measures had been introduced, the most significant being the family liaison team who were using technology to create regular contact for patients. Those who did not have phones or iPads were able to use hospital equipment to do this. Where access to technology was not possible the Trust had put in place a free telephone beside service. Additional support in place included the chaplaincy and mental health services to support families through the difficult time.
488/20	Mrs Dunnett sought assurance that there was sufficient safeguarding resource to respond to issues as and when they arise.
489/20	The Director of Nursing advised that there was appropriate safeguarding resource for both adult and children. The Trust were preparing for an increase in risks and concerns, particularly around children as lockdown started to be eased. There had been an increase across the country in domestic violence and other safeguarding concerns. The strategic lead for safeguarding had been appointed as a new post to the organisation, commencing in July. The model of safeguarding would be reviewed going forward.
490/20	Mrs Ponder asked how social distancing would be maintained as additional services re-opened in order to respond to patients who may be concerned about crowded waiting rooms and common areas such as entering and leaving the hospital.
491/20	The Chief Operating Officer advised that the national steer on social distancing would be followed and this would reflect how the Trust used the estate to ensure an appropriate IPC approach was in place to offer the safest levels of care.
492/20	Adjustments would be made to the way in which services would be offered. Some of these changes had already been made and others would be put in place in respect of routes of ingress and egress and certain patient pathways. Of particular note had been the work to develop the cancer pathway to a green pathway. This would reduce contact with Covid-19 potential and positive patients from entry to the site through to discharge. This would also extend to the staff working with patients, where the working day would be with Covid-19 free patients only.
493/20	Dr Gibson asked that as the Trust moves towards the restoration phase would patients be brought back for elective care on a risk based approach to priority over length of waiting time.
494/20	The Chief Operating Officer noted that the risk based approach would involve a number of elements developed within the organisation but also provided by NHSE and professional bodies. There had already been time spent on developing a risk based approach for the highest level risk patients, as the Trust move progressively to the lower risk patient this would enable a scoring system to be tested and put in place. Work would continue alongside NHSE

	and an understanding of how the services might be run would form part of the recovery phase.
495/20	Dr Gibson asked what features of the current response the Trust would look to retain, considering the e-consultations that had been put in place, the significant change to discharge and the more proportionate level of patients in the emergency department. There had been an increase in capacity resulting in more flexibility.
496/20	The Chief Operating Officer noted that the introduction of technology in clinical work and for e-consultations had been receiving positive feedback from staff and patients. This had reduced the burden on patients attending hospital but gave the opinion required to move to the next stage of the treatment journey.
497/20	The lesser demand seen had not been entirely positive, whilst this had resulted in the ability to be flexible in response to Covid-19 and provide high standards of care, some patients had not attended hospital when they should have done. There had been media campaigns undertaken to encourage attendances. There were ongoing conversations with the CCG and wider system in order to find a suitable alternative for those patients going forward.
498/20	The Chair sought assurance that plans were in place to respond to a second peak should this occur when the lockdown was lifted, particularly in respect of the impact of the additional population visiting the east coast.
499/20	The Chief Operating Officer advised that the scenario described would see the use of the developed surge plan to respond. There was an ongoing dialogue with the local resilience forum and wider system in order to try to prevent such an event as people returning to normal behaviours during the summer. The Trust were well prepared to respond to a surge event.
500/20	Mr Hayward, through the Chair, asked what specialties, other than cancer services would be prioritised to bring patients forward.
501/20	The Chief Operating Officer stated that the restoration phase described the responses being put in place, this included those clinically urgent services that would be needed to prevent harm to patients.
502/20	The Chief Executive offered thanks to Executive colleagues for the considerable effort throughout the incident. One of those areas to lock in following the incident would be the way in which both the Executives and the whole organisation had worked. There had been an exemplary effort from colleagues during the response to the pandemic.
503/20	The Chair also recorded appreciation and that of the Non-Executive Directors, thanking the Chief Executive for the leadership of the team and the Executives for the work undertaken in control of the command centre and enacting the leadership decisions taken.
504/20	Support would need to continue for staff in the long term and there would need to be a risk based approach to calling patients back in to services.
505/20	The Board were clear that the Trust were open for business and that it was a duty to provide confidence to members of the public that they could attend the hospitals when needed and would receive great care. The Trust Board: • **Received the report**

506/20	**Item 9 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 24 April 2020 meeting, the meeting, following national and Board guidance had taken place with a truncated agenda.
507/20	The Committee had received an update in relation to Infection Prevention and Control (IPC) noting that this was an important issue that the Trust needed to be confident around. Having previously had a visit from NHS Improvement prior to the Covid-19 outbreak the Trust were aware that more work needed to be done.
508/20	Through the Director of Nursing leadership the Committee were looking to continue to develop the work on the action plan in response to the NHSI findings whilst providing a focus on Covid-19. Additional resource was being brought in to respond to both the immediate and ongoing work, the Committee were encouraged to see the progress.
509/20	The Committee had considered their work programme to ensure sight was not lost on some of the important business, some of this would form part of the restore response to the pandemic. A number of normal business updates were received.
510/20	A detailed report was received in relation to Covid-19 and the Board were reminded that the Committee were looking at the Quality Impact Assessment process, an update had been received and future reports would be brought to the Committee.
511/20	The Committee noted that there was some progress of work in response to the CQC actions this had clearly slowed during the pandemic however sight had not been lost. There had been some progress on the action plan and the Committee would continue to receive monthly updates. Consideration had been given to accelerating some of the programmes of work should the Trust now be over the peak of Covid-19. These programmes of work would be embedded in to the normal methods of working across the Trust.
512/20	The Committee had received the risk report and taken the opportunity to review the risks and incident management in detail. Questions regarding duty of candour had been raised which had been probed in detail.
513/20	The Committee would continue to meet on a monthly basis in order to provide assurance to the Board. The Trust Board: • **Received the assurance report**
514/20	**Item 10 Integrated Performance Report** The Chair noted that the Board had received the March 2020 report and that the Quality Governance Committee had received some of the quality performance within the report that was the current main priority. Assurance had been received by the Board earlier in the meeting that the finance position was being carefully monitored.
515/20	Dr Prior, through the Chair, sought confirmation of the rejected status of patients and what action was being taken in relation to the referral to treatment 18 weeks incomplete.
516/20	The Chief Operating Officer advised that there was an agreement in place to use independent sector capacity in Nottingham and the East Midlands. As part of this work a triage system

	was put in place that identified those within the greatest risk category. These patients would receive treatment at the BMI hospital in Nottingham due to the ability to offer protected non-covid critical care services. The rejected patients were those where it was felt that they could be treated in a different way and managed in Lincolnshire hospitals. These patients would be placed on to the Trust waiting lists.
517/20	The Chair requested that the Director of Nursing provide context in relation to the falls data.
518/20	The Director of Nursing advised that there had been a fall resulting in death in the last month. The incident was a female patient being cared for in the hospice at Grantham. Oversight of the incident had been taken by the Director of Nursing and would continue through the process. The outcome of the report would be presented to the Quality Governance Committee in due course.
519/20	Mrs Libiszewski sought clarity regarding the number of never events presented in the report and it was felt these did not reflect the numbers discussed through the Quality Governance Committee.
520/20	The Medical Director advised that due to the reporting period the most recent never event had been reported on STEIS on 30th January 2020 however this had occurred earlier. The reason for the delay of reporting was due to discussions with the Clinical Commissioning Group and the need to report the event as a never event. This did not strictly meet the criteria for a never event however the Trust were advised to report in this manner.
521/20	Mrs Ponder sought assurance that the Trust had efficiently used the resources available given that the number of Covid-19 patients had fallen significantly short of the predicted numbers.
522/20	The Director of Finance and Digital noted that the Trust had efficiently used the resources available and noted that there was further work to be undertaken as the financial position was reviewed. This would allow the Trust to understand the direct impact and analyse further the detail, this would be presented back to the appropriate forum prior to presentation to the Board.
523/20	The Chief Operating Officer advised that the Trust had been asked to make preparations in response to the pandemic including the creation of a great deal of spare capacity for the rapid increase in demand. The increase was seen but the demand did not happened. Regionally and nationally there was 50% capacity of general care adult beds as part of the preparation.
524/20	The Medical Director advised that the reality was that the clinical capacity had not been used and in respect of the resource this had not been fully utilised however this needed to be viewed in the round. The Trust had been able to develop new practice much more quickly, including the use of telephone consultations and had been able to improve the understanding of clinical teams and how others worked. Going forward the benefit would be considerable. It was not what had been expected but it had resulted in the Trust being in a better place moving forward, allowing the Trust to provide more efficient services.
525/20	The Director of People and Organisational Development noted that a significant number of clinical and non-clinical staff, where they were no longer undertaking normal duties, had been redeployed to support Covid-19 activities. The workforce had been shifted in order to ensure that the resource was being utilised. The Trust Board: • **Received the report**

	Item 11 Risk and Assurance
526/20	**Item 11.1 Risk Management Report** The Medical Director presented the report to the Board noting that due to the Covid-19 pandemic and the response the nature of the risks had changed considerably, these changes were captured within the report.
527/20	Appended to the paper for the information of the Board was the new quality impact assessment and risk assessment process. The Chair noted that the appendices had been helpful in order to understand the process being applied to service changes.
528/20	Risk 4558 – Local impact of the global coronavirus (Covid-19) pandemic was the highest risk to the Trust. There were a significant number of mitigating actions being taken and the risk was currently rated at 25.
529/20	The Board agreed that the risk register reflected the current risks faced by the organisation and that all actions and mitigations were relevant and appropriate. The Trust Board: • **Received the update** • **Accepted the top risks within the register**
530/20	**Item 11.2 Board Assurance Framework Year End 2019/20** The Chair noted that the Board Assurance Framework 2019/20 had been reviewed by Executive and Non-Executive Directors.
531/20	Disappointment was noted that ratings had not progressed from red by year end however this reflected the challenging environment that the Trust had been in over the previous 12 months. The Board acknowledged that objective 2a – Have 'zero waits' to access our services, had improved to amber. This reflected the work undertaken within the organisation. The Trust Board: • **Received and closed the Board Assurance Framework 2019/20**
532/20	**Item 11.3 Board Assurance Framework 2020/21 – Covid-19** The Chair advised that the draft Board Assurance Framework for 2020/21 presented to the Board had been produced in response to Covid-19 and was focused around the Trust's response.
533/20	It was recognised that this would need to be revised as the Trust moved in to the restoration and recovery phases of the response.
534/20	The current document was a representation of the current position in dealing with the strategic objectives. The strategic objectives had not changed regardless of moving in to a different operating environment from when they were first drafted.
535/20	The strategic objectives had been reviewed and updated to take in to account the impact of the pandemic. The Trust Board: • **Received the Board Assurance Framework 2020/21**

536/20	**Item 12 Any Other Notified Items of Urgent Business** The Chair expressed appreciation to the staff within the organisation in their response to the pandemic. There was more work to do around how the Trust shaped itself in order to respond to the changes and demands on services that would continue to be provided to the highest quality.
537/20	The Chair welcomed feedback from members of the public who had observed the first live streamed public Board meeting.
	The next meeting will be held on Tuesday 2 June 2020, arrangements to be confirmed taking account of national guidance

Voting Members	**7 May 2019**	**4 June 2019**	**2 July 2019**	**6 Aug 2019**	**3 Sept 2019**	**1 Oct 2019**	**5 Nov 2019**	**3 Dec 2019**	**4 Feb 2020**	**3 Mar 2020**	**7 Apr 2020**	**5 May 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	X
Geoff Hayward	A	X	X	X	A	X	X	X	X	X	X	A
Gill Ponder	X	X	X	X	A	X	X	X	X	X	X	X
Jan Sobieraj	X	X										
Neill Hepburn	X	X	X	X	A	X	X	X	X	X	X	X
Michelle Rhodes	X	X	A	A	X							
Kevin Turner	X	X	X	A								
Sarah Dunnett	X	X	X	A	X	X	X	X	X	X	X	X
Elizabeth Libiszewski	X	X	X	X	X	A	X	X	X	A	X	X
Paul Matthew	X	X	X	A	X	X	X	X	X	X	X	X
Andrew Morgan			X	X	A	X	X	X	X	X	X	X
Victoria Bagshaw						X	X	X	X			
Mark Brassington						X	X	X	X	X	X	X
Karen Dunderdale										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~~ 02/04/2020	Deferred due to Covid -19
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	Audit Committee reviewed actions in Jan meeting. Review again at July 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	Due to FPEC in January. Report back to TB Feb Further work ongoing. To be presented to next FPEC date to be confirmed.
4 February 2020	049/20	Integrated Improvement Plan	Board to receive IIP programme of delivery, identifying how changes would be maintained and embedded	Brassington, Mark	05/05/2020	Review underway of all IIP PIDs to confirm how they will be revised to continue.
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	Deferred due to Covid-19. To be prepared when Int Audit review completed.

PUBLIC TRUST BOARD ACTION LOG

Agenda item: 6

3 March 2020	326/20	Assurance and Risk Report Workforce and Organisational Development Committee	Consideration of shortening of medical e-rostering timescale implementation and efficient use of resource	Rayson, Martin	~~07/04/2020~~ 07/07/2020	Dir of People &OD to progress. To advise Board of position July 2020
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
3 March 2020	353/20	Freedom to Speak Up Quarterly Report	Review other Trusts data to consider how greater assurance could be provided	Freedom to Speak up Guardian	07/07/2020	
7 April 2020	410/20	Covid-19	Develop proposal for reporting to Quality Governance Committee re QIAs, patient harm and waiting list impact	Evans, Simon/Dunderdale, Karen	14/04/2020	Report received at QGC meeting 21/04/20 Captured in upward report. Complete
7 April 2020	427/20	Risk Management Report	Develop and further capture oversight by Gold Command to ensure audit trail in place	Hepburn, Neill	05/05/2020	Complete
7 April 2020	429/20	Risk Management Report	Existing risks to be updated in response to the impact of Covid-19	Hepburn, Neill	05/05/2020	Complete
7 April 2020	436/20	Board Assurance Framework 2020/21	Develop a streamlined BAF including a separate Covid-19 objective	Warner, Jayne/Geddes, Cathy	14/04/2020	Complete
7 April 2020	437/20	Board Assurance Framework 2019/20	Circulate 2019/20 BAF to Committee Chairs for review prior to final sign off by Board	Willey, Karen	05/05/2020	Agenda Item. Complete

Title:	ULHT Covid-19 Restore Phase Plan – Executive Summary
Date:	2 June 2020

Author/Responsible Director: Simon Evans, Chief Operating Officer

Purpose of the report:

To provide summary of United Lincolnshire Hospitals NHS Trust response to the Covid-19 pandemic during the *Restore* phase.

The report is provided to the Board for:

Decision		Discussion	√
Assurance	√	Information	

Summary/key points:

This paper provides a summary of the Trust's response to the Covid-19 pandemic during the Restore Phase including high level descriptors of plans for Urgent and Emergency Care (UEC), cancer, elective care, maternity diagnostics and screening services.

The Restore phase will require step up of non-Covid-19 urgent care services as soon as safe to do so. Emphasis of the plan is on a safe restart with full attention to Infection Prevention & Control (IPC) as the guiding principle.

In addition, some elective care should be restarted based on the same IPC guiding principle but with priority being on cancer care and more urgent non-cancer elective care.

Beneficial changes that have been developed in the Manage phase should be 'locked in' and following assessment of risk, quality and equality impact should be continued on a more permanent basis.

The Trust is on standby and ready to deploy surge plans that were tested during the initial Manage phase of the pandemic response. Although these are not expected to be

deployed they are aligned to scenario plans and teams are briefed and prepared, should the need to deploy a surge response be required.

After regional review with regulators, the Trust remains well placed for restoring essential services, with some services already in place and functioning well. Some detail on the full restoration of surgical services is not yet available as options are developed. It is expected that these options will be ready to authorise and mobilise in early June.

Recommendations:

The Board are asked to accept this update, noting the nature of the current national level 4 incident, the nature of frequent new guidance and requirement for all plans to be flexible and responsive.

Strategic risk register	**Performance KPIs year to date**
Covid-19 Strategic Risk	All Standards

Resource implications (e.g. Financial, HR) Resource Implications are in line with authorisation SFIs and Covid19 operating parameters.

Assurance implications
This plan is a key component of the Trust's overall Covid-19 pandemic response campaign strategy, previously presented.

Patient and Public Involvement (PPI) implications In line with National Level 4 response, national guidance and PPI implications issued.

Equality impact Equality Impact Assessments are conducted on significant changes within the authorisation/governance system in place from the outset of the Covid-19 Level 4 Pandemic

Information exempt from disclosure No

Requirement for further review? Yes, further update to be provided July

1 Background

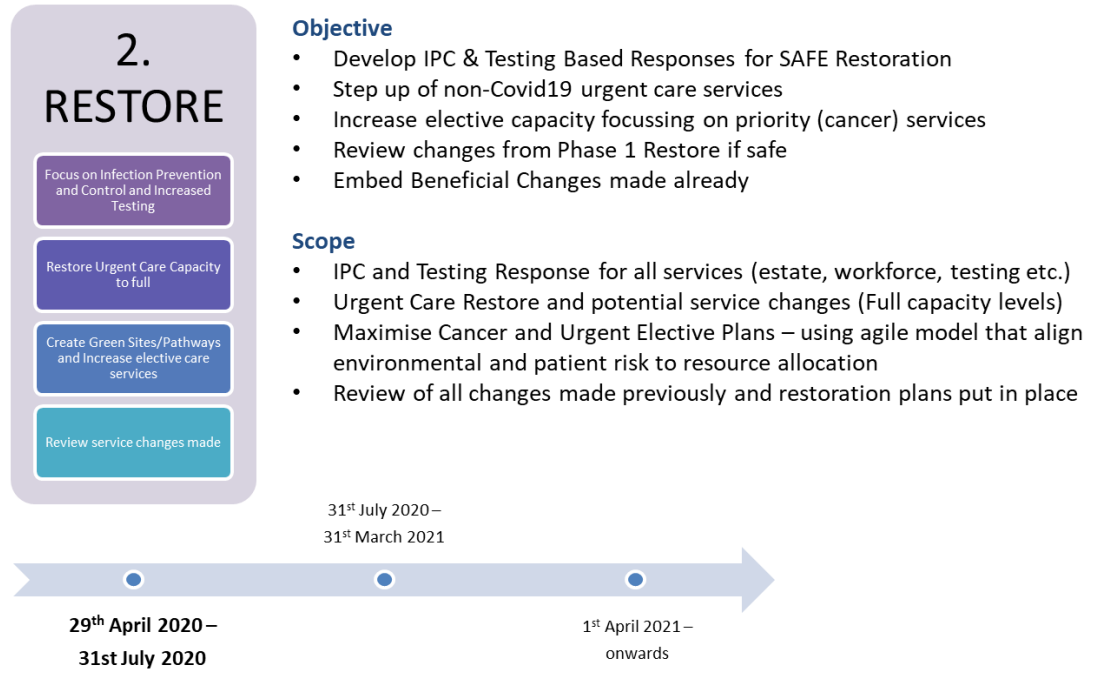
On 30 January the first phase of the NHS's preparation and response to Covid19 was triggered with the declaration of a Level 4 National Incident. At the same time Covid19 was confirmed as a High Consequence Infectious Disease (HCID) and the UK risk level was raised from moderate to high. On 3 March the Department of Health and Social Care issued the Coronavirus action plan; a guide to what you can expect across the UK. This reflected the strengthened legal powers announced by Secretary of State for Health and Social Care.

As NHSEI created national and regional Incident Command Centres (ICCs) and Incident Management Teams (IMTs) all trusts were tasked with enacting their own major incident plans and creating similar structures, 7 days per week and at a minimum 12 hours per day.

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

- Save Life
- Prevent Harm
- Protect the NHS

2 Restore Phase



2.1 Objectives:

The *Restore* phase will require step up of non-Covid19 urgent care services as soon as possible. This must be a safe restart with full attention to Infection Prevention & Control (IPC) excellence as the guiding principle. In addition, some elective care should be restarted based on the same IPC guiding principle but with priority being on P2-P3 cancer care and more urgent non-cancer elective care.

Beneficial changes that have been developed in the *Manage* phase should be 'locked in' and where necessary authorisation should be given to continue on a more permanent basis.

2.2 Timescales:

The *Restore* phase will take place from 28th April for a period up to 31st July 2020. As a Trust with comparatively less impact of Covid19 ULHT is well placed to restore many services to appropriate capacity swiftly.

2.3 Scope:

With planning complete on how and when surge responses could be put in place, the current position faced by the Trust and nationally is that the initial wave of Covid19 demand is subsiding. All modelling suggests that whilst subsiding, Covid19 will be a disease that will be in general population for many more months. During this phase focus will be heavily on infection prevention and control measures as well as use of testing services to create optimum levels of protection for patients and staff. Emphasis will be placed on the safe restoration of services and not to create additional risks to patients and staff.

3 Review of service changes

As part of the *Restore* plans the Trust has conducted a review of all service changes that have taken place during the Manage phase and considered those that could be safely reinstated or kept in place temporarily. These changes have been individually assessed for risk, quality and equality impact through the authorisation process previously described in the *Manage* phase. Sections 6 onwards in this report describe at a high level the approach being taken.

The table below identifies the level of restoration of service anticipated by the end of June 2020. ULHT plans alongside system restoration activities have been reviewed with regional regulators NHSE/I and assumptions tested to ensure that services are being safely restored.

Although many services are indicated at 100% levels it is important to note that these services make reference to essential services and do not include all services. Furthermore where services are described at less than 100% this will be in reference to services that contain a mixture of essential and routine services. Vascular services for example have both essential (urgent) services as well as planned routine services. It is these routine services that may not be in place by the 30th June, although they will feature in future *Recovery* plans.

Service	Anticipated Level of Service to Meet Demand by 30th June 2020	Comments
Neonatal Intensive Care	Delivering 100% Pre-COVID-19	
Adult Critical Care (for non COVID-19 indications)	Delivering 100% Pre-COVID-19	
Cystic Fibrosis	Delivering 100% Pre-COVID-19	Utilisation of technology enabled care - telephone, in line with NUH model of care delivery
Cardiac (Cardiology)	Delivering 50% Pre-COVID-19	Urgent cardiology services maintained, routine elective services to be increased through recovery phase

Specialised surgery in children	Delivering 75% Pre-COVID-19	Emergency surgery sustained 100%, limited elective through Restore phase
Paediatric medicine	Delivering 100% Pre-COVID-19	Utilisation of technology enabled care - telephone
Specialised gynaecology services	Delivering 75% Pre-COVID-19	Full cancer unit service 100%, OP utilisation of technology enabled care - telephone
Vascular Services	Delivering 50% Pre-COVID-19	Urgent servcies maintained in line with Vascular Society guidance, increasing activity into the Restore phase in line with surgical prioritisation guidance
Specialised Neuro-rehabilitation	Delivering 100% Pre-COVID-19	Level 2 unit fully operational
2WW Referrals	Delivering 75% Pre-COVID-19	
Cancer diagnostics	Other - See Comments	Diagnostics is split mainly between Radiology (high volume and continued service) and Endoscopy (lower volume, stopped due to COVID), so overall figure would hide variation. Level of activity still subject to national governing bodies advice (eg JAG) and referral volumes.
Cancer treatment	Delivering 100% Pre-COVID-19	
Delivery of urgent chemotherapy.	Delivering 75% Pre-COVID-19	
Delivery of time critical chemotherapy.	Delivering 100% Pre-COVID-19	
Urgent radiotherapy?	Delivering 100% Pre-COVID-19	
Time critical radiotherapy?	Delivering 100% Pre-COVID-19	
Urgent outpatient appointments at pre-COVID-19 levels.	Delivering 100% Pre-COVID-19	
Urgent diagnostic appointments (including direct access diagnostics available to GPs)	Delivering 100% Pre-COVID-19	
Capacity for cardiology services for PCI and PPCI	Delivering 100% Pre-COVID-19	
Secondary care capacity for urgent arrhythmia services plus management of patients with severe heart failure and severe valve disease.	Delivering 100% Pre-COVID-19	Urgent service maintained fully
Capacity for stroke services for admission to hyperacute and acute stroke units, for stroke thrombolysis and for mechanical thrombectomy.	Delivering 100% Pre-COVID-19	Implementation of temporary hub and spoke model, with all hyper-acute admission to Lincoln site, will be maintained for Restore phase to maintain safe medical provision

4 Infection Prevention and Control Approaches

The Trust will establish green (the term used for non-Covid) pathways/sites for cancer and elective surgery and non-surgical procedures. These pathways will be distinct from blue (the term used for suspected/potential or confirmed Covid) activity and based on the principles of ensuring the highest standards of IPC: minimising the risk of cross-infection, focused on environmental changes, hygiene, social distancing, screening and segregation of staff and patients.

5 Patient and staff testing

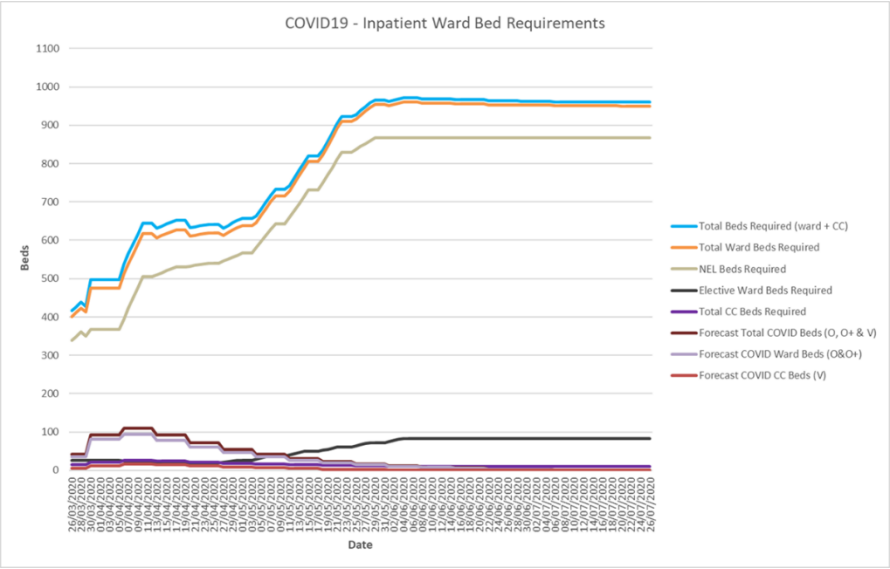
All patients undergoing cancer or elective surgery will be advised to self-isolate for 14 days prior to procedure and will be tested 48-72 hours prior. Patients testing positive will be rescheduled within a clinically appropriate timeframe and advised to follow the self-isolation pathway. Staff screening and testing will be managed by the Occupational Health Staff Testing Cell. Our approach to staff testing will continue in line with PHE guidance, including the adoption of the new antibody tests released in recent weeks. Full detail of how, and the level of testing will take place is still being developed.

6 Urgent and routine surgery and care

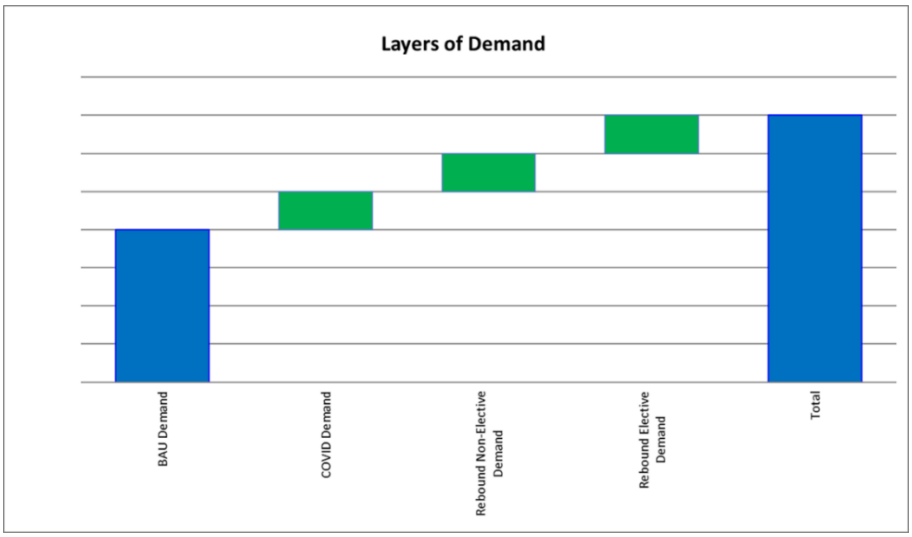
6.1 Urgent and emergency care:

The Trust's urgent and emergency care (UEC) activity has sharply reduced during the *Manage* phase with non-elective admissions at 42% of pre-pandemic average activity. This is likely to a combination of factors including changed healthcare seeking behaviour, reduced incidence of some presentations such as trauma and road traffic accidents and some care being provided through alternative routes.

Current local UEC demand modelling forecasts non-elective admissions to increase by 13.6% per week up to a normal level by the end of May. On to this we must factor a greater bed base requirement due to site configurations to maintain Covid cohort wards and distinct green pathways.



Scenarios have been developed that consider the potential "rebound" of increased demand on urgent care service generated by delayed attendance, deterioration due to delay in seeking medical assistance and postponed activity.



Plans for restoration therefore include scenarios that would utilise surge capacity responses in line with this timeframe should it be required.

6.2 Urgent outpatients and diagnostics:

The Trust continues to provide outpatient consultations for cancer and urgent patients utilising telephone and VC as default to reduce the risk of cross-infection, only offering face to face appointments where clinically required. We will continue to scale up our use of technology-enabled care at pace.

Currently circa. 50% of the Trusts maintained outpatient activity is being conducted over the telephone. This will increase further as more clinicians return to outpatient rotas and resume outpatient activity. The Trust offered VC appointments for the first full month in April and is planning to increase uptake of this at pace through the *Restore* phase.

Therapy outpatient services will ensure urgent patients have access to appointments through new referral triage and prioritisation, maximising the use of telephone and VC consultations, providing face to face clinic appointments only where clinically required following a risk assessment, and ensuring social distancing measures are in place.

The Trust continues to ensure access to urgent diagnostics in line with PHE and national body guidance whilst restoring diagnostics services for long wait patients where safe to do so.

Diagnostics have previously not been ring-fenced for cancer, in line with NHSEI best practice as issued at NHS Midlands & East Cancer Collaborative seminars. However, booking of cancer patients has always been given priority. Currently all diagnostics access is protected for emergency and cancer activity and this will continue. There is in place, the capacity to scan all current and forecast cancer and emergency patients, but not routine and direct access. Throughout the Covid period the Trust has consistently delivered 90-95% access within 7 days.

Endoscopy services nationally are guided by the British Society of Gastroenterologists (BSG) and Joint Advisory Group on GI Endoscopy (JAG) and plans will continue to adhere to their recommendations as and when these change. Endoscopy procedures are considered Aerosol Generating Procedures and current guidance requires significant change in practice that in turn impacts on capacity of the service. Specifically, the additional IPC controls and cleaning time required between patients. Current endoscopy capacity is reduced by 70% of normal activity. Demand management pathways for upper GI and lower GI introduced during the *Manage* phase are proving successful. The Trust continues to monitor and report weekly referrals, performance against DM01 standards and 7 & 10 day cancer standards.

6.3 Urgent surgery and non-surgical procedures:

The Trust will ensure sufficient capacity for urgent and time critical surgery and non-surgical procedures using Royal College of Surgeons (RCS) advice on surgical prioritisation. Green pathways will continue to be used however these pathways are currently extremely limited with mostly Level 2 and 3 (critical care level) surgical activity continuing through green pathways on Lincoln and Pilgrim sites. Restoration plans continue to be developed to increase surgical capacity by circa. 50% from June through the utilisation of additional theatres, extended operating sessions and 7-day working, amongst other strategies. Described in more detail later in this report, the Trust anticipates the use of Independent Sector capacity in Lincoln and Boston with much smaller elements in Nottingham. This will supplement the planned care green pathways in place at Boston and Lincoln.

6.4 Prioritisation and risk stratification:

The approach taken to prioritising elective care is based on clinical risk with the highest priority being cancer treatment, followed by clinically urgent, time critical non-cancer treatment. Only the appropriate levels of capacity for urgent groups across all specialties is in place the process of restarting routine electives will commence. Clinicians across all specialties are risk stratifying high risk patients and ensuring appropriate ongoing care plans are delivered.

6.5 Independent Sector Support:

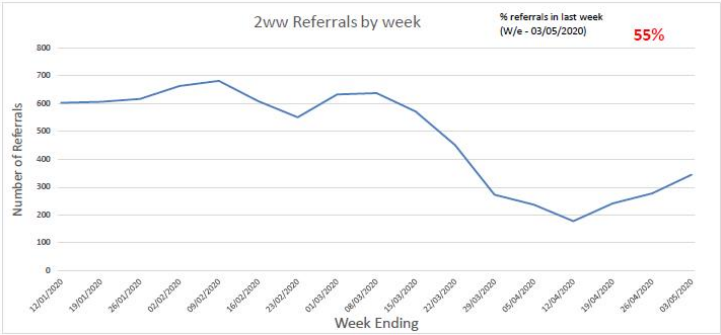
The Trust will seek to make full use of NHS contracted independent sector hospitals in order to increase capacity available to treat cancer and elective long waits.

The system is contacting local Independent Sector providers on a regular basis to understand any surplus capacity by specialty available in the short term. This will be cross-referenced against known pressure points and long waiting patients. As an example, there are a cohort of long waiting patients for General Surgery and ENT which would be suitable for transfer into the independent hospitals. Priority will be given to urgent patients and long waiting patients first. The system is also requesting access to the weekly IS activity returns to understand activity and capacity opportunities. Activity levels are currently being scoped once capacity is understood.

7 Cancer

The Trust has maintained access to essential cancer surgery and other treatment throughout the pandemic in line with national guidance and in collaboration with the regional Cancer Alliance and provider partners. This will continue to ensure delivery of cancer surgery and treatment, making use of our independent sector contracts and local diagnostic capacity. Urgent action was taken in *Manage* phase to ensure the provision of 2WW appointments at pre-Covid-19 levels, using protected pathways.

Cancer referrals from MDT have significantly reduced during the *Manage* phase and it is anticipated that there will be an increase in 2WW clinic and oncology demand during the *Restore* phase. Monitoring of referrals and specialty activity continues and plans for cancer treatment capacity are adjusted accordingly.



Current available 2WW capacity is 100% of pre-COVID capacity but has not been required due to reduced demand. No 2WW capacity has been withdrawn during COVID, supported by use of technology enabled care (telephone, VC). May 2020 14-day performance is at its highest point since November 2017.

Oncology new and follow up outpatient clinic capacity has been maintained and will continue through the *Restore* phase through the adoption of telephone and VC clinics, with face to face appointments provided for patients requiring physical examination.

All chemotherapy clinics, except combined RT/chemotherapy regimens, are now being provided within a green pathway through Grantham District Hospital site and from the mobile unit delivering clinics from Skegness and Spalding, with a further mobile clinic planned to commence from Louth.

Radiotherapy will continue to be delivered from Lincoln County Hospital at reduced capacity to support social distancing and the safety of patients and staff. Demand management protocols are in place based on senior specialist clinician decision making in order to optimise utilisation of the available capacity and facilitate timely access to treatment.

8 CVD, heart attacks and stroke

Capacity is prioritised for acute cardiac interventions and cardiology services, urgent arrhythmia services, severe heart failure and valve disease. Stroke service capacity remains unchanged offering 24/7 access to thrombolysis and 7-day access to TIA Services.

The majority of elective cardiology operating ceased at the end of March with only PPCI and urgent elective device procedures continuing, alongside urgent echo diagnostics to support the cancer pathway. Waiting lists have not grown significantly due to the lack of other diagnostic testing being undertaken in cardiology during the *Manage* phase. The Trust has in place robust monitoring of current urgent, time critical and routine cardiology demand.

On 31 March, in order to maintain capacity, the Trust's stroke pathway was revised to a hub and spoke model, supporting a single consultant on call rota. All Hyper-acute strokes are currently conveyed to and received by our Lincoln site. Patients who self-present to our Pilgrim Hospital site showing symptoms of stroke are transferred to Lincoln. Robust monitoring and weekly reporting to Gold Command of stroke ambulance conveyance and admission activity is in place. This pathway will continue during the Restore phase while being under continual review.

9 Maternity

The Trust will ensure direct and regular contact with all women receiving antenatal and postnatal care, clearly explaining how to access scheduled and unscheduled care and reassuring women of the safest place to receive care. Our obstetrics units will be appropriately staffed including anaesthetic cover.

On 24 March, the Trust issued an interim standard operating procedure (SOP) for the management of Covid-19 in maternity services in line with RCOG guidance along with a minimum antenatal and postnatal pathway. This pathway included a reduction in face to face appointments for low risk women, special consideration of high risk and safeguarding concerns, and a temporary suspension of the home birth service.

Review of antenatal and postnatal appointments for low risk women will continue to reduce unnecessary face to face contacts, while our SOP for high risk women and safeguarding concerns will remain in place. This is in line with Royal College of Obstetrics and Gynaecology and Royal College of Midwifery advice. The home birth service was restored from 18 May 2020.

10 Screening and immunisation

The Trust will prioritise making screening services available for the recognised highest risk groups as identified in individual screening programmes. An increase in the delivery of diagnostic pathways initially focused on backlog clearance of those already in an active screening pathway will take place in the *Restore* phase.

10.1 AAA screening:

The AAA screening programme stopped screening on 16 March 2020 in line with PHE and Vascular Society guidance due to the assessed high risk to a vulnerable patient group. This has resulted in the Trust cancelling circa. 1000 screening appointments. All patients cancelled and all affected surveillance patients have been kept informed to enable full disclosure and ease stress surrounding their diagnoses. At the end of 2019, PHE approved the Lincolnshire AAA screening programme to start the 2020/21 cohort early on 7 January. This decision has supported restoration as the Trust was able to complete over 700 scans of this new cohort before the pandemic started in the UK – a significant proportion of the activity cancelled during the *Manage* phase.

10.2 Bowel screening:

The bowel cancer screening programme remains suspended nationally and the Trust continues to follow guidance set out by JAG and BSG. The Trust has a robust risk stratification process in place, patients are being closely monitored and, where intervention is required, patients are being referred accordingly.

10.3 Breast screening:

The breast screening service is currently suspended in line with national guidance. The high risk service is provided by Nottingham University Hospitals through a service agreement and this service has resumed.

10.4 Diabetic eye screening:

The DES programme stopped the majority of screening on 20 March due to the assessed high risk to this vulnerable group. Patients identified as at clinical risk have continued to be screened.

10.5 Newborn hearing screening:

Our Newborn Hearing Screening Programme will continue to be maintained. Outreach clinics were suspended from 1 April due to insufficient staffing availability and following PHE guidance. Since, parents have been offered screening for their babies while still an inpatient. We recognise the importance of maintaining the NHSP due to its time criticality and plan to re-instate outreach clinics at the earliest opportunity.

Agenda Item

United Lincolnshire Hospitals NHS Trust

Report to:	Trust Board
Title of report:	Quality Governance Committee Assurance Report to Board
Date of meeting:	19th May 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 2019/20 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: Delivering harm free care **Work Programme and ToR** Draft terms of reference and a work programme were received by the Committee that reflected the Integrated Improvement Plan. The work programme detailed all key Committee business and the route through which assurances would be received against each strategic priority. The Committee were advised that the Quality and Safety Oversight Group had been removed resulting in sub-groups reporting directly in to the Committee via upward reports. The Committee noted that there was no specific reference in either document regarding reporting for the divisions or maternity and children's services and requested consideration of this within the terms of reference and work programme. **Performance Dashboard** The Committee noted that the dashboard presented was limited but that improvements were being seen. Assurances were given regarding significant work being undertaken to address c-difficile concerns on Dixon Ward. Further work would be required to ensure ReSPECT and advanced care planning was in place in the community.

	Quality Account The Quality Account was presented to the Committee, it was noted that there had been an extension on the publication date however it was agreed that the account would be published in line with the original publication date, 30 June. The Committee agreed the inclusion of Infection, Prevention and Control in to an existing priority due to the current focus on improvement within the Trust. **COVID-19** The Committee received a verbal update and were advised that the Trust had now moved in to the restore phase of the incident which was being led by the Divisional Managing Director for Surgery with contribution from the Infection, Prevention and Control teams. The number of Covid-19 positive patients and staff continued to reduce and there was now a resurgence of acute patients. Steps were being taken to reinstate all cancer services. Consideration was being given to Covid-19 becoming part of the business as usual for the Trust and how it would affect patient pathways and ways of working for staff. **Mortality** The Committee were advised that in hospital mortality remained on target and that there was concern regarding the increase in crude mortality, possibly attributed to Covid-19 deaths. The Committee noted that both HSMR and SHMI would be affected by deaths caused by Covid-19. There had not yet been an agreed process for coding crude mortality in respect of Covid-19 and it would be difficult to benchmark once in place due to the affects Covid-19 had had on different Trusts. The Committee would receive a thematic review of mortality which identifies good practice and areas of learning. **Infection Prevention Control** The Committee received an upward report from the revised group where a new set of terms of reference had been approved and sought ratification by the Committee. The Committee requested that clarity be provided within the groups' terms of reference in relation to the duties and responsibilities of estates and facilities to ensure engagement with IPC. There would need to be clear direction in reporting to the Committee that did not duplicate reporting to the Finance, Performance and Estates Committee. The Committee noted the concern regarding the currently reported compliance with the hygiene code, this was under review and it was

	expected that the Trust would be partially compliant with the code, which is significantly different to previous reports. The Committee received the SOP in relation to the annual deep clean of wards alongside which there would be an enhanced ward refurbishment programme. **CQC** The Committee were advised that the CQC were supportive of a reduction in the burden of reporting and the Trust would propose a revised reporting schedule. The action plan continued to progress, with some actions being addressed, however activity would increase as the Trust moved through the restoration phase of Covid-19. The Committee discussed the progress of the development of the 2020/21 Clinical Audit plan noting that whilst local audits had been suspended, some national audits had continued. The Committee requested sight of the proposed plan and an indication of the recommencement of internal clinical audit.
	Assurance in respect of other areas: **Board Assurance Framework 2020/21** The Committee received the BAF that had been developed to reflect the impact of Covid-19 and noted that the concerns regarding testing needed to be incorporated. The Committee requested that reporting to the June Committee addressed the risk, control and assurance aspect of the framework in order that assurance ratings could be determined. The Committee would begin to use the BAF effectively in order to frame the meetings. **Risk Report** The Committee received the risk report noting that this continued to reflect the changes made as the Trust moved to the management phase of the Covid-19 incident. A new high risk had been added regarding critical care and the ability to obtain fluids for renal dialysis and pressure points for aesthetic drugs, these issues were both being managed nationally. As the Trust moves through the restore phase of the incident it was expected that there would be significant changes to the register due to the development of green sites and pathways. **Incident Management** The Committee noted that incidents remained static and received an

	update on Never Events including the outcome of the 10 reported in the last financial year. The Committee recognised the opportunity during the restore phase of being able to take action to reduce the likelihood of never events occurring. There would be a launch of the new safety culture within the organisation to support the required improvements. **Ethics** The Committee were advised that the first referral had been made and that advice on the case was being sought.
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 that updates to reflect COVID
Matters identified which Committee recommend are escalated to SRR/BAF	
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	J	J	A	S	O	N	D	J	F	M	A	M
Elizabeth Libiszewski Non-Executive Director	X	X	A	X	X	X	X	X	A	X	X	X
Chris Gibson Non-Executive Director	X	A	X	A	X	A	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
Michelle Rhodes/ Victoria Bagshaw Director of Nursing	X	X	X	D	X	X	X	X	X			

X in attendance A apologies given D deputy attended

NHS
United Lincolnshire Hospitals
NHS Trust

Meeting	Trust Board
Date of Meeting	*2 June 2020*
Item Number	*Item 9.1*
Protecting and Supporting BAME Patients and Staff through Covid 19	
Accountable Director	*Mark Brassington* *Director of Improvement and Integration*
Presented by	*Mark Brassington* *Director of Improvement and Integration*
Author(s)	*Tim Couchman* *Equality and Diversity 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	
2a A modern and progressive workforce	*X*
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	
Financial Impact Assessment	*N/A*
Quality Impact Assessment	*N/A*
Equality Impact Assessment	*Insert detail*
Assurance Level Assessment	*Insert assurance level* • *Moderate*

Recommendations/ Decision Required	• *Board to note actions taken to support BAME staff and patients during Covid 19*

OUTSTANDING CARE
personally DELIVERED

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NHS Trust

Protecting and supporting our Black, Asian and Minority Ethnic (BAME) patients and staff through COVID-19 – 26.05.2020

Mark Brassington
Director of Improvement and Integration,
Deputy Chief Executive and
Executive Sponsor of the BAME Staff Network

One team, many nationalities

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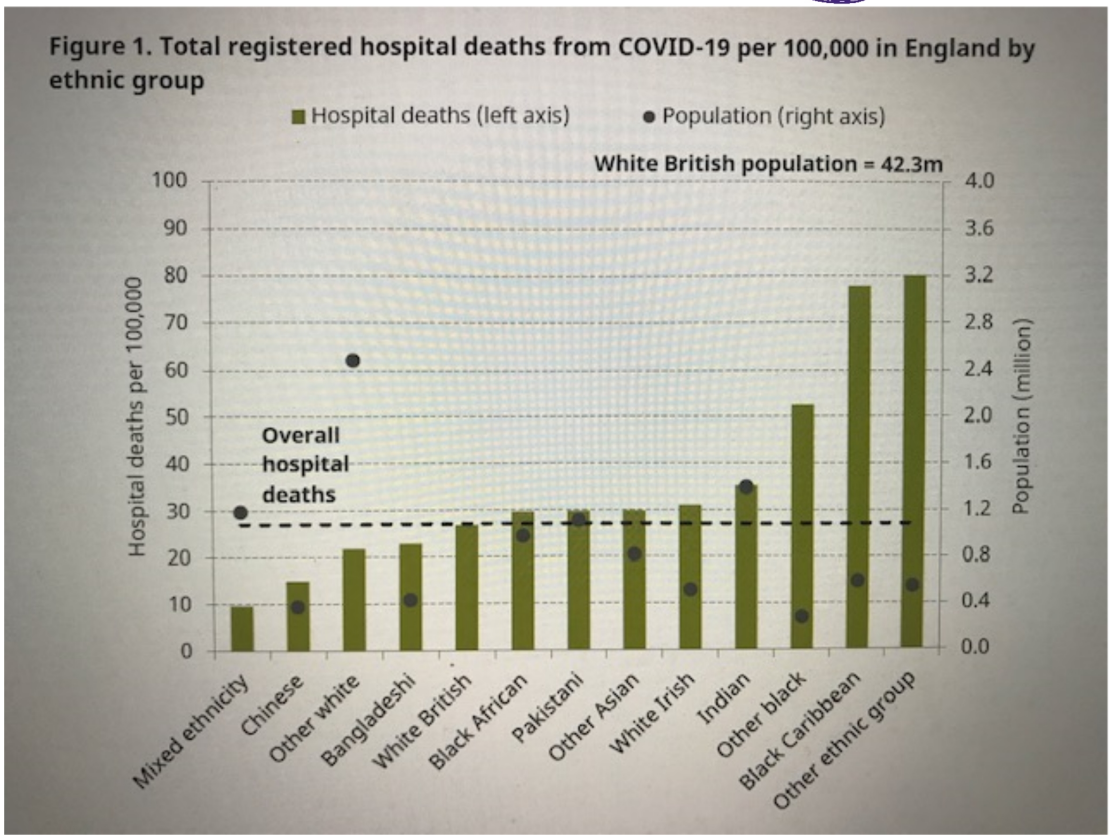
In our WRES submission 2019 11.56% of our staff declared as BAME.

In 2011 census 2.4% of Lincolnshire population BAME.

Disproportionate impact of COVID-19 on BAME people

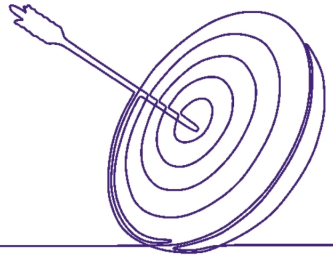
United Lincolnshire Hospitals NHS Trust



Please note further disproportion within BAME groups.

Source: Are some ethnic groups more vulnerable to COVID 19 than others/IFS Briefing Note / May 2020

Protecting and supporting our BAME population



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ULHT includes race in the COVID-19 sitrep recording:

- Testing
- Mortality

Lincolnshire's prevalence and mortality numbers are relatively low and are monitored for potential trends.

Testing numbers are much larger and an analysis template is being developed for appropriate system sharing, so that engagement with and support for community groups can be delivered at a system level.

Prevalence of COVID within our BAME staff is lower than that of non-BAME staff as at 25th May. This remains under review.

Protecting and supporting our BAME staff

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How are we supporting our BAME staff at this time?

Suite of staff support in relation to PPE, risk assessments, Occupational Health, psychological support and upholding social distancing whilst onsite or helping to work more flexible patterns.

In addition as we recognise our BAME staff are potentially more vulnerable

- CEO letter to all BAME staff (4 May 2020), confirming extra support by:
    * Completing a risk assessment for all BAME staff
    * Prioritising FIT testing for BAME staff
    * Offering testing to BAME staff every 14 days or as required

Risk Assessment Update

NHS
United Lincolnshire Hospitals
NHS Trust

52.75% completed (585 returns)

19% nil required

14% required detailed risk assessment

34% required detailed risk assessment and requested swabbing

33% requested swabbing

Outcome

4% Changed role

5% Shielding continued

49% Modified role

42% Continue as normal

Occupational Health working with divisions to complete all required risk assessments

Staff Testing Update

NHS
United Lincolnshire Hospitals
NHS Trust

13.68% (249) of staff tested reporting as positive up to 25th May

Of which;

-16.4% of non BAME staff tested are reported as positive – highest at PHB

- 8.8% of BAME staff tested are reported as positive – highest at PHB

To note;

Site differential likely to be driven by community prevalence

Unsure of the impact of the wider testing programme at PHB and BAME

43% of BAME staff swabbed

16.7% of Non-BAME staff swabbed

Engagement through the BAME staff network

United Lincolnshire Hospitals NHS Trust

Utilising engagement through regular meetings on MS Teams to support and develop the BAME staff network at pace.

Appointment of new interim leadership:

- ✓ Michael Oko, interim chair
- ✓ Saumya Hebbar, interim vice-chair

Developing wider leadership team to deliver tangible outcomes at pace, around the five NHSE/I pillars of:

* Protection
* Decision making
* Engagement
* Media & Comms
* Redesign

Next Steps

NHS
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NHS Trust

Workforce cell to ensure all risk assessments for BAME staff are completed

Workforce cell to monitor trend data and escalate as necessary

Trust Board asked to Note the progress

NHS
United Lincolnshire Hospitals
NHS Trust

To:	Trust Board
From:	Paul Matthew, Director of Finance & Digital
Date:	2nd June 2020

Title:	**Finance Report**

Author/Responsible Director: Paul Matthew, Director of Finance & Digital

Purpose of the Report:

To update the Board on the key Financial Performance issues at Month 12 including; revenue, capital and cash.

The Report is provided to the Board for:

Information		Assurance	
Discussion		Decision	

Summary/Key Points:

- To provide an update on the Month 12 revenue position including; delivery of the control total, access to FRF and PSF, Lincolnshire system support and the impact of Covid-19.
- To provide an update in respect of CIP delivery in year.
- To provide an update on the Month 12 capital position, including how this has been impacted by Covid-19.
- To provide an update on the year end cash position.

Recommendations:

The Board is asked to:

- Note the contents of the report and the year end reported positions for revenue, capital and cash.

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

1. Month 12 Financial Position

1.1 Introduction

1.1.1 The Trust's control total and financial plan for 2019/20 (excluding PSF, FRF and MRET) is a deficit of £70.3m.

1.1.2 Delivery of the financial plan for 2019/20 facilitates the Trust accessing £28.9m of PSF, FRF and MRET funding resulting in a planned deficit of £41.4m.

1.2 Financial Position at Month 12

	Current Month March 2020			Year to Date April 2019 - March 2020		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
Operating income from patient care activities excl Passthrough	32,643	55,619	22,977	389,070	424,972	35,903
Passthrough income	4,232	4,270	37	50,710	50,093	(618)
Other operating income	2,738	3,883	1,145	32,908	35,255	2,347
Employee expenses	(27,383)	(45,194)	(17,811)	(342,620)	(378,787)	(36,167)
Passthrough expenses	(4,232)	(4,270)	(37)	(50,710)	(50,093)	618
Operating expenses excluding employee expenses	(11,705)	(24,857)	(13,153)	(140,592)	(154,461)	(13,870)
OPERATING SURPLUS / (DEFICIT)	**(3,707)**	**(10,549)**	**(6,842)**	**(61,234)**	**(73,021)**	**(11,787)**
NET FINANCE COSTS	(841)	(915)	(74)	(9,106)	(9,175)	(69)
Other gains/(losses) including disposal of assets	0	0	0	0	26	26
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	**(4,548)**	**(11,464)**	**(6,916)**	**(70,340)**	**(82,170)**	**(11,830)**
Add back all I&E impairments/(reversals)	0	10,833	10,833	0	10,833	10,833
Remove capital donations/grants I&E impact	1	19	18	14	155	141
Adjustment to control total re Covid-19	(922)	0	922	(922)	0	922
Adjusted financial performance surplus/(deficit) excluding, MRET, PSF & FRF	**(5,469)**	**(612)**	**4,857**	**(71,248)**	**(71,182)**	**66**
MRET, PSF, FRF	3,256	3,252	(4)	28,928	28,928	0
Adjusted financial performance surplus/(deficit) including, MRET, PSF & FRF	**(2,213)**	**2,640**	**4,853**	**(42,320)**	**(42,254)**	**66**

1.2.1 The Trust's control total has been increased by £0.9m in relation to Covid-19.

1.2.2 The end of year position excluding PSF, FRF & MRET funding is a deficit of £71.2m, or £66k favourable to plan.

1.2.3 By delivering its' control total, the Trust was eligible to access all £28.9m of PSF, FRF and MRET funding, and report a Year End deficit of £42.3m or £66k favourable to plan.

1.3 Key movements

1.3.1 The Year End income position includes £21.3m of transitional support funding from the Lincolnshire commissioners. This support is cash backed with a formal contract variation. The transitional support funding is an informal acknowledgement of the significant increase in NEL activity being seen in Lincolnshire and the resultant pressure of this upon beds, elective targets, costs of delivery and ultimately the Trust financial position.

1.3.2 As requested by NHSE, the Year End position recognises £13.1m of notional income and expenditure in relation to additional pension contributions.

1.3.3 The Year End position includes £1.4m Covid-19 income following confirmation from NHSI that the Trust's revenue submissions in relation to additional costs and lost income were approved.

1.3.4 Whilst the Trust received no additional income to offset the cost of £922k in relation to annual leave carry forward as a result of Covid-19, the Trust's control total has been adjusted for the impact of this.

1.3.5 The APA protected the Trust's income position in relation to the reduction in activity in March, which is estimated to have fallen by c£5.5m.

1.3.6 Agency expenditure of £44.1m in 2019/20 was £23.1m greater than the Trust's agency ceiling.

1.3.7 The Year End deficit includes £10.8m of I&E impairment; I&E impairments are removed to deterimine actual performance in relation to the control total.

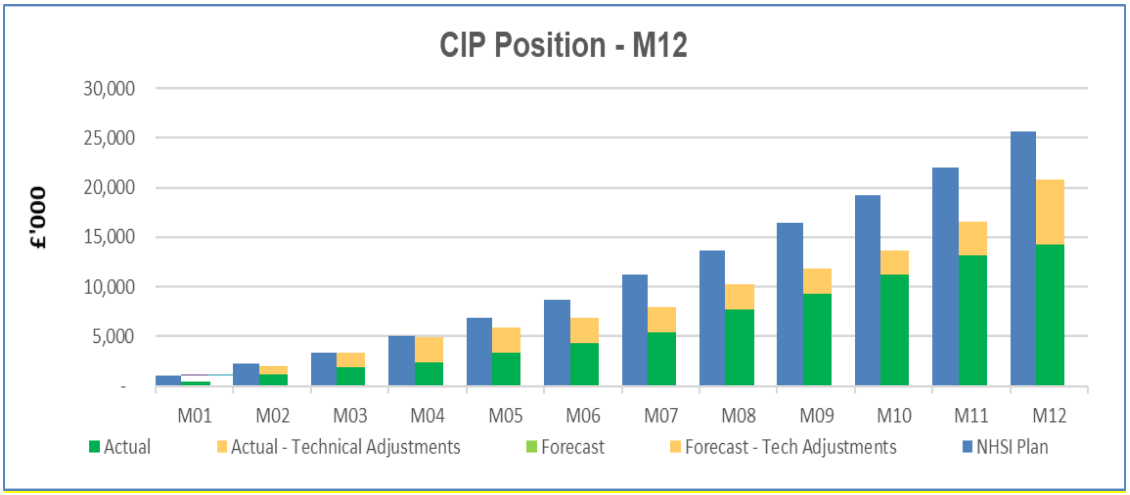
1.4. Cost Improvement Programme (CIP) and Financial Recovery

1.4.1. CIP savings delivery is as follows:

- In-month CIP savings delivery of £4.2m in March is £0.7m more than planned CIP savings delivery of £3.5m.
- Year End CIP savings delivery of £20.7m is £4.9m less than the planned CIP savings delivery of £25.6m.

- Technical CIP savings delivery of £6.5m accounts for 31.1% of total CIP savings delivery.

1.4.2. The chart below shows the profile of CIP delivery throughout 2019/20 and delivery year to date. The stacked bar shows the actual performance on CIP delivery in Green and the impact of the technical savings in Amber.



2 Capital

2.1 M12 Capital Position

Capital expenditure of £31.5m in 2019/20 was within £3k of the adjusted capital resource limit for ULHT.

Capital expenditure in 2019/20 can be summarised as follows:

- £13.6m re: Fire
- £5.9m re: Medical equipment [including COVID-19]
- £4.9m re: Projects including LED, EPC, Radiopharmacy and Louth MRI works.
- £4.7m re: ICT including COVID-19
- £1.7m re: Facilities backlog

Within the overall spend, ULHT has contained expenditure of c£1.8m in relation to COVID-19. Details of expenditure in relation to Covid-19 have been shared with NHSE/I and this should be reimbursed in 2020/21, in order to progress those schemes impacted by supplier/contractor availability in March. The reimbursement will be added to the 2020/21 capital programme.

2.1.1 Year-to-date key spend analysis as follows:

- **Fire**

Group	Description	31st March Spend £'m
Fire	Lincoln	£7.9
	Pilgrim	£3.4
	Grantham	£2.3

- **Medical Devices**

Group	Description	31st March Spend £'m
Medical Devices (Non COVID-19)	Fluoroscopy Machines	£1.2
	MRI Scanner - Grantham	£1.1
	CT Scanners - Pilgrim and Grantham	£0.8
	Theatre Tables - Lincoln, Pilgrim and Grantham	£0.5
	Cardiac Monitoring	£0.2

Group	Description	31st March Spend £'m
Medical Devices (COVID-19)	Ultrasound Machines	£0.6
	Mobile Imaging Equipment	£0.1
	RFID Tags	£0.1
	Intravascular Temp Management Systems	£0.1
	Neonatal Equipment	£0.1
	Test Equipment	£0.1

- **Projects**

Group	Description	31st March Spend £'m
Projects	LED Lighting	£1.5
	Energy Performance Contract	£1.5
	RadioPharmacy	£1.1
	Louth MRI	£0.8

- **IT**

Group	Description	31st March Spend £'m
Digital (Non COVID-19)	e-HR	£1.7
	Cyber Security Measures	£0.8
	PCS and Laptops	£0.6
	Lan Core Switch	£0.5
	e-Prescribing	£0.2
	Pharmacy Robot	£0.1
	Digital Dictation and Speech Recognition	£0.1

Group	Description	31st March Spend £'m
Digital (COVID-19)	VPN Upgrade	£0.0
	PCS and Laptops	£0.5

- **Facilities**

Group	Description	31st March Spend £'m
Facilities	Roof Improvements	£0.3
	Electrical infrastructure Pilgrim/Lincoln	£0.3
	Water access/tanks	£0.2
	2nd IT Room at Pilgrim	£0.2
	Anti-baracading improvements	£0.2
	Asbestos removal on Hemswell	£0.1
	Nurse Call System	£0.1
	Mental Health works	£0.1

3 Balance Sheet, Cash and Borrowings

3.1 Introduction

3.1.1 The extract below from the draft year-end accounts shows the Statement of Financial Position at 31 March 2020.

	31 March 2020	31 March 2019
	£000	£000
Non-current assets		
Intangible assets	4,748	6,341
Property, plant and equipment	214,685	208,749
Receivables	2,534	1,560
Total non-current assets	**221,967**	**216,650**
Current assets		
Inventories	7,037	7,440
Receivables	41,603	22,036
Non-current assets for sale and assets in disposal groups	660	660
Cash and cash equivalents	13,717	7,386
Total current assets	**63,017**	**37,522**
Current liabilities		
Trade and other payables	(50,788)	(51,412)
Borrowings	(380,376)	(114,340)
Provisions	(753)	(608)
Other liabilities	(3,671)	(3,372)
Total current liabilities	**(435,588)**	**(169,732)**
Total assets less current liabilities	**(150,604)**	**84,440**
Non-current liabilities		
Trade and other payables	-	-
Borrowings	(1,482)	(188,196)
Provisions	(3,831)	(2,863)
Other liabilities	(12,579)	(13,081)
Total non-current liabilities	**(17,892)**	**(204,140)**
Total assets employed	**(168,496)**	**(119,700)**
Financed by		
Public dividend capital	267,906	260,042
Revaluation reserve	26,472	32,159
Other reserves	190	190
Income and expenditure reserve	(463,064)	(412,091)
Total taxpayers' equity	**(168,496)**	**(119,700)**

3.1.2 The key points to note are the Cash balance of £13.7m, Current Borrowings of £380.4m, Non-Current Borrowings of £1.5m and Receivables balance of £41.6m

3.2 Cash

3.2.1 The cashflow for the year is shown below.

	2019/20	2018/19
	£000	£000
Cash flows from operating activities		
Operating surplus / (deficit)	(44,093)	(98,926)
Non-cash income and expense:		
Depreciation and amortisation	12,976	11,443
Net impairments	10,833	16,245
Income recognised in respect of capital donations	(75)	(157)
Amortisation of PFI deferred credit	(503)	(503)
(Increase) / decrease in receivables and other assets	(20,529)	2,948
(Increase) / decrease in inventories	403	(641)
Increase / (decrease) in payables and other liabilities	(719)	161
Increase / (decrease) in provisions	1,104	(261)
Net cash flows from / (used in) operating activities	**(40,603)**	**(69,691)**
Cash flows from investing activities		
Interest received	137	122
Purchase of intangible assets	(15)	(1,514)
Purchase of PPE and investment property	(31,092)	(30,379)
Sales of PPE and investment property	33	1,302
Net cash flows from / (used in) investing activities	**(30,937)**	**(30,469)**
Cash flows from financing activities		
Public dividend capital received	7,865	2,479
Movement on loans from DHSC	77,286	99,551
Movement on other loans	1,482	(59)
Capital element of finance lease rental payments	-	(152)
Interest on loans	(8,761)	(5,476)
Other interest	(1)	(2)
Interest paid on finance lease liabilities	-	(5)
Interest paid on PFI, LIFT and other service concession obligations	-	-
PDC dividend (paid) / refunded	-	677
Cash flows from (used in) other financing activities	-	-
Net cash flows from / (used in) financing activities	**77,871**	**97,013**
Increase / (decrease) in cash and cash equivalents	**6,331**	**(3,147)**
Cash and cash equivalents at 1 April - brought forward	**7,386**	**10,533**
Cash and cash equivalents at 31 March	**13,717**	**7,386**

3.2.2 Capital cash has provided support to the overall cash position in 2019/20, enabling the Trust to maintain payments to suppliers despite the in-year revenue deficit. It has been able to do so in two ways – summarised in the table below::

- The cash resources to fund the capital programme come from internally generated depreciation, net loans, PDC and asset sales (2019/20: £31.8m). Where these are collectively greater than the level of capital additions (2019/20: £31.5m;) the surplus can support the overall cashflow position.

- After recognising an asset addition, it may be a few weeks / months before the debt is physically settled with the supplier, again allowing capital cash to buffer any revenue cash shortfall. The capital creditor balance at 31 March was £11.2m.

		Loans - Fire safety / Salix			Total resource
Dep'n	PDC	Rec'd	Repaid	Sales	
13.0	7.9	13.2	(2.3)	0.0	31.8

Capital Creditor b'f	Capital programme additions in month	Payments made	Cum Cash support to revenue via creditors	Excess of Resource over additions	Total cash support provided via capital
10.8	31.5	(31.1)	11.2	0.3	11.5

3.3 Revenue borrowing

3.3.1 The level of borrowings and accrued interest have increased by £78.8m / £0.6m in 2019/20 to £381.9m.

	31 March 2020 £000	31 March 2019 £000
Current		
Loans from DHSC: Revenue Principle	342,338	110,548
Loans from DHSC: Capital Principle	35,521	1,829
Loans from DHSC: Interest	2,517	1,963
Other loans	-	-
Total current borrowings	**380,376**	**114,340**
Non-current		
Loans from DHSC: Revenue Principle	-	163,852
Loans from DHSC: Capital Principle	-	24,344
Other loans : Salix	1,482	-
Total non-current borrowings	**1,482**	**188,196**
Total Borrowings	**381,858**	**302,536**

3.3.2 As outlined within the 2020/21 planning paper, DHSC have set out plans to repay all existing loans and convert them to PDC during the next financial year.

3.3.3 The 2019/20 new borrowing breaks down between:

- Capital DHSC – Statutory Fire Works £11.7m (less repayments £2.3m)
- Capital Salix - £1.5m
- Revenue - £67.9m; of which:
    - Deficit related 18/19 £9.6m
    - Deficit related 19/20: £41.1m
    - Working Capital Support 19/20: £0.8m
    - PSF / FRF advance: £16.4m

3.4 Receivables

3.4.1 Whilst the level of Payables and other working capital elements have remained at similar levels to 31 March 2019, the level of receivables has increased by £19.6m.

This is principally due to the outstanding balance payable by the Lincolnshire CCGs in relation to the 2019/20 settlement, along with the earned by as yet unpaid elements of the 2019/20 PSF / FRF.

To:	Trust Board
From:	Paul Matthew, Director of Finance & Digital
Date:	2nd June 2020
Healthcare standard	All healthcare standard domains

Title:	Integrated Performance Report for April 2020

Author/Responsible Director: Paul Matthew, Director of Finance & Digital

Purpose of the report:
To update the Board on the performance of the Trust for the period 30th April 2020, provide analysis to support decisions, action or initiate change and set out proposed plans and trajectories for performance improvement.

The report is provided to the Board for:

Decision		Discussion	√
Assurance	√	Information	

Summary/key points:
Executive Summary identifies highlighted performance with sections on key Successes and Challenges facing the Trust.

Recommendations: The Board is asked to note the current performance and future performance projections. The Board is asked to approve action to be taken where performance is below the expected target.

Strategic risk register New risks that affect performance or performance that creates new risks to be identified on the Risk Register.	**Performance KPIs year to date** As detailed in the report.

Resource implications (e.g. Financial, HR) None

Assurance implications The report is a central element of the Performance Management Framework.

Patient and Public Involvement (PPI) implications None

Equality impact None

Information exempt from disclosure None

Requirement for further review? None

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Integrated Performance Report

Trust Board
May 2020

EXECUTIVE SUMMARY

Quality

This Committee Performance Dashboard contains a reduced subset of the quality metrics, based on the priority areas for governance and data that is available which enables us to monitor the quality of care and patient outcomes during the response to COVID-19.

There have been 10 Clostridioides difficile infections reported this month which is one more than the monthly trajectory and an increase in numbers from previous reporting periods.

There has been one unwitnessed fall on the MEAU at Lincoln County Hospital this month and the exception report contains a range of actions both in relation to this fall and Trust wide to reduce falls with harm. It has been confirmed that the fall reported in March 2020 (GDH Hospice in Hospital) did not contribute to patient death and a request has been submitted to Commissioners to downgrade this incident accordingly.

Overall SHMI which includes both deaths in-hospital and within 30 days of discharge (December 2018 – November 2019) is 109.85 and is in band 2 (within expected limits) and shows a slight increase from the previous reporting period. Our current in-hospital SHMI is 96.85. An audit has been undertaken of deaths within 30 days to review the patients system wide pathway. This will be presented to Quality Governance Committee in June 2020 and will be taken to the Lincolnshire System Mortality Group (when re-established following COVID19) for discussion as the areas identified relate to out of hospital care.

Sepsis screening compliance for adult inpatients is 88% against a target 90% and the exception report identifies actions being taken.

Sepsis intravenous antibiotic compliance for paediatric inpatients is 87% against a target 90% target % and represents 1 patient (of 8) that was not screened within the timescale. For this patient, they were already receiving antibiotics but at the time of the sepsis screen their cannula became unusable causing the delay.

Sepsis screening compliance for children in A&E is 87.5% and the exception report identifies actions being taken and confirms that no harm was caused as a result of the delay in sepsis screening.

Duty of Candour verbal and written compliance for March 2020 has not improved and poor compliance particularly within the Medicine Division continues. The exception report identifies actions being taken. Accountability letters from the Medical Director are being introduced.

Response rates in inpatient, maternity and outpatient areas were below the Trusts trajectory. Recommend rates in inpatient areas, maternity and outpatients were below the Trusts trajectory. The exception report identifies actions being taken. In addition, the report notes that changes are being made to FFT and therefore that data collection will not be reported.

Operational Performance

On 5th March 2020, in response to the COVID19 pandemic, the Trust enacted the Pandemic Flu plan and elements of the Major Incident Plan, and put in place Command and Control systems. As at the date of writing this report and Trust Board, the Trust continues to operate in this way. The operational performance for April must therefore be seen within the operational context and landscape within which ULHT and indeed the entire NHS are working.

4-hour performance for April was 89.27%. This represents a 13.4% improvement compared to March and positioned the Trust as the third most improved in England for this performance standard. However, the impact of a 30.53% reduction in A&E attendances during the month should be noted.

During April there were 64 >59-minute ambulance handover delays across the Trust, which was 231 lower than March. These delays were due to the segregation pathways established for suspected Covid-19 patients and subsequent reduction in adequate space within the emergency departments. These pathways have subsequently been reviewed.

The deputy divisional nurse leading on urgent and emergency care is seen to be a pivotal role to ensure, secure and assure all measures of quality and performance gains realised through the manage phase are built into restore and embedded into recovery.

RTT performance for March was 79.25%, within 0.05% of the national average performance. The 92% standard was achieved in Breast Surgery and Clinical Oncology.

The Trust reported two RTT 52 week breaches in March. Harm reviews confirmed no patient harm and outcomes and resulting actions have been shared so learning can be embedded in practice.

The overall waiting list size reduced from February to 38,106 (-162) and the March 2020 waiting list size target was achieved.

We have continued to see growth of the partial booking waiting list in April. This has been due to a significant reduction in routine outpatient activity as a consequence of the Trust's response to COVID-19, which has included the cancellation of non-urgent face to face clinical activity and the redeployment of clinical workforce capacity into COVID and urgent care pathways. At the end of April, the number of patients waiting over 6 weeks beyond their follow up appointment due date was 18,090.

Our recovery actions include administrative validation, clinical triage and the scaling up of technology enabled care. As a result of these actions as we moved into May PBWL growth has slowed as waiting list deductions have overtaken additions.

DM01 performance reduced significantly in April as a direct result of Covid-19 impact. 62.33% of patients waiting for a DM01 diagnostic test at the end of April were waiting over 6 weeks. The majority of patients waiting over 6 weeks were within echocardiography and endoscopy diagnostic procedures. We continue to be guided by national and regional body recommendations for the safe restoration of these diagnostics procedures and are proactively planning additional capacity to be implemented at the point when this is possible. In the meantime, demand management pathways are proving successful and we have implemented robust monitoring procedures for patients awaiting diagnostics.

62 Day Cancer performance for March was 77.0% and improved from the previous month, although remains under the agreed performance trajectory. Our Covid-19 cancer restoration plans are focused on maximising cancer treatment activity through green pathways.

Paul Matthew
Director of Finance & Digital
May 2020

PERFORMANCE OVERVIEW

True North	KPI	CQC Domain	2021 Objective	Responsible Director	Target per month	Feb-20	Mar-20	Apr-20	YTD	Pass/Fail	Trend Variation	Kitemark
Harm Free Care	Clostridioides difficile position	Safe	Our Patients	Director of Nursing	9	4	4	10	10	F		
	MRSA bacteraemia	Safe	Our Patients	Director of Nursing	0	1	0	0	0	P		
	Patient falls resulting in severe harm	Safe	Our Patients	Director of Nursing	1.4	0	0	0	0	P		
	Patient falls resulting in death	Safe	Our Patients	Director of Nursing	0	4	1	1	1	F		
	Pressure Ulcers category 3	Safe	Our Patients	Director of Nursing	4.3	3	2	2	2	P		
	Pressure Ulcers category 4	Safe	Our Patients	Director of Nursing	1.3	0	0	0	0	P		Reviewed: 12.06.19 Data available at: Specialty level — Timeliness, Completeness, Validation, Process
	Never Events	Safe	Our Patients	Medical Director	0	1	0	0	0	P		Reviewed: 12.06.19 Data available at: Specialty level — Timeliness, Completeness, Validation, Process
	Number of Serious Incidents (including never events) reported on StEIS	Safe	Our Patients	Medical Director	14	10	9	7	7	P		Reviewed: 12.06.19 Data available at: Specialty level — Timeliness, Completeness, Validation, Process
	Patient Safety Alert compliance (number open beyond deadline)	Safe	Our Patients	Medical Director	0	0	0	0	0	P		
	Hospital Standardised Mortality Ratio - HSMR (basket of 56 diagnosis groups) (rolling year data 3 month time lag)	Effective	Our Patients	Medical Director	100	95.50	96.60	94.80	94.80	P	B	
	Summary Hospital Mortality Indicator (SHMI) (rolling year data 6 month time lag)	Effective	Our Patients	Medical Director	100	109.42	109.18	109.85	109.85	F	B	

PERFORMANCE OVERVIEW

True North	KPI	CQC Domain	2021 Objective	Responsible Director	Target per month	Feb-20	Mar-20	Apr-20	YTD	Pass/Fail	Trend Variation	Kitemark
Harm Free Care	Sepsis screening (bundle) compliance for inpatients (adult)	Safe	Our Patients	Director of Nursing	90%	88.50%	90.00%	88.00%	88.00%	F	A	
	Sepsis screening (bundle) compliance for inpatients (child)	Safe	Our Patients	Director of Nursing	90%	82.00%	94.00%	90.00%	90.00%	P		
	IVAB within 1 hour for sepsis for inpatients (adult)	Safe	Our Patients	Director of Nursing	90%	90.10%	90.00%	94.40%	94.40%	P	A	
	IVAB within 1 hour for sepsis for inpatients (child)	Safe	Our Patients	Director of Nursing	90%	91.00%	83.00%	87.50%	87.50%	F		
	Sepsis screening (bundle) compliance in A&E (adult)	Safe	Our Patients	Director of Nursing	90%	91.50%	92.00%	92.50%	92.50%	P	A	
	Sepsis screening (bundle) compliance in A&E (child)	Safe	Our Patients	Director of Nursing	90%	86.60%	89.00%	87.30%	87.30%	F	A	
	IVAB within 1 hour for sepsis in A&E (adult)	Safe	Our Patients	Director of Nursing	90%	94.00%	96.00%	95.30%	95.30%	P	A	
	IVAB within 1 hour for sepsis in A&E (child)	Safe	Our Patients	Director of Nursing	90%	100.00%	100.00%	100.00%	100.00%	P	A	
	Rate of stillbirth per 1000 births	Safe	Our Patients	Director of Nursing	4.2%	2.57%	2.35%	1.92%	1.92%	P	B	

PERFORMANCE OVERVIEW

True North	KPI	CQC Domain	2021 Objective	Responsible Director	In month Target	Jan-20	Feb-20	Mar-20	YTD	YTD Trajectory	Latest Month Pass/Fail	Trend Variation	Kitemark
Modern and Progressive Workforce	Overall percentage of completed mandatory training	Safe	Our People	Director of HR & OD	95%	91.10%	91.52%	91.14%	91.23%		F		
	Number of Vacancies	Well-Led	Our People	Director of HR & OD	12%	14.54%	14.22%	13.87%	14.64%		F	A	
	Sickness Absence	Well-Led	Our People	Director of HR & OD	4.5%	4.99%	4.97%	4.94%	4.87%		F	H	
	Staff Turnover	Well-Led	Our People	Director of HR & OD	12%	11.38%	11.27%	11.50%	11.09%		P		
	Staff Appraisals	Well-Led	Our People	Director of HR & OD	90%	73.07%	74.38%	72.43%	73.71%		F		

PERFORMANCE OVERVIEW

True North	KPI	CQC Domain	2021 Objective	Responsible Director	In month Target	Feb-20	Mar-20	Apr-20	YTD		Latest Month Pass/Fail	Trend Variation	Kitemark
Valuing Patients Time	Friends & Family Test Inpatient (Response Rate)	Caring	Our Patients	Director of Nursing	26%	28.91%	26.08%		28.22%		P	A	
	Friends & Family Test Inpatient (Recommend)	Caring	Our Patients	Director of Nursing	97%	89.89%	87.59%		88.60%		F		
	Friends & Family Test Emergency Care (Response Rate)	Caring	Our Patients	Director of Nursing	19%	22.22%	22.76%		24.73%		P		
	Friends & Family Test Emergency Care (Recommend)	Caring	Our Patients	Director of Nursing	87%	83.38%	82.00%		81.63%		F		
	Friends & Family Test Maternity (Response Rate)	Caring	Our Patients	Director of Nursing	23%	9.36%	22.40%		18.53%		F		
	Friends & Family Test Maternity (Recommend)	Caring	Our Patients	Director of Nursing	97%	97.14%	96.34%		98.43%		F		
	Friends & Family Test Outpatients (Response Rate)	Caring	Our Patients	Director of Nursing	14%	11.76%	11.75%		11.26%		F	A	
	Friends & Family Test Outpatients (Recommend)	Caring	Our Patients	Director of Nursing	94%	93.60%	93.35%		93.32%		F		
	Mixed Sex Accommodation breaches	Caring	Our Patients	Director of Nursing	0	0			0		F		Timeliness, Completeness, Validation, Process
	No of Complaints received	Caring	Our Patients	Director of HR & OD	70	65	43		732		P		Timeliness, Completeness, Validation, Process
	No of Pals	Caring	Our Patients	Director of HR & OD		575	445		5893				Timeliness, Completeness, Validation, Process
	% Triage Data Not Recorded	Effective	Our Patients	Chief Operating Officer	0%	0.98%	0.72%	0.25%	0.25%		F		
	Duty of Candour compliance - Verbal	Safe	Our Patients	Medical Director	100%	93.00%	83.00%		91.00%		F		
	Duty of Candour compliance - Written	Responsive	Our Patients	Medical Director	100%	73.00%	75.00%		80.50%		F		

PERFORMANCE OVERVIEW

True North	KPI	CQC Domain	2021 Objective	Responsible Director	In month Target	Feb-20	Mar-20	Apr-20	YTD	YTD Trajectory	Latest Month Pass/Fail	Trend Variation	Kitemark
Zero Waiting	4hrs or less in A&E Dept	Responsive	Our Services	Chief Operating Officer	82.0%	68.42%	73.87%	89.27%	89.27%	82.00%	P		
	12+ Trolley waits	Responsive	Our Services	Chief Operating Officer	0	1	0	0	0	0	P		
	%Triage Achieved under 15 mins	Responsive	Our Services	Chief Operating Officer	88.5%	82.47%	85.95%	95.78%	95.78%	88.50%	P	H	
	52 Week Waiters	Responsive	Our Services	Chief Operating Officer	0	0	2		10	0	F		
	18 week incompletes	Responsive	Our Services	Chief Operating Officer	84.1%	82.23%	79.25%		82.84%	83.87%	F		
	Waiting List Size	Responsive	Our Services	Chief Operating Officer	37,762	38,268	38,106		n/a	n/a	F		
	62 day classic	Responsive	Our Services	Chief Operating Officer	85.4%	67.13%	77.04%		68.97%	81.19%	F		
	2 week wait suspect	Responsive	Our Services	Chief Operating Officer	93.0%	81.08%	81.42%		80.69%	93.00%	F		
	2 week wait breast symptomatic	Responsive	Our Services	Chief Operating Officer	93.0%	15.72%	14.63%		44.04%	93.00%	F	L	
	31 day first treatment	Responsive	Our Services	Chief Operating Officer	96.0%	96.27%	95.06%		96.29%	96.00%	F		
	31 day subsequent drug treatments	Responsive	Our Services	Chief Operating Officer	98.0%	95.31%	98.99%		98.70%	98.00%	P		
	31 day subsequent surgery treatments	Responsive	Our Services	Chief Operating Officer	94.0%	88.89%	87.27%		91.71%	94.00%	F		
	31 day subsequent radiotherapy treatments	Responsive	Our Services	Chief Operating Officer	94.0%	94.74%	91.92%		95.41%	94.00%	F		
	62 day screening	Responsive	Our Services	Chief Operating Officer	90.0%	70.59%	81.40%		80.63%	90.00%	F		

PERFORMANCE OVERVIEW

True North	KPI	CQC Domain	2021 Objective	Responsible Director	In month Target	Feb-20	Mar-20	Apr-20	YTD	YTD Trajectory	Latest Month Pass/Fail	Trend Variation	Kitemark
Zero Waiting	62 day consultant upgrade	Responsive	Our Services	Chief Operating Officer	85.0%	77.59%	73.73%		79.50%	85.00%	F		
	diagnostics achieved	Responsive	Our Services	Chief Operating Officer	99.0%	99.08%	91.94%	37.67%	37.67%	98.31%	F		
	Cancelled Operations on the day (non clinical)	Responsive	Our Services	Chief Operating Officer	0.8%	1.74%	1.50%		2.05%	0.80%	F		
	Not treated within 28 days. (Breach)	Responsive	Our Services	Chief Operating Officer	5%	5.94%	16.22%		6.41%	5.00%	F		
	#NOF 48 hrs	Responsive	Our Services	Chief Operating Officer	90%	91.43%	92.50%	82.81%	82.81%	90%	F		
	#NOF 36 hrs	Responsive	Our Services	Chief Operating Officer	TBC	75.71%	83.75%	67.19%	67.19%				
	EMAS Conveyances to ULHT	Responsive	Our Services	Chief Operating Officer	4,657	4,816	4,458	3,756	3,756	4,657	P		
	EMAS Conveyances Delayed >59 mins	Responsive	Our Services	Chief Operating Officer	0	788	295	64	64	0	F		
	104+ Day Waiters	Responsive	Our Services	Chief Operating Officer	5	18	22	25	25	5	F	H	
	Average LoS - Elective (not including Daycase)	Effective	Our Services	Chief Operating Officer	2.80	2.52	3.07	3.18	3.18	2.80	F		
	Average LoS - Non Elective	Effective	Our Services	Chief Operating Officer	4.50	4.48	5.15	3.71	3.71	4.5	P		
	Delayed Transfers of Care	Effective	Our Services	Chief Operating Officer	3.5%	3.67%	3.54%		3.13%	3.5%	F		
	Partial Booking Waiting List	Effective	Our Services	Chief Operating Officer	4,524	11,953	15,103	18,090	18,090	4,524	F	H	
	Outpatients seen within 15 minutes of appointment	Effective	Our Services	Chief Operating Officer	70.0%	36.7%	36.6%	39.1%	39.10%	70.00%	F	A	
	% discharged within 24hrs of PDD	Effective	Our Services	Chief Operating Officer	45.0%	36.5%	37.0%	40.5%	40.50%	45.00%	F		

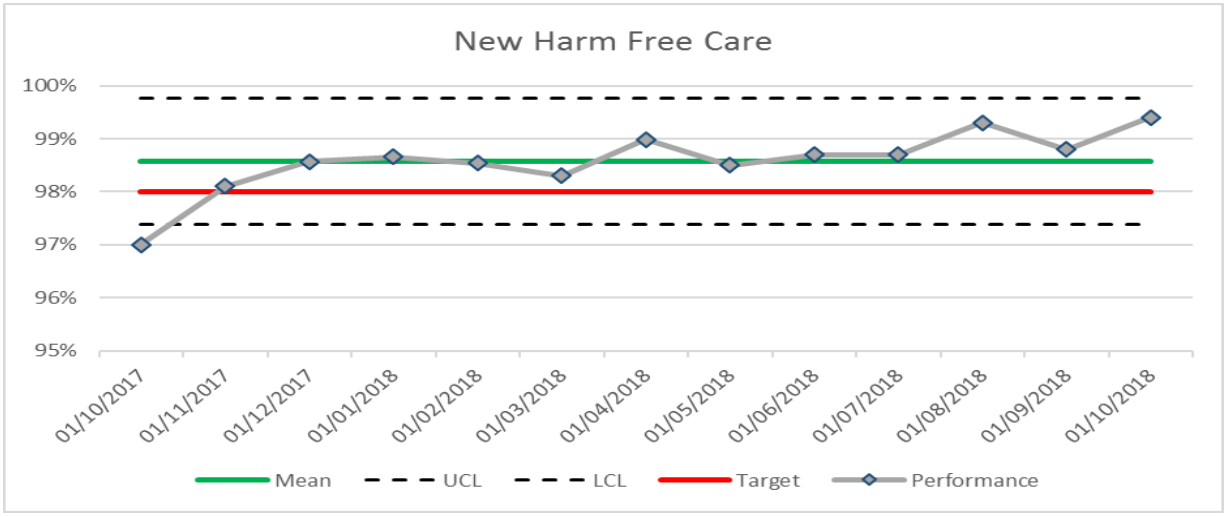
STATISTICAL PROCESS CONTROL CHARTS

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:



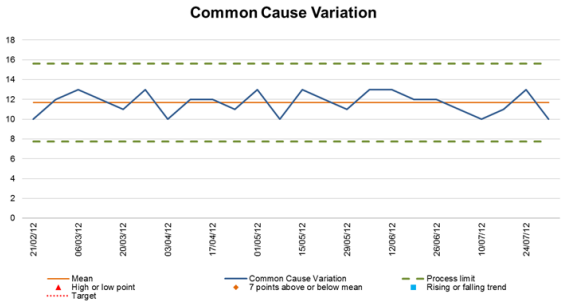
Normal variations in performance across time can occur randomly- without a direct cause, and should not be treated as a concern, or a sign of improvement, and is unlikely to require investigation unless one of the patterns defined below applies.

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

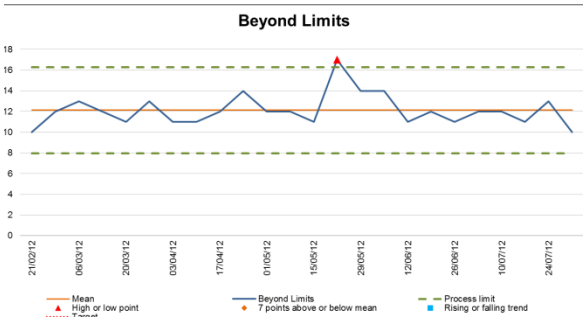
- Normal variation – (common cause) fluctuations in data points that sit between the upper and lower control limits
- Extreme values – (special cause) any value on the line graph that falls outside of the control limits. These are very unlikely to occur and where they do, it is likely a reason or handful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

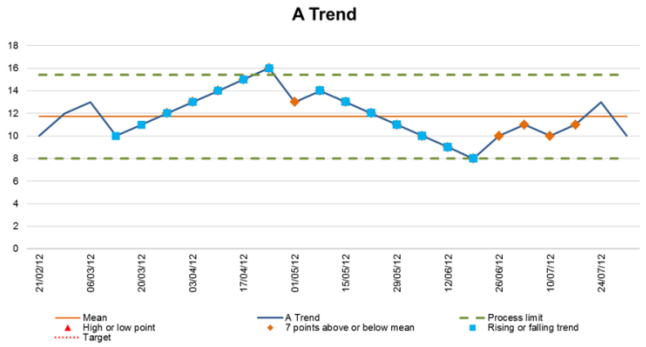


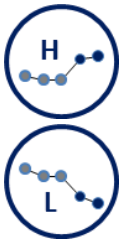
Extreme Values



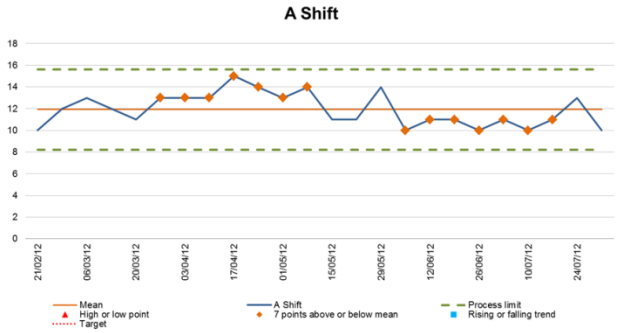
There is no Icon for this scenario.

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

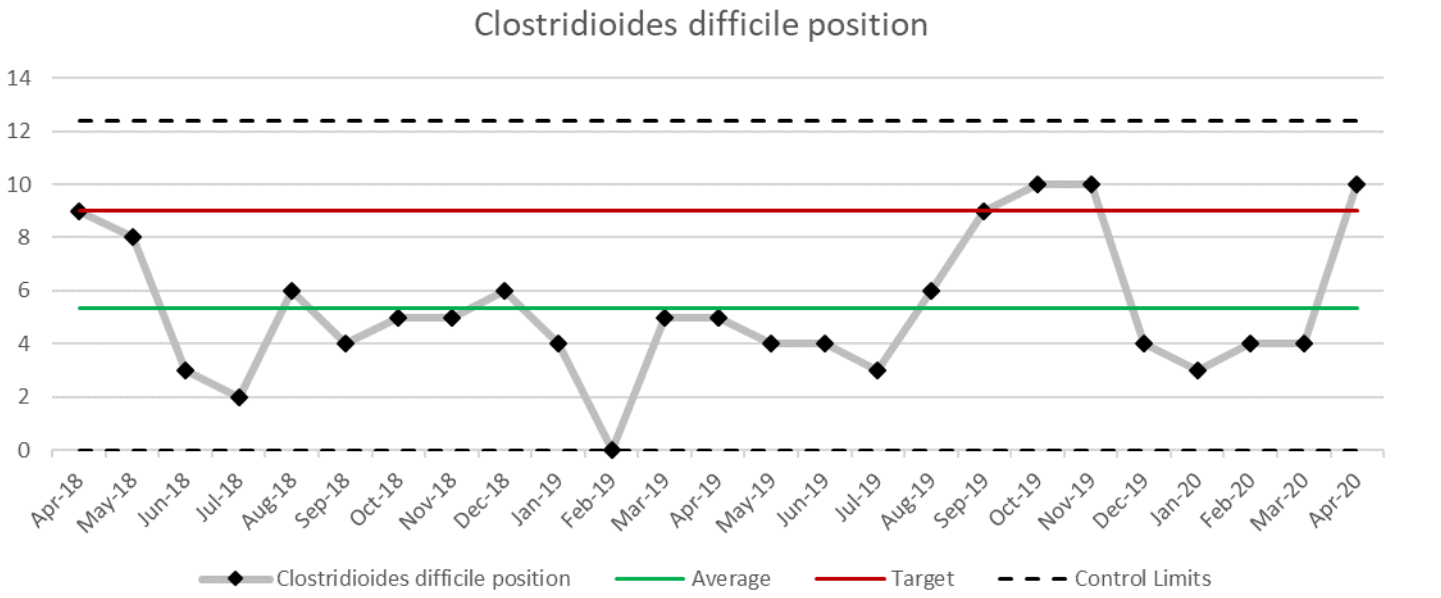
Where the target has been missed for at least 3 of the most recent data points in a row, or in a string of 7 of the most recent data points, at least 5 out of the 7 data points have missed.

HARM FREE CARE – INFECTION CONTROL

Executive Lead: Director of Nursing

CQC Domain: Safe

2021 Objective: Our Patients

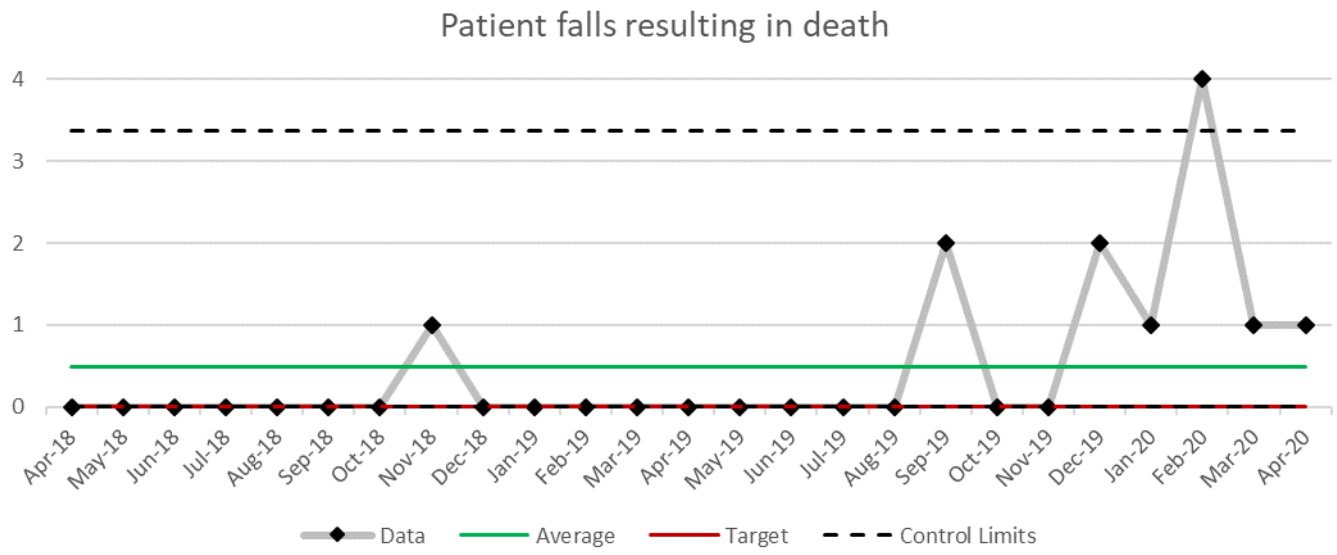


HARM FREE CARE – FALLS

Executive Lead: Director of Nursing

CQC Domain: Safe

2021 Objective: Our Patients



Challenges/Successes

There has been one unwitnessed incident on LCH MEAU. Patient since deceased.

Actions in place to recover:

- The incident has been reported and will be investigated in accordance with Serious Incident requirements..
- The Frailty Nurse Specialist and Consultant Nurse for Frailty will conduct a support visit to the area to review falls safety and identify any additional support required.
- FaLLS -Focus and Lessons Learned Sharing safety messages will be made available so can be used in safety huddles and revised specialty governance meetings.

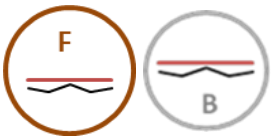
A request has been submitted to downgrade the GDH Hospice in Hospital Serious Incident reported in March 2020 as has been confirmed incident did not contribute to patient death.

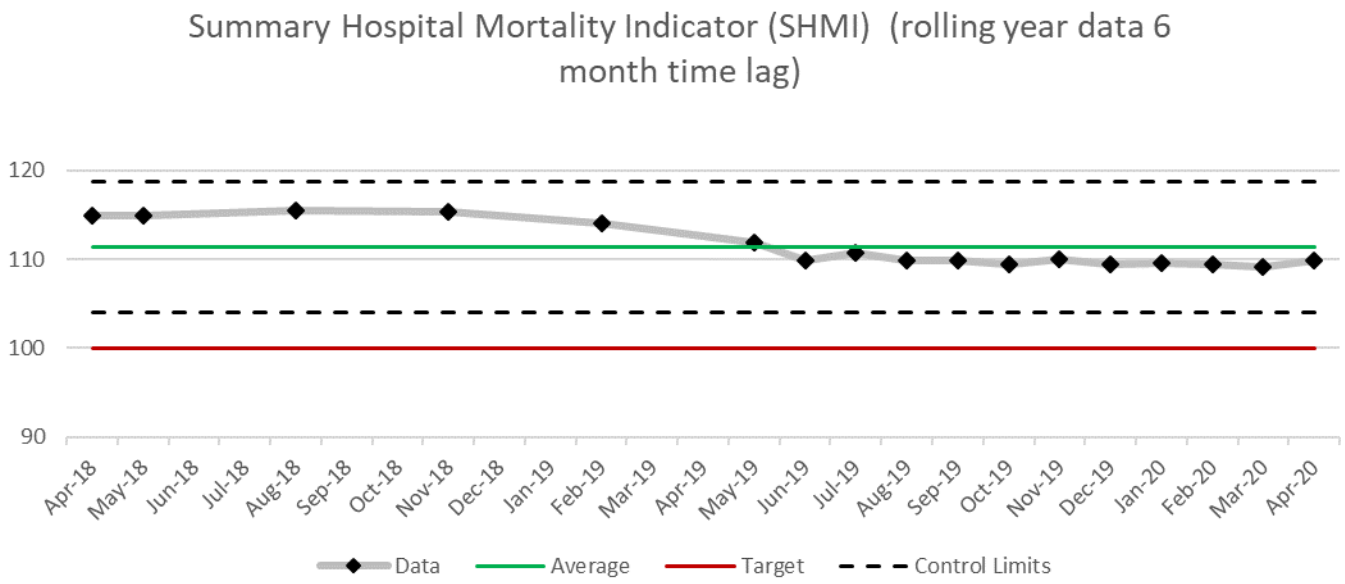
HARM FREE CARE - MORTALITY

Executive Lead: Medical Director

CQC Domain: Effective

2021 Objective: Our Patients





Challenges/Successes

SHMI (Dec 2018 – Nov 2019) is 109.85 which is in band 2 'within expected limits' this is a slight increase from the previous reporting period. SHMI includes both deaths in-hospital and within 30 days of discharge. SHMI's current in-hospital SHMI is 96.85.

Actions in place to recover

An audit has been completed to review deaths within 30 days to review the patients system wide pathway which will be discussed with the Learning Forum once re-established post COVID-19.

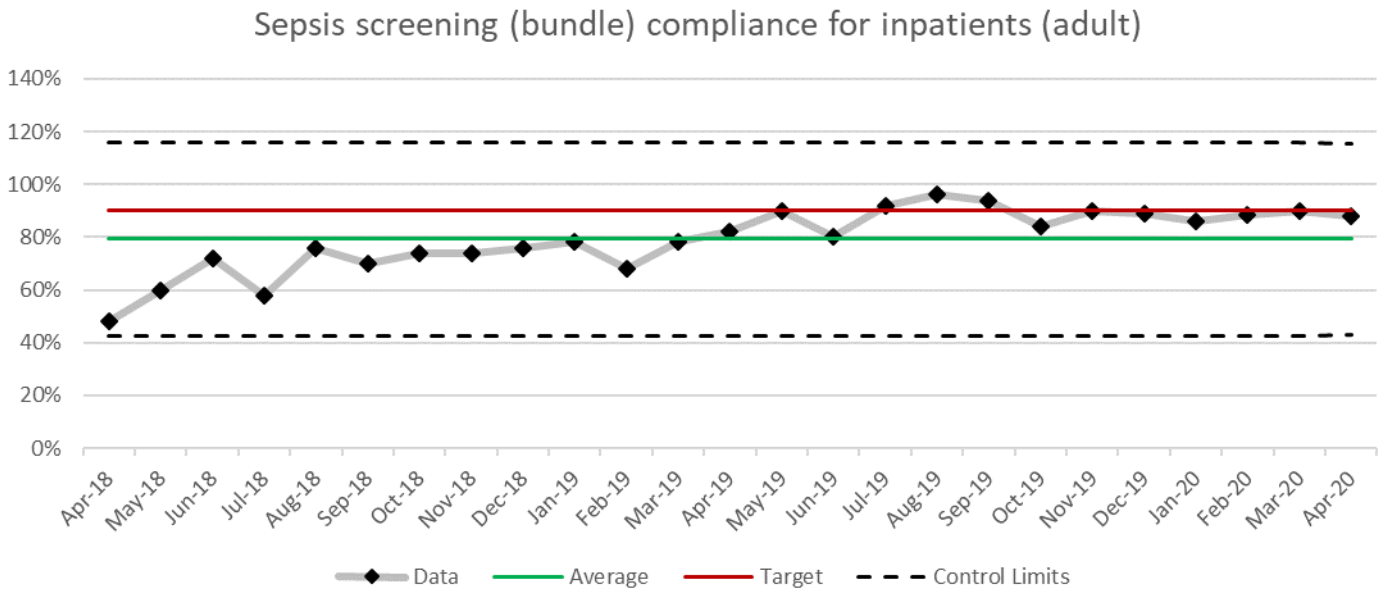
Alerts: COPD is alerting for all deaths in SHMI, however, there are no alerts for in-hospital SHMI.

HARM FREE CARE – SEPSIS SCREENING

Executive Lead: Director of Nursing

CQC Domain: Safe

2021 Objective: Our Patients



Challenges/Successes

Sepsis screening compliance for Adult Inpatients has declined marginally to 88% falling just short of the 90% target.

Actions in place to recover:

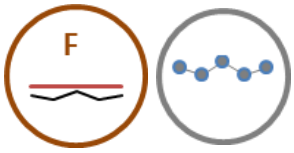
All missed/ delays in screening and treatment are sent to the area manager for investigation to determine if any harm was caused, incident forms are then completed and investigations documented. Area managers discuss missed screens with individual staff members and further training and support offered/ provided.

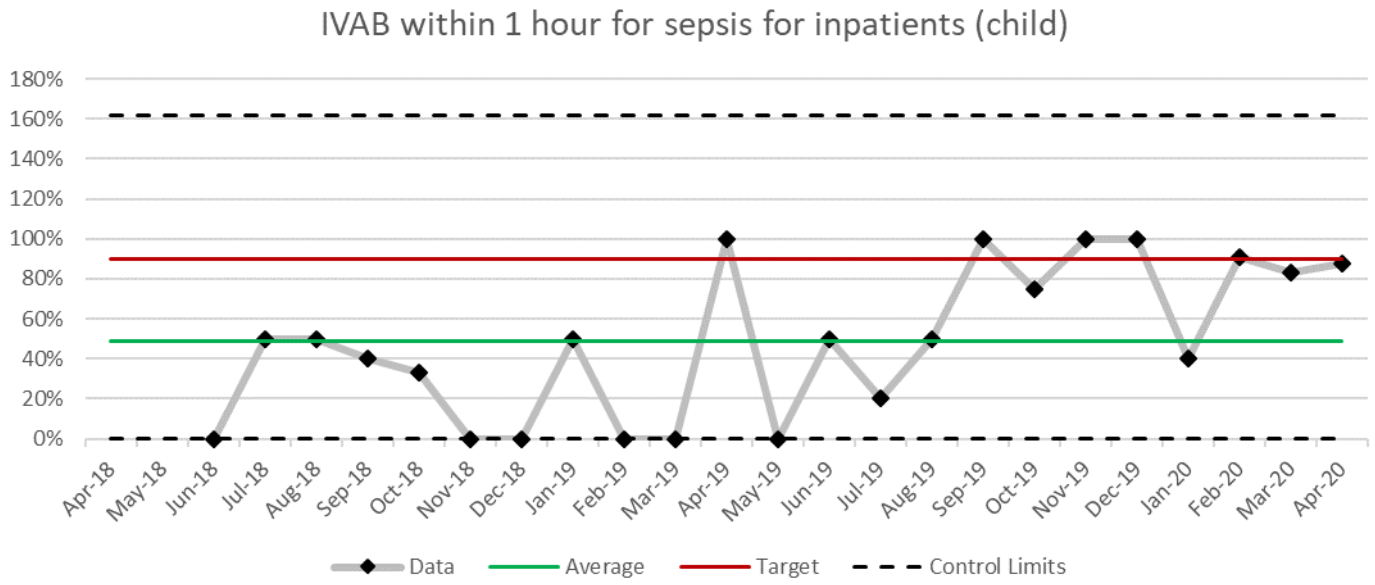
HARM FREE CARE – SEPSIS SCREENING continued

Executive Lead: Director of Nursing

CQC Domain: Safe

2021 Objective: Our Patients





Challenges/Successes

Sepsis intravenous antibiotic compliance for inpatient children has improved to 87.5% which equates to 7 out of 8 patients, falling short of the 90% target.

Actions in place to recover:

Of the 1 patient that had a delay in antibiotic treatment the patient was already receiving antibiotics prior to the observations declining, however at the time of the sepsis screen the cannula became unusable.

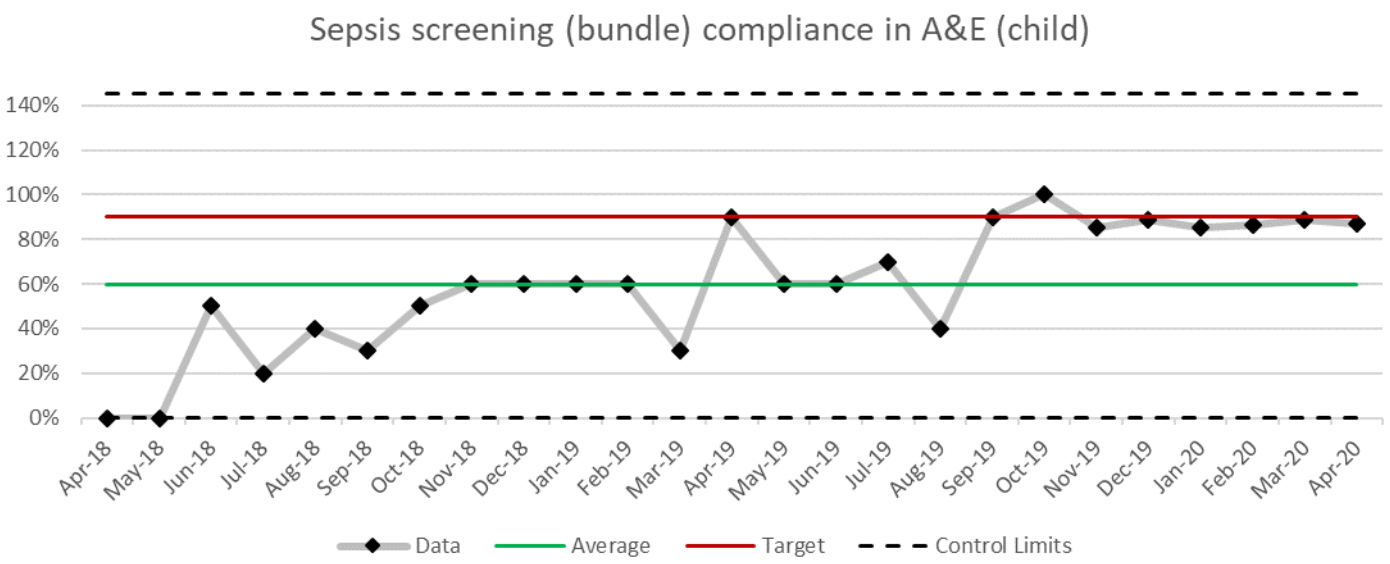
All missed/ delays in screening and treatment are sent to the area manager for investigation to determine if any harm was caused.

HARM FREE CARE – SEPSIS SCREENING continued

Executive Lead: Director of Nursing

CQC Domain: Safe

2021 Objective: Our Patients



Challenges/Successes

Sepsis screening compliance for children in A&E has declined marginally 87% falling just short of the 90% target. Harm reviews gathered on a daily basic and collated on a weekly basis. No harm has come to any of the children requiring sepsis screens that didn't receive them.

Actions in place to recover:

Lessons learned are disseminated to A&E leaders weekly and individual training is provided to staff failing to complete the sepsis screening process.

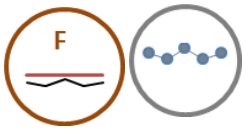
Sepsis practitioners continue to attend A&E safety huddles when able to discuss sepsis for both adults and children, compliance results collected weekly and results shared locally with the teams.

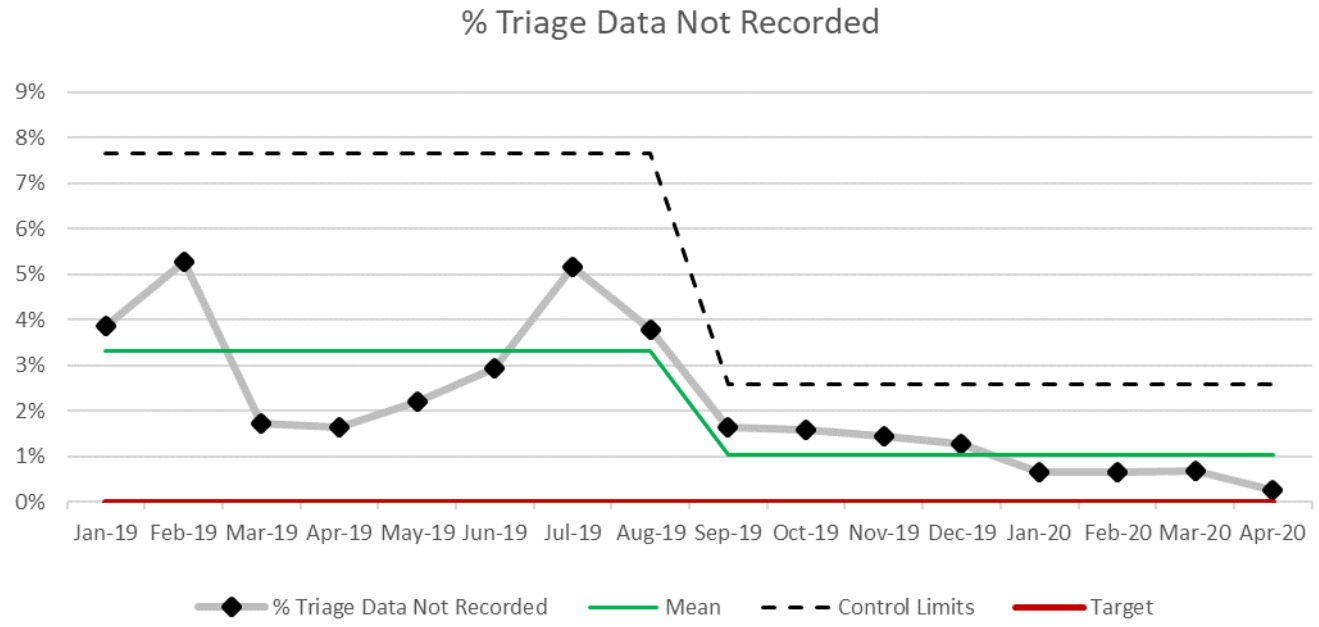
VALUING PATIENTS TIME – % TRIAGE DATA NOT RECORDED

Executive Lead: Chief Operating Officer

CQC Domain: Effective

2021 Objective: Our Patients





Challenges/Successes

- April demonstrated a 0.45% positive variation in performance compared with March and remains well within control limits.
- Achievement against this metric remains co-dependent upon having a fully trained and compliant staffing rota as well as the individual compliance of staff.
- In response to the CQC recommendations the Pre Hospital Practitioner role where possible has been replaced by a registrant. Shifting to this model has continued to generate some disruption in relation to this key performance indicator.
- High levels of agency usage and temporary non-substantive staff continue to be in place in the Emergency Departments, but these staff are familiar to the departments and are deemed competent to both practice and support.

Actions in place to recover:

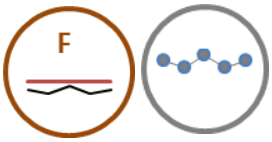
- The actions against this metric are repetitive but still valid.
- The Urgent and Emergency Care Lead Nurse ensures increased compliance and maintenance against this target and improvements continue to be realised.
- The Divisional UEC Operational Leads (DGM and Lead Nurse) continually feedback performance to the clinical teams and address non-adherence to process and seeks rectification measures.
- Triage time is a key patient safety performance indicator and forms an essential part of the department huddles. Overview and scrutiny will be provided through the 3 x daily Capacity and Performance Meetings.

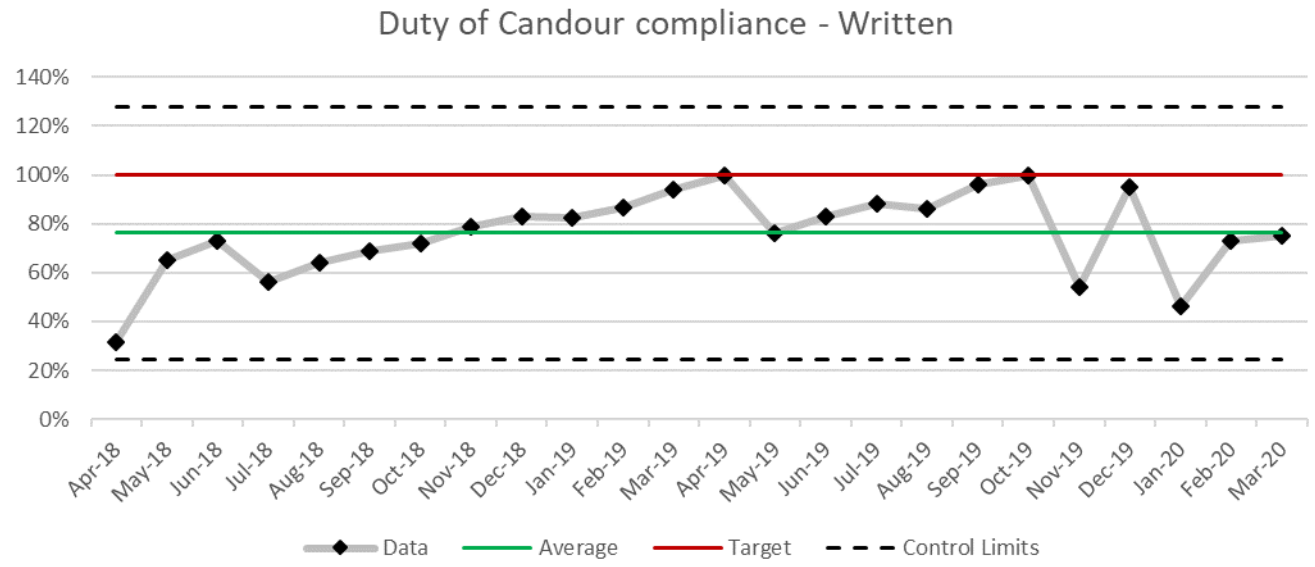
VALUING PATIENTS TIME – DUTY OF CANDOUR

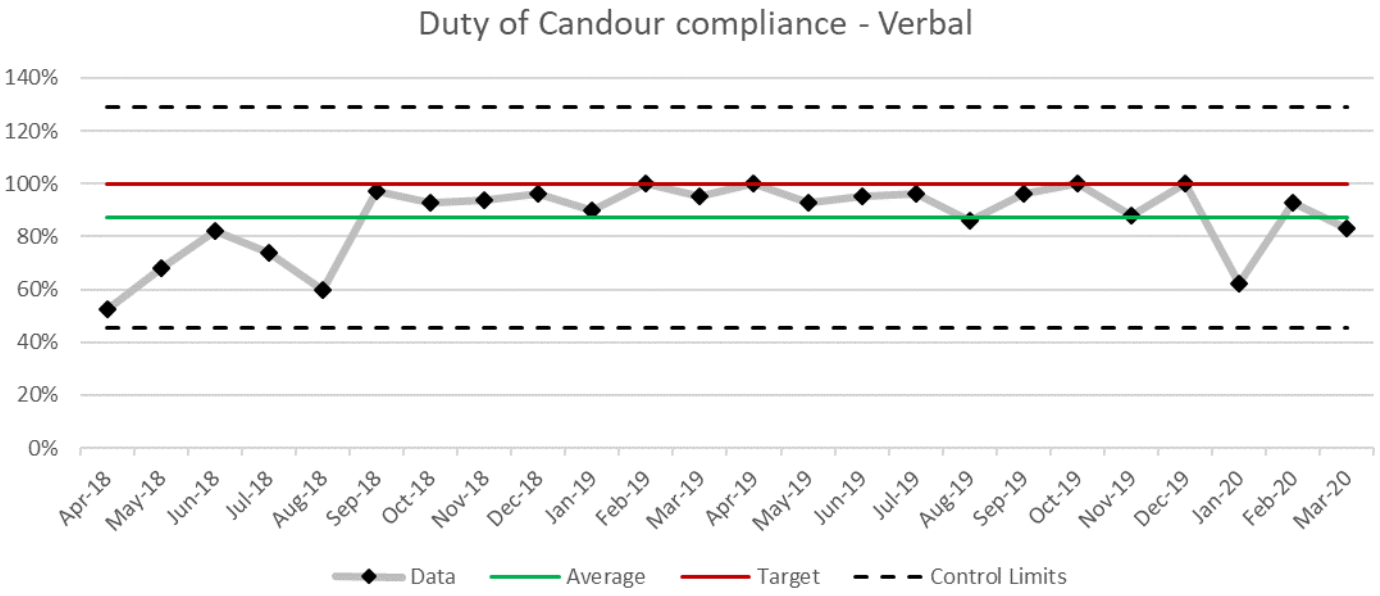
Executive Lead: Medical Director

CQC Domain: Caring/Responsive

2021 Objective: Our Patients







Challenges/Successes

- Duty of Candour 'Notification in person' compliance in March 2020 was 83% (2 non-compliant incidents)
- 'Written follow-up' compliance in March 2020 was 75% (3 non-compliant incidents)

Actions in place to recover:

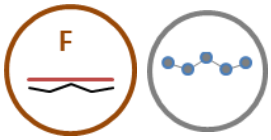
- The Risk & Incident Team within Clinical Governance are providing additional support by drafting written follow-up letters on behalf of clinicians

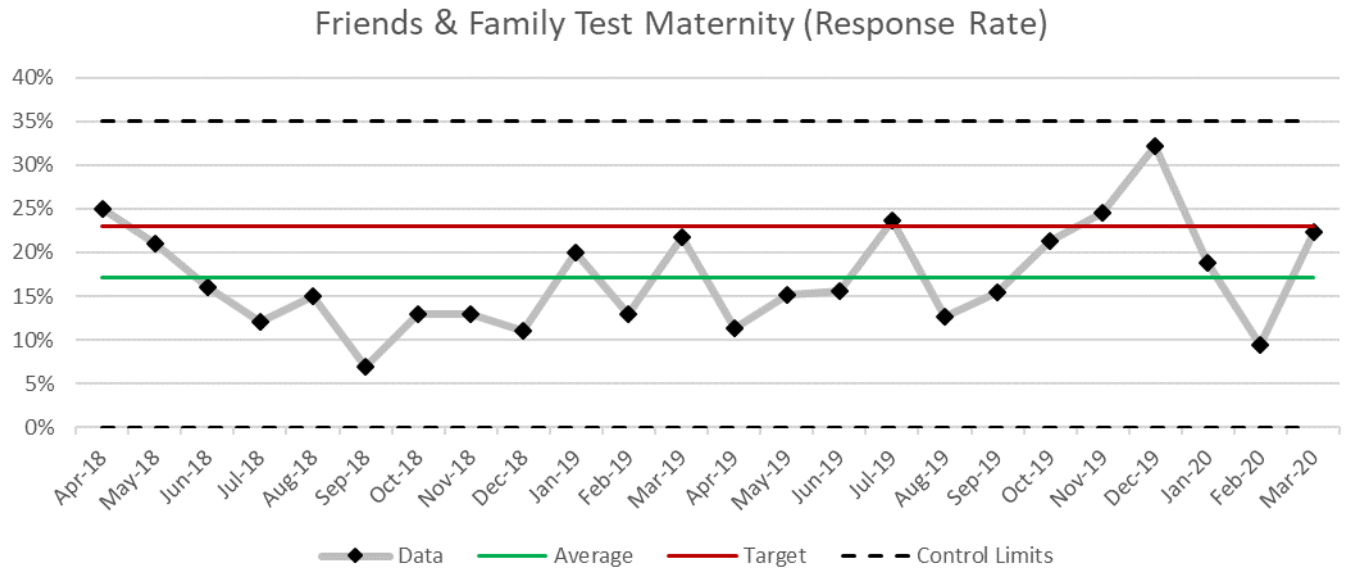
VALUING PATIENTS TIME – FRIENDS AND FAMILY RESPONSE RATES

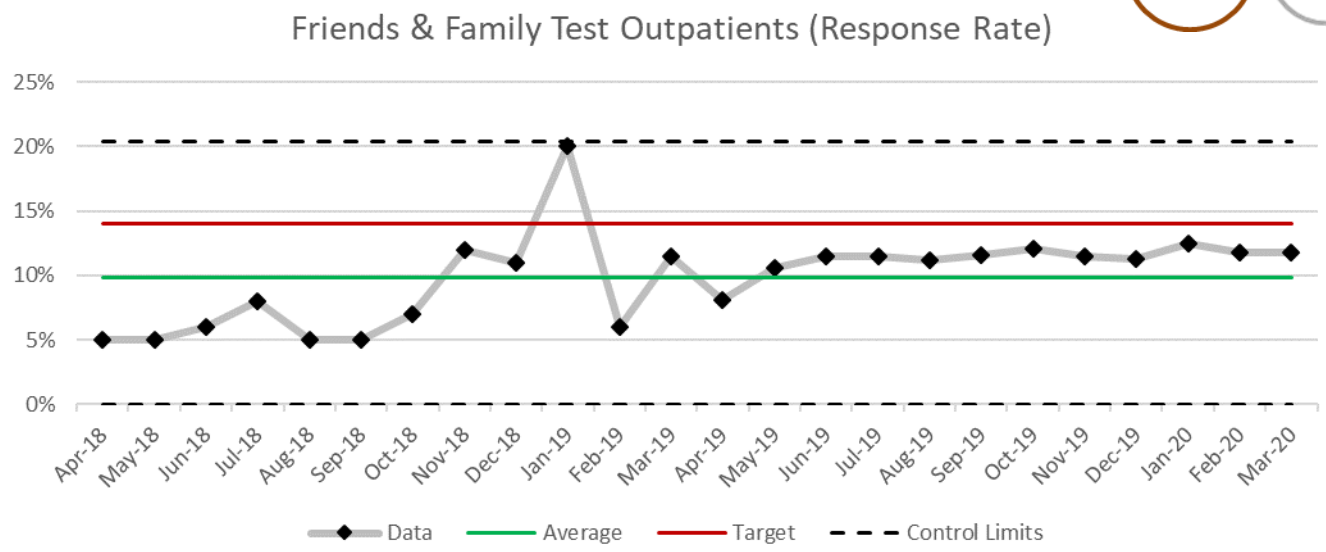
Executive Lead: Director of Nursing

CQC Domain: Caring

2021 Objective: Our Patients





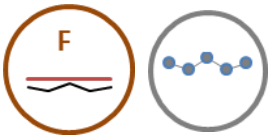


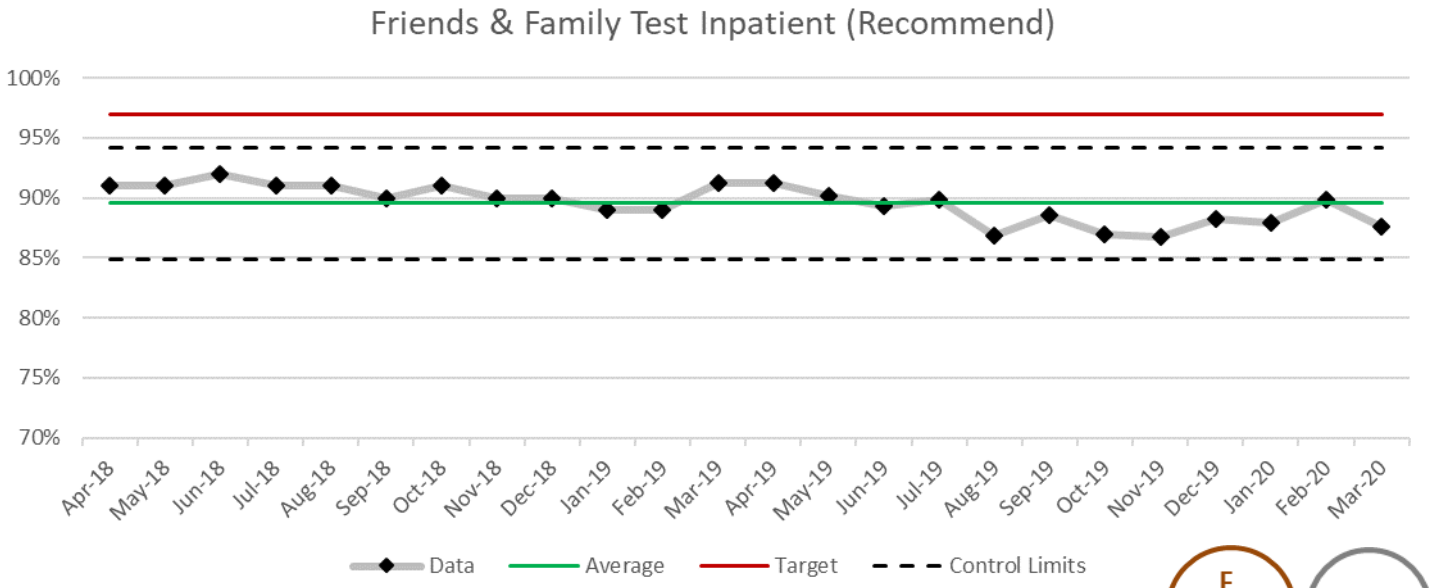
VALUING PATIENTS TIME – FRIENDS AND FAMILY RECOMMEND RATES

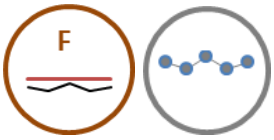
Executive Lead: Director of Nursing

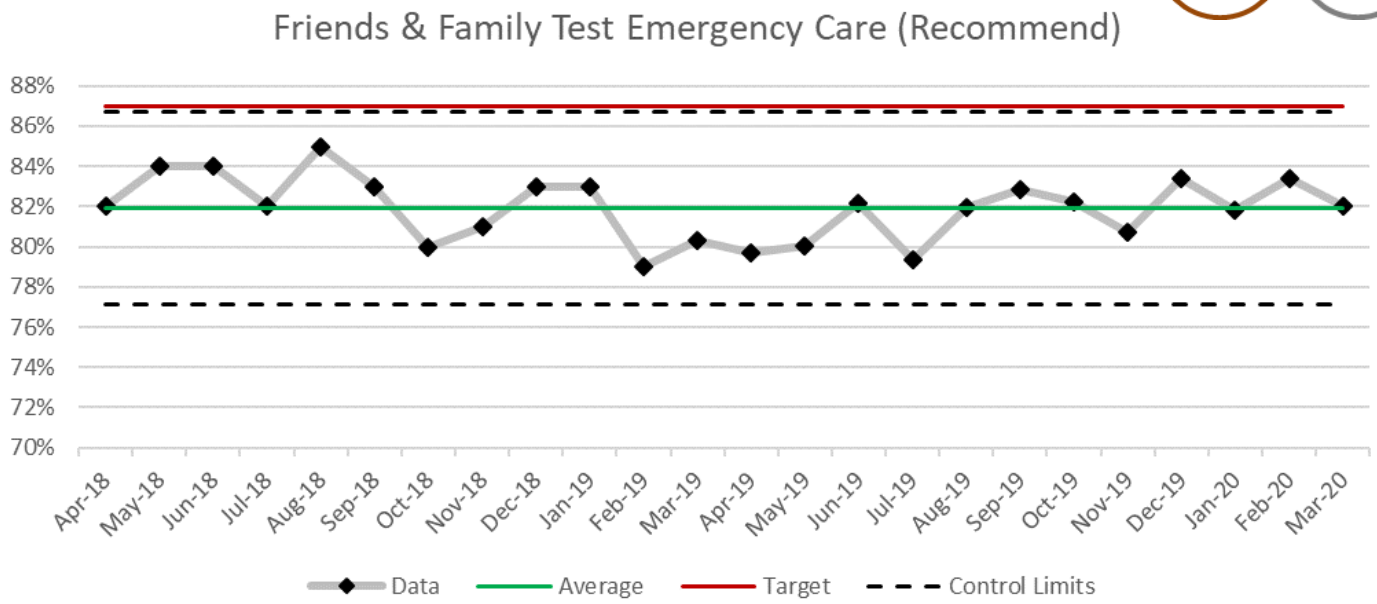
CQC Domain: Caring

2021 Objective: Our Patients







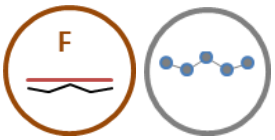


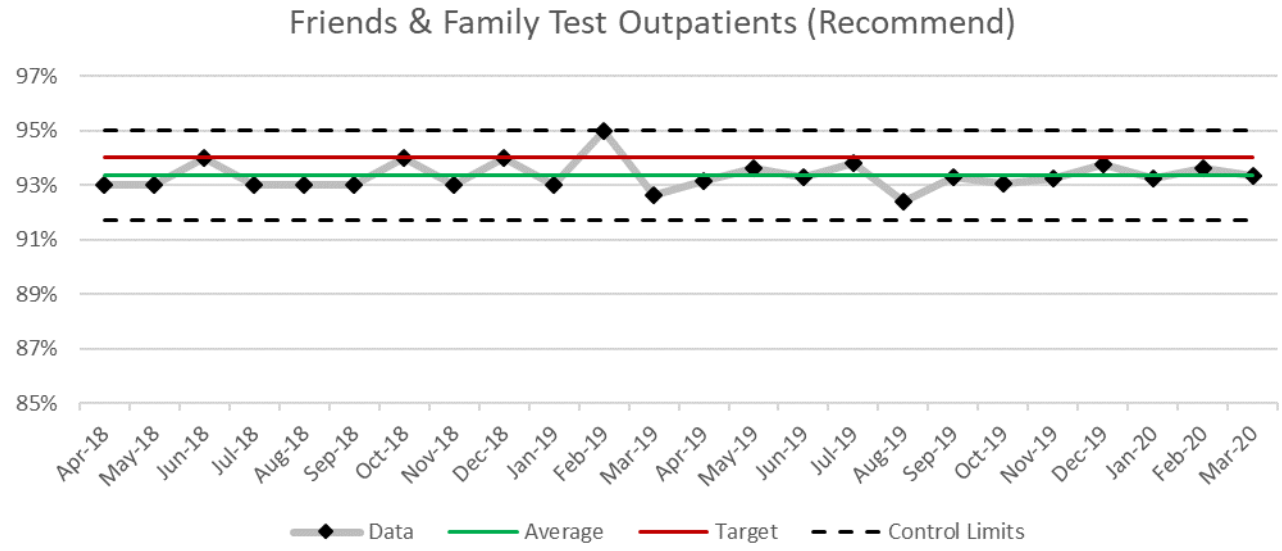
VALUING PATIENTS TIME – FRIENDS AND FAMILY RECOMMEND RATES

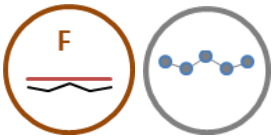
Executive Lead: Director of Nursing

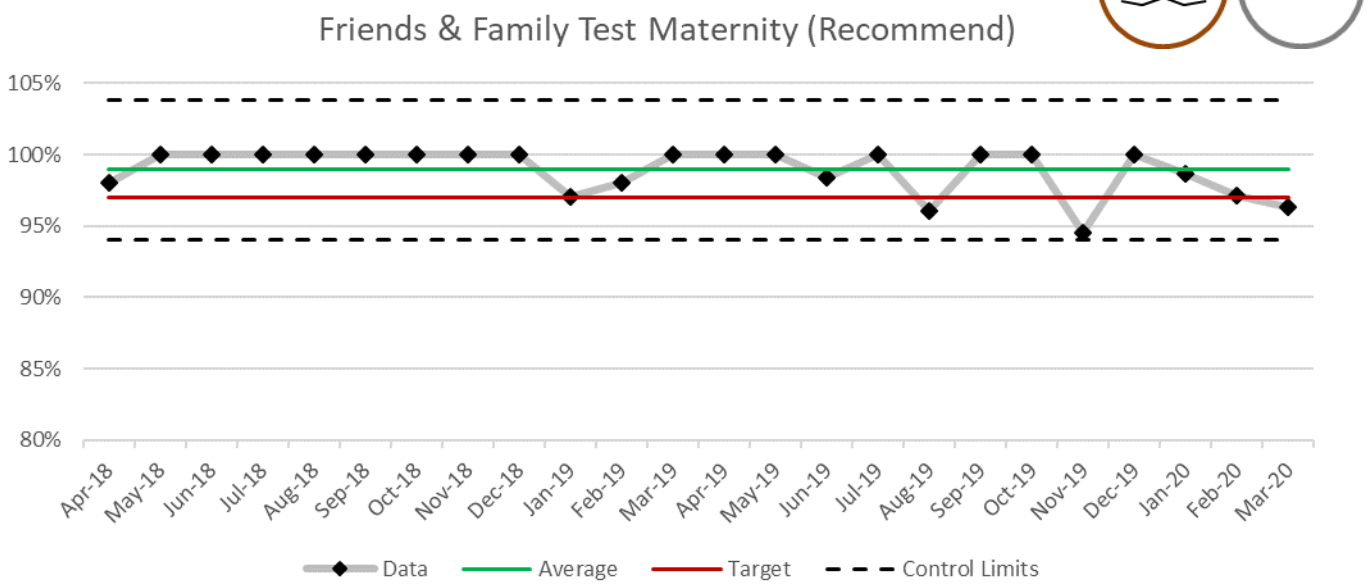
CQC Domain: Caring

2021 Objective: Our Patients









Challenges/Successes

- Overall 91% of patients would recommend and 4% of patients would not recommend. Based on 6,112 ratings and 4,867 comments with 72% of comments received being positive, 6% neutral and 22% negative.
- 445 concerns were taken to PALS during March - 239 for Lincoln and Louth, 31 for Grantham, 174 for Pilgrim and the remainder for community hospitals. 3 PALS concerns was escalated to formal complaints
- The top 3 themes for PALS remain as Communication with Patients/relatives & carers, Appointment Cancellations and facilities (car parking)
- 823 counting compliments were recorded
- Counting Compliments against complaints ratio – 19:1

From April 2020:

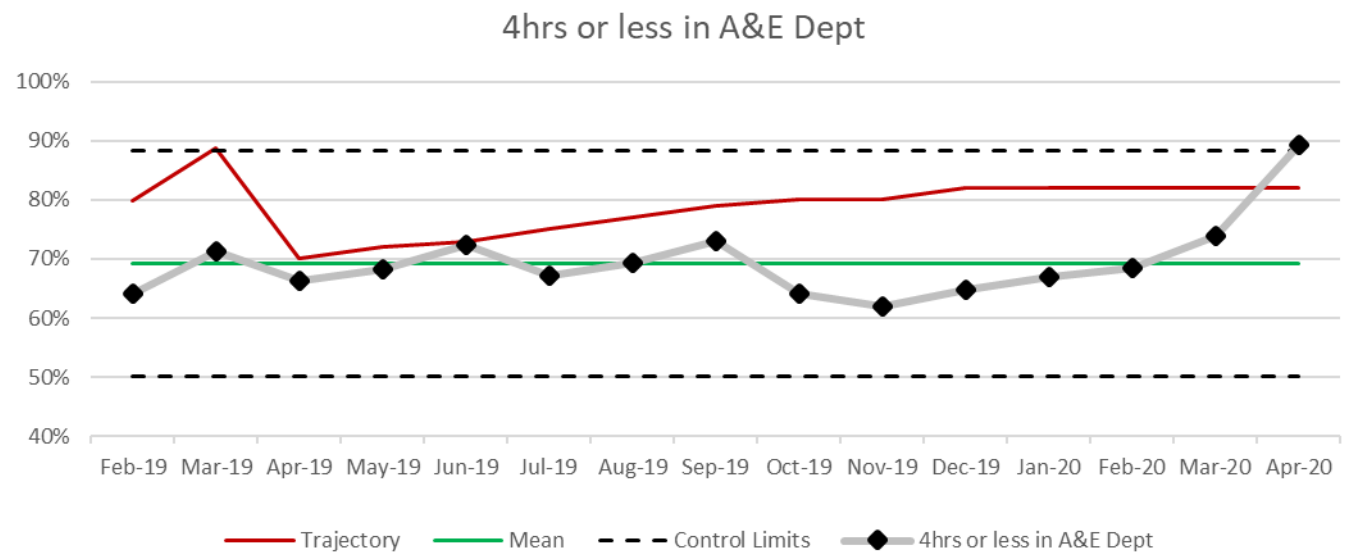
- **NHSE/I have temporarily suspended the friend and family test mandated national reporting until further notice.**
  - As per the guidance, as acute providers we are still able collect patient feedback via "non-contact" channels of communication to prevent the spread of the virus. NHS England have expressed that it is "as important as ever to continue listening to patients and enabling them to raise concerns about the services they are using".
    Therefore, we will continue to operate only the automated methods of feedback collection such as text and automated phone calls only.
  - Wards and Maternity services who currently use FFT cards have ceased surveying until further notice from NHS E&I is received
- **% Response rates have been removed and will no longer feature in national or local reporting following the issue of the new national FFT guidelines**
- **FFT data will no longer be comparable with previous data due to the change in the wording of the question and the answer set.**

ZERO WAITING – A&E 4 HOUR WAIT

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

2021 Objective: Our Services



Challenges/Successes

- On the 3rd March the UK risk level was raised from moderate to high, and an NHS wide Level 4 incident was declared in response to the COVID19 Pandemic. Further Government measures on 18th March included the closure of schools until further notice, the closure of pubs, restaurants, gyms and other social venues on 20th March and full 'lockdown' on 24th March for a period of initially 3 weeks extended by a further 3 weeks.
- This report will provide an update on key performance indicators against a significantly changed and temporary landscape
- April overall outturn for A&E type 1 and primary care streaming delivered 89.27% against an agreed trajectory of 67.72%.
- This demonstrates a 21.55% improvement against trajectory and 13.4% improvement compared with March.
- March ED type 1 and streaming was 13,058 attendances Vs 9072 in April. This represents a 30.53% reduction overall. By site LCH experienced a 32.25% reduction in attendances, GDH a 30.31% reduction in attendances, PHB saw the least reduction at 28.11%.
- By site, for April, LCH delivered 86.74%, PHB delivered 80.19% and GDH 95.83%. The highest day of delivery by site was 23rd April 2020 when LCH and PHB delivered 96.55% and 93.94% respectively. GDH delivered 100% on 6 days through April.
- This improvement should be seen in the context of the increased operating level that the Trust is currently working to and consequent reduced attendances.

Actions in place to recover :

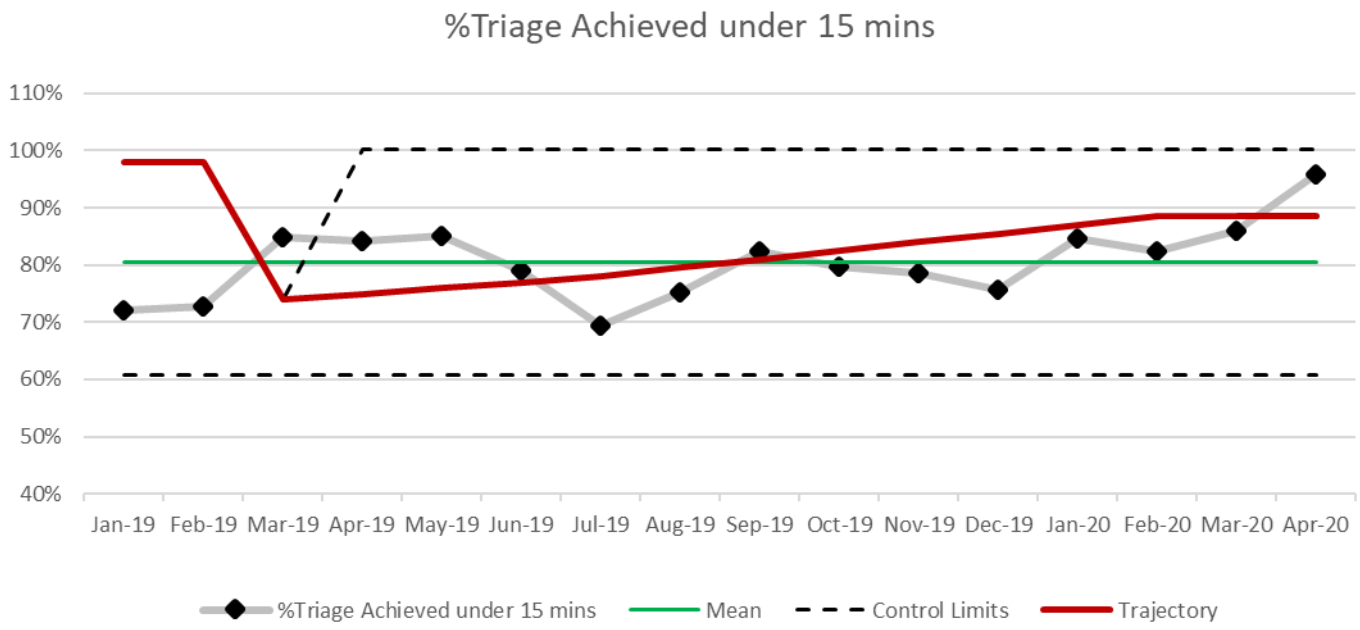
- Those process improvements, not affected by volume, are being considered as part of the Restore phase of COVID management and where they are more transformational, these will be developed as part of the Recovery phase.
- The ability to respond dynamically in all urgent and emergency care access areas will support patients to be seen by the right person in the right service.
- As part of restoration, the extension of primary care streaming is being explored.

ZERO WAITING – %TRIAGE ACHIEVED UNDER 15 mins

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

2021 Objective: Our Services



Challenges/Successes

- Triage under 15 minutes for April delivered an improved position of 95.78% compared with 85.97% in March, a 9.81% improvement, however, the department has seen a third less attendances.
- As we continue to return to normal volume and experience 'rebound' activity as part of restoration measures will be in place to ensure this key metric continues to achieve it's improvement trajectory toward 100%.
- April is the best triage performance for 15 months and this must be seen against a backdrop of the current escalated position within which the country is operating
- 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:

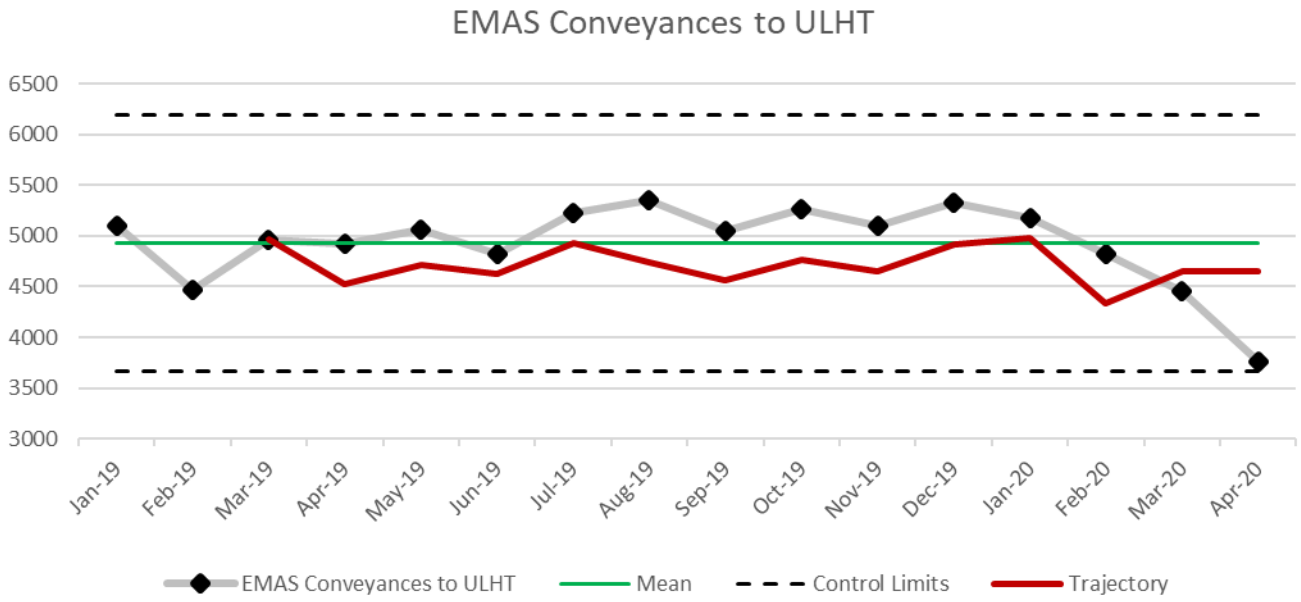
- Reduced volume due to 'lockdown' and Nationally operating in escalated Level 4 will have contributed to the improvement of this key metric.

ZERO WAITING – AMBULANCE CONVEYANCES

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

2021 Objective: Our Services



Challenges/Successes

- Ambulance conveyances for April were 3756, compared to 4458 in March. This represents a 15.75% reduction in conveyances across all sites.
- By site, LCH conveyances were 2077 compared with 2505 in March a 17.09% reduction, PHB was 1428 in April compared with 1717 in March a 16.84% reduction and GDH were 251 compared with 236 in March a 5.98% reduction.
- This represents a reduction of 702 conveyances in April and likely due to operating in escalated measures due to the COVID pandemic.
- The challenge going forward as we move into restore and the continuation of segregated pathways will be managing any increase in conveyance. We are working with EMAS, 111 and CAS to manage 'rebound' demand.

Actions in place to recover

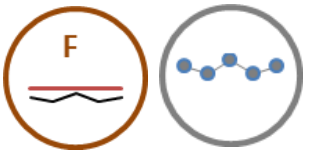
- Restore plans being put in place by the Trust for urgent and emergency care (UEC) include patients being appropriately clinically managed through alternative streams to avoid large numbers of patients in the emergency department leading to possible delays in handover.
- Key to delivering this and the Trusts UEC Restore plan will be to understand the Restore plans being developed by our partners in EMAS.

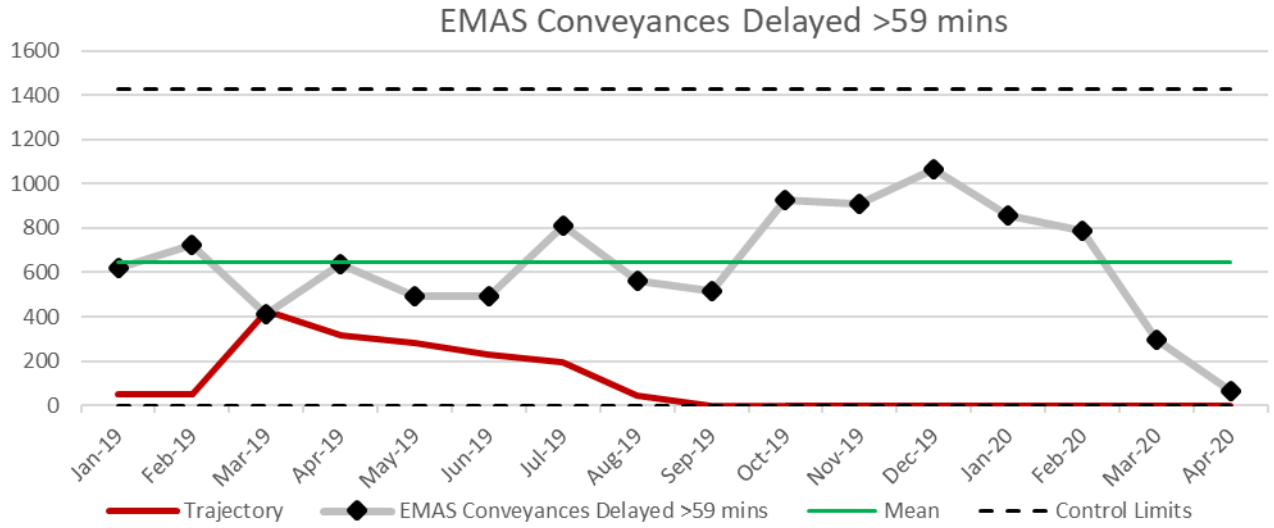
ZERO WAITING – AMBULANCE HANDOVER >59 Mins

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

2021 Objective: Our Services





Challenges/Successes

- During April there were 64 >59 minute ambulance handovers. This is 231 less than March.
- LCH had 27 >59 minute ambulance conveyances in April compared with 171 in March, PHB had 37 >59 minute ambulance conveyances in April compared with 124 in March and GDH had 0 in April and March.
- Delays experienced at LCH and PHB have been as a result of the need to segregate suspected COVID positive patients and there not always being adequate space to safely do this.

Actions in place to recover

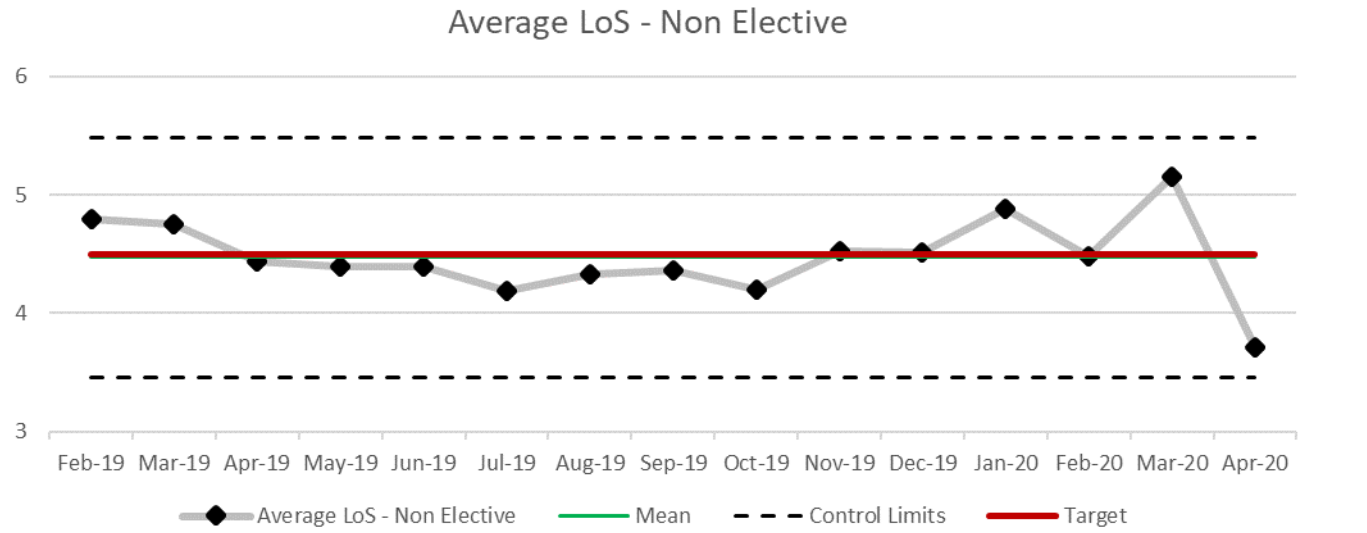
- As part of the UEC Restore plan, RAT will be reinstated as well as maintaining a level of segregation for suspected COVID patients.

ZERO WAITING – AVERAGE LOS NON-ELECTIVE

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

2021 Objective: Our Services



Challenges/Successes

- Average LOS for non-elective admissions saw an improvement during April delivering 3.71 compared with 5.15 in March. This represents an improvement of 1.44 days
- By hospital site, GDH saw a 1.4 LOS improvement, LCH a 1.58 LOS improvement and PHB a 1.22 LOS improvement.
- This is due to a significant reduction in the numbers of patients with a long length of stay (LLOS).
- During March the numbers of patients with a LLOS was 111 compared with 47 in April, a reduction of 64 patients in one month.
- The work of the system wide discharge cell and the implementation of COVID discharge guidance including the temporary suspension of the Care Act will have positively impacted on this performance. Whilst this is a success the challenge will be the sustainability and compliance with the newly implemented discharge guidance.
- This combined with a smaller sample of patients in the hospital and consequent lower occupancy will have led to a reduced non-elective length of stay.
- The stroke pathway was amended during April 2020 which meant that hyper acute

Actions in place to recover

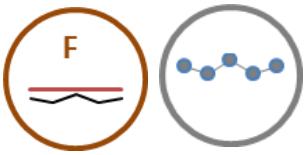
- Multi-agency discharge meetings continue to take place daily action planning patients through their discharge pathway.
- Weekly multi-agency long length of stay meetings for each hospital site in place to support more complex patients through their discharge pathway.
- COVID positive status pathway now agreed across the system and implemented.
- Restore plans being developed to ensure that pace with discharge is not lost as rebound activity is experienced over coming weeks.

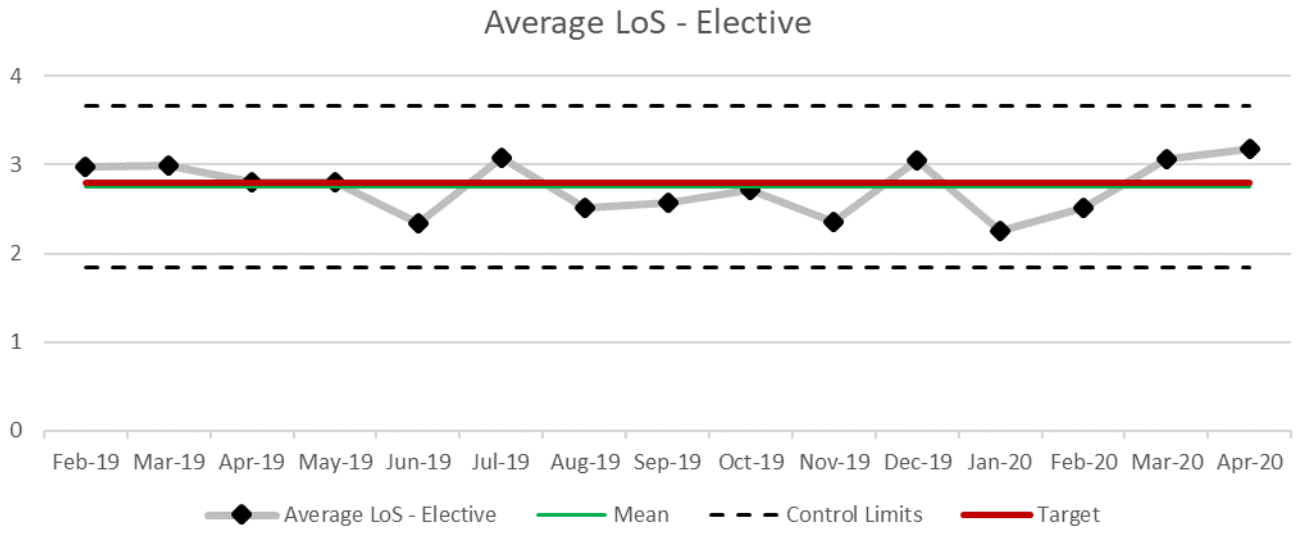
ZERO WAITING – AVERAGE LOS ELECTIVE

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

2021 Objective: Our Services



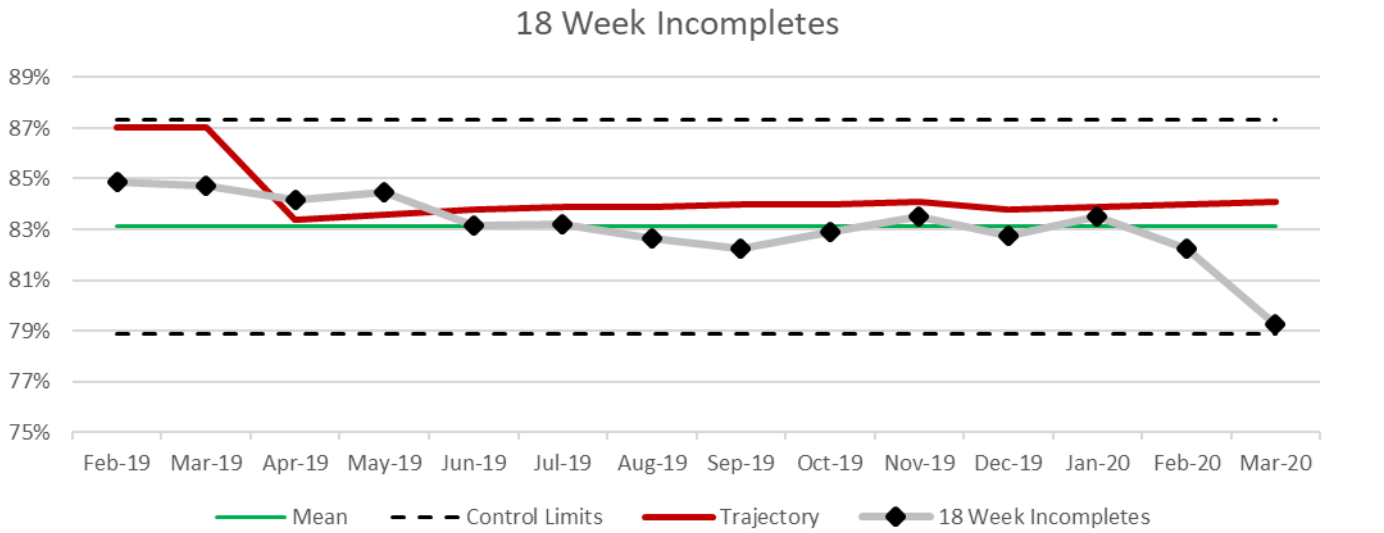


ZERO WAITING - RTT 18 WEEKS INCOMPLETES

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

2021 Objective: Our Services



Challenges/Successes

RTT performance is currently below trajectory and standard.

March saw RTT performance of 79.25%, 2.98% worse than February.

Endocrinology (63.64%) is the lowest performing specialty, from 60.72% last month (+2.91%). Neurology has deteriorated this month with a 0.06% decrease from 78.19% last month to 78.13% in March.

The five specialties with the highest number of 18 week breaches at the end of the month were:

- Gastroenterology - 1012 (Increased by 111)
- Maxillo-Facial Surgery + Orthodontics + Oral Surgery - 996 (Increased by 102)
- ENT - 989 (Increased by 220)
- General Surgery - 811 (Increased by 95)
- Ophthalmology - 671 (Increased by 223)

Actions in place to recover:

As detailed above, performance in Gastroenterology and General Surgery continue to decline. Maxillo-Facial, ENT and Ophthalmology have also seen a decrease in performance.

Work has halted on sending a cohort of General Surgery admitted patients to BMI Park for surgery. Of those previously sent, 6 patients have had operations, 12 have been put on hold due to Covid19 and the remainder were rejected.

Specialties achieving the 18 week standard were:

- Breast Surgery 98.38%
- Clinical Oncology 95.04%
- Cardiothoracic Surgery 100.00% (2 patients)
- Paediatric Diabetic Medicine 100.00% (2 patients)

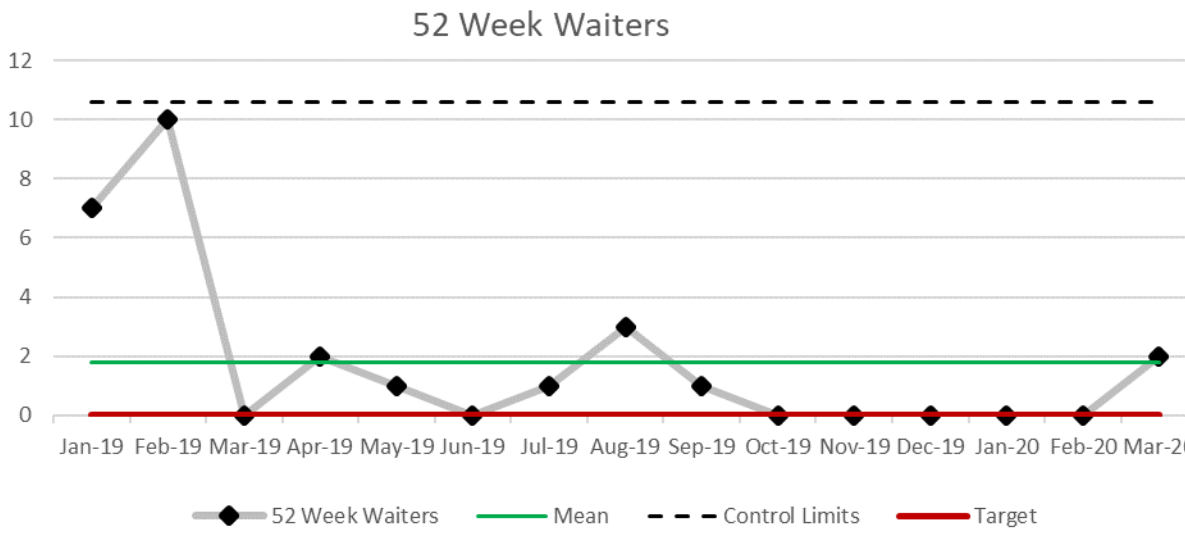
Focussed validation of the incomplete waiting list data quality exclusion pots continued during February, however this has currently been put on hold.

ZERO WAITING – 52 WEEK WAITERS

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

2021 Objective: Our Services



Challenges/Successes

The Trust reported two incomplete 52 week breaches for March end of month. Both of these were due to administration errors. Root cause analysis has been completed by the relevant division and change in process implemented.

Due to the COVID19 situation necessitating the standing down of routine services, unfortunately, it is anticipated that there will be further breaches.

Actions in place to recover

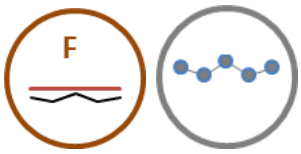
Work is continuing on plans to recommence services, with Cancer and Urgent patients having priority. Recovery and Restoration plans are being discussed and drafted with divisions; reviewing pathways to look at ways to enable provision of routine services.

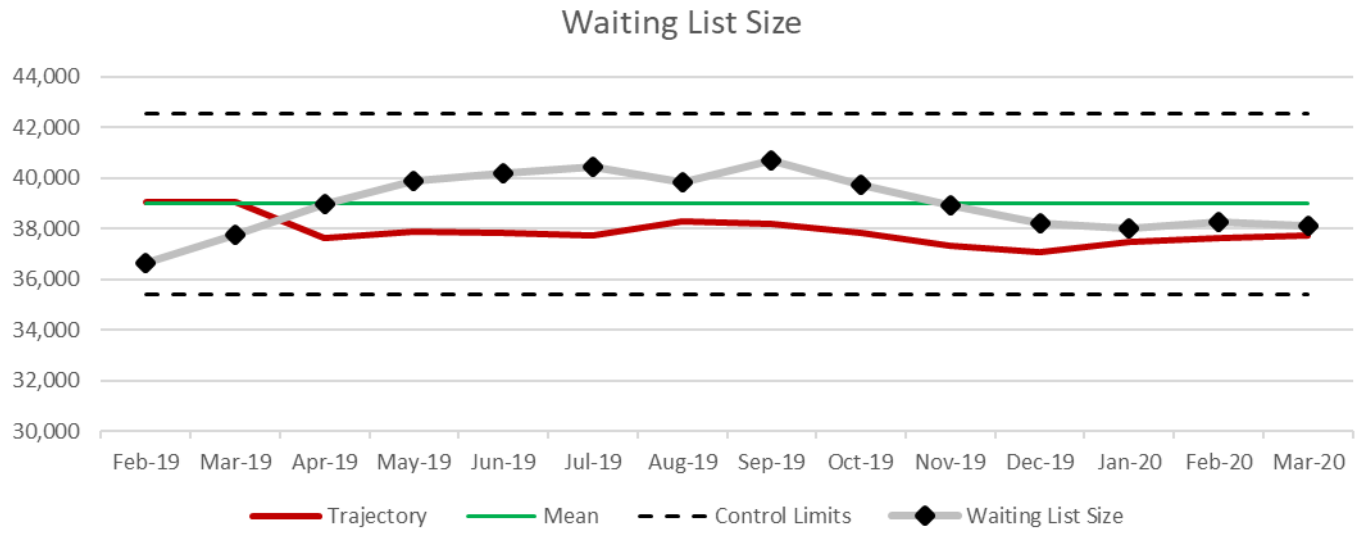
ZERO WAITING – WAITING LIST SIZE

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

2021 Objective: Our Services





Challenges/Successes

Overall waiting list size has improved from February, with March total waiting list decreasing by 162 to 38,106.The incompletes position for March is now approx. 926 less than the March 2018 (39,032) target.

The top five specialties showing an increase in total incomplete waiting list size from February are:

- Neurology + 194
- Trauma & Orthopaedics + 168
- Ophthalmology + 120
- Community Paediatrics + 75
- Rheumatology + 55

The five specialties showing the biggest decrease in total incomplete waiting list size from February are:

- Breast Surgery - 201
- Dermatology - 169
- Cardiology - 132
- Urology - 87
- Colorectal Surgery - 56

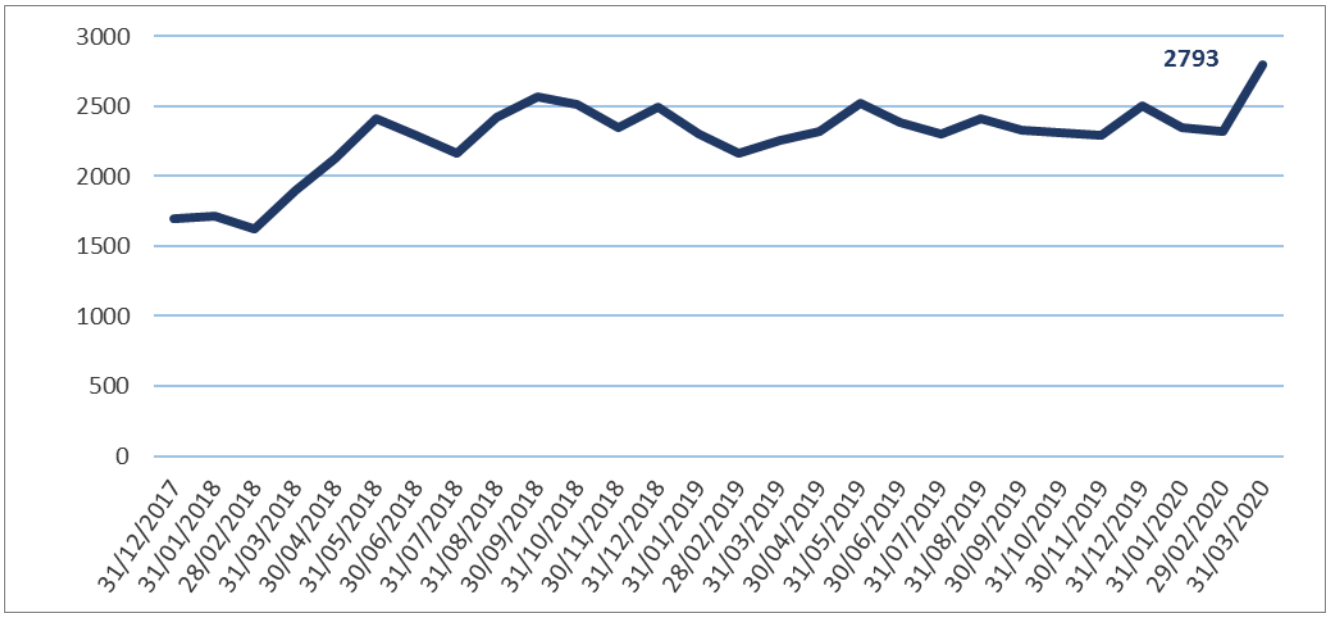
Actions in place to recover

The National Validation Programme of the incomplete waiting list is now completed This started on 16th March following defined criteria as set out in the NECS report. Results and findings have been made available to the trust.

Discussions are currently on hold with CCG/STP colleagues regarding management of the Gastroenterology service. This will resume in the future to look at adopting the same approach that was successfully used for Neurology.

- February to March saw an increase of patients waiting over 40 weeks, +71, with Gastroenterology (+38) showing the largest increase. 9 specialties reduced their position compared to last month, with Diabetic Medicine showing the best improvement of -4 patients from last month.
- The Trust are also working to reduce overall waiting times to 26 weeks. The monitoring/challenge of this target is tracked through the RTT Recovery and Delivery meeting. Currently this meeting is suspended. The chart below shows progress up to 31st March, with an increase of 477 patients from February. The largest increase was seen in Gastroenterology, +97. The largest decrease of -21, being in Endocrinology.

Total Number of Incomplete Patient Pathways at 26 Weeks and Above for ULHT by Month



In response to the Covid19 pandemic, the Trust has suspended all routine Elective Surgery and face to face Outpatient activity. This has had an adverse effect on both Waiting List size and 18w performance. This continues to be monitored with maintenance plans being worked on with the specialties.

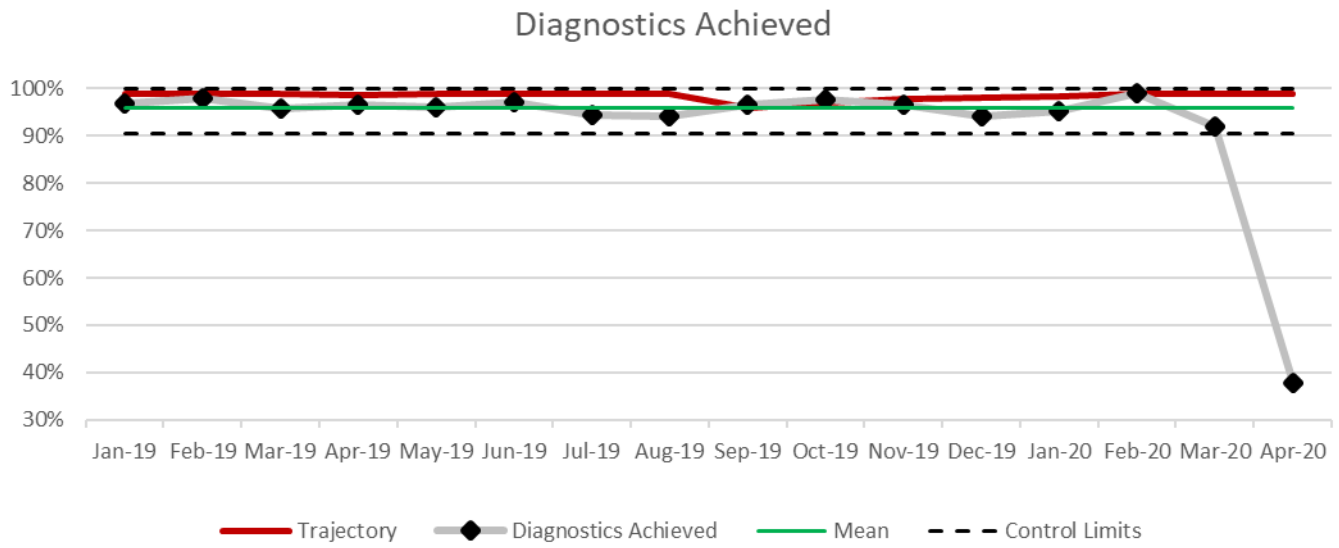
There has been a gradual increase in changing face to face appointments to telephone consultations. The use of video consultations is also being promoted, where appropriate, within the specialties.

ZERO WAITING – DIAGNOSTICS

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

2021 Objective: Our Services



Challenges/Successes:

DM01 performance reduced significantly in April as a direct result of Covid-19 impact. 62.33% of patients waiting for a DM01 diagnostic test at the end of April were waiting over 6 weeks.

The majority of patients waiting over 6 weeks were within echocardiography and endoscopy diagnostic procedures.

Since the end of March only urgent cardiac echo activity has continued to support cancer pathways with all routine activity temporarily stopped.

Endoscopy services nationally are guided by the BSG and JAG and we will continue to adhere to their recommendations on service delivery during COVID-19 as and when these change. Endoscopy procedures are aerosol generating and current guidance is impacting on service capacity due to IPC controls and cleaning time required between patients. Current endoscopy capacity is reduced by 70% of normal activity and is focused on cancer and urgent work.

Actions in place to recover:

Catalysts to commence elective cardiology activity include our ability to comply with East Midlands Cardiac Network guidance on cardiology service COVID restoration and development of green pathways, with the development of a green pathway for TOE procedures, an aerosol generating procedure, being paramount.

Cardiac physiology activity will recommence in early June utilising green pathways on all 3 main sites, and will be vital in supporting the restoration of cardiology activity. Sufficient capacity is a risk due to significant waiting list growth during the COVID Manage phase and anticipated increase in referral activity as other services are restored.

Demand management pathways for upper GI and lower GI introduced during the Manage phase are proving successful. Patients are currently scheduled for barium/CT CAP scans in the first instance and results are reviewed by a senior clinician to determine whether patients still require an endoscopy procedure. Non-2WW and

non-urgent referrals are currently being monitored on a waiting list and patients and referrers are being kept informed and issued clinical advice.

The potential for alternative procedures, such as capsule endoscopy, is being explored.

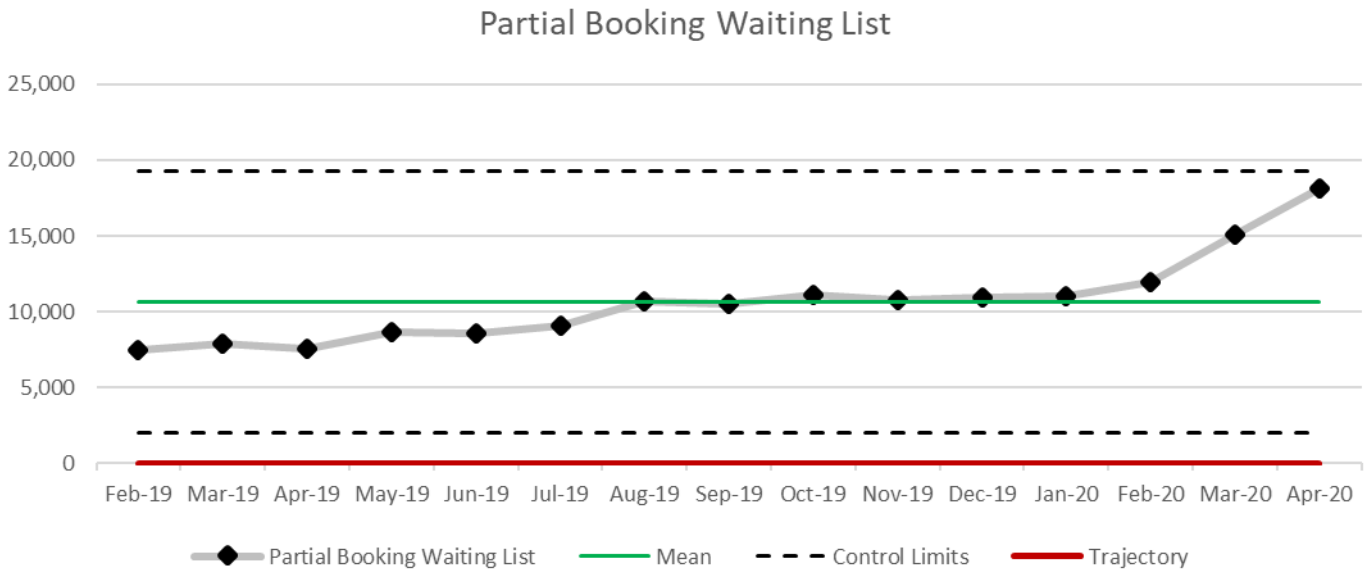
Investment in additional capacity is being planned to support backlog clearance at the time when national guidance enables an increase in activity.

ZERO WAITING – PARTIAL BOOKING WAITING LIST

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

2021 Objective: Our Services



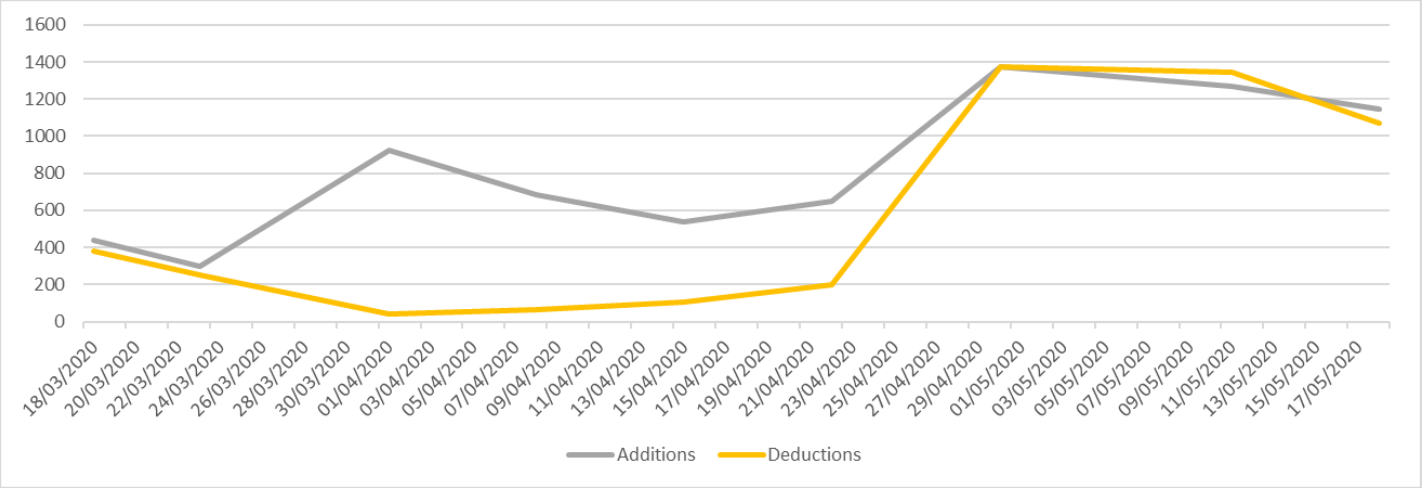
Challenges/Successes:

We have continued to see growth of the partial booking waiting list in April. This has been due to a significant reduction in routine outpatient activity as a consequence of the Trust's response to COVID-19, which has included the cancellation of non-urgent face to face clinical activity and the redeployment of clinical workforce capacity into COVID and urgent care pathways.

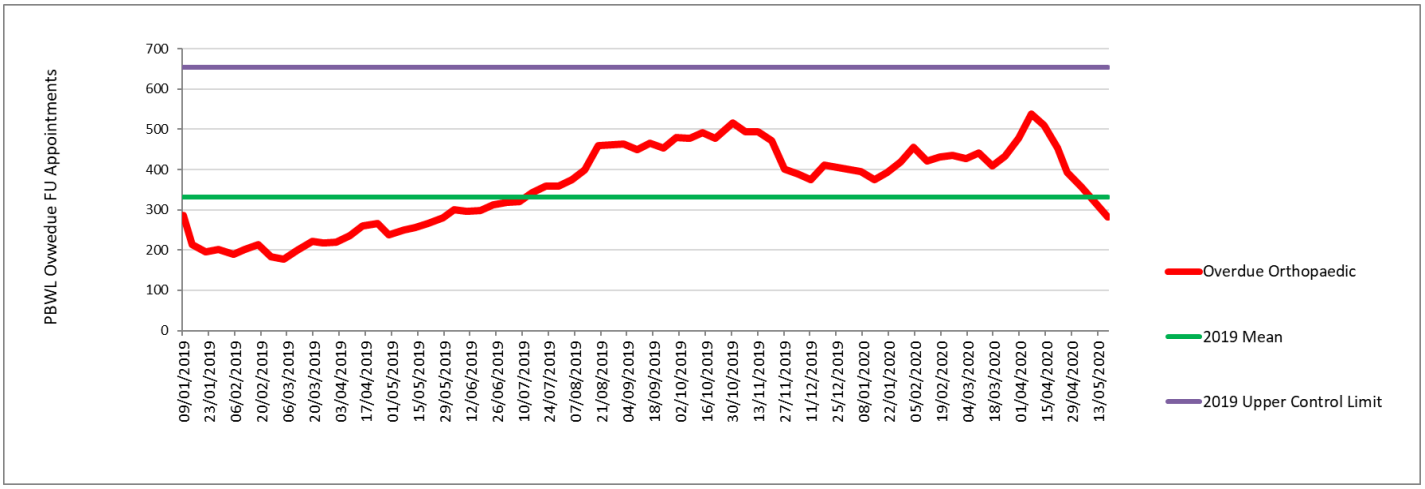
At the end of April the number of patients waiting over 6 weeks beyond their follow up appointment due date was 18,090.

Actions in place to recover:

Our recovery actions include administrative validation, clinical triage and the scaling up of technology enabled care. As a result of these actions as we moved into May PBWL growth has slowed as waiting list deductions have overtaken additions.



A number of surgical specialties have had particular success with transitioning outpatient follow up activity to telephone consultation in order to maintain activity. As an example, orthopaedics has effectively utilised telephone consultations resulting in a reduction in overdue follow up appointments to the lowest volume in over 12 months.



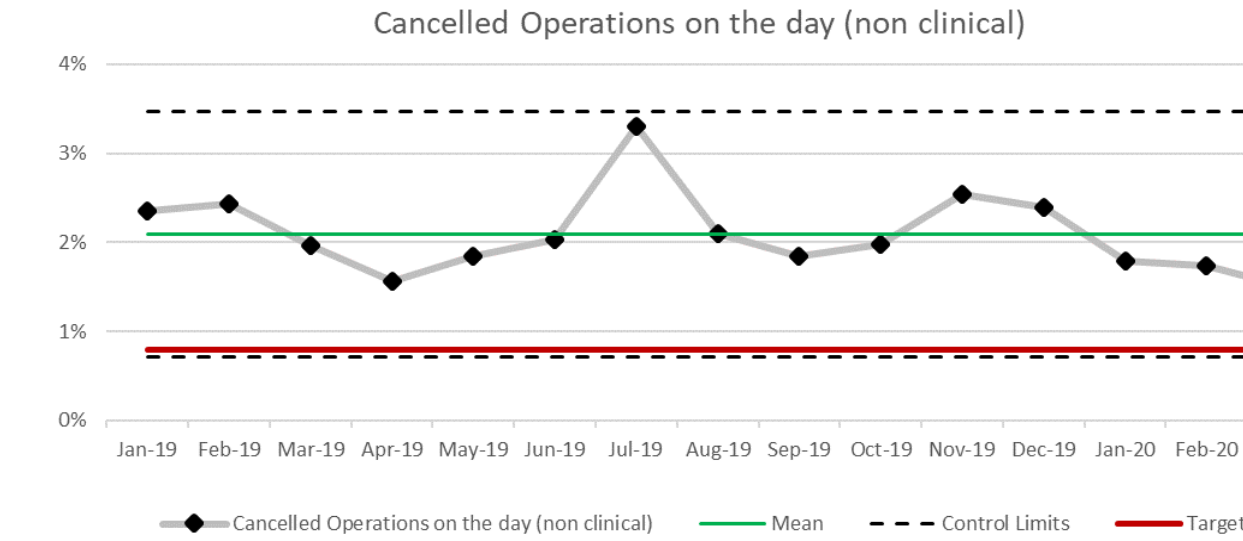
It is anticipated that medical specialties will realise similar achievements once clinicians have been repatriated from the COVID medical rota in early June.

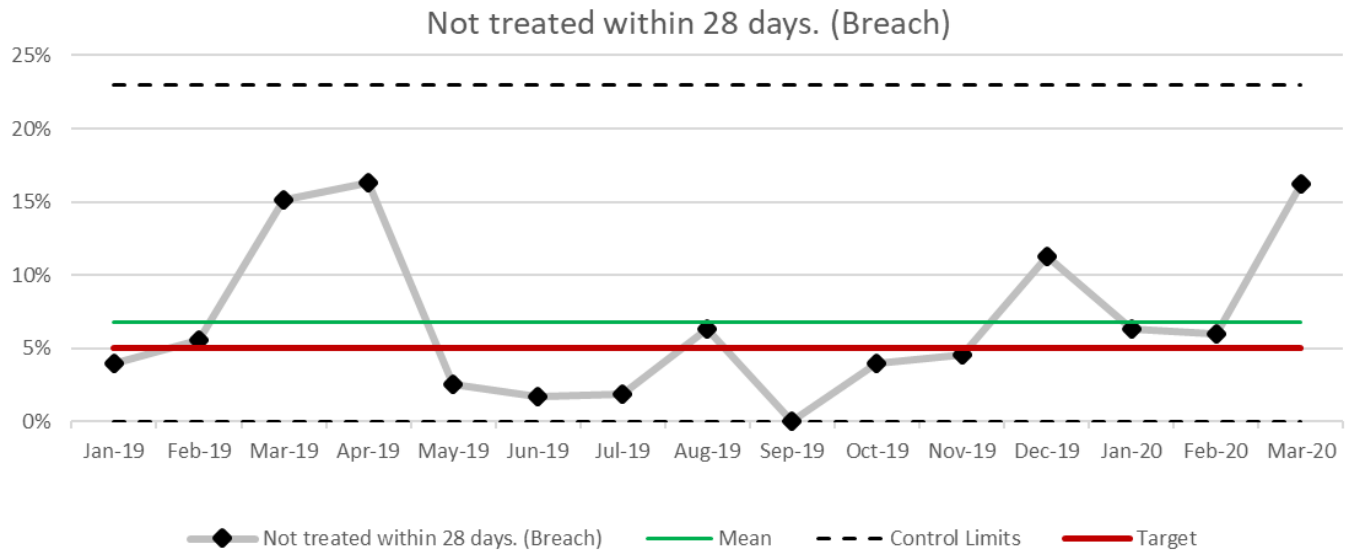
ZERO WAITING – CANCELLED OPS

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

2021 Objective: Our Services



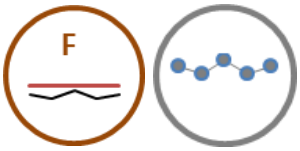


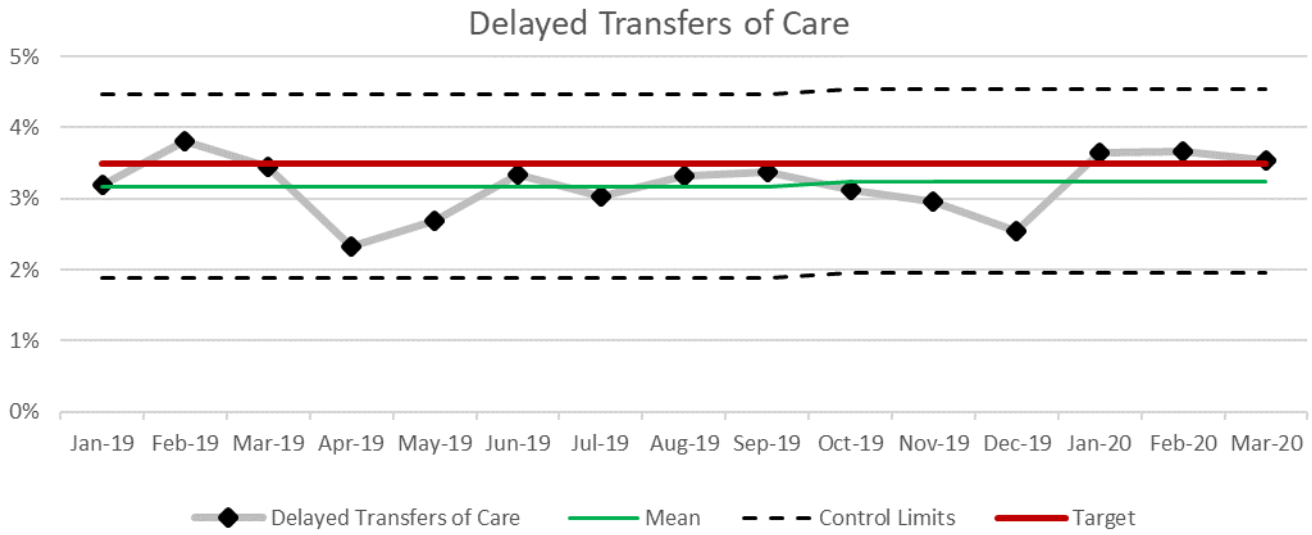
ZERO WAITING – DELAYED TRANSFER OF CARE

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

2021 Objective: Our Services



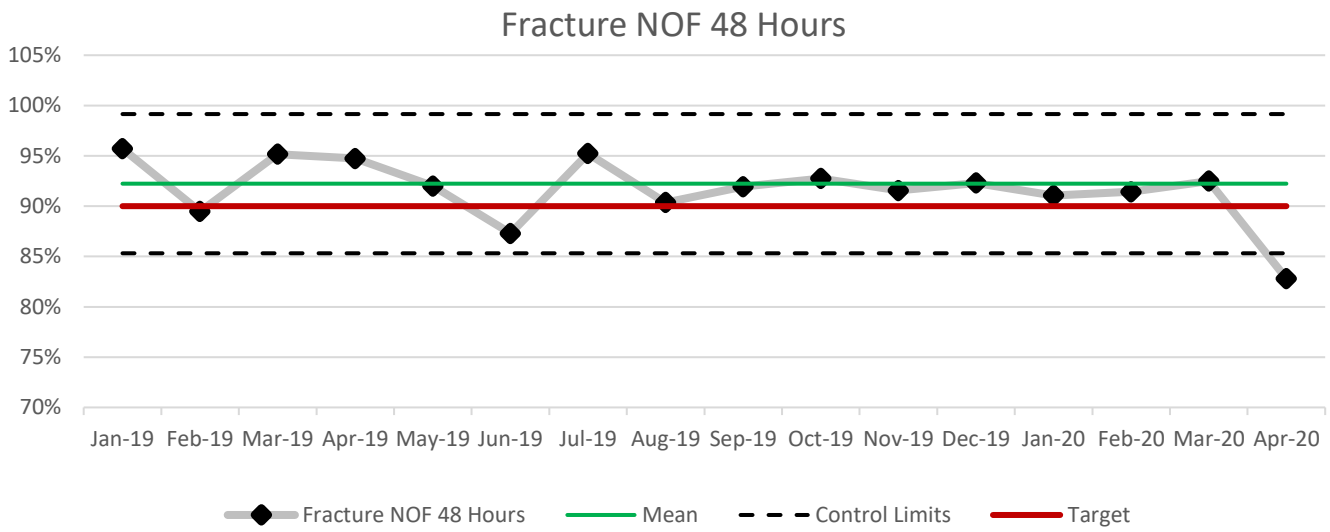


ZERO WAITING – FRACTURE NOF 48 HOURS

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

2021 Objective: Our Services

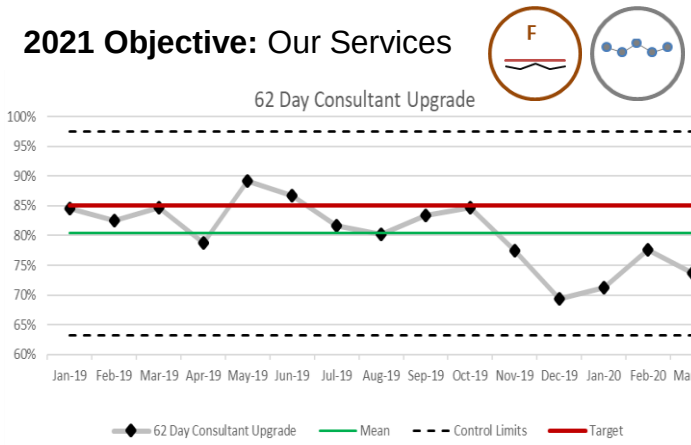


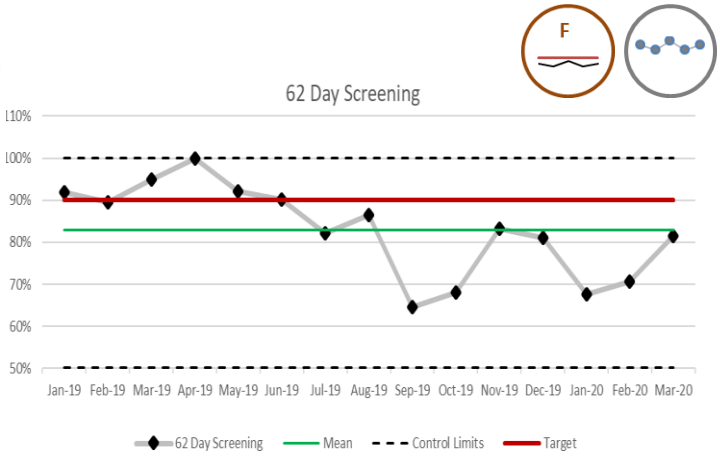
ZERO WAITING – CANCER 62 DAY

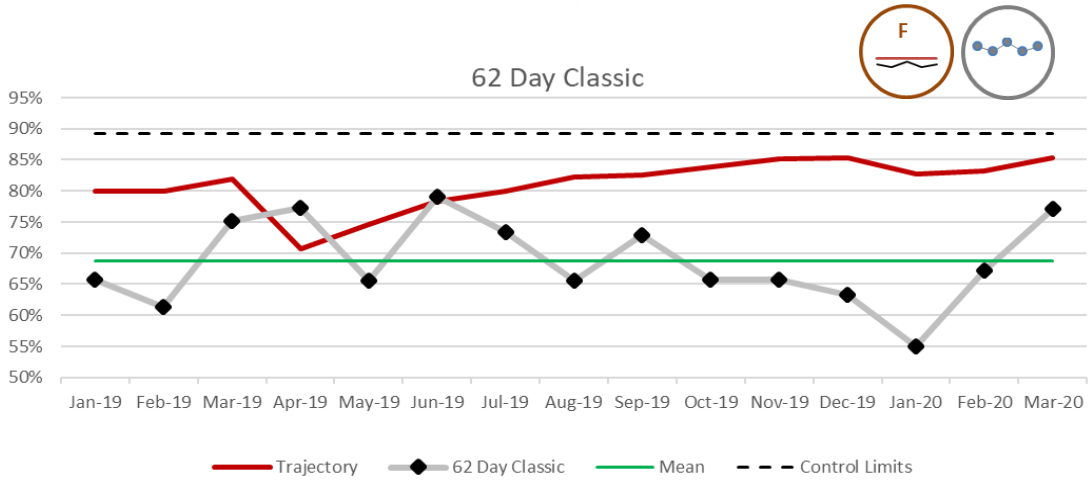
Executive Lead: Chief Operating Officer

CQC Domain: Responsive

2021 Objective: Our Services







Challenges/Successes

March saw the a continued improvement in 62 Day Classic performance the Trust from the low point in January. The 62 Day Classic standard under-performed against the trajectory of 86.6% with only Breast, Skin and Upper GI performing against their agreed trajectory.

Early indications are that our April 62 Day Classic performance will be back to where it was this time last year, with anticipated performance being circa 70% (trajectory 70.8%).

Actions in place to recover:

COVID-19 has put a temporary hold on the work the Cancer Improvement Managers were doing as their efforts are being focused on supporting the operational activity to get cancer patients treated, and are key members of the Cancer Hub.

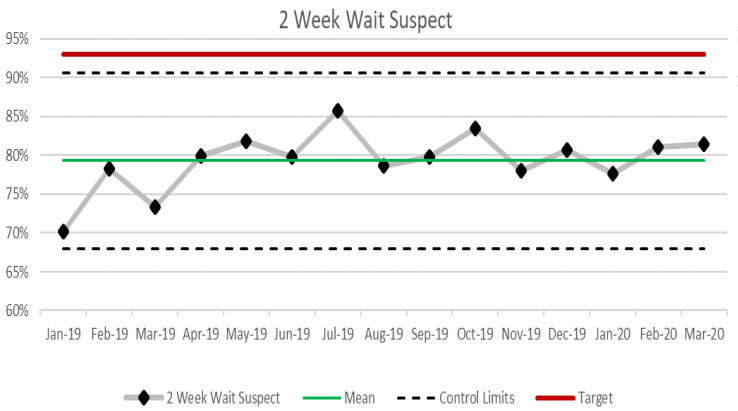
With all effort being to urgently introduce new ways of working during COVID-19, focus on Recovery plans has started as resource is able to be released. The first item to be reviewed is ensuring all 2ww referral forms map directly to the NICE NG12 guidelines of suspect cancer referral criteria, so that these will be in use before the Recovery phase commences.

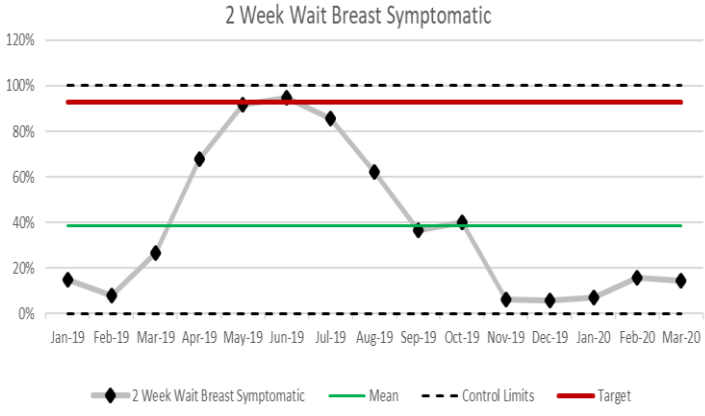
ZERO WAITING – CANCER 2 WEEK WAIT

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

2021 Objective: Our Services





Challenges/Successes

Seven tumour sites met the 14 Day standard in March (Brain, Head & Neck, Lung, Sarcoma, Skin, Upper GI and Urology).

April's forecast tumour site 7 Day performance is as below:

	Apr-20	
7 Day target Referral-to-First OPA 80%	**Total**	**7 Day Prfrmnce %**
Brain/CNS	8	**75.0**
Breast	206	**58.7**
Breast Symptomatic	84	**45.2**
Colorectal	293	**58.7**
Gynaecology	113	**45.1**
Haematology	9	**66.7**
Head & Neck	135	**71.1**
Lung	30	**53.3**
Sarcoma	5	80.0
Skin	157	89.8
Upper GI	50	**36.0**
Urology	100	**57.0**
Totals (excl Breast Sympto)	1107	**62.2**

Actions in place to recover:

The same challenges currently facing the 62 Day standard apply to the Two Week Wait standard. The work being undertaken on the NICE NG12 guideline criteria will have a positive effect on this standard, ensuring a lower volume of higher quality referrals reach the Trust

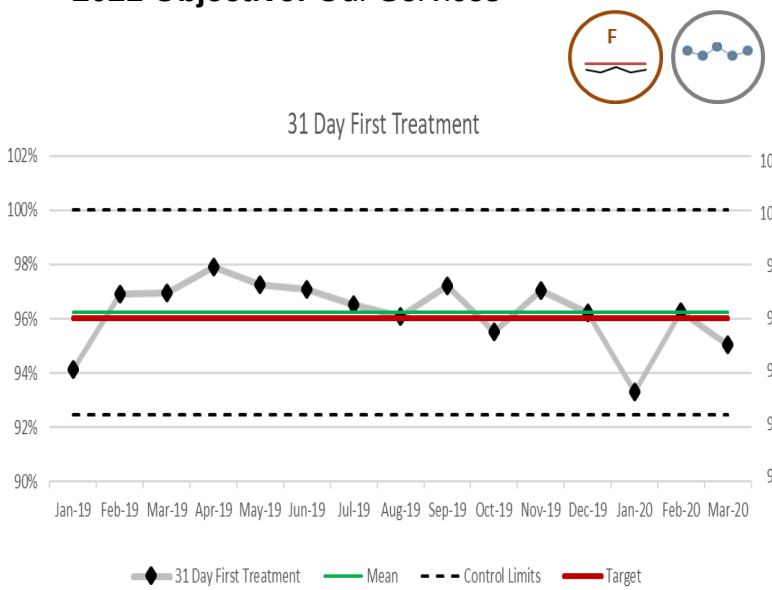
May's Breast 14 Day performance is showing an improved circa 93% performance.

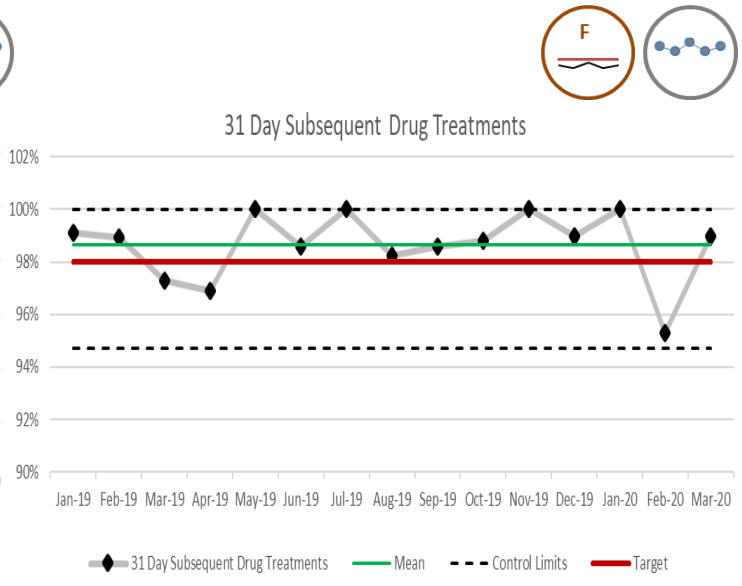
ZERO WAITING – 31 DAY FIRST TREATMENT

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

2021 Objective: Our Services





Challenges/Successes

The Trust achieved the 31 Day Subsequent Drug standard. The 31 Day First and 31 Day Subsequent Surgery standards were missed primarily due to theatre capacity and the 31 Day Subsequent RT standard due to planning and treatment capacity.

Actions in place to recover:

Although all theatre activity initially stopped in the run-up to COVID-19, three theatres per day, four days a week and two theatres for three days a week, have been ring-fenced for cancer surgery. This ring-fenced capacity is allowing a significant number of cancer treatments to proceed and thereby reducing the cancer waiting list backlog.

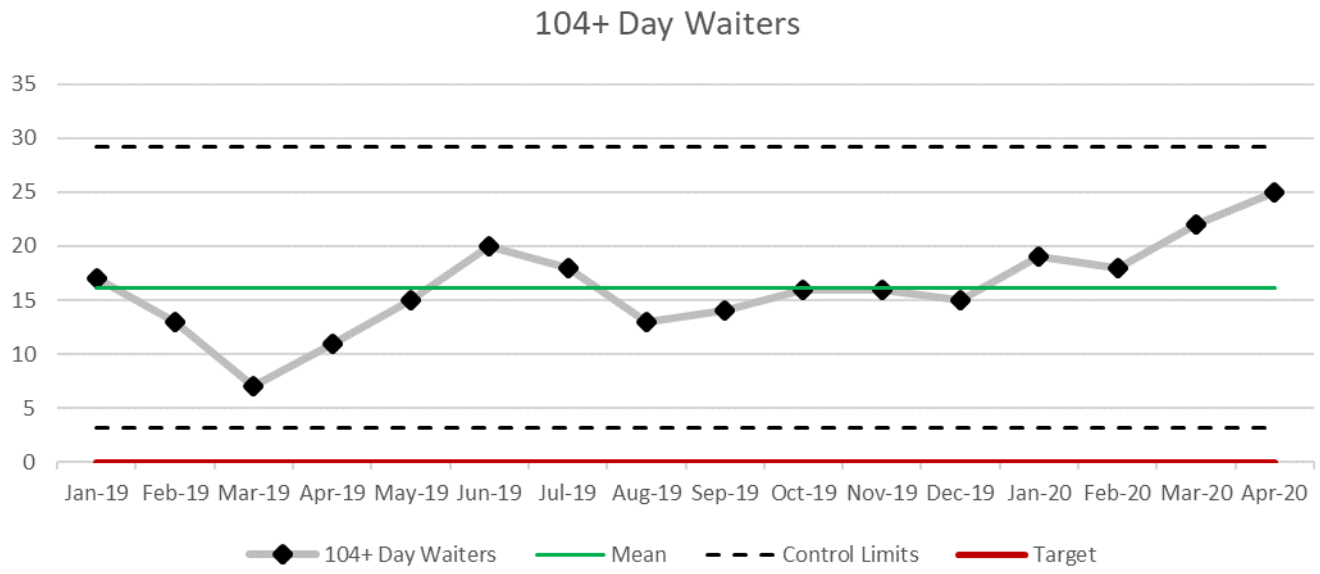
Brachytherapy, which falls under the RT standard, also stopped due to demands on the Anaesthetist resource but discussions are underway to arrange anaesthetic provision alongside the above theatre usage. The stoppage has created a backlog of breach patients, which are likely to be treated in May and June and will have an detrimental impact on the Subsequent RT standard during those months.

ZERO WAITING – 104+ DAY WAITERS

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

2021 Objective: Our Services



Challenges/Successes

The 104+ Day backlog was stabilising week-on-week but the COVID-19 crisis temporarily stopping all diagnostics and treatments, both at ULHT and tertiary centres, has had an impact on these numbers. As of 14th May there were 36 patients waiting over 104 days, significantly above the target of 10 patients. Over half of these patients are on a Colorectal pathway where a large number of patients have declined to attend for investigations during COVID, together with all but emergency Endoscopy procedures stopping. Work continues to reduce the number below 104 days, and minimise the likelihood of those patients becoming a long waiter.

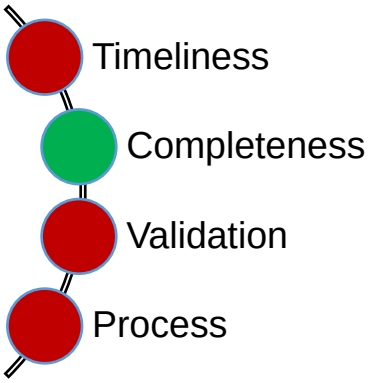
Actions in place to recover:

Focus is being placed on reducing the 62+ Day backlog and thereby minimise the numbers approaching the 104 day mark.

A daily report is issued to the Divisions, highlighting the volumes in their areas with the report allowing immediate drill-down to patient-level detail.

APPENDIX A – KITEMARK

Reviewed:
1st April 2018
Data available at: Specialty level



Domain	Sufficient	Insufficient
Timeliness	Where data is available daily for an indicator, up-to-date data can be produced, reviewed and reported upon the next day. Where data is only available monthly, up-to-date data can be produced, reviewed and reported upon within one month. Where the data is only available quarterly, up-to-date data can be produced, reviewed and reported upon within three months.	Where data is available daily for an indicator, there is a data lag of more than one day. Where data is only available monthly, there is a data lag of more than one month. Where data is only available quarterly, there is a data lag of more than one quarter.
Completeness	Fewer than 3% blank or invalid fields in expected data set. This standard applies unless a different standard is explicitly stated for a KPI within commissioner contracts or through national requirements.	More than 3% blank or invalid fields in expected data set
Validation	The Trust has agreed upon procedures in place for the validation of data for the KPI. A sufficient amount of the data, proportionate to the risk, has been validated to ensure data is: - Accurate - In compliance with relevant rules and definitions for the KPI	Either: - No validation has taken place; or - An insufficient amount of data has been validated as determined by the KPI owner, or - Validation has found that the KPI is not accurate or does not comply with relevant rules and definitions
Process	There is a documented process to detail the following core information: - The numerator and denominator of the indicator - The process for data capture - The process for validation and data cleansing - Performance monitoring	There is no documented process. The process is fragmented/inconsistent across the services

United Lincolnshire Hospitals NHS Trust

To:	**Trust Board**
From:	Medical Director
Date:	June 2020

Title:	**Strategic Risk Report**

Responsible Director: Dr Neill Hepburn, Medical Director

Author: Paul White, Risk Management Lead

Purpose of the Report:
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

The Report is provided to the Trust Board for:

Decision		Discussion	✓
Assurance		Information	✓

Summary/Key Points:

- This report has been revised and expanded to include analysis of current strategic and operational risk exposure across the full Trust risk profile
- 43 out of 84 risks on the strategic risk register are currently rated as Very high or High (51% of the total)
- 43 out of 196 operational (business unit) risks are currently rated High or Very high risk (22% of the total)
- With the exception of risks related specifically to the coronavirus pandemic, the Trust's strategic and operational risk profiles have not changed significantly in the last 21 months

Recommendations
That the Trust Board considers the content of the report and advises if any further action is required.

Strategic Risk Register Significant strategic risks to Trust objectives are referenced within the Board Assurance Framework (BAF).	**Performance KPIs year to date** Performance in reviewing risks in accordance with the Risk Management Policy is reported regularly to the Audit Committee.
Assurance Implications This report enables the Trust Board to review the effectiveness of risk management processes so that it can be assured regarding current risk control strategies and the extent of risk exposure at this time.	
Patient and Public Involvement (PPI) Implications The effectiveness of the Trust's risk and corporate governance arrangements is reported through the Annual Governance Statement (AGS) and is included in the opinion of both internal and external audit. As such, it may influence the degree of confidence that patients and members of the public have in the Trust.	
Equality Impact The Trust's Risk Management Policy has been assessed for equality impact and no issues were identified.	
Information exempt from Disclosure – No	
Requirement for further review? No	

1. Purpose of the Report

1.1 The purpose of this report is to enable the Trust Board to:

- Review the management of risks throughout the Trust and consider the extent of risk exposure at this time
- Evaluate the effectiveness of the Trust's risk management processes

2. Recommendations

2.1 That the Trust Board considers the content of the report and advises if any further action is required.

3. Reasons for Recommendations

3.1 The Trust Board has overall accountability for the management of risk within the organisation.

4. Summary of Key Points

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

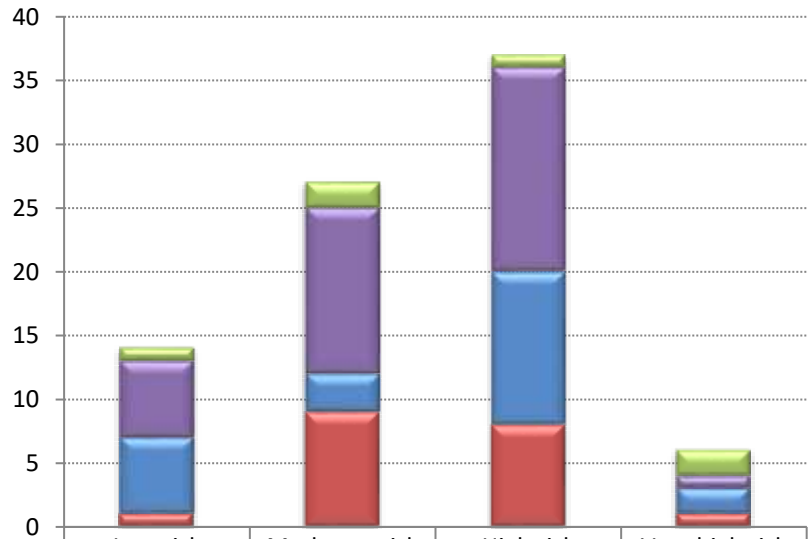
4.5 The Risk Scoring Guide, which is used to assess all risks recorded on the Trust's strategic and operational risk registers, is attached for reference as **Appendix 1**. When defining what constitutes an acceptable risk rating, risk leads are required to consult the Trust's Risk Appetite Statement, which is issued and maintained by the Trust Board alongside the Risk Management Strategy. A copy of the current Risk Appetite Statement is included as **Appendix 2**.

4.6 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 can be updated in the interim if there is evidence that the level of risk has changed. A summary of the Risk Management Process is included as **Appendix 3**.

4.7 All divisional and business unit management teams, as well as members of lead groups, are provided with a range of risk; incident; complaints and claims reports on Datix Dashboards, to support the identification and management of risks within their areas of accountability. These reports continue to be developed to meet the needs of the organisation.

Strategic Risk Profile

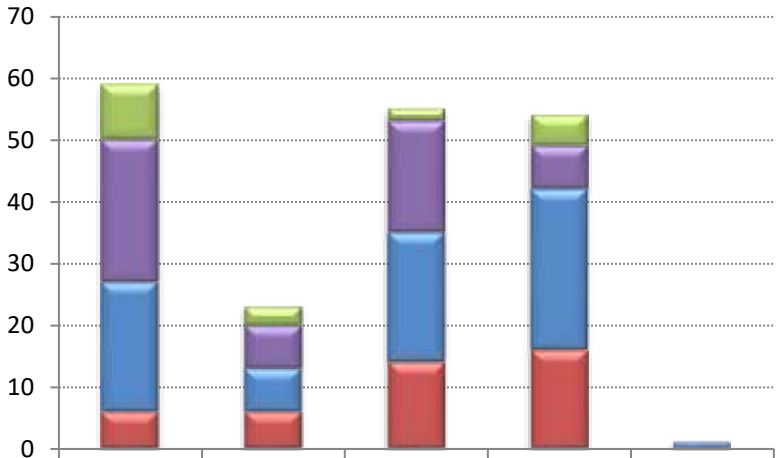
4.8 **Chart 1** shows the number of strategic risks by risk type and current risk rating (taking account of existing controls):



	Low risk	Moderate risk	High risk	Very high risk
Finances	1	2	1	2
Reputation / compliance	6	13	16	1
Service disruption	6	3	12	2
Harm (physical or psychological)	1	9	8	1

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	9	3	2	5	0
Reputation / compliance	23	7	18	7	0
Service disruption	21	7	21	26	1
Harm (physical or psychological)	6	6	14	16	0

Trust risk profile analysis

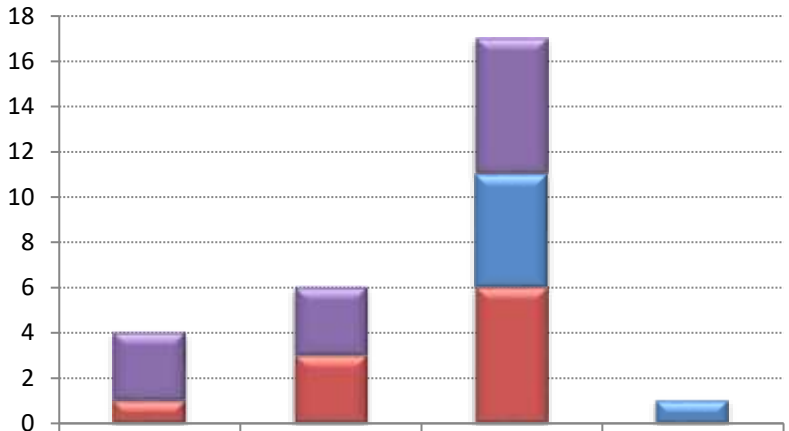
4.10 43 out of 84 strategic risks recorded on Datix are currently rated as Very high or High (51% of the total). This profile has remained largely unchanged for more than 12 months, which indicates that the extent to which the Trust's objectives are at risk has neither increased nor reduced significantly in that time.

4.11 Of the 196 risks recorded on divisional business unit risk registers, 43 (22%) are currently rated as Very high or High. There has been a shift from High risk towards Moderate risk in this profile over the past 3 months. This is due primarily to a process of reviewing older risk entries and aligning them with the criteria specified in the Risk Scoring Guide, rather than a material reduction in risk exposure.

Quality & Safety Risk Profile

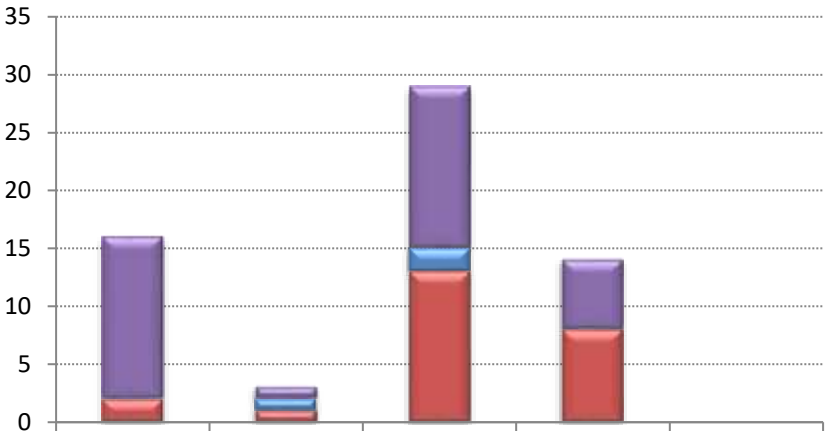
4.12 The Quality Governance Committee (QGC) is the lead assurance committee responsible for oversight of the Quality and Safety Risk Profile. The QGC has continued to meet throughout the Covid-19 pandemic, although with a reduced agenda. Most lead groups have also continued to meet wherever possible.

4.13 **Chart 3** shows the number of strategic quality & safety risks by current risk rating:



	Low risk	Moderate risk	High risk	Very high risk
Finances	0	0	0	0
Reputation / compliance	3	3	6	0
Service disruption	0	0	5	1
Harm (physical or psychological)	1	3	6	0

4.14 **Chart 4** shows the number of operational (Clinical Business Unit) quality & safety risks by current risk rating:



	Very low risk	Low risk	Moderate risk	High risk	Very high risk
Finances	0	0	0	0	0
Reputation / compliance	14	1	14	6	0
Service disruption	0	1	2	0	0
Harm (physical or psychological)	2	1	13	8	0

4.15 **Quality & safety risk profile analysis**

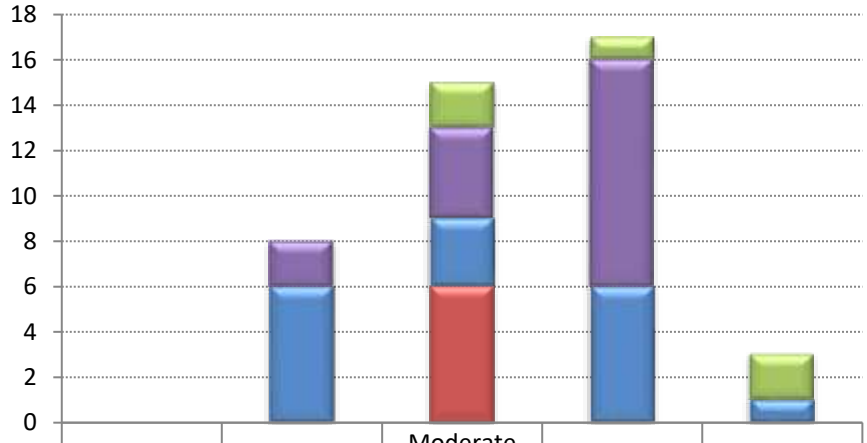
- There have been no material changes to the strategic quality and safety risk profile in the last month; it remains consistent with the overall Trust risk profile, with a slightly higher proportion of High risks (ratings 10-16)

- As part of the Trust's response to the Covid-19 pandemic, there is now an additional strategic risk: Local impact of the global coronavirus (Covid-19) pandemic, risk of harm to patients, staff and visitors; this risk is currently rated as Very high risk (25), with the latest update as follows:
    - The national progression of COVID-19 continues to slow. This is mirrored locally within Lincolnshire. We remain the least affected system across the Midlands. In line with national and regional reporting we are now developing our 'restoration' plan. This plan will focus on infection prevention and control, and increased testing. It will describe how we will be reinstating elements of our services, including full urgent care services and increased elective care services including cancer screening, diagnostics and surgery. This will include a review of the temporary service changes we made in the surge plan
- The strategic risk of prolonged, widespread service disruption due to the outbreak remains at a rating of High risk (16)
- A comprehensive Quality Impact and Risk Assessment process has been used for all service changes as part of the Covid-19 response; this has also been used to inform updates to Clinical Business Unit (CBU) risk registers
- The assessment process has been supported by the Trust's NHS Improvement Director; the Programme Management Office; and the Associate Director of Clinical Governance
- Analysis of Covid-related harm reviews carried out during the pandemic has been requested by the Quality Governance Committee and will be presented next month; this will include incidents of patient linked to the suspension of non-urgent clinical services and postponement of outpatient appointments in recent months
- There are also high risks in the following areas:
    - Patient safety and clinical effectiveness (including the response to deteriorating patients; safety of invasive procedures; delivery of non-invasive ventilation / NIV; safety of handovers; appropriate patient discharge; and safe patient flow decision-making)
    - Safeguarding practice and compliance
    - Medicines safety, compliance and supply

Finance, performance and estates risk profile

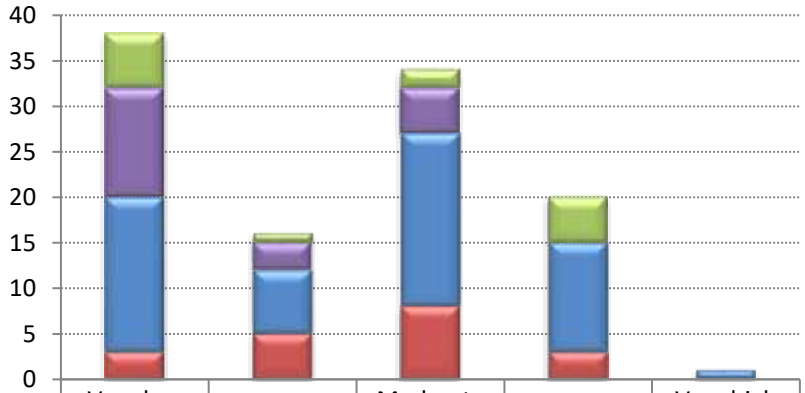
4.16 The Finance, Performance and Estates Committee (FPEC) is the lead assurance committee responsible for oversight of the Finance, Performance and Estates Risk Profile. The FPEC has not met during the Covid-19 pandemic.

4.17 **Chart 5** shows the number of strategic finance, performance and estates risks by current risk rating:



	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	6	3	6	1
Harm (physical or psychological)	0	0	6	0	0

4.18 **Chart 6** shows the number of operational (business unit) finance, performance and estates risks by current risk rating:



	Very low risk	Low risk	Moderate risk	High risk	Very high risk
Finances	6	1	2	5	0
Reputation / compliance	12	3	5	0	0
Service disruption	17	7	19	12	1
Harm (physical or psychological)	3	5	8	3	0

Finance, performance and estates risk profile analysis

4.19 20 of the 43 strategic FPEC risks (47%) are currently rated High or Very high risk, none of which have reduced in over a year. This includes significant risks in the following areas:

- Financial sustainability
- Managing demand for emergency care; planned care; and outpatient appointments
- Estates compliance, infrastructure & safety (specifically, fire safety; electrical safety and infrastructure; water safety & infrastructure; quality of the hospital environment; and asbestos management)
- Cyber security
- Information governance compliance & availability
- Medical device & equipment availability

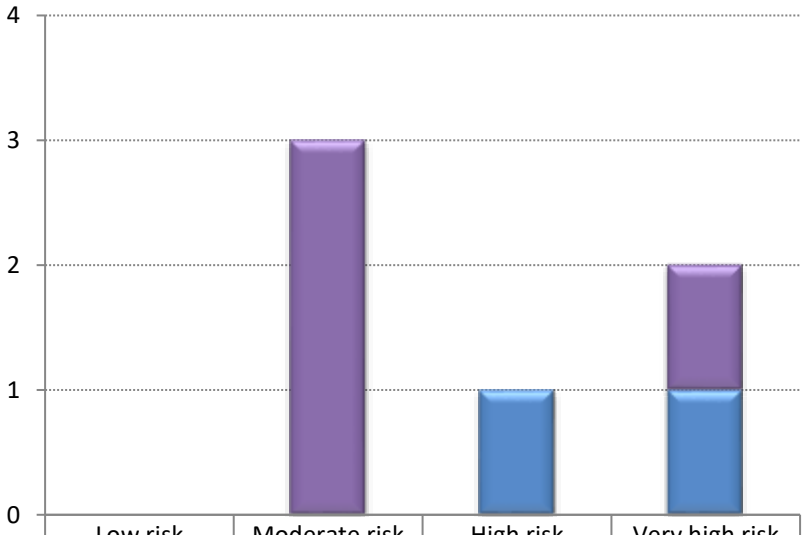
4.20 21 of the 109 operational FPEC risks (19%) are currently rated High or Very high risk. The highest risks in this area relate to:

- Availability of medical devices & equipment (particularly in Diagnostics and Surgery)
- The condition of the estate
- Increased costs associated with reliance on temporary staff to maintain service continuity and safety

Workforce risk profile

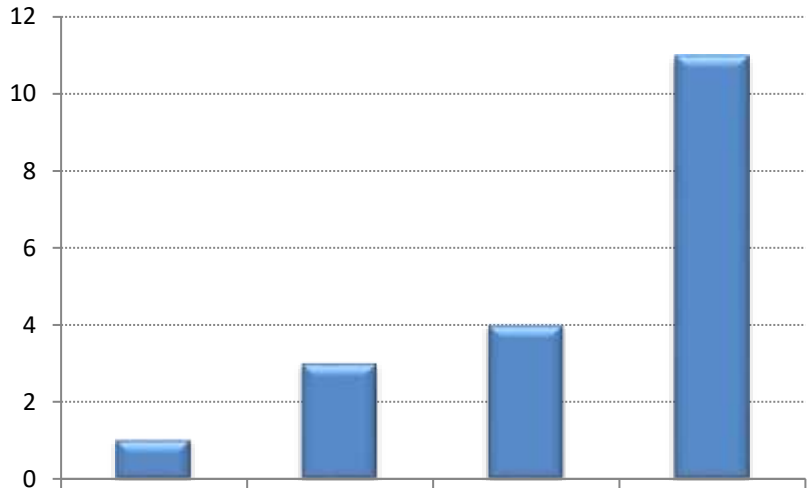
4.21 The Workforce & Organisational Development Committee (WODC) is the lead assurance committee responsible for oversight of the Workforce Risk Profile. The WODC has not met during the Covid-19 pandemic.

4.22 **Chart 7** shows the number of strategic workforce risks by current risk rating:



	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 **Chart 8** shows the number of operational (business unit) workforce risks by current risk rating:



	Very low risk	Low risk	Moderate risk	High risk
Finances	0	0	0	0
Reputation / compliance	0	0	0	0
Service disruption	1	3	4	11
Harm (physical or psychological)	0	0	0	0

Workforce risk profile analysis

4.24 11 of the 19 business units (58%) current assess their workforce capacity and capability as High risk. All of these are Clinical Business Units (CBUs). This has been the unchanged position in terms of risk exposure for more than a year.

Strategic communication and engagement risks

4.25 The following 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)

Appendix 1 – Risk Scoring Guide

	Severity score & descriptor (with examples)				
Risk type	**1 Very low**	**2 Low**	**3 Medium**	**4 High**	**5 Very high**
Harm (physical or psychological)	Low level of harm affecting one or more patients, staff or visitors within a single location.	Low level of harm affecting one or more patients, staff or visitors within a single business unit.	Significant long-term or permanent harm affecting one or more patients, staff or visitors within a single business unit.	Significant long-term or permanent harm affecting multiple patients, staff or visitors within one or more business units.	Significant long-term or permanent harm affecting a large number of patients, staff or visitors throughout the Trust.
Service disruption	Manageable, temporary disruption to peripheral aspects of service provision affecting one or more services.	Noticeable, temporary disruption to essential aspects of service provision reducing the efficiency & effectiveness of one or more services.	Temporary, unplanned service closure affecting one or more services or significant disruption to efficiency & effectiveness across multiple services.	Extended, unplanned service closure affecting one or more services; prolonged disruption to services across multiple business units / sites.	Indefinite, unplanned general hospital or site closure.
Compliance & reputation	Limited impact on public, commissioner or regulator confidence. e.g.: Small number of individual complaints / concerns received.	Noticeable, short term reduction in public, commissioner and / or regulator confidence. e.g.: Recommendations for improvement for one or more services; concerns expressed in local / social media; multiple complaints received.	Significant, short term reduction in public, commissioner and / or regulator confidence. e.g.: Improvement / warning notice for one or more services; independent review; adverse local / social media coverage; multiple serious complaints received.	Significant, long-term reduction in public, commissioner and / or regulator confidence. e.g.: Special Measures; prohibition notice for one or more services; prosecution; sustained adverse national / social media coverage.	Fundamental loss of public, commissioner and / or regulator confidence. e.g.: Suspension of CQC Registration; Parliamentary intervention; vitriolic national / social media coverage.
Finances	Some adverse financial impact (unplanned cost / reduced income / loss) but not sufficient to affect the ability of the service / department to operate within its annual budget.	Noticeable adverse financial impact (unplanned cost / reduced income / loss) affecting the ability of one or more services / departments to operate within their annual budget.	Significant adverse financial impact (unplanned cost / reduced income / loss) affecting the ability of one or more business units to operate within their annual budget.	Significant adverse financial impact (unplanned cost / reduced income / loss) affecting the ability of the organisation to achieve its annual financial control total.	Significant aggregated financial impact (unplanned cost / reduced income / loss) affecting the long-term financial sustainability of the organisation.

Likelihood score & descriptor (with examples)				
1 Extremely unlikely	**2 Quite unlikely**	**3 Reasonably likely**	**4 Quite likely**	**5 Extremely likely**
Unlikely to happen except in very rare circumstances. Less than 1 chance in 1,000 (< 0.1% probability). No gaps in control. Well managed.	Unlikely to happen except in specific circumstances. Between 1 chance in 1,000 & 1 in 100 (0.1 - 1% probability). Some gaps in control; no substantial threats identified.	Likely to happen in a relatively small number of circumstances. Between 1 chance in 100 & 1 in 10 (1- 10% probability). Evidence of potential threats with some gaps in control.	Likely to happen in many but not the majority of circumstances. Between 1 chance in 10 & 1 in 2 (10 - 50% probability). Evidence of substantial threats with some gaps in control.	More likely to happen than not. Greater than 1 chance in 2 (>50% probability). Evidence of substantial threats with significant gaps in control.

Risk scoring matrix						
Severity	**5**	5	10	15	20	25
	4	4	8	12	16	20
	3	3	6	9	12	15
	2	2	4	6	8	10
	1	1	2	3	4	5
		1	**2**	**3**	**4**	**5**
		Likelihood				

Risk rating	**Very low** (1-3)	**Low** (4-6)	**Moderate** (8-10)	**High** (12-16)	**Very high** (20-25)

Appendix 2 – Risk Appetite Statement

The Trust Board is responsible for setting the strategic direction of United Lincolnshire Hospitals NHS Trust. This includes defining the risk appetite, which is the tendency of the organisation to accept risk in particular situations and in pursuit of its goals.

As a provider of healthcare services, the Trust recognises that we operate within an environment where there is and will always be an element of risk in everything that we do. Decisions we make must take account of risks to the safety of our patients; staff; and visitors to our hospital sites as well as the potential impact on our finances, our reputation and the sustainability of our services. We must also consider how great the potential benefits might be, as well as the impact our decisions may have on our partner organisations.

The purpose of this statement is to set out in clear and unambiguous terms the Trust's risk appetite in relation to each of our strategic objectives. It is issued alongside our Risk Management Strategy, so that together they provide a framework that enables effective risk-based decision making throughout the organisation.

The Trust's risk appetite is defined using the following scale:

- Open – prepared to tolerate a high level of risk
- Cautious – prepared to tolerate a moderate level of risk
- Minimal – prepared to tolerate only a low level of risk

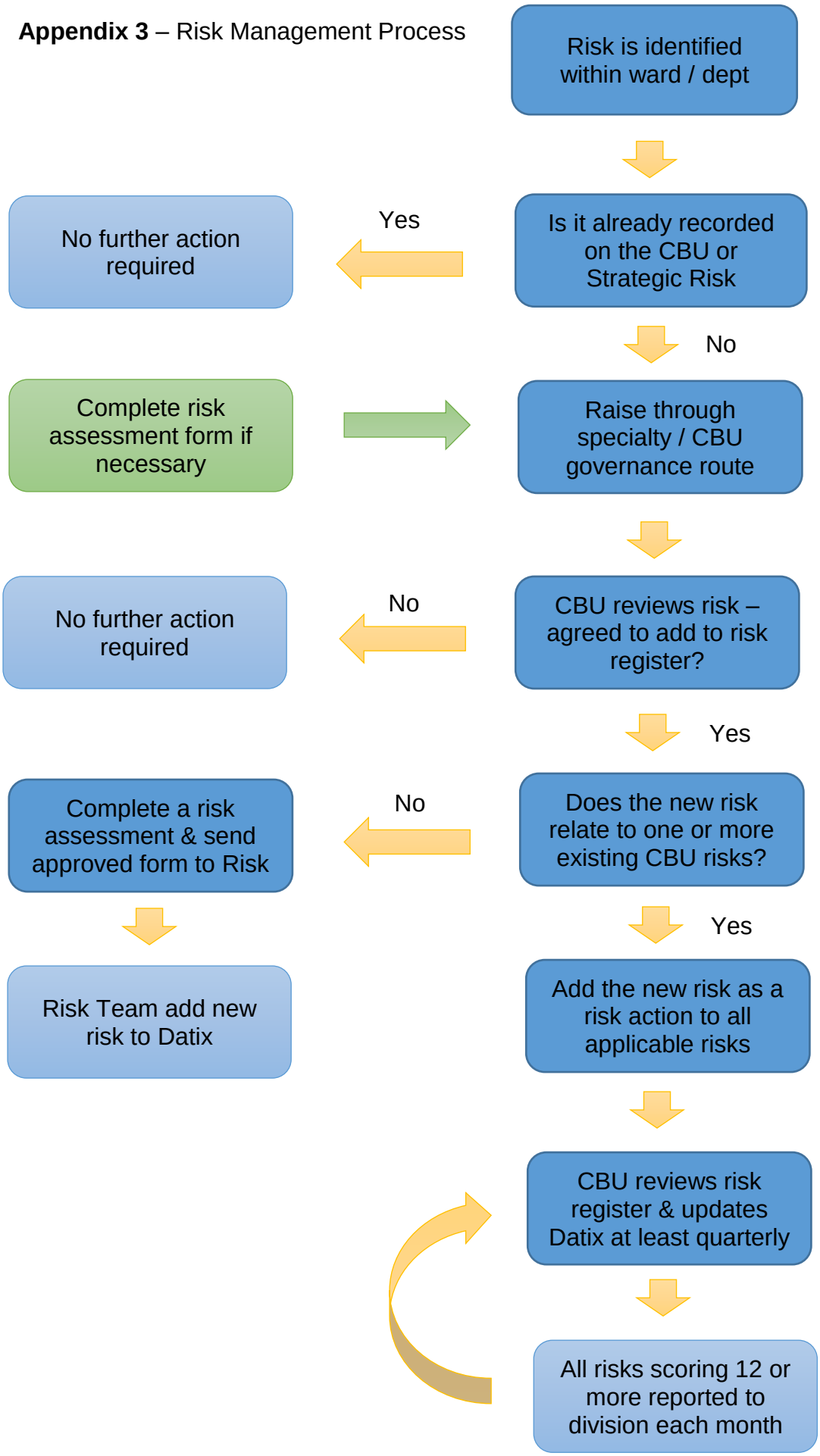
The Trust's current statement of risk appetite in relation to each of its strategic objectives is summarised on the following table, along with a brief explanation of what this means in practical terms:

Trust objective	Risk appetite	Tolerable risk	What this means
Harm free care	Minimal	Low	Low risk options are sought wherever possible; opportunities to innovate and improve the quality of care will be considered where there is evidence of significant potential benefit with low likelihood of harm to patients
Valuing patients time	Cautious	Moderate	Lower risk options are preferred, however it is acknowledged that at times it may be necessary to accept an increased level of risk in order to balance competing demands and make the best use of available resources
Zero waiting	Cautious	Moderate	Lower risk options are preferred; however, it is acknowledged that the Trust may need to adopt new ways of working in order to manage demand and that these changes are likely to come with increased risk and a degree of uncertainty

Trust objective	Risk appetite	Tolerable risk	What this means
Sustainable services	Open	High	The Trust is open to higher risk options to redesign future service provision, where there is convincing evidence of significant potential benefit to the quality and sustainability of services without increased risk to the safety of patients
Modern & progressive workforce	Open	High	The Trust is open to higher risk options to reshape our workforce, where there is convincing evidence of significant potential benefit to the quality and sustainability of services without increased risk to the safety of patients
One team	Cautious	Moderate	Lower risk options are preferred, whilst accepting that by empowering our staff to make decisions we may be exposed to increased levels of risk
Service integration	Open	High	The Trust is open to higher risk options when looking to redesign its services and integrate them with its partners, provided this does not lead to an increase in patient safety risk

This **Risk appetite statement** is made by the Trust Board in May 2019. It will be kept under regular review and updated where necessary.

Appendix 3 – Risk Management Process



Appendix 4 - 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 or 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
4405	Critical infrastructure failure disrupting aseptic pharmacy services	Clinical Support Services	Service disruption	16	High risk
4480	Safe management of emergency demand	Medicine	Harm (physical or psychological)	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
3951	Compliance with regulations & standards for aseptic pharmacy services	Clinical Support Services	Reputation / compliance	16	High risk
4156	Safe management of medicines	Clinical Support Services	Harm (physical or psychological)	16	High risk
4044	Compliance with information governance regulations & standards	Corporate	Reputation / compliance	16	High risk
4437	Critical failure of the water supply	Corporate	Service disruption	16	High risk

ID	Title	Division	Risk Type	Rating (current)	Risk level (current)
4497	Contamination of aseptic products	Clinical Support Services	Harm (physical or psychological)	15	High risk
4481	Availability of patient information	Corporate	Service disruption	12	High risk
4556	Safe management of demand for outpatient appointments	Clinical Support Services	Harm (physical or 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 or 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 or 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 Services	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 Services	Service disruption	12	High risk

ID	Title	Division	Risk Type	Rating (current)	Risk level (current)
4423	Working in partnership with the wider healthcare system	Corporate	Service disruption	12	High risk
4476	Compliance with clinical effectiveness regulations & standards	Corporate	Reputation / compliance	12	High risk
4567	Working Safely during the COVID -19 pandemic (HM Government Guidance)	Corporate	Reputation / compliance	9	Moderate risk
4526	Internal corporate communications	Corporate	Reputation / compliance	8	Moderate risk
4528	Minor fire safety incident	Corporate	Harm (physical or psychological)	8	Moderate risk
4553	Failure to appropriately manage land and property	Corporate	Finances	8	Moderate risk
4424	Delivery of planned improvements to quality & safety of patient care	Corporate	Reputation / compliance	8	Moderate risk
4483	Safe use of radiation	Clinical Support Services	Harm (physical or psychological)	8	Moderate risk
4486	Clinical outcomes for patients	Corporate	Harm (physical or psychological)	8	Moderate risk
4404	Major fire safety incident	Corporate	Harm (physical or psychological)	8	Moderate risk
4389	Compliance with corporate governance regulations & standards	Corporate	Reputation / compliance	8	Moderate risk
4397	Exposure to asbestos	Corporate	Harm (physical or 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 or psychological)	8	Moderate risk
4401	Safety of the hospital environment	Corporate	Harm (physical or psychological)	8	Moderate risk
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

ID	Title	Division	Risk Type	Rating (current)	Risk level (current)
3722	Energy performance and sustainability	Corporate	Finances	8	Moderate risk
4003	Major security incident	Corporate	Harm (physical or 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
4353	Safe use of medical devices & equipment	Corporate	Harm (physical or psychological)	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
4440	Compliance with emergency planning regulations & standards	Corporate	Reputation / compliance	4	Low risk
4441	Compliance with radiation protection regulations & standards	Clinical Support Services	Reputation / compliance	4	Low risk
4467	Impact of a 'no deal' EU Exit scenario	Corporate	Service disruption	4	Low risk
4469	Compliance with blood safety & quality regulations & standards	Clinical Support Services	Reputation / compliance	4	Low risk
4482	Safe use of blood and blood products	Clinical Support Services	Harm (physical or psychological)	4	Low risk
4502	Compliance with regulations & standards for medical device management	Corporate	Reputation / compliance	4	Low risk

ID	Title	Division	Risk Type	Rating (current)	Risk level (current)
4514	Hospital @ Night management	Corporate	Service disruption	4	Low risk

Appendix 5 – 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
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 (Surgery CBU)	Surgery	Service disruption	12	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 (T&O and Ophthalmology CBU)	Surgery	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

ID	Title	Division	Risk Type	Rating (current)	Risk level (current)
4317	Exceeding annual budget (Cardiovascular CBU)	Medicine	Finances	12	High risk
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
4340	Workforce capacity & capability (Cancer Services CBU)	Clinical Support Services	Service disruption	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	Replacement of essential equipment to prevent service disruption (Estates & Facilities)	Corporate	Service disruption	12	High risk
4394	Access to essential areas of the estate (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

ID	Title	Division	Risk Type	Rating (current)	Risk level (current)
4420	Workforce capacity & capability (Children & Young Persons CBU)	Family Health	Service disruption	12	High risk
4425	Workforce capacity & capability (Diagnostics CBU)	Clinical Support Services	Service disruption	12	High risk
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	Service 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	*2 June 2020*
Item Number	*Item 13*
Board Assurance Framework (BAF) 2020/21	
Accountable Director	*Andrew Morgan Chief Executive*
Presented by	*Jayne Warner, Trust Secretary*
Author(s)	*Jayne Warner, Trust Secretary*
Report previously considered at	*N/A*

How the report supports the delivery of the priorities within the Board Assurance Framework	
1a Deliver harm free care	*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 not been reviewed through committee structure as a result of governance arrangements in place during covid incident.*

Executive Summary

Following discussions at the April meeting about how the Board would seek assurance during the Covid 19 national incident it was agreed that a review would be completed of the elements of the 2020/21 Board Assurance Framework acknowledging that some areas would not progress whilst the Trust responded to the incident but that some objectives would remain a focus for the organisation and alternative routes for assurance may need to be identified.

The 2020/21 BAF was being developed based on the objectives within the Trust Integrated Improvement Plan. The launch of the plan within the Trust was paused with the declaration of the national incident in response to the threat from covid - 19.

Moving forward the monthly update of the board assurance framework will be aligned with progress against the Integrated Improvement Plan, an assessment has now taken place of the projects which will continue and those which are paused the draft board assurance framework will be updated as these projects are reviewed to reflect assurances received and where the impact of covid-19 creates a risk to the achievement of the Trust objectives for 2020/21. Some of the objectives will not have been updated and remain paused.

It should be noted that for the May meeting the framework has not been considered by all of the Board Committees. During May the relevant areas of the framework were shared and considered at the Quality Governance Committee.

Board Assurance Framework (BAF) 2020/21

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	Workforce 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 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	Developing a safety culture Improving the safety of Medicines management 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	Declared as a level 4 incident throughout the UK. NHSE to coordinate NHS response. Measures to be put in place locally to ensure safety of public, patients and staff. Trust actions as per national and regional plans Major incident (Gold Command Structure) 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	Control gaps identifed and reported through to Gold Command Structure.	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	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	**TBD**
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	Declared as a level 4 incident throughout the UK. NHSE to coordinate NHS response. Measures to be put in place locally to ensure safety of public, patients and staff. Trust actions as per national and regional plans Major incident (Gold Command Structure) CQC actions monitored through QGC meeting during Covid 19 streamlined governance arrangements Pandemic Flu Plan initiated	Control gaps identifed and reported through to Gold Command Structure.	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	

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
1c	Improve clinical outcomes	Medical Director	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 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	Declared as a level 4 incident throughout the UK. NHSE to coordinate NHS response. Measures to be put in place locally to ensure safety of public, patients and staff. Trust actions as per national and regional plans Major incident (Gold Command Structure) CQC actions monitored through QGC meeting during Covid 19 streamlined governance arrangements Pandemic Flu Plan initiated	Control gaps identifed and reported through to Gold Command Structure.	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	
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	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	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		Control gaps identifed and reported through to Gold Command Structure.	Vacancy rates Turnover rates Rates of appraisal/mandatory training compliance Learning days per staff member Staff survey feedback Sickness/absence data	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	Workforce and Organisational Development Committee	

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
2b	Making ULHT the best place to work	Director of People and Organisational Development	Specific projects paused during Covid 19 response	4083	CQC Well Led	Embedding our values and behaviours Reviewing the way in which we communicate with staff and involve them in shaping our plans Adapting our responsibility framework and leadership programmes in line with the NHS Leadership Compact Revise our diversity action plan for 2021/22 to ensure concerns around equity of treatment and opportunity are tackled Agree and promote the core offer of ULHT, so our staff feel valued, supported and cared for Implementing Schwartz Rounds Embed Freedom to Speak Up and Guardian of safe Working Celebrate year of the Nurse/Midwife			WRES/ DES Data Staff survey feedback Number of staff attending leadership courses Number of Schwartz rounds completed Protect our staff from bullying, violence and harassment			Workforce and Organisational Development Committee	
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 Operate as an ethical			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			Audit Committee	

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
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	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		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			PLACE assessments 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			Finance, Performance and Estates Committee	
3b	Efficient use of our resources	Director of Finance and Digital	Specific projects paused during Covid 19 response		CQC Well Led CQC Use of Resources	Delivering £25m 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			Delivery of CIP Achievement of Financial Plan Achievement of Model Hospital opportunities Improve service line profitability			Finance, Performance and Estates Committee	
3c	Enhanced data and digital capability	Director of Finance and Digital	Specific projects paused during Covid 19 response		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			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			Finance, Performance and Estates Committee	

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	Specific projects paused during Covid 19 response		CQC Caring CQC Responsive CQC Well Led	Supporting the implementation of new models of care across a range of specialties Support Creation of ICS Support the development of an Integrated Community Care programme Support the consultation for Acute Service Review (ASR) Improvement programmes for cancer, outpatients, theatres and urgent care Development and Implementation of new pathways for paediatric services			Numbers of new models of care established Delivery of ASR Year 1 objectives Improvement in health and wellbeing metrics				
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			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				
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 Increasing the number of Clinical Academic posts Refresh of our Research, Development and Innovation Strategy Improve the training environment for medical students and Doctors			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				

Ref	Objective	Exec Lead	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Controls in place during Covid	How identified control gaps are being managed	Source of assurance	Assurances in place during Covid	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating

The BAF management process

The Trust Board has assigned each strategic objective of the 2021 Strategy to a lead assurance committee. Outcomes under each strategic objective are aligned to a lead committee or reserved for review by the Trust Board.

The process for routine review and update of the BAF is as follows:

- The corporate risk register is maintained by the lead executive, in accordance with the Risk Management Policy
- The BAF is updated with any changes to those corporate risks recorded within it; the Trust Board decides which corporate risks are significant enough to warrant inclusion on the BAF, based on recommendations from committees
- The lead assurance committee (or Trust Board, where applicable) reviews the management of risks to each required outcome(as part of their regular work programme), through evaluation of reports and risk assessments provided at Committee by executive leads
- The lead committee identifies any gaps in controls or assurance and ensures there are appropriate plans in place to address them
- The lead committee decides on an assurance rating for each required outcome, based on evidence provided in identified sources of assurance

To facilitate this process, each committee will receive regular reports from specialist groups, executive leads and other sources which provide management information and analysis of relevant key risks, to enable the committee to make a judgement as to the level of assurance that can be provided to the Board. All reports to committees should first have been reviewed and approved by the executive lead.

When deciding on the assurance rating for each outcome the following key should be used:

Effective controls may not be in place and/or appropriate assurances are not available to the Board

Effective controls are thought to be in place but assurances are uncertain and/or possibly insufficient

Effective controls are definitely in place and Board are satisfied that appropriate assurances are available