Bundle Trust Board Meeting in Public Session 7 July 2020

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

1	Introduction, Welcome and Chair's Opening Remarks *Chair*
2	Public Questions *Chair*
3	Apologies for Absence *Chair*
4	Declarations of Interest *Chair*
5.1	Minutes of the meeting held on 2 June 2020 and 11 June 2020 *Chair* Item 5.1 Public Board Minutes June 2020.docx Item 5.1 Public Board Minutes June 2020 Extra-Ordinary.docx
5.2	Matters arising from the previous meeting/action log *Chair* Item 5.2 Public Action log June 2020.docx
6	Chief Executive Horizon Scan Including STP *Chief Executive*
7	Covid -19 Update *To follow* Covid-19 Restore Phase Progress Summary July 2020 Front Sheet.docx
8	Strategic Objective 1 To Deliver high quality, safe and responsive patient services, shaped by best practice and our communities
8.1	Assurance and Risk Report from the Quality Governance Committee *Chair of QGC* Item 8.1 QGC Upward report June 2020v1.doc
8.2	Hygiene Code *Director of Nursing* Item 8.2 Front Cover CQC Hygiene Code - June 2020.docx Item 8.2 Hygiene Code gap analysis May 2020.xlsx
9	Strategic Objective 2 To enable our people to lead, work differently and to feel valued, motivated and proud to work at ULHT
9.1	Workforce Report *Director of People and OD* Item 9.1 COVID Workforce Assurance Report July 2020.docx Item 9.1 Append B.pdf
9.2	BAME Update Item 9.2 Supporting_Our_BAME_Patients_Staff_MB_JUNE_2020_vers_1_1.pptx
9.3	Freedom to Speak Up Update *FTSU Guardian* Item 9.3 FTSU Update.docx
10	Strategic Objective 3 To ensure that services are sustainable, supported by technology and delivered from an improved estate
10.1	Finance Report Month 2 *Director of Finance & Digital* Item 10.1 Finance Report 2021 M2 Final.docx
11	Strategic Objective 4 To implement integrated models of care with our partners to improve Lincolnshire's health and wellbeing

12 Integrated Performance Report

Director of Finance & Digital

Item 12 Integrated Performance Report - Trust Board V3.docx

13 Risk and Assurance

13.1 Risk Management Report

Item 13.1 TB- Strategic Risk Report - July 2020.pdf

13.2 Board Assurance Framework

Trust Secretary

Item 13.2 BAF 2020-21 Front Cover July 2020.docx

Item 13.2 BAF 2020-2021 v29.06.2020.xlsx

15 Any Other Notified Items of Urgent Business

16 The next meeting will be held on Tuesday

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

Agenda Item 5

United Lincolnshire Hospitals NHS Trust

Minutes of the Trust Board Meeting

Held on 2 June 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

538/20	**Item 1 Introduction** The Chair welcomed Board members and members of public who were live streaming to the meeting. In line with guidance on covid-19 the Trust were unable to hold the meeting in public session, as such the facility for live streaming had been made. This was in the interest of keeping patients and staff safe. In line with policy, papers had been published in the usual way and members of the public had been able to submit questions in the usual way. In recognition of working in unusual circumstances the agenda had been streamlined to focus on those issues which detail the Trust response to Covid-19.
539/20	The Chair moved to questions from members of the public. **Item 2 Public Questions** **Q1 from Jody Clarke**

	If Grantham Hospital is potentially a 'Green' site and can deliver some outpatient services as a Covid-19 safe location. **Is there any possibility of having our 24hr access resumed, to avoid unnecessary travel and avoid congregating at one main location, that may not be Covid-19 safe?** The Chief Operating Officer responded: The point raised was valid, particularly in respect of reducing the change for staff and patients contracting Covid-19 within the Trusts' hospitals, this was a key element being worked through. The plans being developed would consider a range of options, not only working through the green pathway but also how the Trust protected those patients attending for elective care and how emergency services were configured. There was not yet a definitive answer however, a range of options were being considered to deliver the safest services at this time.
540/20	**Item 3 Apologies for Absence** Apologies were received from Mr Geoff Hayward, Non-Executive Director
541/20	**Item 4 Declarations of Interest** There were no declarations of interest which had not previously been declared.
542/20	**Item 5 Minutes of the meeting held on 5th May 2020 for accuracy** The minutes of the meeting held on 5th May 2020 were agreed as a true and accurate record subject to the following amendments 445/20 – Mrs Libiszewski asked that further clarity be added on the term green site. Amendment would read - 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 confimed covid) activity and based on the highest principles of ensuring the highest standards of IPC, minimising cross infection, focussed on environmental changes, hygiene, social distancing, screening and segregation of staff and patients. 458/20 – Should read – The Board were reminded that the level 4 incident remained in place 479/20 – Should read – following the government announcement due to be made on 10th May
543/20	**Item 6 Matters arising from the previous meeting/action log** The Chair noted that there were no actions to address and that a number of deferred actions would be addressed post Covid-19
544/20	**Item 7 Chief Executive Horizon Scan including STP** The Chief Executive provided a verbal update to the Board noting that the Trust continued to work on the three facets of the current situation. Managing the incident, ensuring that the Trust made progress to restore urgent and essential services and ensuring that capacity and capability was in place to respond to a potential second surge in cases both in the community and hospitals.

545/20	During the response to the pandemic the Executive Team have been engaging with staff through weekly Facebook live and MS Teams events. Weekly meetings with Staffside representatives had also been held. There had been continued engagement with the workforce which has been important due to the speed at which national policy changes had been taking place.
546/20	There were currently three areas that were being worked through from national policy changes. Antibody testing would be introduced with the expectation that all colleagues will be tested with national expectations on how many tests would be conducted by the NHS during June.
547/20	The implications of Test and Trace were being considered for healthcare staff. The implication of large numbers of staff being contacted due to having been in contact with a positive person rather than the staff member being the index case.
548/20	The Trust were also considering the issues of quarantine if a member of staff had left the country and returned. There needed to be an understanding of how the 14 day quarantine period would work, how services would continue to run and consideration as to whether the staff member should have left the country. The Trust would need to consider the management and recording of absences related to travel.
549/20	The Chief Executive advised that there would be learning undertaken on how the system had managed and led the response to Covid-19. There had been for a number of years a system governance process in place. The current view was that it was now appropriate to review the structure at pace in order that this could be improved and translated in to the future way of working within the NHS.
550/20	Work would be undertaken across the system to redesign the governance structure, this would be led by the Director of Improvement and Integration and updates would be presented to the Board
551/20	The Chair noted that it had been helpful to understand the dialogue with Staffside and that it had been reported that there was positive and mature dialogue. This had been a positive step forward that could be developed. The Trust Board: • **Noted the update**
	Objective 1a Deliver Harm Free Care
552/20	**Item 8.1 COVID-19 Update – 14:55** The Chief Operating Officer presented the report to update the Board of the response to Covid-19 noting that the situation remained rapidly evolving, however the number of patients with confirmed and suspected Covid-19 had reduced.
553/20	Nationally there had been changes around testing and this was expected to continue as more was learnt about Covid-19 and the response from the NHS and wider care sector.
554/20	The Trust were in the restore phase of the 4 stage response, as part of the NHS wider response. The restore phase would be relatively short where the Trust expected to put back in place services that had been significantly changed or paused in order to respond to the

	surge in demand, or where there was a need to protect more vulnerable patients accessing services.
555/20	The more urgent services that were required to ensure patient safety were anticipated to be running at 100% in most cases by the end July. Where it would not be possible to run services at pre-Covid-19 levels the Trust had been able to articulate the reason and decisions, this in the most part had been deliberate in order to ensure patients were not exposed to an increased risk.
556/20	The Trust had increased capacity in preparation for the increase in urgent care demand. There had been a large reduction in demand during the initial phase of Covid-19 with Lincolnshire seeing the greatest reduction. This placed the Trust in a good position to respond to suspected and positive Covid-19 patients.
557/20	There was now a need to restore these services back to full strength in order to respond to day to day demands, plans were progressing well with the expectation that emergency capacity would be back up to pre-Covid-19 levels or greater.
558/20	Work was underway to create green pathways and increase capacity of cancer services which had been paused or reduced in capacity in the early stages of the response. This was a complex exercise driven by ensuring that only those services that could be put in place safely were restored. There may be some change to service provision on some sites as the Trust moved through the increase in capacity.
559/20	Screening services had commenced coming back online however at a lower level in some areas, there would be a continual review of the nature of the reduction in the capacity of services. This would determine the need to reinstate services or provide in a different configuration and would continue until the recovery phase commenced. Upon the commencement of the recovery phase it was anticipated that there would be a larger scale increase in activity across all hospital sites.
560/20	Dr Gibson commented that there had been some national debate regarding what the bed occupancy rate should be through the restore phase. Now there was potential for a second surge and the wish of the Trust to restore services Dr Gibson asked if there was a sense of what the optimum bed occupancy should be over the coming months.
561/20	The Chief Operating Officer acknowledged that this was a complicated situation and the Trust needed to reduce bed occupancy. One measure taken was a large scale review of all clinical areas, whilst occupancy had been high there had been a deliberate reduction in beds and physical infrastructure in order to offer the greatest level of IPC. The Trust were working to an 85% and 92% occupancy rate, using historical occupancy rates but with changes to the physical infrastructure.
562/20	Dr Gibson sought assurance that should there be a second surge that some flexibility had been retained in order to respond to additional Covid-19 patients.
563/20	The Chief Operating Officer noted that as part of the restoration phase the Trust were increasing overall capacity with a series of models that considered not only a gradual increase but also a further surge. The Trust held in reserve plans to deliver surge capacity should there be a requirement.
564/20	Dr Gibson noted that the Trust had introduced a single hyper acute stroke centre as part of the manage phase of Covid-19 and sought assurance that the Trust were taking the opportunity to monitor how this was working both in terms of conveyances and outcome.

565/20	The Chief Operating Officer advised that the changes to the stroke service were necessary due to the limited workforce available to deliver the service safely. This would continue for some time due to the nature of Covid-19 however this was reviewed on a regular basis. Formal reporting was conducted weekly through Gold Command and included conveyances and outcomes. The service appeared to be working effectively however ongoing monitoring would be undertaken.
566/20	Mrs Libiszewski sought further detail on the infection prevention and control (IPC) work being undertaken to protect patients from not only Covid-19 but all other infections.
567/20	The Director of Nursing stated that the Trust had made IPC a priority for the right reason and this was not just about Covid-19 as other bacteria was still present. The Trust needed to be sighted on the fundamental IPC practices and work was underway for the Quality Governance Committee to review governance arrangements and to ensure ward to board assurances were received. There needed to be clear delivery of the IPC standards and practice within the Trust.
568/20	NHS Improvement/England had recently published an IPC Board Assurance Framework and a gap analysis was being completed that would be presented to the Quality Governance Committee. Work around the hygiene code and clarity on the level of compliance would feature in the upward report from the Committee at the July Board.
569/20	The work on the hygiene code would focus on the maintenance, understanding and enactment of policies and procedures. Clarity would be provided on the auditing of those elements to understand where there was evidence of excellent practice and areas where learning was required.
570/20	The Director of Nursing noted that the Trust were looking to ensure that environments were clean and being clear about what environments and practices should look like from both a public and NHS perspective.
571/20	There were significant concerns regarding the estate and this had resulted in the establishment of an annual deep clean schedule that had been signed off by the IPC Group. This provided clarity on the frequency of the deep cleans whilst ensuring that the environment in those ward areas was of the standard required in order to conduct an effective deep clean.
572/20	Mrs Libiszewski thanked the Director of Nursing for the detailed update and observed that the key messages would need to be publicised to support those patients who were anxious about accessing the Trust's hospitals.
573/20	Mrs Dunnett was keen to understand how specialities had been communicating with patients awaiting treatment during the manage phase of Covid-19, particularly in relation to those patients who may be anxious about the waits being experienced.
574/20	The Chief Operating Officer stated that the start of the response to Covid-19 there had been a large communications exercise that was tackled specifically by the clinical teams. Communication with patients detailed the approach being taken by the Trust in relation to the services being provided and the way in which patients could stay in touch with the service.
575/20	As the Trust moves through the restore phase communication links that had been paused would be re-established and contact would be made with those patients who had been affected.
576/20	The Director of Improvement and Integration noted that the process to contact all patients who were on a waiting list had been signed off. The purpose of the contact would be to

	ensure that the status of the patient remained the same. This would take a number of weeks to complete.
577/20	The Chief Executive advised the Board that the presence and visibility of the Trust through the media had been a deliberate approach in order to provide as much detail to the public as possible. Some of these messages could be repeated on social media in order to target more individuals and also address the point of increasing public confidence. This would need to be a continuing approach and way of working for the Trust.
578/20	Mrs Ponder asked if patients would be tested on admission for surgery in addition to being tested 48-72 hours prior to admission and being advised to self-isolate. Mrs Ponder also asked if there would be antibody testing for patients alongside these measures.
579/20	The Chief Operating Officer advised that testing prior to admission was still being worked through and there may still be a need to adjust this for those patients who required a shorted time period prior to admission. There was no plan in place to retest on admission as the anti-gen swab combined with an isolation period significantly reduced the risk level to a nationally accepted level for patients accessing an area described as green.
580/20	Antibody testing did not as yet have any application in the admissions process as this was still being developed. It was expected that antibody testing would be more likely to provide information on the spread of Covid-19 on a population basis. Should there be an application for this test in relation to admission the Trust would follow national guidance. Currently a positive antibody test did not necessarily confer immunity.
581/20	The Chair noted that there had been improvement in performance in some areas of the Trust during the response to Covid-19 through the use of technology. Thanks were expressed to the clinicians and patients for being prepared to work with new technology. This had achieved some strong and positive results. It was hoped that working with technology would continue to progress alongside conducting face to face appointments where necessary.
582/20	Assurance had been received recognising that the Trust had moved to the restore phase and that there was advanced planning underway as to how the Trust would increase service availability in the safest possible way whilst managing IPC arrangements.
583/20	The Board recognised that the level 4 national emergency remained and there could be a need to deploy surge plans should this become a reality of the easing of lockdown. The Trust were in a strong position to move forward with the restoration of services. The Trust Board: • **Received the report**
584/20	**Item 8.2 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 19th May 2020 meeting. The Committee continued to meet with a lean agenda.
584/20	The Committee reviewed the terms of reference and work programme to ensure the sight had not been lost on key issues.
585/20	There had been a review of the reporting structure to the Committee resulting in the removal of the Quality and Safety Oversight Group. This meant that a number of groups would be reporting directly through to the Committee, removing a step in the reporting process. The

	Committee would need to review how this affected the working of the Committee however there was confidence that the Executives would be able to provide oversight and effective upward reporting to the Committee.
586/20	The Quality Account was received and the Board were advised that there had been an opportunity to delay the publication. It was however agreed that the account would be delivered to the original deadline. The Committee agreed to amend a priority in order to include Infection Prevention and Control (IPC). The priority was being developed and would be received at the Committee in July.
587/20	A full report in to Covid-19 was received by the Committee.
588/20	The Committee received the mortality reporting noting that the national reports on HSMR and SHMI would become less relevant due to the impact of Covid-19. The Committee were assured by the work looking at a thematic review of mortality within the organisation and across the system. This would allow for the identification of good practice and learning.
589/20	A full report in to IPC was received and work was being led by the Director of IPC to look at the way in which reporting, governance and detail would be addressed. Mrs Libiszewski advised that Board that there was a lack of confidence in previous reporting. A full review of the hygiene code and other IPC areas was being reported directly to the Committee.
590/20	Compliance levels would not be as previously reported however it would be possible to conduct the due diligence required with action being taken to address this. The annual deep clean programme and standard operating procedure were agreed by the Committee and had commenced. The Committee received significant assurance on the work being undertaken.
591/20	The Board Assurance Framework was received and the Committee were working to this however it was noted that some objectives had been delayed due to Covid-19 and some had been brought forward.
592/20	The Committee received the Risk Report.
593/20	A full update on Never Events had been received with ten being reported in the last financial year. A thematic review had taken place for all events alongside a review of what could be done differently. Prior to Covid-19 the launch of safety culture work had been due to take place. The Committee requested an updated as to when this could be expected to launch as it would be vital to build on the work in response to Covid-19.
594/20	An update on ethics had been received, it was noted that there had been no further updates to report.
595/20	The Committee received an update on the CQC action plan noting that there had been some movement despite the efforts being taken to address Covid-19. There had been some improvements seen on the action plan and updates were received by the Committee on a monthly basis.
596/20	The Director of Nursing wished to labour the point for the Board in relation to IPC in line with statutory responsibilities. Previous reporting had provided assurance of 97% compliance with the hygiene code however, the Board should expect to see a significant decrease. Compliance would be reported to the June Committee meeting and upwardly reported to the Board in July.
597/20	The Chair noted that it was important in the interest of openness and transparency that if this had not previously been correctly reported this would require correction and explanation.

598/20	The clearer line of sight from the frontline to the Committee was noted and there was increased confidence in the IPC work and how this was being managed. The Trust Board: • **Received the assurance report**
	Objective 2a A Modern and Progressive Workforce
599/20	**Item 9.1 Protecting and Supporting BAME Patients and Staff through Covid-19** The Director of Improvement and Integration presented the report noting that this provided detail of the impact of Covid-19 on workforce and the steps being taken to support the workforce.
600/20	Extra meetings with BAME colleagues had taken place in order to listen to staff feedback and ensure additional support was in place. Through the media it was reported that there was a disproportionate impact of Covid-9 on Black, Asian and minority ethnic (BAME) colleagues. The reason for this continued to be explored and a national report was awaited to understand this. Learning would be taken from the national report and the Trust would put, as required, additional measures in to practice.
601/20	The Trust were involved in national recording and reporting of testing and mortality affecting patients and staff, this included ethnicity data and monitoring. Prevalence of Covid-19 in BAME staff was lower in the Trust than in non-BAME staff. This provided some degree of assurance however there was still anxiety amongst staff, as such additional action had been put in place to offer support.
602/20	A letter had been sent to 1109 BAME colleagues outlining the steps to be taken including, risk assessments, fit testing and the offer of testing every 14 days. The repeated testing offered limited value however provided some reassurance to staff. Availability of antibody testing would be considered when this became available.
603/20	As at 25th May that there had been a 52% return rate of risk assessments, this had increased to 62% at the time of the meeting. The outcome of these risk assessments had resulted in 4 out of 10 staff continued to work as normal and 5 out of 10 having some degree of modification to their roll to allow them to remain at work.
604/20	Of the staff tested so far, circa 2000, the positive rate was 13.68%, as of 25th May.
605/20	The Trust were aware that the East Coast and Boston had had a higher prevalence of covid 19 which may have driven some of the prevalence of testing at those sites. There had been a wider testing programme at Pilgrim and with BAME staff, this may have affected some of the testing results due to the increased number of people being tested who were not displaying symptoms. Test results would continue to be monitored.
606/20	Due to the increased discussions with BAME colleagues the BAME network had been relaunched with a new chair and vice chair. This had resulted in a significant level of engagement.
607/20	Dr Prior asked how the Trust compared to other Trusts with a positive testing rate of 13.68% and if the testing programme included agency and non-substantive staff.

608/20	The Director of Improvement and Integration advised that the Trust compared favourably to others and believed that this was reflective of the lesser impact seen as a health community compared to other areas. A request for national and regional data had been made in order to compare the organisation and provide trend data over the course of Covid-19.
609/20	The Director of People and Organisational Development noted that bank staff were tested if they met the criteria for testing. Reassurance had also been sought from the agencies that risk assessments were being completed for BAME staff.
610/20	The Chair was pleased with the approach being taken to support BAME staff in an individual way rather than a blanket approach as this had enable the Trust to respond to individual needs.
611/20	The Board welcomed the new appointment of the BAME Network Chair and Vice Chair and would welcome them to a Board meeting to open a dialogue. The Trust Board: • **Received the report**
	Objective 3b Efficient Use of Resources
612/20	**Item 10.1 Finance Report** The Director of Finance and Digital presented the report noting that the Trust had achieved the control total for 2019/20, turning out a deficit of £41.4m.
613/20	Achievement of the control total lead to in the Trust receiving £28.9m funding.
614/20	There had been £1.4m of Covid-19 costs incurred in final 2-3 weeks of March with £900k of costs incurred for staffing. The staffing cost had not been reimbursed however this had been taken in to account.
615/20	The Trust received £21.3m of external support from the Clinical Commissioning Groups across the year. This acknowledged the additional non-elective activity undertaken by the Trust above the signed contract.
616/20	£44.1m had been spent on agency staffing, a significant rise from the previous year and £23m above the target figure. The Trust did however make significant improvements within the later quarter of the year as tighter controls were exerted. The Trust were commencing the current financial year with a lower run rate.
617/20	In relation to revenue the Trust turned out a £20.7m efficiency delivery, it was noted that within this there had been £6m of non-recurrent technical items transacted.
618/20	The capital programme of £31.5m had been spent this placed the Trust in a positive position and potential national outlier. The Trust now had a track record of spending all available capital. There had been £1.8m of capital costs incurred associated with Covid-19, central reimbursement was awaited.
619/20	Following the expected national announcement regarding the write off for historical debt, the Trust were expecting to have £377m written off.
620/20	The Chief Executive highlighted the progress made on the delivery of the control total, increase in cost savings and delivery of the capital position noting that this was progress for the organisation. The remaining deficit was acknowledged and required further work to

	address however there had not previously been a track record of achieving the control total set for the Trust.
621/20	The Board were asked to acknowledge the positive progress that the Trust had made, there was more to do in order to improve the revenue position however this was a positive step forward.
622/20	The Chair echoed the significant achievements of the organisation and thanked the budget holders who had contributed to the achievement of the position.
623/20	Dr Gibson asked if the shift to public dividend capital (PDC) from historical debt provided the Trust with any revenue benefits going forward.
624/20	The Director of Finance and Digital advised that the Trust expected to see a £2.5m improvement in the revenue position with the move to PDC. A review was being undertaken by the Department of Health and Social Care to determine the rate of interest, this was currently 3.5% on PDC.
625/20	Mrs Ponder sought assurance that whilst the current focus was on Covid-19 that there would be planning in place to ensure that the capital allocation for the year would be spent, in order to place the Trust in a positive position. There would be a need to ensure that the challenges within Estates, Information Technology and Medical Devices were addressed.
626/20	The Director of Finance and Digital noted that planning for those areas was well advanced as it had been built on the previous year capital plan. Further work would be undertaken within Estates to understand how the delivery of the work could be conducted. There was some risk to the delivery of estate work, coming from the construction industry, due to supply and price issues. This would be closely monitored over the coming months and a clear forecast put in place.
627/20	Mrs Libiszewski sought clarification on the restoring of internal governance arrangements for the Finance, Performance and Estate Committee. The Chair advised that this would be restored as soon as was sensible, with a possibility of the first meeting taking place in July. Consideration would then be given to the People and Organisational Development Committee.
628/20	The Trust Board: • **Received the report**
629/20	**Item 11 Integrated Performance Report** The Chair invited members of the Board to receive and note the Integrated Performance Report. The Trust Board: • **Noted the report**
	Risk and Assurance
630/20	**Item 12 Risk Management Report** The Medical Director presented the report to the Board noting that this contained additional detail with the main risks relating to Covid-19 and the Trusts response.

631/20	The Board were advised that harm reviews were being undertaken during the pandemic, which would be reported to the Quality Governance Committee. There remained a concern around clinical effectiveness and medicine supply, particularly regarding anaesthetic supplies.
632/20	There would be further risks associated with the development of new pathways which would be included and reported in July, the development of pathways would inevitably generate some concerns.
634/20	Mrs Libiszewski noted that there was a need to ensure sight was not lost on actions not pertaining to Covid-19 and that these were updated in light of the progress being made that had been highlighted to the Board.
635/20	It was also felt that the risk appetite statement required a refresh as the objectives contained were not correct for the coming financial year.
636/20	The Medical Director proposed that the risk appetite statement would need to be considered through a Board Development session, agreed with Chair, and in line with the Integrated Improvement Plan.
637/20	It was also acknowledged that the risk register required review. **Action – Executive Directors, 7th July 2020**
638/20	Mrs Ponder also noted the need for updates to the register and asked that the risk relating to a no deal Brexit was considered as the time for agreeing transitional requirements was expiring. Mrs Ponder requested that consideration be given to the potential increase of the risk.
639/20	The Chair stated that the risk relating to Covid-19 had been reported for some time as 25 however, after hearing the encouraging activity regarding the restore phase and IPC mitigations these would need to be update within the risk. Whilst this remained as a high risk and was a concern it would be beneficial to understand when this may be reduced given the actions being taken.
640/20	The Trust Board noted and accepted those top risks within the register, recognising the need to review and update risks based on discussions held. The Trust Board: • **Received the update** • **Accepted the top risks within the register**
641/20	**Item 13 Board Assurance Framework** The Chair noted that the 2020/21 Board Assurance Framework had been received however as it was early in the year there it was not yet possible to review the assurance ratings.
642/20	The Quality Governance Committee had received the framework and would start to utilise and populate in order to report the position to the Board.
643/20	The framework would need to be tied in to the work around the Integrated Improvement Plan and there was an expectation that the framework would be presented in a more mature form to the July Board.

	The Trust Board: • **Received the Board Assurance Framework**
644/20	**Item 14 Any Other Notified Items of Urgent Business** No Items
	The next meeting will be held on Tuesday 7 July 2020, arrangements to be confirmed taking account of national guidance

Voting Members	**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**	**2 June 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	X	X	X	A	X	X	X	X	X	X	A	A
Gill Ponder	X	X	X	A	X	X	X	X	X	X	X	X
Jan Sobieraj	X											
Neill Hepburn	X	X	X	A	X	X	X	X	X	X	X	X
Michelle Rhodes	X	A	A	X								
Kevin Turner	X	X	A									
Sarah Dunnett	X	X	A	X	X	X	X	X	X	X	X	X
Elizabeth Libiszewski	X	X	X	X	A	X	X	X	A	X	X	X
Paul Matthew	X	X	A	X	X	X	X	X	X	X	X	X
Andrew Morgan		X	X	A	X	X	X	X	X	X	X	X
Victoria Bagshaw					X	X	X	X				
Mark Brassington					X	X	X	X	X	X	X	X
Karen Dunderdale									X	X	X	X

Agenda Item 5

Minutes of the Extraordinary Trust Board Meeting

Held on 11 June 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
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
Dr Neill Hepburn, Medical Director
Mr Geoff Hayward, Non-Executive Director

645/20	**Item 1 Introduction** The Chair welcomed Board members and those members of the public who were observing the meeting through the live stream.
646/20	The Chair advised that the meeting being held was in addition to the scheduled monthly meetings as the organisation continued to develop plans to respond to the impact of the global pandemic. There was a single paper on the agenda which was seeking approval for a temporary service change as a result of Covid-19.
647/20	The view of the Chair had been that to wait to make the decision at the next scheduled Board meeting would introduce unnecessary delay and operational colleagues needed clarity of direction in order to plan for the next phase of the response.
648/20	As such, the prerogative of the Chair, under the Standing Orders of the Trust had been exercised in order to call the extraordinary meeting.
649/20	Although the Trust was operating in a national emergency structure, and had been and was continuing to respond to national policy and direction, the Board had endeavoured to be as open and transparent as possible about the position and plans in the response phase and

	now as the Trust moved in to restoration. Therefore the decision had been taken to hold the meeting in public in order to continue to behave in the same way and to share the Trusts thinking and discussion with as many people as possible.
650/20	Whilst it had not been possible to allow the public to attend the meeting in person line with guidance on Covid-19 in relation to public gatherings, the Board were live streaming the meeting so that interested parties were able to listen to the discussions. In accordance with the usual procedure papers had been published on the Trusts website and public questions invited in the usual way.
651/20	The Chair welcomed those who had joined the meeting through the live stream and was delighted by the level of interest that had been shown.
652/20	**Item 2 Public Questions** The Chair moved to questions from members of the public advising that the Board would respond to one question per person and would allow a maximum of 30 minutes for the agenda item in line with the usual published procedure for meetings.
653/20	Due to the volume of questions if the Board were unable to respond to all questions within 30 minutes, outstanding questions would receive a written response following the meeting. Where an individual had submitted multiple questions, those questions not responded to in the meeting would again receive a written response.
654/20	**Q1 from Doreen Clarke** **What is the " end vision " of the powers that be for the residents of Grantham and surrounding villages regarding an acceptable maximum travel time to receive a comprehensive service of health care.** **Grantham is on the borders of Lincolnshire, Leicestershire and Nottinghamshire but facilities are being pushed further and further away from this nucleus of expanding occupation as it's hospital is continually being downgraded. Get with the programme please . it could and would play such an important role if the different health authorities would only communicate with each other !** **Put simply, where and when can we expect to be able to access good comprehensive hospital care without having to travel as far as Lincoln or further where they are already unable to cope with ever increasing demand.** The Chief Executive Responded:
655/20	The proposal being discussed was for temporary changes to be made in order to enable the Trust to restore some essential services in response to the pandemic. The proposals do not attempt to cover the end vision and it would be inappropriate to consider this at this time. Any future strategy for health care in Lincolnshire and any proposals to make permanent significant change would need to be led by NHS Lincolnshire Clinical Commissioning Group. It would be within the Clinical Commissioning Group's authority to make changes. It was anticipated that the Clinical Commissioning Group would wish to hold further discussions building on the healthy conversations and work of the Lincolnshire Long Term Plan in the coming months. Based on the proposal presented there would be no discussion regarding the end vision.
656/20	**Q2 from Alfie Kent** **(1) Why do you continue with the charade that there is no intention to close Grantham Hospital.**

	The Chief Executive responded:
657/20	During the past 10 – 11 months as Chief Executive at the Trust there had never been a discussion within the Trust or with any of the Trusts' partners across the system that in any way suggested that anyone had an interest in closing Grantham Hospital. To be clear, there is no charade, intentions, discussions, plans or intent to close Grantham Hospital.
658/20	**Q3 from Lea Crompton** **Rules have changed at North Kent hospital and other hospitals regarding changing to a partner now being able to attend throughout the entire time of a pregnant women being induced. Not for check ups or scans, purely for the inducing and labour of pregnancy from the start of labour - not 4cm (established labour).** **Understandably, this is a scary time for many women, is this something that as a hospital the Lincolnshire hospitals can now also look rolling out, especially with many women writing on forums.** **It would be really nice and reassuring to try and keep things the same across the board, across hospitals, especially as Lincolnshire is also an area of a lower risk.** **I do appreciate the difficulties and thank you in advance for reviewing, whilst also giving pregnant women the support they long deserve during this horrible, but yet now more positive changing situation.** The Director of Nursing responded:
659/20	It was important to note that throughout the period of the surge of Covid-19 the Trust had been under national restrictions. The Trust had continued to support, in a safe way, birthing partners of expectant mothers during the delivery of their babies. This would continue.
660/20	In light of the updated guidance received regarding visiting restrictions the Trust had conducted a review and had made the decision to maintain restrictions. These would remain in place for visiting, prenatal pathway including scans and post-natal whilst mum and baby were in hospital. The Trust would continue to ensure birthing partners were present for the birth of the baby and there would be a continual review, every two weeks, in line with regional guidance though the local maternity network. The Trust recognised that, unlike a number of other areas, the county had not experienced the level of Covid-19 seen elsewhere. As such it was felt that there may be an opportunity for the Trust to remove some of these restrictions earlier, once risk assessments had been undertaken to ensure the safety of staff, mums and babies.
661/20	**Q4 from Colin Musson** **Some of Grantham Staff, locum and full time are reviewing plans to leave U.L.H.T as there is no confidence the Medical Wards will re-open following the long term closure of our A & E.** **How will U.L.H.T re-open the wards in March 2021 if there are insufficient staff to reach the minimum number required to operate safely.** The Director of People and Organisational Development responded:

662/20	The changes proposed were temporary and would be reviewed on a regular basis, the Trust understood the impact that this news would have on staff. The commitment to staff would be to manage them without detriment, jobs would not be taken away, this would be about the repositioning of services. There would be no change to terms and conditions. The Trust were aware that there may be impacts on staff but there would be dialogue with them in order to address any personal circumstances. It was hoped on this basis and having positive conversations that staff would wish to stay with the Trust through the temporary changes.
663/20	At the point of reinstating the medical wards the Trust would ensure that the appropriate level of staff was in place to enable the wards to reopen.
664/20	**Q5 from Alan Bowling** **1) Given the proposal to move outpatients from Grantham, does the board know the reduced number allowed on the bus from Grantham to Lincoln under the Covid changes?** The Chief Operating Officer responded:
665/20	Transport would be picked up in further detail when the paper was discussed. The proposal however detailed that some outpatient services would continue to be delivered from Grantham whilst some would stop. It was fully expected that the proposal would put forward a model that described the 2 week wait and cancer outpatients being delivered in a significant number.
666/20	The benefit the Green Site offered was a level of protection from Covid-19 to vulnerable patients who may not be able to be seen in another configuration, it was fully expected that those services would continue.
667/20	As part of the proposal the Trust have considered transport for those going to and from Grantham and other sites. There would be an increased transport need, as described in the Quality Impact Assessment, and the Trust would work with transport providers to bridge the gap, particularly in relation to vulnerable patients.
668/20	**Q6 from Marie-Therese Biddles** **Has the board considered and put in place adequate measures due to the impact on ambulances (if transporting more, will there be enough for emergency) and return transport for us and patients coming to Grantham for planned surgery, due to poor transport links in the county? Not everyone has access to a car and we have some deprived areas not to mention the inadequate bus service which will also have reduced capacity due to social distancing? Please explain what has been put in place.** The Chief Operating Officer responded:
669/20	Discussions had been held with East Midlands Ambulance Service NHS Trust about the effect the proposal would have on the circa seven ambulances that attended Grantham each day. The detail described in the report in based on historical outpatient models in particular and some of the figure within the report were based on pre Covid-19 numbers.
670/20	One of the benefits of the initial response to Covid-19 was the changing model to outpatient services and the use of telephone and e-consultations. This had significantly reduced the number of people coming in to hospital who were still receiving great care and the required consultations.

671/20	The feedback had been positive and it was expected that this model would continue to be delivered for a large number of outpatients, this would reduce the need to travel for patients.
672/20	**Q7 from Jody Clark** **With the low levels of Coronavirus in our county, why can't the electives be utilised in the private sector, who agreed to non profit care, rather than removing so many of our facilities that many of us will have to travel to unsafe sites, costing us more money and taking more time off work/school and out of our days? Especially with such poor transport links in the county, for those without access to a car** The Deputy Chief Executive responded:
673/20	It was correct that the county had seen low levels of Covid-19 however the response had to be significant even with the low levels. This had been hugely disruptive for patients and staff and unfortunately this would be the case for some time.
674/20	Use of the private sector was included within the proposal however the number of operations that the private sector would be able to undertake would not meet the level of required activity. The Trust would work with private sector colleagues in order to transfer some patients. There would be a need to change the way in which the Trust worked with the private sector in order to meet the level of demand and the patients who required treatment.
675/20	**Q8 from Cllr Ray Wootten** **Simon Stevens states that hospital trusts need to retain their demonstrated ability to quickly respond to surge capacity, both locally and regionally with reference to Covid 19, should it be needed again. Would It not be prudent, at least for the time being to consider retaining extra capacity. How can getting rid of 70 to 80 medical beds at Grantham Hospital be consistent with retaining extra capacity?** **I ask that the board reject the proposals put forward for Grantham Hospital today.** The Chief Operating Officer responded:
676/20	As a point of accuracy, the numbers described at Grantham, although the Trust do typically have 80 beds in operation pre Covid-19, a number of these were elective and so not emergency and medical beds. The number of beds would fluctuate throughout the year.
677/20	Throughout the response to the pandemic the Trust had worked on surge plans, described in previous Board reports, both on the initial response and the work done to plan for a subsequent increase in demand. The plans factored in increased usage at Lincoln and Pilgrim where critical care would be an essential part of the response.
678/20	Should another wave be experienced the Trust had plans in place that had been tested. The proposal was tested as part of this and the Trust would have the requisite emergency capacity at Lincoln and Pilgrim if the transfer of elective care to Grantham was put in place.
679/20	**Q9 from Cllr Linda Wootten** **ULHT have had some of the worst A&E waiting times in England for patients and Ambulance release times.** **Closing down the Grantham A&E and expecting 4603 (19%) annual patients to present at Lincoln or Boston would compound the problems even more, without even taking into account the logistical and financial burden of travel for patients to return home.**

	I ask the Board to reconsider the questionable Temporary downgrade from Grantham's A&E service to an Urgent Treatment Centre. The Chief Operating Officer responded:
680/20	Pre Covid-19 and in the past year, urgent care had been difficult for the Trust, in particular there had been issues with being able to manage the overall capacity. Detailed attention had been paid to this throughout the pandemic response. Overall performance for Accident and Emergency had been average and in keeping with the rest of the country, at times above.
681/20	Throughout the pandemic response, the Trust had been able to offer urgent care services to all who had needed it. There was a track record throughout the pandemic that the Trust had delivered the necessary service for the population in a highly responsive way. The Trust planned to continue to do this as part of any proposal going forward and had considered the dynamic of the changes proposed, particularly in relation to the change to the Urgent Treatment Centre model. There had been initial discussions with neighbouring Trusts where increased activity may be seen.
682/20	The Trust felt that it would be possible to maintain the level of urgent care provision that had been delivered throughout the pandemic and offer the necessary services to patients.
683/20	**Q10 from Vi King** **Please can the public have assurance that you will not use any loop holes to change or close Grantham A/E under Covid19 so not to have a public consultation as its an emergency situation.** The Chief Executive responded:
684/20	The Trust were not looking to use any loop holes or underhand ways of making changes to Grantham Hospital. The proposal was to make temporary changes. Any process to make a permanent change would need to be led by NHS Lincolnshire Clinical Commissioning Group.
685/20	The Chair advised that the allotted 30 minutes of the agenda had now been used and all other questions would be responded to in writing.
686/20	**Item 3 Apologies for Absence** Apologies were received from Dr Neill Hepburn, Medical Director and Mr Geoff Hayward, Non-Executive Director
687/20	**Item 4 Declarations of Interest** Mrs Baylis, Chair declared that in addition to her role as Chair for the Trust she was also the Chair of Lincolnshire Community Health Services NHS Trust.
688/20	Mrs Libiszewski Non-Executive Director declared that she was also a Non-Executive Director at Lincolnshire Community Health Services NHS Trust and that her husband was a Trustee at St Barnabas Hospice.
689/20	Mrs Sarah Dunnett Non-Executive Director declared that she was a Non-Executive Director at North West Anglia NHS Foundation Trust which runs the Peterborough Hospital site.

690/20	Mr Andrew Morgan, Chief Executive declared that he was on a long term secondment to the Trust and that his substantive contract remained with Lincolnshire Community Health Services NHS Trust.
691/20	**Item 5 Temporary Service Changes as a response to Covid-19** The Chair introduced the paper noting the situation faced as a Trust Board was set out in the foreword to the paper. It was underlined that the Board needed to consider how best to discharge its responsibility to provide the services needed now by the whole population of Lincolnshire in the safest way possible.
692/20	There had been a focus on the response phase as a Board, this now needed to be broadened to a wider category of patients who may come to harm if the Trust did not restore some of its services. This would allow the Board to make some temporary changes, allowing the Trust to meet the responsibility in meeting the needs of patients in the safest way possible.
693/20	The Chief Executive took some time to set the paper in context reminding the Board that the level 4 national incident remained as part of the country's response to the worldwide pandemic.
694/20	Those who had worked in the NHS for a number of years would recognise that this was arguably the biggest challenge the NHS had faced in its history. Across society, there had been significant changes in the country in order to try to respond to the pandemic. This had entailed significant temporary changes in the way in which the public went about their business. People had been unable to leave their homes except for specific reasons, travel had been curtailed, the ability to leave and re-enter the country restricted, schools closed, millions of workers furloughed and families had been unable to meet.
695/20	These significant changes, on the whole, had been accepted due to them being temporary but necessary, in order to keep people safe and save lives. The NHS was a key part of society and had made changes as part of the level 4 incident through national instructions. The Trust were obliged to respond to and implement changes advised through the receipt of letters from NHS Improvement/England and had complied with the requirements set out. This had often been done at a significant pace and covered services and capacity that the Trust had available. These changes were put in place to reduce harm and to save lives.
696/20	Instructions and guidance were arising daily and the letter received regarding the second phase of the response to Covid-19 reminded the Trust of the requirement for dedicated surgical and diagnostic capacity for cancer, work to have this in place should now be well advanced.
697/20	The Trust were not alone in terms of the changes and actions being put in place to respond to the pandemic. It had been highlighted in the media of the rise in the NHS waiting list, with an expectation that this would rise from 4.2m to 10m by the end of the year. There was concern raised nationally about the ability of the NHS to clear the backlog whilst managing the ongoing demand being faced. This was in a scenario of constrained capacity by the very necessary need for more stringent Infection Prevention and Control (IPC) measures.
698/20	The Trust were aware that many people on waiting lists were frightened about accessing services due to the fear of transmission of Covid-19, this included some patients who had not been able to leave their homes due to shielding. The Trust were beholden to do everything possible to minimise transmission of Covid-19, work in a way that focused on IPC excellence, reduce transmission and aiding this by separating Covid-19 and non-Covid-19 services and patients.

699/20	The Chief Executive stated that the paper presented would enable the Trust to carry out its duty noting that since the paper had been published the focus had been on Grantham Hospital. Whilst it was understood why this had become the focus, the issues faced were wider than Grantham Hospital and the paper was about access to services for the population of Lincolnshire.
700/20	There had been cynicism regarding the temporary nature of the proposal however these were temporary and part of the response to the pandemic, as circumstances changed there may be a need to alter the changes described. If there was a second surge the Trust may need to switch capacity back to more Covid-19 respiratory care. It would only be possible to do what was known at a particular moment or model ahead. Plans were in place to switch back should this be required.
701/20	It was not possible to be exact about the timelines for the changes, based on the best assessment it was likely that these would need to be in place until the end of March 2021. Dates may change based on current events. As this was a response to a level 4 incident further instruction from NHS England/Improvement may result in the Trust changing its response.
702/20	The proposals had been developed with clinical colleagues within the Trust and the Clinical Commissioning Group had been engaged. Staff side and union colleagues had also been engaged however it was recognised that there was more work to be done regarding involvement going forward. The paper had set out the why and what, but further work was required in respect of how this would be delivered. The Chief Executive assured the Board that this would be done in partnership with staff and stakeholders.
703/20	If the Board agreed to the proposal there would need to be clarity around how the mobilisation was reviewed and assured, this would need to involve daily operational reviews regarding progress with waiting lists and waiting times. There would also need to be weekly reviews with colleagues in partner organisations such as East Midlands Ambulance Service NHS Trust (EMAS) and monthly involvement of the Board assurance committees. Review at the Board in public would take place on a timescale agreed with the Chair.
704/20	The Chief Operating Officer presented the paper to the Board advising that important elements of each section of the paper would be addressed in order to articulate and answer some of the questions as to why the Trust had reached the set of proposals presented. The detail around this would be highlighted and attention would be drawn to the key debates and decisions that had been considered as part of the development of the proposals.
705/20	The introduction articulated the context in which the Trust was operating, the response to all phases had been in line with the level 4 national incident. The Trust were working in an emergency scenario and taking national and regional directives whilst following the national incident objectives, which planned to save lives, prevent harm and protect the NHS. All actions and proposals described aligned to these key objectives.
706/20	The introduction described what actions had previously been taken through the phases to respond to the pandemic. The first being manage, the Trust had put a number of key actions in place and had now moved to the restore phase. The restore phase would enable the Trust to look to change back or put in place services in a different manner. The Trust had ceased elective and outpatient services along with diagnostic and operating services that were needed for cancer care. It had been necessary to cease these services to prepare for the response needed for the surge demand. As the Trust moved to the alternative phase there was a need to consider how to address restoration of these services.

707/20	The challenge described in the proposal articulated the case for change and what the Trust needed to do. The most recent and significant driver, in the public, was the response to cancer treatment and cancer care.
708/20	The Trust was aware that waiting lists were in excess of normal levels and patients had been waiting for periods longer than the statutory and clinically indicated timescales for treatments. At the time of production of the paper, there had been 291 patients waiting for cancer surgery and treatments. This had since increased to 315, to date, with a rate of 15 additional patients every week. It would be imperative to put these services in place at some scale.
709/20	The second key driver was to develop a service response and increase patient and wider public confidence. It had been known since the start of the response to the pandemic that there would be reduced demand. The Trust had seen up to a 60% reduction on emergency demand and cancer referrals had significantly reduced. This had shown that the population had exhibited changes in behaviour and were not accessing services in the way that was needed. Whatever response was to be put in place it must ensure that confidence was increased.
710/20	The Chief Operating Officer noted that aside from cancer and diagnostic services the overall planned routine waiting list was increasing at a substantial rate, approximately 5000 a month. The Trust did not currently have the capacity and services to care safely for those patients.
711/20	Attention needed to be paid to IPC and care delivery in a way that prevented further transmission of Covid-19 whilst restoring and putting in place essential services. This would need to be delivered alongside capacity that could maintain demand and catch up with the volume of patients that required services, in some cases urgently. Within any proposal there was the need to build in future resilience and ability to maintain this, should there be an increase seen in Covid-19.
712/20	The options appraisal had started to consider the best ways in which to meet the conditions, the national letters and directives described an approach whereby the Trust would look to put in place green pathways and sites. This would result in the creation of environments where staff, physical environments and equipment was isolated in such a way that reduced the transmission of Covid-19. It would not be possible to eradicate the risk however services would be put in place in a way that reduced the risk as much as possible.
713/20	The proposal detailed 3 options, the first was not changing services, the second was the potential use of green pathways, essentially having hospitals that would have both large scale mixed blue services, where patients have unknown status of Covid-19 with those services that would be green or Covid-19 free. The third option would be a green site. *Mrs Ponder left the meeting*
714/20	When considering the options, the Trust had considered these against the required conditions of IPC excellence, capacity to deliver at scale not only to restore services to original rate but also to catch up with patients that were overdue and to build future resilience.
715/20	The analysis had resulted in the green site being the best option to achieve the conditions detailed. The options appraisal went on to consider which site this could be located and delivered. The conditions were applied to all sites including Lincoln, Pilgrim, Grantham, Louth and independent sector hospitals available to the Trust.
716/20	The same criteria has been applied as to whether this should be a green site or green pathway to each site. When considered against the IPC standards all but Louth would be suitable with the necessary arrangements being put in place to meet the IPC conditions set.

717/20	The capacity to deliver at scale was then considered with Lincoln and Pilgrim Hospitals having substantial overall bed base and theatre base set to urgent and emergency care, blue services. The majority of inpatient beds were set to emergency services. It would not be possible, from the 5 site options, to accommodate all of the urgent care services required on a single site model.
718/20	Scale and capacity available for all of the other options was also considered. The independent sector capacity, whilst useful and provided ability to create a Green Site model, would be limited in capacity and range of operating that could be conducted. Capacity would be greater at Louth Hospital however this would be dependent on NHS Property Services and other partners who shared Louth Hospital. There would also be a substantial amount of changes required in order to create the required capacity in a safe and IPC compliant way.
719/20	Therefore, Grantham Hospital with 4 theatres, up to 100 beds at full capacity, day case suites and the large outpatient capacity offered the ability to deliver at scale the response to the conditions described.
720/20	In terms of future service resilience, the Trust had considered how the hospitals would behave if there was an increase in demand. Due to large urgent care provision and critical care units at Lincoln and Pilgrim Hospitals there would be no alternative to provide this care elsewhere. Should a surge be seen there would be the need to convert more capacity at Lincoln and Pilgrim Hospitals in order to respond and as a result, this would increase blue services. This increase would reduce the ability to deliver a Green Site model or any real capacity to be able to address the growing waiting lists.
721/20	Regarding future service resilience, Grantham Hospital met all of the conditions for being secure. In terms of urgent care, it was a much smaller provision and could be accommodated at any of the other main sites. The capacity allocated to cancer services and elective could be maintained for a longer period of time. This had been set in the context of the possibility of another surge, however should there be a surge similar to that seen in London or Birmingham, the Trust would need to consider fully converting Grantham Hospital back in order to respond. The Trust had also planned for a scenario where there would be a need for field hospitals however the Chief Operating Officer stated that this was an unlikely scenario.
722/20	The options appraisal was undertaken involving clinical teams, nurses, doctors, administration staff, therapists, IPC specialists and specialists in the area of managing infection diseases. It was identified through this process that Grantham Hospital was the only site that met the conditions set. This had been taken forward in the proposal to consider what more would be required and the details needed in order to deliver such a proposal.
723/20	There had been consideration of the detailed design that would be required and examination of exactly what would need to be done at Grantham Hospital to create a Green Site model. Some services including A&E were blue services and as such, the Trust would need to determine how it would be able to isolate a Green Site. This would need to be protected with IPC and be very low risk for vulnerable cancer patients whilst also maintaining urgent care of some sort, in order to respond to the demand of the local Grantham population. Various aspects of the requirements of the A&E, medical bed base capacity and medical services for emergency admissions had been examined.
724/20	Attention had been paid to the NHS IPC Board Assurance Framework (BAF) which had articulated, alongside the NHS England directives, exactly what should be in place in order to prepare and maintain a Green Site. This included the elimination of nosocomial infection, person to person infection, access and control of the environment to reduce the number of staff and patients mixing in certain areas.

725/20	Considering all of these elements the recommendation was put forward to the Board to convert the A&E at Grantham Hospital to an Urgent Treatment Centre (UTC). By doing so this would give the opportunity to convert to a 24/7 model, there would need to be consideration of the reduced access to major diagnostic services such as MRI and CT. This would create a diagnostic service that would only be available to patients who were vulnerable or immunocompromised.
726/20	In taking this action, the ability to admit medical patients on to the site would be reduced. Having an inpatient ward for patients who did not have a confirmed Covid-19 free status would substantially increase the risk of potential transfer. The detailed design recommendation for the 24/7 UTC would include ambulatory care services giving some access to diagnostics such as x-ray, pathology and ultrasound. This would reduce the impact on some patients needing to attend other sites. The UTC could be isolated in such a way that it would protect the remaining Green Site.
727/20	Conversations were ongoing with teams and services regarding how to create green services and if not then finding alternative accommodation and locations for those services and for staff and patients whilst still offering the necessary local access.
728/20	Within the report outpatients were described as being both within and moving out of the model. These were both true and there would be a change in the provision of outpatient care in order to deliberately create low risk outpatient services for those who were vulnerable or had been shielding. This would also support those patients who were otherwise not confident to access services on a mixed green/blue site.
729/20	The Chief Operating Officer recognised the impact on staff and advised the Board that work continued with staff side colleagues and teams to understand the impact. The Trust did not expect to make material changes to staff contracts without dialogue.
730/20	The teams worked with to date had been understanding of the amount of change happening at both Grantham Hospital and other Trust sites. The implementation section of the proposal, if authorised, described the governance of the programme of change, working at pace, recognising that the Trust remained in an emergency situation and that there was a need to consider a solution, whether that be the solution presented or an alternative to respond urgently.
731/20	The conclusion of the options appraisal was the review of the type of approach to be taken, the site that should be chosen to take the particular option forward and some of the detailed design changes required to fulfil the three conditions of IPC excellence, capacity and scale and future resilience.
732/20	The Trust had undertaken both a Quality Impact Assessment (QIA) and Equality Impact Assessment (EIA) in relation to the proposals. The QIA described the work completed by the clinical teams reflecting on the necessary changes and risks to patients. This was in a context where a number of services were not currently in place. The response therefore, whilst it may describe a risk, was reduced as currently the services were not running.
733/20	There had been consideration of the impact on patients as part of the urgent care changes and the associated risks. The design of ambulatory care would start to address those risks and the mitigation impact of the actions had been described through the QIA. The impact to staff had also been considered through the QIA.
734/20	The EIA had been carried out by the Equality, Diversity and Inclusion Lead with support from other members of the team including Black, Asian and Ethnic Minority managers. All equality

	standards were considered including geographical factors, economic deprivation and domestic abuse. Carrying out such a wide ranging EIA had meant considering many adjustments and mitigations to the proposal.
735/20	Transport had been a major feature of the EIA and the Trust fully expected to adjust transport contract systems and partners and to work with both the Patient Transport Service, EMAS and partners in the emergency ambulance service in order to reduce the impact and mitigate the risk to patients.
736/20	The Chair thanked the Chief Operating Officer for distilling a technical document to identify the issues to be resolved and the challenges being faced. Questions were invited from Board members.
737/20	Dr Gibson sought assurance that the recipient hospitals of the circa 5800 blue patients being diverted away from Grantham would be able to cope and support the transfer.
738/20	The Chief Operating Officer advised that the modelling that had been completed was based on historical behaviours as there had been a change in activity and demand in the services that had not been replicated at any point for urgent care before.
739/20	The figures described a worst case position and a level of demand not currently being seen however the Trust wanted to ensure that services and partners were supported by the demand not being underestimated. When tested and in conversation with other Trusts there was confidence that this level of demand could be managed.
740/20	Dr Gibson noted recent research in relation to oncology that had suggested that for every 3 months surgery was delayed there were 5000 more cancer deaths. Dr Gibson asked that the impact of the changes proposed at Grantham Hospital on cancer deaths across the county be articulated.
741/20	The Chief Operating Officer stated that there had been both historical and recent mortality reviews completed which supported the need for the Trust to move at pace to address the backlog. Failing to deliver an option that treated these patients would almost certainly increase the mortality rate and number of deaths. It was believed that the proposed solution would reduce the waiting list capacity to below the 3 month model in less than 3 weeks and would allow the Trust to recover in a relatively short time frame. It was however important to note that there were a number of other dependencies including patients own desire to want to access cancer services. This must be addressed through increased confidence for patients and demonstrated why a Green Site would be the best solution.
742/20	Mrs Libiszewski asked how the Trust would provide confidence to users of services that there would be a reduced risk of contracting Covid-19 and all other infections whilst in the Trusts care and what approach was being taken, through IPC, to deliver green pathways regardless of which site they were provided.
743/20	Mrs Libiszewski also noted that the paper stated Louth Hospital was not IPC compliant and asked what steps were being taken to address this and IPC in general across the Trust. *Dr Gibson left the meeting*
744/20	The Director of Nursing advised that the primary driver for a Green Site was the reduction of harm to patients, clearly led through a principle of IPC excellence. The Trust were working in line with statutory responsibilities as detailed in the hygiene code and the recently published IPC BAF. The Trust were driving forward four pillars of IPC excellence of maintaining hand hygiene and bare below the elbows, ensuring adequate personal protective equipment (PPE),

	maintaining government guidance on social distancing and swabbing and testing staff and patients.
745/20	These had been the guiding principles to both the Green Site proposal and the response, not just to Covid-19, but all IPC within the Trust. The proposal articulated how the Trust had applied the pillars to the options of both Green Sites and pathways and the areas that were now being recommended to the Board.
746/20	The principles included the separation of care pathways for urgent and planned care with the aim to eliminate the risk of nosocomial infection.
747/20	Based on the data recently released from the Office of National Statistics it was clear that there needed to be a focus on transmission rates, the 4 pillars of IPC supported this. The Trust must also ensure the appropriate levels of PPE. There was a need to manage patients in urgent and emergency care where the Covid-19 status was unknown and care could not be delayed.
748/20	The Director of Nursing noted that it had been identified that Louth Hospital was not currently suitable to support social distancing. The services that were needed at Louth Hospital would be further considered and worked through in order to ensure that the 4 pillars of IPC excellence could be maintained.
749/20	Mrs Dunnett requested further information on the temporary arrangements and the impact on staff.
750/20	The Director of People and Organisational Development advised that the implementation plan continued to be developed and this would be dependent on which services remained on site and which were moved. A number of clinical and non-clinical staff would move away from the site and the Trust were reviewing relocation of staff and the skill mix of staff required to remain. The opportunity would be taken to review those staff who were currently isolating, the establishment of a Green Site would potentially provide an opportunity for staff to return safely to work.
751/20	At the beginning of the incident there had been national agreement between the National Trade Unions and the NHS regarding the management of change during Covid-19. This reaffirmed that the principles of engagement and consultation would remain however recognised that where temporary changes were needed, with no changes to terms and conditions, whilst consultation should be undertaken, there was acceptance that the pace of change would mean this may be conducted without full formal process.
752/20	The Trust were adopting these principles in order to move forward with staff on the proposals, there had been ongoing dialogue with staff side and staff were actively engaged with discuss on the temporary changes.
753/20	Mrs Dunnett asked how the changes would be communicated to both staff, patients and the wider community.
754/20	The Chief Operating Officer noted that as part of the emergency response actions were being taken quickly and discussions were being held with all affected teams. There had been considerable discussion regarding Grantham Hospital however there would be an impact on Lincoln, Louth and Pilgrim Hospitals and independent sector colleagues. The Trust would continue to hold discussions with staff.
755/20	A communications plan had been developed which included patient communications, this was being further developed as the Trust learnt more about the impact for patients. The Trust

	would utilise a range of media mechanisms including digital and signage. There would be a significant communications campaign and if the proposal was authorised this would commence immediately in order to help explain what the changes would mean to patients.
756/20	The Chair asked on Mrs Ponders' behalf about the robustness of the process that was adopted to work through the options within the paper and if there had been any discounted options as part of the process. What had led the Executive Directors to settle on the options presented, the criteria and the methodology by which they had been applied.
757/20	The Chief Operating Officer advised that as part of the original options appraisal consideration had been given to those conditions that were required as part of the initial response and set out in national letters from the Chief Executive and Chief Operating Officer of the NHS. These were IPC, restoration of services to a size that would address the challenges of cancer services and preparedness and resilience should an increase in Covid-19 and urgent care patients be seen.
758/20	Both green pathways and Green Sites had been scored on the approach described and the questions around A&E and UTC had been debated in the various options that could be considered. The options put forward to the Board were an accumulation of debate and scoring of those elements to move to a detailed design that stated IPC was a key driver.
759/20	In order to deliver A&E services there would need to be access to appropriate diagnostics and resuscitation. This would mix the blue and green nature of the hospital to such an extent that it would negate the primary condition of lowering the risk of nosocomial transmission.
760/20	The Chair asked for completeness, for reassurance that the whole proposal had been clinically driven and that clinical teams across the Trust had been engaged in conversations and the options appraisal.
761/20	The Chief Operating Officer stated that the paper had ultimately been driven by the clinical and command centre teams involving the Medical Commander, divisional nursing teams and therapists and other support services.
762/20	The Chair thanked the Chief Operating Officer and noted that the Trust would continue to have dialogue with all staff across the Trust. This provided an opportunity for involvement from staff and would also support professional development of those involved.
763/20	The Chief Executive reinforced the comments made by the Chief Operating Officer stating that throughout the pandemic as Chief Executive of the Trust the assurance always sought was in relation to clinical safety. Ensuring that clinicians had been involved throughout the process with the final question being asked as to whether it was safe to proceed, the responses received had been of the affirmative.
764/20	Mrs Libiszewski noted that the intended list of services to be maintained on the Grantham site included the Hospice in the Hospital and asked what discussions had taken place with the hospice regarding the continued provision and how end of life care would be maintained for the population of Grantham and surrounding areas.
765/20	The Chief Operating Officer stated that from the outset of the pandemic it had been difficult to respond, particularly in relation to end of life care due to the demand and also due to the measures to protect both patients and staff at such a difficult time. The pathways had been worked through with the hospice in relation to the mixed blue and green model to date and work was underway as to how this could revert to the green model whilst maintaining the service. There would be a need to know the Covid-19 status of the patients accessing the service. Whilst this could mean some patients would not be able to receive instant access to

	the service this would allow for continued operation of the hospice with appropriate processes in place to ensure the Green Site remained.
766/20	The Chair noted the need for capital expenditure in order to enable the Trust to introduce different pathways and models of care provision, including digital solutions and asked what plans were in place to upgrade the environment at Grantham Hospital to ensure IPC compliance as had been described.
767/20	The Director of Finance and Digital noted that there was a limited amount of capital required to create a UTC and segregate that area of the site. The Trust were developing a business case to apply for national capital in order to address IPC across the 3 main sites. This would see investment across the organisation of £5m, the refurbishment of a number of wards and specifically a large refurbishment of a single ward on each of the 3 main sites.
768/20	The Trust had received capital funding from the centre allowing for the provision of additional digital equipment including laptops and technical solutions. This funding had allowed the Trust to roll out working from home as well as digital consultations including phone and video conferencing with patients. This had enabled the Trust to work as well as possible in the circumstances without the need to bring patients unnecessarily on to the hospital sites.
769/20	There had been no restrictions in relation to finance and the Trust had enabled everything it could do in the challenging times in order to access what was needed in order to bring forward some capital schemes.
770/20	Mrs Libiszewski noted that the Quality Governance Committee would seek to receive regular assurance reports from the Director of Nursing, Chief Operating Officer and Medical Director regarding the implementation, risks and any mitigations of those risks. Significant review would be undertaken by the Committee which would be upwardly reported to the Board.
771/20	The Deputy Chief Executive stated that there had been a significant impact on the hospital sites and that this had resulted in the Trust not being able to see as many patients as it wanted or needed to. There was a desire to conduct more activity but this would need to be done in a safe manner as outlined in the proposal.
772/20	If the Board did not accept the proposal there was a need to ensure that it was understood that whilst there could be a small increase in activity there would not be the ability to return to pre-Covid-19 levels. This would result in continued increases of waiting lists.
773/20	The proposals discussed would enable the Trust to balance the requirement to address Covid-19 whilst minimising the risk to patients and treat Covid-19 and non-Covid-19 patients by addressing clinical needs.
774/20	The Chair noted that there were no further questions from Trust Board members and offered a summary of the paper and discussions held.
775/20	The Trust Board had the responsibility to provide safe services for the whole population of Lincolnshire. In the midst of a national emergency and as the Trust moved to restore some of the urgent services required, there was a need to ensure that harm was avoided, confidence built and the best possible experience was provided to patients.
776/20	As with other Trusts across the Country, the Trust was facing something on a scale not previously experienced and required the Trust Board to provide decisive leadership in order to make the right decisions in the interest of the whole population of Lincolnshire, irrespective of how difficult this could be. The situation required different thinking and actions as a consequence of the enormity of what was being faced.

777/20	It was recognised and clear from the feedback received that this would not be a straight forward decision and the concerns, expressions and encouragement received were acknowledged. It was the Trust Boards responsibility to balance the competing demand from stakeholders and take in to account the view of patients. It was inevitable that the Trust would need to make some compromises on a short-term basis in order to agree a way forward.
778/20	The virulent nature of Covid-19 required proactive steps to be taken in order to limit the transmission within the Trusts' hospitals as far as possible in order to protect both patients and staff. This required a different approach to that previously taken, which was based on effective risk management to enable the Trust to provide good quality care during the next phase of the response to the pandemic.
779/20	The paper detailed the proposals set out in the approach to restore some critical services with the task of the Trust Board to decide if the conclusion within the paper was the right way forward.
780/20	The paper described the 3 options of do nothing, develop blue/green pathways on the same site and develop a Green Site. The options had been explored against the fundamental conditions in relation to excellence in IPC, capacity of the Trust to deliver and future service resilience.
781/20	The Trust Board needed to be assured that the level of care needed could be provided in the context of Covid-19 being in the community for some time and given recent events nationally, the possibility of a second wave.
782/20	The Trust Board had received assurances on the robustness of the process that had led to the Green Site option within the paper and further consideration as to how this could be established. This had led to Grantham Hospital being the only viable option that met all of the relevant criteria. Colleagues had detailed how this would enable the Trust to create the required large scale surgical service to meet the needs for the whole population of Lincolnshire with the highest levels of IPC, resilience and future needs. This option would also allow urgent care services to be provided from the site in a way that would not compromise the concept of a Green Site.
783/20	It was important that the Trust Board reflected that the creation of the Green Site was only part of the overall reconfiguration required and that all of the hospital sites would need to change activity in order to support the restoration plan as detailed within the paper. These changes would include the establishment of an UTC at Grantham Hospital, which was fundamental to enable the creation of a Green Site for cancer patients and other urgent cases. It was fully recognised that this had been the most controversial part of the paper from the perspective of the Grantham and surrounding area residents, a representation had been made of the case to the Trust and this had been acknowledged.
784/20	There was a need to consider the impact of the recommendations for the whole population and this had been well documented through the use of the infographics and information within the paper, providing clear representation of the modelling assumptions. These were based on the best forecasting available, recognising the abnormal impact of Covid-19.
785/20	The overriding intention should be to ensure that the public received the right care needed in the right place and at the right time. The issues of access and travel had been recognised and there was further work to be done in order to allay concerns. There would be communications undertaken with staff and patients.

786/20	The Board recognised that staff had been tested during the response to Covid-19 and thanked them for their professionalism in the challenging circumstances. It was clear that all staff recognised the immediacy of the threat of Covid-19 was reducing in some areas however there remained patients who would come to harm from delayed treatment and diagnostics. It was hoped that staff would recognise the position and be prepared to continue to work with the Trust Board in order to establish better ways of being able to respond to those patients and provide the level of quality care that the Trust aspired to deliver.
787/20	Most importantly, the proposal had been informed by clinical colleagues and was a temporary change advocated for by clinicians as the safest way possible to balance the need to restore some services, alongside the ongoing provision of urgent and emergency services and other critical care pathways. The clinical judgment of those staff must be respected and reflected in the Trust Boards considerations, along with the advocacy of the development of blue and green pathways. The absolute intensity to focus on adherence of IPC must be a significant influencing factor for decision making. The clinical judgement made was well supported by national guidance.
788/20	The Chair stated that the protocol that governed the decision making process, under normal circumstance, to change to a Green Site in the way proposed, would require consultation as set out in legislation, this was fully acknowledged by the Trust Board. However due to the unprecedented nature of the circumstances and as part of the continued response to Covid-19, which remained a level 4 national incident, the Chair had been advised that the temporary decision would be permitted.
789/20	The Trust Board would not and could not make a decision regarding a long term plan for services delivered by the Trust that formed part of the Lincolnshire Long Term Plan, ongoing service review or Healthy Conversations. As explained by the Chief Executive, these were the legislative responsibilities of NHS Lincolnshire Clinical Commissioning Group. The Trust would want to work with the Clinical Commissioning Group in order to support them to discharge their responsibility for any long-term changes.
790/20	The Trust Board would not be allowed to stray in to the process by default. The decision before the Board was for a short-term service change to restore services to a critical cohort of patients in the safest way possible.
791/20	There was an expectation that the Trust Board would continue to be fully briefed and sighted on how the response continued to develop under the restore phase of the pandemic, as required through national guidance and would support the recovery phase that would run until at least 31st March 2021.
792/20	The proposal presented was based on the best information available however, what had been seen was that the national position changed rapidly and there would need to be flexibility and responsiveness as required.
793/20	The paper contained a clear implementation plan covering governance arrangements and finance. Board members attention was drawn to the detailed IPC BAF, EIQ and QIA which had all been properly considered and were included within the papers.
794/20	The Chair invited voting members of the Board to indicate whether they gave their support of the proposal.
795/20	The Board were being asked to consider approval to proceed with changes proposed and approve the necessary work to deliver those changes, recognising that they were temporary and that any proposal to make them permanent would be subject to public consultation.

796/20	The timescale of the Green Site was the duration of Covid-19 up to at least 31 March 2021. As such, this would be part of the Restore and Recovery phases. This timescale and the wider solution would be subject to quarterly review.
797/20	The Chair indicated that full support and approval was received from voting members of the Board for the outlined proposal.
798/20	The Chair expressed thanks to the Executive Team and wider Trust Leadership Team for the work on developing the proposal in a comprehensive way. This had been undertaken in addition to managing the operational challenges of responding to the pandemic. The Chair was proud of the way staff had demonstrated resilience and leadership skills in responding to the incident. The Trust Board: • **Approved the proposal to proceed with the temporary changes in response to the Level 4 incident response to the Covid-19 pandemic**
799/20	**Item 6 Any Other Notified Items of Urgent Business** No Items
	The next meeting will be held on Tuesday 7 July 2020, arrangements to be confirmed taking account of national guidance

Voting Members	**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**	**2 June 2020**	**11 June 2020**
Elaine Baylis	X	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	X
Geoff Hayward	X	X	X	A	X	X	X	X	X	X	A	A	A
Gill Ponder	X	X	X	A	X	X	X	X	X	X	X	X	X
Jan Sobieraj	X												
Neill Hepburn	X	X	X	A	X	X	X	X	X	X	X	X	A
Michelle Rhodes	X	A	A	X									
Kevin Turner	X	X	A										
Sarah Dunnett	X	X	A	X	X	X	X	X	X	X	X	X	X
Elizabeth Libiszewski	X	X	X	X	A	X	X	X	A	X	X	X	X
Paul Matthew	X	X	A	X	X	X	X	X	X	X	X	X	X
Andrew Morgan		X	X	A	X	X	X	X	X	X	X	X	X
Victoria Bagshaw					X	X	X	X					
Mark Brassington					X	X	X	X	X	X	X	X	X
Karen Dunderdale									X	X	X	X	X

PUBLIC TRUST BOARD ACTION LOG

Agenda item: 6

Trust Board date	Minute ref	Subject	Explanation	Assigned to	Action due at Board	Completed
1 October 2019	1576/19	Smoke Free ULHT	Post implementation review to be presented to the Board	Rayson, Martin	~~07/04/2020~~	Deferred due to Covid -19 Board to agree revised date for review.
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~~ 21/07/2020	Review underway of all IIP PIDs to confirm how they will be revised to continue. Board Development session set for July

PUBLIC TRUST BOARD ACTION LOG

Agenda item: 6

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.
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	Agenda Item
2 June 2020	637/20	Risk Management Report	Review and update of risks required	Executive Directors	07/07/2020	Agenda Item

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*7th July 2020*
Item Number	*Item 7*
ULHT Covid-19 Restore Phase Update – Progress Summary	
Accountable Director	*Simon Evans, Chief Operating Officer*
Presented by	*Simon Evans, Chief Operating Officer*
Author(s)	*Simon Evans, Chief Operating Officer*
Report previously considered at	*Executive Leadership Team*

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

Risk Assessment	Covid-19 Strategic Risk
Financial Impact Assessment	Resource Implications are in line with authorisation SFIs and Covid19 operating parameters.
Quality Impact Assessment	
Equality Impact Assessment	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
Assurance Level Assessment	*Insert assurance level* • *Moderate*

Recommendations/ Decision Required	The Board are asked to accept this progress 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. In addition, the board is asked to offer thanks and gratitude to system partners who have supported the Trust in enacting this complex and challenging phase of the Covid-19 *Restore* plan.

Executive Summary

On 11 May the Trust confirmed it's *Restore* Phase plan as an important component of it's overall Covid 19 campaign strategy. This report presents a high-level review of this *Restore* Phase plan and the progress made to date against required and intended actions.

All service changes made through the Trust's Covid 19 campaign have been assessed for risk, quality and equality impact through the authorisation process previously described in the *Manage* phase. This report describes the approach being taken and progress to date to restore, revert or embed these changes during the *Restore* Phase.

The Trust's *Restore* phase response has been heavily focused on Infection Prevention and Control (IPC) to create optimum levels of protection for patients and staff. An important vehicle to deliver this and an integral component of the Trust's *Restore* phase plan is the creation of a Green site at Grantham, which was approved by Trust Board on 11th June 2020.

The Grantham green site went live on 29 June, an achievement in delivering a large-scale change in a very short time frame. On 1st July cancer surgery commenced and it is anticipated that as efficiency of the surgical model develops over the next month there will be up to 25 cases operated on each day.

At the time of this report, there were no cancer Priority Level 1 cases outstanding and anticipated date to clear all priority Level 2 cases awaiting TCI was 5 weeks (by 9 August). The expected date to clear all priority Level 3 cases and those without a priority level awaiting TCI was 8 weeks (by 26 August). These timescales could be shortened depending on weekend working and productivity increases as teams become acclimatised to the new model of working.

The Trust formally recognises the support it has had from system partners in order to carry out this large scale change. It also recognises the disruption and additional effort required to achieve such a high standard of protection for patients who required urgent and planned care treatments.

The report describes the progress made in enacting *Restore* phase plans and impact on quality and access performance in urgent and emergency care, planned care, cancer, maternity services and screening programmes.

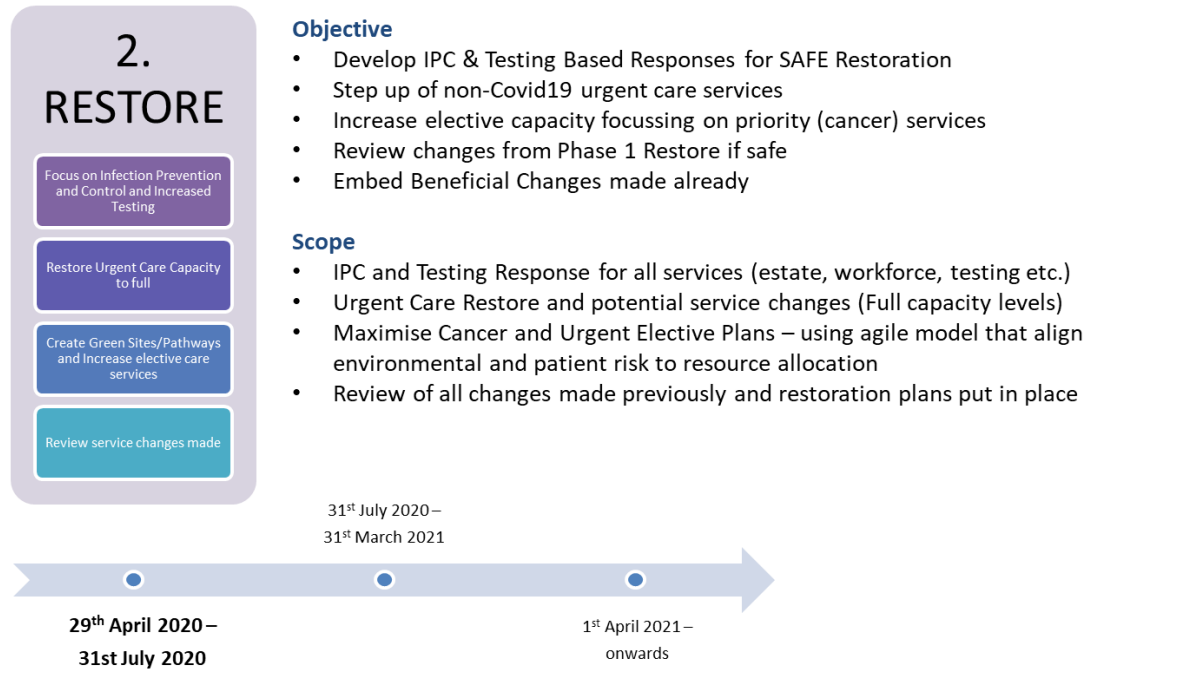
Finally, the Trust's approach to prioritisation, risk stratification and harm review is described and assurance provided regarding monitoring processes in place

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.

On 11 May the Trust confirmed it's Restore Phase plan as an important component of it's overall Covid 19 campaign strategy, which was presented at Trust Board in June. This report presents a summary review of this Restore Phase plan and progress made to date against required and intended actions.

2 Restore Phase



With planning complete on how and when surge responses could be put in place, the current position faced by the Trust and nationally continues to be 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.

3 Review of service changes

All service changes made through the Trust's Covid 19 campaign have been assessed for risk, quality and equality impact through the authorisation process previously described in the *Manage* phase.

Sections 6 onwards in this report describes at a high level the approach being taken and progress to date to restore, revert or embed these changes during the Restore Phase.

The following table identifies the service changes made and whether planning sits within the Restore Phase (by 31 July) or Recovery Phase (August 2020 – March 2021). These plans form part of the system restoration activities that are regularly reviewed with regional regulators NHSE/I and assumptions tested to ensure that services are being safely restored.

Table 1: ULHT service changes deployed during Covid 19

Anaesthetics	Pre-Op assessment change	Moved to virtual pre-operative assessments during Covid, and there is a plan to sustain this change, and only bring patients in when absolutely necessary.	Restore
Audiology	Stop service	Audiology service was paused during covid, but is planned to be reinstated.	Recovery
Audiology	Pathway change	Newborn hearing screening programme was continued during covid, but with no call-backs, there is a plan to restore this.	Restore
Cancer	2ww pathway change	Redesign of 2ww pathway for suspected lung and Upper GI cancer patients. More work is to be undertaken through restore and recovery phase to complete pathway redesign. This will depend on reinstatement of endoscopy services, green site development and pathway specific work.	Restore
Cancer	Pathway change	Lung cancer pathway was changed during covid, some of the adjustments such as clinical triage have worked well, and will be maintained. Some of the changes are not sustainable, such as reduced access to diagnostics and will be developed in the remaining Restore and early recovery phase.	Restore
Cancer	Pathway change	Cancer referral pathways and management of cancer cases was altered to support covid-manage (no endoscopy, risk stratification for treatment, triage of referrals) and while the wider plan is to reinstate cancer diagnosis and treatment clinical pathways, the learning from these pathway changes will be taken and developed for the future to benefit patients of Lincolnshire during restore, recovery and Future NHS.	Restore
Cancer	Pathway Change	Chemotherapy delivered on GDH site during covid-*manage*, with the exception of: chemo-radiotherapy (Lincoln) oral-chemotherapy (patient home) It is likely that this arrangement will continue into Covid-restore and be reviewed for covid-recovery.	Restore
Cardiology	Guidance	Cardiology Primary Care Guidelines - introduced during Covid, have had positive feedback for helping primary care management of patients.	Recovery
Covid pathways	Clinical pathways & hospital sites	Creation of Green and Blue pathways and sites (Green covid free, Blue covid)	Restore
Dermatology	Pathway change	Skin Cancer Pathways - some aspects of the dermatology service have been paused or moved during covid, while retaining as much of the cancer service as possible. In reinstating the service, Green Pathways, social distancing and PPE will be contributing factors to where the service is delivered.	Restore
Dermatology	Pathway change	Dermatology during covid has managed urgent and time sensitive cases, in order to reinstate the routine service, Green pathways, social distancing and PPE will be factored into plans.	Restore
Diabetes and Endocrinology	Pause service	Diabetes and Endocrinology - during covid ULHT Medics have been on a 24/7 medicine rota, and only managed emergency diabetes and endocrine cases. It is possible that at this point, we could develop the community diabetes services to take on the acute backlog at the end of Restore and into Recovery Stage.	Restore
Diagnostics	Pause service	Clinical Neurophysiology service was paused during covid but is planned for restoration with social distancing in place.	Restore
Diagnostics	Pause service	Dexa scanning is planned for restoration	Restore

Diagnostics	Pause service	Endoscopy procedures were halted during Covid-manage, and restoration will require BSG and JAG guidance. There will be a significant impact on capacity due to PPE and Social distancing requirements for AGP. (See later section)	Restore
Diagnostics	Reduced service	MRI service is planned to be reinstated during covid-restore, with social distancing in place.	Restore
Diagnostics	Reduced service	Peripheral site X-ray cover was ceased during covid-manage and staff were redeployed onto other sites. The plan is to restore this service only once demand increases for the peripheral sites again.	Recovery
Diagnostics	Pause Service	Respiratory physiology is planned to be reinstated with PPE and social distancing in place	Restore
Diagnostics	Pathway change	Patients suspected of Upper GI cancer have been offered barium swallows instead of endoscopy during covid-manage. See later section for Restore plans in Endoscopy.	Restore
Diagnostics	Diagnostics	The Urodynamics service paused during Covid-manage and is planned to be reinstated	Recovery
Family Health	Paediatrics	Suspension of Paediatric Surgery - the plan is to reinstate paediatric surgery but this will need to be considered with the Green Pathways.	Restore
Head and Neck	Pathway change	Reduced provision of outpatient services for Otolaryngology at Peripheral sites was introduced during covid and it is proposed that this will continue.	Restore
Head and Neck	Pause service	Orthodontics were managed with as little f2f as possible during manage phase, this service could be restarted outside of the acute setting post-covid.	Recovery
Head and Neck	Pathway change	OMF services have been scaled back during covid, but for the future a large amount of the referrals could be seen by dentists, keeping acute for those who need it.	Recovery
Medicine	Pause service	Medical Day Unit - all non-urgent work paused during Covid, if services retain their left-shift post covid, there is a potential to repurpose Medical Day Unit in the future.	Recovery
Neurology	Pathway change	Neurology covid plan - different aspects of clinical pathways were either paused, moved to GP, or delivered remotely during covid. Some aspects of the changes can be kept, while some are to reinstated as require acute neurology assessment.	Recovery
Rheumatology	Pathway change	Rheumatology covid plan - different aspects of clinical pathways were either paused, moved to GP, or delivered remotely during covid. Some aspects of the changes can be kept, while some are to reinstated as require acute rheumatological assessment.	Recovery
Obstetrics	New pathway	Revised maternity pathways (hospital and community) to optimise the safe use of Video Consultation as part of the pathway. This has been assessed as successful, particularly in regard to the community midwifery clinical pathway – in excess of 500 video consultations.	Restore
Orthopaedics	New pathway	Trauma Assessment Unit Established at Pilgrim Hospital (same as in place for Lincoln) to align the process across sites. It is planned for this to continue.	Recovery
Paediatrics	PAU at Lincoln	Use of Safari Unit as a Paediatric Assessment Unit at the Lincoln Hospital site	Restore
Pharmacy	New pathway	Pharmacy provided deliveries of prescriptions during Covid, and these changes are planned to be reviewed and develop in order to support a permanently increased level of remote outpatient activity	Restore
Pharmacy	Pathway change	Rowlands Pharmacy Supply of Methotrexate - this was a pathway developed during Covid to support patients without requiring clinic attendance.	Recovery
Pharmacy	Pathway change	Pathway for Respiratory - Omalizumab & Mepolizumab. Patients receiving these drugs following referrals from NUH have been receiving their care via Homecare under existing contracts during Covid-Manage. Prior to this patient would have attended clinic for injections.	Recovery
Pharmacy	Pause service	Closure of Louth Hospital Pharmacy Department during Covid Manage phase. Reinstating the service will be in line with the recovery phase. Restarting with other services.	Recovery
Respiratory	Guidance	The guidance given to primary care for management of respiratory conditions during Covid-manage, could be developed and kept with clinical input from primary and acute services.	Recovery
Screening	Pause service	AAA screening service was stopped during Covid-Manage, there is a plan to restore the service but social distancing and PPE measures will reduce capacity from 115 appointments per week to 80.	Restore

Screening	Pause service	Bowel Cancer Screening Programme was paused during Covid, and will be reinstated when guidance is given by BSG and JAG. There will be a significant impact on capacity due to social distancing and PPE necessary in AGP.	Restore
Screening	Pause service	Breast screening will be reinstated, and will have capacity impacts due to social distancing.	Restore
Screening	Pause service	Diabetic eye screening programme was paused during covid but is planned for restoration with social distancing and PPE measures in place, which will impact on capacity.	Restore
Therapies	Pause service	The Hydrotherapy service closed during Covid-manage, and is planned to be restored with social distancing and risk assessments in place.	Recovery
Therapies	Pause service	Spasticity clinics were paused during Covid, and are planned to be reinstated with risk assessments, PPE and social distancing	Restore
Stroke medicine	**Patient flow/discharge**	Due to significant COVID related sickness, consultants shielding and the withdrawal of agency locums, it became urgently necessary to move from 2 x single site on Stroke On Call Rotas (1:4) to one trust wide on call rota to maintain safety and sustainability of access to thrombolysis.	Recovery
Elective Care	**Green Site**	A Green site (Covid-19 free) at Grantham and District Hospital for this next phase of the pandemic. This would mean an increase in elective patients at Grantham hospital, including transfer of chemotherapy, cancer surgery and other surgery from across Lincolnshire.	Restore
A&E	**Urgent Care**	Convert A&E to Urgent Treatment Centre ('UTC') and make physical estate changes to isolate from the rest of site. UTC isolation can be done in a way that removes staff/patient movement between Blue and Green areas. The preferred model converts the A&E, currently open from 8am to 6:30pm, into a 24/7 walk-in UTC treating patients with a NEWS score of 4 and below and using existing x-ray imaging facilities dedicated to the UTC. The UTC will be equipped to diagnose and treat many of the most common ailments people go to A&E for - 81% of patients who attended the A&E will still be able to attend the UTC. Patients may be referred to an urgent treatment centre by NHS 111 or by a GP, and patients can also turn up and walk-in. The Ambulatory Care Unit will be retained to provide day care for patients.	Restore
Medicine	**Inpatient beds**	Withdrawal of medical beds at Grantham - As medical beds will be withdrawn at Grantham a proportion of patients will be treated in the Ambulatory Care Unit (largely GP referrals) at Grantham and a number of patients will be re-routed and admitted at Lincoln.	Recovery

4 Grantham Green site

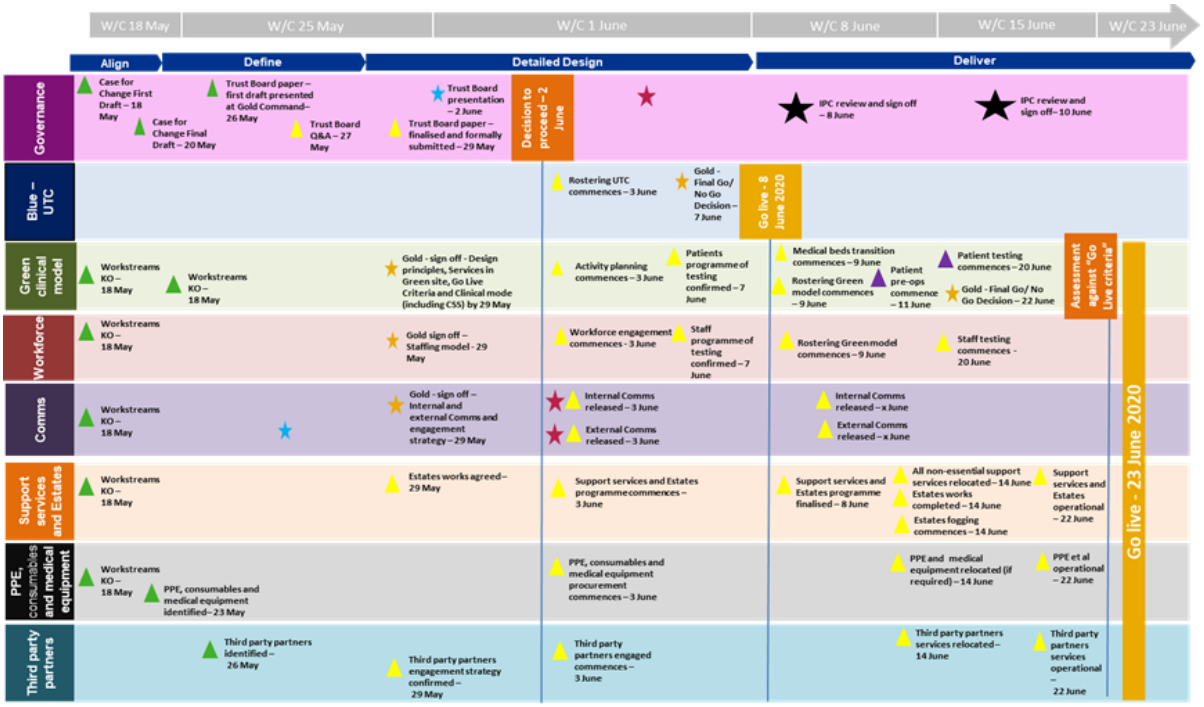
The Trust's Restore phase response has been heavily focused on reducing the risk of hospital acquired Covid-19 and associated Infection Prevention and Control measures. This is with an aim to create optimum levels of protection for patients and staff, drawing on a bundle of measures including social distancing, environmental enhancements, cleaning programmes, hygiene and hand washing, and test and trace. Additional measures are required to ensure that environments can support improvements in IPC including controlling access through hospital areas, reducing footfall wherever possible, and zoning of areas to support Green and Blue designation of areas. An important vehicle to deliver these measures and integral component of the Trust's Restore phase plan is the creation of a Green site.

On June 11th 2020, the Trust Board approved the proposal for temporary reconfiguration of services at Grantham as a Green site with a Blue isolated Urgent Treatment Centre. This decision was made following presentation of a case for the temporary reconfiguration of services as part of the Trust's response to the level 4 incident declared on 30 January 2020. This case for change included the options

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

Approval was given to proceed with the changes proposed and approval for the necessary work to deliver this change to commence, whilst recognising that these are temporary and that any proposal to make them permanent will be subject to public consultation. The timescale for the Green site is the duration of the Covid-19 Restore and Recovery phases up to at least 31 March 2021.

The critical path below describes the workstreams within the project task and finish group and at a very high level the activities required to achieve go live of the Grantham green site by the target 23 June. Behind this sat detailed plans for clinical leadership and governance models, workforce, IPC protocols and procedures, and a go live checklist. Subsequently the Grantham green site went live on 29 June, 6 days overdue owing to uncontrollable factors, and a very credible achievement in delivering a large-scale change in a very short time frame.



The Trust, in collaboration with LCHS, has converted the (currently open from 8am to 8pm) ED into a 24/7 UTC treating patients with a NEWS score of 4 and below and using existing x-ray imaging facilities linked to the centre, maintaining urgent treatment and care to the population of Grantham. This isolated Blue area within the Green site has been achieved in a way that removes staff crossing between Blue UTC and Green site and does not compromise IPC excellence, while affording the option of having completely Green diagnostics and inpatient services.

In order to maintain the highest level of protection and IPC standards on the Green site it has been necessary to relocate a number of services internally as well as with system partners. In order to reduce the number of services on site overall and remove all services that cannot sustain a Green pathway (Covid-negative patients only) a number of new/alternative locations have been identified

and implemented. This approach has reduced both patients and staff need to transfer to other hospital sites across Lincolnshire.

Table 2: Services requiring relocation or new working practices to limit site presence to essential only

System partners	ULHT clinical services	ULHT non-clinical services
LCC – Social workers	**Community midwifery**	**Medical secretaries and**
LPFT - Neuropsychology	**Orthodontics**	**bookings –** Hybrid solution
LCHS – GU Medicine services	**ENT**	**CNN team**
LCHS – SALT	**Audiology**	**Estates/Facilities**
LCHS – AIR in reach into UTC	**Respiratory**	**Procurement**
LCHS- Out of hours	**AAA screening**	**Divisional support**
Macmillan – remain on site	**Plain film x-ray**	**Corporate Nursing**
Uni of Lincoln –student	**Physiotherapy/OT**	**Library**
nursing support	**Paediatrics**	**Finance**
Respiratory physiology	**Dietetics**	**HR**
OT/Physiotherapy	**Surgical and Medicine**	**PALS** – tbc
System Partners (including	**specialist outpatients**	**Operations Centre**
Marie curie)	**Clinical coding**	
	Research office	

In order to maintain local access to these services within Grantham a number of alternative accommodation solutions have been identified in the town area including South Kesteven District Council offices, Grantham Health Centre and commercial office units, as well as mobile diagnostics facilities.

The Trust formally recognises the support it has had from system partners in order to carry out this large scale change and the disruption and additional effort required in order to achieve such a high standard of protection for patients who required urgent and planned care treatments.

The potential for medical inpatient and diagnostic services to share Blue and Green services is significantly short of the IPC principles set and the design principles of a Green site. Therefore, medical inpatient admissions have been removed from the Grantham model temporarily for the duration of the Covid 19 Restore and Recovery phases. The displacement of urgent care activity and medical admissions to other Trust sites and neighbouring providers has been modelled and will be closely monitored.

A formal Quarterly Review of the Green Site Proposal will be presented in October (i.e. presenting the first 3 months of operation.) However, in the interim each month will present important information on attends, ambulances, cancer treatments and incidents specific to Grantham

On 1 July elective surgery commenced within the Grantham Green site and it is anticipated that as efficiency of the surgical model develops over the next month that throughput will see 25 cases through four extended theatres each day.

Additional diagnostic services are planned for one of the offsite Grantham locations further reducing any unnecessary transfers to other hospital sites, and reducing the demand on services in the UTC. Although the Trust is in a priority list for these diagnostic units with many other trusts across the UK. It is likely that x-ray services will be in place off site from August 2020 until the Grantham Green Site model is reverted and services return to previous configuration.

5 Patient and staff testing and screening

All patients undergoing cancer or elective inpatient procedures on a green pathway are being advised to self-isolate for 14 days prior to procedure and tested 48-72 hours prior to admission. Patients attending for an outpatient appointment or day case procedure are advised to self isolate for 7 days.

Our approach to staff testing is aimed at reducing healthcare associated Covid 19 infections in the Trust. Testing our staff is essential to ensure patient safety, maintain confidence in the Trust and protect the health and wellbeing of our staff. Trust protocol is to test all staff with symptoms or the index case if a household member. We do not test non-symptomatic staff.

In the event of an untoward incident or outbreak the Trust has an outbreak plan and staff and patients from the outbreak department will be tested. If a healthcare worker tests positive this will be risk assessed and colleagues who they've been in contact with may subsequently be identified and tested.

We are currently offering staff the opportunity for antibody test, which tests for the presence of antibodies that will demonstrate whether an individual has had the disease.

All staff attending the Grantham green site to work on the green pathway are now required to have a daily health screen, which includes a health and wellbeing assessment and temperature check.

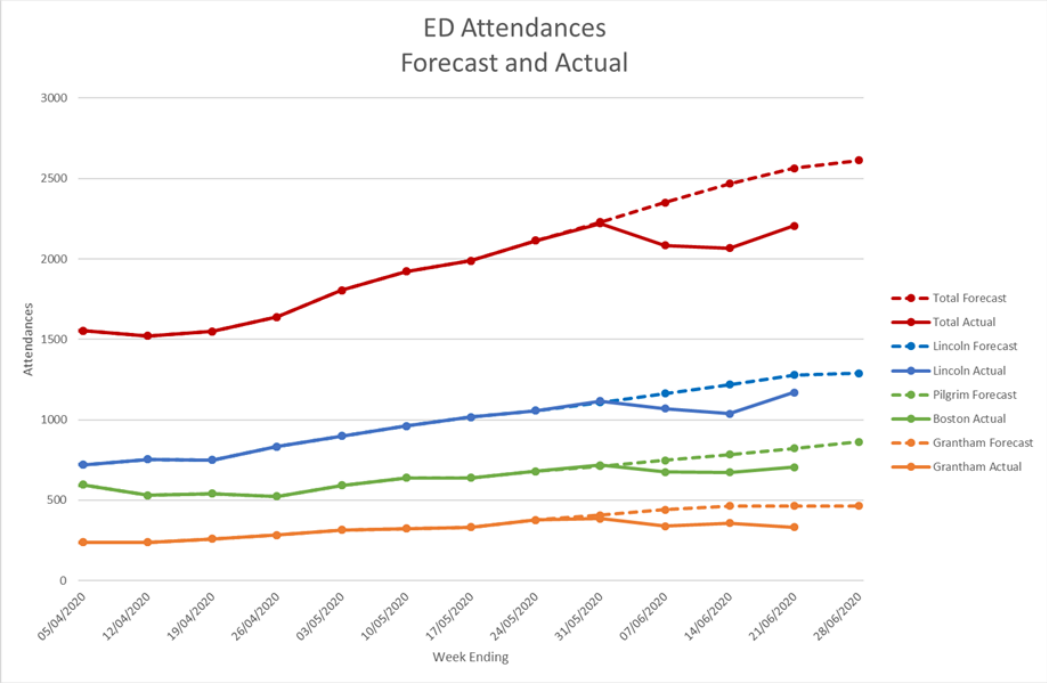
6 Urgent and Emergency Care, Urgent and Routine Surgery

6.1 Urgent and emergency care:

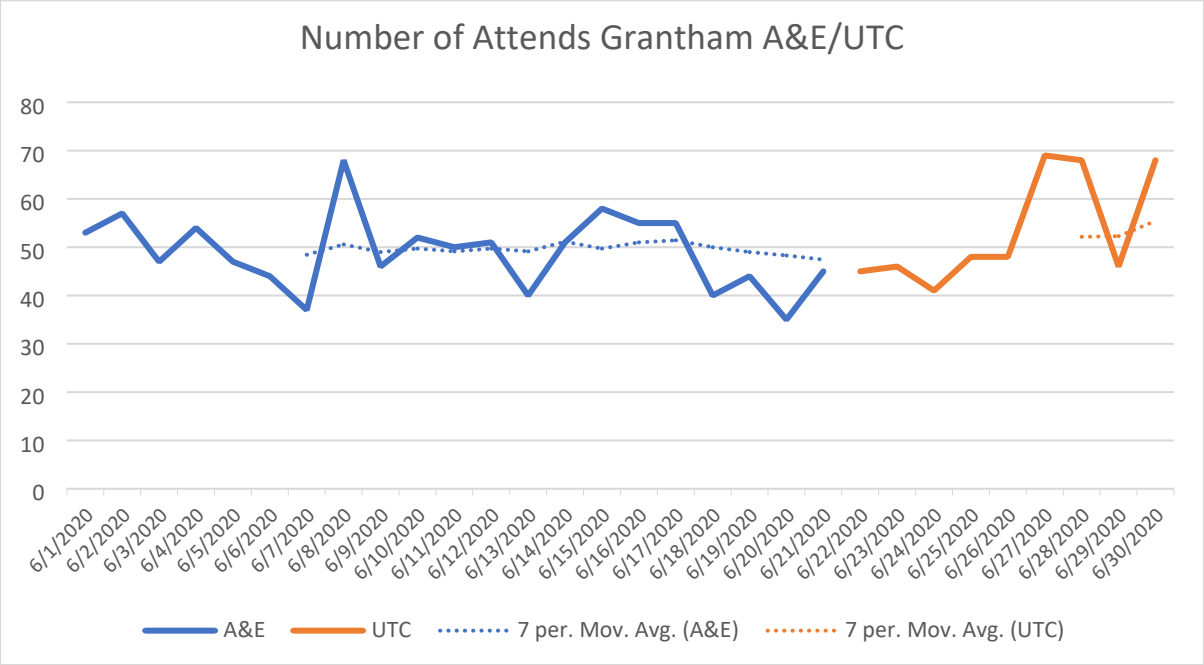
The Trust's urgent and emergency care (UEC) activity reduced during the *Manage* phase with non-elective admissions at 42% of pre-pandemic average activity. Local UEC demand modelling forecasted non-elective admissions to increase by 13.6% per week up to a normal level by the end of May resulting in potential "rebound" of increased demand on urgent care service generated by delayed attendance, deterioration due to delay in seeking medical assistance and postponed activity.

High rates of increase in ED attendances during May drove activity back towards pre-Covid 19 levels; however, in late May and early June the growth rate has plateaued. Currently ED attendance activity compared to pre-Covid 19 levels is

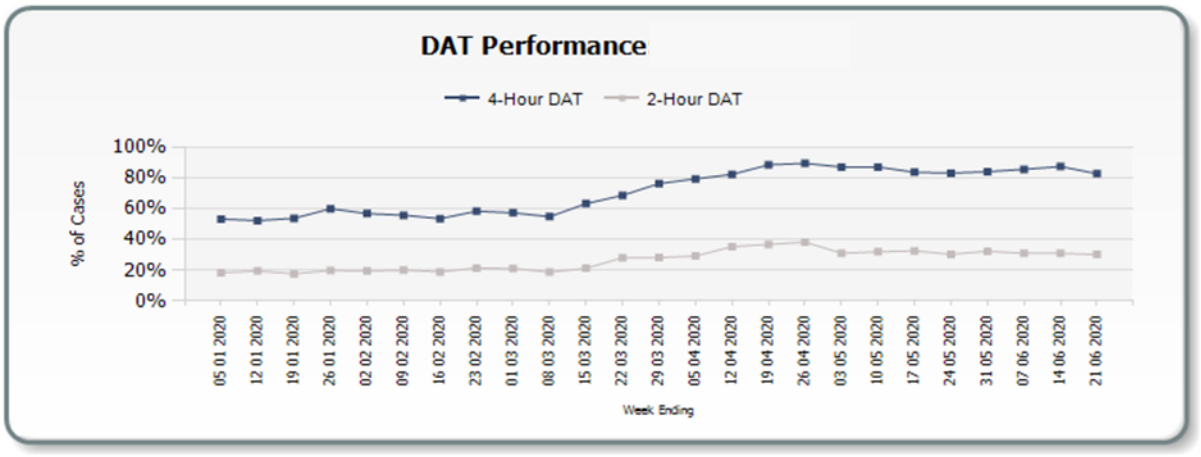
- Lincoln 88%
- Boston 73%
- Grantham 75%



Since transition to an Urgent Treatment Centre (UTC) model Grantham attendances have continued to increase.

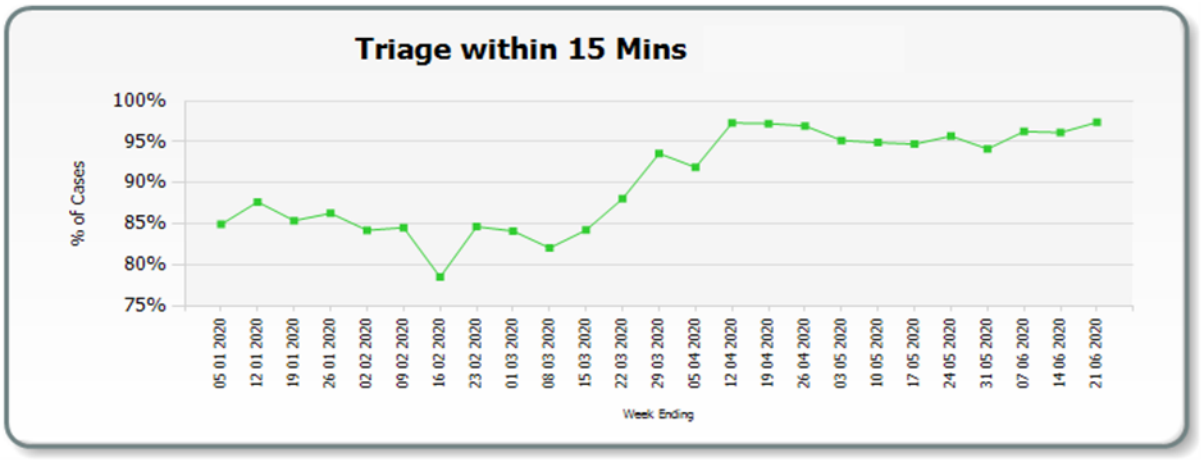


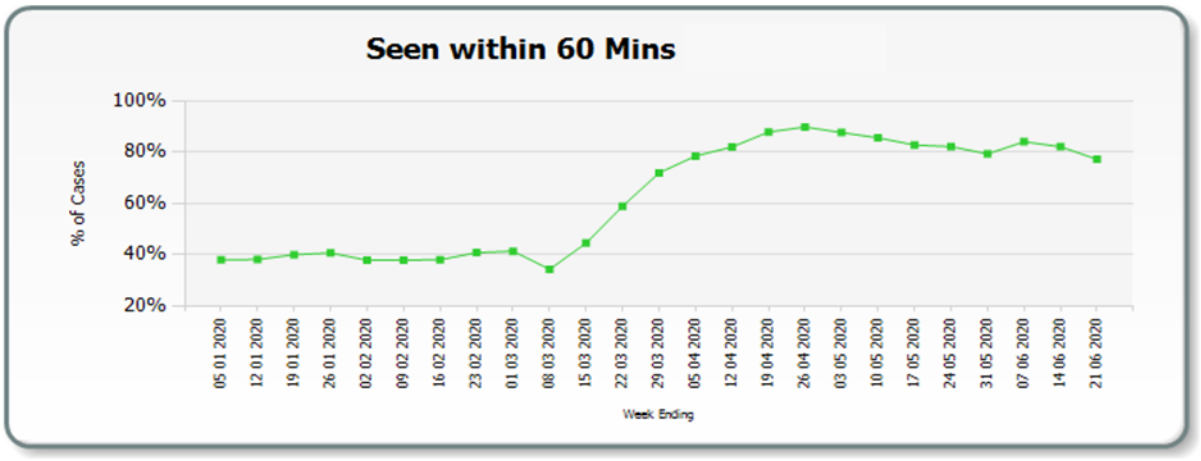
Despite attendances returning to over 80% of pre-Covid 19 levels, the Trust's significantly improved 4-hour performance is being maintained at over 80%. For May, the most recent reporting period, 88.70% was achieved despite a 26% increase in ED attendances compared to the previous month.

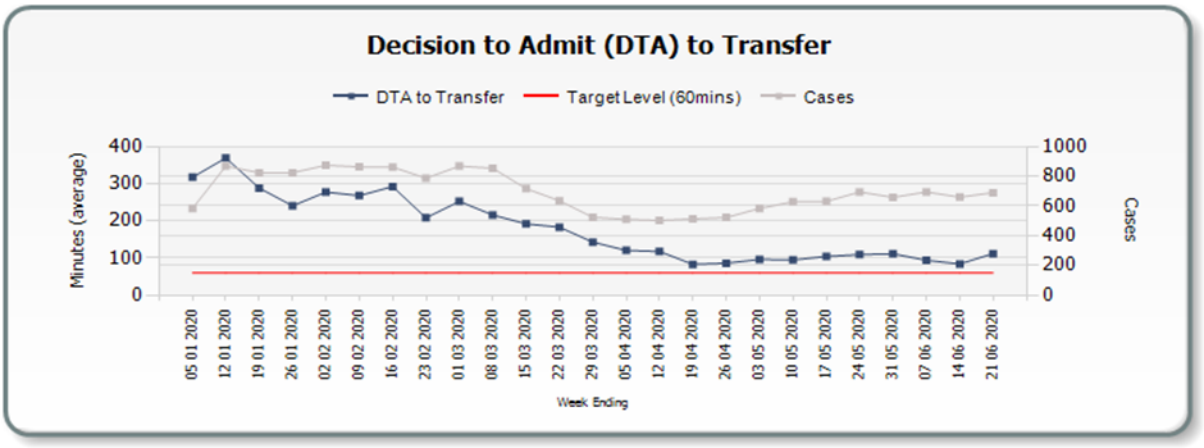


Drivers for this have been the reduction in delays due to triage, being seen by a doctor and time to transfer to a base ward. Ambulance handover delays have also significantly reduced across the Trust.

This success has resulted from coordinated work to restore our UEC capability at the required pace and scheduling immediate changes to our front door model, ED pathways, same day emergency care (SDEC) provision and discharge efficiency.



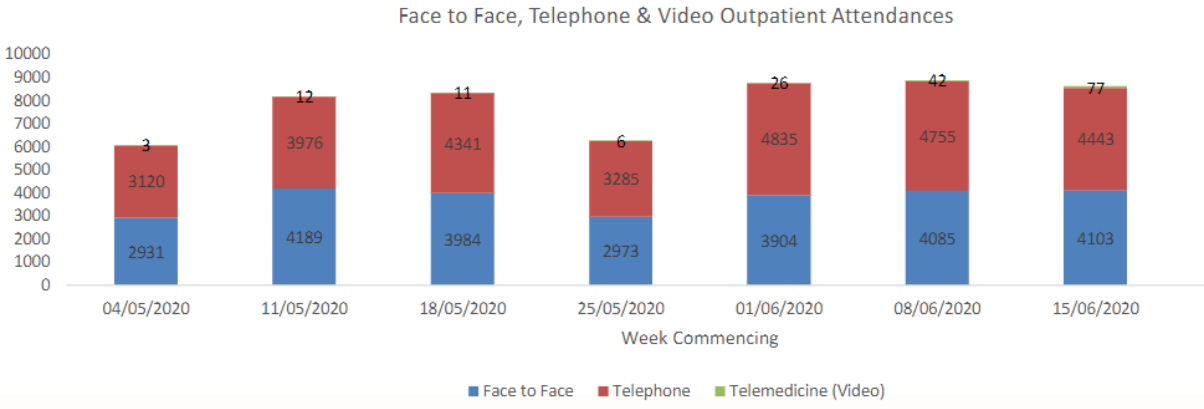




6.2 Outpatients:

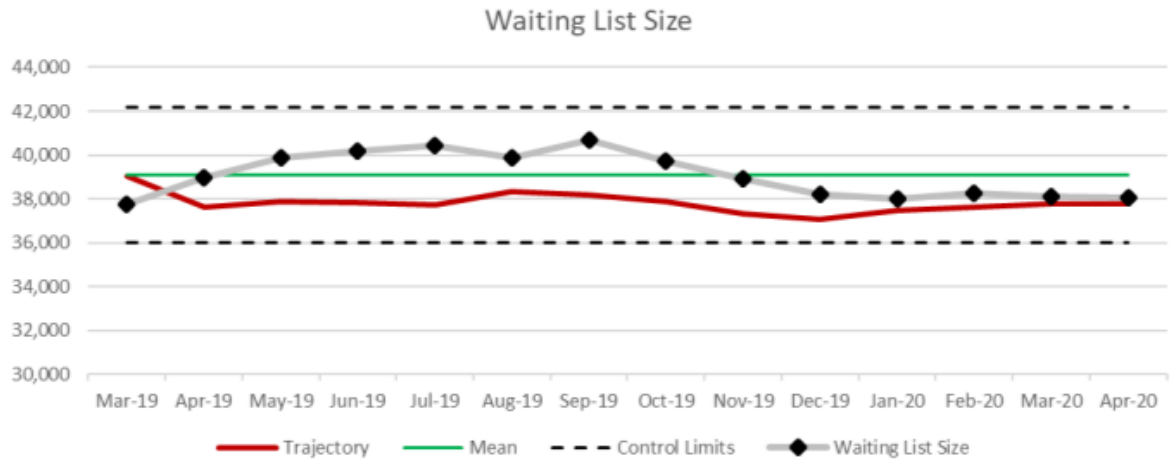
The Trust has continued to provide outpatient consultations for cancer and urgent patients throughout the pandemic, while scaling up routine appointments during June, utilising telephone and VC as default to reduce the risk of cross-infection, only offering face to face appointments where clinically required. The scaling up of our use of technology-enabled care has been very successful, benefiting both patients and clinicians, and our focus is on embedding this new way of working as future business as usual.

During June total outpatient's weekly activity has been approximately 60% of pre-pandemic volume. Currently circa. 55% of the Trusts maintained outpatient activity is being conducted by technology enabled care; over the telephone or by video consultation.

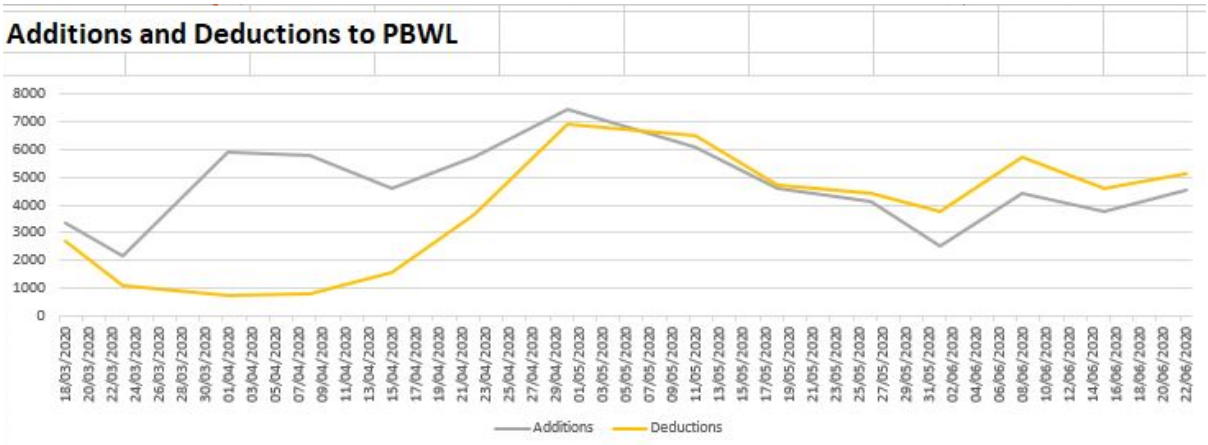


Specialty level waiting list recovery plans are being monitored and current performance is exceeding national and regional peer performance. The Trust reported three RTT incompletes 52-week breaches for April (latest reporting period). However, it should be noted that the volume of 52-week breaches will increase over the next few months, until elective surgery capacity is increased and the admitted backlog has been cleared.

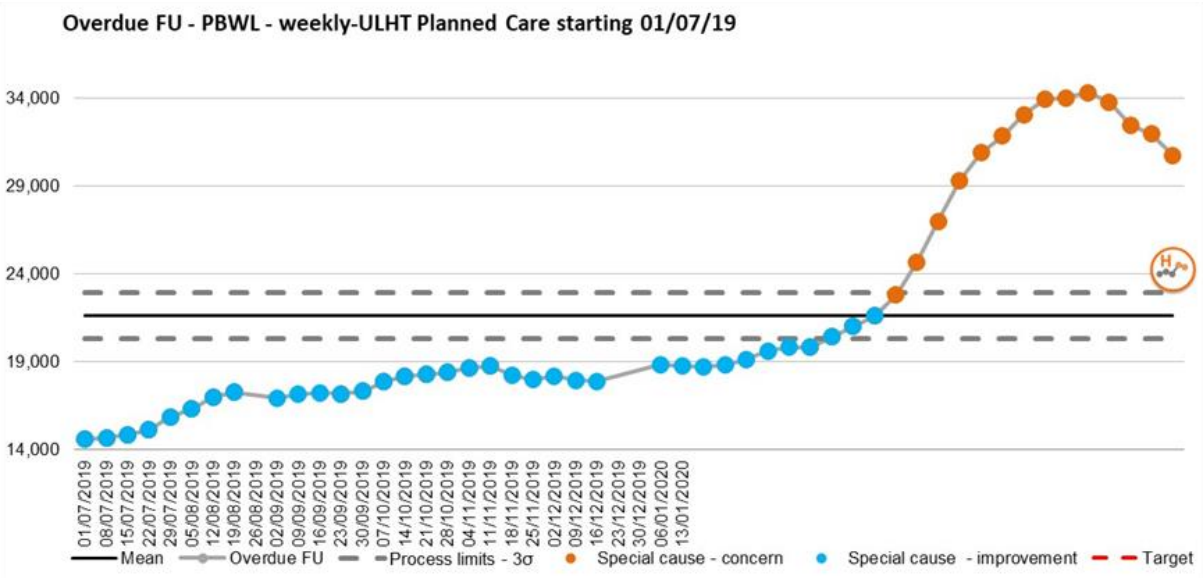
The overall waiting list size has improved from March and remains better than the 2020 target volume.



Following a period of significant growth due to a reduction in routine outpatient activity, the partial booking (follow up) waiting list size has been identified as a key risk. Successful management of this risk so far has been achieved through a programme of recovery actions include clinical triage and validation together with the scaling up of technology enabled care, such as telephone clinics. As a result of these actions waiting list deductions have consistently overtaken additions since mid-May.



Monitoring now illustrates a clear improvement trend and continued reduction of the PBWL by circa. 900 per week.



Risk stratification forms an important part of the Trust's approach to risk management of potential patient harm due to delayed follow up. Prospective clinical reviews are in place across specialties as part of our Covid 19 response in addition to normal operational practices. Our follow up waiting lists are regularly reviewed and prioritised by senior clinicians, with the use of a patient initiated follow up (PIFU) approach wherever suitable to provide patients with the means of self-accessing services if required. We are utilising those health professionals who are shielding during this time to review waiting lists and continue with appointments by telephone or video conferencing from home. If face to face is required we are following all PHE guidelines on IPC.

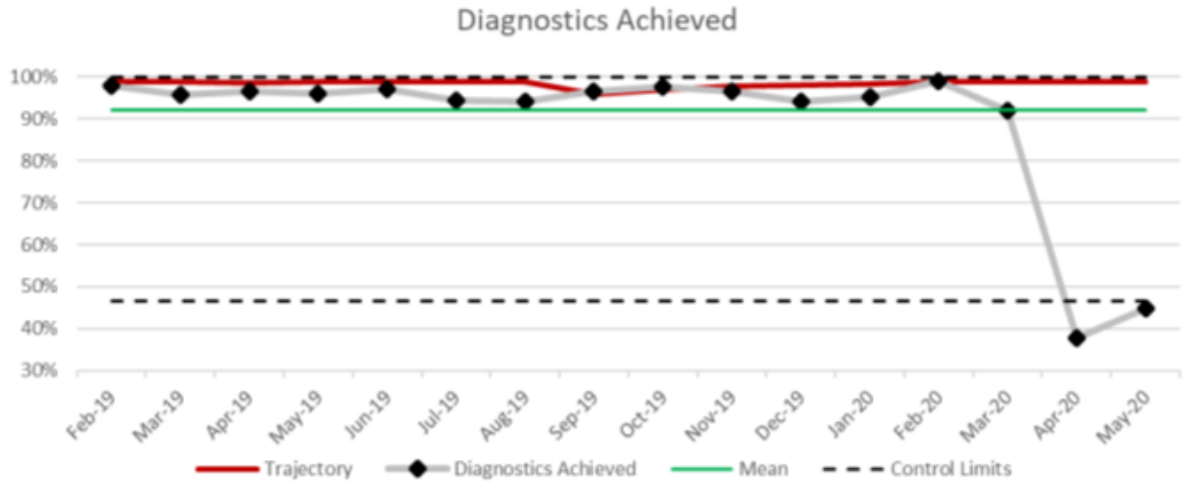
Therapy outpatient services have ensured urgent patients have access to appointments through new referral triage and prioritisation, providing face to face clinic appointments only where clinically required following a risk assessment, and ensuring social distancing measures are in place. Restoration of services to date has involved limited implementation of the reintroduction of outpatients and community provision in order to retain seven day staffing of in-patient settings and support discharge planning.

6.3 Diagnostics

Diagnostics access remains 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 and throughout the pandemic period the Trust has consistently delivered 90-95% access to cancer diagnostics within 7 days.

As a direct result of Covid 19 impact 55% of patients waiting for a DM01 diagnostic test at the end of May were waiting over 6 weeks. This is in line with the average performance of Trust's nationally. Most patients waiting over 6 weeks continue to be 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.

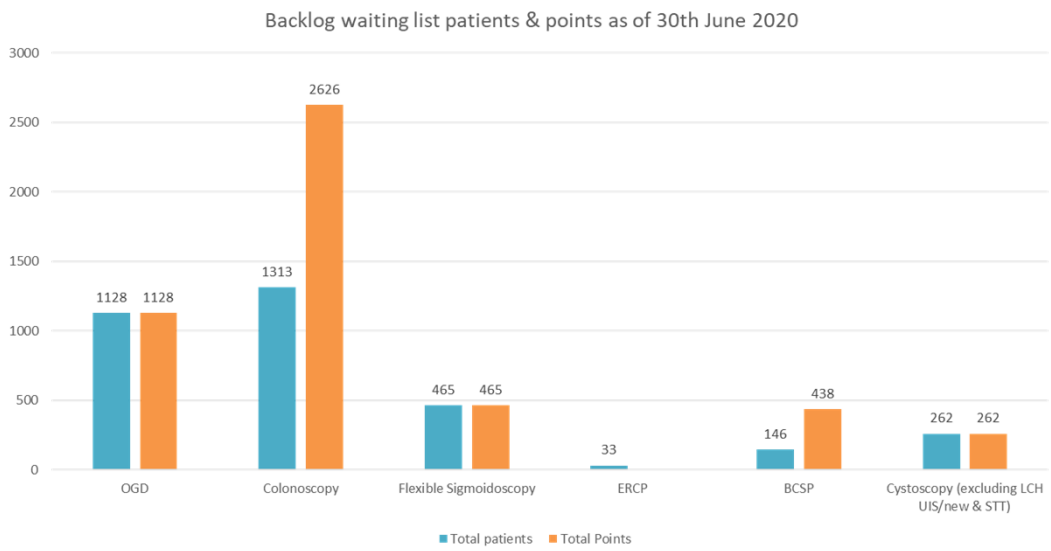


From the end of March only urgent cardiac echo activity continued to support cancer pathways with all routine activity temporarily stopped. This routine activity re-commenced from 8 June as planned at reduced capacity due to social distancing constraints. Estates reconfiguration work has been approved to proceed with investment which will support green pathways for TOE procedures through Lincoln and Pilgrim sites, in addition to Grantham site.

6.4 Endoscopy

6.4.1 Current position

Endoscopy services nationally are guided by the British Society of Gastroenterologists (BSG) and Joint Advisory Group on GI Endoscopy (JAG) and their recommendations remain unchanged. 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.



6.4.2 IPC and ventilation constraints

Under the current PHE guidance, a minimum of 10-12 air exchanges per hour in each procedure room is required. This air exchange requires the room to remain closed for 20 minutes post procedure to allow for airborne droplets to settle. A more efficient ventilation system could potentially reduce this time down to 5 minutes per procedure which would equate to one additional patient per list.

The rooms require cleaning between patients, 10 minutes cleaning time followed by 15 minutes drying time before the next patient and team can enter.

6.4.3 Demand

Demand average based on the last 4 weeks referrals received is 338 points (points are units of endoscopy procedure time measurement) per week. Future demand is difficult to predict due to unknowns in outpatient clinic recovery, screening programme/bowel scope, increased demand of non-GI specialties and any impact on new interventions such as FIT and capsule endoscopy.

If demand returns to pre COVID levels demand would average 700 points per week. Current maximum capacity is 415 points per week. The Endoscopy Recovery Cell is leading development of a strategy to meet this shortfall in capacity of circa. 300 points per week.

6.4.4 Demand management

This recovery strategy will include demand management and alternative capacity plans including:

- Primary Care pathways
- Secondary Care pathways
- Vetting of referrals received
- FIT (faecal immunochemical testing)

- Capsule endoscopy
- Maximisation of capacity through 7 day working and extended session days

6.4.5 Key next actions

To support this recovery strategy the Endoscopy Recovery Cell has identified the following supporting enablers which will be completed within the next few weeks:

- Completion of estates and workforce audits
- Production of a detailed capacity and demand model
- Review of job planning to support additional endoscopy sessions
- Work with estates to review improved ventilation systems in procedure rooms
- Put in place maximum workforce clinical time after reviewing available teams
- Engagement with the independent sector to secure arrangements with all potential IS providers

6.5 Urgent surgery and non-surgical procedures:

The Trust has continued to ensure sufficient capacity for urgent and time critical surgery and non-surgical procedures using Royal College of Surgeons (RCS) advice on surgical prioritisation. Level 2 and 3 (critical care level) surgical activity continues through green pathways on Lincoln and Pilgrim sites, with the earlier described Grantham green site model being the vehicle for all other cancer and elective surgical activity delivery.

Elective surgery commenced at Grantham from 1 July with four theatres running initially Monday to Friday extended days, eventually enabling throughput of a planned 25 surgery cases per day. Once efficiency and capacity are tested and fully understood elective backlog recovery trajectories will be modelled, but initial forecasting is for elective recovery by December 2020.

6.6 Prioritisation, risk stratification and harm review:

The approach taken to prioritising services is based on clinical risk with the highest priorities being cancer treatment, urgent and emergency care, and time critical non-cancer treatment. Only once the appropriate levels of capacity for these priorities is in place the process of restarting routine electives will commence, prioritising long waits.

Although co-dependent, risk stratification (prospective analysis) and harm review (retrospective analysis) should be considered distinctly. Risk stratification forms an important part of the Trust's approach to risk management of potential patient harm as a result of the response to Covid 19. Prospective clinical reviews are in place across urgent and planned care, inpatients and outpatients, cancer and maternity services, as well as other areas, as part of our Covid 19 response in addition to normal operational practices.

The increased UEC demand described earlier in this report raises the potential for delays in ambulance handover times, time patients spend in the ED and delayed discharge, and subsequent risk of harm. To mitigate these risks we have made immediate changes to our front door model, ED pathways, SDEC

provision and discharge efficiency. All such incidents are reported using the Datix incident reporting system, using the Trust's Clinical Harm Review template and Rapid Review Report if applicable. The purpose of a Rapid Review Report is to enable a timely decision to be made as to the level of investigation required following the report of an incident which appears to meet the Serious Incident criteria.

National Guidance issued in March proposed a system of prioritisation for cancer patients requiring surgery. Simultaneously, Royal Colleges issued advice on which treatments should go ahead and which are considered a greater risk due to coronavirus.

Our approach to minimising potential harm has been in line with the three key principles set out in the letter received in June from the National Cancer Director, these being:

1. Capacity: there needs to be sufficient capacity to ensure anyone referred with suspected cancer can be diagnosed and treated promptly
2. Fairness: access to cancer diagnostics and treatment services should be equitable and based on clinical priority
3. Confidence: patients need to have confidence their diagnostics and treatment will take place in an environment and manner that is safe

No moderate or severe harms have been reported in relation to the harm reviews undertaken by the Trust during the response to Covid-19 (93% reported no harm, 7% low harm).

The harm review processes used have been in place within the Trust following co-design and development with the CQC and CCG(s) in 2017.

Learning from harm reviews has fed back into the way that patients on RTT pathways are being tracked, managed and where necessary escalated. As an example, root cause analysis and harm review completed following a gastroenterology 52-week breach in March has led to review and improvements of the standard operating procedure for open referral monitoring and reporting, and hepatology sub-specialty referral mapping, minimising the risk of this happening again in the future.

6.7 Independent Sector Support:

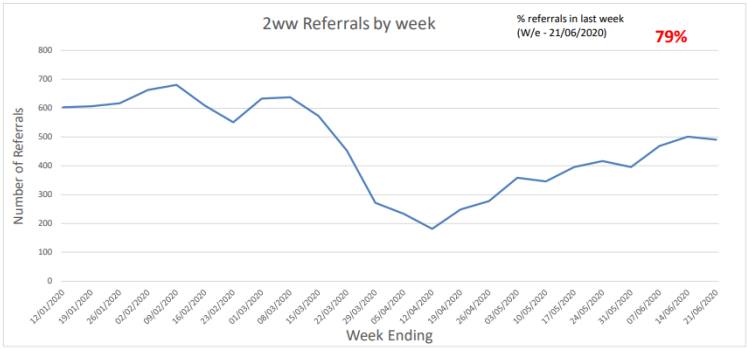
The Trust has been and continues to work with system colleagues to make use of NHS contracted independent sector hospitals in order to increase capacity available to treat cancer, urgent and elective long waits.

At the time of writing BMI Lincoln had undertaken 56 operations on behalf of the Trust; 32 orthopaedics and 24 ophthalmology procedures; this support will continue with plans to maximise available capacity. An agreement has also been reached with Ramsey Boston for 200 endoscopy procedures initially and further opportunity being scoped.

7 Cancer

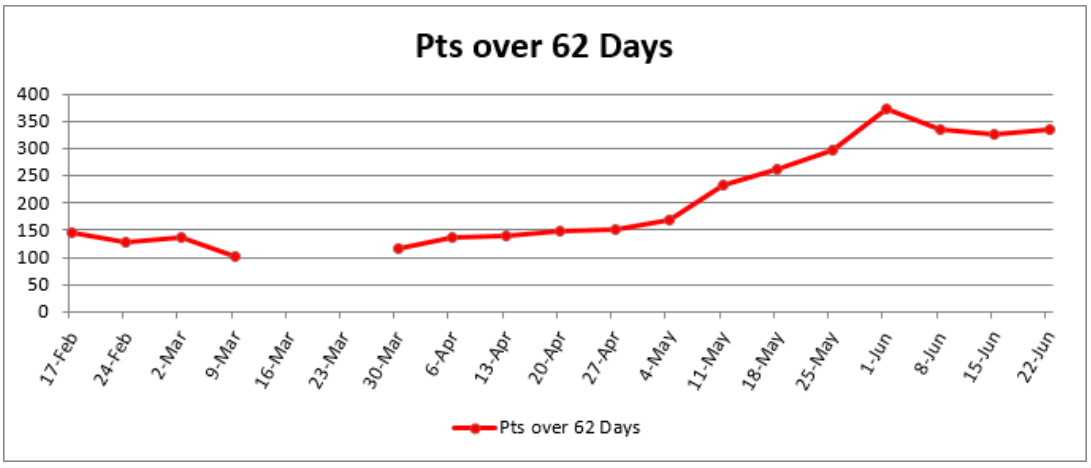
The Trust has maintained urgent access to essential cancer surgery and other treatment, and the provision of 2WW appointments, throughout the pandemic in line with national guidance and in collaboration with the regional Cancer Alliance and provider partners.

2WW referrals significantly reduced during the *Manage* phase and, as anticipated, have increased during the *Restore* phase with some tumour sites now returned to near pre-pandemic activity volume.



	Average referrals on baseline	% referred latest week against base line
Exhibited (non-cancer) Breast Symptoms	38	87%
Suspected brain/central nervous system t	5	40%
Suspected breast cancer	70	84%
Suspected gynaecological cancers	49	108%
Suspected haematological malignancies e	6	50%
Suspected head and neck cancers	62	97%
Suspected lower gastrointestinal cancers	135	73%
Suspected lung cancer	16	44%
Suspected Sarcomas	4	25%
Suspected skin cancers	102	89%
Suspected upper gastrointestinal cancers	52	79%
Suspected urological cancers (excluding t	82	50%
Total	622	79%

The Trust's 62 day cancer standard performance for June is forecast to be circa. 70% against an agreed recovery trajectory of 70.8%. During the course of the pandemic the over 62 day backlog has increased significantly and as of 19 June was 322 patients. This is similar to other Trust's regionally as is the predominance of colorectal pathways within this backlog cohort (73% of the total) due to the suspension of endoscopy procedures.



Cancer surgery commenced on the Grantham Green site from 1 July. At this time, there were no Level 1 cases outstanding and anticipated date to clear all priority Level 2 cases awaiting TCI was 5 weeks (by 9 August). The expected date to clear all priority Level 3 cases and those without a priority level awaiting TCI was 8 weeks (by 26 August).

Table 3: Outstanding ULHT cancer surgery with no TCI by specialty and priority level as at 1 July 2020

Specialty and Priority Level	No Planned TCI
Breast Surgery	**31**
Level 2	21
Level 3	2
No Priority Level	8
ENT	**5**
Level 2	2
Level 3	0
No Priority Level	3
General Surgery	**30**
Level 1	0
Level 2	7
Level 3	22
Gynaecology	**3**
Level 2	1
Level 3	1
Non-cancer	0
No Priority Level	1
Maxillo-Facial Surgery	**3**
Level 2	0
Level 3	1
No Priority Level	2
Urology	**33**
Level 1	0
Level 2	2
Level 3	31
Grand Total	**104**

8 CVD, heart attacks and stroke

Capacity has been 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. Routine catheter lab activity, including angiograms and complex devices, resumed in June as planned. However, restoration of cardioversions and TOE procedures has been delayed as a result of work on the Grantham green site model. Scaling up of these procedures will be prioritised in July and August.

On 31 March, in order to maintain capacity, the Trust's stroke pathway was temporarily 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 temporarily while being under continual review.

9 Maternity services

The Trust's maternity services are currently delivering all antenatal, intrapartum and postnatal care in line with NICE guidance CG62, CG37 and Fetal Anomaly Screening Standards. The services Covid 19 Standard Operating Procedure remains in place to support management of pregnant women who are symptomatic or positive to Covid 19. Whilst all care is in line with national guidance and supports face to face contacts as required, some care continues to be delivered via telephone and video conference, where this is deemed appropriate. This has been a very successful initiative during the pandemic and is something that will be embedded and continue to be used.

Of note, the Trust has seen an increase in domestic abuse disclosure, as has been seen nationally, and safeguarding referrals to MARAC have increased. This is being managed well by the midwifery teams supported by the safeguarding team and in conjunction with other agencies.

10 Screening programmes

During the Restore Phase we have prioritised making screening services available for the recognised highest risk groups as identified in individual screening programmes. Planning to restore screening programmes has been approved by the Trust's ICC, is on track and outlined below. Recovery Phase activity trajectories are under development and will be presented in the August progress update.

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.

National guidance has advised that activity should be reinstated during the Restore and Recovery Phases prioritising those patients at greatest risk of rupture, with plans agreed at local level.

The Trust currently has 572 patients on follow up with identified known small/medium AAA. Our current AAA screening backlog is circa. 900.

AAA screening will recommence in July with follow up of small/medium AAA patients prioritised.

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 contacted regularly to check on wellbeing and, where intervention is required, patients are being referred accordingly.

Screening centres have been advised to manage their own capacity and recommence FIT screening colonoscopies when able. Test kits should recommence following backlog clearance and future capacity has been identified. There is no recommendation from national bodies to recommence bowel scope currently.

The Trust is making use of available independent sector capacity from 6 July. Future capacity is being planned ahead of further national guidance on the reintroduction of bowel scope.

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. Cancer 2WW services have been maintained throughout the pandemic.

National guidance describes programme recovery in two phases. Phase one is risk stratified backlog clearance and our plan to commence phase one from August is on track. Phase two will consist of women aged 53+ and not previously invited and 71+ in the screening slippage auto batch, with phase two start date anticipated March 2021.

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, approximately 2% of total normal screening activity.

National guidance describes recovery in two phases. Phase one is risk stratified backlog clearance of digital surveillance, newly diagnosed, pregnant, and previous low level pathology and DNA patients. The Trust will commence this phase in July. Phase two will consist of all other patients with no pathology noted on last screen, with follow up deference protocol guidance enabling a March 2021 start for this phase.

10.5 Newborn hearing screening:

Our Newborn Hearing Screening Programme has been maintained throughout the pandemic. 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 at the bedside while still an inpatient. Outreach clinics will be resumed from July.

11. Corporate Governance – Review of Covid 19 Business Continuity Arrangements

At the April meeting the Trust Board agreed the measures it would put in place to maintain effective corporate governance arrangements, whilst adhering to national guidance and recognising the operational pressures being experienced by the Trust's executive, clinical and operational teams. The Board agreed the temporary suspension of the current governance structure and creation of Covid-19 specific governance arrangements.

Since April 2020 the position has been reviewed by the Chief Executive and Chair on a rolling weekly basis.

The Trust applied the following principles to meetings:

- Follow national advice and guidance relating to avoiding unnecessary social contact and travel
- Protect patients and staff from harm and avoid the spread of coronavirus
- Release staff time to focus on COVID19 and the delivery of front-line care
- Retain appropriate levels of leadership, governance and assurance

All but the most essential meetings were stood down.

At a corporate level the following principles were agreed:

- Decisions made during the period would continue to be in line with standing orders. The Board adopted a streamlined approach to governance and standing financial instructions.
- The Board acknowledged that its risk appetite and tolerance of risks needed to rise. The BAF was updated to reflect risks relating to Covid-19 and continued to be reviewed by the Board and the Quality Governance Committee monthly.

In order to free up Executive and Senior Staff time from the preparation of papers, attending meetings the following changes were agreed:

- Trust Board moved to being held virtually on a monthly basis, lasting no more than two hours. The agenda agreed by the Chair and Chief Executive. Board papers continued to be published on the website and members of the public will be able to submit questions in the normal way. The public will not be able to attend the meeting due to national social distancing requirements. Microsoft Teams has allowed the public to observe Board meetings online with over 140 people watching the June Board meeting in this way.
- Board Development sessions will be stood down
- The Audit Committee to meet (virtually) only as necessary to enable the completion of the final accounts process
- The Quality Committee to meet virtually on a monthly basis to focus on assuring the board on patient safety
- The People & OD Committee and Finance, Performance and Estates Committee were stood down. This position would be kept under review.

All Board and Committee papers would be kept brief, with only critical issues brought to the Board/ Committees attention.

Matters for approval were either:

- Deferred if not urgent
- Circulated vie email, allowing time for response and decision recorded by Trust Secretary/ Deputy Trust Secretary
- Discussed between Chief Executive or nominated Executive with appropriate Board/ Committee Chair for Chairs action

As the Trust moves to restore some services the Board are asked to consider re-instating some additional governance arrangements. It is proposed that monthly meetings for both the Finance, Performance and Estates Committee and the Workforce and OD Committee are re-introduced but with a lean agenda.

The focus for the meetings will be as follows:

- Finance, Performance and Estates Committee
    - Assurance on financial position and governance arrangements
    - Assurance on statutory responsibilities in respect of the estate
    - Assurance against performance standards
- Workforce and OD Committee
    - Assurance on workforce planning
    - Assurance on values and behaviours

The Trust Board and Quality Governance meetings will continue in line with current arrangements. These arrangements will continue to be kept under review, including providing the opportunity for the public to attend Board meetings when social distancing guidelines and access to appropriate venues allow.

Agenda Item

NHS
United Lincolnshire Hospitals
NHS Trust

Report to:	Trust Board
Title of report:	Quality Governance Committee Assurance Report to Board
Date of meeting:	23rd June 2020
Chairperson:	Liz Libiszewski, Non-Executive Director
Author:	Karen Willey, Deputy Trust Secretary

Purpose	This report summarises the assurances received and key decisions made by the Quality Governance Assurance Committee (QGC). The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board's response. This assurance committee meets monthly and takes scheduled reports from all Trust operational committees according to an established work programme. The Committee worked to the 2020/21 objectives. The Trust are in the 'Restore' phase in response to Covid-19 and as such the meeting was held via Microsoft Teams with a reduced agenda to focus on key priorities
	Lack of Assurance in respect of SO 1a Issue: Deliver harm free care **Work Programme** The Committee received the work programme which detailed all key committee business and the route through which assurances would be received. The Committee noted that clarity would be required on the reporting requirements for Equality and Diversity, Divisional reporting, Safety Culture. CQC reporting would also require inclusion on the work programme. **Performance Dashboard** The Committee noted that there had been minimal changes to the performance dashboard with no change in mortality and a slight improvement regarding duty of candour. There had been 1 MRSA reported which was currently being reviewed through a RCA. There had been some instances of sepsis in both adult and children's inpatient services however these were not a cause for concern due to the amount of working being undertaken to change the position. The Committee noted that the dashboard was limited due to Covid-19 and requested a timescale as to when a more populated dashboard would be received. **Harm Review process** The Committee received the harm review report noting that the process

	was not capturing all pathways of care and multiple processes exist. There would be a need to streamline the process and ensure this was in line across the divisions. The Committee requested that this was included on the risk register. There was an expectation that there would be an increase of harm reviews as the Trust moved through the restore and recovery phases. The Committee expressed concern regarding the process of harm reviews and requested that a remedial action plan was put in place to address the themes being seen and ensure confidence in the process. **Clinical Harm Review – Covid-19 pandemic** The Committee were advised that the paper related to those deaths reviewed between 1st April and 15th May 2020, deaths may have occurred outside of this period. It was noted that there had been more deaths at Pilgrim than Lincoln and good practice had been identified including communication with families. A retrospective review of ethnicity would be applied to those reviews that had been conducted. Plans were in place to ensure learning was shared across the organisation. The report would be included in the System Review Meeting papers. **Infection Prevention Control Upward Report** The Committee were advised that a full review of the hygiene code had been completed. There would be a move away from reporting percentages of achievement to descriptions – compliant, partial compliance and non-compliance. The Committee were advised that compliance with the hygiene code had reduced to 50%. The Committee noted that there continued to be little assurance with regard to water sampling and the hygiene code. Immediate action had been taken. The committee were concerned that the process for approval and updating of infection prevention and control policies had not been conducted and contributed to significant areas of low compliance within the Hygiene Code. The committee asked for an update on progress re the management of corporate and clinical policy management. IPC policies were being enhanced with a 'policy on a page' and where additional information would be needed these would be considered as 'guidance at a glance'.

	The Trust recognised it would need capital funding to address some of the estate issues affecting the Hygiene Code**.** **Safeguarding Group Upward Report** The Committee approved for publication the Modern Slavery Statement 2020-2021 and Safeguarding Service – Statement of Intent 2020-2021. The Committee were advised of the issues being faced regarding training and noted that alternative solutions were being sought. The Committee noted a new lead for Safeguarding has been appointed.
	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. The Committee requested clarity on the criteria for rating the papers and the alignment to the BAF. **Incident and Risk Management Report** The Committee were advised that reporting levels were much lower, these had been triangulated with mortality, complaints and coroners which had confirmed the level of reporting. The Committee requested a review of the Aseptic risk, currently rated at 15, due to the use of the new temporary unit. **Internal Audit Reports** The Committee received for information the Compliance with Legislation and Governance – Board Assurance Framework internal audit reports and noted the actions required. **Intensive Care National Audit and Research Centre (ICNARC) Report on Covid-19 in critical care for May 2020** The Committee received the report noting this provided a summary of data relating to patients critically ill with confirmed Covid-19. This had been reviewed by the Trust and it was noted there were no areas of concern. **CQC Must and Should do actions** The Committee received the updated action plan, noting some progress

	against the plan and were advised that there had been an agreement to reduce the reporting burden. Formal notification was awaited. In order to continue progression of the action plan during Covid-19 some staff had been identified to support the work being undertaken. The Committee were advised that as part of the emergency support framework developed by the CQC there would be a table top review undertaken which would focus on IPC, IPC BAF, hygiene code and the current position of the must and should do actions. The Committee requested that future reports included progress on the hidden child, including those outside of paediatrics and Emergency Departments. **CQC Emergency Support Framework** The Committee received the framework for information noting that this had been benchmarked against the IPC framework. **Quality Account** The Committee received the final version of the Quality Account that would be shared with stakeholders for comment ahead of final sign off and publication in July.
Issues where assurance remains outstanding for escalation to the Board	The Committee wished to alert the Board to the compliance against the hygiene code, noting that this had reduced and actions were in place to address areas of concern. Urgent work to be conducted to enhance the Harm review process and ensure a consistent approach is adopted across the Trust. The Board are asked to note the lack of progress on ensuing the availability of up to date policies and procedures.
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.

Agenda Item

Attendance Summary for rolling 12 month period

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

X in attendance A apologies given D deputy attended

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*Tuesday 7th July 2020*
Item Number	*8.2*
Accountable Director	*Karen Dunderdale* *Director of Nursing*
Presented by	*Karen Dunderdale* *Director of Nursing*
Author(s)	*Kevin Shaw, Deputy DIPC* *Hygiene Code Gap Analysis Update*
Report previously considered at	*Infection Prevention & Control Group* *10 June 2020* *Outcome*

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

Risk Assessment	*Corporate risk register reference 4141*
Financial Impact Assessment	*None noted*
Quality Impact Assessment	*None noted*
Equality Impact Assessment	*None noted*
Assurance Level Assessment	*Insert assurance level* • *Limited*

Recommendations/ Decision Required	• *For information*

Executive Summary

In January 2020 the Trust reported a hygiene code compliance position of 97%.

Following visits by the CQC in 2019 and subsequently NHSE/I in January 2020 it was apparent that the true Trust compliance position did not reflect the reported position.

In February 2020, the new Director of Nursing/DIPC immediately instructed that a full and comprehensive review of the Hygiene Code was undertaken.

There are 10 criterion which make up the Hygiene Code and each has been assessed to determine if the compliance was met and as to whether the compliance was embedded into practice.

The revised Hygiene Code was presented at the Infection Prevention and Control Group. The outcome of the review found that the Trust is compliant with 5 criterion, partially compliant with 3 criterion and non-compliant with 2 criterion.

A comprehensive IPC delivery plan is being developed with timescales to demonstrate embedded improvements.

United Lincolnshire Hospitals NHS Trust
Infection Prevention and Control Hygiene Code Gap Analysis

Introduction

Section 21 of the H&SCA 2008 enables the Secretary of State for Health to issue a Code of Practice about healthcare associated infections. The Code contains statutory guidance about compliance with the registration requirement relating to infection prevention (regulation 12 (2) (h) and 21(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Providers should also note that Regulation 15 is also relevant.

The law states that the Code must be taken into account by the CQC when it makes decisions about registration against the infection prevention requirements 12(h) and 21(b). The regulations also say that providers must have regard to the Code when deciding how they will comply with registration requirements. So, by following the Code, registered providers will be able to show that they meet the regulation on infection prevention. However, they do not by law have to comply with the Code. A registered provider may be able to demonstrate that it meets the registration requirement regulation in a different way (equivalent or better) from that described in this document.

CQCs guidance about compliance with the regulations includes a reference to this code of practice in relation to the 'premises and equipment' regulation (regulation 15) as CQC consider this code to be relevant for the purposes of meeting that regulation.

To become and stay registered, providers must meet the full range of registration requirements. The CQC has published guidance about how to comply with all the requirements other than the one on `infection control. This guidance is contained in the CQC Guidance for providers on meeting the regulations.1

The Code does not replace the requirement to comply with any other legislation that applies to health and adult social care services, for example, the Health and Safety at Work Act 1974 and the Control of Substances Hazardous to Health Regulations 2002.

The Hygiene Code

The table below is the 'Code of Practice' for all providers of healthcare and adult social care on the prevention of infections under The Health and Social Care Act 2008. This sets out the 10 criteria against which a registered provider will be judged on how it complies with the registration requirements related to infection prevention. Not all criteria will apply to every regulated activity. Parts 3 and 4 of this document will help registered providers interpret the criteria and develop their own risk assessments.

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

ULHT IP&C Hygiene Code Gap analysis template 2018-2019									
Link code	Criterion	Title	Sub section	Guidance statement	Current position statement	Compliance	Embedded	RAG rating	Evidence of compliance
HC1	1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.							
			Appropriate management and monitoring arrangements	These should ensure that:					
HC1.1				a registered provider has an agreement within the organisation that outlines its collective responsibility for keeping to a minimum the risks of infection and the general means by which it will prevent and control such risks;	There is an IPC strategy however it is not embedded	Y	N		
HC1.2				there is a clear governance structure and accountability that identifies a single lead for infection prevention (including cleanliness) accountable directly to the head of the registered provider;	The new DIPC has redefined the governance and accountability structures	Y	Y		
HC1.3				the mechanisms are in place by which the registered provider ensures that sufficient resources are available to secure the effective prevention of infection. These should include the implementation of an infection prevention and cleanliness programme, infection prevention and cleanliness infrastructure and the ability to monitor and report infections;	A review of the IPC resource is needed	N	N		
HC1.4				all relevant staff, whose normal duties are directly or indirectly concerned with providing care, receive suitable and sufficient information on, and training and supervision in, the measures required to prevent the risks of infection;	Content and delivery of training is currently under review	N	N		
HC1.5				assurance is in place to ensure that key policies and practices are being implemented, updated and adhered to appropriately;	Policies and guidance current being updated. Assurance processes are being updated to ensure there is a clear governance process	N	N		
HC1.6				a decontamination lead is designated, where appropriate;	There is currently no oppointed Decontamination Lead	N	N		
HC1.7				a water safety group and water safety plan are in place	Water safety group exists however there are concerns regarding the oversight of water quality	Y	N		
			Risk assessment	A registered provider should ensure that it has:					
HC1.8				made a suitable and sufficient assessment of the risks to the person receiving care with respect to prevention of infection;	Admission documentation in place however frequent gaps in completion and accuracy	N	N		
HC1.9				identified the steps that need to be taken to reduce or control those risks;	Not all IPC risk assessments properly completed	N	N		
HC1.10				recorded its findings in relation to the first two points;	Notes unreliable due to lapses above	N	N		
HC1.11				implemented the steps identified; and	Process not reliable	N	N		
HC1.12				methods and interventions in place to monitor the risks of infection to determine whether further steps are needed to reduce or control infection	Processes need to be improved with regard to interventions	N	N		
			Directors of Infection Prevention and Control	The DIPC in NHS Provider organisations should:					
HC1.13				provide oversight and assurance on infection prevention (including cleanliness) to the Trust board or equivalent,. They should report directly to the board but are not required to be a board member;	New DIPC is Director of Nursing and sitting executive	Y	Y		
HC1.14				be responsible for leading the organisation's infection prevention team;	DIPC reviewed the structure and is IPT overall lead	Y	Y		
HC1.15				oversee local prevention of infection policies and their implementation;	DIPC is IPC group chair	Y	Y		
HC1.16				be a full member of the infection prevention team and antimicrobial stewardship committee and regularly attend its infection prevention meetings;	DIPC is IPC group chair	Y	Y		

HC1.17		have the authority to challenge inappropriate practice and inappropriate antimicrobial prescribing decisions;	New DIPC is Director of Nursing and sitting executive	Y	Y	
HC1.18		have the authority to set and challenge standards of cleanliness	New DIPC is Director of Nursing and sitting executive	Y	Y	
HC1.19		assess the impact of all existing and new policies on infections and make recommendations for change;	policies and guidance currently under review and will go to IPC Group	y	N	
HC1.20		be an integral member of the organisation's clinical governance and patient safety teams and structures, water safety group; and	Issues still remain regarding the managemtn of water safety	Y	N	
HC1.21		produce an annual report and release it publicly as outlined in Winning ways: working together to reduce healthcare associated infection in England.	Annual report has not been produced for 2019-20	N	N	
	Assurance framework	**Activities to demonstrate that infection prevention and cleanliness are an integral part of quality assurance should include:**				
HC1.22		regular presentations from the DIPC and/or the infection prevention team to the NHS board or registered provider. These should include a trend analysis for infections, antimicrobial resistance and antimicrobial prescribing and compliance with audit programmes;	New report formats being introduced	N	N	
HC1.23		quarterly reporting to the NHS board or registered provider by clinical directors and matrons (including nurses who do not hold the specific title of 'matron' but who operate at a similar level of seniority and who have control over similar aspects of the patient or the patient's environment). What is reported on will vary according to the local arrangements. For example it may include:	New site meeting format yet to be commenced	N	N	
HC1.24		- monthly cleanliness scores (unless this is done via the estates and facilities team);	these are produced at IPG by E&F	Y	Y	
HC1.25		- annual Patient Led Assessments of the Care Environment (PLACE) scores plus monthly scores (where this is agreed practice); and	PLACE is used within the Trust	Y	Y	
HC1.26		A review of mandatory and voluntary surveillance data, including antimicrobial resistance (drug-bug combinations), outbreaks and serious incidents;	ASSG and IPC reports go to IPG but new formats need embedding	Y	N	
HC1.27		evidence of appropriate action taken to deal with occurrences of infection including, where applicable, root cause analysis and/or post infection review; and	Better more rapid and robust system needed for outbreaks	N	N	
HC1.28		an audit programme to ensure that policies have been implemented	new audit programme being assessed	N	N	
	Infection prevention including cleanliness programme	**The infection prevention including cleanliness programme should:**				
HC1.29		set objectives that meet the needs of the organisation and ensure the safety of service users, health care workers and the public;	Cleaning plan not established. Deep clean programme in place. Need plan for specific cleanliness audits and support to clinical and housekeeping teams	N	N	
HC1.30		identify priorities for action;	Need for wider cleanliness plan	N	N	
HC1.31		provide evidence that relevant policies have been implemented; and	Cleaning scores produced show areas not fully complying	N	N	
HC1.32		report progress against the objectives of the programme in the DIPC's annual report or the Infection Prevention Lead's annual statement	No annual statement produced	N	N	
	Infection prevention and cleanliness infrastructure	**An infection prevention infrastructure should encompass:**				
HC1.33		in acute healthcare settings, for example, an infection prevention team consisting of an appropriate mix of both nursing and consultant medical expertise (with specialist training in infection prevention and cleanliness), other healthcare workers and appropriate administrative and analytical support, estates and facilities management and adequate information technology – the DIPC is a key member of the Infection prevention team;	The team needs review of structure and composition. No analyst support. Consultant microbiologists support from Pathlinks.	N	N	

HC1.34		in acute settings, have a multidisciplinary antimicrobial stewardship committee to develop and implement the organisation's Antimicrobial stewardship programme drawing on Start Smart Then Focus:	ASSG meets monthly. Minutes go to IPG	Y	Y	
HC1.36		24-hour access to a nominated qualified infection control doctor (ICD) or consultant in health protection/communicable disease control. The registered provider should know how to access this advice	On call microbiologist 24hr access and PHE East Midlands Centre on call for notifiable infections	Y	Y	
	Movement of service users					
HC1.37		There should be evidence of joint working between staff involved in the provision of advice relating to the prevention of infection; those managing bed allocation; care staff and domestic staff in planning service user referrals, admissions, transfers, discharges and movements between departments; and within and between health and adult social care facilities	Need for formal review of discussions regarding movement of patient flow through the hospital	N	N	
HC1.38		A registered provider must ensure that it provides suitable and sufficient information on a service user's infection status whenever it arranges for that person to be moved from the care of one organisation to another, of from a service user's home, so that any risks to the service user and others from infection may be minimised. If appropriate, providers of a service user's transport should be informed of the service user's infection status	There is a process for notification of patient infectious status however this is not embedded	Y	N	

ULHT IP&C Hygiene Code Gap analysis template 2018-2019									
Link Code	Criterion	Title	Sub section	Guidance statement	Current position statement	Compliance	Embedded	RAG rating	Evidence of compliance
HC2	2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections	With a view to minimising the risk of infection, a registered provider should ensure that:						
HC2.1				it designates leads for environmental cleaning and decontamination of equipment used for diagnosis and treatment (a single individual may be designated for both areas);	The trust does not have an identified decontamination lead and decon*tamination lead doctor.* The role of lead for environmental cleaning is undertaken by the Facilities manager.	N	N		
HC2.2				in healthcare, the designated lead for cleaning involves directors of nursing, matrons and the infection prevention team or persons of similar standing in all aspects of cleaning services, from contract negotiation and service planning to delivery at ward and clinical level. In other settings, the designated lead for cleaning will need to access appropriate advice on all aspects of cleaning services;	A new E&F group is being developed to address	N	N		
HC2.3				in healthcare, matrons or persons of a similar standing have personal responsibility and accountability for maintaining a safe and clean care environment:	Matrons handbook being rolled out New work required to comply and embed	Y	N		
HC2.4				the nurse or other person in charge of any patient or resident area has direct responsibility for ensuring that cleanliness standards are maintained throughout that shift;		N	N		
HC2.5				all parts of the premises from which it provides care are suitable for the purpose, kept clean and maintained in good physical repair and condition;	The trust has an estate that dates from 1890 to the current day and has a significant backlog of maintenance issues. The poor condition of the fabric of the buidling means that thorough cleaning is difficult to achieve and maintain on a consistent basis in some areas. The trust housekeeping resource is below the national benchmarking figures. Following an external review additional resources are being considered. Cleaning standards are monitored on a weekly basis and the figures reported upwards via the IPCC on a monthly basis.	N	N		
HC2.6				the cleaning arrangements detail the standards of cleanliness required in each part of its premises and that a schedule of cleaning responsibility and frequency is available on request;	The NHS Cleaning manual is used with minor alterations to reflect the local conditions. Cleaning schedules and frequencies are available in all areas. SOPs have been developed for use post deep clean	Y	Y		
HC2.7				there is adequate provision of suitable hand washing facilities and antimicrobial hand rubs where appropriate;	Handwash basins are avilable in all clinical areas, however the design of some handwash basins some do not meet the current HTM standard e.g. some sinks still have overflow; some sinks have a drain directly below the tap. The three trust A+E departments do not have sufficient numbers of sinks to meet HTM standards for provision. Antimicrobial hand rub is available in all clinical areas.	Y	N		

		there are effective arrangements for the appropriate cleaning of equipment that is used at the point of care, for example hoists, beds and commodes – these should be incorporated within appropriate cleaning, disinfection and decontamination policies; and	The methodologies for this are covered by the NHS Cleaning Manual. This is not compliant or embedded			
HC2.8				N	N	
		the storage, supply and provision of linen and laundry are appropriate for the level and type of care	A linen handling policy is in place and is currently under review by Estates and Facilities and IPC. An issue has been identified on the Grantham site where linen is transported to the ward in open cages.			
HC2.9				Y	Y	
	Policies on the environment					
		Premises and facilities should be provided in accordance with best practice guidance and assured with NHS PAM or similar model. The development of local policies should take account of infection prevention and cleanliness advice given by relevant expert or advisory bodies or by the infection prevention team and this should include provision for liaison between the members of any infection prevention team and the persons with overall responsibility for the management of the service user's environment. Policies should address but not be restricted to: cleaning services; building and refurbishment, including air-handling systems; waste management; laundry arrangements for the correct classification and sorting of used and infected linen; planned preventative maintenance; pest control; management of drinkable and non-drinkable water supplies; minimising the risk of Legionella and other water supply and building related infections eg Pseudomonas aeruginosa and aspergillus by adhering to national guidance; and food services, including food hygiene and food	Estates and facilities currently do not have an NHS PAM model. The trust has a consultation process for policies and this process includes IPC review where relevant. The policies not yet developed include: cleaning services, building and refurbishement including air handling systems, pest control (a contract for this is in place), PPM. Policies for electrical safety and asbestos management are currently under development.			
HC2.10				N	N	
	Cleaning services	**The arrangements for cleaning should include:**				
		clear definition of specific roles and responsibilities for cleaning;	Job descriptions for housekeeping staff specify roles and responsibilities for cleaning, including a diagramatic representation of the hierarchy.			
HC2.11				Y	Y	
HC2.12		clear, agreed and available cleaning routines;	Cleaning schedules are available as above.	Y	Y	
		sufficient resources dedicated to keeping the environment clean and fit for purpose;	The trust housekeeping resource is below the national benchmarking figures. Following an external review additional resources are being considered.			
HC2.13				N	N	
		consultation with ICTs or equivalent local expertise on cleaning protocols when internal or external contracts are being prepared; and	IPCT are consulted when changes are being considered to be included in policy.			
HC2.14				Y	Y	
		details of how staff can request additional cleaning, both urgently and routinely	There are agreed procedures for requesting additional housekeeping.			
HC2.15				Y	Y	
	Decontamination	**The decontamination lead should have responsibility for ensuring that policies exist and that they take account of best practice and national guidance. They should consider guidance under the following headings:**				

HC2.16	Decontamination of the environment – including cleaning and disinfection of the fabric, fixtures and fittings of a building (walls, floors, ceilings and bathroom facilities) or vehicle:	Deep clean + HPV Nat policy for cleaning in development. Quality of clean needs improving	N	N	
HC2.17	Decontamination of linen – including correct classification and sorting of used linen (e.g. soiled and fouled linen, infectious linen, heat labile linen) and disinfection of linen:		Y	Y	
HC2.18	Decontamination of equipment – including cleaning and disinfection of items that come into contact with the patient or service user, but are not invasive devices (eg beds, commodes, mattresses, hoists and slings, examination	SOPs for care equipment needed on all wards	N	N	
HC2.19	Reusable medical devices should be reprocessed at one of the following three levels: - sterile (at point of use); - sterilised (i.e. having been through the sterilisation process); clean (i.e. free of visible contamination)	have current compliance and audit certficates which have been seen by the decontamination lead doctor. Flexible endoscopes are processed through an automated system on site at the point of use. This system is certificated, has an annual service and microbiological monitoring of water quality is conducted by Path Links in line with national standards. Nasoendoscopes have a specific protocol for disinfection at the point of use by a recognised process. IPC and Matron Ward audits are undertaken to observe cleanliness of resuable equipment cleaned in the clinical environment. No current oversight of this process at IPG	Y	N	
	The decontamination policy should demonstrate that:				
HC2.20	it complies with guidance establishing essential quality requirements and a plan is in place for progression to best practice;	all policies being reviewed	Y	N	
HC2.21	decontamination of reusable medical devices takes place in compliant facilities that are designed for the process of decontaminating medical devices through validated processing systems and controlled environmental conditions to ensure all potential environmental, cross-infection, handling and medical device usage risks are minimised;	Sterile services are provided by Steris who have current compliance and audit certificates which have been seen by the decontamination lead doctor. Flexible endoscopes are processed through an automated system on site at the point of use. This system is certificated. No oversight of this function at IPG	Y	N	
HC2.22	appropriate procedures are followed for the acquisition, maintenance and validation of decontamination equipment;	See local policies/ procedures for Steris and endoscopy. No nominated decontamination lead to oversee	Y	N	
HC2.23	staff are trained in cleaning and decontamination processes and hold appropriate competences for their role; and	Steris: part of certification. Endoscopy: records are held centrally. No nominated decontamination lead to oversee	Y	N	
HC2.24	a record-keeping regime is in place to ensure that decontamination processes are fit for purpose and use the required quality systems	Records are held locally on the site of the service provision. No nominated decontamination lead to oversee	Y	N	

	ULHT IP&C Hygiene Code Gap analysis template 2018-2019								
Link Code	Criterion	Title	Sub section	Guidance statement	Current position statement	Compliance	Embedded	RAG rating	Evidence of compliance
HC3	3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance							
HC3.1				Systems should be in place to manage and monitor the use of antimicrobials to ensure inappropriate and harmful use is minimised and patients with severe infections such as sepsis are treated promptly with the correct antibiotic. These systems draw on national and local guidelines, monitoring and audit tools such as NICE guidelines, guidance on patient group directions, the TARGET toolkit in primary care and Start Smart then Focus in secondary care (SSTF).	All antimicrobial related incidents are reported via Trust Datix system. These will then be collated by the antimicrobial pharmacists to produce a monthly incident report and shared through antimicrobial stewardship strategy (ASSG), IPCC, Medicines Optimisation (MOps) monthly meetings. This report is also included in the monthly Antimicrobial Trust Wide Report (ASTR) which is published onto the Intranet on monthly basis.	Y	Y		
HC3.2				Where appropriate, providers should have in place an antibiotic stewardship committee responsible for developing, implementing and monitoring the organisation's stewardship programme. This must be supported by strong leadership across clinical specialties but it could be part of an existing committee such as a drug and therapeutic committee rather than a new body. Membership of this committee will vary dependent on the setting but should include representation from microbiology/infectious diseases, pharmacy and the organisations' director of infection prevention and control or equivalent. The committee should report antimicrobial stewardship activities to the Trust board via the organisation's Director of Infection Prevention and Control or equivalent	A monthly antimicrobial stewardship strategy group (ASSG) meeting is held to provide assurance to the IPC committee. Members of ASSG include antimicrobial pharmacists (chair), microbiologists, DIPC, lead interface pharmacist (CCG), and clinicians. There were a few clinicians who attend regularly but attendance from clinicians generally remains poor despite communications sent out in Oct 16.	Y	Y		
HC3.3				Providers should develop a local antimicrobial stewardship policy drawing on national guidance (including the British National Formulary, Public Health England the National Institute of Care Excellence) that takes account of local antimicrobial resistance patterns. Policy should cover diagnosis, treatment and prophylaxis of common infections and prescribers should be encouraged to record allergy status, reason for antimicrobial prescription, dose and duration of treatment. Adherence to prescribing guidance and compliance with in hospital post-prescribing review at 48-72 hours should be monitored and audited on a regular basis, with data fed back to prescribers and incorporated into patient safety reporting systems to Boards and Commissioners. Benchmarking should be used to demonstrate progress in antimicrobial stewardship	NICE NG 15 was revisited in Feb 17 and showed that we are now 82% compliant with national recommendations, a significant improvement from 55% back in Sep 15 before the antimicrobial pharmacy team first came into action in Oct 15. We have a Trust Antibiotic Formulary and Guidance which includes diagnosis, treatment and prophyaxis of common infections, documentation of allergy information, and 72 hours IV-PO switch.	Y	Y		
HC3.4			Microbiologists to comment	Providers should have access to timely microbiological diagnosis, susceptibility testing and reporting of results, preferably within 48 hours. Prescribers should have access at all times to suitably qualified individuals who can advise on appropriate choice of antimicrobial therapy.	Microbiology laboratory services are available 24-7. A consultant microbiologist is avilable for clinicians to contact at all times.	Y	Y		
HC3.5			Microbiologists to comment	In secondary care providers should report local antimicrobial susceptibility data (drug-bug combinations) and information on antimicrobial consumption to the national surveillance body. Surveillance information should be used by the stewardship committee or equivalent to monitor local resistance patterns and guide local prescribing policy. This information should be communicated back to prescribers in primary and secondary care to improve prescribing quality.	Antimicrobial susceptibility data is reported through SSGS to PHE in line with national guidance. Local consumption data is monitored and reported via a monthly consumption report produced by the antimicrobial pharmacists. The consumption data is shared with ASSG, IPCC, MOps and local commissioner as part of the consumption CQUIN. Clinicians from areas with unusually high consumption will be approached by the antimicrobial pharmacists to understand the reasons for high consumption and identify any actions needed.	Y	Y		
HC3.6				Providers should ensure that all prescribers receive induction and training in prudent antimicrobial use and are familiar with the antimicrobial resistance and stewardship competencies	The antimicrobial pharmacists conduct regular teaching sessions to junior doctors at induction, all levels of clinicians at grand rounds, and nurses on IV study days.	Y	Y		

	ULHT IP&C Hygiene Code Gap analysis template 2018-2019								
	Criterion	Title	Sub section	Guidance statement	Current position statement	Compliance	Embedded	RAG rating	Evidence of compliance
HC4	4	**Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion.**							
			Information for service users and visitors						
HC4.1				Information should be developed with local service user representative organisations, which could include Local Healthwatch and Patient Advice and Liaison Services (PALS).	Three patient information leaflets meeting these criteria are currently available on the intranet and external internet sites.				
			Areas relevant to the provision of information include:						
HC4.2				general principles on the prevention of infection and key aspects of the registered provider's policy on infection prevention, which takes into account the communication needs of the service user;	Trust-specific leaflet available: last issued in October 2010. Leaflet states it is available in other languages, large print, audio and braille formats via the Public Involvement Team.				
HC4.3				the roles and responsibilities of particular individuals such as carers, relatives and advocates in the prevention of infection, to support them when visiting service users;	Up-to-date information available on public website				
HC4.4				the importance of appropriate use of antimicrobials;	Strategic Health Authority leaflet dated 2009 on public website.				
HC4.5				supporting service users' awareness and involvement in the safe provision of care;	Catheter passport agreed for use as a whole health economy				
HC4.6				the importance of compliance by visitors with hand hygiene;	Up-to-date information available on public website . Posters available in the clinical area to advise on hand hygiene technique and advise where hand sanitiser is available.				
HC4.7				the importance of compliance with the registered provider's policy on visiting;	Up-to-date information available on public website regarding number of permitted visitors, and specifying when visitors should avoid visiting due to potential infection risk:				
HC4.8				reporting concerns relating to hygiene and cleanliness including hand hygiene;	Strategic Health Authority leaflet on Public Website: out of date. This advises service-users to report concerns.				
HC4.9				explanations of incident/outbreak management and action taken to prevent recurrence	No patient information meeting these criteria currently				
			A registered provider should ensure that:						

	accurate information is communicated in an appropriate and timely manner;	A trust handover checklist is completed and sent when a patient is transferred: this includes information on MRSA, CPE assessment and any recent episodes of diarrhoea.	
HC4.10			
	this information facilitates the provision of optimum care, minimising the risk of inappropriate management and further transmission of infection; and		
HC4.11		See above	
HC4.12	where possible, information accompanies the service user	See above	

ULHT IP&C Hygiene Code Gap analysis template 2018-2019									
Link Code	Criterion	Title	Sub section	Guidance statement	Current position statement	Compliance	Embedded	RAG rating	Evidence of compliance
	5	**Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people**							
HC5				Registered providers, excluding personal care providers, should ensure that advice is received from suitably informed practitioners and that, if advised, registered providers should inform their local health protection team of any outbreaks or serious incidents relating to infection in a timely manner.	IP team, consisting of: band 8a nurse, two band 7 nurses, three band 6 nurses, three band 3 infection prevention assistants. Consultant microbiologists are established for 6WTE: curently 4.6WTE in post. Antimicrobial pharmacist (0.5 WTE). PHE HPT representative attends the monthly IPCC meeting. Incidents and outbreaks are communicated to the HPT in a timely manner and PHE are routinely invited to attend outbreak and incident meetings.				IPC organisational chart. Minutes of outbreak/ incident meetings with PHE attendance recorded available on request. .
HC5.1				Arrangements should demonstrate that responsibility for infection prevention is effectively devolved to all groups in the organisation involved in delivering care.	IPC responsibilities are not currently reflected in job descriptions/ appraisal paperwork as routine.				JD's state compliance with trust policies including IP&C
HC5.2									

	ULHT IP&C Hygiene Code Gap analysis template 2018-2019								
Link Code	Criterion	Title	Sub section	Guidance statement	Current position statement	Compliance	Embedded	RAG rating	Evidence of compliance
HC6	6	**Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.**	A registered provider should, so far as is reasonably practicable, ensure that its staff, contractors and others involved in the provision of care co-operate with it, and with each other, so far as is necessary to enable the registered provider to meet its obligations under the Code:						
HC6.1				Infection prevention would need to be included in the job descriptions and be included in the induction programme and staff updates of all employees (including volunteers). Contractors working in service user areas would need to be aware of any issues with regard to infection prevention and obtain 'permission to work'.	Standard IPC responsibilities statement not available from HR on request. IPC training is included in trust induction programme and core learning for all staff.				
HC6.2				Where staff undertake procedures, which require skills such as aseptic technique, staff must be trained and demonstrate proficiency before being allowed to undertake these procedures independently.	Aseptic technique training provided by clinical education team to newly qualified nurses and as part of routine IV training competency. There is currently no robust programme for ongoing training and assessment of this technique.				

	ULHT IP&C Hygiene Code Gap analysis template 2018-2019								
Link Code	Criterion	Title	Sub section	Guidance statement	Current position statement	Compliance	Embedded	RAG rating	Evidence of compliance
HC7	7	Provide or secure adequate isolation facilities.							
				A healthcare registered provider delivering in-patient care should ensure that it is able to provide, or secure the provision of, adequate isolation precautions and facilities, as appropriate, sufficient to prevent or minimise the spread of infection. This may include facilities in a day care setting.					A daily sideroom priority system is now in place on all sites. This is led by the IP&C team to support operational bed capacity
HC7.1					Single side room isolation provision is available on all sites.				
				Policies should be in place for the allocation of patients to isolation facilities, based on a local risk assessment. The assessment could include consideration of the need for special ventilated isolation facilities. Sufficient staff should be available to care for the service users safely.	In date policy available, including risk assessment for identifying patients in need of isolation, and prioritisation tool to assist with use of side rooms.				
HC7.2									Isolation policy (see Criterion 9).

	ULHT IP&C Hygiene Code Gap analysis template 2018-2019									
Link Code	Criterion	Title	Sub section	Guidance statement	Current position statement	Compliance	Embedded	RAG rating	Evidence of compliance	Milestone
HC8	8	Secure adequate access to laboratory support as appropriate.								
				A registered provider should ensure that laboratories that are used to provide a microbiology service, in connection with arrangements for infection prevention (including cleanliness), have in place appropriate protocols. These laboratories should operate according to the standards required by the relevant national accreditation bodies. In adult social care, the service user's General Practitioner will arrange such testing and take responsibility for submitting specimens to the laboratory when necessary for the treatment and management of disease.	Path Links Microbiology laboratory is CPA accredited: all SOPs are in line with national SMIs and are available on request. UKAS accreditation is being sought and inspections					
HC8.1			Protocols should include:		are due in Oct 2017.	Y	Y		SOPs available on request.	
				a microbiology laboratory policy for investigation and surveillance of antimicrobial resistance and healthcare associated infections; and	ULHT has current policies on surveillance and AMR and surveillance of HCAIs is carried out by the IPC team. Policies are					
HC8.2					being reviewed	N	N			
HC8.3				standard laboratory operating procedures for the examination of specimens1; timely reporting	Turnaround data is avalable on request.	Y	Y			
HC8.4					KPIs are monitored and are being met.	Y	Y		Turnaround data is avilable on request.	

ULHT IP&C Hygiene Code Gap analysis template 2018-2019									
Link Code	Criterion	Title	Sub section	Guidance statement	Current position statement	Compliance	Embedded	RAG rating	Evidence of compliance
HC9	9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.							
				A registered provider should, in relation to preventing, reducing and controlling the risks of infections, have in place the appropriate policies concerning the matters mentioned in a) to y) below. All policies should be clearly marked with a review date and the review date adhered to.	not all policies not in date at time of review 010620. Infectio Prevention hosts policies from estates, occupational health and PHE but not estates, water, waste,decontamination, endoscopyas they are held by the relevant divisions but no links to these				
HC9.1						N	N		
				Any registered provider should have policies in place relevant to the regulated activity it provides. Each policy should indicate ownership (i.e. who commissioned and retains managerial responsibility), authorship and by whom the policy will be applied. Implementation of policies should be monitored and there should be evidence of a rolling programme of audit and a date for revision stated.	no rolling programme of updating or eviewing Policies, No multidisciplinary review process eg with microiology team				
HC9.3						N	N		
			a. Standard infection prevention and control precautions		policy on intranet expired 011116	N	N		
HC9.4				Preventing infections reduces the overall need to use antimicrobials and helps to reduce selection pressure for the development of antimicrobial resistance.					
HC9.5				Policy should be based on evidence-based guidelines, including those on hand hygiene at the point of care and the use of personal protective equipment;					
				Policy should be easily accessible and be understood by all groups of staff, service users and the public.	policies are arranged in 5 categories on the intranet page but are difficulkt to find. A to Z would be easier with hyoplinks to toher areas as required				
HC9.6						N	N		
HC9.7				Compliance with the policy should be audited					
HC9.8				Provisions on regular refresher training, support for patients to clean their hands, and products for staff with occupational dermatitis are among the issues that should be covered in the hand hygiene policy					
			b. Aseptic technique		ANTT policy on intranet expired 011217. **New policy was created 1306 19 but not passed through IPCC and not forwarded to policy group either for discussion /approval**	N	N		
HC9.9				Where aseptic procedures are performed:					
HC9.10				clinical procedures should be carried out in a manner that maintains and promotes the principles of asepsis;					
				education, training and assessment in the aseptic technique should be provided to all persons undertaking such procedures;	No bespoke ANTT training had been available up to 2019 when Stephen Rowley pack purchased and put onto the Intranet for staff to access. Clinical Educators assisting staff with training across the Trust				
HC9.11						N	N		
HC9.12				the technique should be standardised across the organisation; and					
HC9.13				an audit should be undertaken to monitor compliance with the technique					
			c. Outbreaks of communicable infection						
				The degree of detail in the policy should reflect local circumstances. A low risk, single-specialty facility or provider of primary					
HC9.14				care will not require the same arrangements as those providing the full range of medical and surgical care;					
				Professional advice on infection prevention for regulated activities may be drawn from a number of expert sources. Table 2					
HC9.15				outlines the most likely arrangements for the different regulated activities;					
				Policies for outbreaks of communicable infection should include initial assessment, communication, management and organisation, plus investigation and control, including vaccination where appropriate;	current outbreak/incident policy on intranet expired 311217 **New outbreak and incident management policy was created 17 01 19 but not passedtrough relevant chanels**				
HC9.16						N	N		
HC9.17				The contact details of those likely to be involved in outbreak management should be reviewed at least annually;					
				All registered providers should report significant outbreaks of infection to their local health protection teams at an early					
HC9.18				stage, including outbreaks in service users who are detained under the Mental Health Act 1983, if advised to do so by					
				suitably informed practitioners					
			d. Isolation of service users with an infection (see also criterion 7)						
				The isolation policy should be evidence based and reflect local risk assessment	isolation principles are not applied consistently or correctly across the Trust as patients are not isolated on suspicion of infection and time of sample rather				
HC9.19					retrospectively on results.	N	N		
HC9.20				Indications for isolation should be included in the policy, as should procedures for the infection prevention and control	current policy on intranet				
				management of service users in isolation;	expired 110519.	N	N		

HC9.21		Information on isolation should be easily accessible and understood by all groups of staff, service users and the public				
	e. Safe handling and disposal of sharps					
		Relevant considerations include: risk management and training in the management of mucous membrane exposure and sharps injuries and incidents;	safe handling of sharps policy is held by occupational health and current policy on intranet expired on 040818			
HC9.22				N	N	
HC9.23		provision of medical devices that incorporate sharps protection mechanisms where there are clear indications that they will provide safe systems of working for staff				
HC9.24		a policy that is easily accessible and understood by all groups of staff;				
HC9.25		safe use, secure storage and disposal of sharps;				
HC9.26		auditing of policy compliance				
	f. Prevention of occupational exposure to blood-borne viruses (BBVs) including prevention of sharps injuries		current policy is held by occupational health and current policy on intranet expired 011118			
				N	N	
		Measures to avoid exposure to BBV's (hepatitis B and C and HIV) should include: immunisation against hepatitis B, as set out in Immunisation against infectious disease, better known as 'The Green Book' (published by Public Health England);	there is a link to PHE in section 4 of the policy which has current expiry date of 141017			
HC9.27				N	N	
HC9.28		the wearing of gloves and other protective clothing;				
		the safe handling and disposal of sharps, including the provision of medical devices that incorporate sharps protection where there are clear indications that they will provide safe systems of working for staff; and	trial requested may 2019 for trial of new system for sharpes managemnet but committee never met to discuss			
HC9.29				N	N	
HC9.30		measures to reduce risks during surgical procedures				
	g. Management of occupational exposure to BBVs and post-exposure prophylaxis					
		Management should ensure:	current policy is held by occupational health and current policy on intranet expired 011118			
				N	N	
HC9.31		that any member of staff who has a significant occupational exposure to blood or body fluids is aware of the immediate action required and is referred appropriately for further management and follow-up;				
HC9.32		provision of clear information for staff about reporting potential occupational exposure – in particular the need for prompt action following a known or potential exposure to HIV or hepatitis B; and				
HC9.33		arrangements for post-exposure prophylaxis for hepatitis B and HIV				
	h. Closure of rooms, wards, departments and premises to new admissions					
		A system should be in place for the provision of advice from the local health protection team/DIPC/ICT for the registered provider;	outbreak meetings are held postumously in many cases with limited attendance. However in most recent outbreak cases this has been made a higher priority and attendance / meeting has been improved just need to see this sustained			IPCC attendance on request. Minutes of outbreak meetings available
HC9.34				N	N	
HC9.35		There should be clear criteria in relation to closures and re-opening;				
HC9.36		The policy should address the need for environmental decontamination prior to re-opening				
	i. Disinfection					
HC9.37		The use of disinfectants is a local decision, and should be based on current accepted good practise.		N	N	
	j. Decontamination of reusable medical devices					
		Decontamination involves a combination of processes and includes cleaning, disinfection and sterilisation, according to the intended use of the device. This aims to render a reusable item safe for further use on service users and for handling by staff;	no specific poliy			
HC9.38				N	N	
		Effective decontamination of reusable medical devices is an essential part of infection risk control and is of special importance when the device comes into contact with service users or their body fluids. There should be a system to protect service users and staff that minimises the risk of transmission of infection from medical devices. This requires that the device or instrument set can be clearly linked in a traceable fashion to the individual process cycle that was used to decontaminate it, such that the success of that cycle in rendering the device safe for reuse can be verified;	there is a decontamination of endoscopes policy but this expired on 10 08 18			
HC9.39				N	N	
		Reusable medical devices should be decontaminated in accordance with manufacturers' instructions and current national or local best practice guidance. This must ensure that the device complies with the 'Essential Requirements' provided in the Medical Devices Regulations 2002 where applicable. This requires that the device should be clean and, where appropriate, sterilised at the end of the decontamination process and maintained in a clinically satisfactory condition up to the point of use;	green is clean stickers used across the Trust but not consistently			
HC9.40				N	N	
HC9.41		Management systems should ensure adequate supplies of reusable medical devices, particularly where specific devices are essential to the continuity of care;				
		Reusable medical devices employed in invasive procedures, for example, endoscopes and surgical instruments have to be either individually identifiable or identified to a set of which they are a consistent member, throughout the use and decontamination cycle in order to ensure subsequent traceability;				
HC9.42						
HC9.43		Systems should also be implemented to enable the identification of service users on whom the medical devices have been used;				
		Decontamination of single-patient use devices, i.e. that equipment designated for use only by one patient, should be subject to local policy and manufacturer's instructions	staff are unsure between single use and single patient use equipment eg blood pressure cuffs			
HC9.44				N	N	

	k. Single-use medical devices					
		Policies should be in place for handling devices for single use only. Single-use medical devices should be used once and disposed of safely.	no specific policy. Brand new cleaning and disinfection of ward based equipment was started in September 2019	N	N	
HC9.45						
	l. Antimicrobial prescribing					
		Prescribing should generally be harmonised with that in the British National Formulary and draw on national guidance, including guidance for specific infections such as gonorrhoea. However, local guidelines may be required in certain circumstances;	current policy on intranet expired 011119	N	N	
HC9.46						
		Procedures should be in place to ensure prudent prescribing and antimicrobial stewardship. There should be an ongoing programme of audit, revision and update with feedback to management, prescribers and administrators. In healthcare settings this is usually monitored by the antimicrobial management team or local prescribing advisors. Antimicrobial pharmacists and CCG prescribing advisors can support these activities	consultant antimicrobial pharmacist and team now embedded into Trust Practices such as antimiicrobial ward rounds with microbiologistas and IPT varies across Trust	N	N	
HC9.47						
	m. Reporting of infection to Public Health England or local authority and mandatory reporting of healthcare associated infection to Public Health England					
		This includes a requirement for NHS Trust Chief Executives to report all cases of MRSA, MSSA and E. coli bacteraemias and Clostridium difficile infection in patients aged two years or older that are identified in their institution. The independent sector hospitals are also expected to report cases in a similar manner. The requirements of this system will vary from time to time as directed by the Department of Health.	all HCAI's are reported through the PHE reporting system and data collected and shared on a monthly basis to site and IPCC (IPCG) meetings	Y	Y	
HC9.48						
HC9.49		**Health Protection (Notification) Regulations 2010**				
		These require attending doctors (registered medical practitioners) to notify the Proper Officer of the local authority of cases of specified infectious disease or of other infectious disease or contamination, which present, or could present, significant harm to human health, to allow prompt investigation and response. The regulations also require diagnostic laboratories testing human samples to notify Public Health England of the identification of specified causative agents of infectious disease.	labs inform physician of results and they complete notification form	Y	Y	
HC9.50						
	n. Control of outbreaks and infections associated with specific alert organisms					
		This should take account of local epidemiology and risk assessment. These infections must include, as a minimum, MRSA, MSSA and E.coli bloodstream infections, respiratory infection, viral haemorrhagic fever, diarrhoeal outbreaks, Clostridium difficile infection and transmissible spongeiform encephalopathies.				
HC9.51						
		MRSA				
HC9.52		**The policy should make provision for:**	policy is in date	Y	N	
		screening of NHS patients on emergency or elective admission to relevant high risk specialties. The arrangements for undertaking screening will be subject to local agreement;	**routine screening was suspended due to the coronavirus pandemic in march 2020**	Y	N	
HC9.53						
HC9.54		suppression regimens for colonised patients when appropriate;				
HC9.55		isolation of infected or colonised patients;				
HC9.56		transfer of infected or colonised patients within organisations or to other care facilities;				
HC9.57		antibiotic prophylaxis for surgery; and				
HC9.58		undertaking a post infection review (PIR) on patients with a MRSA bacteraemia				
		Clostridium difficile				
HC9.59		**The policy should make provision for:**	policy isin date	Y	Y	
HC9.60		surveillance of Clostridium difficile infection;				
HC9.61		diagnostic criteria;				
HC9.62		isolation of infected service users and cohort nursing;				
HC9.63		environmental decontamination;				
HC9.64		antibiotic prescribing policies; and				
HC9.65		contraindication of anti-motility agents				
		Glycopeptide resistant enterococci (GRE)				
HC9.66		**The policy should make provision for:**	no specific policy for Trust	N	N	
HC9.67		Identification of high-risk groups;				
HC9.68		Isolation and prevention of cross-infection; and				
HC9.69		Prophylaxis for surgical and invasive procedures				
		Carbapenem resistant organisms (CROs), Acinetobacter, extended spectrum beta-lactamase (ESBLs) and other antibiotic resistant bacteria				
HC9.70		**The policy should make provision for:**	current policy expired 010618	N	N	
HC9.71		surveillance and/or screening of patients at high risk of drug-resistant infection;				
		procedures for managing infected patients to prevent spread of infection	Trust has CPE and CRO definitions and staff are very unsure of what to do with these patients relating to specifically cleaning after the patient has been discharged or has passed away	N	N	
HC9.72						
		Viral haemorrhagic fevers (VHF)				
		The policy should refer to the latest guidance from the Advisory Committee for Dangerous Pathogens (ACDP) and make	Trust does have a specific policy which expired on 31 12 17	N	N	
HC9.73		**provision for:**				
HC9.74		appropriate staff to be trained in how to isolate and risk assess patients at risk of VHF;				
		appropriate staff to be aware of the special measures to be taken for nursing VHF patients, and to be properly trained in the				
HC9.75		application of full isolation procedures and use and safe removal of personal protective equipment (PPE);				
HC9.76		patient risk assessment and categorisation;				
HC9.77		confirmed cases to be handled under full isolation measures in a high- security infectious diseases unit or equivalent;				
HC9.78		handling of patient specimens at the appropriate containment level;				
HC9.79		follow-up of all staff in contact with the patient at every stage of care; and				
HC9.80		special measures for the handling, and on-site treatment, of all waste and laundry;				

HC9.81		special measures for transporting patients with VHF			
		Creutzfeld-Jakob diease (CJD), variant CJD (vCJD) and other human prion diseases	this policy currently states as created 170816 but has no review date - presume now out of date and needs a		
HC9.82			review urgently	N	N
HC9.83		The policy should make provision for the management of patients with, or at increased risk of, CJD/vCJD and other human prion diseases			
HC9.84		**Relevant policies for other specific alert organisms**			
HC9.85		The specific alert organisms that follow may be relevant to any unit admitting, or treating as outpatients.			
		Control of tuberculosis, including multi-drug resistant tuberculosis:	there is currently no links on the intranet page that take you to the COMMUNITY TB		
HC9.86			policy.	N	N
		Isolation of infectious patients;	**However a new specific policy for TB in hospital was created 14 118 but has not been passed through the policy**		
HC9.87			**committee or the Trust IPCC**	N	N
HC9.88		Transfer of infectious patients within care organisations or to other care facilities;			
HC9.89		contact tracing; and			
HC9.90		treatment compliance			
HC9.91		**Respiratory viruses:**	Policy is in date	Y	Y
HC9.92		alert system for suspected cases;			
HC9.93		isolation criteria; and			
HC9.94		infection prevention and control measures			
HC9.95		for influenza measures to avoid exposure should include immunisation, as set out in Immunisation against infectious disease, better known as 'The Green Book' (published by Public Health England)			
		Diarrhoeal infections:	C Diff & GDH Policy is in date; Norovirus policy current policy		
HC9.96			expired 13 04 19	N	N
HC9.97		isolation criteria;			
HC9.98		infection prevention and control measures; and			
HC9.99		cleaning and disinfection policy			
	o. CJD/vCJD				
		Advice on the handling of instruments and devices in procedures on patients with known or suspected CJD/vCJD, or at increased risk of CJD/vCJD, including disposal/quarantine procedures, is provided in guidance from the Advisory Committee	current policy on intranet		
HC9.100		on Dangerous Pathogens (ACDP) TSE working group.	expired 170816	N	N
	p. Safe handling and disposal of waste				
		The risks from waste disposal should be properly controlled. In practice, in relation to waste, this involves:	curent waste disposal policy		
HC9.101			sits with the estates team	N	N
HC9.102		assessing risk;			
		developing appropriate policies;	specific points are embedded within separate infection		
HC9.103			prevention policies	N	N
HC9.104		putting arrangements in place to manage risks;			
HC9.105		monitoring, auditing and reviewing the way in which arrangements work;			
HC9.106		being aware of statutory requirements and; legislative change and managing compliance			
HC9.107		Precautions in connection with handling waste should include:			
HC9.108		training and information (including definition and classification of waste);			
HC9.109		personal hygiene;			
HC9.110		segregation and storage of waste;			
HC9.111		the use of appropriate personal protective equipment;			
HC9.112		immunisation;			
HC9.113		appropriate procedures for handling such waste;			
HC9.114		appropriate packaging and labelling;			
HC9.115		suitable transport on-site and off-site;			
HC9.116		clear procedures for dealing with accidents, incidents and spillages;			
HC9.117		appropriate treatment and disposal of such waste			
		Systems should be in place to ensure that the risks to service users from exposure to infections caused by waste present in the environment are properly managed, and that duties under environmental law are discharged. The most important of these are:			
HC9.118					
HC9.119		duty of care in the management of waste;			
HC9.120		duty to control polluting emissions to the air;			
HC9.121		duty to control discharges to sewers;			
HC9.122		obligations of waste managers;			
HC9.123		collection of data and obligations to complete and retain documentation including record keeping; and			
HC9.124		requirement to provide contingency plans and have emergency procedures in place			
		Systems should be in place to ensure that the risks to service users from exposure to infections caused by waste present in the environment are properly managed, and that duties under environmental law are discharged. The most important of these are:			
HC9.125					
HC9.126		duty of care in the management of waste;			
HC9.127		duty to control polluting emissions to the air;			
HC9.128		duty to control discharges to sewers;			
HC9.129		obligations of waste managers;			
HC9.130		collection of data and obligations to complete and retain documentation including record keeping; and			
HC9.131		requirement to provide contingency plans and have emergency procedures in place			
	q. Packaging, handling and delivery or laboratory specimens				

		Biological samples, cultures and other materials should be transported in a manner that ensures that they do not leak in transit and are compliant with current legislation. Staff who handle samples must be aware of the need to correctly identify, label and store samples prior to forwarding to laboratories. In addition, they must be aware of the procedures needed when the container or packaging becomes soiled with body fluids.	sits with Pathlinks	Y	Y	
	r. Care of deceased persons					
		Appropriate procedures should include:		N	N	
HC9.133		risk assessment of potential hazards;				
HC9.134		the provision of appropriate facilities and accommodation;				
HC9.135		safe working practices;				
HC9.136		arrangements for visitors;				
HC9.137		information, instruction, training and supervision; and				
HC9.138		health surveillance and immunisation (where appropriate)				
	s. Use and care of invasive devices					
		Policy should be based on evidence-based guidelines and should be easily accessible by all relevant care workers. Compliance with policy should be audited. Information on policy should be included in infection prevention and control training programmes for all relevant staff groups.		N	N	
	t. Purchase, cleaning, decontamination, maintenance and disposal of equipment					
		Policies for the purchase, cleaning, decontamination, maintenance and disposal of all equipment should take into account infection prevention and cleanliness advice that is given by relevant experts or advisory bodies or by the Infection prevention team.	sits with procurement teams	N	N	
	u. Surveillance and data collection					
		For all appropriate healthcare settings, there should be evidence of local surveillance and use of comparative data, where available, to monitor infection rates, antimicrobial resistance and antimicrobial consumption and to assess the risks of infection. This evidence should include data on alert organisms, and other infections where appropriate, alert conditions and woundinfection per clinical unit or specialty. When appropriate or where they exist, recognised definitions should be used.	current polkicy on intranet expired 12 12 17	N	N	
		Electronic reporting to Public Health England of clinical laboratory isolates is recommended where the appropriate information technology is in place. There should also be timely feedback to clinical units, with a record of achievements and actions taken as a result of surveillance. Post-discharge surveillance of surgical site infection should be considered and, where practicable, should be implemented.	surveillance nurse has been working on a SOP for surveillance for over 12 months but not agreed upon (time frame includes and extended period of sickness) New surveillance policy was going to be produced arround this agreed SOP			
	v. Dissemination of information					
		There should be a local protocol on information sharing when referring, admitting, transferring, discharging and moving service users within and between health and adult social care facilities. This is to facilitate surveillance and optimal management of infections in the wider community. Guidance on data protection legislation also needs to be observed.		N	N	
	w. Isolation facilities					
		There should be a policy concerning the appropriate provision and maintenance of isolation facilities. This should address:	Trust has a limited amount of singlel rooms for isolation needs and no appropriate negative pressure isolation facilities	N	N	
HC9.144		potential sources of infection				
HC9.145		The types of isolation facility needed for different infections;				
HC9.146		The use of protective measures and equipment				
HC9.147		The management of outbreaks				
	x. Uniform and dress code					
		Uniform and workwear policies ensure that clothing worn by staff when carrying out their duties is clean and fit for purpose. Particular consideration should be given to items of attire that may inadvertently come into contact with the person being cared for. Uniform and dress code policies should specifically support good hand hygiene.	currently has sat outside the IP team and led by the chief nurse. Nationally (pre COVID - 19) there was nnational meetings and drive towards a national uniform for the whole of England and ULHT had been invited to participate at the national level.	Y	N	
	y. Immunisation of service users					
		Registered providers should ensure that policies and procedures are in place with regard to the immunisation status of service users such that:	sits with occupational health	Y	Y	
HC9.149		there is a record of all immunisations given				
HC9.150		the immunisation status and eligibility for immunisation of service users are regularly reviewed in line with Immunisation against infectious disease ('The Green Book') and other guidance from Public Health England				
HC9.151		following a review of the record of immunisations, all service users are offered further immunisation as needed, according to the national schedule.				
HC9.152						

	ULHT IP&C Hygiene Code Gap analysis template 2018-2019								
Link Code	Criterion	Title	Sub section	Guidance statement	Current position statement	Compliance	Embedded	RAG rating	Evidence of compliance
HC10	10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection							
			Registered providers should note that this criterion also covers staff education and training and ensure that policies and procedures are in place in relation to the prevention of infection such that:						
				all staff can access occupational health services or access appropriate occupational health advice;	United Lincolnshire Hospitals NHS Trust (ULHT) is compliant with Criterion 10 in that all members of staff have access to the Occupational Health and Wellbeing Service. Staff can refer themselves or be referred by their line manager.	Y	Y		OH records, HR & OD Policies
HC10.1				occupational health policies on the prevention and management of communicable infections in care workers are in place;	The OH Service has guidance in place the Occupational Health & Wellbeing Services (OH&WBS) Communicable Diseases Guidelines	Y	Y		OH records of advice given
HC10.2				decisions on offering immunisation should be made on the basis of a local risk assessment as described in Immunisation against infectious disease ('The Green Book'). Employers should make vaccines available free of charge to employees if a risk assessment indicates that it is needed (COSHH Regulations 2002);	All immunisations against infectious disease are assessed and follow the Department of Health, NHS England and the Green Book recommendations. All ULHT employees are offered immunisations free of charge, if a risk assessment indicates that they are required, confidential record of all immunisations is maintained for each employee in ULHT.	Y	Y		OH records of immunisation given and role employee
HC10.3				there is a record of relevant immunisations;	OH has a management system in place that has a data base of all inmuisations that are given by the sevice with review appointmebts where needed	Y	Y		OH records
HC10.4				the principles and practice of prevention of infection (including cleanliness) are included in induction and training programmes for new staff. The principles include: ensuring that policies are up to date; feedback from audit results; examples of good practice; and action needed to correct poor practice;		Y	N		Induction and core training at 89%
HC10.5				there is appropriate ongoing education for existing staff (including support staff, volunteers, agency/locum staff and staff employed by contractors), which should incorporate the principles and practice of prevention and control of infection. Clinical staff should have an ongoing understanding of the risk from existing, new and emerging infectious diseases and take this into account when assessing patients;		N	N		Review of training needs
HC10.6				there is a record of training and updates for all staff; and		Y	Y		Held by HR
HC10.7				the responsibilities of each member of staff for the prevention of infection are reflected in their job description and in any personal development plan or appraisal		Y	Y		JDs state individuals must follow trust polices
HC10.8									
HC10.9			Occupational health services for staff should include:						

		risk-based screening for communicable diseases and assessment of immunity to infection after a conditional offer of employment and ongoing health surveillance;	On offer of employment each employee is screened for communicable diseases and assessment of immunity to infection after a conditional offer of employment and ongoing health surveillance in line with the Department of Health, NHS England and the Green Book recommendations. Any staff who are identified as requiring immunisations are offered the relevant immunisations and those staff that require a review	Y	Y		OH Policies and guidance and all staff confidential employment records
HC10.10							
HC10.11		offer of relevant immunisations; and		Y	Y		OH records
		having arrangements in place for regularly reviewing the immunisation status of care workers and providing vaccinations to staff as necessary in line with Immunisation against infectious disease ('The Green Book') and other guidance from Public Health England	All immunisations against infectious disease are assessed and follow the Department of Health, NHS England and the Green Book recommendations. All ULHT employees are offered immunisations free of charge to employees if a risk assessment indicates that they are required, confidential record of all immunisations is maintained for each employee in ULHT.	Y	Y		OH records
HC10.12							
	Occupational health services in respect of BBVs should include:						
		having arrangements for identifying and managing healthcare staff infected with hepatitis B or C or HIV and advising about fitness for work and monitoring as necessary, in line with Department of Health guidance;	The service has arrangements for identifying and managing healthcare staff infected with hepatitis B or C or HIV are in line with the UK Advisory Panel for Healthcare Workers Infected with Blood-borne Viruses . All staff infected with hepatitis B or C or HIV are initially screened by the OH physician or will give advice on their management, All HIV infected case are managed directly by the OH physician. The service has a policy in place for the risk assessment and appropriate management of all accidental occupational exposure to blood and body fluids in the trust. The policy	Y	Y		management of individual cases reflected in their OH records
HC10.13							
		liaising with the UK Advisory Panel for Healthcare Workers Infected with Blood-borne Viruses when advice is needed on procedures that may be carried out by BBV-infected care workers, or when advice on patient tracing, notification and offer of BBV testing may be needed;	As above	Y	Y		
HC10.14							
HC10.15		a risk assessment and appropriate referral after accidental occupational exposure to blood and body fluids; and	PEP policy in place	Y	Y		
		management of occupational exposure to infection, which may include provision for emergency and out-of-hours treatment, possibly in conjunction with accident and emergency services and on-call infection prevention and control specialists.		Y	Y		
HC10.16			AS above				
HC10.17		This should include a specific risk assessment following an exposure prone procedure.	AS above	Y	Y		
	Occupational health services in respect of influenza should include:						

HC10.18	arrangements for provision of influenza vaccination for healthcare workers where appropriate	As plan for the 2017/18 season and some other flu information, we normally commence vaccination as soon as they arrive the first week in October we understand there may be a slight delay but that will not effect us. NHS England have attached CQUIN to this year's flu campaign, the payment schedule is outlined below. NHS England have indicated in this document the final measurement for delivery flu vaccines frontline staff will be the end of February 2018.The information from NHS England on the value of the CQUIN to the trust is that it is worth £235.000 for delivery of 70% and over.	Y	Y		record of vacinations	

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board - Public*
Date of Meeting	*7th July 2020*
Item Number	*Item 9.1*
Accountable Director	*Martin Rayson, Director of People & OD*
Presented by	*Martin Rayson*
Author(s)	*Martin Rayson*
Report previously considered at	*None*

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

Risk Assessment	*4567*
Financial Impact Assessment	*None required*
Quality Impact Assessment	*None required*
Equality Impact Assessment	*None required*
Assurance Level Assessment	*Insert assurance level* • *Moderate*

Recommendations/ Decision Required	• *Board are asked to note the report and the recommendations for improvement made, which will be followed up by the Workforce & OD Committee*

Executive Summary

The purpose of the report is to provide the Board with assurance regarding the actions taken to ensure that:

1). The Trust had sufficient workforce capacity to effectively respond to the manage and restore phases of the COVID 19 national incident

2). Appropriate action was taken to minimise the COVID risks to the ULHT workforce, with a particular focus on staff at greatest risk.

3). The well-being needs of our staff understood and addressed.

The paper considers different aspects of workforce management through COVID, compares the action taken by ULHT against recommended best practice and also provides an opportunity to highlight the very positive response of our workforce to the challenges the Trust has faced.

Overall the Trust has been in a position to adequately resource its plans through the manage and restore phases. Whist very sadly one member of staff did die as a consequence of COVID, overall the steps taken to protect our staff have kept our staff safe and there has been a positive response to the actions taken in respect of staff well-being (including communicating with our staff).

There are lessons that the organisation can learn from the experience of managing our staff through COVID and action will be taken to address identified weaknesses in our approach (for example in our ability to collect and report accurate data).

1. Workforce Demand

1.1 As part of the structure created to respond to the COVID Level 4 Major Incident, a workforce cell was established to address the issues around workforce supply and demand. It was challenging to move from a “distributed” approach to managing the workforce to more centralised control and it was not always clear initially how many staff were working from home, or who had been redeployed. However, over time, staff resources were deployed to meet the challenges arising from the COVID incident.

1.2 The reduction in non-critical activity, enabled the Trust to cope in workforce terms with the increased COVID demand and the increased levels of absence, through the redeployment of staff on a temporary basis. Around 300 clinical staff and 200 non-clinical staff were redeployed from non-COVID areas and non-priority tasks, to COVID-related priorities.

1.3 The Cell produced a surge plan based on the requirement for 50 additional critical care beds and 980 general beds. In summary, the need to staff additional critical care beds would trigger a transfer of Registered Nurse capacity into ITU. Alongside the need for additional general beds, this triggered a reduction in the registered nurse to patient ratio and a significant increase in the requirement for non-registered staff. The position would be exacerbated by current vacancy levels. There was a pressure also on estates and facilities staff also, required for cleaning etc.

1.4 In the plan, the proposal was to meet this additional capacity through:

- Continued redeployment of staff – including non-clinical staff redeployed to ward support roles
- Revised temporary medical rotas
- Access to additional agency staff
- The recruitment to a temporary COVID bank of additional facilities and estates staff and University students, trained to undertake some of the roles of a HCSW.

1.5 The Surge Plan remains in place, should there be a further spike in COVID admissions. The Workforce Cell is now focused on responding to the workforce issues associated with restoration and recovery, notably the creation of the Green Site, the implications of having significant numbers of staff working from home for long periods and the need to provide suitable adjustments for staff who have been isolating, to enable them to return to work.

1.6 In terms of supporting the implementation of Project Green at Grantham, there has been significant HR support to assist in understanding and managing the impacts on staff, developing a set of principles to support our commitment to there being no detriment to staff, a manager tool-kit to support the conversations they have had with their staff and on-site well-being and counselling support.

1.7 In addition to the ULHT Workforce Cell, there is a Cell at Lincolnshire system level co-ordinating the system response and addressing those issues that warrant a cross-organisation response.

2. Maximising Workforce Supply

Absence

2.1 Our pre-COVID sickness absence rate was around 5%. As the chart below shows, from the end of March onwards the number of staff absent grew significantly. This was a consequence of four factors:

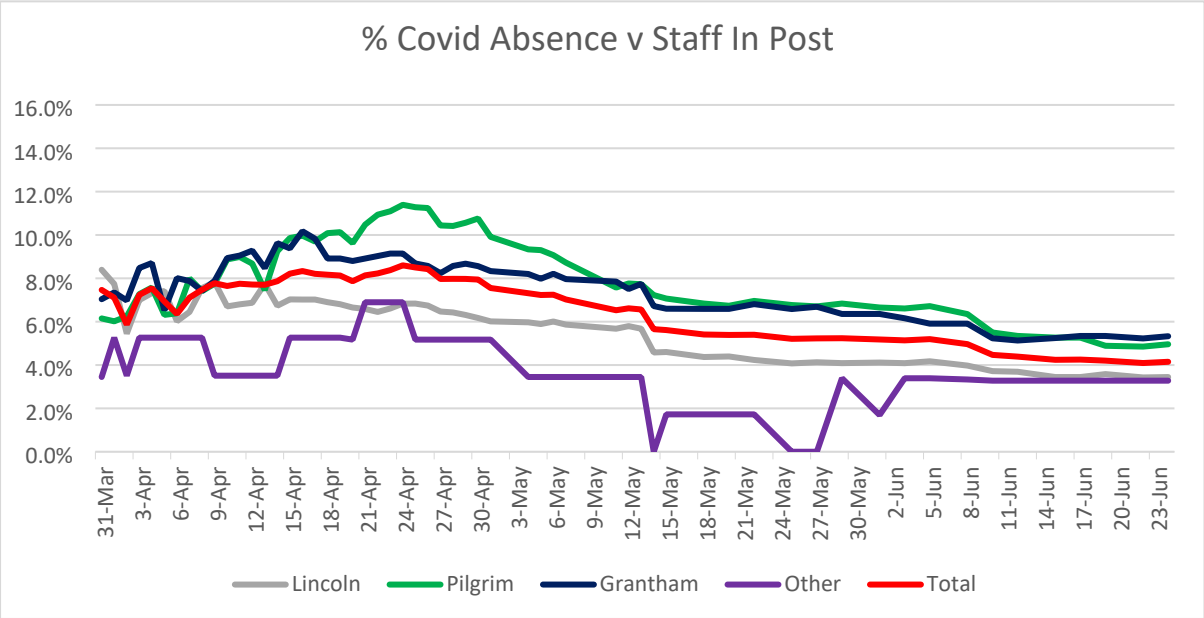
- The number of staff sick with COVID

- The number of staff self-isolating in line with Government guidance, because household members were symptomatic

- The number of staff either "shielding" (because they had received a letter from the NHS, as a consequence of being in the most high risk categories) or "isolating" (because they have underlying health conditions and, following risk assessment, were advised to work from home)

- Staff who are absent sick with stress

2.2 We are required to report nationally staff absent for COVID reasons and within the overall absent figures, the percentage of staff who fall into those categories are shown in the chart below:

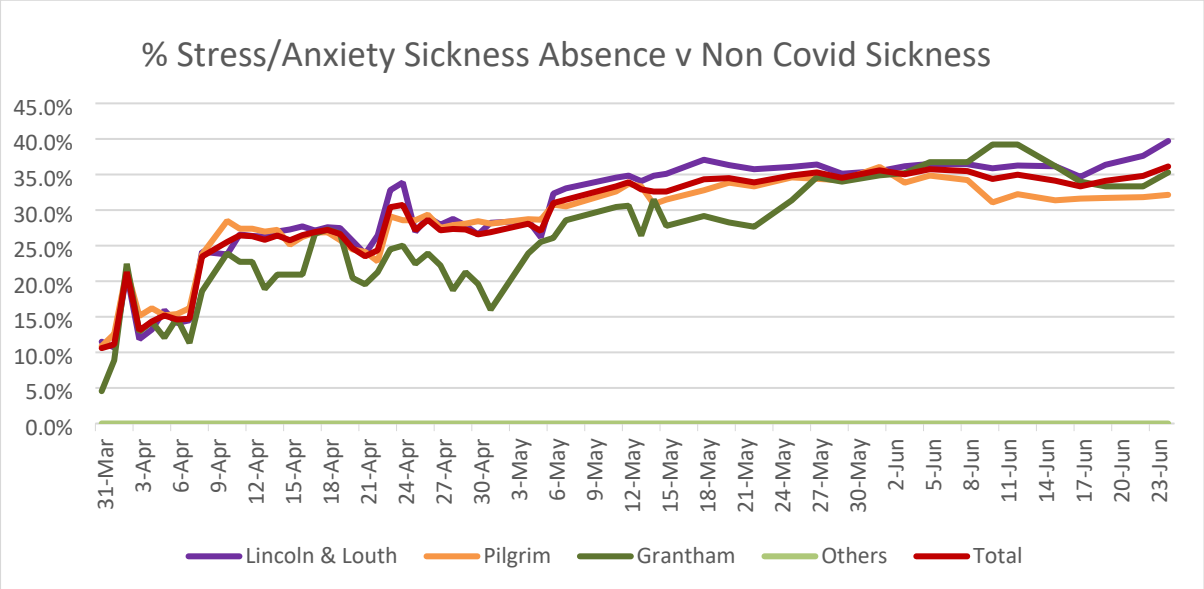


2.3 The number absent peaked on 24th April when 679 staff were away. Since then, numbers have steadily declined. There has not been significant reduction since mid-May because the remainder represent those who are shielding or isolating.

2.4 Test and trace has added to the number absent isolating. If contacts are through work we have been able to risk assess (looking at appropriate use of PPE for example) and thereby can minimise impact. On 24th June there were 37 absentees as a consequence of contact with the test and trace service.

2.4 We did quickly identify that there was significant increase in the percentage of absence relating to stress, reflecting the broad challenge of living and working during COVID.

The percentage of absence due to stress in non-COVID reported absence increased from around 15% to 35%. This has fluctuated by site depending upon how COVID has impacted, with Pilgrim initially being a hot spot, but recently an increase on the Grantham site.



2.5 Our Employee Relations and Occupational Health teams have been working with staff to understand the cause of their stress absence as a consequence of the increase we have seen. Factors inside and outside of work and only a proportion directly related to COVID, have caused this increase in stress absence.

2.6 We have had to adapt from reporting absence a month in arrears to absence reporting on the day. This has highlighted a number of issues:

- Our use of two systems to record absence (ESR and Healthroster) and the need to reconcile between the two

- Managers do not always close down periods of absence when the individual returns to work

- The extent to which there is an on-going dialogue between the manager and absent member of staff is patchy.

2.7 This does highlight the importance of the project we are running as part of the Integrated Improvement Plan (IIP) to implement the Empactis Attendance Management System to improve the management of absence. This system will help address the above issues. Those Trusts who had the System in place have reported that they have found the system extremely valuable in helping to manage COVID absence.

3. Maximising Attendance

3.1 We have taken steps to ensure that our staff are able to continue to fulfil their duties. Around 200 staff were offered accommodation, either in Progress Housing or in local hotels.

3.2 I am sure the Board would wish to recognise the commitment made by our staff over the last three months. We have become aware of some examples of exceptional sacrifice from staff who have truly "gone the extra mile" to look after our patients. A number of anonymised stories are included in Appendix A. They are anonymised, as they simply reflect stories we have become aware of and there will be others of which we are not aware.

4. Redeployment

4.1 As a response to COVID we have had to redeploy a significant number of staff, both clinical and non-clinical staff. Approximately 300 clinical staff were redeployed, for example, from Theatres to ICU and outpatients to ward areas.

4.2 160 non-clinical staff were also redeployed from services ceasing, or scaling back to priority COVID-related work between 23rd March and 27th May. These staff in particular supported Estates and Facilities housekeeping and catering functions.

4.3 Management of this process was very challenging because of the pace of change around COVID, but the experience of staff was generally very positive and it has caused us to consider whether periods working in other, potentially patient-facing areas, should be built into job descriptions. This does help to reinforce the sense of one team, focused on the core vision of "Outstanding Care, Personally Delivered."

5. Additional Recruitment

5.1 To support the Trust response to the pandemic, a number of initiatives were instigated in order to provide additional supply of resource.

<u>COVID Bank Staff</u>

5.2 An initial recruitment advert for "Generalists" was posted across social media channels in order to recruit staff. The primary purpose of the Bank was to generate a pool of resource to support roles across the facilities directorate including housekeeping, catering, portering and switchboard functions. The role was advertised at a Band 2 under a zero hours contract.

5.3 Following a significant response, 180 offers were made resulting in 146 contracts being issued. Allocation of work to the COVID Bank was undertaken via the newly formed Redeployment Hub who also arranged initial inductions and completion of the on-line induction prior to commencement in post. It was noted however that due to the level of demand not being as high as original projected, only around 50 bank staff were utilised. Despite this, we have maintained communication with all those recruited onto the Bank to ensure they are aware of the current situation but also have access to any upcoming bank opportunities.

<u>University of Lincoln – Patient Support Assistants</u>

5.4 As part of the Trust workforce planning process, it was identified that, should the Trust experience Super Surge, there was a risk that we would not have enough HCSW's to undertake basic patient physiological assessments on the wards.

5.5 To address this, it was agreed by the Director of Nursing and Gold Command that we should source and train a cohort of staff that could support our ward based staff within COVID and non-COVID areas. The University of Lincoln (UoL) was approached to create a 2 day training programme to provide individuals with the basic knowledge and skills to undertake this role. In addition to the training, it was agreed that we would commit to providing 5 days paid work to all those who completed the programme, thereby enabling them to apply their learning within a ward environment upon completion. Following review by the DoN and Gold Command, the programme was signed off and commissioned for a total of 60 new staff.

5.6 Due to the specialist nature of the role required, the University of Lincoln agreed to promote the opportunities of a paid training bank role to their students undertaking health and care related study within the university. A total of 52 students were recruited to the position, 47 of whom went on to complete the mandatory 2 day training programme.

5.7 As a result of the Super Surge not materialising, we have been unable to utilise the UoL students within the original role on the wards. Some students have since returned to their home regions and therefore do not wish to continue. However, others have still been utilised in other administrative functions across the Trust where redeployed staff have not been available and where good admin and ICT skills have been required.

C19 Doctors Support Workers

5.8 In order to provide assistance to our medics during surge, the role of "Doctors Support Worker" was devised targeting Medical students. A total of 23 were offered positions all of whom have been working for us on a 20 hour/week basis up until the end of June. There has been very positive feedback from the individuals employed and the juniors they have supported, to the extent that we may view this as a pilot in advance of permanent appointments being made to these support roles.

Bring Back Scheme

5.9 Emergency legislation at the beginning of the COVID incident enabled recently retired professional staff to re-join the NHS workforce, through a process that was coordinated at a national and regional level. Lincolnshire did not benefit from this scheme to the same level of other regions and indeed, some of the staff offered to ULHT were not prepared to work in clinical areas and therefore we did not engage them. In total only 8 of the 42 staff put forward from what was termed the "Bring Back Scheme" came to work at ULHT.

Student Nurses

5.10 A number of student nurses were also recruited onto the HCSW Bank to provide additional support to the Trust.

AHP Bank

5.11 Due to low numbers of allied health staff within the Trust, the AHP team chose to set up their own Physio and OT Bank staff that would sit within Health Roster and could be called upon as and when necessary. A total of 18 individuals were recruited, resulting in contracts being issued to 11 of them.

6. Testing

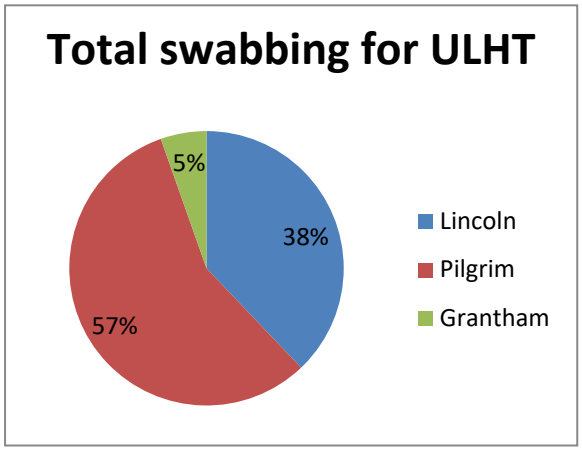
6.1 The Trust has been undertaking the antigen test (swabbing staff) in line with national guidance and reflecting the capacity available at the NLAG lab. Our criteria for swabbing staff have therefore been:

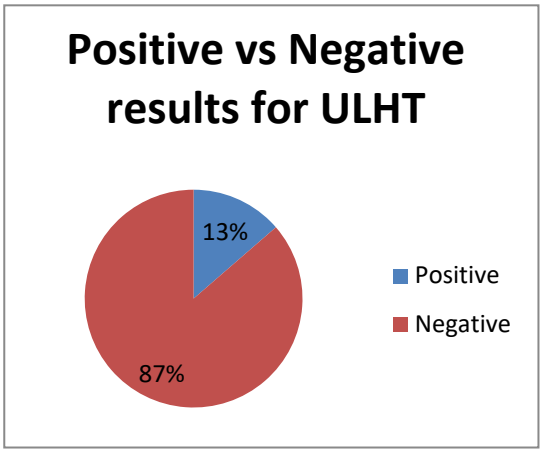
- Staff with symptoms
- Staff and the index case where a family member is symptomatic
- Staff where we are concerned there may be a cluster of cases in an area (defined as five cases over a 14 day period, although this may be amended based on latest guidance)

All other staff can be swabbed if they wish, but will be processed through the national system.

6.2 These are the results of the swab test activity to 24th June.

Total STAFF swabbing up to and including24th June 2020						
Staff Swabbed	**Lincoln**	**Pilgrim**	**Grantham**	**Positive**	**Negative**	**In Progress**
1951	742	1105	105	260	1660	4



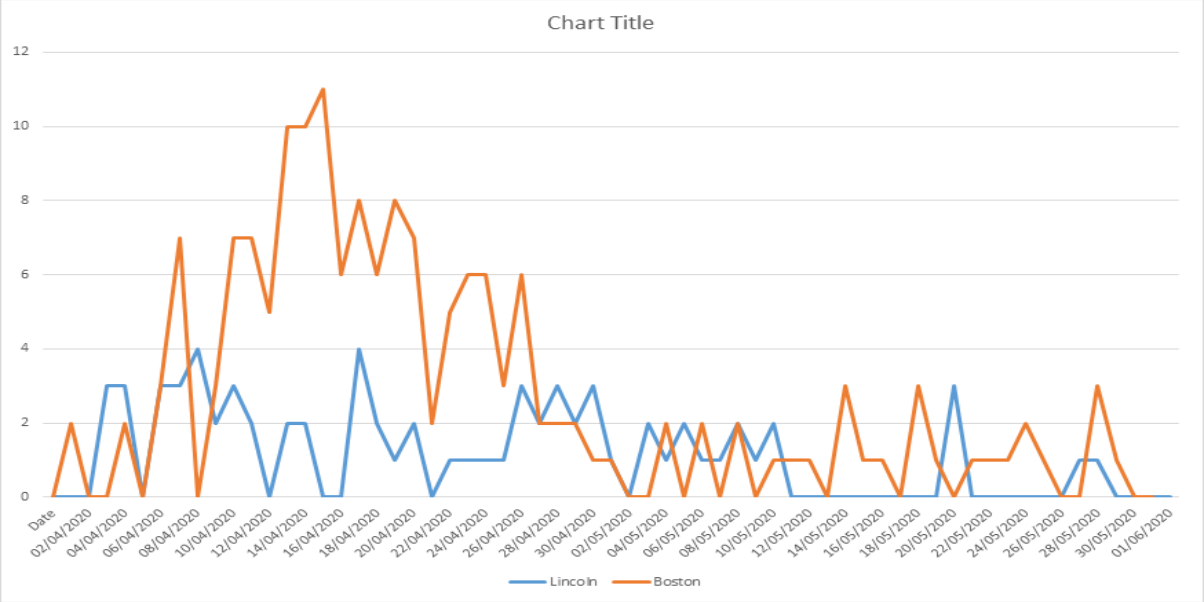


Positive out of 9,104 staff	**2.85%**
Positive out of the staff swabbed	**13.33%**

6.3 Through early intervention when a household member has symptoms, we have enabled over 1100 staff to return to work earlier than the 14 day isolation period might have allowed.

6.4 The graph below shows the trend for staff testing positive through to the beginning of June (numbers testing positive in last 7 days). What the graph shows is the higher level of positive tests at Pilgrim compared to Lincoln. It also shows the reducing

number of staff testing positive since the peak in mid-April. I am advised that the trend has continued through June.



6.4 The Board received a report in June about the national concerns about the impact of COVID 19 on the BAME community and the action taken as a consequence by the Trust.

6.5 In preparation for the establishment of a Green Site, the Trust has reviewed its approach to testing and agreed a revised and on-going approach, which is set out below:

- Education and training of staff - adherence to Infection Prevention, PHE, National Guidance
- Symptomatic Swabbing - in place 7 days a week
- Antibody Testing - commenced 3rd June, 250 tests per day available
- Daily health screening – to commence at Grantham 29th June.
- Random swab testing using home testing kits – not yet authorised nationally
- Use National Testing site for BAME and asymptomatic staff - in place.

6.6 Our approach to staff testing has reflected national guidance and best practice from other organisations impacted on by COVID. It has also had to reflect capacity limitations at the labs we use and issues regarding the efficiency of national testing.

6.7 The risk assessment process and testing regime has place great strain on our Occupational Health Team. They have worked extremely hard to meet all of the needs of the Trust, drawing in redeployees to boost capacity. The experience has demonstrated the need to enhance use of support systems and manage data more effectively within the Team. This was something already highlighted pre-COVID in a management review and will be addressed in the months ahead.

7. Managing Risks To Our Staff

7.1 The Trust has been seeking to effectively managing the risks to our workforce since the on-set of the COVID incident. In doing so, we have been utilising the most up-to-

date national guidance available to us, related either to the use of PPE, or the broader management of risk. This includes guidance from the Health & Safety Executive Working Safely during Coronvirus (COVID 19) outbreak to manage the risk of coronavirus in our Trust to work safely and protect people.

7.2 HM Government issued more comprehensive guidance on how to work safely called "Working Safely During COVID 19" on 11 May 2020. The requirement was for all businesses to translate the guidance into specific actions, following an assessment of risk to be completed in consultation with unions or workers.

7.3 The Trust has adopted a structured approach to assessing and managing workforce risks. The Health & Safety Team have:

- Populated a Strategic Trust Risk Register item in relation to COVID-19 and social distancing (Risk Register ID 4567). This assessment reflects the approach adopted, control measures identified and the residual risk identified at this time and will be reviewed according to the Risk Management Strategy.

- Put in place Operational Health & Safety Risk Assessment templates for the following (jointly worked through with staffside):

  COVID-19 Social Distancing at Work – Office based Staff
  COVID -19 Social Distancing for Contractors whilst working on site
  COVID- 19 Social Distancing with specific reference to 'working in or from a vehicle'- staff using Fleet Service vehicles
  COVID -19 Social Distancing with specific reference to Inbound and outbound of goods – staff working in supply departments

- To emphasise our joint commitment and work together, a "5 Steps Poster" has been signed by Andrew Morgan and Staff side and is displayed in key/ prominent points such as Main Reception across the Trust, as well as in all departments. This is a reflection of the Trust's commitment to Staying COVID Secure.

- All managers have been tasked with risk assessing all work areas. Managers are required to use to the generic assessment to implement control measures to their local areas, for example by putting in place social distancing measures, staggering shifts and providing additional handwashing facilities. The Health & Safety Team will review all completed assessments.

7.4 The Government guidance indicated that, where possible, staff should be undertaking their work from home. The work of all staff has been reviewed to determine whether all or part of their role could be conducted at home. We believe that around 700 staff have been doing so. There have been some issues about our ability to manage home-workers effectively, highlighting the need for some management development focused on managing at a distance. What this should also question is whether we should more systematically adopt agile working and home-working within this. The Trust did initiate an "agile working project" during 2019 and our experience through COVID suggests that the project should be reinvigorated.

7.5 All employees have an equal level of responsibility for ensuring and maintaining health & safety standards. This responsibility is being emphasised through:

- Communications in SBAR
- The work of the Safety Champions, who do regular visits of ward areas

- Briefings by managers of their staff
- The FIVE STEPS TO SAFER WORKING TOGETHER poster referred to above
- An e-learning module for staff on Working Safely- Social Distancing has been produced by the Health & Safety Team and will be launched shortly.

7.6 This organisational and workplace assessment has been supplemented by an individual risk assessment process, whereby individual's with underlying health conditions were assessed to determine what adjustments were necessary to enable them to continue to undertake their work safely, including working from home. Risk assessments were undertaken for members of staff in the following categories:

- Staff with shielding letters (extremely vulnerable)
- Staff and volunteers aged over 70
- Staff with underlying health conditions (clinically vulnerable)
- Pregnant women.

Data on the risk assessments undertaken is included in paragraph 7.9.

7.7 Our risk assessment is adapted to reflect the latest PHE guidance. We are now on version 16 of the risk assessment. In May we responded to the latest research into the impact of COVID-19 on the BAME community and asked all 1100 staff associating with BAME to undertake an assessment. Whilst simply associating with BAME does not necessarily mean adjustments need to be made, the risk assessment was made to reflect potential risks to particular groups within BAME, where age was also a factor.

7.8 At Appendix B you will find a NHSE/I framework for assessing risk. The ULHT structure described above reflects the NHSE/I best practice framework.

7.9 The risk assessment process for "at risk" staff is coming under increasing national scrutiny. We requires us to the report the following information to the Board and this was the position as at Tuesday 30th June:

- Number of staff risk-assessed and percentage of whole workforce, broken down by staff group (risk assessments recorded in Occupational Health, total numbers includes bank staff)

All ULHT staff - completed risk assessments	Total	% against total numbers
Nurse/Midwife	397	15.68%
Doctor/Dentist	523	53.86%
Estates & Ancillary	176	14.99%
Allied Health Professionals	205	43.80%
Admin	178	9.76%
Other	123	5.00%
Total	**1602**	**16.97%**

Others include Additional Clinical Services (HCSW's, etc), Ad Prof Scientific & Technic, Students and Healthcare Scientist.

- Number of black, asian and minority ethnic (BAME) staff risk assessments completed, and percentage of total risk assessments completed and of whole workforce

BAME	Total	% against BAME staff (1090)	% against total numbers
Nurse/Midwife	140	12.80%	5.53%
Doctor/Dentist	461	42.20%	47.48%
Estates & Ancillary	23	2.10%	1.94%
Allied Health Professionals	166	15.20%	35.47%
Admin	31	2.80%	1.70%
Other	0	0%	0%
Total	**821**	**75.32%**	**8.70%**

.

- Additional mitigation over and above the individual risk assessments in settings where infection rates are highest – examples of action taken, included swab testing of all staff members in particular areas.

7.10 One issue that is immediately evident is the proportionately low level of risk assessments undertaken on the "other" group. Some of this group are in frontline health care roles. We will explore further whether this is a consequence of a lack of awareness among this group of risk and the assessment process, or whether it is coincidental.

8. Supporting Our Staff - Health & Well-Being

8.1 Very early in the incident, the Trust set up a staff wellbeing group which has met weekly since March. Representatives are drawn from Staff-side, Occupational Health, Communications, Chaplaincy, Patient Experience and Organisational Development.

8.2 We have produced a weekly (now fortnightly) staff wellbeing brochure which tackles a range of topics each week, with the main aim of informing staff what support is available to them. The booklet is very widely distributed across the Trust and has been very well received.

8.3 The help available (incorporating national and system offers) includes:

- Lincolnshire Health and Wellbeing Line (staffed by staff from across the system including ULHT)
- LPFT Emotional Wellbeing Helpline
- Notifying all staff that there are trained Mental Health First Aiders available and contacting these individuals asking them to reach out to colleagues
- Notifying all staff that there are Health and Wellbeing Champions and contacting these staff asking them to reach out to colleagues
- Offering coaches

In addition, the Trust has:

- Provided free tea and coffee to staff in all departments
- Worked collaboratively with partners from LCHS and LPFT to share good practice on staff wellbeing
- Supported the setting up of 70+ Wobble Room across the Trust
- Met in person with wide range of Catering, Portering and Housekeeping staff to address their wellbeing concerns

- Made over 200 wellbeing calls to staff off sick with stress or recently returned to work from stress related absence to check in with them, offer support and/or signpost to additional help
- Distributed free Easter eggs, flowers and more
- Provided free meals for staff
- Provided free staff car parking
- Provided staff accommodation
- Set up virtual facilitated community spaces/networks which have evolved over the past few months to respond to needs
- Provided debrief training for managers in key areas such as ED
- Provided counselling services for staff in key critical areas including ICU and Theatres
- Responded to bespoke concerns, for example within Family Health Services at Pilgrim, and provided listening and support events.
- Sent around 1000 letters to the children of our staff members (and badges), signed by the Chief Executive
- Set up an Amazon wish list and distributed Care Packages following hundreds of public donations to hundreds of teams Trust wide. The public donations have been accompanied by messages of support from the public, a few of which have been included below:

We owe each and every one of you a debt we will never be able to repay. Thank you all from the bottom of our hearts for everything you are doing.
From one soldier to a group of others fighting a very different war. With the greatest appreciation and respect. From a loving family.
You are all heroes! Thanks
Thank you all for your caring and commitment. Every one of you is a real life hero. Stay well
You are all incredible. So proud to have family in the NHS, we couldn't get through this nightmare without you. Thank you.
Thank you for all your hard work and dedication not just this time but all year round. With love from Thomas aged 4 months, a former NICU inmate.
Thanks for all your unselfish and courageous actions in these testing times, stay safe and healthy..
You absolute heroes! The words THANK YOU will never be enough, stay safe and strong.
Many thanks for all your hard work from all the chefs at RAF Coningsby.
Thank you for everything you are doing, we are praying protection, peace and wisdom over you all.

> *We haven't got the words to convey our gratitude to you all. We have talked about what must go through your heads each time you wake up but you still get up and go. You are amazing*

8.4 The team are now reviewing the support available into the recovery phase, recognising that the impact of COVID will be long-term and reactions can be delayed. As part of this, we are now working with system partners to design and develop a Lincolnshire approach to psychological wellbeing services system wide.

9. Supporting Our Staff – Communications & Engagement

9.1 The Trust has recognised the importance of communicating regularly and fully with our staff. Our weekly communications round-up and CX blog have continued and a comprehensive set of intranet pages built, including a set of FAQs covering workforce issues.

9.2 Sessions have been held with the BAME network and the MACs at Pilgrim and Grantham, so that the voice of particular groups of staff is heard.

9.3 Alongside this, we have published a daily SBAR for staff and have introduced a Facebook Live session with all Executives, which takes place at least once a week.

9.4 There has been a weekly session with staffside and other TU reps, replacing the more formal EPF and JNF meetings. These have been well-attended and have given a sense of real partnership working, enabling us to work together to resolve some of the issues staff are facing. There has also been a daily briefing for the staffside secretary from COVID Gold. These arrangements reflect the spirit of the national agreement signed by the national Trade Unions and employers.

9.5 Overall, feedback on our communications and engagement work has been very positive and staff have reported feeling involved with the direction of travel of the Trust. Communications around the changes at Grantham have proved a bit more challenging, a consequence of the history at Grantham and the complex nature of the changes being made there.

9.6 We wish to build on the improvements made. We have re-established the Staff Engagement Group, to work with us to embed what has worked well and to act as a sounding board, helping understand better the mood of the organisation and the actions we can take to ensure effective two-way communications and engagement with change.

10. Comparison With Best Practice

10.1 We have compared the ULHT response with best practice identified by NHSE/I. Appendix C takes NHSE/I guidance and point by point reviews the actions taken by ULHT.

10.2 The actions taken at the Trust reflect the best practice identified. Two areas where on reflection more action could have been taken, were:

- Providing more support to line managers to ensure they effectively carried out their role in support staff at greatest risk.

- Promoting all the sources of advice and support available to those at greatest risk

11. Recommendations

Trust Board to accept the report and the assurances given on the management of the workforce through COVID

Trust Board to ask Workforce and OD Committee for an update after six months on progress made in addressing the issues identified

Staff Stories *Appendix A*

These are anonymised extracts from the letters submitted by staff requesting a CX letter for their children. They represent only a proportion of those received, but give the Board a flavour of the impact of the COVID incident on the lives of some of our staff;

HCSW Lincoln County Hospital

Both children have been amazing during these times it has been so hard on them both being out of school and mummy still going to work it has been especially hard for my little boy (6) who has autism and needs routine and yet not once has he moaned or had a meltdown he has been a real champ. I thought they would struggle and not understand but not have they proved me wrong they have been an absolute credit

Deputy Sister Lincoln County Hospital

My daughter especially struggled letting me come to work midst the Covid-19 outbreak. This letter would be amazing to help her understand why and to know the hospital is doing its best to keep me safe. Which I know you are.

Deputy Sister Pilgrim Hospital

Please could you include in the letter that mummy is safe wearing all her protective equipment, as this would be a great help to my eldest (6) worrying about mummy going to work.

Sister Lincoln County Hospital

My son has never complained he's told me every day he loves me and is proud of me, to be absolutely honest I don't know what I'd have done without him the last few months. He's not a little child he's a teenager and stands taller than me but that just means he understands the dangers better and therefore worries more. We are a team and I want him to be recognised for this please.

Consultant Pilgrim Hospital

Boys have been managing in an exemplary way with their disciplined day routine. They never complained even if I was returning late from work or had to stay away from home for my on call duties. Always stayed in positive spirits in the lockdown. Helped me in all household work like cleaning and cooking. Took every precaution in pandemic. Never let their fears overpower them whenever I left home for work or shopping despite knowing that their mum (me) is a cancer survivor. They have been a strong support through the pandemic enabling me to provide and lead the NHS services safely.

Senior Manager Trust Wide

My son has had to spend a lot of time occupying himself during the days (he has been really lonely), he has really missed his friends and school, but he has coped really well with this. He has had to home school to fit round my working hours and has tried really hard with his school work. I am really proud of him and how he is coping.

Staff Nurse Lincoln County Hospital

Redeployed to ICU. At the beginning of deployment the teenagers stayed with their father while I was at work. He then had to isolate with COVID symptoms so for the last few weeks they have been alone at home while I have been at work. They have done me proud by competing homework and making their own meals. They have handled this amongst their other challenges.

Radiographer Pilgrim Hospital

Last June our home was heavily damaged during the Wainfleet flood, we still continue to live elsewhere while we repair our home. Our 7 year old lost all of his toys and experienced a situation that none of us would like our children to experience and now this year he has had this to contend with. For a 7 year old he is incredibly grown up and myself and his Dad are immensely proud of his strength, resilience, sense of humour and continued care for others.

Sister Grantham and District Hospital

Children moved out to two different houses to live with family/ friends to keep them safe. Lives have been totally disrupted and wonderfully proud of how they have coped.

HCSW Pilgrim Hospital Boston

My 6 year old has moved out of the family home as she's severely asthmatic and has moved in with her grandparents to minimise contact with as many people as possible, she has been there since lockdown started and is yet to see me in person. She's been there for 2 and a bit months now and is doing remarkably considering the circumstances.

Site Manager Lincoln County Hospital

I would love it if you could include in the letter recognition of my daughters will power to stick to the rules therefore ‘protecting’ me & her sister in ED, from having to move out from home in the early days of uncertainty , her worries that we may become seriously ill from working with patients but trying to hide her worry from us, all the missed kisses & hugs when we thought we may be symptomatic so kept away from her and also missing the love of her life……football!!!

Nurse Specialist Pilgrim Hospital

They have been in school everyday since lockdown and although they’ve found it tough and unfair as their friends have all been at home and they had to be at school they accept that mummy has had to work.

They’ve been really scared I would die as they lost their father a few years ago so it’s just me looking after them.

Assessment against the NHS Employers Guidance Appendix C

Managing Risks To The Workforce

PHE has published guidance on testing and personal protective equipment and this should be followed as part of the design of infection prevention and control compliant safe systems of work	ULHT PPE guidance has been regularly updated, as the guidance we have received has changed. We have had clear policies on testing staff, reflecting national guidance and our views on how to keep patients and staff safe. We have agreed a new testing regime that will support green sites and pathways.
Reflect on the intelligence available regarding their organisation. This would include data on absence due to COVID-19, any worker deaths due to COVID-19, staff survey data, WRES and WDES data, and any pulse survey data	A daily workforce report was prepared and published on teams giving summary data for areas such as absence and testing. Examples of action taken in response to available data are: 1). The Trust has responded to national intelligence, for example in relation to the risk to BAME groups and acted to assess the particular risk to that group. 2). Testing data was used to identify clusters and when this occurred (6A at Pilgrim, for example) a specific investigation was undertaken and action to encourage and enforce social distancing taken. 3). A significant increase in the proportion of staff absent owing to stress was noticed (100% increase) and follow up action taken to contact those individuals to offer support.
Consult with staff networks and trade unions regarding the approach to be taken to risk assessment and agreeing how a continued dialogue can be maintained	Weekly meetings held with all members of EPF. Daily meetings between COVID Gold and staffside secretary. Workplace risk assessment process agreed jointly between health and safety and staffside. Re-ignited the BAME Staff Network and appointed a new Chair and Vice-Chair who are bringing energy and enthusiasm to this and reaching out to colleagues through a variety of media. Mark Brassington acts as the Exec Sponsor for this Network.
Communicate to all workers, whatever their professional background or work area, describing the approach being taken to risk	Regular communication with staff through daily SBAR regarding the risk assessment process. We quickly established a specific email address

assessment, reassuring them as to the nature of the assessment being undertaken and the support available to them. The organisation's policy regarding confidentiality should be clearly stated (and complied with).	(COVID- HRenquiries@ulh.nhs.uk) where any concerns regarding staff risks were directed. We wrote to 1100 staff who are recorded as associating with BAME groups regarding the management of the additional risks associated with that group. All staff engaged in the risk assessment or testing process are advised of the OH approach to managing the confidentiality of data.
Share the agreed local risk assessment tool or guidance with all team members to help them identify whether they are in an at-risk group	The risk assessment tool relating to social distancing in the workplace has been widely shared to ensure staff understand the options available and steps to be taken to keep staff safe.
Explain the need for staff to discuss with their manager any concerns as a result of the risk assessment guide or any concern or anxiety they might have (and offer them alternative routes of support prior to these discussions).	OH work with line managers to ensure the outcomes of risk assessments are understood and appropriate adjustments made as a consequence. Connections were made with the well-being services available and the well-being group itself to ensure concerns and anxieties were addressed.
Agree alternative routes through which individuals might raise concerns or flag the need for a risk assessment discussion	Outside of OH and our well-being services, we did not promote alternative means to raise concerns.
Review and repeat risk assessments as necessary in line with individual circumstances, emerging evidence, and/or national guidance	We are now on version 16 of the risk assessment documentation, reflecting the need to regularly update it as PHE guidance changes. Initial risk assessments are being reviewed in light of those changes to PHE guidance and changes to the adaptations that can be made to working environments to enable staff to return to site-working if appropriate e.g. green pathways
Provide guidance to those managing services regarding the follow-up conversations about risk with their team members, including the potential responses to protect or support staff.	As part of the process of reviewing risk assessments, managers are having scenario-based training on how to have follow-up conversations with staff. Q and As have also been produced to assist managers.

Support & Advice

Trade union colleagues and local partnership forums are an invaluable source	Weekly meetings are help with staffside and TUs

of support to the organisation and their expertise and insights should be used in constructing local approaches to risk assessment.	Staff side Chair has been a regular and key member of the Staff Wellbeing Group which meets weekly to identify wellbeing issues and escalates issues where necessary to the Director of People and OD.
Other networks such as those for black and minority ethnic (BME) or disabled staff will also be an important area of support and insight to organisations	The BAME network has met on a number of occasions and their insight and views were used to shape the response to concerns about the impact of COVID on people who associate with BAME. Other networks have not been as proactive – *just need to check if other meetings held?*
Occupational health teams, chaplains, and freedom to speak up guardians are invaluable sources of advice and insight	The Trust has had a staff well-being group meeting weekly to gather insight into the concerns of staff. They have helped shape the well-being offer, which is updated and published bi-weekly (was weekly). Now focused on well-being through the Restoration and Recovery phases. A ULHT Wellbeing Twitter account was established to publicise sources of support alongside the usual communications channels. ULHT Chaplains regularly use ULHT Together FB page to promote their role in staff wellbeing.
Advisory functions (where available) including HR, infection prevention and control, health and safety, and governance	Specific HR and staff wellbeing enquiry lines established early on as part of the COVID response.

Support To Managers

Organisations working together in the south east have prepared two helpful resources which may assist those managing services and team members to have the purposeful and supportive conversations recommended by this guidance: ***Wellbeing coaching questions - for managers*** ***121 wellbeing check-in template - for staff***	These documents have been used by the HRBPs as part of the Managers' toolkit for Project Green. These documents will be issued to all managers in the next 2 weeks. The staff wellbeing booklet has regularly included guidance for managers on leadership through this period and how to support staff wellbeing.

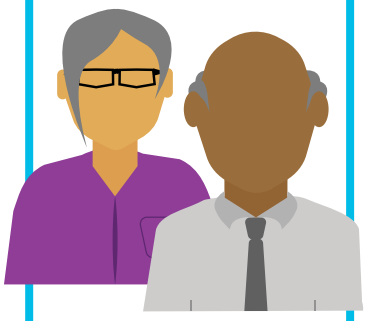
COVID-19 RISK REDUCTION FRAMEWORK FOR HEALTHCARE WORKERS

Employers to assess health safety and welfare of employees including:

1. Workplace assessment
2. Workforce assessment
3. Individual assessment

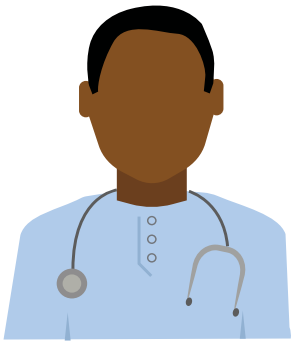
Age and ethnicity:

- BME ethnicity aged above 55, particularly in those with comorbidities
- white european ethnicity aged over 60



Sex:

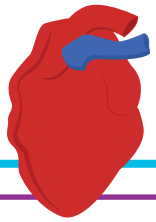
Males at higher risk



Underlying health conditions including:

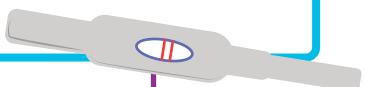
Clinical vulnerable groups including:

- hypertension
- cardiovascular disease (CVD)
- diabetes mellitus (DM)
- chronic kidney disease (CKD)
- chronic obstructive pulmonary disease (COPD)



Pregnancy:

- All pregnant women should have a risk assessment.
- Women > 28 weeks pregnant or have underlying condition should be recommended to stay at home.
- Women < 28 weeks pregnant should only work in patient facing roles where risk assessment supports this.



Employers to discuss implications and to take appropriate measures to mitigate risk of COVID-19 infection risk to NHS staff.

A. Risk reduction framework needs to be used in conjunction with NHS Employers' guidance.

B. Employers need to take into consideration health care settings such as primary or community care, hospital settings or environments where aerosol generating procedures are performed.

Source: Risk reduction framework for NHS staff at risk of COVID-19 infection, Faculty of Occupational Medicine

OUTSTANDING CARE
personally DELIVERED

NHS
United Lincolnshire Hospitals
NHS Trust

Protecting and supporting our Black, Asian and Minority Ethnic (BAME) colleagues through COVID -19 – 29.06.2020

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

Introduction

NHS
United Lincolnshire Hospitals
NHS Trust

It is becoming evident that COVID-19 is shining a very bright light on inequalities and discrimination which were already there and have been for a very long time. It is also highlighting the crucial importance for organisations to refocus with increased commitment and pace to the wider equality, diversity and inclusion agenda.

In recent weeks and months an increasing amount of research and recommendations within this field has been produced and we are seeking to implement and integrate these recommendations, to ensure patients, service users and staff are cared for, protected and supported especially through these challenging times.

This update seeks to provide the Trust Board with a current position with regards to our understanding of impact upon our BAME colleagues during our initial response to COVID-19.

We have planned a Trust Board Development session on the 21st July where we will discuss in more detail;

- an overview of the position at United Lincolnshire Hospitals NHS Trust, particularly in relation to Black, Asian and Minority Ethnic people, but also other vulnerable groups.
- highlight some of important work we are undertaking, particularly in relation to our BAME staff and our staff networks receiving the BAME Networks action plan.
- the new and emerging research and recommendations with the wider equality, diversity and inclusion work of the organisation
- agree a number of specific board related actions to support and strengthen this crucial work.

ULHT Context

NHS
United Lincolnshire Hospitals
NHS Trust

NHS United Lincolnshire Hospitals NHS Trust

One team, many nationalities

British	8044	Malaysian	46
Bulgarian	12	Nigerian	47
Egyptian	29	Pakistani	74
Filipino	50	Polish	111
Greek	11	Portuguese	29
Indian	173	Romanian	31
Irish	43	Spanish	24
Italian	32	Sri Lankan	15
Latvian	13	Sudanese	22
Lithuanian	32	Rest of the world	175

These figures count staff and bank staff from across ULHT and are from the Trust ESR as of January 2020. Nationalities where we have fewer than 11 members of staff are classed as 'rest of the world'. These nationalities were from all around the world.

- In 2011 census 2.4% of Lincolnshire population BAME
- In our WRES submission 2019 11.56% of our staff declared as BAME
- Proportion of BAME staff in ULHT higher in clinical roles
- WRES Indicators 1-4 (process measures) improving [seniority of positions held, recruitment, formal disciplinary processes and access to training and development]
- WRES Indicators 5-8 (cultural measures) deteriorating [staff's self-reported experience in relation to bullying and harassment, discrimination and equality of opportunity]

Response to COVID

NHS
United Lincolnshire Hospitals
NHS Trust

Since the arrival of COVID-19, we have implemented a number of important measures to actively protect and support our BAME colleagues.

- Individual letter of support to every BAME member of staff
- Individual Risk Assessment of all BAME staff
- Communication regarding PPE
- Increased offer of testing for BAME staff
- Increased frequency of BAME support meetings and utilisation of MS Teams
- Implementation of a Lincolnshire NHS Provider Rapid Equality Assessment tool, including high level data analysis relating to BAME people
- NHS Lincolnshire CEOs and Chairs Black Lives Matter Statement

Staff Testing - Update

NHS
United Lincolnshire Hospitals
NHS Trust

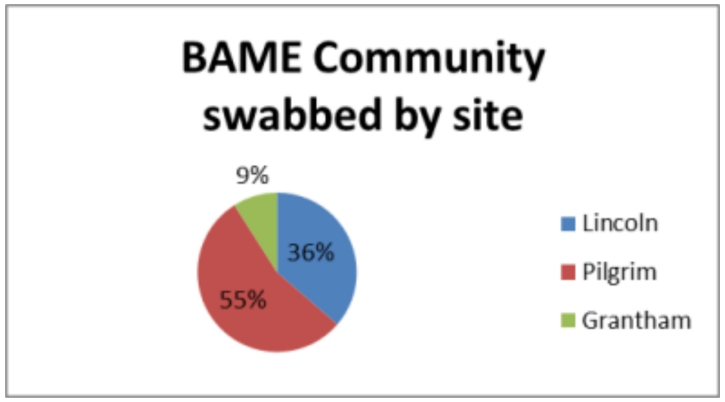
13.23% (260) of staff tested reporting as positive up to 29th June

[25th May - 13.68% (249)]

N.B this includes pillar 1 testing and any pillar 2 testing when staff inform us of their result

Of which;

- 8% of BAME staff tested are reported as positive [25th May - 8.8%]



50% of BAME staff swabbed / 17.5% of Non-BAME staff swabbed

BAME Risk Assessment - Update

United Lincolnshire Hospitals NHS Trust

73.3% completed (792 returns) - [May 25th - 52.75% completed]

22% nil required

15% required detailed risk assessment

30% required detailed risk assessment and requested swabbing

33% requested swabbing

Outcome

6% Changed role

6% Shielding continued

46% Modified role

42% Continue as normal

BAME Risk Assessment – Next Steps

NHS
United Lincolnshire Hospitals
NHS Trust

- Each Division has dedicated leads to ensure risk assessments completed by 10th July
- Daily position provided to the divisions

Role	Total employees per staff group	CSS	Family Health	Medicine	Surgery	Corporate	Estates and Facilities	Total nil responses per staff group	% per staff group
Clinicians	615	1	17	63	66	11	0	158	25.7
Nursing	183	0	3	15	9	19	0	46	25.1
Housekeepers/Porters	28	0	0	0	0	1	7	8	28.5
Admin	46	5	1	1	2	7	1	17	36.9
Additional Clinical Support	218	14	0	13	4	23	0	54	24.77
Total nil responses per division		**20**	**21**	**92**	**81**	**61**	**8**		

- DoN, MD and COO providing professional oversight

Trust Board asked to Note;

- Progress made to date against our enhanced testing offer and risk assessments for BAME colleagues

- Planned board development session on 21st July where more detailed information will be shared on our inclusion work, with a BAME focus and associated plans including specific asks of the Trust Board

Meeting	*Public Trust Board*
Date of Meeting	*7 July 2020*
Item Number	*Item 9.3*
Freedom to Speak Up - Update	
Accountable Director	*Chief Executive*
Presented by	*Jayne Warner* *Freedom to Speak Up Guardian*
Author(s)	*Jayne Warner* *Freedom to Speak Up Guardian*
Report previously considered at	*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	
1c Improve clinical outcomes	
2a A modern and progressive workforce	
2b Making ULHT the best place to work	*X*
2c Well Led Services	*X*
3a A modern, clean and fit for purpose environment	
3b Efficient use of resources	
3c Enhanced data and digital capability	
4a Establish new evidence based models of care	
4b Advancing professional practice with partners	
4c To become a university hospitals teaching trust	

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

Recommendations/ Decision Required	• *The Trust Board are asked to note the planned review and refresh of speaking up arrangements in the Trust.*

Executive Summary

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

In 2019 the National Guardian's office published a Freedom to Speak Up Index report bringing together staff survey questions indicative of culture and ratings of the CQC. The index enabled Trusts to see how their FTSU culture compared to others. A positive speaking up culture is associated with high performing organisations, as rated by the CQC.

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

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

The Board had identified speaking up and the guardian of safe working roles as specific areas of focus within year one of the Integrated Improvement Plan for the Trust and a project initiation document had been developed. In early 2020 the Trust had appointed Trust FTSU Champions to support better publicising with staff the role of the Guardian and greater awareness as well as providing further options for staff in who they could approach when they wanted to speak up. Covid 19 has meant that some of the planned activities for the Champions have had to be curtailed. As lockdown is eased this work will be re-established.

To further develop and strengthen arrangements the Trust will review and refresh the current arrangements using the Trust Board Self assessment tool. The Executive Leadership Team has agreed that as part of this review it is the intention moving forward to create a stand alone post of FTSU Guardian and to move away from this forming part of the role for the Trust Secretary to allow for the appropriate focus on both Corporate Governance and Speaking Up in the organisation.

Meeting	*Trust Board*
Date of Meeting	*7th July 2020*
Item Number	
Finance Report	
Accountable Director	*Paul Matthew, Director of Finance and Digital*
Presented by	*Paul Matthew, Director of Finance and Digital*
Author(s)	*Finance Team*
Report previously considered at	*N/A*

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

Risk Assessment	*4386, 4385 4384, 4383, 4382*
Financial Impact Assessment	*N/A*
Quality Impact Assessment	*N/A*
Equality Impact Assessment	*N/A*
Assurance Level Assessment	• *Limited*

Recommendations/ Decision Required	• *Note contents of the report*

Executive Summary

To update the Board on the key Financial Performance issues at Month 2 including; Revenue, capital and cash.

- **The revenue position at month 2 including the impact of Covid-19.**

The reported Month 2 financial position is a breakeven I&E position against plan and actual as per the interim national financial framework and funding.

The year to date position is breakeven inclusive of an accrual for £0.7m of additional top-up funding relating to May

The Month 2 financial position includes £5.8m of additional costs in relation to Covid, but no Covid income to offset those costs. The Month 2 financial position also includes no Covid income to offset any loss of other operating income as a result of Covid; £0.6m of income has been lost Estates and Facilities in relation to car parking and catering.

- **CIP position at month 2**.

The draft financial plan for 2020/21 included a CIP savings target of £27.0m. However, when operational planning was suspended and Payment by Results replaced by a block payment funding approach, the block payment calculation deliberately excluded the planned tariff efficiency factor.

While actual CIP delivery is not reported for Month 2, it is noted that the non-recurrent maternity incentive payment the Trust earned in 2019/20 has been automatically applied for 2020/21, such that the planned non-recurrent CNST saving of £634,692 is delivered

- **The capital position at month 2 including the impact of Covid-19.**

Capital expenditure of £1.1m has been incurred as at May 2020 including £300k of Covid costs

- **The cash position at month 2 including the impact of COVID-19 and block payment arrangements.**

The increased cash balance – now £72.9m (April £63.6m). This resulting from the interim 'Covid' cash measures put into place by DHSC for the period April – October 2020.

The overall value and volume of invoices unpaid has reduced from January pre-Covid levels of £20.8m / 8961 to £9.4m / 2724 at 31 May 2020. This is in response to the DHSC instruction to make payment of invoices wherever possible within 5 days of receipt

- **The high level April – July forecast requested by NHSE/I**

Trusts have been asked to complete a forecast Income and Expenditure forecast to the end of July 2020; this forecast will inform NHSE/I about the Trusts' requirement for additional top-up funding.

  - A break-even position is forecast to the end of July.
  - The forecast assumes that over the period the Trust will have additional expenditure in relation to Covid of £11.3m:
  - To deliver an overall break-even position the forecast assumes the Trust will require £3.4m of additional top-up funding for the period to the end of July:
  - It is noted that the requirement for additional top-up funding of £3.4m needs to be considered in the following context: the Trust will have lost c1.2m of income in relation to catering and car parking as a result of Covid-19 and incurred c£11.3m of additional costs in relation to Covid-19.

1. Month 2 Financial Position

1.1 Introduction

1.1.1 The Trust submitted a draft financial plan for 2020/21 (excluding PSF) of a deficit of £78.0m. Whilst the Trust did not accept its control total deficit of £56m in the draft plan submission, delivery of the financial plan for 2020/21 would have facilitated the Trust accessing £5.1m of FRF funding resulting in a planned deficit of £72.9m.

1.1.2 While a final plan submission was timetabled in April 2020, the national operational planning process has been suspended as a result of Covid pandemic, and the final plan submission has been deferred.

1.1.3 Payment by Results (PbR) has been temporarily suspended and replaced with Block payments, which are then augmented by a national top-up payment where Trusts' actual cost base is higher than the income guaranteed under Block payments. Providers are also to claim for additional costs where the block payments do not equal actual costs to reflect genuine and reasonable additional marginal costs due to COVID-19. All Trusts are required to make a Covid-19 submission on a monthly basis as part of regular monthly financial reporting. This is intended to provide Trusts with sufficient funding to deliver a break-even position.

1.2 Financial Position at Month 2

	Current Month May 2020			Year to Date April 2020 to May 2020		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
Operating income from patient care activities	36,737	37,619	882	73,474	75,390	1,916
Other operating income	11,261	11,444	183	22,522	22,254	-268
Employee expenses	-30,849	-34,011	-3,162	-61,698	-67,086	-5,388
Operating expenses excluding employee expenses	-16,545	-14,524	2,021	-33,090	-29,501	3,589
OPERATING SURPLUS / (DEFICIT)	**604**	**527**	**-77**	**1,208**	**1,058**	**-150**
NET FINANCE COSTS	-605	-559	46	-1,210	-1,095	115
Other gains/(losses) including disposal of assets	0	0	0	0	0	0
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	**-1**	**-31**	**-30**	**-2**	**-37**	**-35**
Remove capital donations/grants I&E impact	0	18	18	0	37	37
Adjusted financial performance surplus/(deficit) incl Top-Up	**-1**	**-13**	**-12**	**-2**	**0**	**2**

1.2.1 Payment by Results has been temporarily suspended from the start of 2020/21 and replaced with a Block payment, which is then augmented by a national top-up payment where a Trusts' actual cost base is higher than the income received as a Block payment.

1.2.2 The Month 2 financial position includes a block payment in relation to Patient Care Activities of £36m for April and £36m for May, and a top-up payment of £8.3m for April and £8.3m for May.

1.2.3 Providers are also to claim for additional costs where the block payments do not equal actual costs to reflect genuine and reasonable additional marginal costs due to Covid; all Trusts are required to make a Covid submission on a monthly basis as part of regular monthly financial reporting. This is intended to provide Trusts with sufficient funding to deliver a break-even position.

1.2.4 The Month 2 financial position includes £5.8m of additional costs in relation to Covid, but no Covid income to offset those costs. The Month 2 financial position also includes no Covid income to offset any loss of other operating income as a result of Covid; £0.6m of income has been lost Estates and Facilities in relation to car parking and catering.

1.2.5 The reported Month 2 financial position is a breakeven I&E position against plan and actual as per the interim national financial framework and funding.

1.2.6 The year to date position is breakeven inclusive of an accrual for £0.7m of additional top-up funding relating to May.

1.3 Key headlines

Operating Income from Patient Care Activities

1.3.1 Operating Income from Patient Care Activities includes a block payment of £36m in April and £36m in May in relation to Patient Care Activities. Shadow monitoring of activity on a Payments by Results basis determined that actual activity of £21.1m was delivered in April and activity of £25.5m was delivered in May, such that actual activity delivered year to date is £25.4m lower than the block income the Trust received. However, the draft plan didn't fully account for system intentions, and these would potentially have reduced the shortfall in the patient care related activity income position. The system intentions, though, would have necessitated the need for the Trust to withdraw costs to offset the income loss, and it may have proved difficult for the Trust to have pulled out sufficient costs to fully offset the loss of income.

1.3.2 **Appendix 1** highlights key POD activity levels from 1/4/2019 to 31/05/2020.

1.3.3 While overall Activity continues to be below both plan and trend, the following key movements are noted:

- A&E activity increased in May to c9,000 attendances from c6,000 in April [compared to an average of c12,000 attendances per month in 2019/20.
- Non-elective activity is starting to increase.
- Daycase and Elective activity remains at reduced levels.
- Outpatient activity remains materially under both plan and trend; there is, though, a slight increase in face-to-face firsts and non-face-to-face follow up activity.
- Most areas of non-PbR activity are under-performing and screening activity has still not resumed.
- Pass-through activity is also under plan which will also be reflected in expenditure.

1.3.4 The majority of the remaining Income from Patient Care Activities relates to income from Road Traffic Accidents, Overseas Visitors, Private Patients, Hospice in the Hospital, Community Dietetics, and notional income from NHS England in relation to additional employers pension contributions - the notional income for the latter is offset by notional expenditure in relation to additional employers pension contributions.

1.3.5 Operating Income from Patient Care Activities year to date is higher than planned because the block payment did not take into account the £2.6m notional income from NHS England in relation to additional employers pension contributions – nor did it take into account the offsetting expenditure in Pay.

Other Operating Income

1.3.6 Other Operating Income includes top-up funding as per the block of £8.3m for April and £8.3m for May. It also includes an accrual for a further top-up of £0.7m in May to enable the Trust to deliver a break even position in May.

1.3.7 Other than the top-up funding and the income for Education and Training, the balance of Other Operating Income is not guaranteed.

1.3.8 As a result of Covid-19, the Trust's income in relation to Car Parking and Catering has fallen by £0.6m in comparison to normal 2019/20 levels.

Expenditure

1.3.9 The Trust has been required to complete Covid-19 revenue cost reporting as part of regular monthly financial reporting.

1.3.10 Within the overall expenditure position, costs of £5.8m have been identified in relation to Covid-19, including £3.0m of additional Pay costs and £2.8m of additional Non-Pay costs.

1.3.11 These additional costs are largely absorbed in the overall position by the reduction in marginal costs associated with lower activity levels.

1.3.12 The reduction in marginal costs as a result of lower activity levels is primarily manifests within Non-Pay and the reduction in marginal costs is in line with the impact expected by the finance team when modelling the reduction in activity.

Pay

1.3.13 The Month 2 Pay position is £5.4m adverse to plan including £3.0m of additional Pay costs in relation to Covid. Excluding the additional Pay costs in relation to Covid, Pay is £2.4m adverse to plan, including £2.6m of notional expenditure in relation to additional employers pension contributions which was not taken into account when NHS England did not take into account when setting the Block payment.

1.3.14 The Month 2 Pay position includes:

- The actual cost of the 2020/21 pay award for A4C staff
- The actual cost of the 2020/21 pay award for training doctors
- Central provision for a 2% pay award in 2020/21 for Middle Grades and Consultants
- Central provision for the 2020/21 local CEA – based upon 2/12th of estimated pot for 2020/21 – as well as provision for payment of the balance of the 2019/20 local CEA.

1.3.15 Agency expenditure of £44.1m in 2019/20 was £23.1m greater than the Trust's agency ceiling of £21.0m. However, as a result of measures taken, Agency expenditure fell from an average of £3.8m per month in the first three quarters of 2019/20 to £3.1m per month

in January and in February. However, while agency expenditure rose in March to £3.5m as a result of Covid-19, it fell back to £3.1m in April and rose only marginally in May to £3.2m. The £0.1m increase in May can be attributed to an increase in Nursing Agency; an increase in nursing agency might be expected as the number of occupied beds has increased during May.

1.3.16 Inclusive of expenditure in relation to Covid-19, agency expenditure year to date of £6.3m would extrapolate on a straight line basis to an outturn of £37.7m; £6.4m lower than expenditure of £44.1m in 2019/20, but £16.7m higher than the Trust's agency celling of £21.0m for 2020/21.

1.3.17 Bank expenditure in 2019/20 averaged £2.1m per month throughout most of 2019/20. However, while bank expenditure rose in March to nearly £2.6m, it fell back to £2.2m in April. Bank expenditure rose to £2.4m in May. However, accruals in May have been increased to reflect a proposal to MNSF which sees medical extra duty rates uplifted during Covid-19. The impact of this agreement being applied to shifts worked since the start of the pandemic in March has added £250k to the year to date position, of which £71k relates to March, £96k relates to April and £83k relates to May.

1.3.18 Inclusive of expenditure in relation to Covid-19, bank expenditure year to date of £4.6m would extrapolation a straight line basis to an outturn of £27.6m; £2.3m higher than expenditure of £25.3m in 2019/20.

1.3.19 Allowing for the rate change in extra duty, the total expenditure on Bank and Agency expenditure in April and May has remained largely flat at c£5.4m per month, which represents no overall change relative to total Bank & Agency expenditure of c£5.3m in January and February i.e. pre-Covid-19.

1.3.20 See **Appendix 2** for Agency & Bank expenditure charts. These chart the trend in overall expenditure over the last 14 months, with expenditure summarised into three staff categories: Medical, Nursing and Midwifery and Other.

1.3.21 The Agency chart shows that in all three categories we have seen a downward trend in expenditure over the period, but the overall split is not greatly changed: Medical agency expenditure continues to account for c66% of overall agency expenditure, Nursing and Midwifery for c24% and Other for c10%.

1.3.22 Conversely, the Bank chart shows that in all three categories have seen an upward trend in expenditure over the period, but again the overall split is not greatly changed: Medical

bank expenditure continues to account for c50% of overall bank expenditure, Nursing & Midwifery for c40% and Other for c10%

1.3.23 However, while overall expenditure on Bank and Agency staffing has remained flat, £2.2m of expenditure to date in 2020/21 has been categorised as additional expenditure in relation to Covid-19. A further £0.8m of substantive pay (i.e. overtime) has also been categorised as additional expenditure in relation to Covid-19.

Non Pay

1.3.24 While Non-Pay in relation to patient activity remains low in Month 2, this has been offset by additional costs in relation to Covid-19.

1.3.25 A large proportion of the additional Non-Pay cost in relation to Covid-19 is non-recurrent in nature e.g. expenditure on additional beds/mattresses and non-clinical equipment for additional areas opened in preparation for surge.

1.3.26 Some of the costs, though, are likely to continue and even increase as we restore services e.g. PPE, cleaning costs etc.

1.3.27 As the Trust begins to restore services, resulting in increased patient activity volumes, our Non-Pay costs will increase e.g. our use of MSSE, blood, pathology, drugs, prosthesis etc. will increase.

1.3.28 Inevitably, as a result of the pandemic, the price of some of our consumables will have been affected.

1.3.29 Work in Procurement/Finance is underway to identify any material inflationary pressures in order to enable the Trust to both understand the extent of these pressures from a budgetary perspective and to determine if any mitigating action can be taken.

1.4. Divisional budget positions

1.4.1. Whilst operational planning has been suspended and providers are currently being funded to break-even, it remains important that the Trust understands where it is against its original plans and continues to build budgetary control as a discipline within the Trust.

1.4.2. The 2020/21 opening expenditure budget for Divisions and Directorates is based on the Full Year Effect (FYE) of the 2019/20 budget uplifted to 2020/21 prices for pay and

material non-pay items such as CNST. A central Non-Pay reserve has been established to capture other Non-Pay inflation increases. Non Pay inflation funding will be allocated subject to Director of Finance approval once we have greater clarity regards inflationary impacts.

1.4.3. The 2020/21 Patient Care Contract Model is primarily based on the demand signed off by the divisions. It is acknowledged that this will not in many cases be the level of activity being delivered in the initial months of the financial year. However, it is imperative that we have an income plan against which to fund expenditure budgets, an activity baseline to monitor activity against, the ability to quantify the impact and opportunities due to Covid, and detail to underpin future contract negotiations. It is acknowledged, though, that the current activity plan excludes the impact of any system intentions as this work was not fully mature when negotiations paused to factor into the current activity model for 2020/21. It is anticipated that the system activity modelling work will be restarted in due course and that these ambitions will in some cases overlap with the activity changes enacted at pace in the Trust due to Covid.

1.4.4. While activity growth/contraction from an agreed base case will be funded/removed from expenditure budgets on a marginal rate basis (as previously agreed), this has not been possible for Month 2. It remains the intention, though, to undertake this work when a contract with commissioning partners is agreed.

1.4.5. As per agreed budget setting principles for 2020/21, the premium cost of Agency Staff in relation to medical staffing vacancies and registered ward nursing vacancies is not funded. Nor has a Vacancy Factor been applied to Pay budgets to reflect the fact that the Trust does not fill all of its posts all of the time. This is in part listening to the Divisions and accounting for their views in the construct of their budget envelopes. A review of the funded establishment for the Urgent and Emergency Care Clinical Business Unit within Medicine is being undertaken and the staffing establishment will be amended once this has been approved.

1.4.6. Investment Reserves included as part of the financial plan for 2020/21 were reviewed in May by the Executive Leadership Team, and following this meeting a number of reserve issues have been made as part of Month 2 financial closedown. These reserve issues include recurrent funding in relation to business cases previously agreed but not transacted through budgets, as well as non-recurrent funding for other workstreams such as the on-going work in relation to ‘Operational Excellence’.

1.4.7. The planned 2020/21 CIP targets have not been allocated to Divisional and Directorate expenditure budgets; indeed, CIP targets will only be allocated when clarity has been provided in respect of the 2020/21 national NHS financial regime and the impact of this on the Trust's financial trajectory.

1.4.8. The draft financial plan expected a deficit of £14m by the end of Month 2. Noting how the budget allocated to each Division has been set (as per above), budgetary performance in comparison to the draft plan is summarised by the following table:

Division	Year to Date at Month 2		
	Budget £k	Actual £k	Variance £k
Operational Divisions			
Clinical Support Services	-21,636	-19,571	2,065
Family Health	-9,117	-8,878	239
Medicine	-19,548	-19,711	-162
Surgery	-20,378	-17,575	2,803
Director Of Estates & Facilities	-5,810	-6,610	-800
Sub-Total - Operational Divisions	**-76,489**	**-72,346**	**4,143**
Sub-Total - Corporate	**-10,783**	**-10,315**	**468**
Sub-Total - Corporate Finance	**73,291**	**82,661**	**9,370**
Trust Total	**-13,981**	**0**	**13,981**

1.4.9. The above table shows the direct income and expenditure budget positions for each Division (without any CIP target allocations as stated above). It is noted that contract NHS patient care income targets and income actuals are not allocated to Division in the table above; the actual income position, though, reflects a block payment rather than actual activity on a Payments By Results basis. If we allocated the contract NHS patient care income targets and actuals on a Payments By Result basis, all four of the Clinical Divisions would report an adverse budgetary position, such is the impact of Covid upon activity volumes.

1.4.10. It is further noted that the identified additional costs of Covid have been removed from Divisional budgets, such that they show their direct budget positions net of the cost of Covid. The one exception to this is Estates & Facilities, where the loss of income in relation to car parking and catering is manifest, but if we exclude the income loss of

£0.6m to date as a result of our response to Covid, Estates and Facilities still report a deficit of £0.2m.

1.4.11. See **Appendix 3** for the Divisional breakdown by Type with NHS patient care income targets and income actuals allocated to Division. It is noted that this is based upon internal budgets, which are aligned to the draft financial plan; as per the draft financial plan, divisional budgets sum to a deficit of £14m in Month 2. The balance of the block payment for Patient Care Activities and the top up payment are held centrally within Corporate Finance.

1.5. Cost Improvement Programme (CIP) and Financial Recovery

1.5.1. The draft financial plan for 2020/21 included a CIP savings target of £27.0m. However, when operational planning was suspended and Payment by Results replaced by a block payment funding approach, the block payment calculation deliberately excluded the planned tariff efficiency factor. While this reflects the fact that providers ability to deliver efficiency savings is likely to have been adversely impacted by the need to deal with the pandemic, providers are nonetheless expected to continue development of their cost improvement programmes and ensure that savings delivery is maximised.

1.5.2. The Trust recognises that there are likely to be efficiency savings as a result of our response to Covid e.g. reductions in bed and mattress hire as a result of the purchase of additional beds and mattresses. The Trust also recognises that there may be efficiency savings in relation to pathway changes enacted as a result of our response to Covid, and that these need to captured and recorded. Work has commenced to ensure that we capture these and savings opportunities and both realise and quantify the full extent of these benefits. The Trust is also reviewing its original Cost Improvement Programme to determine how this has been affected by the pandemic.

1.5.3. The Trust previously agreed that each of the four clinical divisions and the Estates and Facilities Division would receive funding equivalent to a band 8A post for CIP support to replace any current / local arrangements in place. Recruitment to the posts this funds is underway to ensure we build appropriate capacity to enable the Trust to maximise savings delivery in 2020/21 - three posts have been appointed thus far and start dates for those staff are being agreed. Furthermore, Finance and the PMO are working together to refresh CIP governance and QIA processes to ensure that as we transition through the stages of the Trust response to Covid we have this in place. This process will include engagement with the Divisions.

1.5.4. While actual CIP delivery is not reported for Month 2, it is noted that the non-recurrent maternity incentive payment the Trust earned in 2019/20 has been automatically applied for 2020/21, such that the planned non-recurrent CNST saving of £634,692 is delivered. The expectation remains, though, that the Trust will ensure that the safety actions incentivised through the maternity incentive scheme are met.

1.5.5. Finally, it is noted that as part of the Cost Improvement Programme we seek to reduce our reliance upon temporary staffing (bank and agency) by reducing turnover and increasing substantive staffing numbers through recruitment activities. Focus upon this is required if savings delivery is to be maximised in 2020/21.

1.6. Forecast

1.6.1. When the decision was announced that PbR would be suspended from 1 April 2020 and replaced with block payments and top-funding allocations, provider Trusts were informed that this would initially be till the end of July 2020. As part of Month 2 financial reporting, Trusts have been asked to complete a forecast Income and Expenditure to the end of July 2020; this forecast will inform NHSE/I about the Trusts' requirement for additional top-up funding.

1.6.2. The Trust has therefore completed a high level Income and Expenditure forecast for the first four months of 2020/21 and this forecast is summarised as follows:

High level Income & Expenditure forecast - April 2020 to July 2020

Category	Actual M1	Actual M2	Forecast M3	Forecast M4	Forecast M1-4
Income					
Operating income from patient care activities	37,771	37,619	37,695	37,695	150,780
Other operating income	10,811	11,445	11,961	12,153	46,370
Income Total	**48,582**	**49,063**	**49,656**	**49,848**	**197,150**
Employee expenses					
Employee expenses Agency	-3,078	-3,201	-3,322	-3,422	-13,024
Employee expenses Bank	-2,199	-2,406	-2,356	-2,506	-9,467
Employee expenses Substantive	-27,798	-28,404	-28,397	-28,099	-112,698
Employee expenses Total	**-33,075**	**-34,011**	**-34,076**	**-34,027**	**-135,189**
Operating expenses excluding employee expenses					
Depreciation	-1,071	-1,071	-1,071	-1,071	-4,284
Other Operating expenses excluding employee expenses	-13,906	-13,454	-13,976	-14,216	-55,553
Operating expenses excluding employee expenses Total	**-14,977**	**-14,525**	**-15,047**	**-15,287**	**-59,837**
Net Finance Costs	-536	-559	-552	-552	-2,199
Net Finance Costs	**-536**	**-559**	**-552**	**-552**	**-2,199**
Other gains/(losses) including disposal of assets	0	0	0	0	1
Other gains/(losses) including disposal of assets	**0**	**0**	**0**	**0**	**1**
Surplus/(Deficit) For The Period	**-5**	**-31**	**-19**	**-18**	**-73**
Below Line Adjs	18	18	18	18	73
Adjusted financial performance Surplus/(Deficit)	**13**	**-13**	**0**	**0**	**0**

1.6.3. The key points to note in relation to the high level forecast are as follows:

- **Overall forecast**
  - A break-even position is forecast to the end of July.

- **Forecast of additional expenditure in relation to Covid**
  - The forecast assumes that over the period the Trust will have additional expenditure in relation to Covid of £11.3m:

	Actual M1	Actual M2	Forecast M3	Forecast M4	Forecast M1-4
Additional Costs of Covid	**-2,530**	**-3,239**	**-2,918**	**-2,622**	**-11,309**

  - It is noted that the above table shows that the additional costs of Covid are forecast to begin to reduce in June and July.
  - It is further noted that NHSE/I have written to Trusts to make clear they expect to see some of the additional expenditure either slow or stop as we move to the next phase of the response to the pandemic.

- **Income forecast**
  - Income is generally forecast to be flat, reflecting the block nature of the majority of our income.
  - The notable exception is the forecast in relation to top-up funding: to deliver an overall break-even position [given the forecast Pay and Non-Pay position for June and July] the forecast assumes the Trust will require £3,444k of additional top-up funding for the period to the end of July:

	Actual M1	Actual M2	Forecast M3	Forecast M4	Forecast M1-4
Additional top-up funding	0	738	1,257	1,449	3,444

  - It is noted that the requirement for additional top-up funding of £3.4m needs to be considered in the following context: the Trust will have lost c1.2m of income in relation to catering and car parking as result of Covid and incurred c£11.3m of additional costs in relation to Covid.

- **Pay forecast**
  - Pay is forecast to be flat overall at c£34m per month in June & July.
  - Although flat overall, the mix of Pay between Substantive, Bank and Agency is forecast to change.
  - Agency Pay is forecast to increase by c£100k in June and a further £100k in July driven by an assumption of increased expenditure on Nurse Agency - as bed occupancy increases, it is assumed that Nurse Agency expenditure will return to pre-Covid levels.
  - Bank Pay is forecast reduce marginally in June as a result of non-recurrent arrears in May [for an agreed increase in Medical extra duty rates applied from the start of the pandemic] being largely offset by an assumed increase of £150k in Bank Pay as a result of 'Restore'
  - A further £150k increase is forecast in Bank Pay in July; again related to 'Restore'.
  - Substantive Pay is forecast to be largely flat in June relative to May, before falling by c£300k in July as a result of reduced overtime and enhancements as the required response to Covid changes.

- **Non Pay**
  - Non Pay is generally forecast to be flat.
  - The forecast does, though, assume costs will grow by £440k in June & further £440k in July reflecting higher activity volumes as a result of the Trust having entered the 'Restore' phase of its response to Covid.
  - It is noted, though, that the forecast cost increase as a result of activity growth is a high level estimate prior to the production and costing of detailed plans, and as a result the actual cost impact may be different.
  - The increase in activity-related costs is partly offset by a forecast reduction in the additional costs of Covid of £150k in June & further £200k in July.

1.6.4. As more detailed plans for 'Restore' are developed and costed, it is expected that the high level forecast assumptions modelled within the forecast will be tested and Trust Board will be updated accordingly.

2 Capital

2.1 STP Capital update

2.1.1 As updated in M1 reporting, Lincolnshire STP received a letter from Mark Mansfield, dated 5th May, outlining a system-level capital envelope for 2020/21.

2.1.2 Following review and clarification of funding included within the Lincolnshire STP envelope offer from NHSE/I, the joint decision made across Lincolnshire was to reject the envelope offer as this detrimentally impacted delivering the key priorities within 2020/21. There was a c£3.3m 'gap' identified and ULHT would need to reduce the agreed priorities by c£1.8m to meet the offer.

2.1.3 Lincolnshire STP currently awaits the formal response to this.

2.1.4 However continued collaborative working is happening to ensure there is are clear information flows, prioritisation processes and consistent documentation for capital allocations across the three providers, whilst incorporating STP representation.

2.2 M2 ULHT Capital Position

2.2.1 Capital expenditure of £1.1m has been incurred as at May 2020 including Covid costs, and this can be summarised as follows:

- £404.5k re: Fire
- £336.4k re: Covid
- £286.1k re: Projects including LED, Medical School and Pilgrim A&E/UTC
- £27.9k re: Facilities backlog
- £26.2k re: ICT [excluding Covid]

2.2.2 The Trust has received a memorandum of understanding to confirm that it will be reimbursed in full for the remaining 2019/20 Covid capital expenditure incurred of c£1.7m (£178k was received in 19/20). Details of 2020/21 expenditure in relation to

Covid continue to be shared with NHSE/I as per revised guidelines provided and this is expected to be reimbursed.

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

Fire

Group	Description	31st May Spend £'000
Fire	Grantham	£271.7
	Pilgrim	£88.2
	Lincoln	£28.7
		£388.6

Medical Devices

Group	Description	31st May Spend £'000
Medical Devices (Non COVID-19)	No spend	
		£0.0

Projects

Group	Description	31st May Spend £'000
Projects	LED Lighting	£245.6
	Pilgrim A&E Development	£11.8
	Medical School	£10.9
	EPC Project	£5.3
	CT Installation	£4.6
	Clinic 7	£3.5
	Theatre Storage	£2.4
		£284.1

Digital

Group	Description	31st May Spend £'000
Digital (Non COVID-19)	e-HR	£12.1
	Windows 7 to Windows 10	£14.1
		£26.2

Facilities

Group	Description	31st May Spend £'000
Facilities	Water access/tanks	£27.3
	Electrical infrastructure Pilgrim/Lincoln	£0.6
		£27.9

Covid

Group	Description	31st May Spend £'000
COVID-19	Medical Device - RFID Tracking	£88.3
	Medical Device - Arctic ICU temp control	£54.0
	Estates - Pilgrim Bostonian enabling works	£52.0
	Medical Device - ED Equipment	£27.4
	Medical Device - Sherlock PICC machine	£25.1
	Digital - ICT PCs and installation	£34.3
	Medical Devices - Portacount Machine	£15.0
	Medical Device - Diagnostic ECG machines	£13.1
	Medical Devices - Fukuda Monitor	£9.7
	Medical Device - 3D Printer	£9.7
	Medical Device - Bladder Scanner	£7.8
		£336.4

3 Risks

3.1.1 The risks in relation to the financial position are summarised as follows:

- That virtual outpatient attendances are not being fully recorded; this could impact both future Trust income and service planning.
- That staff will not be able to take their annual leave and take back TOIL, and as a result will require payment for this.
- That the Trust may incur additional/premium rate costs to restore and recover services.
- That the focus upon managing Covid and planning for the restoration of services is at the expense of work on ‘plan for every post, which is required to build upon the step change seen in Medical Agency costs in the final quarter of 2019/20.
- That non pay prices have been impacted as a result of Covid and as NHS providers attempt to restore services this will manifest in higher than expected operating costs.
- That the focus upon managing Covid and planning for the restoration of services is at the expense of work to identify, develop and implement cost efficiency savings plans.

4 Balance Sheet, Cash and Borrowings

4.1 Introduction

4.1.1 The Statement of Financial Position below shows the 31 May 2020 against the 2019/20 year end position. The latter of these being the position pre-audit.

Statement of Financial Position

	31 March 2020	31 May 2020
	£000	£000
Non-current assets		
Intangible assets	4,748	4,469
Property, plant and equipment	214,685	213,907
Receivables	2,534	2,512
Total non-current assets	**221,967**	**220,888**
Current assets		
Inventories	7,037	7,168
Receivables	41,603	19,208
Non-current assets for sale and assets in disposal groups	660	150
Cash and cash equivalents	13,717	72,901
Total current assets	**63,017**	**99,427**
Current liabilities		
Trade and other payables	(50,788)	(42,599)
Borrowings	(380,376)	(380,376)
Provisions	(753)	(728)
Other liabilities	(3,671)	(45,379)
Total current liabilities	**(435,588)**	**(469,082)**
Total assets less current liabilities	**(150,604)**	**(148,767)**
Non-current liabilities		
Trade and other payables	-	-
Borrowings	(1,482)	(3,281)
Provisions	(3,831)	(3,989)
Other liabilities	(12,579)	(12,495)
Total non-current liabilities	**(17,892)**	**(19,765)**
Total assets employed	**(168,496)**	**(168,532)**
Financed by		
Public dividend capital	267,906	267,906
Revaluation reserve	26,472	26,472
Other reserves	190	190
Income and expenditure reserve	(463,064)	(463,100)
Total taxpayers' equity	**(168,496)**	**(168,532)**

4.1.2 The key points to note are:

- The increased cash balance – now £72.9m (April £63.6m). This resulting from the interim 'Covid' cash measures put into place by DHSC for the period April – October 2020.

  Under these arrangements all clinical activity has been moved to be paid via block until October 2020, with payment made a month in advance on 15th of the month. Payments relating to both April and May 2020 were received during April. Payments will remain one month in advance until the temporary 'Covid' cash measures cease and the NHS payments system returns to 'normal'.

  The monthly block value the Trust receives is c£36.0m.

  In addition, a Top Up Payment is also paid monthly to Trusts, calculated on each Trust's recent financial performance in the anticipation that this will bridge any cash shortfall from the block income payment to the forecast costs incurred. The Trust is receiving c£8.3m top up per month.
- Other liabilities have increased by £41.7m reflecting the one month block payment received in advance.
- Receivables have fallen £22.4m (April £15.2m) reflecting a reduction in accrued income as invoices have been raised relating to 2019/20 activity and subsequently paid in month. During May the final PSF / FRF payments of £8.8m from 2019/20 were received.
- Payables have fallen as the level of capital creditors / accruals have reduced by £7.9m during April and May.
- The overall value and volume of invoices unpaid has reduced from January pre-Covid levels of £20.8m / 8961 to £9.4m / 2724 at 31 May 2020. This is in response to the DHSC instruction to make payment of invoices wherever possible within 5 days of receipt.

4.2 Cash

4.2.1 The cashflow for the first two months of 2020/21 along with the pre-audit cashflow from 2019/20 is shown below.

	Full Year 2019/20	April-May 2020
	£000	£000
Cash flows from operating activities		
Operating surplus / (deficit)	(44,093)	1,058
Non-cash income and expense:		
Depreciation and amortisation	12,976	2,142
Net impairments	10,833	-
Income recognised in respect of capital donations	(75)	-
Amortisation of PFI deferred credit	(503)	(84)
(Increase) / decrease in receivables and other assets	(20,529)	22,417
(Increase) / decrease in inventories	403	(131)
Increase / (decrease) in payables and other liabilities	(719)	39,738
Increase / (decrease) in provisions	1,104	133
Net cash flows from / (used in) operating activities	**(40,603)**	**65,273**
Cash flows from investing activities		
Interest received	137	2
Purchase of intangible assets	(15)	-
Purchase of PPE and investment property	(31,092)	(8,400)
Sales of PPE and investment property	33	510
Net cash flows from / (used in) investing activities	**(30,937)**	**(7,888)**
Cash flows from financing activities		
Public dividend capital received	7,865	-
Movement on loans from DHSC	77,286	-
Movement on other loans	1,482	1,799
Interest on loans	(8,761)	-
Other interest	(1)	-
Net cash flows from / (used in) financing activities	**77,871**	**1,799**
Increase / (decrease) in cash and cash equivalents	**6,331**	**59,184**
Cash and cash equivalents at 1 April - brought forward	**7,386**	**13,717**
Cash and cash equivalents at period end	**13,717**	**72,901**

4.2.2 Capital cash provided support to the overall cash position in 2019/20, enabling the Trust to maintain payments to suppliers despite the in-year revenue deficit. During April and May this support has reduced from £11.5m to £4.3m as year-end capital creditors have been paid.

			Loans - Fire			Total						
	Dep'n	PDC	Rec'd	Repaid	Sales	resource	Capital Creditor b'f	Capital programme	Payments made	Cum Cash support to	Excess of Resource	Total cash support
Full Year 2019/20	**13.0**	**7.9**	**13.2**	**(2.3)**	**0.0**	**31.8**	10.8	**31.5**	**(31.1)**	**11.2**	**0.3**	**11.5**
April	1.1	0.0	1.8	0.0	0.5	**3.4**	10.8	0.7	(7.4)	**4.1**	**2.7**	**6.8**
May	1.1	0.0	0.0	0.0	0.0	**1.1**	4.1	0.4	(0.9)	**3.6**	**0.7**	**4.3**

4.2.3 The receivables / payables movement within the cashflow reflect the balance sheet comments at paragraph 3.1.2.

4.3 Revenue borrowing

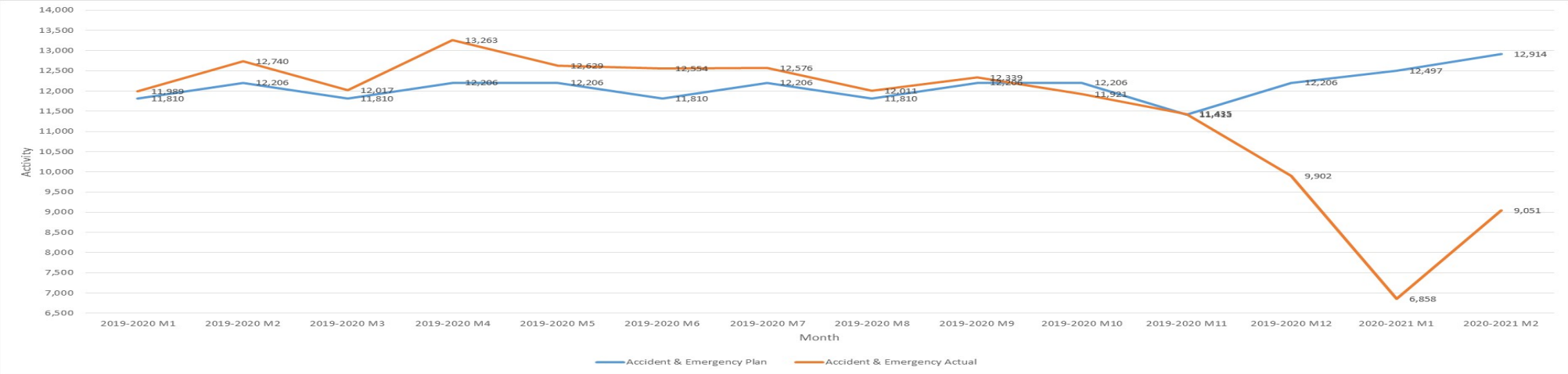
4.3.1 The level of borrowings and accrued interest have increased by £1.8m during April / May to £383.7m. This is as a result of the Trust receiving the second instalment of the Salix Energy Fund loan - £1.8m.

	31 March 2020	31 May 2020
	£000	£000
Current		
Loans from DHSC: Revenue Principle	342,338	342,338
Loans from DHSC: Capital Principle	35,521	35,521
Loans from DHSC: Interest	2,517	2,517
Other loans	-	-
Total current borrowings	**380,376**	**380,376**
Non-current		
Loans from DHSC: Revenue Principle	-	-
Loans from DHSC: Capital Principle	-	-
Other loans : Salix	1,482	3,281
Total non-current borrowings	**1,482**	**3,281**
Total Borrowings	**381,858**	**383,657**

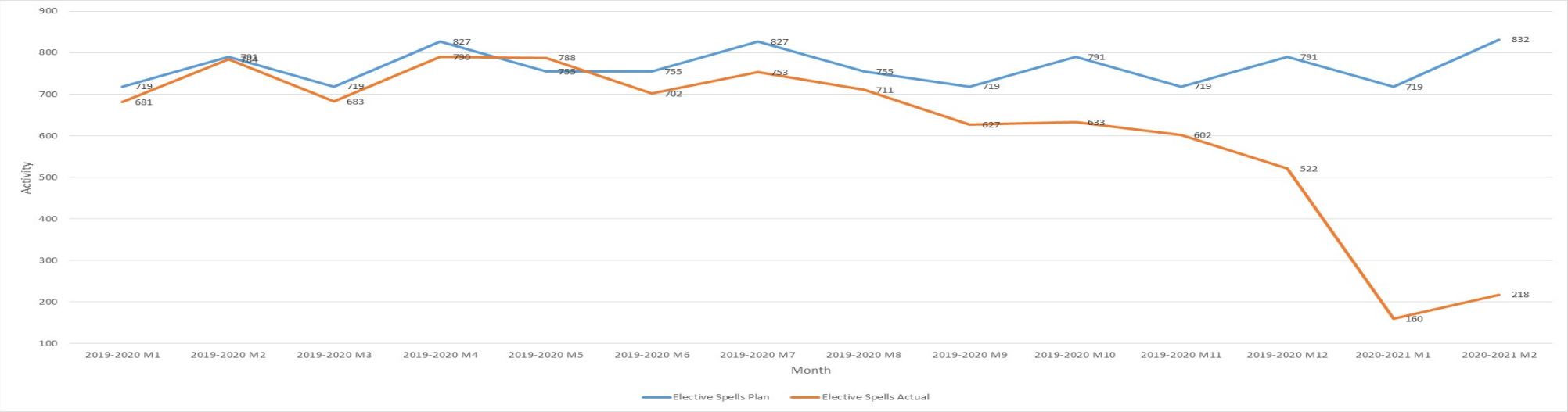
4.3.2 As outlined previously, DHSC have set out plans to repay all existing loans and convert them to PDC during the next financial year. We anticipate this to be transacted in September.

Appendix 1 – Activity Graphs

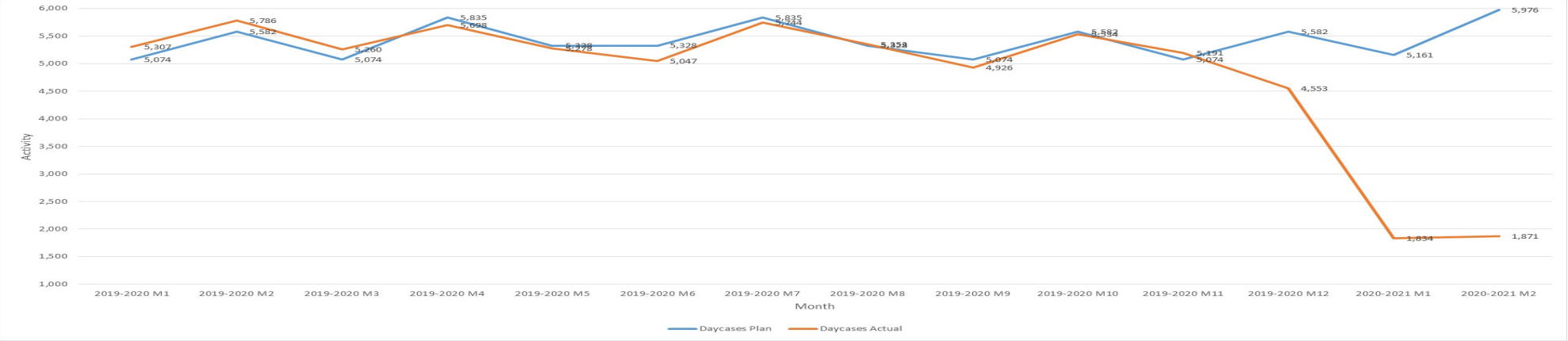
A&E – Plan v Actual - Period 1/4/19 to 31/5/20 (14 months)



Electives – Plan v Actual - Period 1/4/19 to 31/5/20 (14 months)

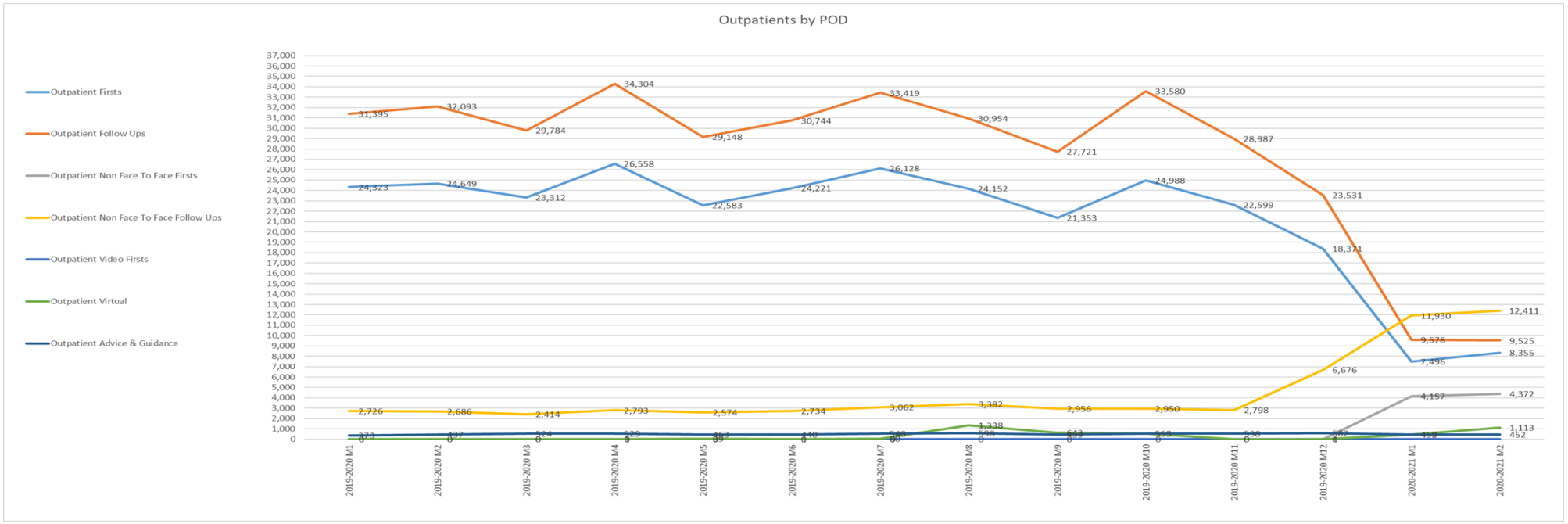


Daycases – Plan v Actual - Period 1/4/19 to 31/5/20 (14 months)



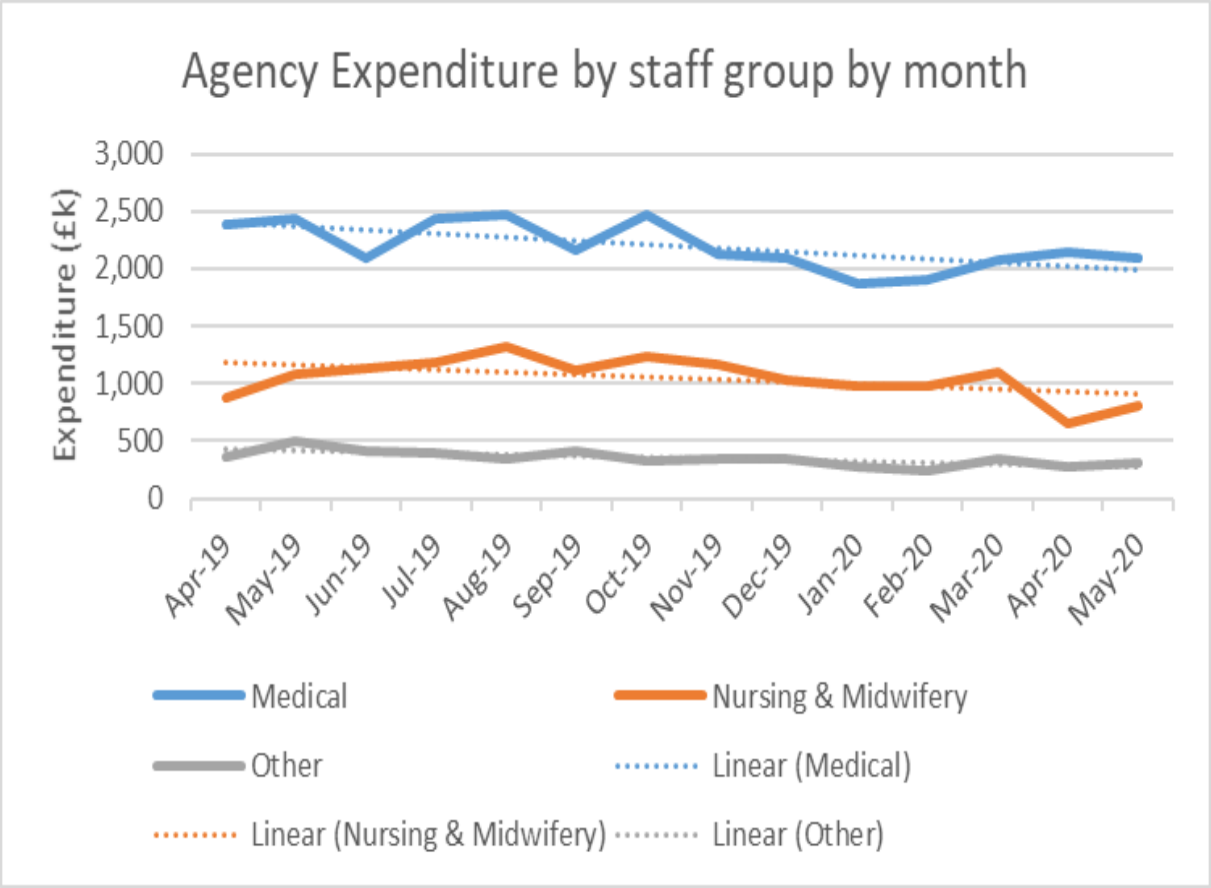
Outpatients – Actuals Comparison - Period 1/4/19 to 31/5/20 (14 months)

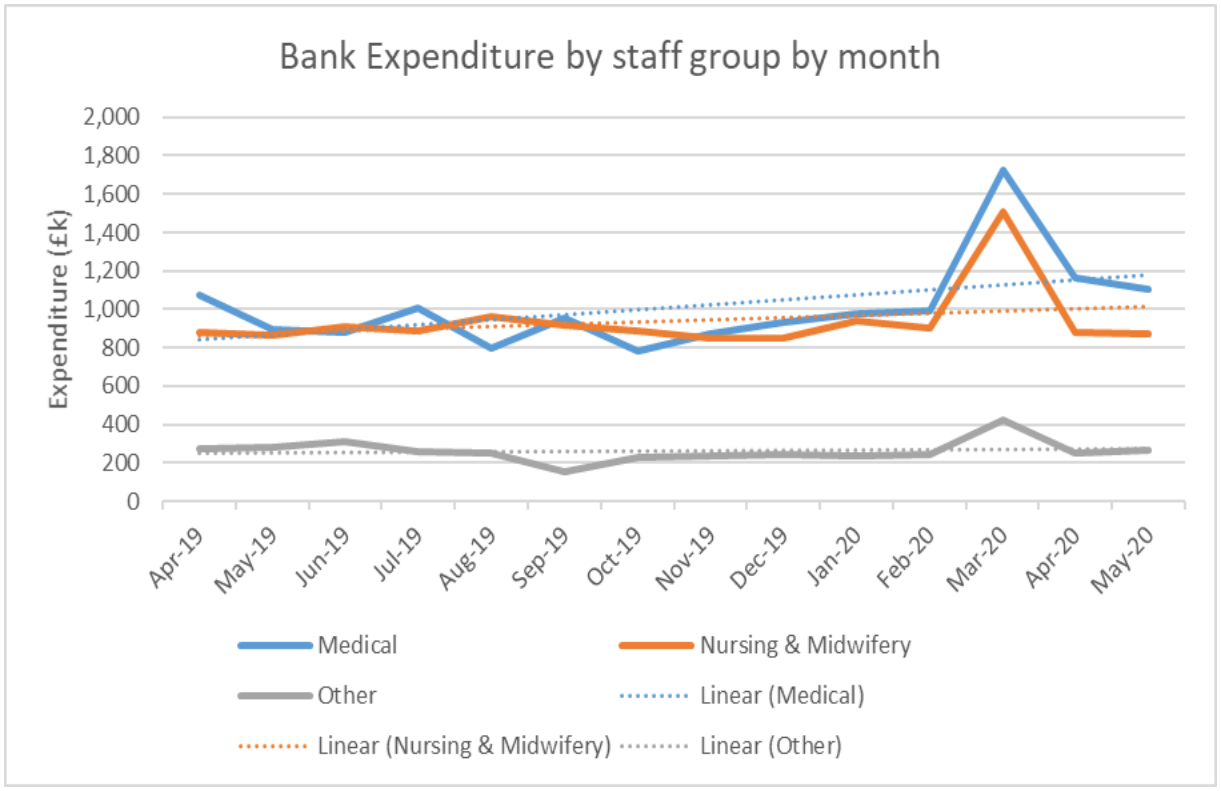
	2019-2020												2020-2021	
	Activity Units												Activity Units	
Activity	**LY M1**	**LY M2**	**LY M3**	**LY M4**	**LY M5**	**LY M6**	**LY M7**	**LY M8**	**LY M9**	**LY M10**	**LY M11**	**LY M12**	**YTD M1**	**YTD M2**
Month	2019-2020 M1	2019-2020 M2	2019-2020 M3	2019-2020 M4	2019-2020 M5	2019-2020 M6	2019-2020 M7	2019-2020 M8	2019-2020 M9	2019-2020 M10	2019-2020 M11	2019-2020 M12	2020-2021 M1	2020-2021 M2
Outpatient Firsts	24,323	24,649	23,312	26,558	22,583	24,221	26,128	24,152	21,353	24,988	22,599	18,371	7,496	8,355
Outpatient Follow Ups	31,395	32,093	29,784	34,304	29,148	30,744	33,419	30,954	27,721	33,580	28,987	23,531	9,578	9,525
Outpatient Non Face To Face Firsts	0	0	0	0	0	0	0	0	0	0	0	0	4,157	4,372
Outpatient Non Face To Face Follow Ups	2,726	2,686	2,414	2,793	2,574	2,734	3,062	3,382	2,956	2,950	2,798	6,676	11,930	12,411
Outpatient Video Firsts	0	0	0	0	0	0	0	0	0	0	0	0	8	8
Outpatient Video Follow Ups	0	0	0	0	0	0	0	0	0	0	0	0	16	22
Outpatient Virtual	0	0	0	1	39	1	60	1,338	642	555	0	1	459	1,113
Outpatient Advice & Guidance	373	437	524	529	463	440	548	598	439	553	538	582	452	452


Outpatients by POD
Outpatient Firsts
Outpatient Follow Ups
Outpatient Non Face To Face Firsts
Outpatient Non Face To Face Follow Ups
Outpatient Video Firsts
Outpatient Virtual
Outpatient Advice & Guidance
2019-2020 M1
2019-2020 M2
2019-2020 M3
2019-2020 M4
2019-2020 M5
2019-2020 M6
2019-2020 M7
2019-2020 M8
2019-2020 M9
2019-2020 M10
2019-2020 M11
2019-2020 M12
2020-2021 M1
2020-2021 M2

Appendix 2 – Pay Graphs

Agency & Bank expenditure - Actuals Comparison - Period 1/4/19 to 31/5/20 (14 months)




Bank Expenditure by staff group by month
Expenditure (£k)
2,000
1,800
1,600
1,400
1,200
1,000
800
600
400
200
0
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20
May-20
Medical
Nursing & Midwifery
Other
Linear (Medical)
Linear (Nursing & Midwifery)
Linear (Other)

Appendix 3 – Divisional YTD positions at Month 2 inclusive of NHS patient care income targets & actuals

Quantum Level	Type	YTD Budget £k	YTD Actual £k	YTD Variance £k
Clinical Support Services	PbR Income	10,382	6,612	-3,770
	Income	847	770	-77
	Pay	-13,060	-11,959	1,101
	Non Pay	-9,423	-8,382	1,041
Clinical Support Services Total		**-11,254**	**-12,959**	**-1,705**
Family Health	PbR Income	10,356	8,059	-2,297
	Income	288	301	13
	Pay	-7,012	-6,992	20
	Non Pay	-2,392	-2,187	205
Family Health Total		**1,239**	**-819**	**-2,058**
Medicine	PbR Income	26,512	16,415	-10,097
	Income	547	556	10
	Pay	-15,748	-17,196	-1,448
	Non Pay	-4,347	-3,071	1,276
Medicine Total		**6,964**	**-3,296**	**-10,259**
Surgery	PbR Income	21,578	8,937	-12,641
	Income	538	498	-40
	Pay	-15,680	-14,925	755
	Non Pay	-5,236	-3,148	2,088
Surgery Total		**1,200**	**-8,638**	**-9,838**
Director Of Estates & Facil	Income	1,250	576	-674
	Pay	-3,661	-3,614	47
	Non Pay	-3,399	-3,572	-173
Director Of Estates & Facil Total		**-5,810**	**-6,610**	**-800**
Sub-Total - Operations		**-7,661**	**-32,323**	**-24,662**
Corporate	Income	2,645	2,608	-37
	Pay	-6,055	-5,588	467
	Non Pay	-7,374	-7,336	38
Sub-Total - Corporate		**-10,783**	**-10,315**	**468**
Sub-Total - Corporate Finance		**4,449**	**42,601**	**38,152**
Remove capital donations/grants I&E impact		**14**	**37**	**23**
Adjusted Deficit		**-13,981**	**0**	**13,981**

Meeting	Trust Board
Date of Meeting	7th July 2020
Item Number	Item number allocated by admin
Integrated Performance Report for May 2020	
Accountable Director	Paul Matthew, Director of Finance & Digital
Presented by	Paul Matthew, Director of Finance & Digital
Author(s)	Sharon Parker, Performance Manager
Report previously considered at	N/A

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

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

Recommendations/ Decision Required	• *The Board is asked to note the current performance and future performance projections. The Board is asked to approve action to be taken where performance is below the expected target.*

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 has been one reported MRSA Bacteraemia which will be the first case within this current financial year. The incident has been reported in accordance with the Serious Incident Framework.

Overall SHMI which includes both deaths in-hospital and within 30 days of discharge (January 2019 – December 2019) is 109.73 and is in band 2 (within expected limits) and shows a slight increase from the previous reporting period. Our current in-hospital SHMI is 97.10. 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.

At the end of May 2020 there were 2 Patient Safety Alerts that remained outstanding, both had a deadline of April 2020 and both related to Medical Devices. The outstanding alerts have been escalated to the Chair of the Clinical Engineering management team for action.

Sepsis screening compliance for both adult and children inpatients has fallen to 84.2% and 84% respectively against a target of 90% and the exception report identifies actions being taken. Sepsis screening compliance for children in A&E has fallen again this month to 83% 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 April 2020 have both improved to 100% for verbal and 89% for written compliance. Ongoing discussions, through the Patient Safety Group, are being held each month with the Divisions and the Risk and Incident Team are continuing to support the Divisions to achieve compliance.

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 May must therefore be seen within the operational context and landscape within which ULHT and indeed the entire NHS are working.

4-hour performance for May was 88.70%, achieved despite a 26.26% increase in ED attendances compared to the previous month.

During May there were 27 >59 minute ambulance handover delays across the Trust, which was 37 lower than April. This performance improvement was achieved against a backdrop of a 13.8% increase in ambulance conveyances compared to the previous month. This continued improvement has been supported by the reintroduction of RAT and review of segregation pathways established for suspected Covid-19 patients.

RTT performance for April was 71.25%, 7.99% worse than March. The 92% standard was achieved in six specialties, including Breast Surgery and Clinical Oncology.

The Trust reported three incomplete 52 week breaches for April end of month. Root cause analysis has been completed by the relevant division and change in process, where required, implemented.

Overall waiting list size has improved from March, with April total waiting list decreasing by 59 to 38,047.

Following a period of growth due to a significant reduction in routine outpatient activity as a consequence of the Trust's response to COVID-19, the partial booking waiting list size has stabilised in May. Furthermore, subsequent monitoring into June demonstrates four weeks of continued reduction of the PBWL by circa. 900 per week.

Our recovery actions include administrative validation, clinical triage and the scaling up of technology enabled care. As a result of these actions waiting list deductions have consistently overtaken additions.

As a direct result of Covid-19 impact 55.04% of patients waiting for a DM01 diagnostic test at the end of May were waiting over 6 weeks. This is in line with the average performance of Trust's nationally. The majority of patients waiting over 6 weeks continue to be 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.

April Cancer 62 Day Classic performance was 66.1%, which was under recovery trajectory, with only Upper GI and Urology performing against their agreed trajectories. COVID-19 placed a temporary hold on the system's Cancer Improvement Programme as efforts have been focused on supporting the operational activity to get cancer patients currently on a pathway treated. This programme has now resumed prioritising ensuring all 2ww referrals map directly to the NICE NG12 guidelines of suspect cancer referral criteria, so that these will be in use before the Recovery phase commences. 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 lower volume/higher quality referrals reach the Trust.

Paul Matthew
Director of Finance & Digital
June 2020

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

PERFORMANCE OVERVIEW

True North	KPI	CQC Domain	2021 Objective	Responsible Director	Target per month	Mar-20	Apr-20	May-20	YTD	Pass/Fail	Trend Variation
Harm Free Care	Clostridioides difficile position	Safe	Our Patients	Director of Nursing	9	4	10	4	14	P	
	MRSA bacteraemia	Safe	Our Patients	Director of Nursing	0	0	0	1	1	F	
	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	1	1	0	1	P	A
	Pressure Ulcers category 3	Safe	Our Patients	Director of Nursing	4.3	2	0	1	1	P	
	Pressure Ulcers category 4	Safe	Our Patients	Director of Nursing	1.3	0	0	1	1	P	
	Never Events	Safe	Our Patients	Medical Director	0	0	0	0	0	P	
	Number of Serious Incidents (including never events) reported on StEIS	Safe	Our Patients	Medical Director	14	8	7	10	17	P	
	Number of Regulation 28 (Prevention of future deaths reports) issued	Safe	Our Patients	Medical Director	0	0	0	0	0	P	
	Patient Safety Alert compliance (number open beyond deadline)	Safe	Our Patients	Medical Director	0	0	0	2	2	F	
	Hospital Standardised Mortality Ratio - HSMR (basket of 56 diagnosis groups) (rolling year data 3 month time lag)	Effective	Our Patients	Medical Director	100	96.60	94.80	95.00	94.90	P	B
	Summary Hospital Mortality Indicator (SHMI) (rolling year data 6 month time lag)	Effective	Our Patients	Medical Director	100	109.18	109.85	109.73	109.79	F	B

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

PERFORMANCE OVERVIEW

True North	KPI	CQC Domain	2021 Objective	Responsible Director	Target per month	Mar-20	Apr-20	May-20	YTD	Pass/Fail	Trend Variation	Kitemark
Harm Free Care	Sepsis screening (bundle) compliance for inpatients (adult)	Safe	Our Patients	Director of Nursing	90%	90.00%	88.00%	84.20%	86.10%	F	A	
	Sepsis screening (bundle) compliance for inpatients (child)	Safe	Our Patients	Director of Nursing	90%	94.00%	90.00%	84.00%	87.00%	F		
	IVAB within 1 hour for sepsis for inpatients (adult)	Safe	Our Patients	`	90%	90.00%	94.40%	95.20%	94.80%	P	A	
	IVAB within 1 hour for sepsis for inpatients (child)	Safe	Our Patients	Director of Nursing	90%	83.00%	87.50%	No positive screens in sample	87.50%			
	Sepsis screening (bundle) compliance in A&E (adult)	Safe	Our Patients	Director of Nursing	90%	92.00%	92.50%	93.00%	92.75%	P	A	
	Sepsis screening (bundle) compliance in A&E (child)	Safe	Our Patients	Director of Nursing	90%	89.00%	87.30%	83.00%	85.15%	F	A	
	IVAB within 1 hour for sepsis in A&E (adult)	Safe	Our Patients	Director of Nursing	90%	96.00%	95.30%	96.00%	95.65%	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%	2.35%	1.92%	1.93%	1.93%	P	B	

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

PERFORMANCE OVERVIEW

True North	KPI	CQC Domain	2021 Objective	Responsible Director	In month Target	Mar-20	Apr-20	May-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%	91.14%	89.69%	88.80%	89.24%		F		
	Number of Vacancies	Well-Led	Our People	Director of HR & OD	12%	13.87%	13.28%	12.52%	12.90%		F	L	
	Sickness Absence	Well-Led	Our People	Director of HR & OD	4.5%	4.94%	4.95%	4.99%	4.97%		F	A	
	Staff Turnover	Well-Led	Our People	Director of HR & OD	12%	11.50%	11.45%	11.00%	11.23%		P		
	Staff Appraisals	Well-Led	Our People	Director of HR & OD	90%	72.43%	70.30%	69.48%	69.89%		F		

True North	KPI	CQC Domain	2021 Objective	Responsible Director	In month Target	Mar-20	Apr-20	May-20	YTD		Latest Month Pass/Fail	Trend Variation	Kitemark
Valuing Patients Time	Mixed Sex Accommodation breaches	Caring	Our Patients	Director of Nursing	0	0	0	0	0		P		Reviewed: 12.06.19 Data available at: Specialty level — Timeliness, Completeness, Validation, Process
	% Triage Data Not Recorded	Effective	Our Patients	Chief Operating Officer	0%	0.72%	0.25%	0.18%	0.21%		F		
	Duty of Candour compliance - Verbal	Safe	Our Patients	Medical Director	100%	83.00%	100.00%		100.00%		P		
	Duty of Candour compliance - Written	Responsive	Our Patients	Medical Director	100%	75.00%	89.00%		89.00%		F		

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

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		

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

PERFORMANCE OVERVIEW

True North	KPI	CQC Domain	2021 Objective	Responsible Director	In month Target	Mar-20	Apr-20	May-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%	73.73%	73.43%		73.43%	85.00%	F	B	
	diagnostics achieved	Responsive	Our Services	Chief Operating Officer	99.0%	91.94%	37.67%	44.96%	41.32%	99.00%	F		
	Cancelled Operations on the day (non clinical)	Responsive	Our Services	Chief Operating Officer	0.8%	1.50%	2.04%	1.40%	1.72%	0.80%	F		
	Not treated within 28 days. (Breach)	Responsive	Our Services	Chief Operating Officer	0	12	36	19	55	0	F		
	#NOF 48 hrs	Responsive	Our Services	Chief Operating Officer	90%	92.50%	82.81%	87.14%	84.98%	90%	F		
	#NOF 36 hrs	Responsive	Our Services	Chief Operating Officer	TBC	83.75%	67.19%	72.86%	70.02%				
	EMAS Conveyances to ULHT	Responsive	Our Services	Chief Operating Officer	4,657	4,458	3,756	4,357	4,057	4,657	P		
	EMAS Conveyances Delayed >59 mins	Responsive	Our Services	Chief Operating Officer	0	295	64	27	46	0	F	L	
	104+ Day Waiters	Responsive	Our Services	Chief Operating Officer	5	22	25	45	70	10	F		
	Average LoS - Elective (not including Daycase)	Effective	Our Services	Chief Operating Officer	2.80	3.07	3.18	3.51	3.35	2.80	F		
	Average LoS - Non Elective	Effective	Our Services	Chief Operating Officer	4.50	5.15	3.71	3.47	3.59	4.5	P		
	Delayed Transfers of Care	Effective	Our Services	Chief Operating Officer	3.5%	3.54%	Submission suspended		3.13%	3.5%			
	Partial Booking Waiting List	Effective	Our Services	Chief Operating Officer	4,524	15,103	18,090	18,154	18,122	4,524	F	H	
	Outpatients seen within 15 minutes of appointment	Effective	Our Services	Chief Operating Officer	70.0%	36.6%	39.1%	32.7%	35.90%	70.00%	F	A	
	% discharged within 24hrs of PDD	Effective	Our Services	Chief Operating Officer	45.0%	37.0%	40.5%	37.4%	38.95%	45.00%	F		

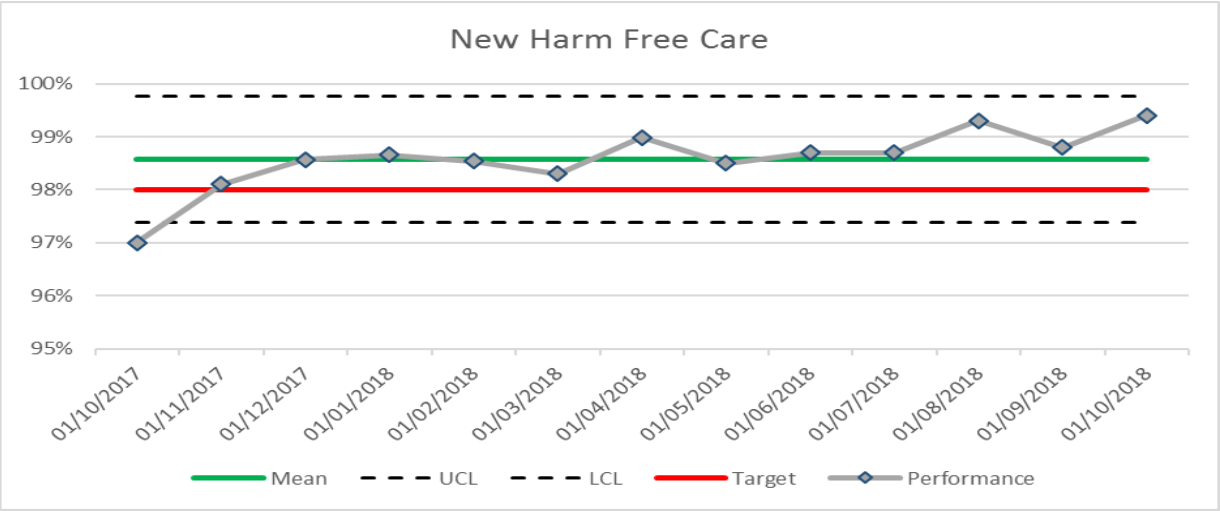
STATISTICAL PROCESS CONTROL CHARTS

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:



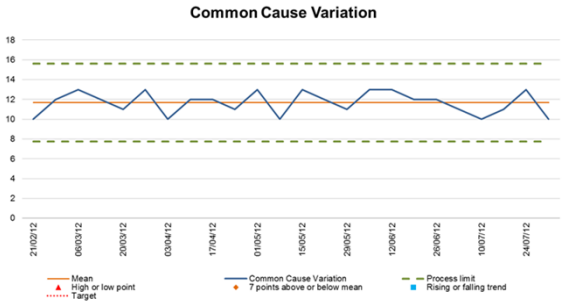
Normal variations in performance across time can occur randomly- without a direct cause, and should not be treated as a concern, or a sign of improvement, and is unlikely to require investigation unless one of the patterns defined below applies.

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

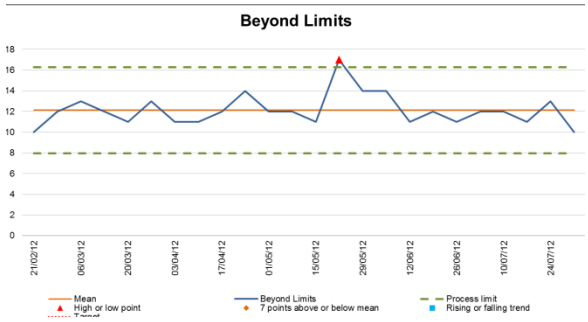
- Normal variation – (common cause) fluctuations in data points that sit between the upper and lower control limits
- Extreme values – (special cause) any value on the line graph that falls outside of the control limits. These are very unlikely to occur and where they do, it is likely a reason or handful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

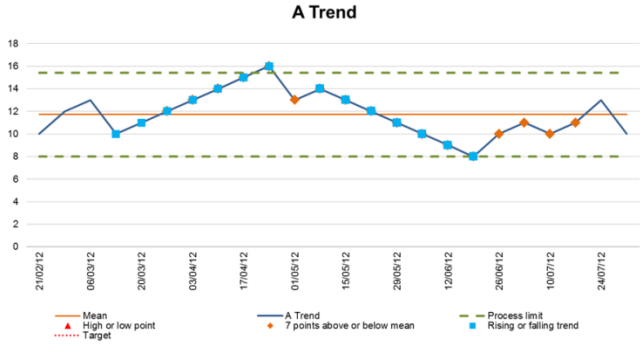


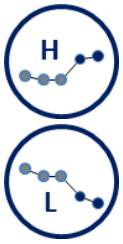
Extreme Values



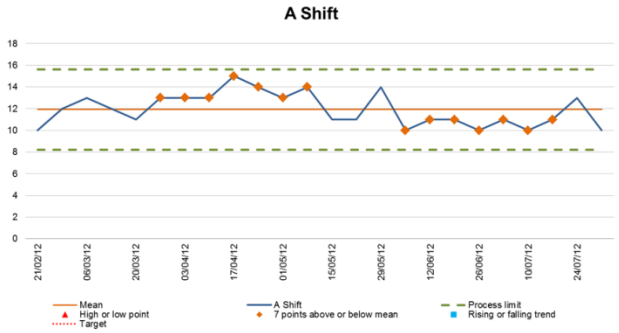
There is no Icon for this scenario.

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

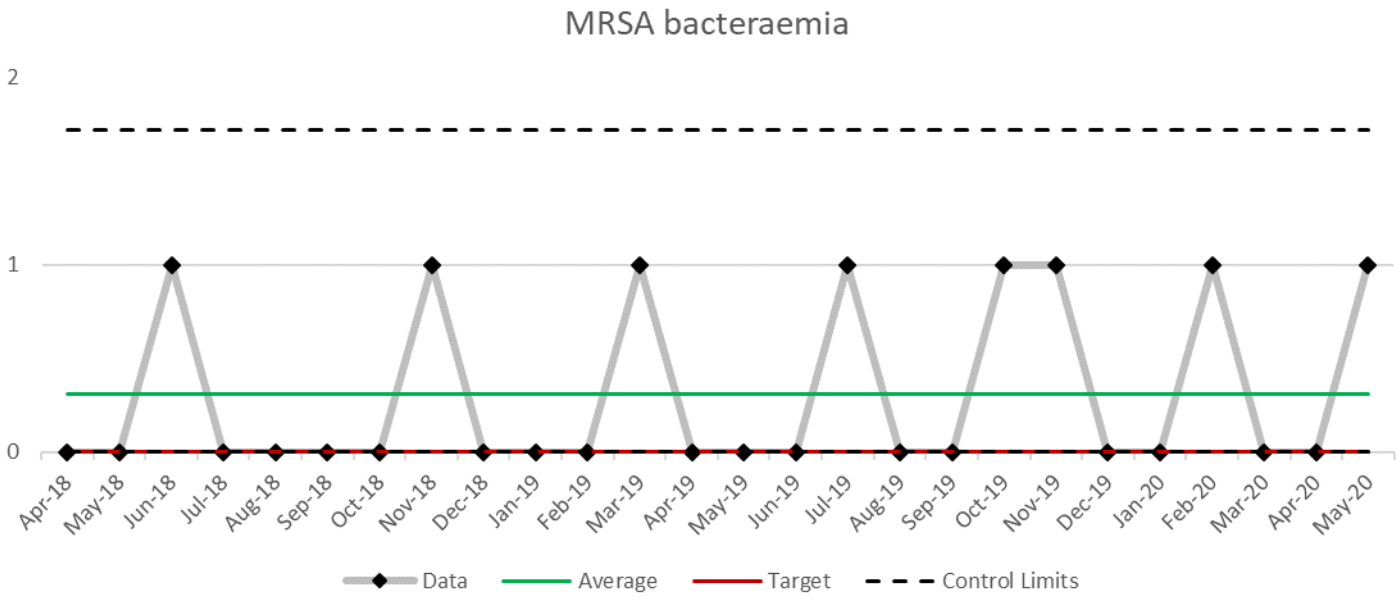
Where the target has been missed for at least 3 of the most recent data points in a row, or in a string of 7 of the most recent data points, at least 5 out of the 7 data points have missed.

HARM FREE CARE – INFECTION CONTROL

Executive Lead: Director of Nursing

CQC Domain: Safe

2021 Objective: Our Patients



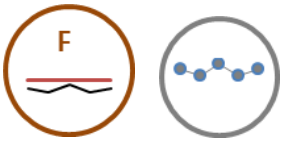
Unfortunately there was 1 MRSA bacteraemia reported in May 2020 which is currently being investigated. This is the first case for the year and the Trust trajectory is to have zero cases.

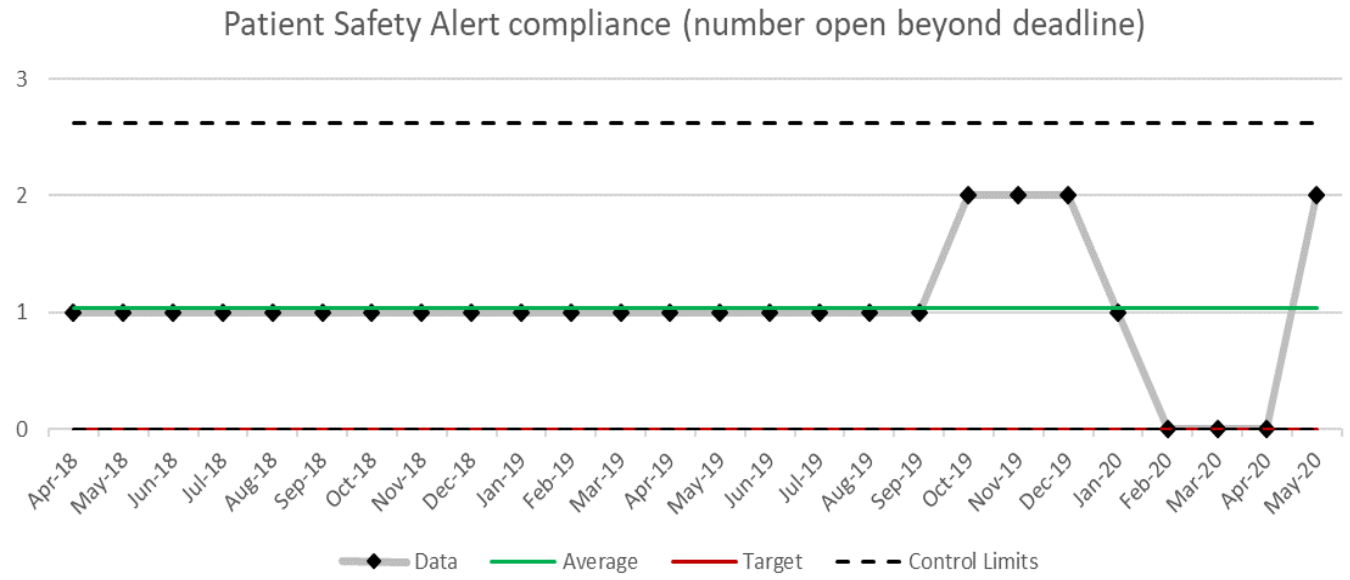
HARM FREE CARE – PATIENT SAFETY ALERT COMPLIANCE

Executive Lead: Medical Director

CQC Domain: Safe

2021 Objective: Our Patients





Challenges/Successes

At the end of May there were 2 Patient Safety Alerts that remained outstanding; both had a deadline of April 2020 and concern medical devices

Actions in place to recover:

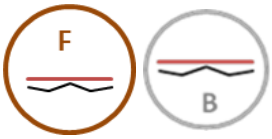
The outstanding alerts have been escalated to the Clinical Engineering management team for action

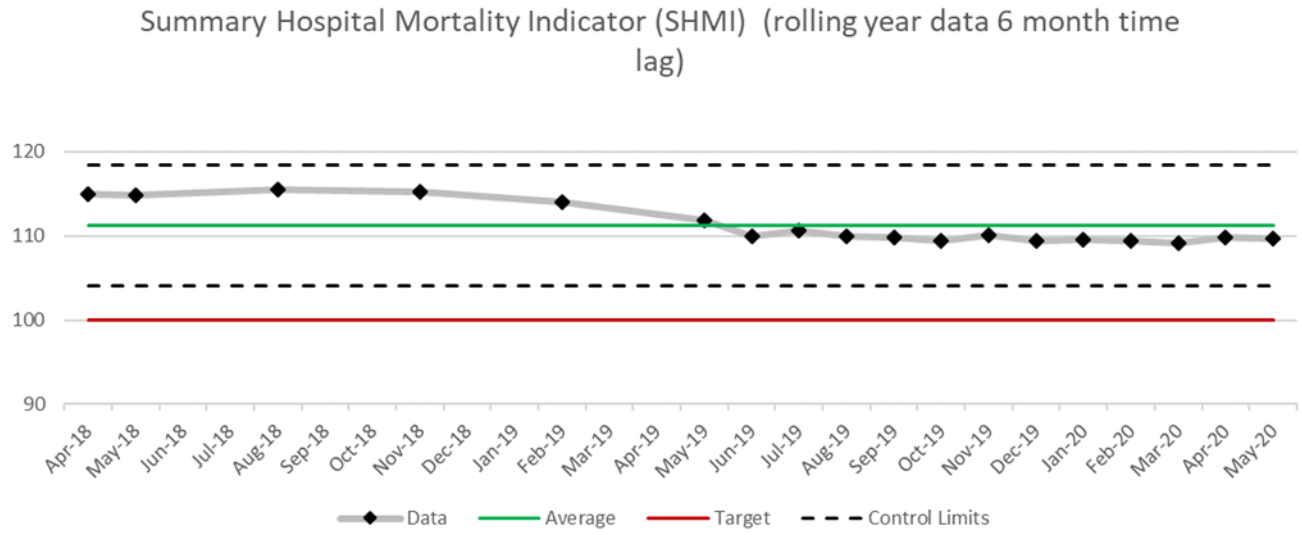
HARM FREE CARE - MORTALITY

Executive Lead: Medical Director

CQC Domain: Effective

2021 Objective: Our Patients





Challenges/Successes

SHMI (January 2019 to December 2019) is 109.73 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 97.10.

Dr Foster excludes COVID-19 related deaths.

Actions in place to recover

A review of COVID-19 related deaths has been presented to QCG in June.

ResPect forms are completed in over 90% of death, but further work is required to improve the quality of the record in 30%.

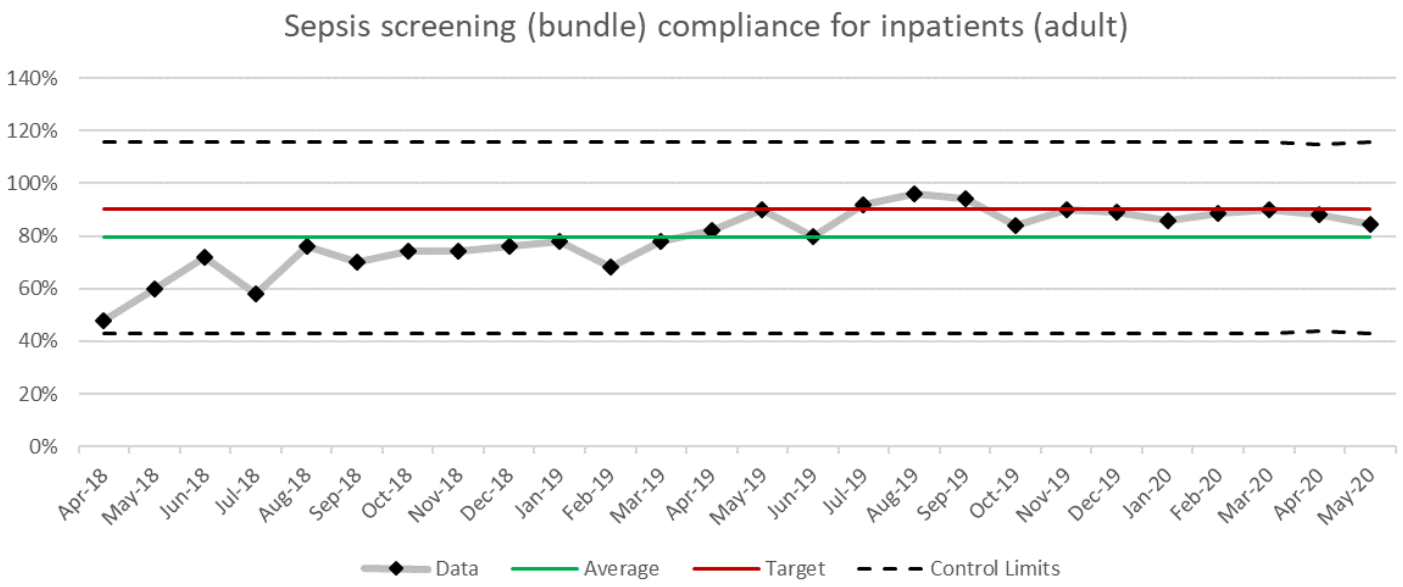
Alerts: There are no alerts.

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 to 84.2% 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.

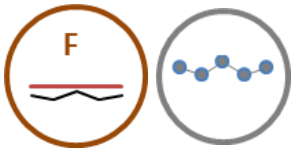
Due to Covid-19 sepsis practitioners have been unable to 'pop in' to ward areas however have been able to assist when required. Many staff have been redeployed from other which may account further to the decline in data results.

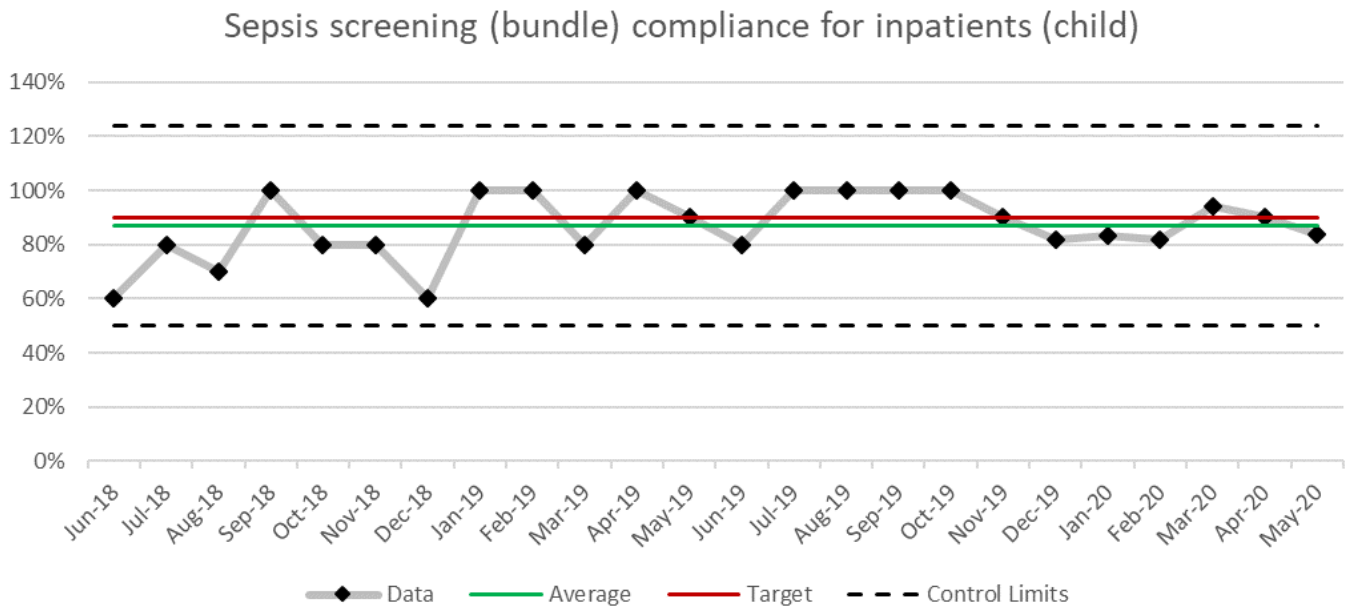
HARM FREE CARE – SEPSIS SCREENING continued

Executive Lead: Director of Nursing

CQC Domain: Safe

2021 Objective: Our Patients





Challenges/Successes

Sepsis intravenous antibiotic compliance for inpatient children has declined slightly to 84% which equates to 21 out of 25 patients, falling short of the 90% target.

Actions in place to recover:

Of the 3 patients that had a delay in screening none were diagnosed as sepsis and all were treated in a timely manner for their individual conditions.

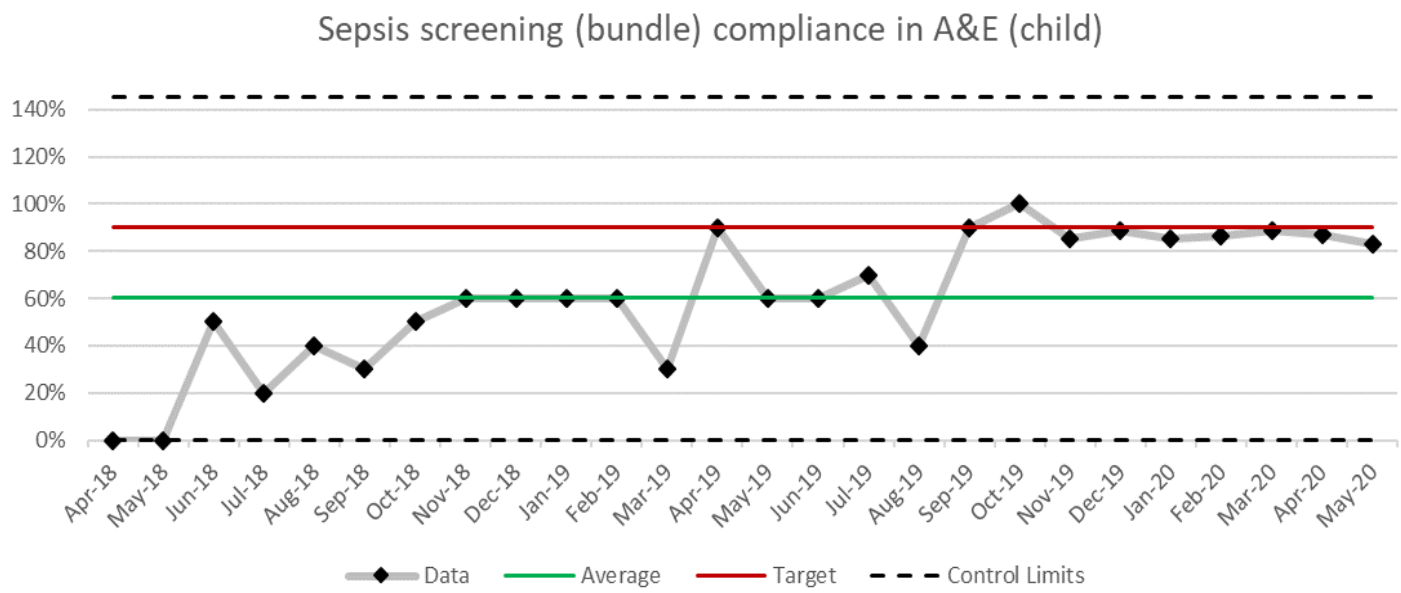
Designated paediatric Resuscitation and Sepsis Practitioner employed into the team who will oversee all paediatric areas across the trust.

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 to 83% 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.

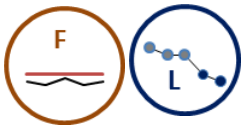
Designated paediatric Resuscitation and Sepsis Practitioner employed into the team who will oversee all paediatric areas across the trust.

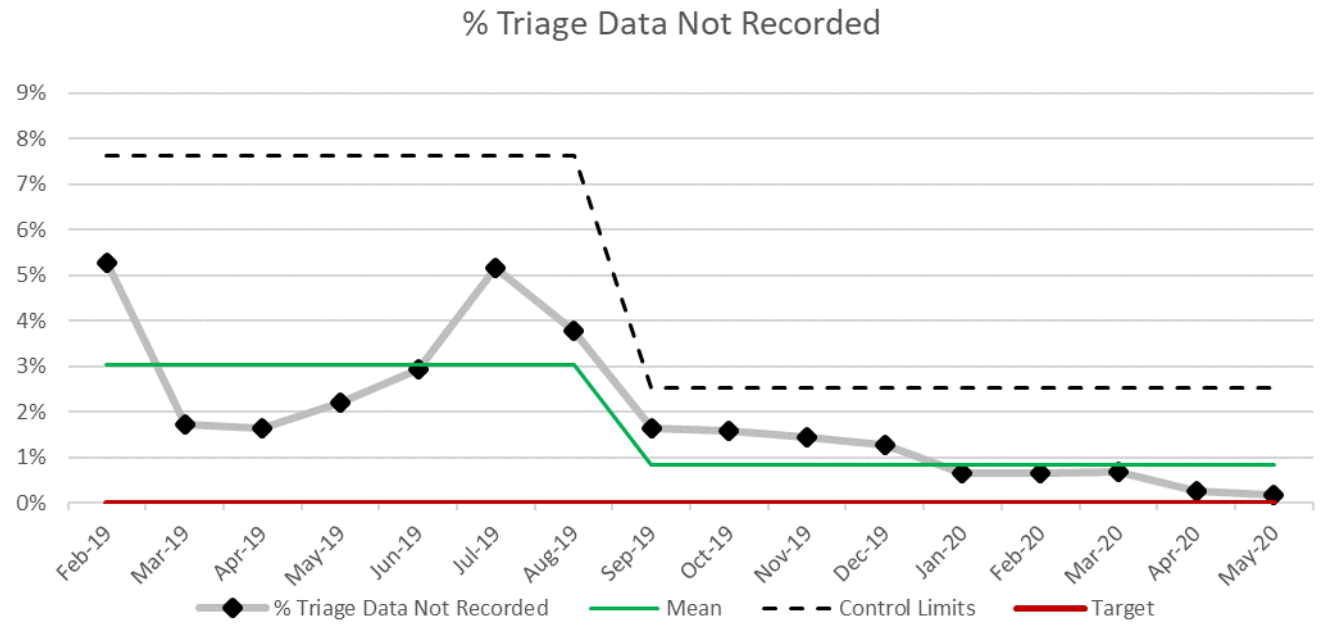
VALUING PATIENTS TIME – % TRIAGE DATA NOT RECORDED

Executive Lead: Chief Operating Officer

CQC Domain: Effective

2021 Objective: Our Patients





Challenges/Successes

- May demonstrated a 0.07% positive variation in performance compared with April 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. Continued disruption by moving to this model is still evident in relation to this key performance indicator.
- Temporary redeployment of staff unfamiliar with the Emergency Departments, has caused some operational issues during May, particularly overnight.

Actions in place to recover:

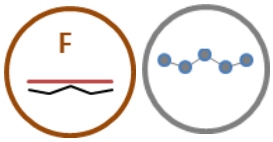
- The actions against this metric are repetitive but still valid.
- The Urgent and Emergency Care Lead Nurse ensures increased compliance and maintenance against this target and improvements continue to be realised.
- The Divisional UEC Operational Leads (DGM and Lead Nurse) continually feedback performance 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.

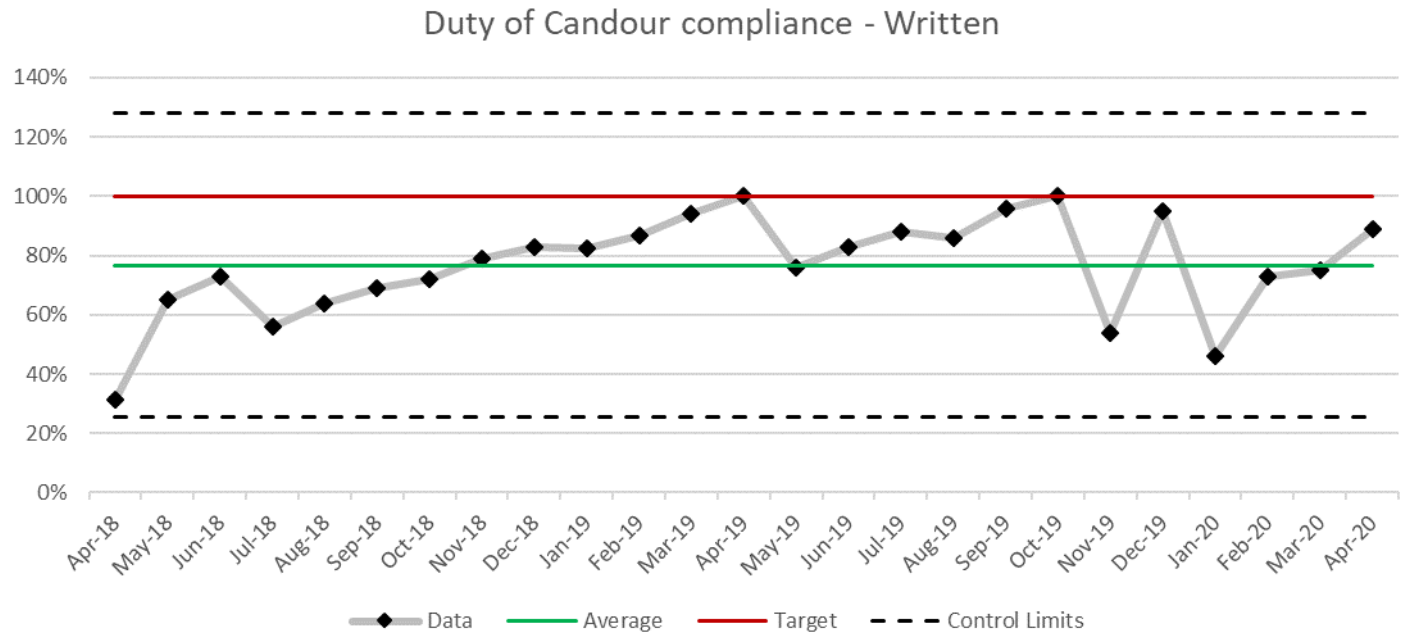
VALUING PATIENTS TIME – DUTY OF CANDOUR

Executive Lead: Medical Director

CQC Domain: Caring/Responsive

2021 Objective: Our Patients





Challenges/Successes

- Duty of Candour 'Notification in person' compliance in April 2020 was 100% (for 9 notifiable incidents)
- Written follow-up' compliance in April 2020 was 89% (1 non-compliant incident, in Family Health Division; this has now been completed)

Actions in place to recover:

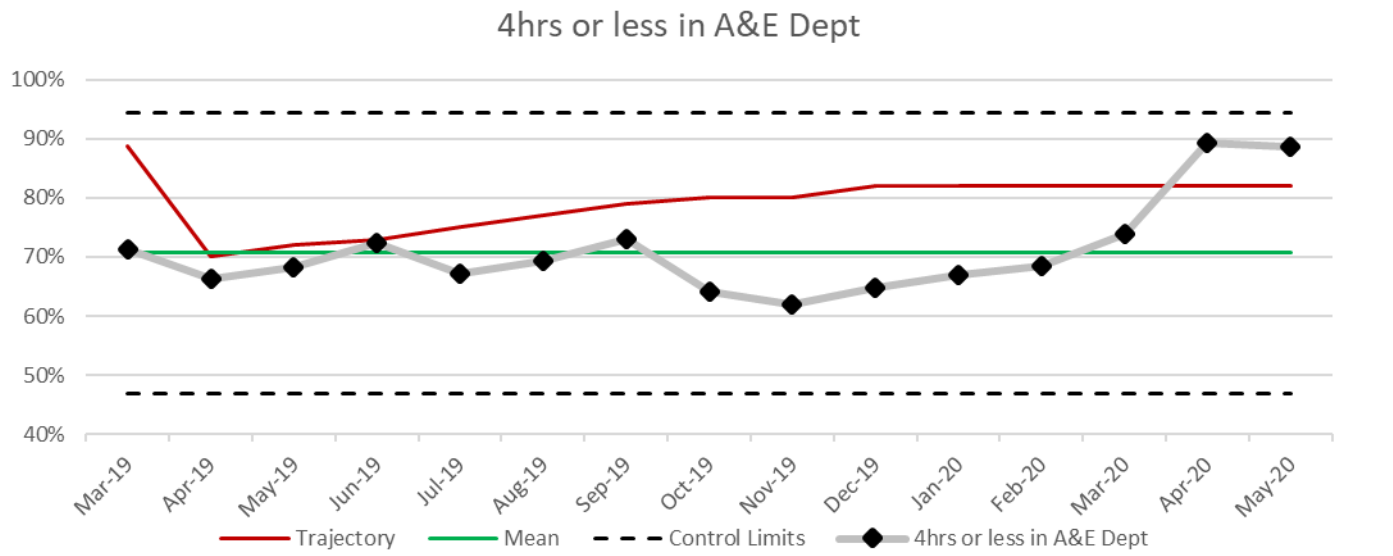
- The Risk & Incident Team within Clinical Governance are providing additional support by drafting written follow-up letters on request

ZERO WAITING – A&E 4 HOUR WAIT

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

2021 Objective: Our Services



Challenges/Successes

- The UK risk level remains high and an NHS wide Level 4 incident has continued throughout May in response to the COVID19 Pandemic.
- This report provides an update on key performance indicators against a significantly changed and temporary landscape.
- Full 'lockdown' continued during May, although the public were encouraged to seek urgent medical care via Urgent Care Centres and Emergency Departments resulting in increased attendances.
- May ED type 1 and streaming was 12,302 attendances verses 9,072 in April. This represents a 26.26% increase overall. By site LCH experienced a 27.20% increase in attendances, GDH a 24.60% increase in attendances and PHB saw an increase of 25.48%.
- May overall outturn for A&E type 1 and primary care streaming delivered 88.70% against an agreed trajectory of 68.52%.
- This demonstrates a deterioration of 0.57% compared with April outturn, although this is still an improvement against trajectory of 20.18%.
- By site, for April, LCH delivered 87.81%, PHB delivered 87.33% and GDH 96.85%. The highest days of delivery by site was 2nd May when PHB delivered 95.56% and 3rd May when LCH achieved 94.23%. GDH delivered 100% on 8 days through May.
- This improvement should be seen in the context of the increased operating level that the Trust is currently working to and an increase in ED attendances and non-elective admissions.

Actions in place to recover :

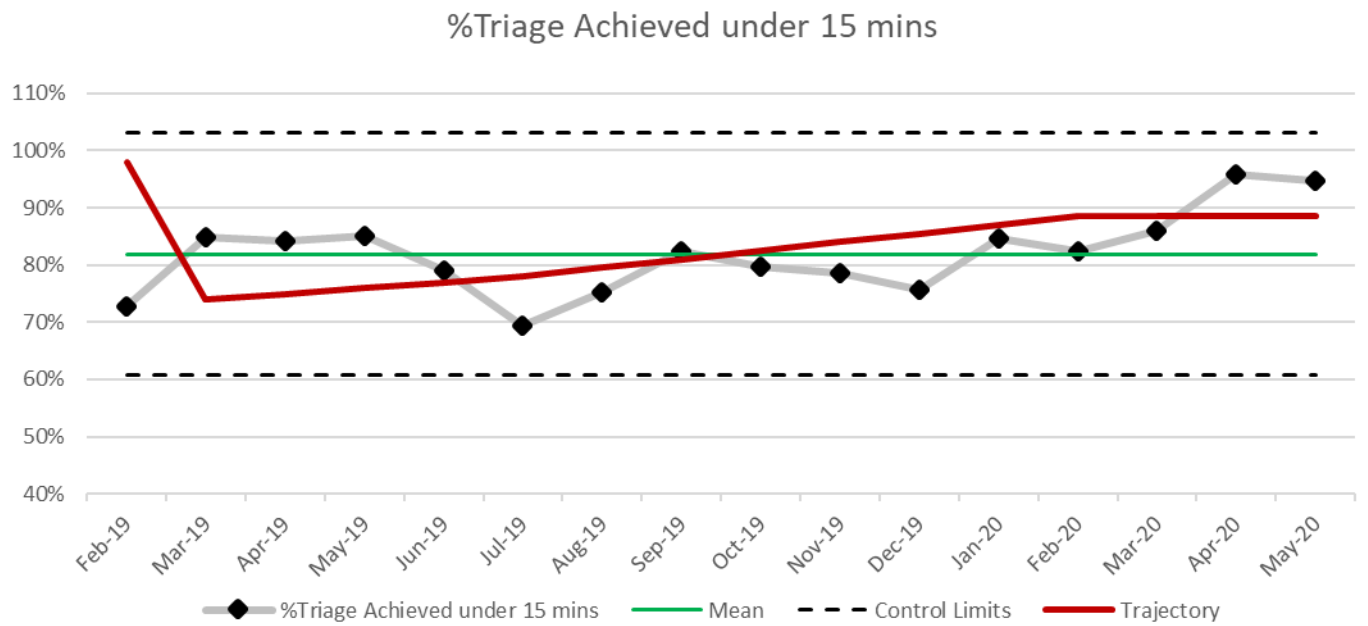
- Those process improvements, not affected by volume, have been reflected in the Restore phase of COVID management and where they are more transformational, these will be developed as part of the Recovery phase.
- The ability to respond dynamically in all urgent and emergency care access areas will support 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

- Whilst triage under 15 minutes delivered an improved position in April, there was a slight deterioration in May, 94.70% compared to 95.78% in April. The balance between managing the blue pathway and green pathway has been problematic, especially at times of increased volume of patients in the departments
- 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%.
- 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:

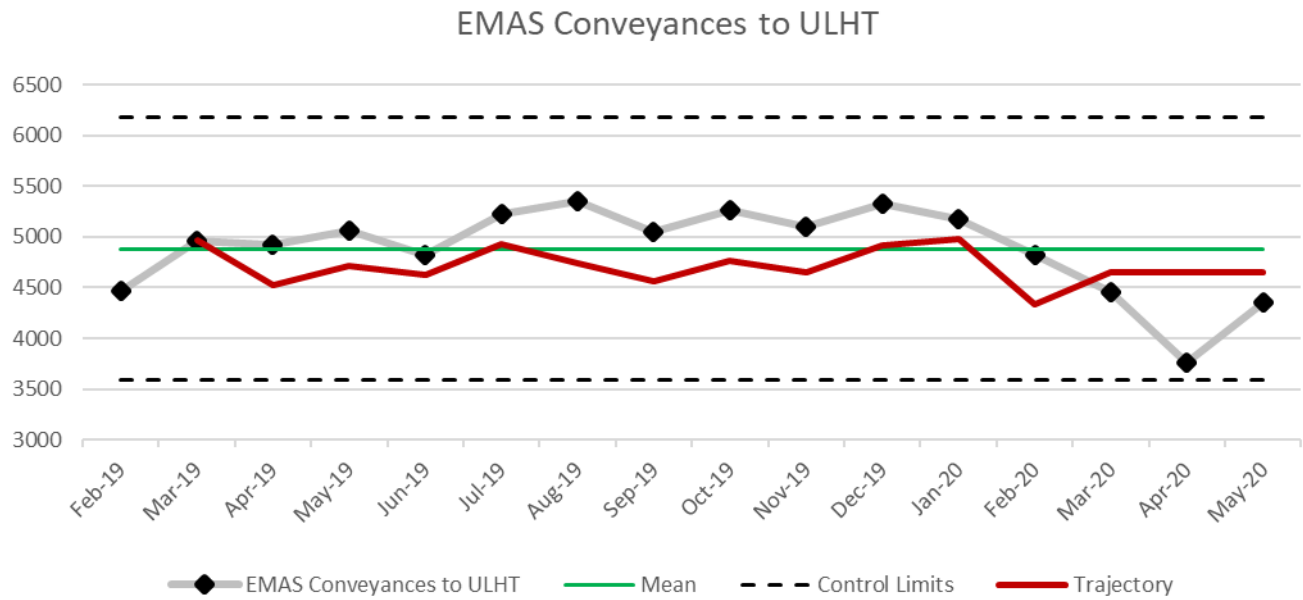
- Reduced volume due to 'lockdown' and Nationally operating in escalated Level 4 will have contributed to the improvement of this key metric. However, as a return to levels more in line with Pre Covid attendances, the focus must remain on achievement.

ZERO WAITING – AMBULANCE CONVEYANCES

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

2021 Objective: Our Services



Challenges/Successes

- Ambulance conveyances for May were 4357, compared to 3756 in April. This represents a 13.80% increase in conveyances across all sites.
- By site, LCH conveyances were 2520 compared with 2077 in April, a 17.58% increase, PHB was 1603 in May compared with 1428 in April, a 10.92% increaase and GDH continued to experience a reduction in conveyance 234 compared to 251 in April 251, a 6.78% reduction.
- This represents an increase of 601 conveyances in May, with the largest impact being seen at LCH.
- The continued challenge, as we move through restore and into recovery, whilst maintaining the segregated pathways, will be managing further increases in conveyance. We are working with the System to reduce our overall attendances and conveyances by ensuring all admission avoidance pathways are robust and communicated clearly.

Actions in place to recover

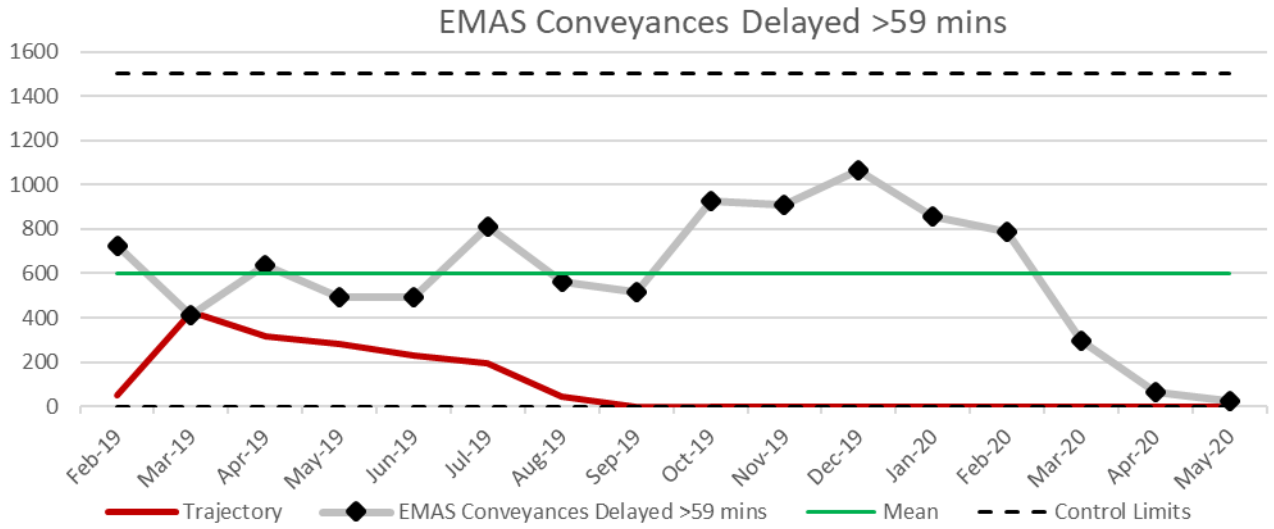
- Restore plans being put in place by the Trust for urgent and emergency care (UEC) include patients being appropriately clinically managed through alternative streams to avoid large numbers of patients in the emergency department leading to possible delays in handover.
- Key to delivering this and the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

ZERO WAITING – AMBULANCE HANDOVER >59 Mins

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

2021 Objective: Our Services



Challenges/Successes

- During May there were 27 >59 minute ambulance handovers. This is 37 less than April.
- LCH had 17 >59 minute ambulance conveyances in May compared with 27 in April, 7 of these have been attributed to the Women and Family Health Division. PHB had 9 >59 minute ambulance conveyances in May compared with 37 in April, 2 of which have been attributed to neonatal transfers and GDH had 1 in May compared to 0 in April.
- Delays experienced at LCH and PHB have improved as a result of the ability to 'flex' the segregated pathways more proactively.
- This improvement should be also be considered against the backdrop of a 13.80% overall increase in conveyance during May.
- Handover delays in Maternity and neonatal transfer times are being reviewed both internally and externally.

Actions in place to recover

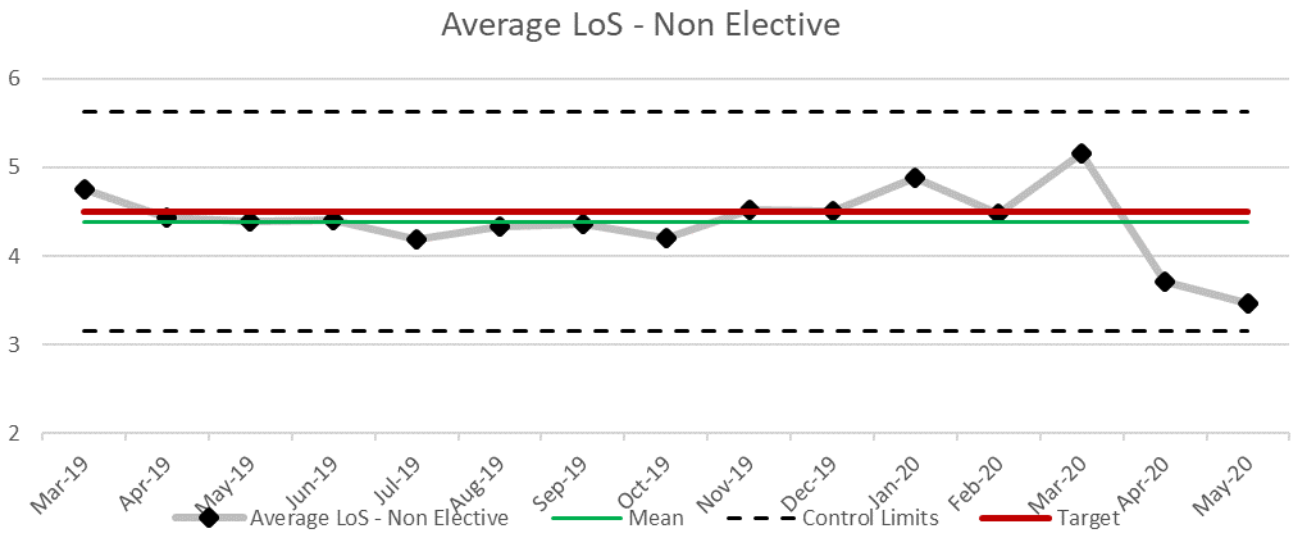
- RAT has been reinstated as well as maintaining a level of segregation for suspected COVID patients.

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 a continuing improvement during May delivering 3.47 compared with 3.71 in April. This represents an improvement of 0.24 days
- During May the numbers of patients with a LLOS increased from 47 in April to 69 in May. An increase of 22 patients
- The work of the system wide discharge cell and the implementation of COVID discharge guidance including the temporary suspension of the Care Act initially impacted positively on this performance, however, with the introduction of a local patient swabbing agreement for all patients requiring on going care within Adult Social Care, discharge delays of >72 hours post medically optimised are being experienced.
- The stroke pathway was amended during April 2020 which meant that hyper acute
- Non elective admissions have increased by 25.23% in May. 2914 admissions versus 2179 in April. This upward trend is continuing.

Actions in place to recover

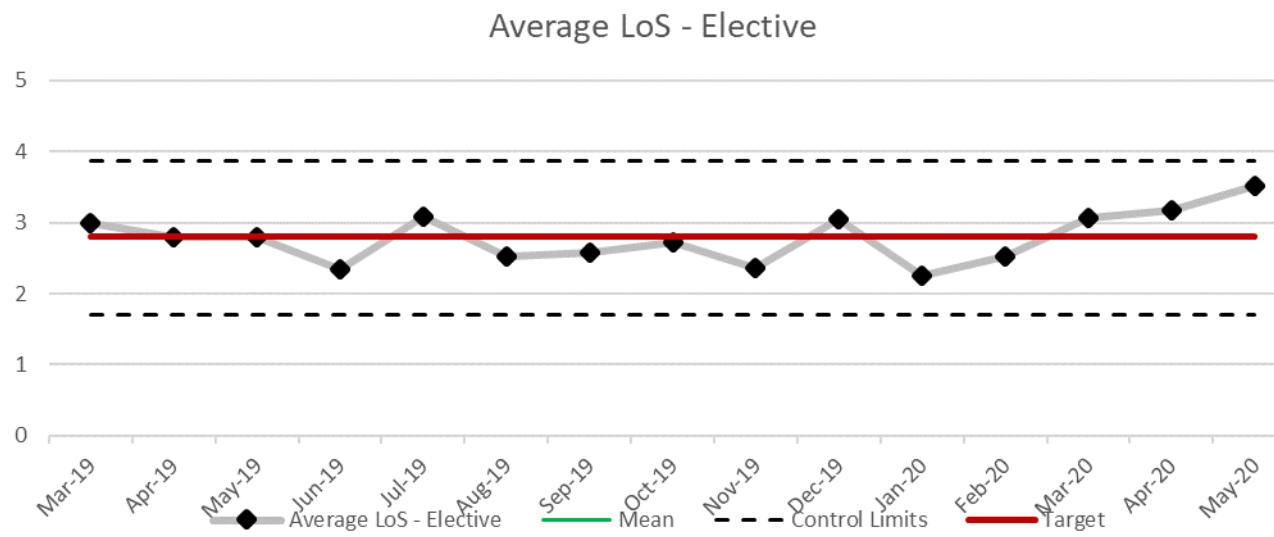
- Multi-agency discharge meetings continue to take place daily action planning patients through their discharge pathway.
- Weekly multi-agency long length of stay meetings for each hospital site in place to support more complex patients through their discharge pathway.
- Patient swabbing agreement being reviewed to allow more flexibility in terms of valid swab result timescales to reduce >72 hour delays to discharge
- System wide Restore plans being developed to ensure that pace with discharge is not lost as activity increases are experienced over coming weeks.

ZERO WAITING – AVERAGE LOS ELECTIVE

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

2021 Objective: Our Services

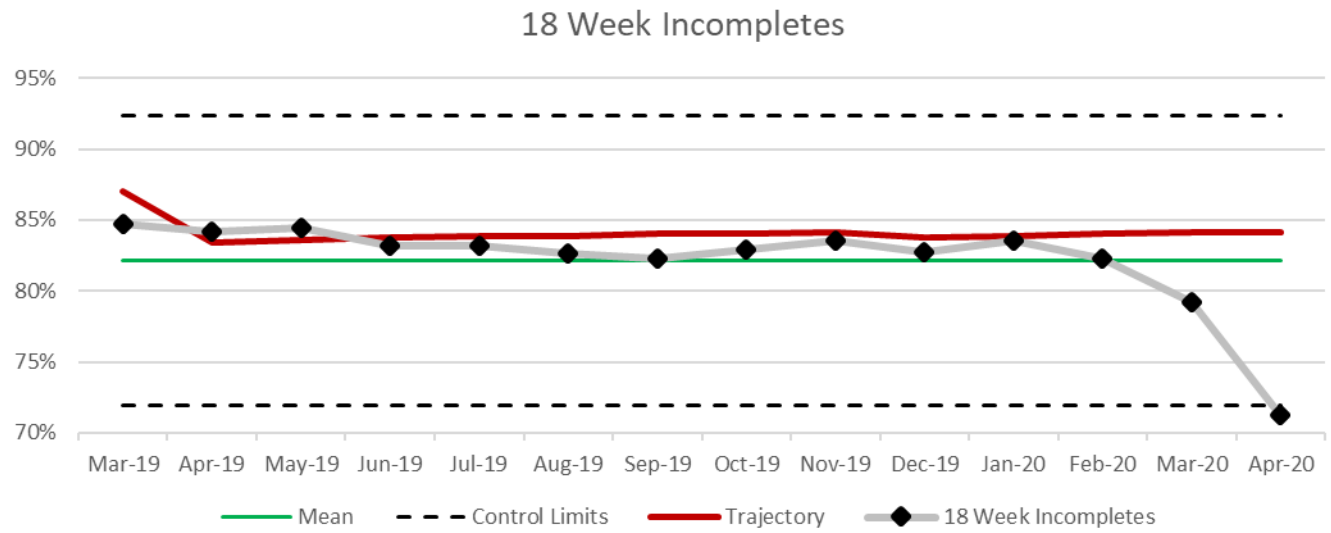


ZERO WAITING - RTT 18 WEEKS INCOMPLETES

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

2021 Objective: Our Services



Challenges/Successes

RTT performance is currently below trajectory and standard.

April saw RTT performance of 71.26%, 7.99% worse than March.

Maxillo-Facial Surgery, Orthodontics and Oral Surgery (53.98%) is the lowest performing specialty, from 66.98% last month (-12.99%). Neurology has deteriorated this month with a 7.16% decrease from 78.13% last month to 70.97% in April.

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

- Ophthalmology - 1356 (Increased by 685)
- Maxillo-Facial Surgery + Orthodontics + Oral Surgery - 1334 (Increased by 338)
- ENT - 1327 (Increased by 338)
- Gastroenterology - 1210 (Increased by 198)
- General Surgery - 961 (Increased by 150)

Actions in place to recover:

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

Currently, in order to support routine activity, work is commencing on sending admitted patients from some specialties to Independent Sector providers for surgery.

Specialties achieving the 18 week standard for April were:

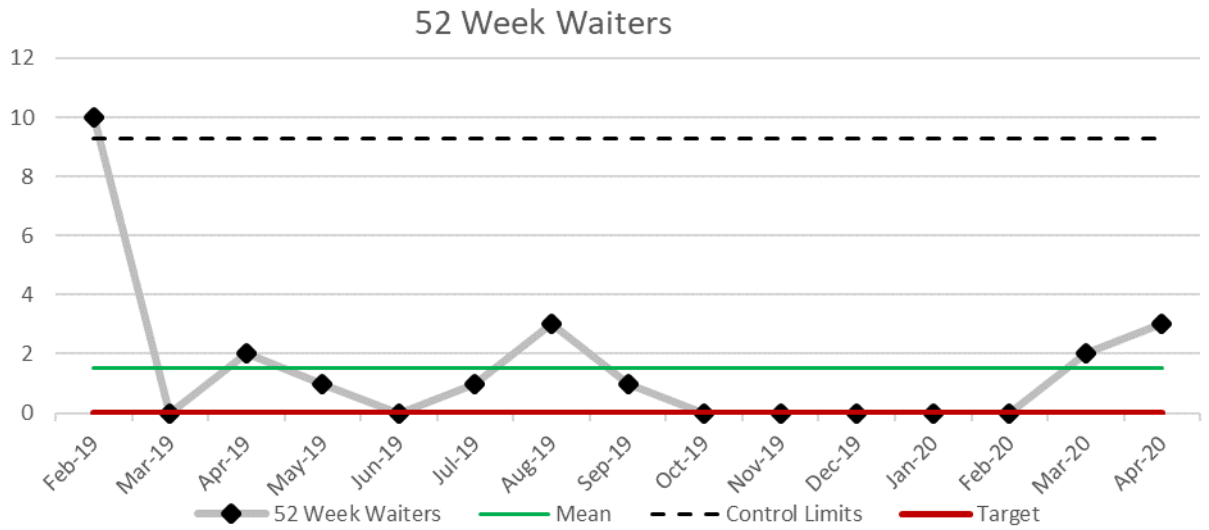
- Breast Surgery 95.48%
- Clinical Oncology 95.08%
- Cardiothoracic Surgery 100.00% (2 patients)
- Paediatric Diabetic Medicine 100.00% (5 patients)
- Paediatric Urology 100.00% (6 patients)
- Transient Ischaemic Attack 94.64%

ZERO WAITING – 52 WEEK WAITERS

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

2021 Objective: Our Services



Challenges/Successes

The Trust reported three incomplete 52 week breaches for April end of month. Root cause analysis has been completed by the relevant division and change in process, where required, implemented.

Due to the COVID19 situation necessitating the standing down of routine services, unfortunately, it is anticipated that there will be additional breaches submitted for next month.

Actions in place to recover

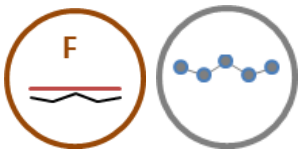
Work is continuing within services for Cancer and Urgent patients.
Recovery and Restoration plans continue to be discussed and revised; accounting for a changing environment. Divisions are reviewing pathways to look at ways to enable provision of routine services. This is being worked through in conjunction with the Trusts “Green” plan.

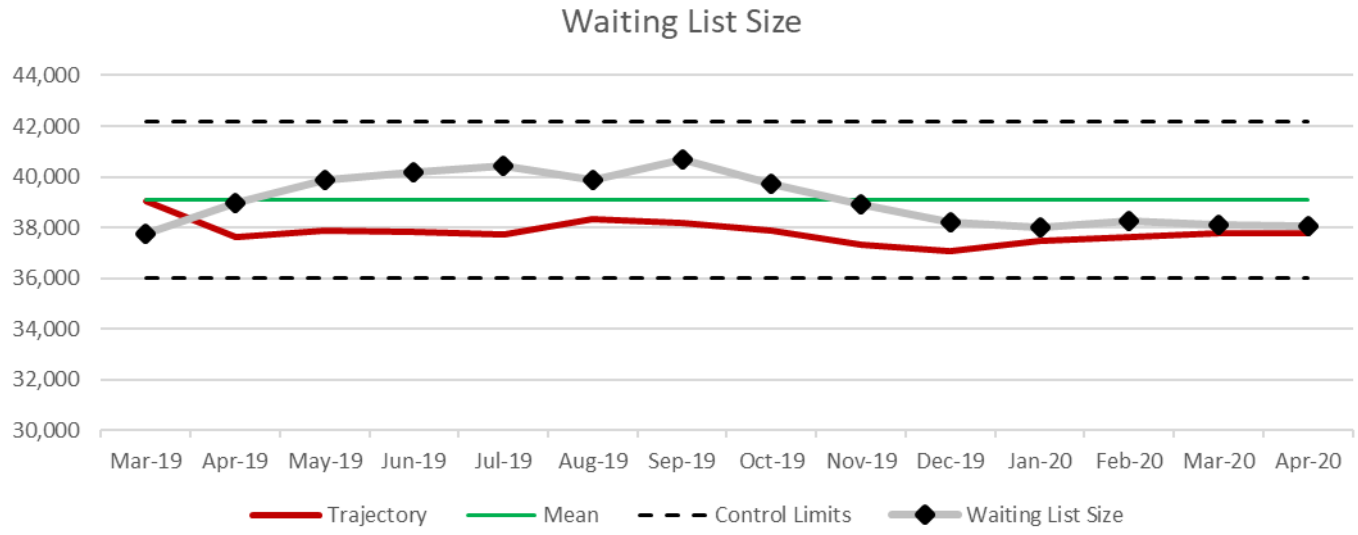
ZERO WAITING – WAITING LIST SIZE

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

2021 Objective: Our Services





Challenges/Successes

Overall waiting list size has improved from March, with April total waiting list decreasing by 59 to 38,047.The incompletes position for April is now approx. 985 less than the March 2018 (39,032) target.

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

- Neurology + 237
- Respiratory Medicine + 146
- Ophthalmology + 129
- Gynaecology + 94
- Rheumatology + 90

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

- Cardiology - 182
- General Surgery - 127
- Maxillo-Facial Surgery + Orthodontics + Oral Surgery - 117
- Trauma & Orthopaedics - 106
- Urology - 105

Actions in place to recover

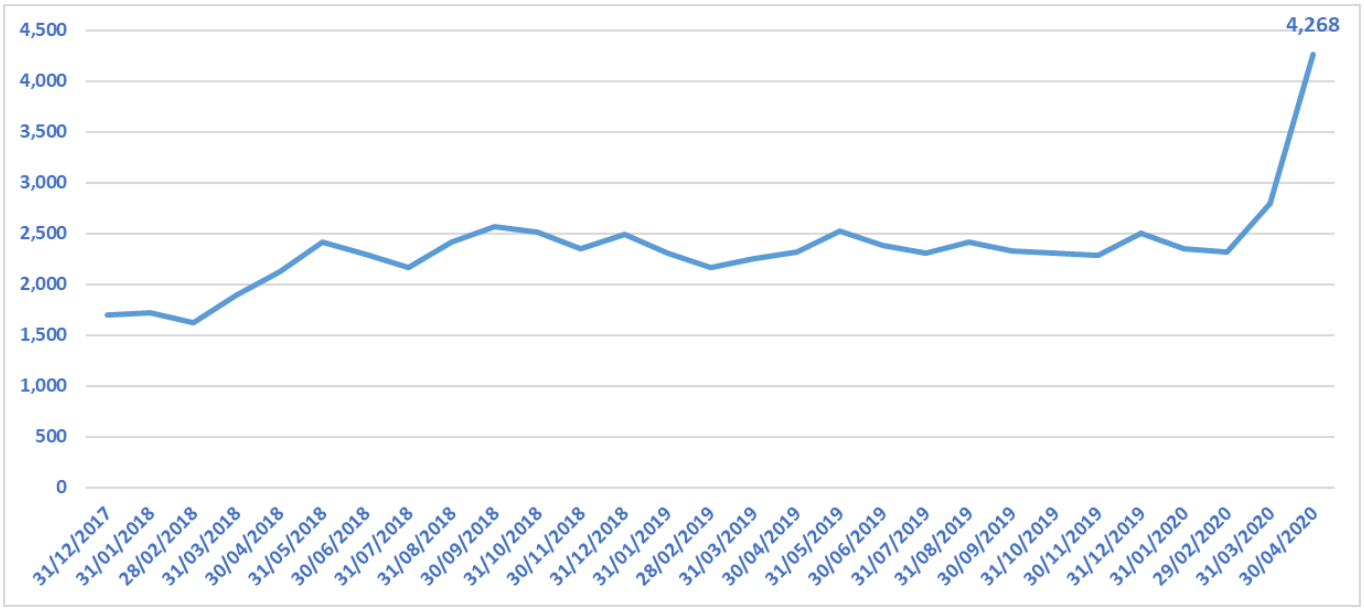
Discussions are currently being held with CCG/STP/NHSE/I colleagues regarding a new approach to the current Advice & Guidance used by the Trust. A working group has been established to look at and evaluate a different system, with a plan being worked on to undertake a pilot of this. If successful it is anticipated that this could reduce the number of referrals into the Trust.

- March to April saw an increase of patients waiting over 40 weeks, +207, with General Surgery (+42) showing the largest increase. 4 specialties reduced their position compared to last month, with Paediatrics showing the best improvement of -2 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 30th April, with an increase of 1475 patients from March. The largest increase was seen in ENT, +256. The largest decrease of -2, being in Breast Surgery.

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



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

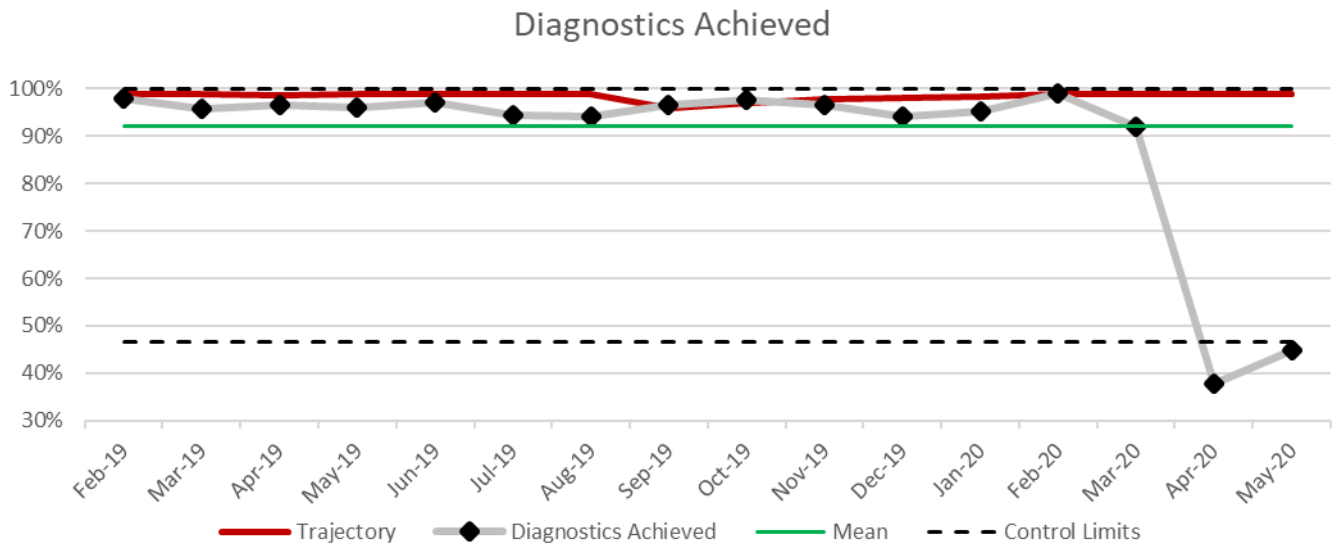
There has been an increase in changing face to face appointments to telephone consultations. The use of video consultations has also increased, where appropriate, within the specialties.

ZERO WAITING – DIAGNOSTICS

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

2021 Objective: Our Services



Challenges/Successes:

As a direct result of Covid-19 impact 55.04% of patients waiting for a DM01 diagnostic test at the end of May were waiting over 6 weeks. This is in line with the average performance of Trust's nationally.

The majority of patients waiting over 6 weeks continue to be within echocardiography and endoscopy diagnostic procedures.

From the end of March only urgent cardiac echo activity continued to support cancer pathways with all routine activity temporarily stopped. This routine activity re-commenced from 8 June as planned at reduced capacity due to social distancing constraints.

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 50% of normal activity and is focused on cancer and urgent work.

Actions in place to recover:

Estates reconfiguration work has been approved to proceed with investment which will support green pathways for TOE procedures through Lincoln and Pilgrim sites, in addition to Grantham site.

Demand management pathways for upper GI and lower GI introduced during the Manage phase continue to prove 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.

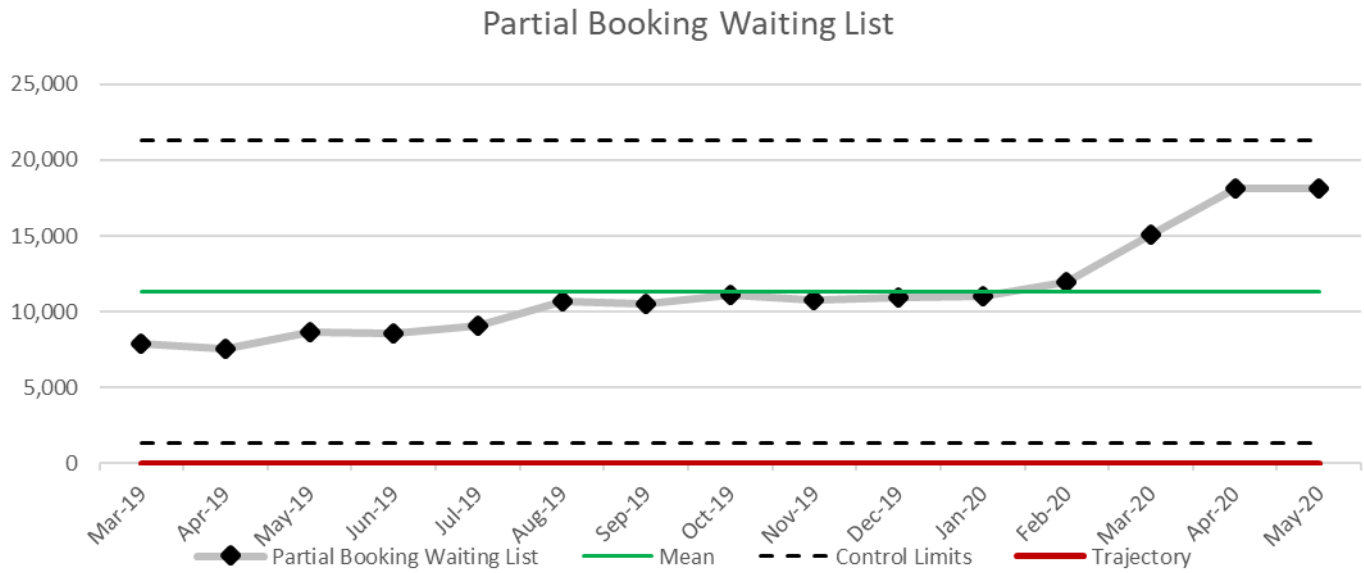
The potential for alternative procedures, such as capsule endoscopy, is being explored.

ZERO WAITING – PARTIAL BOOKING WAITING LIST

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

2021 Objective: Our Services

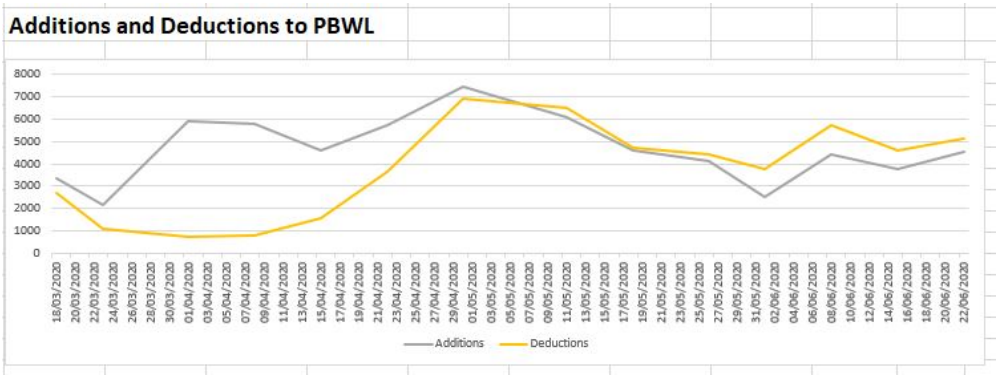


Challenges/Successes:

Following a period of growth due to a significant reduction in routine outpatient activity as a consequence of the Trust's response to COVID-19, the partial booking waiting list size has stabilised in May. Furthermore, subsequent monitoring into June demonstrates four weeks of continued reduction of the PBWL by circa. 900 per week.

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 waiting list deductions have consistently overtaken additions.

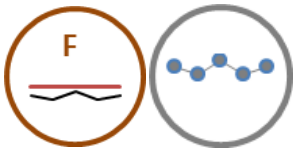


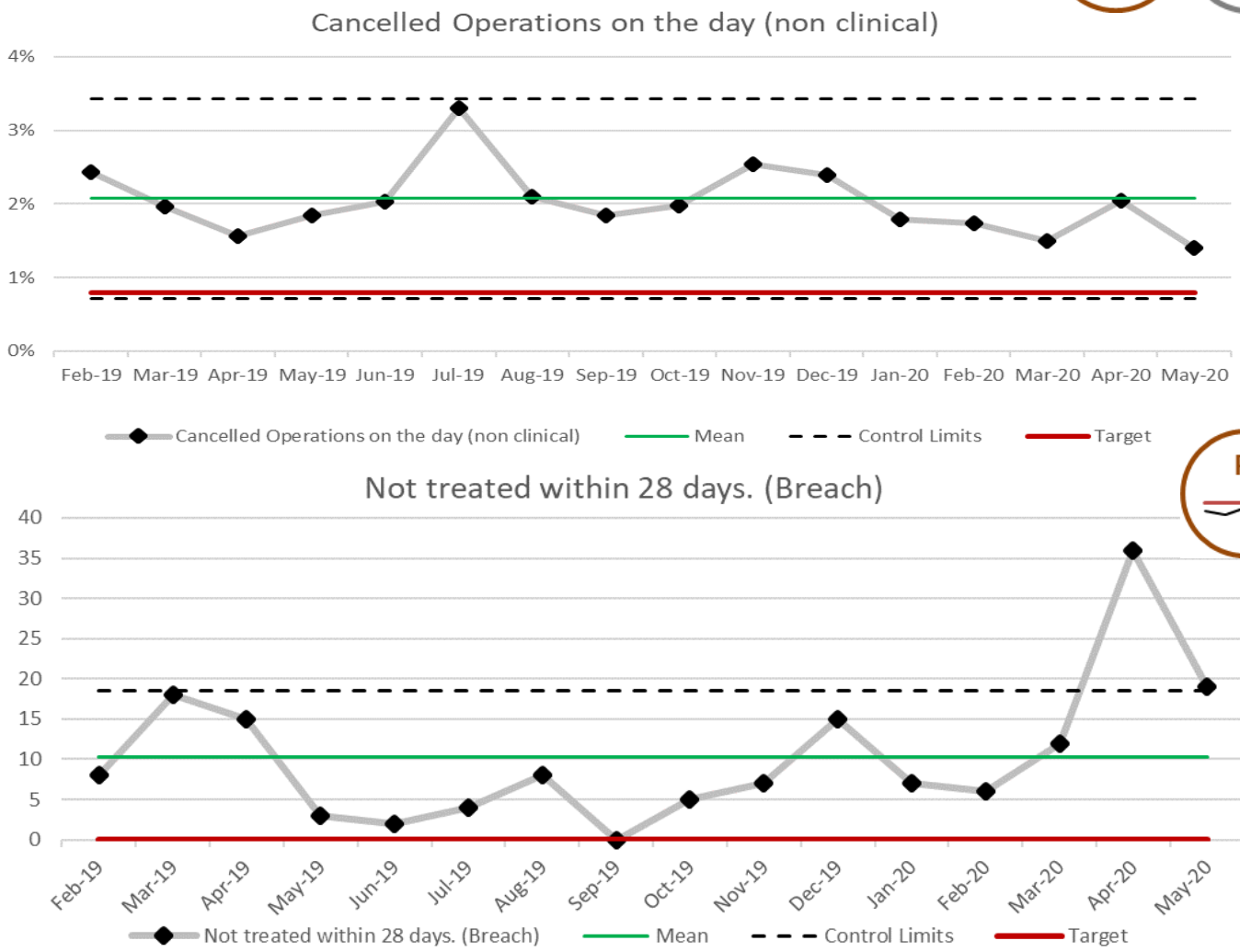
ZERO WAITING – CANCELLED OPS

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

2021 Objective: Our Services





Non clinical cancellation reasons include lack of availability of ITU/HHUD/level 1 bed provision, and lack of time to complete the list.

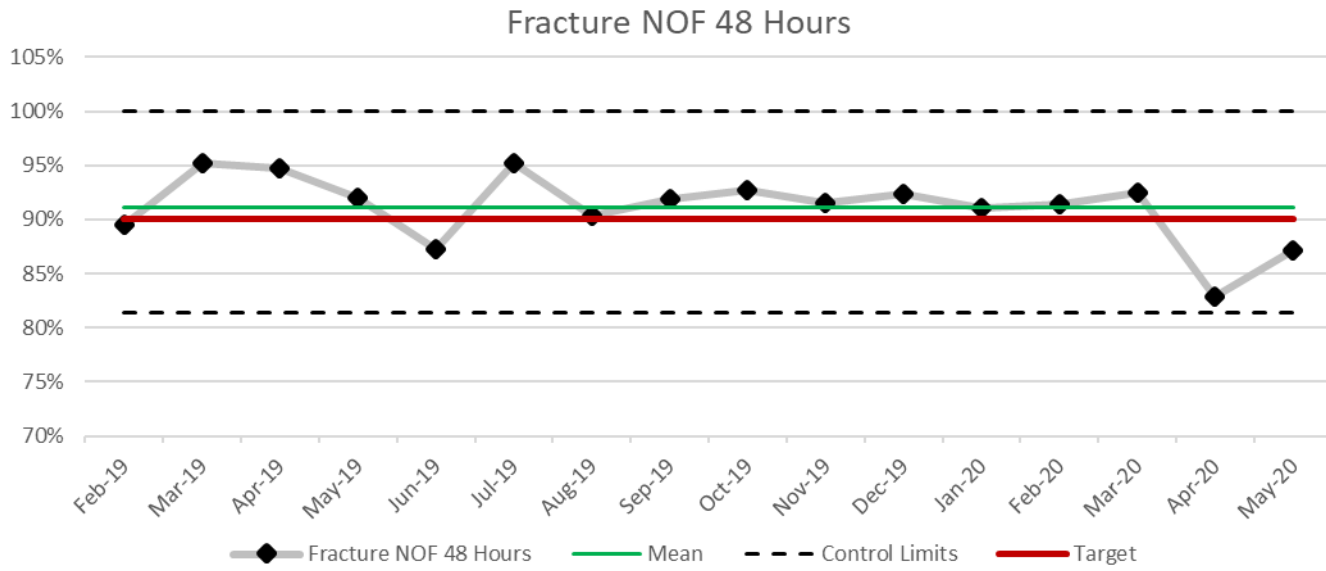
This has been a particular challenge due to the pressures on ITU bed capacity and the additional requirements for donning and doffing. ITU capacity is improving so we do not expect to see cancellations due to bed space moving forward. Lack of time to complete lists are primarily due to preceding cases overrunning due to complexity.

ZERO WAITING – FRACTURE NOF 48 HOURS

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

2021 Objective: Our Services



There are processes in place to ensure our time to theatre is within 36 hours where a patient is medically fit. However, due to the PPE used in the trauma theatre for AGP procedures, this has dramatically reduced the amount of trauma listed per day.

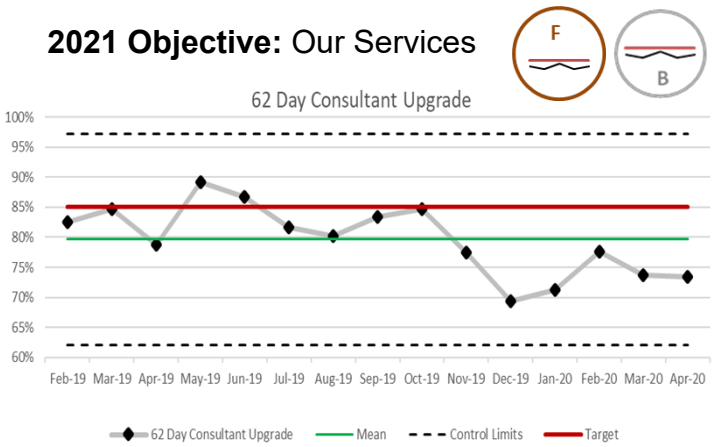
Trauma and Orthopaedics have not seen a reduction in NOF's during COVID but a reduction in theatre time has impacted on our time to theatre targets.

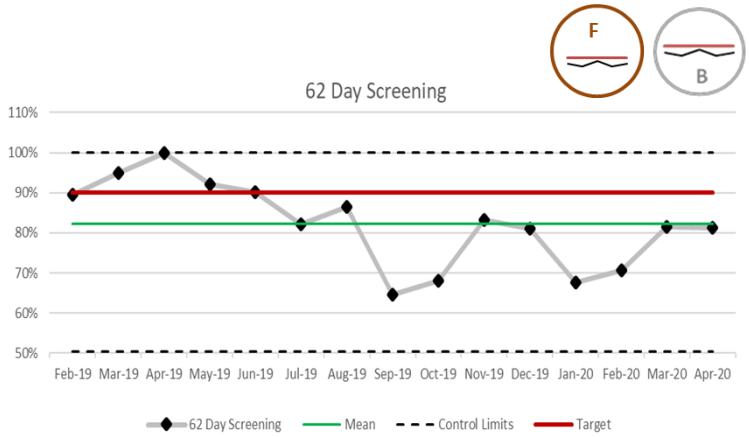
ZERO WAITING – CANCER 62 DAY

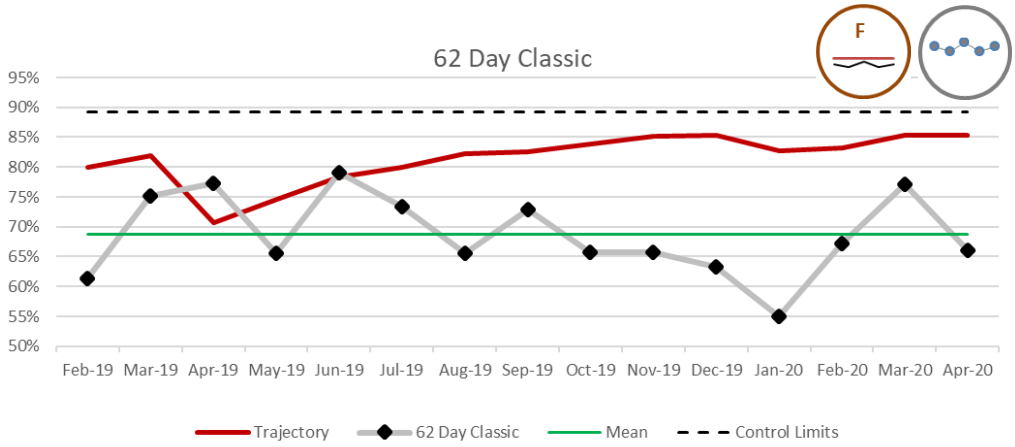
Executive Lead: Chief Operating Officer

CQC Domain: Responsive

2021 Objective: Our Services







Challenges/Successes

April saw a deterioration in the 62 Day Classic performance to 66.1%, under-performed against the trajectory of 70.8% with only Upper GI and Urology performing against their agreed trajectory.

Early indications are that our May 62 Day Classic performance will be similar to where it was this time last year, with anticipated performance being circa 65% (trajectory 74.8%).

Backlog of 62 day classic treatment

Actions in place to recover:

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

The Green Site model approved at the Extraordinary Board on 11th June will provide a substantial increase in operating capacity (adding an additional 4 theatres for 5 days and then increasing to 6-7 days), together with an ambition of increased confidence for patients who require surgery.

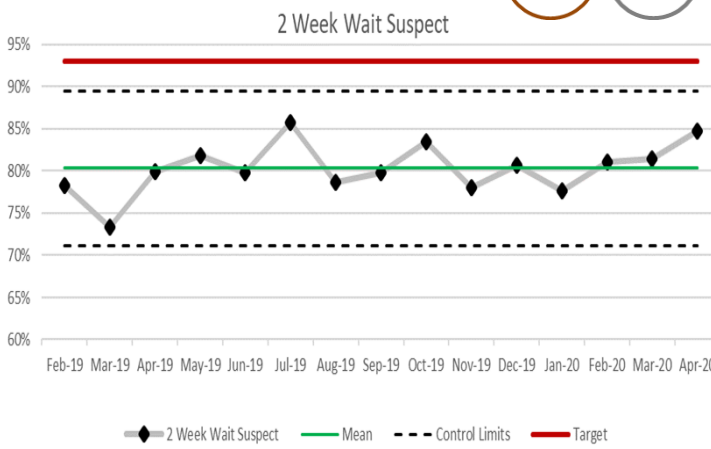
The new model will start in July and will address a substantial part of the 62 day waiting list in early weeks of operation.

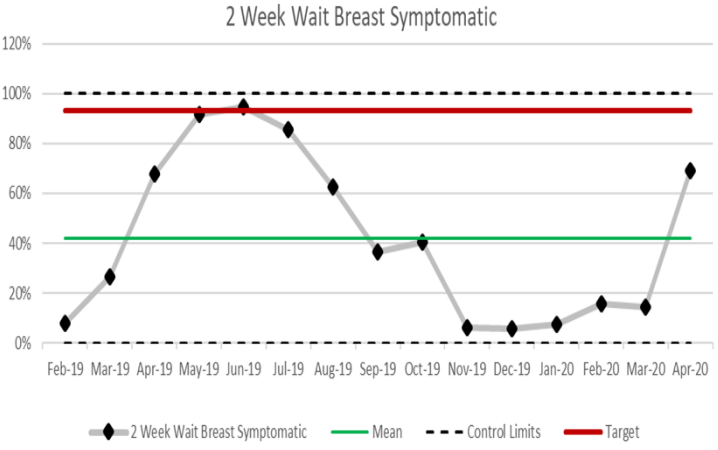
ZERO WAITING – CANCER 2 WEEK WAIT

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

2021 Objective: Our Services





Challenges/Successes

Only five tumour sites met the 14 Day standard in April (Haematology, Lung, Sarcoma, Skin and Urology) with Gynaecology narrowly missing at 92.92% (standard 93%).

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

7 Day target Referral-to-First OPA 80%	May-20 Total	May-20 7 Day Prfrmnce %
Brain/CNS	7	100.0
Breast	210	29.5
Breast Symptomatic	84	23.8
Colorectal	308	54.6
Gynaecology	130	30.0
Haematology	6	66.7
Head & Neck	173	58.4
Lung	46	67.4
Sarcoma	8	87.5
Skin	221	97.7
Upper GI	118	38.1
Urology	96	50.0
Totals (excl Breast Sympto)	1323	55.0

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 lower volume/higher quality referrals reach the Trust.

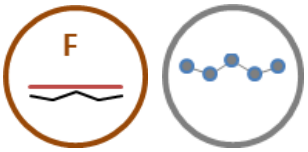
May's Breast 14 Day performance is showing an improved performance at 95.7%.

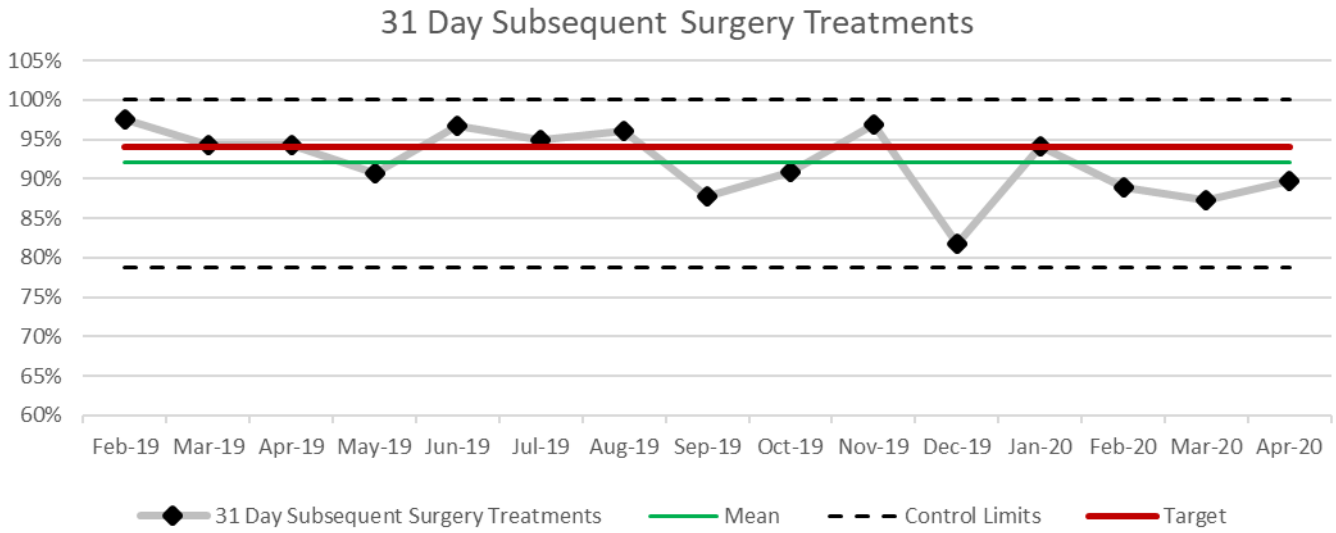
ZERO WAITING – 31 DAY SUBSEQUENT SURGERY TREATMENTS

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

2021 Objective: Our Services





Challenges/Successes

The 31 Day Subsequent Surgery standards were missed primarily due to the impact of COVID and the consequent lack of theatre 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.

The Green Site model approved at the Extraordinary Board on 11th June 2020 will provide a substantial increase in operating capacity (adding an additional 4 theatres for 5 days and then increasing to 6-7 days), together with an ambition of increased confidence for patients who require surgery.

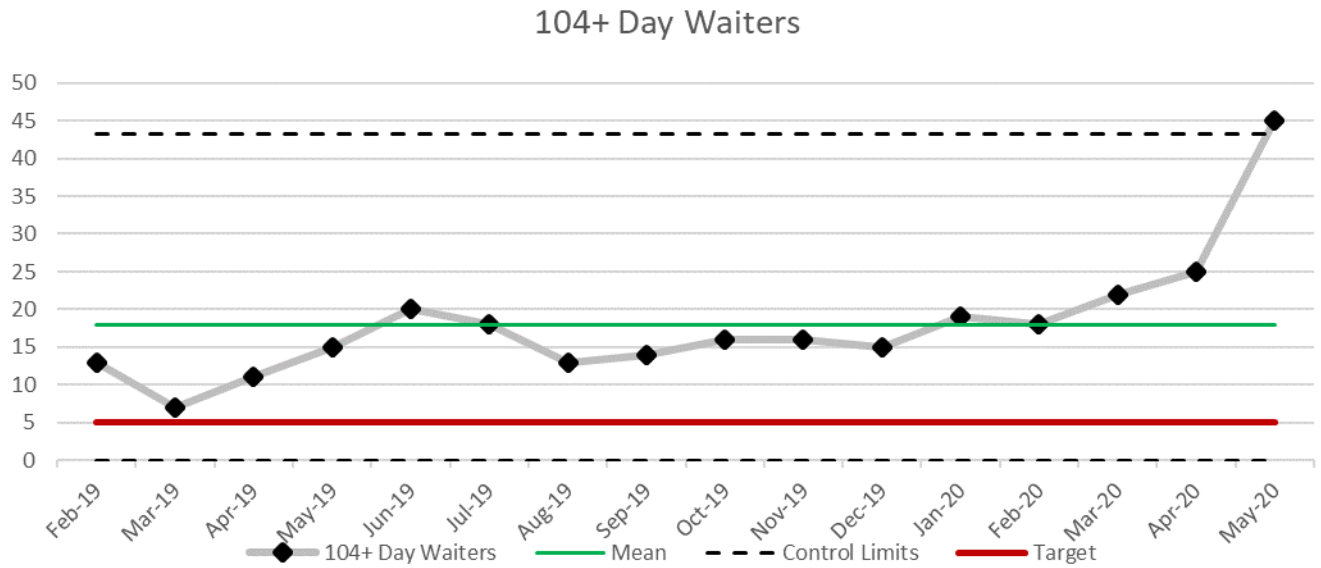
The new model will start in July and will contribute significantly to the delivery of 31-day subsequent surgery.

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 pre-COVID but the crisis temporarily stopped diagnostics and treatments, both at ULHT and tertiary centres, and this has had a significant impact on these numbers. As of 17th June there were 79 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 are waiting for an Endoscopy procedure or have declined to attend for investigations during COVID. There is a weekly review of all patients over 104 days with the Cancer Lead Clinician.

Actions in place to recover:

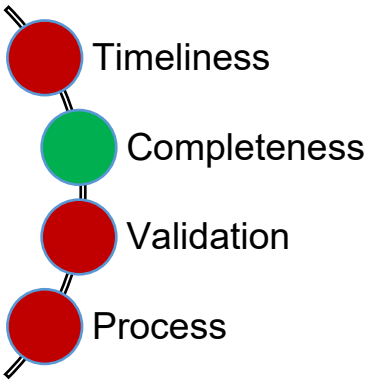
The national focus for cancer as we transition from the Restore to Recovery phase is to reduce the 62+ Day backlog and this will consequently minimise the numbers approaching the 104 day mark.

The Green Site model approved at the Extraordinary Board on 11th June will provide a substantial increase in operating capacity (adding an additional 4 theatres for 5 days and then increasing to 6-7 days), together with an ambition of increased confidence for patients who require surgery.

The new model will start in July and will address a substantial part of the 104 day waiting list in early weeks of operation.

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. This is run along side the harm review process which is carried out of all 104+ day patients.

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

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*7th July 2020*
Item Number	*13.1*
Strategic Risk Report	
Accountable Director	*Dr Neill Hepburn, Medical Director*
Presented by	*Dr Neill Hepburn, Medical Director*
Author(s)	*Paul White, Risk Management Lead*
Report previously considered at	*N/A*

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

Risk Assessment	*Multiple – please see report*
Financial Impact Assessment	*None*
Quality Impact Assessment	*None*
Equality Impact Assessment	*None*
Assurance Level Assessment	*Moderate*

Recommendations/ Decision Required	• *To review the report and identify any areas requiring further action*

Executive Summary

41 out of 82 strategic risks recorded on Datix are currently rated as Very high or High (50% of the total). This profile has remained largely unchanged for more than 12 months.

Local impact of the global coronavirus (Covid-19) pandemic, risk of harm to patients, staff and visitors; is currently rated as Very high risk (25). This risk will need to be reassessed to take account of the developing course of the pandemic and changes to Trust services.

Recommendations made following a report on the current Harm Review Process are being taken forward by the Operations and Clinical Governance teams.

The risk associated with the UK's exit from the EU in December 2020 has been reviewed and increased from Low (40 To Moderate (8) due to the degree of uncertainty caused by a lack of progress with trade talks. No further guidance has been issued by the national lead to date.

The workforce risk profile remains the same as last month.

Of the 196 risks recorded on divisional business unit risk registers, 44 (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, as CBUs have reviewed and updated some older risks.

Purpose

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

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

Key messages

Introduction

4.1 The Trust's risk registers are recorded on the Datix Risk Management System. They are comprised of two distinct layers, which are defined in the Trust's current Risk Management Strategy as:

- Strategic risk register – used to manage significant risks to the achievement of Trust-wide or multi-divisional objectives
- Operational risk registers – used to manage significant risks to the objectives of divisional business units and their departments or specialties

4.2 Each strategic risk has an Executive lead, with overall responsibility for its management; and a Risk lead, who is responsible for reviewing the risk and updating the risk register in accordance with the Trust's Risk Management Policy. The majority of strategic risks are also aligned with the appropriate assurance committee of the Trust Board and assigned to a lead group to enable regular scrutiny of risk responses and mitigation plans to take place.

4.3 Each operational risk has a divisional lead and a business unit risk lead. Operational risks are also aligned with the Trust's assurance committee and lead group governance arrangements.

4.4 Strategic and operational risk registers consist of two types of risk:

- Core risks – that are set by the Risk Management Strategy and remain open on the appropriate risk register even when managed down to an acceptable level, so as to continue to provide valuable assurance as to their effective management
- Non-core risks – that are added in response to the identification of a specific threat or vulnerability that is outside of the scope of the core risk register

4.5 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**.

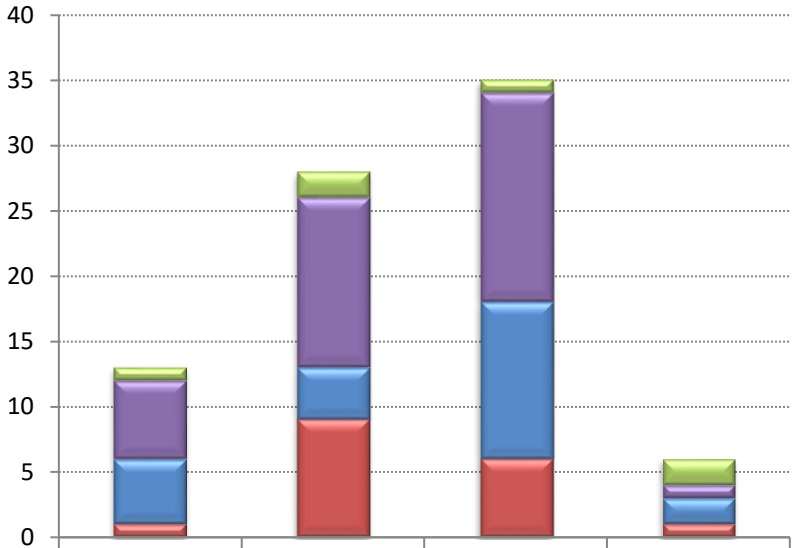
4.6 All entries on the strategic or operational risk registers should be formally reviewed and updated on a quarterly basis as a minimum requirement, although they can be updated in the interim if there is evidence that the level

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

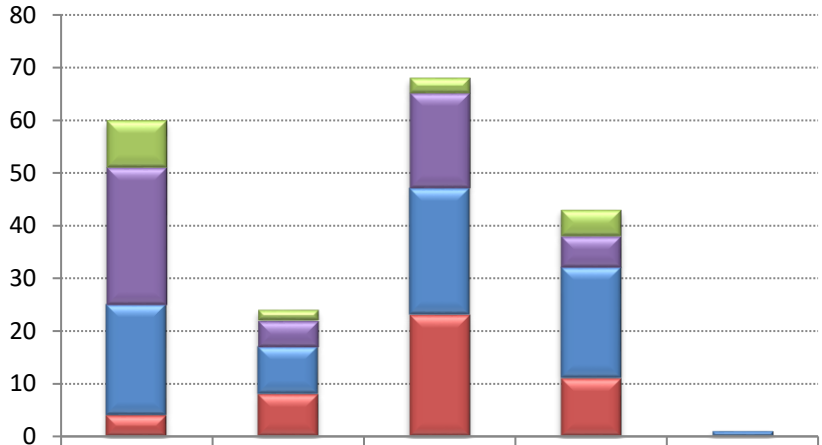
4.8 **Chart 1** shows the number of strategic risks by risk type and current risk rating (taking account of existing controls):



	Low risk	Moderate risk	High risk	Very high risk
Finances	1	2	1	2
Reputation / compliance	6	13	16	1
Service disruption	5	4	12	2
Harm (physical or psychological)	1	9	6	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	2	3	5	0
Reputation / compliance	26	5	18	6	0
Service disruption	21	9	24	21	1
Harm (physical or psychological)	4	8	23	11	0

Trust risk profile analysis

4.10 41 out of 82 strategic risks recorded on Datix are currently rated as Very high or High (50% 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 The Medical Director; Director of Nursing and Director of HR&OD have this month reviewed the risks for which they are executive lead. The following High and Very high strategic risks are currently assessed as 'not assured' due to insufficient progress with the risk management plan and will be highlighted in reports to the lead committees and groups:

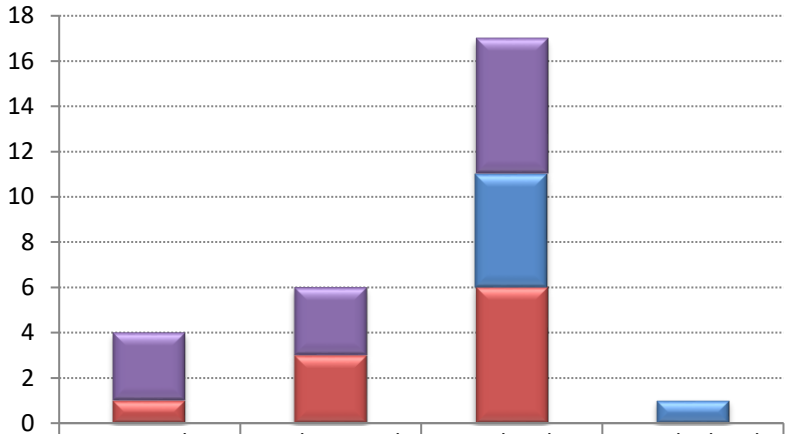
- Patient safety compliance
- Aseptic pharmacy services
- Medicines safety
- Safeguarding compliance & practice
- Workforce engagement
- Workforce capacity & planning

4.12 Of the 196 risks recorded on divisional business unit risk registers, 44 (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

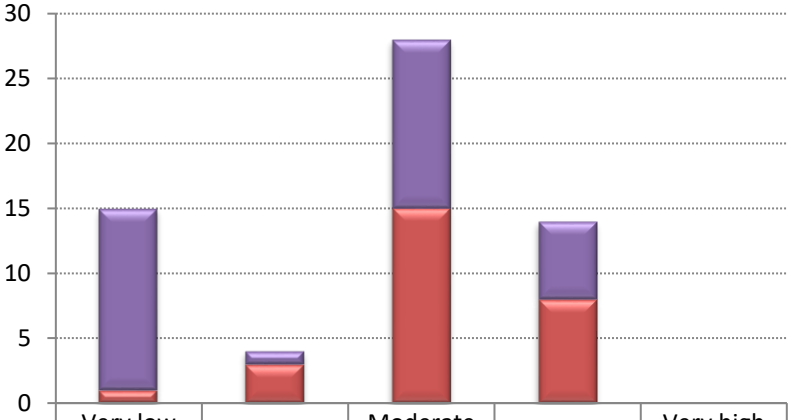
4.12 The Quality Governance Committee (QGC) is the lead assurance committee responsible for oversight of the Quality and Safety Risk Profile. The QGC has continued to meet throughout the Covid-19 pandemic, although with a reduced agenda. Most lead groups have also continued to meet wherever possible.

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	13	6	0
Service disruption	0	0	0	0	0
Harm (physical or psychological)	1	3	15	8	0

Quality & safety risk profile analysis

4.15 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 12-16) and lower proportion of Moderate risks (8-10).

4.16 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):

- The national progression of COVID-19 continues to slow, which is mirrored locally within Lincolnshire. We remain the least affected system across the Midlands. The Trust's restoration plan is now in progress, focussed on infection prevention and control, and increased testing whilst reinstating elements of our services, including full urgent care services and increased elective care services including cancer screening, diagnostics and surgery
- This risk will need to be reassessed to take account of the developing course of the pandemic and changes to Trust services
- The strategic risk of prolonged, widespread service disruption due to the outbreak remains at a rating of High risk (16)
- Clinical Business Unit (CBU) risk registers are being used to document assessments and mitigations that are specific to particular specialties and services
- Analysis of Covid-related harm reviews was presented to the Quality Governance Committee this month; this identified that the current process is used to review potential patient harm due to delays in outpatient processes as well as for handover delays outside A&E; the review made recommendations for strengthening the existing process that are being taken forward by the Operations and Clinical Governance teams

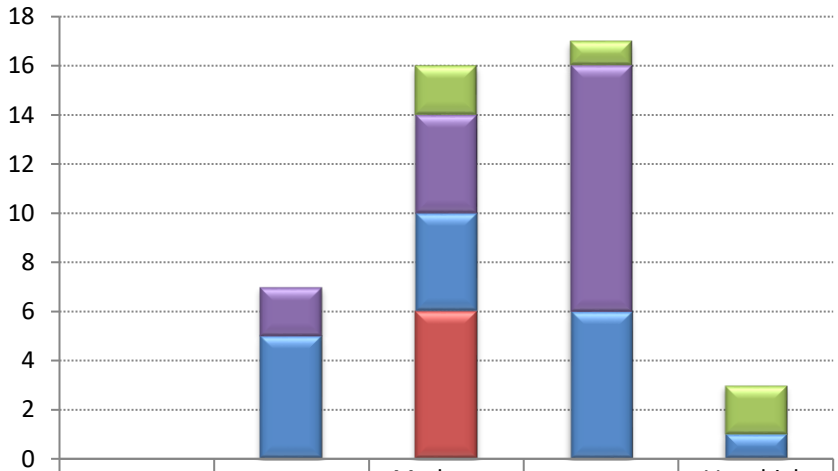
4.17 There are also currently High risks to quality and safety in the following areas:

- Patient safety and clinical effectiveness (reviewed by the Patient Safety Group and Clinical Effectiveness Group orespectively):
    - The response to deteriorating patients;
    - Safety of invasive procedures;
    - Delivery of non-invasive ventilation (NIV);
    - Safety of patient handovers;
    - Appropriate patient discharge; and
    - Safe patient flow decision-making)
    - An up to date assessment of patient falls risk is taking place, including a review of learning from recent Serious Incidents
- Safeguarding practice and compliance – the Safeguarding Group reviews these risks and mitigation plans at each meeting
- Medicines safety, compliance and supply – the Chief Pharmacist is in the process of reassessing risks associated with aseptic services, in light of temporary mitigations and future long term plans

Finance, performance and estates risk profile

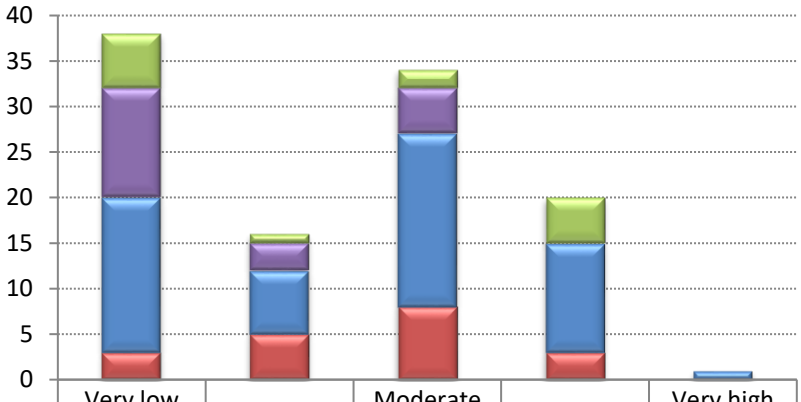
4.18 The Finance, Performance and Estates Committee (FPEC) is the lead assurance committee responsible for oversight of the Finance, Performance and Estates Risk Profile. The FPEC has not met during the Covid-19 pandemic.

4.19 **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	5	4	6	1
Harm (physical or psychological)	0	0	6	0	0

4.20 **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

4.21 20 of the 43 strategic FPEC risks (47%) are currently rated High or Very high risk, none of which have reduced in the past 12 months. This includes significant risks in the following areas:

- Financial sustainability – these risks are due for review in light of the government's announcements on reducing NHS debt
- Managing demand for emergency care; planned care; and outpatient appointments – these risks have been affected by the pandemic response and will ned to be reassessed in light of subsequent service changes (such as the use of video calls for 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

4.22 The strategic risk of significant disruption to services due to the UK's exit from the European Union in December 2020 has been reviewed this month and increased from Low risk (4) to Moderate risk (8). This increase reflects the growing uncertainty and anxiety within the business community due to a lack of progress with trade negotiations, largely as a consequence of the impact of the Covid-19 pandemic. No further advice or guidance has been received from the national lead for EU Exit, therefore there is no action for the Trust to take at this time.

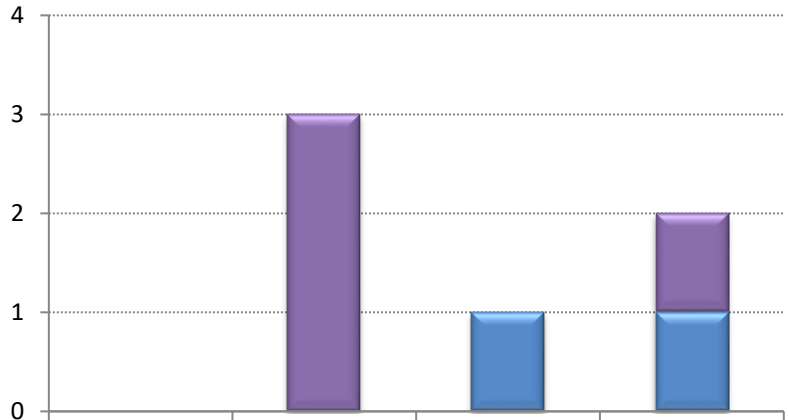
4.23 21 of the 109 operational FPEC risks (19%) are currently rated High or Very high risk, unchanged from last month. The highest risks in this area relate to:

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

Workforce risk profile

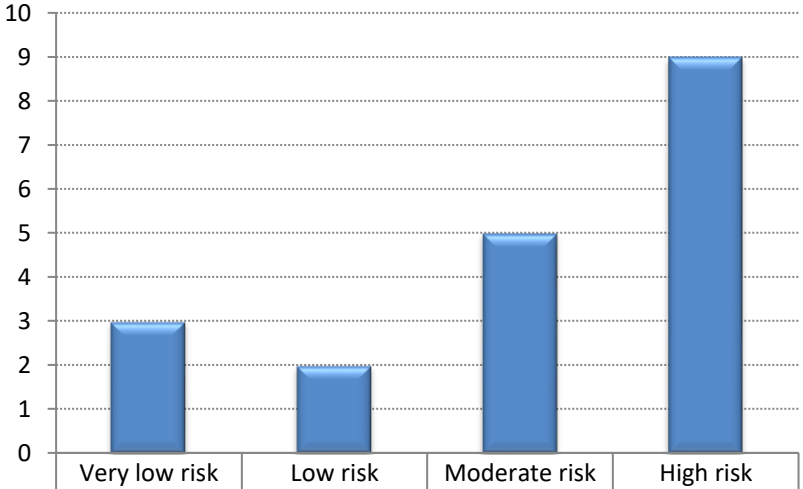
4.24 The Workforce & Organisational Development Committee (WODC) is the lead assurance committee responsible for oversight of the Workforce Risk Profile. The WODC has not met during the Covid-19 pandemic.

4.25 **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

4.24 **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	3	2	5	9
Harm (physical or psychological)	0	0	0	0

Workforce risk profile analysis

4.24 9 of the 19 business units (47%) current assess their workforce capacity and capability as High risk. All of these are Clinical Business Units (CBUs). This has reduced from 11 (58%) this month as CBU risk register have been reviewed and updated.

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

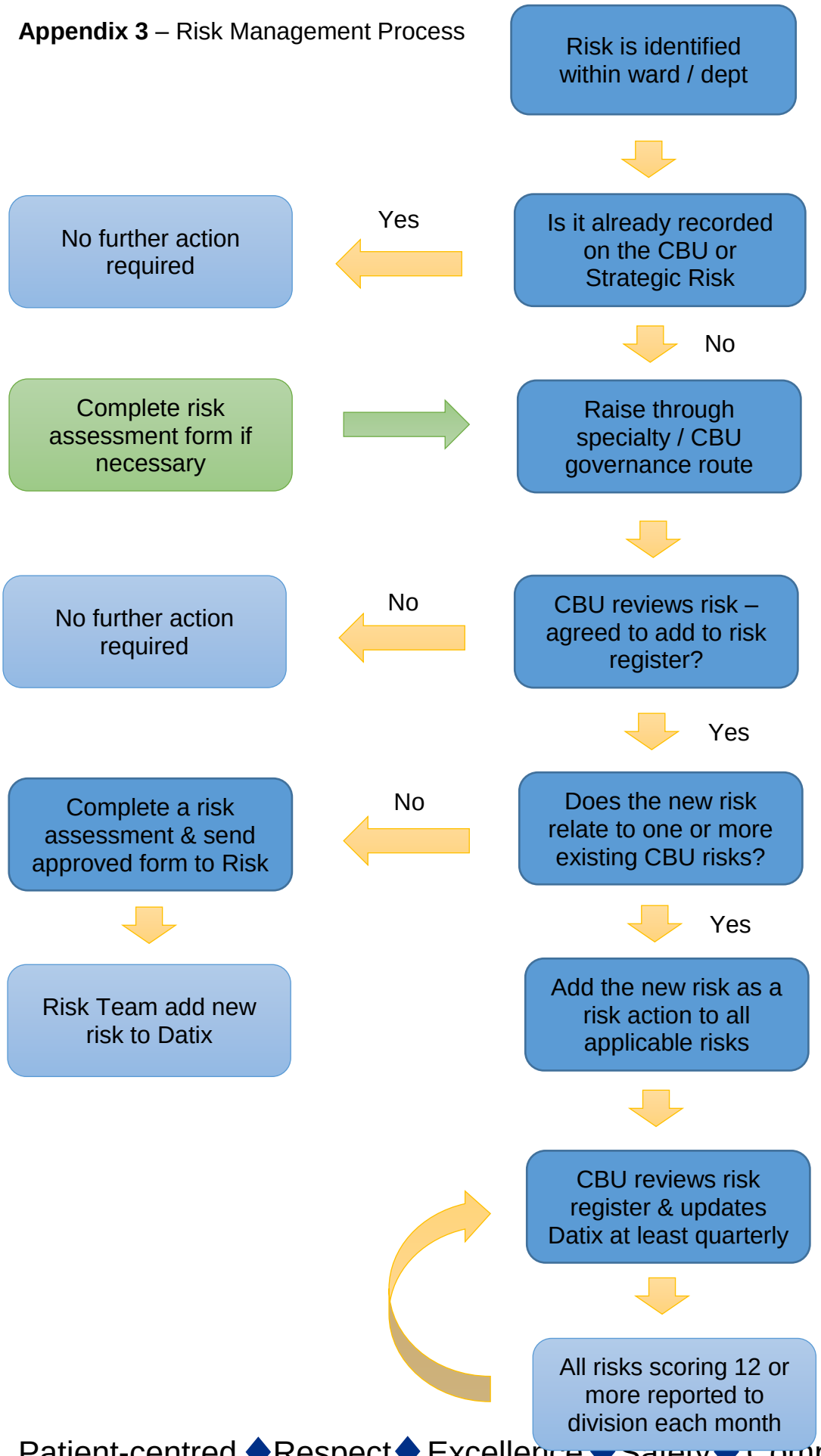
The Trust's current statement of risk appetite in relation to each of its strategic objectives is summarised on the following table, along with a brief explanation of what this means in practical terms:

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 / psychological)	25	Very high risk
4175	Capacity to manage emergency demand	Medicine	Service disruption	20	Very high risk
4362	Workforce capacity & capability (recruitment, retention & skills)	Corporate	Service disruption	20	Very high risk
4083	Workforce engagement, morale & productivity	Corporate	Reputation / compliance	20	Very high risk
4382	Delivery of the Financial Recovery Programme	Corporate	Finances	20	Very high risk
4383	Substantial unplanned expenditure or financial penalties	Corporate	Finances	20	Very high risk
4480	Safe management of emergency demand	Medicine	Harm (physical / psychological)	16	High risk
4437	Critical failure of the water supply	Corporate	Service disruption	16	High risk
4405	Critical infrastructure failure disrupting aseptic pharmacy services	Clinical Support	Service disruption	16	High risk
4403	Compliance with electrical safety regulations & standards	Corporate	Reputation / compliance	16	High risk
4384	Substantial unplanned income reduction or missed opportunities	Corporate	Finances	16	High risk
4144	Uncontrolled outbreak of serious infectious disease	Corporate	Service disruption	16	High risk
3520	Compliance with fire safety regulations & standards	Corporate	Reputation / compliance	16	High risk
3688	Quality of the hospital environment	Corporate	Reputation / compliance	16	High risk
3690	Compliance with water safety regulations & standards	Corporate	Reputation / compliance	16	High risk
3720	Critical failure of the electrical infrastructure	Corporate	Service disruption	16	High risk
3951	Compliance with regulations & standards for aseptic pharmacy services	Clinical Support	Reputation / compliance	16	High risk
4156	Safe management of medicines	Clinical Support	Harm (physical / psychological)	16	High risk
4044	Compliance with information governance regulations & standards	Corporate	Reputation / compliance	16	High risk
4497	Contamination of aseptic products	Clinical Support	Harm (physical / psychological)	15	High risk

ID	Title	Division	Risk Type	Rating (current)	Risk level (current)
4481	Availability of patient information	Corporate	Service disruption	12	High risk
4556	Safe management of demand for outpatient appointments	Clinical Support	Harm (physical / psychological)	12	High risk
4176	Management of demand for planned care	Surgery	Service disruption	12	High risk
4181	Significant breach of confidentiality	Corporate	Reputation / compliance	12	High risk
4179	Major cyber security attack	Corporate	Service disruption	12	High risk
4157	Compliance with medicines management regulations & standards	Clinical Support Services	Reputation / compliance	12	High risk
4043	Compliance with patient safety regulations & standards	Corporate	Reputation / compliance	12	High risk
4145	Compliance with safeguarding regulations & standards	Corporate	Reputation / compliance	12	High risk
4146	Effectiveness of safeguarding practice	Corporate	Harm (physical / psychological)	12	High risk
3689	Compliance with asbestos management regulations & standards	Corporate	Reputation / compliance	12	High risk
3503	Sustainable paediatric services at Pilgrim Hospital, Boston	Family Health	Service disruption	12	High risk
4142	Safe delivery of patient care	Corporate	Harm (physical / psychological)	12	High risk
4081	Quality of patient experience	Corporate	Reputation / compliance	12	High risk
4082	Workforce planning process	Corporate	Service disruption	12	High risk
4368	Efficient and effective management of demand for outpatient appointments	Clinical Support	Reputation / compliance	12	High risk
4300	Availability of medical devices & equipment	Corporate	Service disruption	12	High risk
4385	Compliance with financial regulations, standards & contractual obligations	Corporate	Reputation / compliance	12	High risk
4402	Compliance with regulations and standards for mechanical infrastructure	Corporate	Reputation / compliance	12	High risk
4406	Critical failure of the medicines supply chain	Clinical Support	Service disruption	12	High risk
4423	Working in partnership with the wider healthcare system	Corporate	Service disruption	12	High risk
4476	Compliance with clinical effectiveness regulations & standards	Corporate	Reputation / compliance	12	High risk

ID	Title	Division	Risk Type	Rating (current)	Risk level (current)
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 / psychological)	8	Moderate risk
4553	Failure to appropriately manage land and property	Corporate	Finances	8	Moderate risk
4483	Safe use of radiation	Clinical Support	Harm (physical / psychological)	8	Moderate risk
4486	Clinical outcomes for patients	Corporate	Harm (physical / psychological)	8	Moderate risk
4424	Delivery of planned improvements to quality & safety of patient care	Corporate	Reputation / compliance	8	Moderate risk
4467	Impact of a 'no deal' EU Exit scenario	Corporate	Service disruption	8	Moderate risk
4404	Major fire safety incident	Corporate	Harm (physical / psychological)	8	Moderate risk
4389	Compliance with corporate governance regulations & standards	Corporate	Reputation / compliance	8	Moderate risk
4397	Exposure to asbestos	Corporate	Harm (physical / psychological)	8	Moderate risk
4398	Compliance with environmental and energy management regulations & standards	Corporate	Reputation / compliance	8	Moderate risk
4399	Compliance with health & safety regulations & standards	Corporate	Reputation / compliance	8	Moderate risk
4400	Safety of working practices	Corporate	Harm (physical / psychological)	8	Moderate risk
4401	Safety of the hospital environment	Corporate	Harm (physical / psychological)	8	Moderate risk
4363	Compliance with HR regulations & standards	Corporate	Reputation / compliance	8	Moderate risk
4138	Patient mortality rates	Corporate	Reputation / compliance	8	Moderate risk
4141	Compliance with infection prevention & control regulations & standards	Corporate	Reputation / compliance	8	Moderate risk
3687	Implementation of an Estates Strategy aligned to clinical services	Corporate	Service disruption	8	Moderate risk
3721	Critical failure of the mechanical infrastructure	Corporate	Service disruption	8	Moderate risk
3722	Energy performance and sustainability	Corporate	Finances	8	Moderate risk

ID	Title	Division	Risk Type	Rating (current)	Risk level (current)
4003	Major security incident	Corporate	Harm (physical / psychological)	8	Moderate risk
4177	Critical ICT infrastructure failure	Corporate	Service disruption	8	Moderate risk
4180	Reduction in data quality	Corporate	Reputation / compliance	8	Moderate risk
4182	Compliance with ICT regulations & standards	Corporate	Reputation / compliance	8	Moderate risk
4351	Compliance with equalities and human rights regulations, standards & contractual requirements	Corporate	Reputation / compliance	8	Moderate risk
4352	Public consultation & engagement	Corporate	Reputation / compliance	8	Moderate risk
4353	Safe use of medical devices & equipment	Corporate	Harm (physical / 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	Reputation / compliance	4	Low risk
4469	Compliance with blood safety & quality regulations & standards	Clinical Support	Reputation / compliance	4	Low risk
4482	Safe use of blood and blood products	Clinical Support	Harm (physical / psychological)	4	Low risk
4502	Compliance with regulations & standards for medical device management	Corporate	Reputation / compliance	4	Low risk
4514	Hospital @ Night management	Corporate	Service disruption	4	Low risk

Appendix 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	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	Service disruption	12	High risk
4169	Availability of essential information (Pharmacy)	Clinical Support	Service disruption	12	High risk
4170	Workforce capacity & capability (Pharmacy)	Clinical Support	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 / 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
4297	Workforce capacity & capability (Therapies & Rehabilitation)	Clinical Support	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 / psychological)	12	High risk
4304	Health, safety & security of staff, patients and visitors (Specialty Medicine CBU)	Medicine	Harm (physical / 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 / psychological)	12	High risk
4317	Exceeding annual budget (Cardiovascular CBU)	Medicine	Finances	12	High risk
4320	Workforce capacity & capability (Cardiovascular CBU)	Medicine	Service disruption	12	High risk

ID	Title	Division	Risk Type	Rating (current)	Risk level (current)
4322	Safety & effectiveness of patient care (Cardiovascular CBU)	Medicine	Harm (physical / 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 / 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	Service disruption	12	High risk
4372	Compliance with regulations & standards (Outpatient Services)	Clinical Support	Reputation / compliance	12	High risk
4391	Health, safety & security of staff, patients and visitors (Estates & Facilities)	Corporate	Harm (physical / 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 / 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 / psychological)	12	High risk
4420	Workforce capacity & capability (Children & Young Persons CBU)	Family Health	Service disruption	12	High risk
4425	Workforce capacity & capability (Diagnostics CBU)	Clinical Support	Service disruption	12	High risk
4429	Availability of essential information (Diagnostics CBU)	Clinical Support	Service disruption	12	High risk
4435	Access to essential areas of the estate (Diagnostics CBU)	Clinical Support	Service disruption	12	High risk

ID	Title	Division	Risk Type	Rating (current)	Risk level (current)
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 / psychological)	12	High risk

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*7 July 2020*
Item Number	*Item 13.2*
Board Assurance Framework (BAF) 2020/21	
Accountable Director	*Andrew Morgan Chief Executive*
Presented by	*Jayne Warner, Trust Secretary*
Author(s)	*Karen Willey, Deputy Trust Secretary*
Report previously considered at	*N/A*

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

Risk Assessment	*Objectives within BAF referenced to Risk Register*
Financial Impact Assessment	*N/A*
Quality Impact Assessment	*N/A*
Equality Impact Assessment	*N/A*
Assurance Level Assessment	*Insert assurance level* • *Limited*

Recommendations/ Decision Required	• *Board to consider assurances provided in respect of Trust objectives noting that framework has not been reviewed through committee structure as a result of governance arrangements in place during covid incident.*

Executive Summary

The relevant objectives of the 2020/21 BAF were presented to the Quality Governance Committee during June and all other objectives reviewed and updated by the Executive Directors.

The Quality Governance Committee was able to identify an assurance rating for objective 1a – Deliver Harm Free Care based on the assurance reports received however did not receive reports in relation to objectives 1b – Improve Patient Experience and 1c – Improve Clinical Outcomes.

As such the Committee was not able to provide assurance ratings for these objectives.

Where the Committees have not met due to Covid-19 governance arrangements, indicative assurance ratings have been provided by the Executive Directors as part of the BAF review process.

The following assurance ratings have been identified:

Objective		Assurance Rating
1a	Deliver harm free care	**R**
1b	Improve patient experience	Rating not provided
1c	Improve clinical outcomes	Rating not provided
2a	A modern and progressive workforce	**R**
2b	Making ULHT the best place to work	**R**
2c	Well led services	**A**
3a	A modern, clean and fit for purpose environment	**R**
3b	Efficient use of resources	**G**
3c	Enhanced data and digital capability	**A**
4a	Establish new evidence based models of care	**R**
4b	Advancing professional practice with partners	**G**
4c	To become a University Hospitals Teaching Trust	**A**

Board Assurance Framework (BAF) 2020/21 - June 2020

Strategic Objective	Board Committee
Patients: To deliver high quality, safe and responsive **patient** services, shaped by best practice and our communities	Quality Governance Committee
People: To enable our **people** to lead, work differently and to feel valued, motivated and proud to work at ULHT	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 identified and reported through to Gold Command Structure. Reviews of the Incident Management Structure are Conducted at the end of each phase and include any gaps in controls. Audits of changes are carried out internally and externally as part of NHSE change processes.	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	**R**
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 identified and reported through to Gold Command Structure. Reviews of the Incident Management Structure are Conducted at the end of each phase and include any gaps in controls. Audits of changes are carried out internally and externally as part of NHSE change processes.	Getting real time patient and carer feedback Hold 6 listening events Thematic reviews of complaints and compliments User involvement numbers National patient surveys Number of locally implemented changes as a result of patient feedback	Assurance received through daily/weekly briefing processes with Chair/CEO/ Execs	Assurance gaps to be identified through Trust Board streamlined governance process and Quality Governance Committee	Quality Governance Committee	**Assurance papers not received due to COVID-19, therefore the Committee could not provide a rating**

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 identified 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	**Assurance papers not received due to COVID-19, therefore the Committee could not provide a rating**
SO2	**To enable out people to lead, work differently and to feel valued, motivated and proud to work at ULHT**												
2a	A modern and progressive workforce	Director of People and Organisational Development	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	Declared as a level 4 incident throughout the UK. NHSE to coordinate NHS response. Major incident (Gold Command Structure) CQC actions monitored through QGC meeting during Covid 19 streamlined governance arrangements Pandemic Flu Plan initiated	Control gaps identified 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	**R**

Ref	Objective	Exec Lead	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Controls in place during Covid	How identified control gaps are being managed	Source of assurance	Assurances in place during Covid	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating
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	R
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	Review of Executive Portfolios Complete On hold Covid command structure in place On hold On hold Board Development sessions on hold due to covid Covid command structure in place PID in place. Paper to ELT w/c 29 June 2020	Covid Command and decision making structure alongside Board agreed lean governance arrangements	Third party assessment of well led domains Internal Audit assessments Completeness of risk registers Annual Governance Statement Number of Shared decision making councils in place Numbers of in date policies	No assurance received Head of Internal Audit Opinion received showing improved position on previous year Annual Governance Statement - Completed.	No assurance received on policies. Escalated from Quality Governance Committees paper to ELT w/c 29 June, escalation and rapid review of actions and blockers.	Audit Committee	A

Ref	Objective	Exec Lead	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Controls in place during Covid	How identified control gaps are being managed	Source of assurance	Assurances in place during Covid	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating
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	Declared as a level 4 incident throughout the UK. NHSE nationally and then regionally coordinate NHS response through a command and control process. Major incident (Gold Command Structure) employed locally. Estates and Facilities Cell reviews the key elements of environmental conditions to support the increasing demands on IPC, and complex infection control measures required. Health & Safety conditions are reviewed in the context of Estates and Facilities Cell and are reviewed by Silver Incident command and then subsequently Gold sign off.	Control gaps identified and reported through to Gold Command Structure. Reviews of the Incident Management Structure are Conducted at the end of each phase and include any gaps in controls. Audits of changes are carried out internally and externally as part of NHSE change processes.	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	Assurance received through daily/weekly briefing processes with Chair/CEO/ Execs Monthly and where necessary extraordinary board meetings review the response to Covid which include measures required to ensure environments are suitable/fit for purpose in the context of Covid. Datasets and addition reporting measures are in place that describe key environmental issues (supply of oxygen in wards as an example) to NHSE in addition to local usage for assurance purposes.	Assurance gaps identified are addressed through the command structure governance process, and mitigation steps taken. Additional reporting by exception is put in place to provide evidence and contribute to assurance process.	Finance, Performance and Estates Committee	R
3b	Efficient use of our resources	Director of Finance and Digital	Efficiency schemes do not cover extent of savings required - £27.0m Continued reliance on agency and locum staff to maintain services at substantially increased cost Failure to achieve recruitment targets increases workforce costs Unplanned expenditure (as a result of unforeseen events) or financial penalties Failure to secure all income linked to coding or data quality issues	4382 4383 4384	CQC Well Led CQC Use of Resources	Delivering £27m CIP programme in 20/21 Delivering financial plan Utilising Model Hospital, Service Line Reporting and Patient Level Costing data to drive focussed improvements Implementing the CQC Use of Resources Report recommendations Working with system partners to deliver the Lincolnshire Plan.	Deliver a monthly break-even position after taking Coivd-19 costs into account.	Divisional Financial Review Meetings Centralised agency & bank team Financial Strategy and Annual Financial Plan Performance Management Framework System wide savings plan Internal Audit: Integrated Improvement Plan - Q2 Temporary Staffing - Q1 Education Funding - Q3 Estates Management - Q4 Workforce Planning - Q2	Delivery of CIP Achievement of Financial Plan Closing the Model Hospital opportunity gap Improve service line profitability	Financial Reporting to Board Covid-19 financial governance process Suspension of national financial regime	Management of control gaps being reintroduced in a phased way from July 2020. Continue to await national guidance.	Finance, Performance and Estates Committee	G
3c	Enhanced data and digital capability	Director of Finance and Digital	Tender for Electronic Health Record is delayed or unsuccessful Tactical response to Covid-19 may impact in-year delivery. Major Cyber Security Attack Critical Infrastructure failure	4177 4179 4180 4182 4481	CQC Responsive	Improve utilisation of the Care Portal with increased availability of information Commence implementation of the electronic health record Undertake review of business intelligence platform to better support decision making Implement robotic process automation Improve end user utilisation of electronic systems Complete roll out of Data Quality kite mark	Cyber Security and enhancing core infrastructure to ensure network resilience. Roll-out IT equipment to enable agile user base.	Digital Services Steering Group Digital Hospital Group Operational Excellence Programme Outpatient Redesign Group	Number of staff using care portal Delivery of 20/21 e HR plan Number of RPA agents implemented Ensuring every IPR metric has an associated Data Quality Kite Mark Delivering improved information and reports Implement a refreshed IPR	Schemes paused to enable tactical response to Covid-19. Limited progress being made where possible.	Management of control gaps being reintroduced in a phased way from July 2020. Steady implementation of PowerBI through specific bespoke dashboards and requests. Continue to review this as part of wider BI platform Workplan being drafted to ensure compliance before end of Financial year, delayed by resource availability.	Finance, Performance and Estates Committee	A

Ref	Objective	Exec Lead	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Controls in place during Covid	How identified control gaps are being managed	Source of assurance	Assurances in place during Covid	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating
SO4	**To implement integrated models of care with our partners to improve Lincolnshire's health and well-being**												
4a	Establish new evidence based models of care	Director of Improvement and Integration	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	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) NHSE/I returns regarding waiting lists and delays in access for services Clinical review process and Harm review process in place	Control gaps identified and reported through to Gold Command Structure	Numbers of new models of care established Delivery of ASR Year 1 objectives Improvement in health and wellbeing metrics	Assurance received through daily/weekly briefing processes with Chair/CEO/Execs COVID reporting to Trust Board monthly	Assurance gaps to be identified through Trust Board streamlined governance process and Quality Governance Committee	Finance, Performance and Estates Committee	**R**
4b	Advancing professional practice with partners	Director of Nursing	Specific projects paused during Covid 19 response		CQC Caring CQC Responsive CQC Well Led	Supporting the expansion of medical training posts Support widening access to Nursing and Midwifery and AHP Support expansion of Paediatric nursing programme Developing System wide rotational posts Scope framework to support staff to work to the full potential of their licence Ensure best use of extended clinical roles and our future requirement	Nursing, Midwifery and AHPs have been feeding into the practice placement offers as coordinated by Health Education England, and have employed students who have opted in to extended clinical placements throughout the COVID pandemic. This includes all branches of nursing and midwifery.	Students who are on placement have been allowed to choose where they wish to work and have been supported in their request. There is a formal route of raising any concern via HEE, HEIs and locally. Any issues have been managed in a timely manner	Increase in training post numbers Numbers on Apprenticeship pathways Numbers of dual registrants Numbers of joint posts and non medical Consultant posts Numbers of pre-reg and RN child	Feedback has been sought from the students in practice and the Assistant Director of Nursing has engaged in the weekly strategic calls hosted by HEE	The Medical Director would be required to add information around medical staffing		**G**
4c	To become a University Hospitals Teaching Trust	Medical Director	Specific projects paused during Covid 19 response			Developing a business case to support the case for change 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			Workforce and Organisational Development Committee	**A**

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

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