Bundle Trust Board Meeting in Public Session 1 September 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 4 August 2020

Chair

Item 5.1 Public Board Minutes August 2020 v1.docx

5.2 Matters arising from the previous meeting/action log

Chair

Item 5.2 Public Action log August 2020.docx

6 Chief Executive Horizon Scan Including STP

Chief Executive

Item 6 Chief Executive Report, 020920.docx

7 Covid-19 Update

Chief Operating Officer

To follow

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

Item 8.1 QGC Upward report August 2020 v1.doc

8.2 Patient Safety Incident Management Report

Item 8.2 TB - Incident Management Report - including Never Events and other Serious Incidents - September 2020.docx

8.3 Quality Account

Medical Director

Item 8.3 Front Sheet Quality Account.docx

Item 8.3 Quality Account 2019-20 v 4.docx

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

9.1 Assurance and Risk Report from the People and Organisational Development Committee

Item 9.1 POD - Upward Report - August 2020.doc

9.2 Safer Staffing Report

Director of Nursing

Item 9.2 Safer Nurse Staffing august 2020.docx

9.3 Flu Best Practice Checklist

Director of People and OD

Item 9.3 Board-Report - 2020-21 Flu Vaccination Campaign.docx

Item 9.3 Appendix A - Flu Self Assessment.docx

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

10.1 Assurance and Risk Report from the Finance, Performance and Estates Committee

Item 10.1 FPEC Upward Report August 2020.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
	Integrated Performance Report - Trust Board.pdf
13	Risk and Assurance
13.1	Risk Management Report
	TB - Strategic Risk Report - September 2020.pdf
13.2	Board Assurance Framework
	Item 13.2 BAF 2020-21 Front Cover September 2020.docx
	Item 13.2 BAF 2020-2021 v20.08.2020.xlsx
14	Board Forward Planner
	Trust Secretary *For Information*
	Item 14 Board Forward Planner 2020 v 1.doc
15	Any Other Notified Items of Urgent Business
16	The next meeting will be held on Tuesday 6 October 2020

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

Agenda Item 5

United Lincolnshire Hospitals NHS Trust

Minutes of the Trust Board Meeting

Held on 4 August 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
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)
Dr Maria Prior, Healthwatch Representative
Mr Jon Young, Deputy Director of Finance

Apologies
Mr Geoff Hayward, Non-Executive Director
Ms Cathy Geddes, Improvement Director, NHS Improvement
Mrs Anna Richards, Associate Director of Communications
Mr Paul Matthew, Director of Finance and Digital

951/20	**Item 1 Introduction** The Chair welcomed Board members and members of the public who had joined the live stream to the meeting. In line with guidance on Covid-19 the Board continue to hold meetings in public session through the use of MS Teams live. In line with policy, papers had been published on the Trust website a week ahead of the meeting and the public able to submit questions in the usual manner.
952/20	The Chair moved to questions from members of the public. **Item 2 Public Questions** **Q1 – Jody Clark** **How many patients have been transferred from Grantham's UTC, since the changes in June? And without breaking confidentiality, can you tell us what sort of conditions are being transferred?**

953/20	The Chief Operating Officer responded: The information provided runs until 27th July, giving information about the first month of operating. 21 inter-facility transfers took place, meaning that these patients were transferred from Grantham to one of the Trusts other hospitals. The types of conditions have not yet been fully coded however these include urinary tract infections, traumatic head injuries and pyrexia. It has not been possible as yet to group main themes.
954/20	**Q2 – Sue McQuinn** **Following the removal of A&E services from Grantham Hospital, could the board please provide figures on how this has impacted those in Grantham & surrounding areas needing emergency treatment.** **I would like to see figures including** **a) People who have attended Grantham UTC and then been sent to A&E elsewhere.** **b) People from Grantham & surrounding areas who've been directed by 111/999 to other A&Es.** **c) Those who have an address in Grantham & surrounding areas who have presented at other A&E sites (not just ULHT).**
955/20	The Chief Operating Officer responded: As previously stated there had been 21 in the period since opening of the UTC. The Chief Operating Officer noted that official reports would be presented to the Board on a quarterly basis and these figures would be contained within the report. The report was due to be presented to the Board in October and would provide a comprehensive review. The data regarding patients directed by 111 to other A&Es is not held within the Trust. However it has been possible by proxy to use the data held within the Trust based on the postcode within the Grantham catchment area of patients attending. By proxy the Trust had identified that 64 patients had accessed Lincoln and Pilgrim hospitals that came from within the postcode catchment area. In relation to other A&Es not within the Trust it had been possible to confirm with North West Anglia Foundation NHS Trust that 28 patients had attended Peterborough hospital. This equated to approximately one person per day accessing A&E. Prior to the change of Grantham to a UTC approximately 1500 patients accessed the A&E service. Since the UTC opened there had been 1887 patients access the UTC, this demonstrated a substantial increase in patients accessing the UTC service. The vast majority of which were within core hours.
956/20	**Item 3 Apologies for Absence** Apologies were received from Mr Geoff Hayward, Non-Executive Director, Mr Paul Matthew, Director of Finance and Digital, Ms Cathy Geddes, Improvement Director NHSE/I and Mrs Anna Richards, Associate Director of Communications

957/20	**Item 4 Declarations of Interest** There were no declarations of interest which had not previously been declared.
958/20	**Item 5.1 Minutes of the meeting held on 7 July 2020 for accuracy** The minutes of the meeting held on 7 July 2020 were agreed as a true and accurate record subject to the following amendments 869/20 – Should read – Single hyper-acute stroke service
959/20 960/20 961/20	**Item 5.2 Matters arising from the previous meeting/action log** The Chair noted that a number of actions remained deferred due to the Trust response to Covid-19 or had been completed. The following actions were discussed. 1641/19 and 1642/19 - NHS Improvement Board Observations and actions – Review again at October Audit Committee 077/20 – Review of Trust Operating Model and Governance – Internal audit review still awaited
962/20 963/20 964/20 965/20 966/20 967/20 968/20	**Item 6 Chief Executive Horizon Scan including STP** The Chief Executive presented the report to the Board noting that the Covid-19 and NHS People plan elements of the report were now out of date due to the release of the Covid-19 response phase 3 letter from NHS England/Improvement (NHSE/I) and NHS People Plan. **System Issues** The Chief Executive noted that the key points to highlight were that the Government had agreed that the NHS incident level should move from a level 4 to level 3. The Chief Executive reminded Board members that a level 4 incident required NHSE/I to lead through national command and control input in order to support the NHS response. This had now changes to a level 3 which required the response of a number of health organisations across geographical areas in a NHS region. This had meant that the move from a national to regional level incident. The focus of the letter was on the NHS accelerating the restart of non-Covid-19 service whilst preparing for a possible second peak. Trusts had been asked to retain Emergency Preparedness, Resilience and Response (EPRR) centres as Covid-19 remained in general circulation and local outbreaks were occurring. The NHS may revert to a level 4 incident if circumstances changed. Three priorities had been set out in the letter received. Firstly, from 1st August Trusts should accelerate the return to near normal levels of non-Covid-19 health services, making full use of the capacity available in the window of opportunity between now and winter. Secondly, preparation for winter demand pressures alongside continued vigilance in light of further probable Covid-19 spikes locally and possibly nationally. Thirdly, do the above in a way that would take in to account the lessons learnt in the first Covid-19 peak that would lock in beneficial changes and explicitly tackle fundamental changes, including support for staff and action on inequalities and prevention.

969/20	Commentary on the new financial arrangements had been included along with increased system working. Thanks had been expressed to those in the NHS and partners who had worked with Trusts during phases 1 and 2. Phase 3 had now commenced.
970/20	The NHS People Plan 2020/21 had now been published titled, We are the NHS, People Plan for 2020/21. There were four focused areas of the report, looking after our people, belonging in the NHS, new ways of working and growing for the future. The NHS People Promise had also been published.
971/20	Further detail regarding both the NHS People Plan and Phase 3 letter would be presented at a future meeting.
972/20	The remainder of the report was as written with the national flu campaign underway for 2020, the system was participating in lessons learnt from phases 1 and 2 of the Covid-19 response. The Independent Medicines and Medical Deceives Safety Review had published its first report which had received national media coverage and the NHS needed to consider the report.
973/20	Work on system governance arrangements had now been formalised.
	Trust Specific Issues
974/20	The Chief Executive noted the importance of the Integrated Improvement Plan (IIP) for the Trust advising that this remained a central piece of work for the Trust and that the implementation was crucial to ensure delivery of the ambitions set.
975/20	NHSE/I had established a regional governance process and the Trust Chair was a member of the Strategic Transformation and Recovery Board. The Chief Executive was also a member of the Recovery and Restoration working group.
976/20	The Trust were exploring a suitable way in which to conducted the Staff Awards in a socially distanced way in order to finalise these and were also looking to commence the current years' awards.
977/20	The Chair noted that there would be a further devoted session for the Board in relation to the Phase3 letter due to the significant implications. There would also be sessions in relation to the NHS People Plan and promise.
978/20	The Director of Nursing noted the emergency support framework with the CQC that focused on Infection Prevention and Control (IPC) advising that assurance had been offered around current governance arrangements and practices. There was more work to be undertaken however this confirmed that the Trust were moving in the right direction in relation to IPC.
979/20	The Chair offered thanks to the Director of Nursing for leading the IPC work and it had been positive to see that the CQC were assured. This would ensure a good foundation for any future inspections.
980/20	Dr Gibson sought clarity on system governance asking how this was linked together. The Chief Executive noted that this was outlined in the Phase 3 letter and the there was a clear national intent to move to Integrated Care Systems (ICS). This would result in a single Executive Lead and Non-Executive Chair of a Partnership Board that would see more work undertaken through the system. The letter however did not include information regarding statutory standing of the arrangements and how resources would be determined. There was however a clear expectation of the move to an ICS by April 2021.

981/20	The current governance in place in Lincolnshire would be in place for the remainder of the financial year. There were 12 system priorities that would need to be worked through to ensure delivery. There was a need for the Trust to ensure that there was appropriate Non-Executive Director involvement.
982/20	Regional colleagues would need to identify how the role to steer the region and provider oversight along with the stewardship would be achieved. It had been requested through the Phase 3 letter that regional teams provided a development plan to move to an ICS, this would provide clarity to the governance arrangements
983/20	The Chair noted that there were a number of different strands of governance currently with a need to understand how individual organisations contributed to the overall system plan. The Chair had been clear during discussions that the value from the Non-Executive Directors in both the provider Trusts and Clinical Commissioning Groups was utilised. There would be further discussions held and a briefing session arranged to share the detail about how this would be seen going forward. The Trust Board: • **Noted the update and significant assurance provided**
984/20	**Item 6.1 Covid-19 Update** The Chief Operating Officer presented the paper to the Board noting that this reflected the position to the point of publication.
985/20	When the report was published the NHS was operating on a level 4 incident as such the tone of the report and areas described were set within that context. Due to the reduction of the national incident level and the move to the recovery phase this would be the last report that referenced the restore phase.
986/20	The paper represented the closing down of key objectives of the restore phase around the focus on infection prevention and control (IPC), restoration of urgent care services, development of green site/green pathways, Covid-19 secure areas and a review of all service changes that had taken place both in phase 1 and the restore phase.
987/20	There had been considerable IPC preparation within the organisation to ensure environments were appropriate to enact the highest levels of IPC including the development of the green site and testing regimes. The Trust continued to undertake swabs and provide the necessary personal protective equipment for staff. Through the progression of Covid-19 the Trust had altered the response as more was understood about the spread of the infection.
988/20	Urgent Care was in place at full capacity in line with pre Covid-19 levels and the Trust had started to see demand exceeding those levels. This indicated that the public were confident in accessing the Trust's services. The increase had added additional pressures to the Trust particularly on the Lincoln site. There had been a marked improvement on ambulance handovers.
989/20	The Trust had opened services and created capacity to treat patients safely through the opening of the green site at Grantham. More than 200 patients had been operated on at the green site in a Covid-19 secure environment since its introduction.
990/20	In addition there had been a marked progression of the increase of capacity within diagnostics but the Board were asked to note the significant backlog that needed to be worked through. This included patients waiting over 62 and 104 days for cancer treatments.

991/20	There was a national and regional expectation that Trusts would achieve a complete reduction in the waiting list of those patients waiting 104 days or more and a 20% reduction of those waiting for more than 62 days for treatment. The Trust aimed to achieved a 50% reduction of those patients waiting more than 62 days.
992/20	The Board noted the review of services that had changed or paused during the early stages of the response. All services that had been identified to restart had now commenced and plans were in place to increase the overall offer and breadth of services that would restart. The Trust would now need to respond to the phase 3 letter and increase all electives services and restore all services to full breadth and capacity. There was a need to make the most of the opportunity between now and the winter period to treat as many elective patients as possible.
993/20	The Director of Nursing noted that the report articulated IPC excellence and the work undertaken to keep patients safe but wished to indicate the proactive nature of the Trust in keeping patients safe and improving the patient experience.
994/20	The Chief Operating Officer noted the importance of the point and indicated that the IPC focus had been part of the introduction of the green site and the increase in number, breadth and locations available to patients in the Grantham area.
995/20	The Gonerby Road treatment centre and health clinic had started as an opportunity to offer diagnostic services to reduce patients transferring to Lincoln or Pilgrim. The offer had since increased to a broader range of outpatients and diagnostics and there was consideration to develop this in to a regional diagnostics centre. It was believed that the Trust would be the first in the region to deliver a regional centre. This was being supported by national and regional partners and was just one example of where the Trust were improving patient experience.
996/20	Dr Prior asked that the factors preventing the Trust from meeting the target of 25 patients being operated on per day at Grantham were outlined and if there was a plan in place to achieve this or if the target would be revised.
997/20	The Chief Operating Officer noted that there had been some disappointment over the achievement of 17-18 patients being operated on and work had been undertaken to understand the position. Dr Prior also asked for surgical activity levels at Pilgrim and Lincoln to be outlined.
998/20	There had been a focus on inpatient operations and the backlog of patients who required urgent surgery. There had been some substantial, lengthy and complex patients who had not been seen during Covid-19. There were also other surgeries that could take a full day to complete and so a single case would take a full days list. The clinical teams were prioritising those patients who needed to be seen and the Trust were now coming to the end of those long and more complex cases. Day cases would be introduced resulting in shorter surgeries and it was expected that there would be a continued increase towards 25 cases per day.
999/20	The activity at Lincoln and Pilgrim were being managed through a green pathway with only one theatre at each site operating in order to ensure that these remained Covid-19 secure. This included the designation of a separate ward and recovery centre. Those cases being seen were for critical care and as such the numbers were low and estimated to be less than a quarter of the activity at Grantham.
1000/20	Mrs Libiszewski noted that for endoscopy, colorectal patients made up a significant amount of longer waiting patients. Concern was raised about the reinstatement of the screening programme and the impact this would have on the demands for services. Mrs Libiszewski

	asked how this would be addressed due to the high risk nature of the patients and could capacity be increased to meet demand as screening was reintroduced.
1001/20	The Chief Operating Officer acknowledged the concerns raised noting that the service was almost completely shut down at the beginning of Covid-19 in order for the risk to those patients to be understood. This created a sizeable backlog but the team had been working on this with an emergency response cell dedicated to endoscopy.
1002/20	Progress had been made in the way in which colonoscopies could be carried out and the reclassification of the procedure as non-aerosol generating had meant that the time set aside to clean and decontaminate rooms after a procedure had changed. This had resulted in increased capacity within the service.
1003/20	It was anticipated over the coming weeks that the cancer backlog in relation to colonoscopy would have been caught up and the service would start to work through a normal and sustainable level of backlog.
1004/20	The potential increase that may be seen in referrals had been factored in and included within capacity plans. Joint working was taking place with Leicester and independent sector providers in order to utilise the independent sector capacity to support.
1005/20	Mrs Dunnett noted the move at pace to use technology for outpatient appointments and stated that it would be interested to hear how the quality of care and patient experience was being assessed as the new approach was introduced.
1006/20	The Chief Operating Officer noted that the largest impact for technology had been telephone clinics. These had been conducted for some time but had greatly increased during Covid-19. The feedback so far had been positive and supported patients who did not need to attend on site and reduced the level of risk for those patients with comorbidities.
1007/20	E-consultation had been well received however it was acknowledged that there was further work to be undertaken on the breadth of patient feedback in relation to all services. Historical mechanisms of patient feedback surveys would not necessarily capture the feedback in a suitable way. Bespoke patient feedback systems were being considered to support the Trust receiving feedback.
1008/20	Mrs Dunnett asked what the impact on patients had been given that there had been delays in treatment, people not seeking medical help and the suspension of national programmes and if there had been an increasing trend of acuity.
1009/20	The Chief Operating officer advised that there had been an increase in the acuity of patients accessing services that hadn't done so during the delay and manage phases of the response. There had been a continued increase in the number of patients accessing services and levels of demand would suggest people are now comfortable accessing urgent care services.
1010/20	Mrs Dunnett also asked how the Trust would address the priority within the phase 3 letter of health inequalities.
1011/20	The Chief Operating Officer noted that health inequalities had become more evident throughout the response to Covid-19 and phase 3 would examine health inequalities in more detail. The first 2 stages of the response had been in an emergency with changes made at pace. The next phase would be more prolonged and offer an opportunity to review the impact and reflect on areas of deprivation that may need to be addressed.

1012/20	Mrs Ponder asked what mechanisms would be put in place to capture feedback from both staff and patients particularly at the new facilities.
1013/20	The Chief Operating Officer advised that consideration had been given to this. There were a number of national tools available however the timeliness and focus of those feedback systems were very general. The Trust were designing something bespoke to Grantham in order that feedback could be provided in that locality on the experiences of patients.
1014/20	Feedback from the changes introduced from the 11th June including the 4 new locations to offer a wider ranges of services would be used to ensure that the right configuration was in place.
1015/20	The Director of People and Organisational Development noted that the Trust had introduced the NHS Pulse Survey to staff which would seek staff experiences through Covid-19 and how they feel that organisation had addressed health and well-being needs. A different approach would be taken for those staff at Grantham.
1016/20	Weekly meetings were being held with Staffside colleagues and there had been involvement with Staffside on the developments at Grantham. A celebration week for admin and clerical staff was underway and all staff groups within the Trust would be recognised for the contribution that had been made throughout Covid-19. The Executive Directors were visiting admin and clerical teams including those at the Grantham sites. This would offer an opportunity for staff to give direct feedback.
1017/20	The Chair noted the positive position of having carried out over 200 surgeries and the forecast of an increase was promising. The Chair expressed the thanks of the Board for the focus that was being given to ensure patients could receive treatment.
1018/20	The Board noted the moderate assurance provided by the report and accepted the progress update. It was noted that new guidance was being received and that this would be reflected in future reports. The Trust Board: • **Received the report noting the moderate assurance**
1019/20	**Item 7 Patient/Staff Story** The Chair noted that since the Trust Board meetings had taken place on MS Teams patient and staff stories had not been received. The Board were keen not to lose sight of these stories in order to ensure that they remained connected to the organisation.
1020/20	The Chair welcomed Jo Woolley, Team Leader Children's Palliative Care, who had joined the meeting and the Director of Nursing introduced the story.
1021/20	The Director of Nursing noted that this was the first patient story at the Board since she had commenced in post with the Trust. The story demonstrated an innovative team who had recognised a potential issue, addressed this and sought feedback from staff and families.
1022/20	The patient story video was played for Board members. This detailed how the Children's Palliative Care Team has recognised the difficulty of keeping in touch with their patients and families during Covid-19. In order that the connection with the patients could be maintained the team recorded a series of bedtime stories and messages for the children which the parents could play to them.

1023/20	The team recognised the importance of the children still hearing the voices of staff that they were familiar with in order to maintain the relationship that had been built up over time.
1024/20	The video contained feedback from both staff and the families which had had a great impact on them. The children had been delighted to hear from the staff members during Covid-19 even though they were unable to visit and it provided a connection for the team with the families.
1025/20	The Chair recognised that this had been a great initiative by the team and had clearly had a significant impact on the children and their families. The Chair thanked the team for the effort that had been put in to not only the initiative but to the video that had been created.
1026/20	The Chair asked if this was something that could be further developed.
1027/20	The Team Leader Children's Palliative Care advised that the initiative had been picked up by others in the area including hospices who were now using the story telling idea. The team wished to continue the initiative but were concerned about how to connect and reach older children. The team were currently exploring ideas of how to stay in touch with this group of patients.
1028/20	The Director of Nursing thanked the Team Leader Children's Palliative Care and team for the wonderful initiative that whilst simple was heartfelt and effective. The Director of Nursing considered if this could be applied in the adult arena and used for those with learning disabilities and dementia. There could be a number of different applications.
1029/20	The Team Leader Children's Palliative Care was sure that it could be adapted but could also support the initiative with dementia patients and the use of memory props through songs and stories.
1030/20	The Board members through the MS Teams chat expressed their thanks for the story to the Team Leader Children's Palliative Care and congratulated her on the success of the initiative.
1031/20	The Chief Executive asked what support the team might need in order to develop this further.
1032/20	Team Leader Children's Palliative Care responded that the team would like to present this through children's wards and clinics but that IT support would be required in order to achieve this.
1033/20	The Chief Executive offered the support of the IT department to consider ways in which this could be achieved.
1034/20	The Chair thanked the Team Leader Children's Palliative Care for demonstrating the initiative and supporting patients' through the difficult time. The Trust Board: • **Received the patient story**
	Objective 1 To Deliver high quality, safe and responsive patient services, shaped by best practice and our communities
1035/20	**Item 8.1 Assurance and Risk Report Quality Governance Committee** The Chair of the Quality Governance Committee, Mrs Libiszewski provided the assurances received by the Committee at the 21st July 2020 meeting.

1036/20	The Committee reviewed the risk register and had been able to provide RAG ratings to the objectives within the Board Assurance Framework.
1037/20	As received by the Board the Committee received the harm review process, a further update would be received in September.
1038/20	An upward report from the Infection Prevention and Control Group had been received and an update provided in relation to performance against the hygiene code and improvements made against indicators.
1039/20	A full report was received in relation to the MRSA colonisation issue that the Trust had experienced. This was now closed and assurance had been received that actions had been taken in order to manage the group of patients.
1040/20	The first report from the Nursing, Midwifery and Allied Health Professionals Forum was presented to the Committee who welcomed the input and review from the group. Mrs Libiszewski noted that the reported 98% fill rate should read 95% and was a typographical error in the committee report.
1041/20	The National Inpatient Survey and Cancer Surveys were received and would be discussed by the Board. Both of the surveys were dates, actions plans had been requested by the Committee.
1042/20	As requested by Dr Gibson the Committee received a report on the Hyper Acute Stroke Services which provided the outcomes for patients, it was clear that these had not been impacted by the changes. The service remained fragile and there was an intention to conducted another review and consider further actions. This would be reported back to the Committee.
1043/20	The Committee were able to review the CQC Must and Should Do actions and despite Covid-19 there had been continued progress. Further review work would take place and the Committee were please that significant work was taking place across the organisation to prepare for potential future visits. The Trust Board: • **Received the assurance report**
1044/20	**Item 8.2 National Inpatient Survey**
1045/20	The Director of Nursing presented the report to the Board noting that the National Inpatient Survey report related to the survey undertaken in September 2019 and that the outcome was not satisfactory.
1046/20	The report demonstrated that the Trust were in a similar position to other organisations however when reviewed in detail the Trust performance was in a worse position on some indicators.
1047/20	Some of the key themes and core issues were around the quality of engagement with staff and patients and communications with patients. An action plan had been produced and would be overseen by the Quality Governance Committee. Any actions would be taken in line with the Integrated Improvement Plan (IIP).

1048/20	It was recognised that there was a delay in the report from the National Inpatient Survey and there was a need to understand the live position. This was being picked up by the Trust undertaking Pulse checks with staff and patients.
1049/20	Overall the report was disappointing and was presented to the Board for information, this would continue to be overseen by the Quality Governance Committee.
1050/20	Dr Prior reflected the disappointment with the report but welcomed the proposed introduction of the evidence based co-design methodology and looked forward to HealthWatch being asked to be involved.
1051/20	The Chair recognised that there was more work that needed to be undertaken and welcomed the support and involvement of HealthWatch.
1052/20	Dr Gibson raised concern that patients were not being advised of medication side effects or that they were unaware of danger following discharge. Dr Gibson sought assurance that these areas of concern would be a priority within the action plan.
1053/20	The Director of Nursing provided reassurance that these areas would be addressed. There would be triangulation of patient feedback along with complaints and incidents recorded within Datix. Driving this through the IIP would ensure the use of continuous and quality improvement methodologies to support specific issues.
1054/20	The Chair noted the disappointment with the report recognising that it would be within the gift of the Trust to resolve. It was positive to hear that quality improvement methodology would be used and that this would be linked to the IIP, this would provide structure. The Board supported the recommendations made within the paper to develop divisional actions plans alongside a corporate action plan linking to the IIP and patient experience plan. The Trust Board: • **Received the report noting the limited assurance**
1055/20	**Item 8.3 National Cancer Survey** The Medical Director presented the report to the Board noting that as with the previous report the survey had been undertaken at the end of 2019 and was a mandatory reporting tool commissioned by NHS England.
1056/20	The resulted of the survey had been published in 2020 with the purpose to monitor progress in cancer care, drive quality improvement, assist commissioning and to inform the work of stakeholders and the third sector.
1057/20	61 questions were asked with one third reported as slightly better than national average and a third slightly worse. The overall positon placed the Trust below the national average. Significant work would be required to improve.
1058/20	As a result of the survey an action plan had been prepared with specific objectives however this had not been fully implemented due to Covid-19. There had been a significant impact on Macmillan Cancer Support and the ability for some posts identified within the Cancer Strategy to be funded due to the reduction in fundraising as a result of Covid-19. The had particularly impacted on the Cancer Matron and Patient Experience Manager. There was a need to revise the action plan and this would be presented to the Patient Experience Group in September, prior to being reported to the Quality Governance Committee in October.

1059/20	The had been a significant improvement where the Trust had been able to invest, particularly in Breast Cancer and Dermatology services, there had been specific project support received to develop the services.
1060/20	There had also been positive progress regarding research however there required further improvement in the enrolment of patients in research studies.
1061/20	The Chair noted disappointment with the results of the survey and noted that the Cancer Strategy had not been seen by the Board. It was assumed that this was a partnership between the Trust, other NHS providers and charitable providers in order to support patients.
1062/20	The Chair requested sight of the Cancer Strategy at the Board as this would provide greater oversight for Board members but also ensure that there was an appreciation as to where the Trust would fit in to the collaborative approach in response to treating patients living with cancer. **Action: Medical Director 1 September 2020**
1063/20	The Trust Board noted the content of the report and opportunity for improvement and looked forward to seeing how this could be done in partnership with colleagues across the system. The Board noted the limited assurance provided and endorsed the recommendations within the paper. The Trust Board: • Received the report noting the limited assurance • Endorsed the recommendations
	Objective 2 To enable our people to lead, work differently and to feel valued, motivated and proud to work at ULHT
1064/20	**Item 9.1 Assurance and Risk Report Workforce and Organisational Development Committee** The Deputy Chair of the Workforce and Organisational Development Committee, Mrs Dunnett provided the assurances received by the Committee at the 15th July 2020 meeting. This had been the first meeting of the Committee since the introduction of lean governance arrangements due to Covid-19 reflected with a reduced agenda.
1065/20	The Committee agreed the new terms of reference which reflected the Integrated Improvement Plan although it was acknowledged that further work was required in order to match risks and the performance dashboard.
1066/20	Mrs Dunnett noted that limited assurances were received in relation to objectives 2a and 2b however the Committee were positive of the improvements being made. There had been progress regarding medical recruitment and a reduction was being seen in medical vacancies. There were also transformation plans in place for safer staffing.
1067/20	The Committee were assured of the work being undertaken on the wider workforce people plan and the NHS People Plan would be received by the Committee in August.
1068/20	The upward report from the Guardian of Safe Working (GoSW) was received which demonstrated that the Trust had been acting in a timely manner to concerns being raised.

	There was a clear response and progress on actions following the results of the most recent staff survey. This included the introduction of the quarterly pulse surveys, the results of these would be monitored by the Committee.
1069/20	The Committee wished to escalate to the Board the current level of appraisal and mandatory training and the risk associated with divisional workforce places. It would be key to put these in place however difficulties would be experienced whilst the divisions moved through the recovery and restoration phases post Covid-19.
1070/20	The Chair was pleased that the terms of reference had been signed off by the Committee and that there had been positive progress in relation to the GoSW.
1071/20	The Director of People and Organisational Development noted that since the Committee there had been some movement, particularly in relation to how the Trust would respond to phase 3 of the incident. Meetings with divisions would address workforce planning for the remainder of the year and in to the following year which would address the concerns of the Committee.
1072/20	The NHS People Plan included an expectation regarding appraisals and it was noted that there would be conversations between staff and managers to address this. The intention would be to find a way for the discussions to be held in the next two months. There would then be a mechanism in place to increase the appraisal completion rate during the period.
1073/20	The Chair was reassured to hear of the workforce planning process established with the divisions and whilst sympathetic to the situation noted that workforce plans underpinned the work of the Trust and achievement from an operational perspective. The Trust Board: • **Received the assurance report**
1074/20	**Item 9.2 WRES/WDES Annual Submission** The Director of People and Organisational Development presented the annual submission of the WRES and WDES to the Board noting that due to submission deadlines it had not been possible to present the reports to the Workforce and Organisational Development Committee.
1075/20	The report highlighted the actions that the Trust had taken during Covid-19 in order to manage the risk to staff, particularly those with protected characteristics. The People Plan also built on the recognition through the Covid-19 period that the NHS needed collectively to do more in terms of both health inequalities and addressing the needs of staff.
1076/20	Both reports made reference to the make-up of the Board and the lack of Board representation from both a Black, Asian, Minority Ethnic (BAME) perspective and members with a disability.
1077/20	For the Workforce Disability Equality Standards information had been provided against 11 metrics with 3 highlighted to the Board. The first being the difference between staff reporting as working with a disability in ESR and a higher percentage being reported through the National Staff Survey. The Trust needed to address this in order to understand why staff felt unable to indicate through a formal process that they were working with a disability. This would constrain the ability of the Trust to support staff and address any issues that they may face.
1078/20	The second metric to highlight to the Board was the capability procedure. The indicator shows a high figure however there was a real differential between non-disabled and disabled

	staff going through a capability procedure. The figures were small and so in fact the statistic was distorted, there were concerns raised about the legitimacy of the data.
1079/20	The MAPLE network, relating to metric 9b, was in the early stages of development and it was important for the Trust to work with the group to address issues identified within other indicators, particularly those in the national staff survey.
1080/20	Work would be undertaken to grow the network in order that it could work with the Trust to address issues identified. An action plan would be developed and this would be integrated in to the Integrated Improvement Plan to ensure development and delivery.
1081/20	The Workforce Race Equality Standards (WRES) had been discussed at a Board development session in July with the Chair and Vice Chair of the network, as such the Board were aware of the issues and what was being done to address concerns.
1082/20	The Director of People and Organisational Development noted that there was a particular focus on the results of the National Staff Survey which had shown a large difference between the BAME and non-BAME communities. Particularly in relation to bullying and harassment and how staff were treated.
1083/20	Work was being taken forward in terms of cultural intelligence across the system and would be funded by Health Education England. This would seek to ensure and cascade information through provider organisations to provide a greater awareness of cultural differences and the impact on staff groups.
1084/20	The issues identified through the National Staff Survey and narrative from BAME conferences would be important in changing the dynamic and experience of staff in the organisation. There would again be an action plan produced in relation to WRES in order to address areas of concern.
1085/20	Some actions were already being taken forward including talent management, through this approach it would be possible to ensure appropriate representation at senior levels from those in currently under represented groups. There was a need to ensure the actions identified were reflected within the Integrated Improvement Plan.
1086/20	Mrs Ponder asked what consideration have been given to ensure that the right individuals attended the workshops that had been arranged to address the concerns of bullying and harassment.
1087/20	The Director of People and Organisational Development noted that initially individuals had been invited and there had been involvement from the BAME network to develop the workshops. Although the number of people from both the BAME and disabled groups were responding to indicate that they had experienced bullying was high, this remained high in general across the organisation. It was planned that the workshops would be linked to the overall work for the implementation of the values of the organisation which addressed compassion and respect. The intention would be for all staff to participate in a values workshop.
1088/20	Dr Gibson raised concerns that the figures, presented within the WDES report regarding disabled staff, did not appear accurate against the percentages reported. The Director of People and Organisational Development noted that this could be due to the significant increase in response rates.

1089/20	The Chair noted that the WDES report identified that the disability status of some Board members was unknown, in order to ensure behaviours were modelled across the Trust there would be a review to ensure this had been accurately captured.
1090/20	It was noted that within the WRES reporting template relating to the review of disciplinary cases, there could be an opportunity for Non-Executive Director involvement in order to provide independent oversight of the process.
1091/20	The Chair requested that this opportunity be considered. **ACTION – Director of People and Organisational Development, 1 September 2020**
1092/20	The Chair asked if there was a development programme for aspirant members of the organisation from Band 7 upwards in order to support them to progress. The data demonstrated that there was a good proportion of staff but it was not clear what the Trust were doing to support progression.
1093/20	The Director of People and Organisational Development stated that the talent management programme would identify those who wished to progress and those who were assessed as having the talent to progress. A programme would be put in place to give access to programmes that would place staff in the best possible place to apply and be successful at higher levels of the organisation.
1094/20	The Chair noted that there would be benefit in the Board discussing the culture intelligence work in a Board Development session.
1095/20	The Board approved the papers for publication subject to the relevant data being confirmed.
1096/20	***Post meeting note –*** *The Director of People and Organisational Development confirmed that the WDES data presented was correct and as consequence of the increased response rate to the staff survey the actual figures had risen and percentages reduced.* The Trust Board: • **Received the annual submissions** • **Approved the reports for submission**
	Objective 3 To ensure that service are sustainable, supported by technology and delivered from an improved estate
1097/20	**Item 10.1 Assurance and Risk Report from the Finance, Performance and Estates Committee** The Chair of the Finance, Performance and Estates Committee, Mrs Ponder provided the assurances received by the Committee at the 23rd July 2020 meeting.
1098/20	The Committee had not met for the previous three months and whilst the agenda was reduced the Committee were not able to complete the agenda due to deep diving the items discussed. Items not discussed would be prioritised at the next meeting.
1099/20	The fire enforcement notices had £5.8m spend remaining on items required to complete the actions required, along with the required backlog maintenance works.
1100/20	The Committee raised concerns regarding the additional £2m required to complete the works, which included extra costs to achieve lockdown requirements that had not been included in original business case for fire improvement works.

1101/20	Due to measures taken in response to Covid-19 there was an expected delay of 4-6 months in completion of the work. Lincolnshire Fire and Rescue (LFR) had been in discussion with the Trust and were considering either an extension or the move of outstanding works to an action plan. A decision was awaited on the course of actions to be taken.
1102/20	Assurances were received in relation to the confined spaces enforcement notices that all work had been undertaken to comply and the Health and Safety Executive had been notified. There remained insufficient capacity within the in-house rescue team and as such a high-risk rescue service had been contracted. Further work would be completed to ensure that contracts had followed the correct procurement route. If there was a need, the Committee had been advised that, LFR would support a rescue.
1103/20	The Committee were advised that as a result of the suspension of the national planning process and use of block contracts, many financial planning activities and budget monitoring had not taken place.
1104/20	All Covid-19 finances were being approved through Gold Command and the Director of Finance and Digital. The Committee had requested a paper to the next meeting that documented the processes in place to track costs and provide scrutiny that a robust system was in place.
1105/20	The Trust had broken even at month 3 including the absorption of £7.2m Covid-19 costs. The Committee were advised of an expected increase in Covid-19 costs due to the use of Moy Park in Grantham as part of the Green Site.
1106/20	The Committee noted that pay remained a concern and that there had been an increase in agency spend. Plans were in place to address this however there continued to be a rise.
1107/20	Cost Improvement Plans were in place and delivery had commenced however there was not as yet assurance on the delivery of the in-year target due to figures not yet being allocated to divisional budgets.
1108/20	Capital spend had been planned in order to ensure the amount available to the Trust would be spent. A further update would be provided to the Committee.
1109/20	The Committee requested an assurance paper on the finance tracking for the process adopted during the delay, restore and recovery phases of Covid-19, this would be received by the Committee in August.
1110/20	The performance dashboard had demonstrated a reduction in performance due to the suspension of services during Covid-19 however there had been a positive impact on surgery and waiting list figures due to the Grantham Green Site. The Committee requested a review of the process for restoration of services to include a summary of the priority actions and timescales.
1111/20	The Committee agreed that the Board Assurance Framework was reflective and amended objective 3b, efficient use of resources from green to red as a result of the discussion held at the previous Board meeting.
1112/20	The Chair appreciated that the Committee had a large agenda and that some items had been deferred. Support was offered in order to provide a steer whilst operating in a lean governance manner. This would ensure the Committee received the right items for discussion and that assurances were received, whilst maintaining realistic expectations of the Committee, and the upward feed to the Board.

	The Trust Board: • **Received the assurance report**
1113/20	**Item 10.2 Business Case Pilgrim A&E** The Director of Improvement and Integration presented the business case to the Board seeking approval to submit the outline business case to NHSE/I for capital of £36.3m on Pilgrim hospital site.
1114/20	It was noted that there would be a revenue costs to the Trust but that this would bring about improvement to the Urgent Treatment Centre, expand resus, reconfigure the majors area in the ED and improve the diagnostic services on site.
1115/20	The money allocated from the Prime Minister's visit had seen the Trust awarded with £21.3m of funding to improve facilitates at Pilgrim. The case of need at Pilgrim was clear due to the poor infrastructure and the ED being too small for the level of demand.
1116/20	The Trust recognised that there were ongoing issues regarding poor patient experience and this had been picked up through CQC reports and the outstanding section 31 notices. The Trust received positive feedback relating to the caring nature of staff but it was recognised that the experience of patients identified overcrowding as an issue.
1117/20	Since the announcement of the funding work had been undertaken as part of a Lincolnshire Project Team, inclusive of patient representatives, to develop the outline business case. The Board were asked to note that £21.3m funding had been allocated but that the business case now requested £36.3m.
1118/20	The original amount had been determined by the combining of two separate cases put forward by the Trust at a national level when the allocation was made. The increase had been due to the length of time since the original cases were developed where costs had increased. A high level of contingency had been included due to the length of the build and the uncertainty of the impact of Brexit and the pandemic affecting costs.
1119/20	The Trust had followed the Treasury green book approach which provided a clear process that would provide the best value for money. This approach did not tie in to the arbitrary capital amount but looked at identifying the requirements for the organisation in order to deliver the best strategic and economical case and experience for patients. The regional and national teams had been kept up to date regarding the costs and were aware of the change throughout the process.
1120/20	The business case described the need for the improvement, economic impact, how works might be contracted and completion of the works. The preferred option would be the demolition of an existing building due to the poor condition and high level of backlog maintenance.
1121/20	This would result in a new majors and resus facility being built and the existing ED footprint being refurbished for a larger UTC. With the expansion of the resus bays it would be possible for a CT scanner to be located within the ED.
1122/20	Space would also be available for joint working with other providers and a dedicated paediatric area and bereavement facilities.

1123/20	The Trust would look to use national contractors and most likely source through a national framework agreement in order to achieve the build more quickly and against approved costing measures.
1124/20	As the full business case was developed this would be explored further and presented back to the Board. The project intent and approach was supported by the Lincolnshire System and supported by both the regional and national teams. At this stage the additional requested capital had not been agreed and it was hoped that this would be secured through the next stage of the process.
1125/20	If the regional team declined the request for additional capital an alternative way forward had been outline in the business case. This would ensure time was not lost however the scheme would be reduced to the order of £24.3m. Elements of the development including bereavement and joint working facilities would be lost and it was felt that this did not offer the best value for money.
1126/20	The Trust Board were asked to support the business case for onward submission to the process through NHSE/I which would take approximately 6-8 weeks. This would initiate the contracting discussion in order to develop the proposal to a full business case which would be presented back to the Board in January 2021.
1127/20	It was anticipated that the project would take between two and two and a half years meaning that the handover and opening of the building would take place in the winter of 2023.
1128/20	The Chair noted the importance as a Board to try to improve the environment at Boston, particularly in relation to the ED. The Board needed to do everything it could to ensure the successful passage of the business case to NHSE/I and progress as soon as timescales would allow.
1129/20	The Chief Executive strongly supported the business case however there was a need to ensure wherever possible that the timescales were truncated. Handover in November 2023 felt too far away given the much needed improvements required. Where it was possible for the Trust to influence timescales this would be done.
1130/20	The Chair noted that members of the Board supported the business case for onward submission and supported the pace of the project. The Chair noted that this had been a great technical case that had received some revision to ensure it read strongly however felt that the opening pages lack impact. This would be addressed outside of the meeting.
1131/20	The business case required approval and submission to the regulators in order to progress, it was the right thing to do to consider values for money and to apply for capital to support the professionally identified needs at Pilgrim.
1132/20	The Board were aware of the paediatrics issue at Pilgrim and discussions had been held, this needed to be emphasised within the submission.
1133/20	The Board were provided with significant assurance from the report and supported the preferred way forward at a cost of £36.3m with revenue costs of £0.4m. The Board approved the onward submission of the outline business case to NHSE/I for review. The Trust Board: • **Received the report** • **Supported the preferred way forward** • **Approved the submission of the business case to NHSE/I**

	Item 11 Objective 4 To implement integrated models of care with our partners to improve Lincolnshire's health and wellbeing
1134/02	**Item 12 Integrated Performance Report** The Board noted the content of the report and that preceding discussions from the Board Committee upward reports have provided an overview of the content. There had been no areas of concern noted in the reports from the Board Committees. The Trust Board: • **Received the report**
	Risk and Assurance
1135/20	**Item 13.1 Risk Management Report** The Director of Nursing presented the report to the Board drawing attention to the fact that a review of the operating model and systems and processes had been commissioned. As a result the report was being developed.
1136/20	A review of the risk register was being undertaken to ensure that this informed the Board Assurance Framework. The report was currently data rich and the intention was to offer the Board more analysis to ensure that issues and mitigations were provided in order that assurance could be received.
1137/02	The Quality Governance Committee had identified a specific risk regarding safeguarding and the Board were informed that the Deputy Director for Safeguarding had commenced in post and would be keen to meet with members of the Board.
1138/20	It was noted that there had not been many changes across risk within the past 12 months and whilst assurance could be taken from this there was a level of concern as to why the Trust were not seeing a level of change.
1139/20	The Chair noted the summary and acknowledged the lack of movement of risk. It would be beneficial to understand that risks had been reviewed so that the Board were aware of the position. The Covid-19 would require review as this had been rated at 25 throughout the duration of the pandemic. A review ahead of any potential second wave would be required.
1140/20	The Board accepted the top risks within the risk register and the Chair noted that it was appropriate to review the format of the report in order to receive assurance. The Trust Board: • **Accepted the top risks within the risk register** • **Received the report and noted the moderate assurance**
1141/20	**Item 13.2 Board Assurance Framework** The Board Assurance Framework (BAF) had been presented to all Board Committees in July and a number of reports had been received by the Board that supported the objectives and underlined the current assurance ratings.

1142/20	There had been positive movement with some ambers being recorded, particularly in relation to objective 2c – Well Led Services. The Chair noted that the more that could be done to build assurance ahead of any CQC inspection would be very welcome.
1143/20	The Trust Secretary advised Board members that the BAF had also been considered by the Audit Committee in July in order to review the adequacy and effectiveness. The Trust Board: • **Received the report**
1144/20	**13.3 Upward Report Audit Committee** The Chair of the Audit Committee Mrs Sarah Dunnett provided the upward report to the Board noting that the amber rating for objective 2c on the BAF had been supported by the Committee.
1145/20	The Committee had finalised the annual audit letter and ISA260 from the external auditors, PricewaterhouseCoopers, and related to the 2019-20 year end audit of accounts and annual letter. Both were consistent with the discussions of the Committee and the Board. The letter would now be published on the Trust website.
1146/20	The recommendations within the ISA260 were that the Trust would need to strengthen internal controls, this would be monitored by the Committee.
1147/20	The meeting had been the last one for PricewaterhouseCoopers as the Trust moved to external auditors Mazaars, who had been appointed as auditors across the Lincolnshire system. Work with the new external audit providers would commence in September 2020.
1148/20	The Committee received and agreed the revised internal audit plan for 2020/21. This would be undertaken on a reduced timetable due to Covid-19 however there was confidence that areas of risk were being covered. It had been agreed by the Executive Leadership Team (ELT) and auditors that there would be the capacity to deliver the plan within the timeframe stated.
1149/20	The Committee noted, that partly due to Covid-19, implementation of the recommendations from Internal Audit had slowed however assurances were received from the Executives that there was focus on enacting the recommendations. The Committee would continue to have oversight.
1150/20	The first local counter fraud progress report had been received along with the annual report. This had been consistent with the information provided to the Committee throughout the year and was consistent with the green counter fraud rating for the Trust.
1151/20	The counter fraud plan for 2020/21 was agreed and this aligned to both local and national risks identified. The Committee were content that sufficient resource was in place to deliver the plan.
1152/20	The Committee received the quarterly compliance report and further work had been requested regarding levels of pharmacy write off, review of staff overpayments to leavers, recovery of overseas income and levels of waivers.
1153/20	The Committee were also updated in respect of policy management and would continue to have oversight.

1154/20	The Trust Secretary advised that work being undertaken in relation to policies would bring together the different arms of policy management. This had been agreed in order to allow the Trust to move a number of policies that were out of date back in to date. A fast track process to address policy management had been agreed by the ELT. Audit Committee would have oversight as part of its remit.
1155/20	Policy approval, for the time being, would not be through the Board Committees in order to move the position at pace.
1156/20	Mrs Libiszewski noted that the Audit Committee met less frequently than other Committees and as such asked how there would be assurance against the plan that this was meeting timescales.
1157/20	The Trust Secretary noted that the improvements were being monitored on a fortnightly basis through ELT however, would be happy to discuss with the Committee Chairs how information could be shared in order to provide assurance. The Trust Board: • **Received the upward report**
1158/20	**Item 14 Board Forward planner** The Trust Secretary advised the Board that the forward planner was not yet completed however was bring presented as part of the move to return to business as usual. The forward planner would confirm that the Board would meet the required duties over the course of the year.
1159/20	The Chair noted that it was timely to review the forward planner to ensure that this captured those items that were required to be reported to the Board. If Directors wished to include additional items of the forward planner these should be identified to the Trust Secretary to consider how these could be built in to the forward plan.
1160/20	**Item 15 Any Other Notified Items of Urgent Business** There were no other notified items of urgent business
	The next meeting will be held on Tuesday 1 September 2020, arrangements to be confirmed taking account of national guidance

Voting Members	**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**	**7 July 2020**	**4 Aug 2020**
Elaine Baylis	X	X	X	X	X	X	X	X	X	X	X	X
Chris Gibson	X	X	X	X	X	X	X	X	X	X	X	X
Geoff Hayward	A	X	X	X	X	X	X	A	A	A	A	A
Gill Ponder	A	X	X	X	X	X	X	X	X	X	X	X
Neill Hepburn	A	X	X	X	X	X	X	X	X	X	A	X
Michelle Rhodes	X											
Sarah Dunnett	X	X	X	X	X	X	X	X	X	X	X	X

Elizabeth Libiszewski	X	A	X	X	X	A	X	X	X	X	X	X
Paul Matthew	X	X	X	X	X	X	X	X	X	X	X	A
Andrew Morgan	A	X	X	X	X	X	X	X	X	X	X	X
Victoria Bagshaw		X	X	X	X							
Mark Brassington		X	X	X	X	X	X	X	X	X	X	X
Karen Dunderdale						X	X	X	X	X	X	X

PUBLIC TRUST BOARD ACTION LOG

Agenda item: 6

Trust Board date	Minute ref	Subject	Explanation	Assigned to	Action due at Board	Completed
1 October 2019	1576/19	Smoke Free ULHT	Post implementation review to be presented to the Board	Rayson, Martin	~~07/04/2020~~	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 October Audit Committee
5 November 2019	1747/19	Assurance and Risk Report Finance, Performance and Estates Committee	Business case review of fire works to be completed and reported back to Finance, Performance and Estates Committee detailing spend	Matthew, Paul	~~3/12/2019~~ ~~03/03/2020~~ 25/07/2020	Fireworks reviewed at July FPEC meeting-BC review still awaited.
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	Int Audit review still awaited
3 March 2020	343/20	Staff Survey Results	Review staff survey indicator in relation to violence from patients to identify hot spots to focus activity and support	Rayson, Martin	~~07/04/2020~~ 07/07/2020	Deferred due to Covid-19
4 August 2020	1062/20	Cancer Strategy	To be shared with Board	Neill Hepburn	01/09/2020	Shared in reading room on ibabs - Complete
4 August 2020	1091/20	WRES/WDES Annual Submission	Consideration of the opportunity for Non-Executive Directors to provide independent oversight to disciplinary reviews	Rayson, Martin	01/09/2020	

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Public Trust Board*
Date of Meeting	*2 September 2020*
Item Number	*Item 6*
Chief Executive's Report	
Accountable Director	*Chief Executive*
Presented by	*Andrew Morgan, Chief Executive*
Author(s)	*Andrew Morgan, Chief Executive*
Report previously considered at	*N/A*

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

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

Recommendations/ Decision Required	• *To note*

Executive Summary

1. System Issues

a. As explained elsewhere on the Board agenda, work is underway to produce the draft summary system plan in response to Phase 3 of the COVID Pandemic. Phase 3 is the Recovery phase and focuses on 3 priority areas for the NHS, namely; accelerating the return to near-normal levels of non-COVID health services; preparing for winter demand pressures alongside continuing vigilance in light of a probable COVID spike; doing these two things in a way that takes account of the lessons learned during the first COVID peak. The draft plan needs to be submitted to NHSE/I by 1st September, with the final plan being due on 21st September. In-between these two dates there will be progress review sessions with NHSE/I. It will be important to ensure appropriate Lincolnshire system governance and sign-off for the system plan.

b. Further guidance has been issued relating to the work that the system needs to complete if it is to move to Integrated Care System (ICS) status by 1st April 2021. This expectation was set out in the operational planning guidance for 2020/21 and is consistent with the NHS Long Term Plan. The Lincolnshire System has an ICS progress development review with NHSE/I on 2nd September.

c. The next system quarterly review with NHSE/I is on 9th September. These review meetings were put on hold during the previous phases of the COVID pandemic.

d. The NHS People Plan for 2020/21 'We are the NHS' has been published. The document sets out the action that the people in the NHS can expect from their leaders and from each other, for the rest of 2020/21. The six areas of focus are as follows; responding to new challenges and opportunities; looking after people; belonging in the NHS; new ways of working and delivering care; growing for the future; supporting our NHS people for the long term. At the same time, the 'Our NHS People Promise' was published. This is the promise that all the people in the NHS must make to each other about how we work together to improve the experience of working in the NHS.

e. The first meeting of the NHS Midlands Leadership Team has taken place. This new group brings together the NHS Midlands Regional Leadership Team of NHSE/I and the STP/ICS leads from the eleven systems in the Midlands. The Lincolnshire STP member is John Turner. The focus of the NHS Midlands Leadership Team is oversight of the following areas; regional business; operational planning; strategy and transformation. The group will meet monthly.

2. Trust Issues

a. Dates are being set for a series of virtual Integrated Improvement Plan (IIP) launch events for staff. The Board will recall that the original events had to pause in March due to the COVID pandemic. These events are intended to

bring staff back up to speed on the content of the IIP and the link between the IIP and the Outstanding Care Together programme.

b. The Trust has received £2m national capital to help improve Pilgrim Hospital A&E department prior to winter. The funding will help with improvements to the waiting area and the clinical area. This is in addition to the funding linked to the Outline Business Case for Pilgrim Hospital A&E that was considered by the Board at its August meeting.
c. The Trust is looking to relaunch its Charity over the coming weeks in order to maximise the funding available and the use of this funding to benefit patients and staff. It is clear that there is considerable appetite from staff to appropriately use charitable funds in this way.
d. A new Leading Together Forum (LTF) is being created in the Trust to bring together key leaders from all levels and parts of the Trust, to focus on OD, behaviour and culture issues.
e. The Trust's Medical Director, Dr Neill Hepburn, has announced that he will be returning to full time clinical practice in Dermatology in the Trust, after 3 years in post as Medical Director. Neill has agreed to continue in the Medical Director role until a new appointment is made. The Trust will now push ahead with the national advert for his successor.
f. The Trust has advertised the substantive Director of Nursing role, bearing in mind that Dr Karen Dunderdale is currently filling the post on a secondment basis.

Report to:	Trust Board
Title of report:	Quality Governance Committee Assurance Report to Board
Date of meeting:	18th August 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 **Safeguarding Upward report** The Deputy Director of Safeguarding reported that his first meeting had been enthusiastic and well attended. Concerns were raised regarding compliance with training and the need to put e-learning in place to address concerns. It was anticipated that the e-learning package would be available from September. The Committee were advised of the gap with Safeguarding Adults Level 3 and the need to identify those staff who required training. The Committee noted that nationally it is reported that there is a significant increase in domestic violence and the impact that this would have, this would continue to be monitored and staff asked to remain aware of the rise. The Committee requested future reports contained divisional data for training compliance. **Infection Prevention Control Upward Report** The Committee received the upward report noting that the root cause analysis framework for hospital acquired infections had been approved. Water flushing had again been reported with limited assurance due to inconsistent reporting. Assurance was provided that a paper based process was in place to evidence flushing as a short term solution.

	Compliance with the hygiene code continued to increase with 7 of the 10 criterion being reported as compliant. A repository of evidence continued to be built to support compliance. The Committee noted the significant work and progress relating to deep cleans and this had remained on track month on month since the onset of Covid-19. Recruitment would take place to the maintenance team in order to ensure that minor repairs could be supported alongside the deep clean programme. **Patient Safety Group upward report** The Committee noted that there had been an increase in the number of medical examiners within the Trust meaning that all deaths were being reviewed. Issues continued to be experienced with the use of ReSPECT and further work was needed to maximise the potential as an advanced care planning document. The report highlighted concerns regarding patient moves, particularly the time and for those patients at end of life. There had been an increase in patients being moved to inappropriate areas due the pressures being faced to make additional space. The Committee requested that this was considered by the Patient Safety Group in order to identify how the issues was being measured and addressed. **Clinical Effectiveness Group upward report** The Committee received the report noting that this summarised a lot of activity undertaken by the group. The Committee noted the steady improvement of compliance with NICE guidance and noted the difficulty with the completion of Technology Appraisals however compliance was increasing. Ongoing discussion regarding policy and guidelines was noted regarding these being more readily accessible for clinical teams. The Committee noted the intended move to SharePoint that should improve access. **Incident Management Report including SI Never Events** The Committee were advised of a Never Event that had occurred at the end of July and assurance was provided that the Committee would receive specific reports relating to Never Events as they arise. There remained a number of open incidents on Datix and a significant number of overdue actions arising from incident investigations. The Committee were concerned by the number of open actions relating to Never Events.

	The Committee were advised that immediate action would be taken to work through all outstanding actions with divisions. The Committee were advised of 2 independent SI investigations that were being carried out by the Healthcare Safety Investigation Branch (HSIB), both incidents relate to Maternity Services. **Medicines management internal audit actions update** The Committee received the review of the actions in response to the progress made. It was noted that there had been work regarding medicines reconciliation and that this had improved due to access to WebV. The Committee noted however that there was a lack of clarity on the progress of actions and uncertainty of the requirements for funding in order to complete a number of actions. The Committee requested that a further report be presented that identified milestones. Consideration should be given to the understanding of the actions that could be taken and those that require investment.
	Lack of Assurance in respect of SO 1b Issue: Improve patient experience **National Inpatient survey action plan** The detailed action plan was presented to the Committee. These actions needed to be linked to the IIP and Patient Experience plan to be themed. The Committee noted that discharge, maternity and cancer would also require inclusion within the action plan. There would be a need to align the action plan to services in order that clarity of expectations would be provided. Other patient experience reports such as the NACEL and Cancer survey outcomes also needed to be pulled in to the IIP which enabled the key themes to be identified and addressed. The action plan would be updated and presented back to the Committee in October.
	Assurance in respect of other areas: **Committee Performance Dashboard** The Committee received the dashboard noting that there had been 4 falls during July with one resulting in a death. All falls were currently being reviewed and taken through appropriate processes. An increase in grade 2 pressure ulcers had been seen which was positive for the Trust as demonstrated that there was earlier detection of deterioration of skin integrity with a continued low level of grade 3 and 4

	damage. An improvement across all sepsis indicators had been seen and it was hoped that with the dedicated resource in place this improvement would continue. The Committee were alerted to the fact that there had been, as previously highlighted, an increase in crude mortality due to Covid-19. Currently it was not possible to apply a correction and as such true performance was difficult to monitor during this period. The Committee noted that further work on a number of indicators would take place in order to provide better oversight. **CQC Must and Should do actions** The Committee noted that there was now momentum in addressing the actions post Covid-19 however the Committee were keen to see this develop. The action plan had been developed to include all other areas of concern raised within reports that had not been formalised as actions. The plan would be further developed to include timescales and milestones in order to step up the narrative and provide further assurance. Divisional confirm and challenge session would take place in September led by the Chief Executive in order to support the divisions to self-assess against the CQC domains. The Committee noted that the relationship meetings with the CQC continued on a monthly basis and the outcome of these had been increasingly positive. **Quality Account** The Committee received the final Quality Account noting that this included comments from stakeholders. The Committee noted some minor points that required refinement and based on the changes being made approved the Quality Account for onward reporting to the Board ahead of publishing. The Committee expressed thanks to the team for continuing to work on the Quality Account during Coivd-19 which meant that publishing of the document had not been delayed.
Issues where assurance remains outstanding for escalation to the Board	
Items referred to other Committees for	No items referred to other committees

Assurance	
Committee Review of corporate risk register	The Committee reviewed the risk register accepting the top risks within the register noting the intention for a review of the risk register to be undertaken
Matters identified which Committee recommend are escalated to SRR/BAF	None
Committee position on assurance of strategic risk areas that align to committee	The Committee considered the reports which it had received which provided assurances against the strategic risks to strategic objectives.
Areas identified to visit in dept walk rounds	No areas identified.

Attendance Summary for rolling 12 month period

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

X in attendance A apologies given D deputy attended

Meeting	*Trust Board*
Date of Meeting	*Tuesday 1st September 2020*
Item Number	*Item 8.2*
Incident Management Report (including Never Events & other Serious Incidents)	
Accountable Director	*Dr Karen Dunderdale, Director of Nursing*
Presented by	*Dr Karen Dunderdale, Director of Nursing*
Author(s)	*Paul White, Risk & Incident Lead*
Report previously considered at	*Patient Safety Group (7th August 2020) Quality Governance Committee (18th August 2020)*

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

Risk Assessment	*4043 – Compliance with patient safety regulations & standards (High risk - 12)*
Financial Impact Assessment	*None*
Quality Impact Assessment	*None*
Equality Impact Assessment	*None*
Assurance Level Assessment	*Limited*

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

Executive Summary

- The Trust's patient incident reporting rate per 1,000 bed days has remained at an average of 38 throughout the past 18 months, compared with a national average in 2019 of 50
- The number of incidents reported each month, and the severity of harm, are in line with the national average for acute hospital trusts
- The number of open patient incidents on Datix as of 11th August 2020 was 1,512
- As of 12th August 2020 there were 1,600 overdue actions arising from incident investigations recorded on Datix which means that 86% of agreed actions are currently overdue
- There are 132 open actions relating to Never Events, of which 127 are currently overdue
- 65% of investigations are being completed within 4 weeks of being reported
- 14 Serious Incidents were declared in July, which means that there are now 51 on-going and 46 awaiting CCG approval
- 2 independent SI investigations (both occurring within Maternity) are currently being investigated by the HSIB
- Recent Divisional Investigations are being prioritised, with a thematic review of older incidents planned to identify scope for potential learning
- A report on the implications of the new national Patient Safety Incident Response Framework (PSIRF) and a gap analysis against current ULHT policy and procedure is being undertaken and will report to the Patient Safety Group in October

1. Purpose

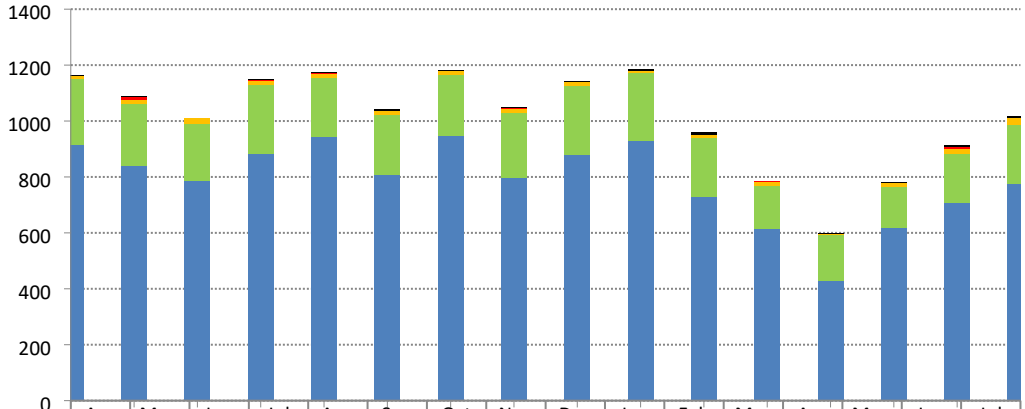
1.1 The purpose of this report is to provide the Trust Board with an overview of the effectiveness of the Trust's incident management policy and procedures (including the management of Never Events and other Serious Incidents).

2. Introduction

2.1 The Trust uses the Datix Risk Management System for the reporting and review of unexpected or unintended incidents that have caused or could have caused harm to patients. The Datix system is also used to support the management of incidents affecting staff, visitors and assets. The scope of this report is limited to incidents affecting patients, as it is provided to the Patient Safety Group (PSG) and Quality Governance Committee (QGC).

3. Patient safety incident investigations

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



	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020	Apr 2020	May 2020	Jun 2020	Jul 2019
5 - Death	1	2	0	2	1	4	3	2	3	4	8	0	2	1	6	4
4 - Severe Harm	2	8	0	4	2	2	1	3	1	1	0	1	0	0	4	3
3 - Moderate Harm	11	15	19	11	17	16	12	15	15	8	12	11	3	13	18	24
2 - Low Harm	235	223	201	247	211	213	220	234	244	243	214	157	163	147	176	212
1 - No harm	916	840	788	885	942	808	947	796	881	929	727	614	429	619	709	775

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

3.3 This analysis demonstrates that the Trust has continued to report patient incidents consistently throughout the Covid-19 pandemic response. The average number of incidents reported each month is just over 1,000. This is in line with the national average for acute hospital trusts in 2019.

3.4 A breakdown of these patient incidents by severity of harm shows that 78% of incidents reported by the Trust resulted in no harm; 21% in low harm; and less than 1% in moderate harm, severe harm or death. This is also in line with the national average.

3.5 **Table 1** shows a breakdown of the 1,512 open patient safety incident investigations (as of 4th August 2020) by division and Clinical Business Unit (CBU) or corporate department:

Division & CBU	Open incidents	Change
Medicine Division	**682**	**+64**
Urgent & Emergency Care CBU	399	+16
Specialty Medicine CBU	241	+43
Cardiovascular CBU	42	+5
Surgery Division	**314**	**+98**
Surgery CBU	118	+34
Theatres & Critical Care CBU	89	+22
Trauma & Orthopaedics and Ophthalmology CBU	107	+42
Family Health Division	**162**	**+38**
Women's Health and Breast CBU	132	+38
Children & Young Persons CBU	30	-
Clinical Support Services Division	**315**	**+55**
Diagnostics CBU	83	+21
Outpatients CBU	65	+10
Pathology	43	-1
Cancer Services CBU	76	+17
Pharmacy CBU	42	+6
Therapies & Rehabilitation CBU	6	+2
Corporate Services	**39**	**+7**
Operations	14	+4
Estates & Facilities	12	+2
Corporate Nursing	7	-
Medical Directorate	5	+1
Digital (ICT)	1	-
Total	1512	+262

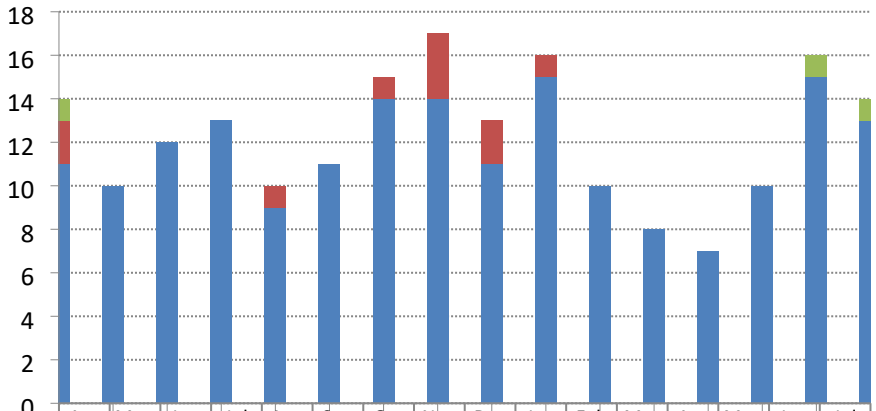
3.6 Of these open patient incidents, 54% were reported on Datix prior to the start of July 2020 and are therefore overdue (the Trust's incident Management Policy states that departmental investigations should be completed within 4 weeks of reporting).

3.7 The breakdown of overdue investigations by division is shown on **Table 2**:

Division	Number overdue	% overdue
Medicine	369	54%
Surgery	147	48%
Family Health	58	33%
Clinical Support Services	209	67%
Corporate	31	76%

4. Serious Incidents

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



	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020	Apr 2020	May 2020	Jun 2020	Jul 2020
Independent Serious Incident investigation (StEIS)	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
Never Event Serious Incident (StEIS)	2	0	0	0	1	0	1	3	2	1	0	0	0	0	0	0
Serious Incident (StEIS)	11	10	12	13	9	11	14	14	11	15	10	8	7	10	15	13

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

4.3 There has been 1 Never Event recorded in July and this was reported verbally to the Trust board last month. There were 10 Never Events declared by the Trust in 2019/20.

4.4 **Table 2** shows the number of Serious Incidents open within the Trust, broken down by division (as of 4th August 2020):

Division	Serious Incidents (StEIS) open	Change (this month)
Medicine	26	+5
Surgery	14	+4
Family Health	8	+3
Clinical Support Services	3	-
Total	51	+12

4.5 There were also 46 completed SI investigations awaiting approval and closure by the CCG.

4.6 The number of Serious Incident investigations open within the Trust has been steadily increasing throughout the 2020/21 financial year to date (there were 32 open at the end of March 2020). The majority of SI investigations continue to be carried out by the temporary SI Team within Clinical Governance. It should also be noted that during the Covid-19 pandemic response the CCGs have not been enforcing the using 60 working day deadlines specified for completing SI investigations, therefore no SI investigations have been overdue so far this financial year.

4.7 As of 12th August 2020 there were 1,600 overdue actions arising from incident investigations recorded on Datix (these are actions with a due date up to and including July 2020). This is out of a total of 1,866 open actions arising from incidents, which means that 86% of agreed actions are currently overdue.

4.8 **Table 3** shows a breakdown of these overdue actions by division and CBU:

Division & CBU	Total
Medicine Division	921
Cardiovascular CBU	80
Specialty Medicine CBU	392
Urgent & Emergency Care CBU	449
Surgery Division	324
Surgery CBU	147
Theatres & Critical Care CBU	12
Urology, Trauma & Orthopaedics and Ophthalmology CBU	165
Family Health Division	153
Children & Young Persons CBU	29
Women's Health and Breast CBU	124
Clinical Support Services Division	100
Cancer Services CBU	61

Division & CBU	Total
Diagnostics CBU	31
Outpatients CBU	3
Pharmacy CBU	2
Therapies & Rehabilitation CBU	3
Corporate	102
Digital (ICT)	2
Estates & Facilities	8
Human Resources & Organisation Development	2
Operations	90
Total	**1600**

4.9 There are 132 open actions relating to Never Events, of which 127 are currently overdue.

4.10 Divisional Governance Managers have been tasked with reviewing and updating all overdue actions within their respective divisions by the end of August.

5. Divisional Investigations

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

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

	Divisional investigations open	Change (this month)
Medicine	24	+2
Surgery	7	+1
Family Health	1	-
Clinical Support Services	1	-
Total	33	+3

5.3 The number of open Divisional Investigations has been steadily reducing over the past 6 months, but there remain 27 that are overdue (the Trust's Incident Management Policy states that Divisional Investigations should be completed within 8 weeks of the decision to set the level of investigation).

5.4 The current focus of Clinical Governance support for Divisional Investigations is to prioritise the most recent incidents, as they represent the greatest likelihood of identifying potential learning. A thematic review of older incidents is planned, to determine whether a full investigation is still required or if there

have been other similar investigations since they were reported which may supersede the requirement for a full investigation.

6. Risks

6.1 The risk of non-compliance with patient safety regulations and standards, leading to regulatory action, is recorded as a core risk on the strategic risk register (Risk ID 4043) with a current rating of High risk (12). There is one mitigating action planned in relation to incident management, specifically to address the volume of Never Events declared in 2019/20.

6.2 Based on the level of incident reporting within the Trust and the current volume of open incidents and open actions related to these investigations, the strategic risk register will be updated to reflect an increase in risk level.

6.3 As part of the national Patient Safety Strategy a new Patient Safety Incident Response Framework (PSIRF) is currently being trialled within a small number of trusts. The current National Reporting and Learning System (NRLS) and Strategic Executive Information System (StEIS) will be replaced with a new national patient safety system. The initial documentation has been published for information and represents a significant change in approach. A report on the implications of the new PSIRF and a gap analysis against current ULHT policy and procedure is being undertaken and will report to the Patient Safety Group in October.

7. Conclusions & recommendations

7.1 As the Trust recovers from the impact on services of the Covid-19 pandemic response, it is important that a focus on appropriate, proportionate and timely review of patient incidents is maintained in order to mitigate the risk of regulatory action. The continued provision of management information, via Datix Dashboards, supported by training for managers and lead investigators, are key to the future effectiveness of incident management within the Trust.

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

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*1st September 2020*
Item Number	*Item 8.3*
Quality Account	
Accountable Director	*Dr Neill Hepburn, Medical Director*
Presented by	*Dr Neill Hepburn, Medical Director*
Author(s)	*Bernadine Gallen, Quality & Safety Manager*
Report previously considered at	*Quality Governance Committee August 2020 Approved*

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	*Nil*
Financial Impact Assessment	*Nil*
Quality Impact Assessment	*NIl*
Equality Impact Assessment	*Nil*
Assurance Level Assessment	*Insert assurance level* • *Moderate*

Recommendations/ Decision Required	• *To approve the Quality Account*

Executive Summary

The Quality Account is a report about the quality of services offered by ULHT. The report should be published by the 30th June 2020, however, due to COVID-19 NHSE/I have launched a revised deadline of the 15th December 2020. Draft Quality Accounts to be presented to stakeholders by the 15th October 2020.

Due to COVID-19 NHS providers are no longer expected to obtain assurance from their external auditor on their 2019/20 Quality Account so there will be no review of any quality indicators or the content within the Quality Account. There will be no limited assurance report.

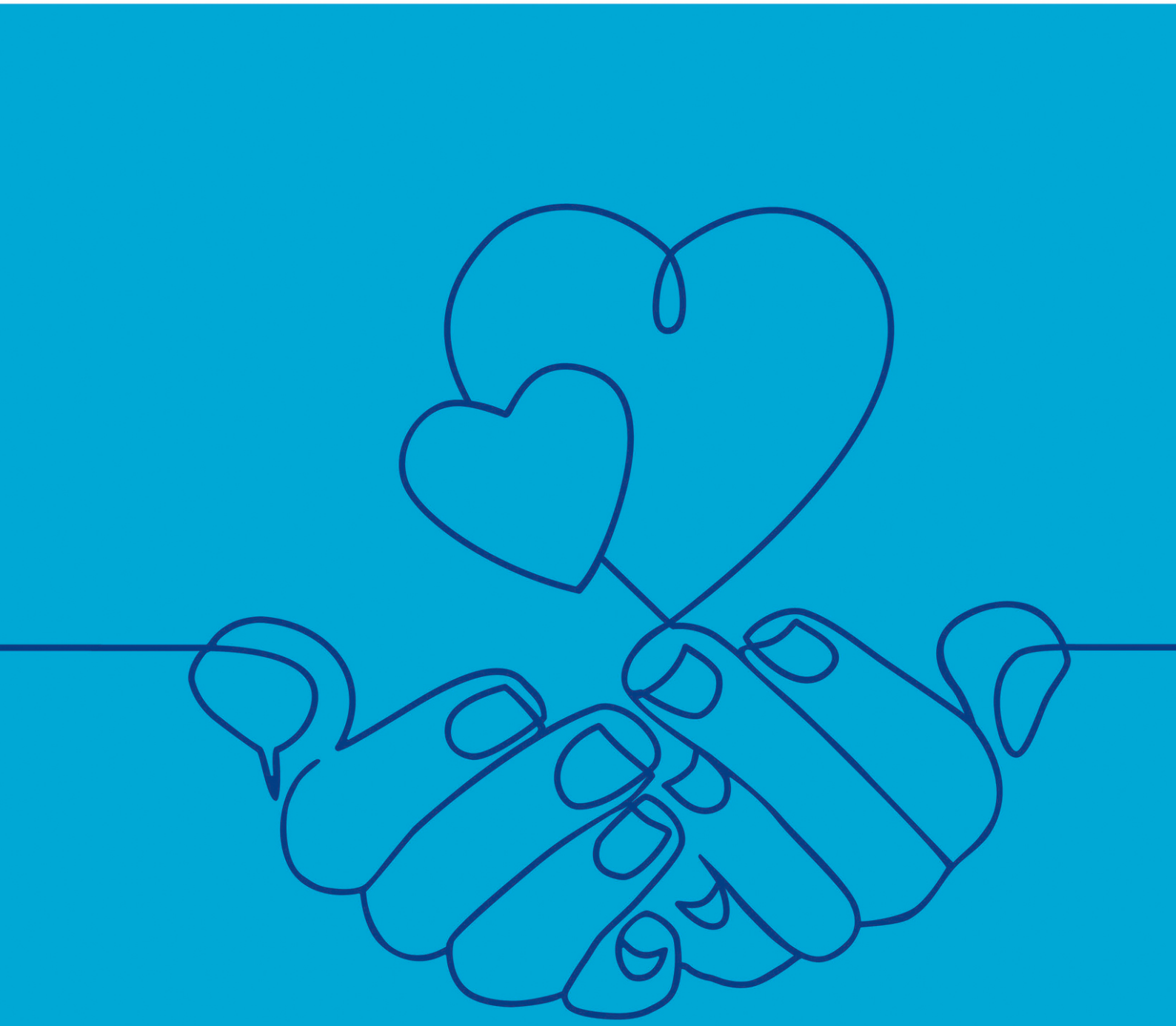
The draft Quality Account has been presented to Healthwatch and Health Scrutiny Committee for Lincolnshire. Their statements have been incorporated within the Quality Account

Our Lead Commissioner have also sent their statement which has been included.

The 2019-20 Quality Account will be signed off by the Chief Executive and Chair when approved by the Trust Board.

ULHT QUALITY ACCOUNT 2019-20

NHS
United Lincolnshire Hospitals
NHS Trust



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GLOSSARY OF ABBREVIATIONS

A&E	Accident and Emergency
AAA	Aortic Abdominal Aneurysm
BAF	Board Assurance Framework
BTS	British Thoracic Society
CABG	Coronary Artery Bypass Graft
CAF	Cyber Assessment Framework
CCG	Clinical Commissioning Group(s)
COPD	Chronic Obstructive Pulmonary Disease
CPA	Care Programme Approach
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CRN	Clinical Research Network
DATIX	Incident Reporting System
DNACPR	Do Not Attempt Cardiopulmonary Resuscitation
DSP Toolkit	Data Security and Protection Toolkit (DSP Toolkit)
DToC	Delayed Transfer of Care
DVT	Deep Vein Thrombosis
ED	Emergency Department
eDD	Electronic Discharge Document
EMAS	East Midlands Ambulance Service
ECIST	Emergency Care Intensive Support Team
FFAP	Falls and Frailty Audit Programme
FFT	Friends and Family Test
GDH	Grantham District Hospital
GIRFT	Getting It Right First Time
GP	General Practitioner
HES	Hospital Episode Statistics
HQIP	Health Quality Improvement Partnership
HSMR	Hospital Standardised Mortality Ratio
IBD	Inflammatory Bowel Disease
ICNARC	Intensive Care National Audit and Research Network
ICS	Integrated Care System
IG	Information Governance
IIP	Integrated Improvement Plan
IP&C	Infection Prevention and Control
IVAB	Intravenous Antibiotics
KPI	Key Performance Indicator
LCH	Lincoln County Hospital
LCRF	Lincoln Clinical Research Facility
LeDeR	Learning Disability Mortality Review Programme
LOS	Length of Stay
LUCADA	Lung Cancer Audit (National)
MADE	Multi-Agency Discharge Event
MBRACE	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries
MCA	Mental Capacity Act
MDT	Multi-Disciplinary Team
MI	Myocardial Infarction

MINAP	Myocardial Infarction National Audit Programme
MoRAG	Mortality Review Assurance Group
MorALS	Mortality Assurance and Learning Strategy Group
N/A	Not Applicable
NBCA	National Bowel Cancer Audit
NCEPOD	National Confidential Enquiry into Patient Outcomes and Death
NHS	National Health Service
NHSi	National Health Service Improvement
NHSLA	National Health Service Litigation Authority
NIS	Network and Information Systems
NICE	National Institute for Health and Care Excellence
NICOR	National Institute for Cardiovascular Outcomes Research
NIV	Non-Invasive Ventilation
NJR	National Joint Registry
NMC	Nursing and Midwifery Council
NNAP	National Neonatal Audit Programme
NPCA	National Prostate Cancer Audit
NIHR	National Institute for Health Research
NRLS	National Reporting Learning System
NVD	National Vascular Database
PALS	Patient Advice and Liaison Service
PbR	Payment by Results
PHB	Pilgrim Hospital Boston
PHSO	Parliamentary and Health Service Ombudsman
PICANet	Paediatric Intensive Care Audit Network
PROMs	Performance Reported Outcome Measures
QGC	Quality Governance Committee
QSIR	Quality, Service Improvement and Redesign
QSOG	Quality and Safety Oversight Group
RCEM	Royal College of Emergency Medicine
RCP	Royal College of Physicians
RCT	Randomised Control Trials
ReSPECT	Recommended Summary Plan for Emergency Treatment
RTT	Referral to treatment
SHMI	Standardised Hospital-Level Mortality Indicator
SHOT	Serious Hazards of Transfusion
SOF	Single Oversight Framework
SOP	Standard Operating Procedure
SQD	Safety Quality Dashboard
SSNAP	Sentinel Stroke National Audit Programme
STP	Sustainability and Transformation Programme
TARN	Trauma Audit Research Network
TOM	Trust Operating Model
UEC	Urgent and Emergency Care Programme
ULHT	United Lincolnshire Hospitals NHS Trust
VTE	Venous Thromboembolism
WTE	Whole Time Equivalent
7DS	Seven Day Services

CONTENTS

PART 1

PART 2

PART 3

NHS
United Lincolnshire Hospitals
NHS Trust

PART 1

OUTSTANDING CARE
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CHIEF EXECUTIVE'S STATEMENT

Welcome to the Quality Account for United Lincolnshire Hospitals NHS Trust for 2019-20. This document provides an overview of all of the activity that has been taking place within our hospitals to improve quality over the last year.

During the year, we continued to monitor and improve the quality of care that we provide, whilst we remained in quality special measures. We still have more to do but our excellent improvement in mortality rates is an example of where we've made a huge difference. From being flagged as having a high Hospital Standardised Mortality Ratio (HSMR), this year we recorded our lowest ever HSMR and were one of the best performers in the country - a great achievement.

Elsewhere, the year has been very challenging for Lincolnshire's hospitals, with difficulties meeting some of the NHS constitutional standards, continuing financial challenges and record levels of A&E attendances over the winter.

Our new Trust Operating Model (TOM) which is a clinically led Trust operating model was launched at the beginning of the year which has seen us restructure and bring in new senior management capability to help address these challenges and standardise practice across all of our sites and services.

In addition, the results of our most recent Care Quality Commission (CQC) inspection from June and July 2019 rated the Trust as 'Requires Improvement' overall - the same rating it received following the last inspection in 2018.

The CQC recognised that whilst improvements have been made in some areas, there is still much more that needs to be done and we remain in quality special measures for the time being. We also remain in financial special measures as our financial position has not improved.

Many of the issues identified by the CQC and others are around our staffing shortages, estates issues, lack of digital maturity, governance processes and financial pressures. It is also clear that we need to focus on recruitment, leadership, staff training and competencies, staff engagement and addressing workforce inequalities going forward.

We also had the results of an unannounced CQC inspection at our A&E departments at Lincoln County Hospital and Pilgrim Hospital, Boston in January 2020. Overall, both departments were rated as 'Inadequate', the same as they were following our previous inspections.

The report acknowledges the amount of pressure that both departments have been under over the last few months, but also unfortunately identifies a number of areas where inspectors felt significant improvements need to be made. Work is already underway to address the highlighted issues.

We have also seen a number of positive improvements and developments during the year. We have put extensive efforts into improving the involvement and engagement of our staff, which resulted in a record response rate to the National NHS Staff Survey, and some improvements in the results across some areas. We have also achieved our long-held objective of becoming a Smokefree Trust, which we believe is the right thing to do for our staff, patients and visitors.

In August we had a visit from Prime Minister Boris Johnson, who pledged £21.3 million for a new urgent and emergency care unit at Pilgrim hospital, and we continued with our £35 million investment in fire safety measures across our sites, which have really transformed the look and feel of our hospital buildings.

From April 2020, the Trust's new Integrated Improvement Plan will be launched and looks to simplify our ambition as an organisation and how we will work together to improve for the future. Part of this is to provide a simple vision, which is to provide 'Outstanding care, personally delivered'.

We believe that we are moving in the right direction and that, with our excellent staff, we can really make the changes needed to improve the quality and safety of care that we deliver to the people of Lincolnshire.

During March 2020, a global outbreak of Coronavirus (COVID-19) initiated a national incident across the UK. For Lincolnshire's hospitals this meant we had to implement a range of measures to ensure we were prepared for a potential surge in the number of patients we might see. We continue to work closely with national health bodies to inform our plans and ensure that both our patients and staff remain safe and well-cared for.

With NHS Trusts focused on responding to the COVID-19 pandemic, we are not expected to obtain assurance from our external auditor on our quality account for 2019/20.

On the basis of the processes the Trust has in place for the production of the Quality Account, I can confirm that to the best of my knowledge the information contained within this report is accurate.

Andrew Morgan

Chief Executive

PRIORITIES FOR IMPROVEMENT IN 2020-21

Deciding our quality priorities for 2020-21

In order to determine our priorities we have consulted with a number of stakeholders including our Trust Quality Governance Committee (QGC) and our commissioners. The QGC on behalf of the Board approved the priorities and there will be regular reports on progress to QGC throughout the year.

We have ensured that our quality priorities are aligned with this year's Trust's Integrated Improvement Plan (IIP), Lincolnshire-wide system quality priorities and our Commissioning for Quality and Innovation (CQUINs). We have taken into account our progress throughout the year against last year's priorities to help decide which priorities need an ongoing focus within this year's Quality Account. The priorities also reflect some of the key areas that were raised in the CQC report published in October 2019.

The following improvement priorities for the Trust have been identified for particular focus in 2020-21. These priorities may be extended over the coming years to ensure they are fully embedded within our organisation. All of the priorities have been selected as they are really important for patient experience and they all encompass the Care Quality Commission(CQC) domains as demonstrated below.

PRIORITY 1 – CARE OF RESPIRATORY PATIENTS

Why have we selected this Priority?

Respiratory disease affects one in five people and is the third largest cause of death in England (after cancer and cardiovascular disease). Hospital admissions for lung disease have risen over the past seven years at three times the rate of all admissions generally.

Respiratory diseases are a major factor in winter pressures faced by the NHS; most respiratory admissions are non-elective and during the winter period these double in number.

The annual economic burden of asthma and COPD on the NHS in the UK is estimated as £3 billion and £1.9 billion respectively. In total, all lung conditions (including lung cancer) directly cost the NHS in the UK £11billion annually.

Incidence and mortality rates from respiratory disease are higher in disadvantaged groups and areas of social deprivation, with the gap widening and leading to worse health outcomes. The most deprived communities have a higher incidence of smoking rates, exposure to higher levels of air pollution, poor housing conditions and exposure to occupational hazards.

Our Current Status

The Getting it Right First Time (GIRFT) national team, visited United Lincolnshire Hospitals NHS Trust to review respiratory services on 27th November 2019.

The ambition of the GIRFT programme is to identify examples of innovative, high quality and efficient service delivery. Conversely, it also looks at areas of unwarranted variation in clinical practice and / or divergence from the best evidence-based care. The work culminates in a set of national recommendations aimed at improving the quality of care and reducing expenditure on complications, litigation, procurement and inappropriate treatments.

Two of the areas identified by the GIRFT national team for improvement within respiratory medicine were:

- Non-Invasive Ventilation (NIV) services and NIV in-reach into A&E.
- Management of Chronic Obstructive Pulmonary Disease (COPD), asthma and pneumonia patients.

What will success look like?

To deliver against the GIRFT recommendations the following will be implemented:

- Our NIV services are in line with national standards and patient outcomes monitored.
- 25% increase in patients having their blood gas checked 2 hours post commencement of NIV.
- 25% increase in patients having their NIV commenced within 1 hour at the Lincoln site.
- A Trust-wide options appraisal for in-reach NIV service to A&E will be developed – this is inclusive of identifying and managing patients with COVID-19.
- A competency framework for A&E staff.
- 100% of ward staff to have completed their NIV competencies.
- Trust-wide protocol fast track pathway for NIV to meet British Thoracic Society (BTS) standards.
- The asthma service will be reviewed.
- Asthma pathway to be process mapped.
- Asthma bundles are aligned to national guidance and patient outcomes monitored.
- Pathway standardised operating procedure (SOP) for asthmatic patients will be developed and implemented.
- 100% of asthma patients to have been referred to a Respiratory Specialist within 24 hours (Monday – Friday).

How will we monitor progress?

In response to the GIRFT visit and recommendations the Trust has developed a Respiratory Improvement Group to manage and implement the improvements suggested.

A quarterly report will be presented at Patient Safety Group.

A quarterly report will be presented at Quality Governance Committee on the progress of their milestones.

Ongoing submission of data for national asthma and COPD audit programme.

PRIORITY 2 – SAFE DISCHARGE OF OUR PATIENTS

Why have we selected this Priority?

Unnecessarily prolonged stays in hospital are bad for patients. This is due to the risk of unnecessary waiting, sleep deprivation, increased risk of falls and fracture, prolonging episodes of acute confusion (delirium) and catching healthcare-associated infections. All can cause an avoidable loss of muscle strength leading to greater physical dependency (commonly referred to as deconditioning). Tackling long stays in hospital reduces risks of patient harm, disability and unwarranted cost, particularly for those who are intrinsically vulnerable because they have mild or moderate frailty and/or cognitive disorder, and for whom a different, more positive outcome can be achieved if the right steps are taken very early in their admission.

A 'Delayed Transfer of Care' (DToC) occurs when a patient is ready to leave a hospital or similar care provider but is still occupying a bed. Delays can occur when patients are being discharged home or to a supported care facility, such as a residential or nursing home, or are awaiting transfer to a community hospital or hospice. DToCs can cause considerable distress and unnecessarily long stays in hospital for patients.

A 25% increase in reported DTOC days across England from 2015-16 to 2016-17 has resulted in pressure to reduce delays, with national targets and requirements set by the Department of Health.

Estimates from the National Audit Office (NAO) amount the cost to the NHS for delayed discharges to be around £800 million a year.

The proportion of delayed transfers due to social care has risen steeply since 2014, but the majority of delays (58% in 2016-17) are still attributed to the NHS.

Numerous studies have shown that effective action by hospitals to improve patient flow beyond A&E has the greatest impact on length of stay. Whole system collaboration to expedite discharges is also important.

Our Current Status

As an organisation we have struggled with continuing operational pressures that have seen our hospitals in and out of level three and four escalation status and using escalation beds for many months. Average bed occupancy at ULHT is consistently over 92% (and tends to be higher in winter months). NHS England advises that Trusts should keep bed occupancy below 92%. 85% is sometimes cited as the maximum safe level of occupancy.

We need to change the way we deliver services to ensure we are able to provide safe, quality care that improves the patient's experience and at the level of efficiency which our commissioners and the general public demand of us. Discharge planning needs to be started on admission to enable effective discharge plans to be initiated and families / carers are involved.

It is hoped that DToC rates can be improved through system working with health and social care partners to improve discharge processes, including system wide electronic demand and capacity monitoring, and the implementation of the NHS Trusted Assessor model for patients discharged to care homes. ULHT also has a discharge team working seven days a week.

A number of key initiatives have been adopted at ULHT to minimise discharge delays and to improve the discharge experience for our patients. The 'SAFER' patient flow bundle, 'Red2Green days', long length of stay reviews and '10 by 10' have been shown to reduce the length of stay of those admitted.

It is hoped that implementing these initiatives will allow us to recognise and unblock discharge delays, improve discharge preparedness and reduce bed occupancy which will improve patient safety and experience.

What will success look like?

- Improved patient flow across the system as per timetable.

- Reduced length of stay (LOS).
- Increased proportion of patients discharged before 10am.
- Reduced DToC rate.
- Reduced ward moves for new patients admitted.
- Increased proportion of patients discharged with their electronic discharge document (eDD).
- SAFER Patient Flow Bundle utilised in all wards.
- Multi Agency Discharge Event (MADE) strategy to be implemented on a permanent basis and MADE events to be held with system partners.
- Fewer incidents relating to unsafe discharge.
- Lincolnshire Collaborative will meet 6 weekly to review inappropriate admissions and work with our system partners to reduce these.
- Our SHMI data will be analysed to identify themes for patients who die within 30 days of discharge.

How will we monitor progress?

There is a Discharge working group who have developed work streams to address the areas that required improving.

A quarterly report will be presented at Patient Safety Group.

A quarterly report will be presented at Quality Governance Committee on the progress of their milestones.

PRIORITY 3 – CARE OF THE DETERIORATING PATIENT

Why have we selected this Priority?

Patients who are admitted to hospital believe that they are entering a place of safety, where they, and their families and carers, have a right to believe that they will receive the best possible care. They feel confident that, should their condition deteriorate, they are in the best place for prompt and effective treatment. NICE guideline CG50 states that there is evidence to the contrary. Patients who are, or become, acutely unwell in hospital may receive suboptimal care. This may be because their deterioration is not recognised, or because despite indications of clinical deterioration it is not appreciated, or not acted upon sufficiently rapidly. Communication and documentation are often poor, experience might be lacking and provision of critical care expertise, including admission to critical care areas, delayed.

While escalation of the deteriorating patient may be appropriate for the majority of our inpatients, it must also be recognised that part of planning effective care should also involve the recognition of care ceilings and which treatments should be offered or indeed accepted by patients. ReSPECT is a process that creates personalised recommendations for a person's clinical care in a future emergency in which they are unable to make or express choices.

Sepsis is a complex condition associated with poor outcomes when the diagnosis is delayed and treatment is not started promptly and in the context of the deteriorating patient has many human and environmental factors that may impede timely delivery of treatment.

Maintenance of an adequate fluid balance is vital to health. Inadequate fluid intake or excessive fluid loss can lead to dehydration, which in turn can affect cardiac and renal function and electrolyte management. Inadequate urine production can lead to volume overload, renal failure and electrolyte toxicity.

Our Current Status

ReSPECT was introduced in ULHT in February 2019 and is now widely used throughout the Trust, it was intended to be used to address some of the concerns in effectively planning emergency care and treatment plans for patients. Audit work carried out within the Trust demonstrates it is commonly used as a DNACPR tool rather than for all care and treatment decisions and further work must be completed in order to maximise its full potential as an advanced care planning document.

Trust –level audit data from the Safety Quality Dashboard (SQD):

Metric Title	Nov-2019	Dec-2019	Feb-2020
Number of ReSPECT forms	108	99	108
Capacity and representation completed	86.9%	83.8%	88.9%
Demographics correct (including date)	98.1%	98.0%	94.4%
Patient/family/carer involved (or reason evident)	91.6%	90.9%	95.3%
Summary of relevant information completed	100.0%	98.0%	100.0%
Full explanation and record of names	72.9%	77.8%	72.0%
Name of person involved in the making of the plan	78.5%	80.8%	74.8%
Personal preferences completed	82.7%	88.1%	87.3%
Clinician details completed	97.2%	99.0%	100.0%
Clinical recommendations, care & treatment completed	84.3%	88.9%	89.8%
Countersigned by senior clinician within 24 hours	89.0%	85.9%	95.5%
CPR recommendations made and signed by a clinician	100.0%	100.0%	100.0%

Sepsis compliance has improved however, the Trust is not consistently achieving the 90% target for screening and administering IVAB within 1 hour. The Trust results as of February 2020:

Sepsis screening compliance for inpatients (adult)	88.5%
Sepsis screening compliance for inpatients (child)	82.0%
IVAB within 1 hour for sepsis for inpatients (adult)	90.1%
IVAB within 1 hour for sepsis for inpatients (child)	91.0%
Sepsis screening compliance in A&E (adult)	91.5%
Sepsis screening compliance in A&E (child)	86.6%
IVAB within 1 hour for sepsis in A&E (adult)	94.0%

What will success look like?

- Early detection and treatment of deteriorating patients. 100% clinical members of the resuscitation team to be identified as a potential instructor for the Intermediate Life Support (ILS) course to maximise number of available instructors across all sites, thereby increasing potential course enrolments.

- Acute Illness Management (AIMs) course adopted within the Trust, and all four senior resuscitation practitioners will become full instructors to deliver this course.

- 90% compliance for sepsis 6.

- Improve sepsis learning throughout the Trust with the introduction of a train the trainer scheme. Assessment criteria to be formulated for trainers to be examined against to maintain repeatable standards across the Trust.

- Introduce a fluid balance e-learning package for non-registered staff.

- Effective process for Trust and system wide dissemination to share learning and joint working. This will be overseen by the deteriorating patient group.

- ReSPECT process is being utilised across the Trust and becoming embedded into practice. To audit compliance on 10 sets of notes within the emergency admission wards to improve quality.

How will we monitor progress?

There is a Deteriorating Patient working group who have developed work streams to address the areas that required improving.

A quarterly report will be presented at Patient Safety Group.

A quarterly report will be presented at Quality Governance Committee on the progress of their milestones.

PRIORITY 4 – DELIVERING HARM FREE CARE: DEVELOPING OUR SAFETY CULTURE

Why have we selected this Priority?

High reliability organisations are able to deliver effectiveness, efficiency and safety despite them having the potential for high risk and harm and they minimise errors through teamwork, awareness of potential risk and constant improvement. This involves not only preventing errors or failures, but also learning quickly and taking action to prevent reoccurrence. As a healthcare organisation, ULHT is constantly dealing with complex situations and is exposed to significant risk, therefore adopting the principles of a high reliability organisation will be a key part of our approach to creating a culture of safety.

Using a high reliability approach will enable us to develop, implement and embed a safety culture which will ensure that all our staff understand, collaborate, develop and share learning in relation to patient safety across the organisation. It will support our staff to consistently ensure and maintain the safety of our patients and to feel able to report incidents without fear of reprisal; to question practice or resources and feel that they work in an environment of learning, openness and transparency.

Our Current Status

ULHT has recognised that a key step in becoming a high reliability organisation is to change our safety culture as currently we do not have the conditions required to consistently ensure and maintain the safety of our patients or for staff to understand, collaborate, develop and share learning in relation to patient safety across the organisation.

The Trust had ten Never Events for 2019-20. An audit was conducted in January 2020 to review compliance with the WHO Surgical Safety Checklist which demonstrated a lack of clarity and consistency across ULHT policies and SOPs which are open to local interpretations.

Improving patient safety by learning from adverse events will encourage a safety culture throughout the organisation. It will also ensure that we can demonstrated sustained changes in practice occur.

The CQC have highlighted that we need to improve learning from incidents. Our Staff survey scores for questions that are used for the ‘safety culture theme’ are below national average and relatively static.

What will success look like?

- To move towards becoming a high reliability organisation by focusing on surgical / invasive procedures and safe clinical use of medicines (prescribing and administration).

- Deliver the requirements of the National Patient Safety Strategy for 2020-21.

- Have a theatre safety group to ensure safe care is delivered and to protect our patients from errors, injuries, accidents and infections.

- There will be a programme of enhanced safety visits / safety conversations in Theatres to empower our staff to review redundant or flawed systems and processes to empower our staff to discuss redundant or flawed systems and processes.

- A safety culture survey (from a recognised provider) will be undertaken in Theatres and Emergency Departments.

- Introduce new mechanisms and ways to improve how learning and continuous improvement is shared and spread.

- There will be zero surgical Never Events.

How will we monitor progress?

A theatre safety group will develop work streams to address the areas that required improving.

A quarterly report will be presented at Quality Governance Committee on the progress of their milestones.

PRIORITY 5 – INFECTION PREVENTION AND CONTROL

Why have we selected this Priority?

As the national post COVID-19 priority moves through the Restore and Recovery phases, Infection Prevention and Control (IPC) excellence has been identified as one of the key drivers of quality and safety and is at the heart of all forward planning for ULHT. Patients should be cared for on clean and safe environments and by staff who are well trained and supported.

The hygiene code forms the basis of the required standards for IPC in all registered organisations and sets out the ten overarching criteria that ULHT will aspire to achieve embedded compliance to. The hygiene code is comprehensive and there is a significant piece of work to fully understand our true position against compliance.

Our Current Status

We are currently in the process of assessing our embedded compliance position against the hygiene code standards. This is a lengthy process as there are over 150 compliance items to be assessed.

As a Trust we are asking a question of each compliance item:

- Can we demonstrate that we have assurance of embedded compliance?

Where any gaps are identified, a robust, risk based plan of action will be produced.

What will success look like?

Having oversight, control and ownership of every line item within the hygiene code is the aim. Success will be a detailed and robust plan of action with key milestones for delivery. The milestones will be set to ensure progress is maintained. Once the plan and timescales have been agreed they will be added to the annual work plan for monthly assessment.

- 90% return rate and 95% compliance of the metrics for the Front Line Ownership (FLO) audit.

- 95% return rate and 95% compliance of metrics for the hand hygiene audit.

- 100% of policies to be update (total of 27 policies).

- 5% reduction in all Healthcare Associated Infection (except COVID-19).

How will we monitor progress?

The Trust will monitor progress monthly through a report to the Infection Prevention and Control Group chaired by the Director of Infection Prevention and Control.

An upward report will be presented to the board for quality and assurance oversight.

LOOKING BACK: PROGRESS MADE SINCE PUBLICATION OF 2018-19 QUALITY ACCOUNT

This section of the Quality Account presents in summary the Trust's progress since the publication of last year's account against the identified improvement priorities.

In 2019-20 these were:-

1. • Patient and Carer Experience
2. • I would recommend my organisation as a place to work/If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation
3. • Ensuring effective systems for reviewing mortality
4. • Ensuring people are being cared for in the right place at the right time - Respiratory Patients

Introduction

The Quality Account for 2018-19 outlined the Trust's proposed quality improvements for the year ahead (2019-20). These priorities were identified following engagement with patients, the public, staff and external stakeholders. During the year 2019-20 we have been monitoring our progress against these priority ambitions through our governance framework. The priorities that we have not carried forward will become 'business as usual' and we will have defined work streams to enable the Trust to deliver on the improvements not achieved in 2019-20.

The Trust has not fully achieved all its priority ambitions however there is evidential progress in several areas with sustained patient safety improvements. We set ourselves ambitious targets and have achieved 92% of the individual elements. Through our governance arrangements we aim to improve our delivery of the priorities by holding the identified leads to account on the

delivery of their priorities. The priorities have also been aligned with the Trust Integrated Improvement Plan.

Trust performance

This section provides detail on how the Trust has performed against the four priority ambitions of 2019-20. Results relate to the period 1st April 2019 – 31st March 2020 or the nearest period available. Mechanisms of measurement vary by priority and by the availability of national benchmark.

Benchmark

- Milestone achieved
- Milestone not achieved
- Milestone superseded

PRIORITY 1 2019-20 – PATIENT AND CARER EXPERIENCE

WE SAID WE WOULD:	
Success Measure	**Result**
Our Friends and Family Test (FFT) and national in-patient scores will align with national averages.	
We will see improvements in valuing patients time with more people seen on time or within 15 minutes of their outpatient appointment and reduced waiting for information and discharge.	
Our new SUPERB patient feedback dashboard will be used across the Trust to provide meaningful and useful patient feedback intelligence to enable patient centred improvement actions and initiatives.	
We will introduce a process to align patient experience with staff experience at team and service level. This will incorporate how we are engaging clinical staff.	
We will review our complaints process to ensure patients receive high quality and timely responses.	
All our services will have identified FAB Experience Champions who will drive local level improvements in patient experience supported by the Patient Experience Team.	
Co-design of services will be systematic and our leaders will be skilled in engaging with service users.	

Data Source

The FFT is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience.

A Survey Monkey questionnaire was conducted to collect feedback on valuing patients time which has demonstrated an improvement, however, the data source has changed as the original data collection was ineffective.

WHAT MORE DO WE NEED TO DO TO ACHIEVE OUR SUCCESS MEASURES?

The FFT data is shared with each Division and is discussed at Speciality Governance Meetings to understand the reasons for the feedback. Top themes are waiting times particularly relating to A&E and discharge. Work to improve demand / capacity, discharge preparedness, flow and 'red to green' will have an impact as they become embedded. Communication continues to be a feature with work reviewing our current training, alongside staff charter and behaviours workshops is ongoing.

PRIORITY 2 2019-20 – I WOULD RECOMMEND MY ORGANISATION AS A PLACE TO WORK IF A FRIEND OR RELATIVE NEEDED TREATMENT, I WOULD BE HAPPY WITH THE STANDARD OF CARE PROVIDED BY THIS ORGANISATION.

WE SAID WE WOULD:

Success Measure	Result
Relaunching the 2021programme with a clear focus that patients really are our number one priority.	
Supporting the development of the new triumvirates.	
Ensuring that all Divisions are holding staff charter workshops for all staff.	
Creating a refreshed approach to leadership.	
Developing and embedding a coaching culture within ULHT and working with partners in the system to enhance our coaching capacity and capability.	
Adopting a consistent and robust approach to values based recruitment and selection for all senior posts building on the TOM Assessment Centre model.	

Data Source
Utilising data from within the Organisational Development Team.

WHAT WE NEED TO DO TO ACHIEVE OUR SUCCESS MEASURES?

The 2021 programme has been superseded by the launch of the Integrated Improvement Plan (IIP). The IIP has patients at the heart of this plan.

PRIORITY 3 2019-20 – ENSURING EFFECTIVE SYSTEMS FOR REVIEWING MORTALITY

WE SAID WE WOULD:

Success Measure	Result
There will be Medical Examiners available in the Bereavement Centre to complete the initial review and be a point of contact for junior doctors.	
Increase in the number of deaths screened by the Medical Examiners.	
Specialities will review the cases referred by the Medical Examiners within a timely period.	
Bereaved families will have had contact the Medical Examiner / Medical Examiner Assistant.	
A strategic learning group will be implemented – Mortality Assurance Learning Strategy (MorALS) Group.	
Widespread sharing of lessons learnt promulgated throughout the Trust.	
A reduction in SHMI to within expected limits (band 2).	
Yearly updates to the 2019-21 Mortality Reduction Strategy.	

Data Source

Datix as this is utilised to input all Medical Examiner reviews.

Utilising data from Dr Foster and NHS Digital for SHMI.

WHAT MORE DO WE NEED TO DO TO ACHIEVE OUR SUCCESS MEASURES?

MoRALS group has not been initiated due to COVD-I9 and the move to a Lincolnshire wide approach to learning. This group will be launched when the Trust goes into the recovery stage.

PRIORITY 4 2019-20 – ENSURING PEOPLE ARE BEING CARED FOR IN THE RIGHT PLACE AT THE RIGHT TIME – RESPIRATORY PATIENTS

WE SAID WE WOULD:

Success Measure	Result
Completion of key interventions within 4 hours for Chronic Obstructive Pulmonary Disease (COPD) and Community Acquired Pneumonia (CAP) bundles: • Rapid confirmation by chest x-ray • Rapid scoring of disease severity • Guided antibiotic therapy	
Improvements in the uptake of bundles for COPD and CAP patients.	
Improvements in completion of bundles for COPD and CAP patients.	
Development of a Standard Operating Procedure for the prompt delivery of NIV.	
Patients who meet evidence-based criteria for acute Non-Invasive Ventilation (NIV) should start NIV within 60 minutes of the blood gas result associated with the clinical decision to provide NIV and within 120 minutes of hospital arrival for patients who present acutely.	
Participation in the national British Thoracic Society audits to enable national comparison.	

Data Source

Internal audit conducted to review compliance with care bundles.

National audits to review compliance with NIV.

WHAT MORE DO WE NEED TO DO TO ACHIEVE OUR SUCCESS MEASURES?

The Trust is participating in the national Getting It Right First Time (GIRFT) programme of which respiratory is a key work stream. The Trust has developed an overarching action plan on the key recommendations made by the GIRFT team of which NIV is included. The Trust has included the NIV pathway within this year's priorities.

Staff are performing the key interventions within 4 hours however they are not utilising the bundles instead documenting the findings within the clinical narrative.

STATEMENT OF ASSURANCE

Review of services

During 2019-20, the United Lincolnshire Hospitals NHS Trust (ULHT) provided and/or subcontracted 103 relevant health services.

The ULHT has reviewed all the data available to them on the quality of care in 103 of these relevant health services.

The income generated by the NHS services reviewed in 2019-20 represents 94.9% of the total income generated from the provision of NHS services by the ULHT for 2019-20.

PARTICIPATION IN CLINICAL AUDITS

During 2019-20 45 national clinical audits and 4 national confidential enquiries covered relevant health services that ULHT provides.

During that period ULHT participated in 95% of national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that ULHT was eligible to participate in during 2019-20 are as follows: (see tables below). Audits not achieving have an action plan developed to enable the Trust to achieve full compliance.

The national clinical audits and national confidential enquiries that ULHT participated in during 2019-20 are as follows: (see tables below)

The national clinical audits and national confidential enquiries that ULHT participated in, and for which data collection was completed during 2019-20, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Audits	ULHT Participation	Reporting Period	Number and % Required
Peri- and Neonatal			
Perinatal Mortality Surveillance (MBRRACE-UK) Saving Lives Improving Mothers Care (MBRRACE-UK)	Yes	January – December 2017 Published October 2019 2015-2017 Published November 2019	No case ascertainment reported No case ascertainment reported
Neonatal Intensive and Special care (NNAP)	Yes	1st January – 31st December 2018	Trust 608 PHB 237, LCH 371 case ascertainment is not reported
Children			
Paediatric Intensive Care (PICANet)	N/A	This audit is applicable to specialist centres	N/A
Paediatric Cardiac Surgery (NICOR Congenital Heart Disease Audit)	N/A	This audit is only applicable to specialist centres	N/A

National Audits	ULHT Participation	Reporting Period	Number and % Required
National Childrens and Young Peoples Asthma Audit	Yes	1st June 2019- 31st January 2020 Report awaited	Trust 70 LCH 38, PHB 32
Diabetes (RCPH National Paediatric Diabetes Audit)	Yes	1st April 2018 – 31st March 2019 (report published March 2020)	277 cases submitted. (case ascertainment is not reported)
National Epilepsy 12 Audit	Yes	5th July 2018 – 30th November 2019 Report awaited	103 (case ascertainment is not reported
Acute Care			
National Emergency Laparotomy Audit (NELA)	Yes	Year 1st December 2018 – 30th November 2019	Cases submitted PHB 108, LCH 77
Cardiac Arrest (National Cardiac Arrest Audit) ICNARC	Yes	1st April 2019- 31st December 2019	Case ascertainment is not reported
Intensive Care National Audit Research (ICNARC)	Yes	1st April 2018- 31st March 2019	Trust 1226 LCH 697, PHB 529
Care of Children in EDs (RCEM)	Yes	1st August 2019- 31st January 2020 Report awaited	Trust 371 LCH 230, PHB 141
Mental Health Adults (RCEM)	Yes	1st August 2019- 31st January 2020 Report awaited	Trust 257 LCH 188, PHB 69
Assessing Cognitive Impairment in Older People (RCEM)	Yes	1st August 2019- 31st January 2020 Report awaited	Trust 326 LCH 178, PHB 148
National Audit Seizure Management (NASH3)	No	1st November 2018 - 30th June 2019	PHB 48/30 (160%) LCH no data submitted
National Adult Asthma Audit	Yes	1st November 2018 – 31st March 2019 Report published December 2019	Trust 172 LCH 77, PHB 77, GDH 18 Case ascertainment is not reported
Chronic Obstructive Pulmonary Disease (COPD) Royal College Physicians	Yes	14th September 2017– 30th September 2018	Trust 1025 LCH 467, PHB 427, GDH 131 Case ascertainment is not reported
BTS Community Acquired Pneumonia	Yes	1st December 2018 – 31st January 2019 Report published August 2019	Trust 86 (71.6%) LCH 28 (46.6%) PHB 58 (96.6%)
BTS Non Invasive Ventilation	Yes	1st February 2019 – 31st March 2019 Report published August 2019	Trust 21 LCH 17, PHB 4, Case ascertainment is not reported
Long Term Conditions			
Diabetes (National Adult Diabetes Audit)	Yes	1st January 2018 – 31st March 2019	Case ascertainment is not reported (data is linked to local CCG)

National Audits	ULHT Participation	Reporting Period	Number and % Required
Diabetes (National Adult Diabetes Inpatient /Survey/ Audit HARMs)	Yes	September 2019	Case ascertainment not yet available, report due May 2020
Diabetes National Audit Foot Care	Yes	2015 - 2018	Case ascertainment is not reported
National Pregnancy in Diabetes Audit	Yes	2016 - 2018 Published October 2019	Trust 120 LCH 70, PHB 50 case ascertainment is not reported
National IBD Registry Ulcerative Colitis and Crohn's Disease (National IBD Audit) biologics Audit	No	2018 – 2019 Report Published October 2019	No data submitted
National Parkinson's Audit	Yes	1st May – 30th September 2019 Report published February 2020	Trust 99 PHB 23, PHB Physio 16, LCH Occupational Therapy 10, GDH 50 case ascertainment is not reported
National End of Life Audit	Yes	April – May 2019 Report published February 2020	Trust 86 LCH 40, PHB 40, GDH 6 (100%)
National Audit Dementia	Yes	April – October 2018 Report Published July 2019	162/150 (108%)
Elective Procedures			
BAUS Urology Nephrectomy	Yes	1st January 2016 – 31st December 2018	178/199 (89%)
BAUS Urology Percutaneous Nephrolithotomy	Yes	1st January 2016 – 31st December 2018	26 case ascertainment is not reported
BAUS Urology Female Stress Urinary Incontinence	N/A	Applicable to specialist centres only	N/A
BAUS Urology Urethroplasty	N/A	Applicable to specialist centres only	N/A
Cardiac Arrhythmia (NICOR)	Yes	April 2016 – March 2017 Report published July 2019	478 case ascertainment is not reported
Coronary Angioplasty (NICOR Adult Cardiac Interventions Audit)	Yes	1st April 2018 – 31st March 2019 Report published January 2020	1038 eligible cases – case ascertainment is not reported
National Vascular Registry including NVD - Carotid Interventions Audit	Yes	2019 Report 2018 2016-2018	26 cases Infra-renal AAA, 42 cases Carotid Endarterectomy 22 cases Emergency Repair Ruptured AAA 154 cases Major Limb Amputation

National Audits	ULHT Participation	Reporting Period	Number and % Required
Rheumatoid and Early Inflammatory Arthritis	Yes	Commenced May 2019	Not yet reported
Hip, Knee, Ankle and Shoulder Replacements (National Joint Registry)	Yes	1st January – 31st December 2018 2019 Report	1162 – procedures by operation date – case ascertainment is not reported
National Elective Surgery Patient Reported Outcome Measures (National PROMs Programme) Overall patient participation rate Participation by each PROM 1.Hip Replacement 2.Knee Replacement	Yes	PROMs April 2018 – March 2019 –Finalised report Patients who completed a pre-operative questionnaire	755/849 (88.9%) 18/19 1. 383, 92.1% 2. 372, 85.9%
Surgical Site Infection	Yes	1st May 2019 - 30th September 2019	case ascertainment is not reported
Coronary Artery Bypass Graft (CABG) and Valvular Surgery (Adult Cardiac Surgery Audit)	N/A	Applicable to specialist centres only	N/A
National Ophthalmology Database (NOD) Audit	Yes	September 2017 – August 2018	1655 (47%)
Cardiovascular Disease			
Stroke Care (National Sentinel Audit of Stroke) SSNAP	Yes	April 2019 – December 2019	793/796 (99.6%)
Acute Myocardial Infarction and Other Acute Coronary Syndrome (MINAP)	Yes	1st April 2017 – 31st March 2018. Report published November 2019	1282 (121.90%)
Heart Failure	Yes	April 2017- March 2018 Report	1062 (91%)
Cancer			
Prostate Cancer (NPCA)	Yes	1st April 2017 – 31st March 2018	464 (100%)
National Audit of Breast Cancer in Older Patients	Yes	January 2017- December 2017	Case ascertainment is not reported
Lung Cancer (LUCADA)	Yes	Patients diagnosed with lung cancer first seen between 1st January 2017 and 31st December 2017	452 cases submitted case ascertainment is not reported
Bowel Cancer (NBCA)	Yes	Patients diagnosed between 1st April 2017 and 31st March 2018	LCH + GDH 204 (70%), PHB 128 (121%)
Oesophago-Gastric Cancer (National O-G Cancer Audit)	Yes	Patients diagnosed between 1st April 2016 and 31st March 2018	206 (65-74%) (tumour records submitted)

National Audits	ULHT Participation	Reporting Period	Number and % Required
Trauma			
Falls and Fragility Fracture Audit Programme (FFAP) Hip Fracture (National Hip Fracture Database) National Audit Inpatient Falls (NAIF)	Yes Yes	1st January 2018 – 31st December 2018 1st January 2019 – 16th August 2019	Trust 821 PHB 342 (95.5%), LCH 479 (107.2%) 12/12 (100%)
Trauma Audit Research Network (TARN) Trauma	Yes	January 2018 – July 2019 (TARN data)	Trust 1092 (100+%) PHB 480 (100+%),LCH 612 (100+%)
Blood Transfusion			
National Comparative Blood Transfusion Audit – Medical use of Red Cells	Yes	2019	Not yet reported
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance	Yes	April 2019 – March 2020	Trust 14/14 (100%) LCH 8, PHB 5, GDH 1

The National Confidential Enquiry into Patient Outcome and Death (NCEPOD)

During 2019-20 hospitals were eligible to enter data in up to 4 NCEPOD studies. Below is a summary of those studies in which ULHT participated. Studies for which ULHT were exempt are not listed. Action plans are developed for any areas not achieving the recommended standards.

National	ULHT Participation	Reporting Period	Number and % Required
Confidential Enquiries			
Out Hospital Cardiac Arrest (OHCA)	Yes	2019-2020 Clinical questionnaire Case note Organisational questionnaire completed	 13/13 (100%) 12/13 (92.3%) 3/3 (100%)
Dysphagia (This study is still open the figures are not yet final)	Yes	2019-2020 Clinical questionnaire Case note (only one requested) Organisational questionnaire completed	 8/10 (80%) 1/1 (100%) 0/3 (0%)
Acute Bowel Obstruction (Please note that case notes were limited to 2 per hospital site)	Yes	2019-2020 Clinical questionnaire Case note Organisational questionnaire completed	 2/13 (15.3%) 4/4 (100%) 3/3 (100%)
Long Term Ventilation (Please note there was only 1 case eligible included relating to community, case notes were only requested for acute admission therefore not applicable)	Yes	2019-2020 Community Clinical questionnaire Case note Organisational questionnaire completed	 1/1 (100%) NA 1/1 (100%)

The reports of 36 national clinical audits were reviewed by the provider in 2019-20 and ULHT intends to take the following actions to improve the quality of healthcare provided (see tables below).

Descriptions of outcomes and improvements from a sample of the national audits:

National Audit	Headline Results and Actions Taken
MINAP (heart attack and Ischaemic heart disease)	• Lincolnshire Heart Attack Centre 24/7 continues to provide good quality care year on year as demonstrated on the latest national report published November 2019 • Procedure to open up blocked heart vessels quickly to restore coronary blood flow - 96% of patients met the door to balloon time of 90 minutes compared to the national average of 88% • Collaborative work with EMAS continuing to ensure eligible patients are taken directly to the Heart Attack Centre • Prescribing preventative medications above the national average for all eligible patients ULHT has been sustained at 100% PHB, 98.9% LCH • Patients requiring angiography within 72 hours met best practice tariff 6/11 months • Patient outcomes are good with timely interventions and secondary prevention prescribing, which improves patients quality of life following a heart attack
TARN (Trauma)	• Trauma meetings held at Lincoln and Pilgrim to discuss findings and shared learning continues • Transfer to Trauma Centre continues to be reviewed with the Trauma Network to ensure eligible patients are transferred for specialist care ongoing • On-going work to review and improve compliance with standards with updated reports and dashboards actions discussed at the Trauma meetings • Trauma lead appointed at PHB • Increased ate of survival
Hip Fracture	• Sharing best practice across the trust to improve the patient pathway data is available via site dashboards which records data live • Monthly governance meeting to review data time to theatre and discuss improvements where needed • Length of stay is similar to the national average of 15 days

	• Patients who did **not** develop a pressure ulcer nationally is 96.7%, PHB 97.9, LCH 97.1% • Patients returned to their original residence within 120 days better than the national average, national 70.5%, PHB 80.6%, LCH 74.9%
Stroke	• Improving compliance with NICE standards strategy in place to improve areas requiring improvement • Results are shared at the speciality Governance meetings • Scoring A-E used for stroke units with A being the highest score to achieve the latest published report October 2019- December 2019 shows Pilgrim as a D and Lincoln as a C • Strategy to improve data submissions is working well with case ascertainment of a high standard 90%+ • Lower mortality rates compared to the national average
Cardiac Arrest	• Education and training around deteriorating patient is on-going
Bowel cancer data	• Review of surgeon outcomes completed and reported • Process for submitting data reviewed and has improved from last year case ascertainment from latest report LCH and GDH 70%, PHB 121%. (PHB received 121% as the number of cases submitted was higher than the number expected by the National Bowel Cancer Audit) • Data quality reviewed action data from the MDT will be recorded and submitted at the time of the MDT and data issues highlighted for early completion • Clinical Nurse Specialists have supported data submissions to NBOCA
PROMs	• Ongoing recruiting of patients for Hip and knee replacement surgery via pre-assessment clinics to complete the questionnaire before surgery 88.9% of patients completed a pre-operative PROM during 2018/2019 • Data is reported every four months to monitor progress with participation rates and outcome measures • The joint replacement procedure is explained to patients to ensure patients are aware of the risks and benefits of the surgery • Patients who had a hip or knee joint replacement reported improvement with daily activities
Hip, Knee and Ankle Replacements (National Joint Registry NJR)	• On-going review of NJR process to improve quality of data submission to the national database annual data quality audit taking place • Improve timely data submission monthly review of submissions

	compared to the number of operations completed • Consultants have access to Clinician feedback to review their own practice and compare to peers
Falls Audit	• Falls risk assessment in place • Inpatient falls linked to the national hip fracture database automated notification to the site Consultant lead • Review of inpatient falls with a fractured neck of femur by a Consultant lead data submitted on line
Chronic Obstructive Airways Disease (COPD)	• Data validation process in place • Best practice tariff achieved for one of three quarters of the year reported • Care bundle in place in line with British Thoracic Society (BTS) best practice standards further update will be required April 2020 • Compliance with the best practice standards discussed at the Speciality Governance meeting
National Vascular Registry	• Aortic Abdominal Aneurysms Infra-Renal, 100% discussed at MDT compared to 82% nationally, formal anaesthetic risk assessment 100% compared to 95.4% nationally, Pre-op CT/MR angiography 96% compared to 89.3% nationally • Carotid Endarterectomy time from symptoms to surgery 70% within 14 days • Data reviewed by the clinicians in line with outcome reporting • Mortality rate as expected
National Emergency Laparotomy Audit (NELA)	• Good process in place to collect and submit data • Best Practice Tariff (BPT) met since April 2019 latest report 96% BPT met. To meet this BPT a consultant anaesthetist and a consultant surgeon are present in theatre.
Intensive Care National Audit (ICNARC)	• Good compliance with the quality metrics • No outlier alerts • Ongoing data collection and review by the Intensive care units • Review at Speciality Governance • Mortality rate within the expected

Local Clinical Audit

The reports of 98 local clinical audits were reviewed by the provider in 2019-20 and ULHT intends to take the following actions to improve the quality of healthcare provided: (see tables below):

The local audit plan is linked to National Institute for Health and Clinical Excellence (NICE), CQC, Best practice and key priorities for the Trust.

Examples of actions taken locally:

Local Audit	Actions - Improvements
Early Neonatal Sepsis Audit (Neonates)	The results showed: • 100% compliance in commencing antibiotics for rIsk factors • Babies with a raised CRP - inflammatory level blood test had a full septic screen • More babies were given full septic screen than indicated by the guideline • Update staff on changes to the guideline
Accuracy of Report of Musculoskeletal Radiograph done by Radiographer. (Radiology)	• Compliant • Accuracy of report: 96.5% • Sensitivity of report: 97.1% • Specificity of report: 95.5% • To review and ensure standards are met and maintained
NICE TA419 Apremilast for Treating Moderate to Severe Psoriasis (Dermatology)	• 16 patients were identified on Apremilast for psoriasis between Dec 2017 to Dec 2018 • Our results showed that at baseline 69% had both PASI and DLQI scores recorded • 56% fulfilled NICE criteria to start Apremilast. • At 16 weeks, 56% compliant with NICE (3 stopped according to guidelines • 6 continued according to guidelines • To use online PASI calculator to calculate PASI score in clinic, and to document both PASI and DLQI at baseline and 16 weeks.

	• All dermatology medical and nursing staff made aware • Apremilast form updated

VTE Prophylaxis (Elderly Care)	• VTE risk assessment completed 100%
	• None had renal impairment
	• 97% prescribed and given medication in line with guidelines
	• The risk assessment was not always reviewed by a senior:
	  o Presented and discussed at the Medicine Audit meeting
	  o Seniors to ensure assessment is reviewed
	  o To include as part of the junior doctor induction

PARTICIPATION IN CLINICAL RESEARCH

Clinical research is an essential part of maintaining a culture of continuous improvement. Our Research and Innovation Department has a strong record of patient recruitment, as well as collaborative working with other organisations including the National Institute for Health Research (NIHR) East Midlands Clinical Research Network. There is a continuous effort to ensure that high-quality research is a part of the culture at ULHT.

The number of patients receiving relevant health services, provided or sub-contracted by ULHT in 2019-20, that were recruited during that period to participate in research approved by a research ethics committee 1,203. The total number of patients/participants recruited for portfolio and non-portfolio studies was 1,233. These patients/participants were recruited from a range of specialities including the following disease areas: Blood, Cancer, Cardiovascular, Critical Care, Dementias and Neurodegenerative Diseases, Eye, Metabolic and Endocrine, Musculoskeletal, Neurological, Oral and Gastrointestinal, Public Health, Respiratory, Skin, Stroke, Surgery and Trauma and Emergency Care.

The Trust is delivering trials within a wide variety of specialities and recruited from 16 disease areas in 2019-20. This increasing level of participation in clinical research demonstrates ULHT's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. In addition, by participating in NIHR portfolio trials and recruiting patients, the Trust is playing an important role in improving patient care and in developing new and innovative drugs, treatment and services. Research evidence shows that hospitals that participate in clinical trials have been shown to improve patient care and outcomes.

Due to the increased number of commercial and non-commercial trials, Lincolnshire patients are benefitting by receiving the latest medications and treatment options. The Trust has implemented the findings of trials which has helped the Trust in improving patient care, as well as achieving cost savings.

The Trust is involved in conducting about 89 clinical research studies including studies in follow up. During 2019-20, the following number of patients were recruited:

- Cardiovascular – 122 patients.
- Cancer Randomised Controlled Trials (RCT) – 259 patients.
- Cancer non-RCT – 164 patients.

Since the establishment of the NIHR, the Trust has been using the national system for approving all studies (portfolio and non-portfolio) and to carry out risk assessments. In 2019-20, the Trust has approved 35 portfolio studies.

In the last four years, over 35 publications have resulted from our involvement in clinical research, helping to improve patient outcomes and experience across the NHS.

The Research and Innovation Department is committed and will continue to play an important role in the following areas:

- Cancer
- Cardiovascular
- Critical Care
- Metabolic and Endocrine
- Public Health
- Respiratory

USE OF THE COMMISSIONING FOR QUALITY AND INNOVATION (CQUIN) FRAMEWORK

A proportion of ULHT's income in 2019-20 was conditional upon achieving quality improvement and innovation goals agreed between ULHT and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2019-20 and the following 12-month period are discussed below.

As Lincolnshire moves towards an Integrated Care System, the vision for quality is focused on developing a single framework for system-wide quality assurance, with a shared commitment to the development of a culture of quality improvement. This would focus on ensuring the delivery of effective care, the assurance of the safety of the services that are offered to patients and supporting people to have a positive experience of care.

In 2019-2020 the focus will be on ensuring that quality improvement is embedded into everyone's business, and to support the delivery of consistently high-quality care. In moving towards this vision and ambition for Lincolnshire, it is recognised that it is necessary to develop an integrated and collaborative approach to quality governance and assurance across Lincolnshire, that minimises duplication, reduces variation and delivers improved outcomes for the people of Lincolnshire. The Trust has agreed to utilise the CQUIN funding to develop and implement the quality priorities and will not be participating in the national CQUIN schemes.

Due to COVID-19 Q4 attainment was granted automatically. A summary of the achievements of the CQUIN milestones for 2019-20 is demonstrated below:

CQUIN schemes

CQUIN	Q1	Q2	Q3	Q4	Value	Value Received
Ensuring effective systems for learning from healthcare incidents and deaths in all care settings					£107,0975	£107,0975
Recommend my organisation as a place to work / if a friend or relative needed treatment, I would be happy with the standard of care provided by the organisation					£107,0975	£107,0975
Ensuring people are being cared for in the right place at the right time - Respiratory patients					£107,0975	£107,0975
Deteriorating Patient, empowering staff to monitor, manage and escalate the physiological deterioration and further developing our approach to patients with sepsis					£107,0975	£107,0975

Specialised CQUIN schemes

CQUIN	Q1	Q2	Q3	Q4	Value	Received
Hospital Medicines Optimisation					£205,528	£161,731
Embedding the Armed Forces Covenant to support improved health outcomes for the Armed Forces Community					£14,643	£14,643
Active involvement of clinicians in clinical engagement to create a culture of care, where primary care and secondary care clinicians view collaboration as valuable and an essential approach to further improve NHS dental services to achieve the change and developments required to produce a modernised NHS					£60,534	£60,534

Green: Fully achieved
Red: Not achieved
Amber: Partially achieved
Grey: N/A

For 2019-20, £4,564,605 of ULHT's contracted income was conditional on the achievement of these CQUIN indicators (£8,139,192 in 2018-19). The Trust has received 99.0% of the total CQUIN value for 2019-20.

The following CQUINs have been selected by the Trust for 2020-21:

- Care of the respiratory patient
- Safe discharge of our patients
- Care of the deteriorating patient
- Embedding organisational development schemes
- Delivering harm free care

CARE QUALITY COMMISSION (CQC) STATEMENTS

The Care Quality Commission (CQC) are the regulators of quality standards within all NHS Trusts. They monitor our standard of care through inspections, patient feedback and other external sources of information. The CQC publishes which Trusts are compliant with all the essential standards of care they monitor and which organisations have 'conditions' against their services which require improvements to be made.

ULHT is required to register with the Care Quality Commission (CQC) and its current registration status is registered. ULHT has the following conditions on registration: the Trust was given regulatory action on section 31 on 28th June 2019 and 27th February 2020. The CQC has taken enforcement action against ULHT during 2019-20.

ULHT has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

Between 11th June to 18th July 2019, CQC inspected a total of five core services provided by the Trust across four locations. They inspected urgent and emergency services, medical care (including older people's care), critical care, maternity and services for children and young people at Lincoln County and Pilgrim Hospital. They did not inspect services at Grantham and District Hospital or County Hospital, Louth. There was also a review of the well-led domain at Trust level.

The CQC rate the Trust on the following domains:

Safe

Are people protected from abuse and avoidable harm?

Effective

Does peoples care and treatment achieve good outcomes and promote, a good quality of life, and is it evidence-based where possible?

Caring

Do staff involve and treat people with compassion, kindness, dignity and respect?

Responsive

Are services organised so that they meet people's needs?

Well-led

Does the leadership, management and governance of the organisation assure the delivery of high-quality patient-centred care, support learning and innovation and promote an open and fair culture?

The Trust received its final report in October 2019 which rated the Trust as 'Requires Improvement' overall, however to remain in 'Special Measures' so the Trust can receive the support required to make further improvements.

The Trust's ratings for whether its services safe, effective, caring, responsive and well-led remained the same as in 2018. Services for safe, effective, responsive and well-led all remained as 'Requires Improvement' and 'Good' for caring.

The CQC made an unannounced visit to A&E at Lincoln County Hospital and Pilgrim Hospital on the 7th January 2020 which was to follow up actions the Trust had taken following the CQC focused inspection on the 11th June to 18th July 2019. The report was published on the 27th February 2020.

The key findings from the CQC visit between 11th June to 18th July 2019:

- Some services did not always have enough staff to care for patients and keep them safe.

- Managers monitored the effectiveness of the service and used the findings to make improvements but did not always achieve good outcomes for patients. In some services not all key services were available seven days a week.

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

- Leaders did not always run services well using reliable information systems and support staff to develop their skills. Services did not always engage well with patients and the community to plan and manage services and not all staff were committed to improving services continually.

However, the CQC did acknowledge there were improvements since their previous visit in 2018:

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

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

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

- Services made it easy for people to give feedback.

- Most services supported staff to develop their skills. Most staff understood the service's vision and values, and how to apply them in their work. Most staff were focused on the needs of patients receiving care. Services engaged well with patients and the community to plan and manage services.

The Trust has developed the Integrated Improvement Plan which aligns the CQC 'Should Do' and 'Must Do' to the Trusts key priorities. The Integrated Improvement Plan is the single-vehicle that ULHT will adopt to deliver improvements for patients, staff and ULHT as an organisation.

The CQC domains were reported as:

SAFE	EFFECTIVE	CARING	RESPONSIVE	WELL LED
REQUIRES IMPROVEMENT	REQUIRES IMPROVEMENT	GOOD	REQUIRES IMPROVEMENT	REQUIRES IMPROVEMENT

Ratings for United Lincolnshire Hospitals NHS Trust compared to previous CQC visit

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

→← same as previous inspection
↑Up one rating from previous inspection
↓ Down one rating from previous inspection
↓↓ Down two ratings from previous inspection
↑↑Up two ratings from previous inspection

Ratings for Lincoln County Hospital compared to previous CQC visit

Ratings for Lincoln County Hospital

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

Ratings for Grantham and District Hospital previous CQC visit in 2018

Ratings for Grantham and District Hospital

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

Ratings for Pilgrim Hospital compared to previous CQC visit

Ratings for Pilgrim Hospital

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

Ratings for Louth Hospital from previous CQC visit in 2018

Ratings for County Hospital, Louth

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

DATA QUALITY

NHS Number and General Medical Practice Code validity

ULHT submitted records during April 2019 to December 2019 at the Month 9 inclusion date to the Secondary Uses service for inclusion in the Hospital Episode Statistics (HES), which are included in the latest published data. The percentage of records in the published data:

which included the patient's valid NHS number was:

- 99.8% for admitted patient care (National performance 99.4%)
- 99.9% for outpatient care (National 99.7%)
- 98.8% for accident and emergency care (National 97.7%)

which included the patient's valid General Medical Practice Code was:

- 100.0% for admitted patient care (National performance 99.7%)
- 100.0% for outpatient care (National 99.6%)
- 99.9% for accident and emergency care (National 98.8%)

Information Governance Toolkit attainment levels

All organisations that have access to NHS patient data and systems must complete the Data Security and Protection Toolkit (DSP Toolkit) to demonstrate that they are practicing good data security and that personal information is handled correctly. The DSP Toolkit encompasses the 10 National Data Guardian's data security standards as set out in the Data Security and Protection Standards for health and care. It also includes the requirements of Cyber Essentials and the key elements of the Network and Information Systems (NIS) Regulations 2018 Cyber Assessment Framework (CAF).

There are no longer attainment levels, instead the toolkit works on either 'standards met' or 'standards not met'. All organisations are expected to achieve 'standards met' on the DSP Toolkit.

ULHT's toolkit publication for 2018-19 was 'standards not met'. Due to this we were required to provide an improvement plan detailing how we were going to bridge the gap to meet the DSP Toolkit 'Standards Met'. The Trust is required to meet these actions by 30th September 2020.

Clinical coding

ULHT was not subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission.

Data quality

Data quality is an important element of safe, quality care at acute sites and is a continuing focus for improvement. ULHT will be taking the following actions to improve data quality:

- Continually review the main Key Performance Indicators (KPIs) that are reported to the Trust Board and Board Committees. This involves understanding the metric itself, how it is calculated and assurance around underlying robustness of the metric, data source and collation/publishing.

- This led to the introduction of a Data Quality Kite-mark assigned to individual KPIs alerting the end user to 4 indicators: Timeliness, Completeness, Validation and Process. Further work will ensure that all metrics are assigned a kite-mark, and those assigned already are reviewed and updated as required.

- Further embedding and exploitation of the Medway (Patient Administration System) following the implementation mid-2014 and subsequent upgrade to v4.8 in October 2017, process maps and standard operating procedures continue to be reviewed for patient flow through hospital (outpatients, day cases, inpatients) and data quality reports identified at key stages to ensure any data input errors are flagged earlier and highlighted to relevant teams for correction and any training needs identified.

- Work is ongoing to test upgrades to the latest version of Medway.

- Following the restructure of the Clinical Coding department, increasing established head count to 41WTE (whole-time equivalents), we are looking at what improvements can be made, including internal audit and training, and improved engagement with the four Clinical Divisions.

- An example of this is the “Coding Triangle”, which is a clinician, manager and clinical coder working together on a particular pathway or dataset to ensure that what happens to the patient is recorded accurately by the clinician and interpreted and coded correctly by the Clinical Coder.

- The structure of the Data Quality function and wider Information Services team has been reviewed to ensure we support the needs of the Trust. A business case is being developed to support this additional resource requirement.

- Ongoing development of the data warehouse and front end visualisation tools that will enable more timely reporting of information and assist with data quality reporting throughout the Divisions in the Trust

LEARNING FROM DEATHS

In March 2017, the National Quality Board (NQB) introduced guidance for NHS providers on how they should learn from the deaths of people in their care. The purpose of the guidance is to help standardise and improve the way acute, mental health and community Trusts identify, report, review, investigate and learn from deaths, and engage with bereaved families and carers in this process.

Measure	QTR 1 Apr 19 – Jun 19	QTR 2 Jul 19 – Sep 19	QTR 3 Oct 19 – Dec 19	QTR 4 Jan 20 – Mar 20	Comments
Number of patients that have died within ULHT	498	490	593	595	During 2019-20, 2176 of ULHT patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:
Number of deaths that have had a case record review/Investigation. For 2019-20 the reviews and investigations are conducted as one however this will change in the future	287	311	431	462	By March 2020, 1491 case record reviews and investigations have been carried out in relation to 2176 of deaths included above. In 1491 of cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out.
Number/percentage of deaths that escalated with problems in care In relation to each quarter, this consisted of: 20 representing 4.02% for the first quarter 42 representing 8.57% for the second quarter 40 representing 6.75% for the third quarter 10 representing 1.68% for the fourth quarter	20	42	40	10	112 representing 5.15% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. These numbers have been estimated using the grading system that highlights potential areas of concern in care. All cases that are graded 2 and 3 automatically get escalated to our Mortality Surveillance Group (MoRAG) for further review. A selection of reviews graded 1 or below are also referred for a more in-depth analysis.

Summary of what ULHT has learnt from case record reviews and investigations conducted in relation to deaths.

ULHT have learnt from case note reviews and from completing in-depth reviews on Dr Foster Diagnosis Alerts. We have disseminated learning on a number of thematic lessons using a modality of communication systems:

- Sepsis Care Bundles
- Fluid management
- Appropriate management of pleural effusion
- Unstable angina patients and risk stratification
- Misplaced nasogastric tube Never Event
- Non-invasive Ventilation (NIV)
- Administration of medication by the wrong route
- Monitoring anticoagulation/INR checking on discharge
- Opiate toxicity
- In-depth Diagnosis Alert reviews undertaken
- Review on patients who passed away within 30 days of discharge

Description of actions that ULHT have taken in 2019/20, and proposes to take forward in consequence of what the ULHT has learnt.

ULHT have taken the following actions to promulgate learning throughout the Trust:

- Patient Safety Briefings in relation to thematic reviews from investigations
- Clinical Coding Masterclass held Tri-annually- The importance of accurate documentation
- Increasing the number of Medical Examiner's within the Trust to screen deaths and escalate to concerns to the appropriate Specialty or Trust-wide learning
- In-depth reviews undertaken for alerting diagnoses and learnings disseminated to the appropriate forums and assurance given to Patient Safety Group

Assessment of the impact of actions which were taken by ULHT during 2019-20

From actions taken ULHT have appreciated and recognised the impact of:

- Sustained reduction of our HSMR and in the top 25% nationally
- Speciality Governance Meetings have specific information pertaining to their mortality
- Increased engagement and understanding of mortality from across different staff groups

Measure	QTR 1 Apr 19 – Jun 19	QTR 2 Jul 19 – Sep 19	QTR 3 Oct 19 – Dec 19	QTR 4 Jan 20 – Mar 20	Comments
Number of reviews / investigations completed which took place before the start of the reporting period	160	82	33	17	292 case record reviews and investigations completed after 31st March 2019 which related to deaths which took place before the start of the reporting period.
Number/Percentage of deaths that are judged likely not to be problems in care	478	448	553	585	2064 representing 94.85% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the grading system below.

United Lincolnshire Hospitals NHS Trust have been using a grading of avoidability since January 2016. The review grading is outlined below:

- Grade 0- Unavoidable Death, No Suboptimal Care.
- Grade 1- Unavoidable Death, Suboptimal care, but different management would not have made a difference to the outcome.
- Grade 2- Suboptimal care, but different care MIGHT have affected the outcome (possibly avoidable death)
- Grade 3- Suboptimal care, different care WOULD REASONABLY BE EXPECTED to have affected the outcome (probable avoidable death).

Measure	QTR 1 Apr 19 – Jun 19	QTR 2 Jul 19 – Sep 19	QTR 3 Oct 19 – Dec 19	QTR 4 Jan 20 – Mar 20	Comments
A revised estimate of Number/Percentage of deaths that are judged likely not to be problems in care	N/A	N/A	N/A	N/A	0 representing 0% of the patient deaths during 2019/20 are judged to be more likely than not to have been due to problems in the care provided to the patient. All are included in the table above.

NHS DIGITAL INDICATORS

The following data relating to national reporting requirements in the Quality Account are provided by NHS Digital. NHS digital provide data for 15 mandatory indicators, based upon the recommendations by the National Quality Board. The last two previous reporting periods available on NHS Digital for ULHT are to be reported within the Quality Account.

Domain 1: Preventing people from dying prematurely

The data made available to the Trust by NHS Digital with regard to - The value and banding of the Summary Hospital-level Mortality Indicator (SHMI) for the Trust for the reporting period

Description	Nov18-Oct19	Dec18-Nov19	ULHT
ULHT SHMI / Band	109.85/2	109.73/2	109.73/2
National Average	100.36	100.39	100.39
Best(B) / Worse(W) National Performance	69.09(B)/ 119.57(W)	68.89(B)/ 119.99(W)	68.89(B)/ 119.99(W)

The data made available to the Trust by NHS Digital with regard to - The percentage of patient deaths with palliative care coded at either diagnoses or speciality level for the Trust for the reporting period

Description	Dec 18-Nov 19	Jan19-Dec19	Jan19-Dec19
ULHT %	30	29	29
National Average %	36	36	36
Best(B) / Worse(W) National Performance %	58(B) / 11(W)	59(B)/ 10(W)	59(B) / 10(W)

The ULHT considers that this data is as described for the following reasons:

Our patients' data is submitted to the Secondary Uses Service and is linked to data from the Office for National Statistics death registrations to capture deaths which occur outside of hospital.

The ULHT intends to take the following actions to improve this mortality rate and so the quality of its services, by:

- Implementing the actions defined within the Mortality Reduction Strategy
- Monitoring compliance with Sepsis Screening
- Monitoring compliance with Care Bundles
- Increase the number of Medical Examiners the Trust has in post

Domain 3 Helping people to recover from episodes of ill health or following injury

The data made available by NHS Digital with regard to the Trust's patient reported outcome measures scores for - Total/Primary Hip replacement surgery & Knee replacement surgery-EQ:5D Index

Description	2017-18	2018-19	2019-20*
ULHT EQ:5D index Hip Replacement surgery - (L) Low, (H) High	0.46(L)/0.46(H)	0.45(L)/0.46(H)	N/Av
National Avg EQ:5D index Hip Replacement surgery - (L) Low, (H) High	0.46(L)/0.47(H)	0.46(L)/0.47(H)	N/Av
ULHT EQ:5D index Knee Replacement surgery - (L) Low, (H) High	0.33(L)/0.33(H)	0.32(L)/0.33(H)	N/Av
National Avg EQ:5D index Knee Replacement surgery - (L) Low, (H) High	0.34(L)/0.34(H)	0.34(L)/0.34(H)	N/Av

The data made available by NHS Digital with regard to the Trust's patient reported outcome measures scores for - Total/Primary Hip replacement surgery & Knee replacement surgery-VAS Index

Description	2017-18	2018-19	2019-20*
ULHT VAS index Hip Replacement surgery - (L) Low, (H) High	12.63(L)/12.69(H)	12.85(L)/13.16(H)	N/Av
National Avg VAS index Hip Replacement surgery - (L) Low, (H) High	13.90(L)/14.20(H)	14.10(L)/14.40(H)	N/Av
ULHT VAS index Knee Replacement surgery - (L) Low, (H) High	7.11(L)/7.62(H)	6.04(L)/6.31(H)	N/Av
National Avg VAS index Knee Replacement surgery - (L) Low, (H) High	8.20(L)/8.30(H)	7.50(L)/7.60(H)	N/Av

The data made available by NHS Digital with regard to the Trust's patient reported outcome measures scores for - Total/Primary Hip replacement surgery and Knee Replacement Surgery-Oxford Score

Description	2017-18	2018-19	2019-20*
ULHT Oxford hip surgery score - (L) Low, (H) High	21.63(L)/22.29(H)	20.83(L)/21.01(H)	N/Av
National Avg Oxford Hip surgery score - (L) Low, (H) High	22.20(L)/22.70(H)	22.30(L)/22.70(H)	N/Av
ULHT Oxford Knee surgery score - (L) Low, (H) High	16.80(L)/16.91(H)	16.48(L)/16.54(H)	N/Av
National Avg Oxford Knee surgery score - (L) Low, (H) High	17.10(L)/17.30(H)	17.2(L)/17.30(H)	N/Av

The ULHT considers that this data is as described for the following reasons:

The data is taken from NHS Digital PROMs data set.

The ULHT intends to take the following actions to improve PROMS outcomes and so the quality of its services by

- The Clinical Team reviewing their data
- Providing clear expectations to patients prior to surgery

Data available is the percentage improved not the index figure and is only for primary not revisions.

Therefore, National performance is not available.

**ULHT and National Performance data is not available at this time*

The data made available to the trust by NHS Digital with regard to the percentage of patients aged— (i) 0 to 15 - Readmitted to a hospital which forms part of the Trust within 30 days of being discharged from a hospital which forms part of the trust during the reporting period (emergency readmissions)

Description	2017-2018	2018-2019	2019-2020**
ULHT readmitted within 30 days: 0-15	11.4%	11.5%	12.23%
*National Average: 0-15	N/Av	N/Av	N/Av
Best(B) / Worse(W) National Performance: 0-15	1.7%(B) / 54.9%(W)	1.8%(B) / 69.2%(W)	N/Av

The data made available to the trust by NHS Digital with regard to the percentage of patients aged— (ii) 16 or over - Readmitted to a hospital which forms part of the Trust within 30 days of being discharged from a hospital which forms part of the trust during the reporting period (emergency readmissions)

Description	2017-2018	2018-2019	2019-2020**
ULHT readmitted within 30 days: 16+	11.7%	11.9%	N/Av
*National Average: 16+	N/Av	N/Av	N/Av
Best(B) / Worse(W) National Performance: 16+	2.2%(B) / 64.1%(W)	2.1%(B) / 57.5%(W)	N/Av

The ULHT considers that this data is as described for the following reasons:

The data is taken from the Trust's Patient Administration System (Medway).

The ULHT intends to take the following actions to improve this indicator and so the quality of its services by:

- Improving communications with GP practices so that they can do more effective patient follow up work
- Working collaboratively with the CCG to ensure Gold Standard Framework is implemented
- Ensuring ReSPECT forms are completed appropriately

** National Performance data is not available*

***Data not available for 2019-20 at this time*

Domain 4 Ensuring people have a positive experience of care

The data made available by NHS Digital with regard to the Trust's Responsiveness to the personal needs of its patients during the reporting period

Description	2017-18	2018-19	2019-20*
ULHT	66.8	64.6	N/Av
National Average	68.6	67.2	N/Av
Best(B) / Worse(W) National Performance	85.0(B) / 60.5(W)	85(B) / 58.9(W)	N/Av

The ULHT considers that this data is as described for the following reasons:

The data is provided by the national survey contractor.

The ULHT intends to take the following actions to improve this indicator and so the quality of its services by

- Launching the Integrated Improvement Plan (IIP) which is our 5-year Improvement Plan

**ULHT and National Performance data is not available at this time*

The data made available by NHS Digital with regard to the percentage of staff employed by, or under contract to, the Trust during the reporting period - Who would recommend the Trust as a provider of care to their to family and friends

Description	2018	2019	2020*
ULHT Strongly agree(SA) /Agreed (A)	9%(SA)/ 39%(A)	10%(SA)/ 40%(A)	N/Av
National Average Strongly agree(SA) /Agreed(A)	20%(SA)/ 50%(A)	21%(SA)/ 49%(A)	N/Av
Best(B) / Worse(W) National Performance	77% (B) / 0%(W)	93%(B) / 0%(W)	N/Av

The ULHT considers that this data is as described for the following reasons:

The data has been sources from NHS Digital and compared to published survey results.

The ULHT intends to take the following actions to improve this indicator and so the quality of its services by

- Launching the Integrated Improvement Plan (IIP) which is our 5-year Improvement Plan. The IIP identifies the key priorities for the Trust over the next 5 years 2020-2025 ensuring we are focused on the right things for both our patients and our staff.

**ULHT and National Performance data is not available at this time*

The data made available to the Trust by NHS Digital for all acute providers of adult NHS funded care, covering services for inpatients and patients discharged from Accident and Emergency (types 1 and 2). Patients who would recommend the Trust to Family and friends: % recommended

Description	Dec 2019	Jan 2020	Feb 2020
ULHT A&E / National Avg/ Best(B)-Worst(W)	83 /84 / 100(B)-50(W)	82 /85 / 100(B)-34(W)	82 /82 / 99(B) -40(W)
ULHT Inpatients/National Avg/ Best(B)-Worst(W)	93 /96 / 100(B)-82(W)	93 /96 / 100(B)-80(W)	93 /96 / 100(B)-73(W)
ULHT Maternity /National Avg/ Best(B)-Worst(W)	100 /97 / 100(B)-65(W)	99 /97 / 100(B)-80(W)	97 /97 / 100(B)-86(W)

The ULHT considers that this data is as described for the following reasons:

The data has been sources from NHS Digital and compared to published survey results.

The ULHT intends to take the following actions to improve this indicator and so the quality of its services by:

- Improving our communication and keeping our patients informed and updated on their care and treatment.

Domain 5 Treating and caring for people in a safe environment and protecting from avoidable harm

The data made available to the Trust by NHS Digital with regard to the percentage of Patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.

Description	QTR1 Apr 19-Jun 19	QTR2 Jul 19-Sep19	QTR3 Oct 19-Dec 19
ULHT %	97.19%	97.58%	97.93%
National Avg %	95.63%	95.47%	95.33%
Best(B) / Worst(W) National Performance %	100%(B) /69.76%(W)	100%(B) / 71.72%(W)	100%(B) / 71.59%(W)

The ULHT considers that this data is as described for the following reasons:

The data has been sourced from NHS Digital and compared to internal data.

The ULHT intends to take the following actions to improve this indicator and so the quality of its services by:

- Provide pharmacological and / or mechanical thromboprophylaxis to eligible patients
- Provide VTE risk assessment rate data to clinical areas
- Present to the Thrombosis Prevention Group to highlight where changes to practice are required

The data made available to the Trust by NHS Digital with regard to the rate per 100,000 bed days of cases of C difficile infection reported within the Trust amongst patients aged 2 or over during the reported period

Description	2017/18	2018/19	2019/20*
ULHT	18.3	13.8	18.0
National Avg	13.6	12.2	N/A
Best(B)-Worst(W) National Performance	0(B)/ 90.4(W)	0(B)/ 79.7(W)	N/A

The ULHT considers that this data is as described for the following reasons:

The data has been sourced from NHS Digital and compared to internal data.

The ULHT intends to take the following actions to improve this indicator and so the quality of its services by:

- The data set is used to inform meetings that take place. Clinical teams are able to direct the focus of actions and interventions to ensure that infection numbers are as low as possible

** This is the latest data ULHT has available internally therefore National performance is not available*

The data made available to the Trust by NHS Digital with regard to the number and, where available, rate of Patient Safety Incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death

Description	Oct 17-Mar 18	Oct 18- Mar 19	Oct 19-Mar 20
ULHT %	1.55	0.75	0.52
National Avg %	N/A	N/A	N/A
ULHT Total No of Incidents (T) / Severe or Death (SD)	6,399(T) / 99(SD)	6,291 (T) / 47 (SD)	6316(T) / 33(SD)

The ULHT considers that this data is as described for the following reasons:

The data has been sourced from NHS Digital and compared to internal data.

The ULHT intends to take the following actions to improve this indicator and so the quality of its services by:

- Actively encourage a culture of open reporting and widespread sharing of learning from incidents to improve patient safety
- Undertaking a structured programme of work to ensure that we learn and improve
- Being open and transparent about our safety work, our incidents and our actions for improvement

** National Performance data is not available at this time*

Explanatory Notes

All data published as descripted and provided from NHS Digital website correct at time of reporting for the periods available.

https://digital.nhs.uk/data-and-information/indicators/indicator-portal-collection/quality-accounts

Summary Hospital-level Mortality Indicator SHMI

This is an indicator which reports on mortality at Trust level across the NHS in England using a standard and transparent methodology. It is produced and published quarterly as an official statistic by NHS Digital with the first publication in October 2011. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. SHMI is reported every 6 months and has a 6-month time lapse and in hospital death rate should mirror HSMR therefore HSMR can be a predictor for this. NHS Digital does not retrospectively refresh data from the previous reporting period.

Patient Reported Outcome Measures (PROMS)

PROMS is an optional questionnaire that is filled out in pre-operative surgery and a follow up questionnaire is sent post-surgery. The measures required for the Quality Account is to report on the Adjusted Average Health Gain for Hip Replacement Primary, Total Hip Replacement, Knee Replacement Primary and Total Knee Replacement, rounded to two decimal places. The data does not include Knee or Hip replacement revisions.

NHS England undertook a consultation on the national PROMs programme in 2016. As a result of the findings of that consultation, NHS England has taken the decision to discontinue the mandatory varicose vein surgery and groin-hernia surgery national PROM collections. As a result of the NHS England consultation, the Trust has not participated in the collection of the varicose vein and groin hernia surgery due to the low number of patients that would be available for this cohort which would not allow for sufficient modelled records to equate for an adjusted health gain.

Readmission within 28 days of discharge

The most recent period for this is 2011/12- there is no further information available past this date on NHS digital. This is a measure of readmissions within 28 days of a patients discharge, there are two metrics required to be reported 0-15 years and 16+ years, the indicator measure taken for the last two periods is the “Indirectly age, sex, method of admission, diagnosis, procedure standardised percent.”

Responsiveness to inpatients personal needs

The indicator value is based on the average score of five questions from the National Inpatient Survey, which measures the experiences of people admitted to NHS hospitals.

Staff Survey

This data has been taken from the Staff Survey Question 21d results that have been published upon NHS Staff Survey website.

Friends and Family Test

This data has been taken from the Friends and Family responses received for the Trust as published on NHS Digital for the last two reporting periods. The National Average for England is excluding independent sector providers. Maternity data has been taken from Trust Question 2-asked in birth setting. This is relevant to Pilgrim and Lincoln sites only.

Clostridioides Difficile Infection

The data is taken from table 8b of the NHS Digital published annual table for the last two reporting periods and the metric is the infection rate per 100,000 bed days.

Clostridioides Difficile is a gram positive bacteria that causes diarrhoea and other intestinal disease when competing bacteria in a patient or person's gut are wiped out by antibiotics. Clostridioides Difficile infection can range in severity from asymptomatic to severe and life threatening, especially among the elderly. People are most often nosocomially infected in hospitals, nursing homes, or other institutions, although Clostridioides Difficile infection in the community and outpatient setting is increasing.

The description is the rate of Clostridioides Difficile infections per 100,000 bed days for patients aged two or more on the date the specimen was taken during the reporting period.

The data definition is described as:

- Numerator: The number of Clostridioides Difficile identified within a trust during the reporting period.
- Denominator: The number of bed days (divided by 100,000) reported by a trust during the reporting period.

The scope of the indicator includes all cases where the patient shows clinical symptoms of Clostridioides Difficile infection, and has a positive laboratory test result for Clostridioides Difficile recognised as a case according to the trust's diagnostic algorithm. A Clostridioides Difficile episode lasts for 28 days, with day one being the date the first positive specimen was collected. A second positive result for the same patient, if collected more than 28 days after the first positive specimen, should be reported as a separate case, irrespective of the number of specimens taken in the intervening period, or where they were taken. Specimens taken from deceased patients are to be included.

The following cases are excluded from the indicator:

- people under the age of two at the date the sample of taken; and
- where the sample was taken before the fourth day of an admission to the trust (where the day of admission is day one).

Venous Thromboembolism (VTE) Risk Assessment

Venous Thromboembolism (VTE) is a term that covers both deep vein thrombosis (DVT) and its possible consequence: pulmonary embolism (PE). A DVT is a blood clot that develops in the deep veins of the leg. If the blood clot becomes mobile in the blood stream it can travel to the lungs and cause a blockage (PE). The risk of hospital-acquired VTE can be greatly reduced by risk assessing patients on admission to hospital and taking appropriate action to prevent a VTE from occurring. Where clots happen the assessment, prescription and administration of appropriate medication is assessed to see if this has all been done correctly.

NICE guidance has given advice on the scope of who to include within the cohort - surgical inpatients, in-patients with acute medical illness, trauma inpatients, patients admitted to Intensive Care Unit, cancer inpatients, patients undergoing long term rehabilitation, patients admitted to a hospital bed for day-case or surgical procedure and private patients attending NHS hospital.

The patients out of scope are patients under 18 years (however in March 2018 NICE updated their guidelines and have lowered the age to 16 years and above from 18 years), people attending outpatients and people attending A&E who are not admitted. The Trust signed up to the Midland and East Cohort agreement. The National target is for at least 95% of patients to be risk assessed for VTE within 24 hours of admission. The results are collated through an electronic system known as Medway.
Compliance with VTE assessment:
2018-19 = 96.66%
2019-20 = 97.23%

Patient Safety Incidents

This metric is the number and where available, rate of patient safety incidents that occurred within the Trust during the reporting period, and the percentage of such patient safety incidents that resulted in severe harm or death as published in the Patient Safety Indicators latest file on NHS Digital. The national Average is not available as the England reporting is not within the same time frames.

OMITTED NOTE the following Domains and metrics were not applicable for ULHT reporting:

Domain 1

- Patients on Care Programme Approach (CPA) followed up within 7 days of discharge from psychiatric inpatient stay - **Mental Health Community**
- Category A telephone calls (Red 1 and Red 2 calls); emergency response within 8 minutes - **Ambulance**
- Category A telephone calls; ambulance response within 19 minutes **- Ambulance**
- Patients with suspected ST elevation myocardial infarction who received an appropriate care bundle (Domain 1 and 3) **- Ambulance**
- Patients with suspected stroke assessed face to face who received an appropriate care bundle (Domain 1 and 3) **- Ambulance**

Domain 2

- Admissions to acute wards where the Crisis Resolution Home Treatment Team were gate keepers**- Mental Health Community**

Domain 4

- Patient experience of community mental health services **- Mental Health Community**

PART 3

NHS
United Lincolnshire Hospitals
NHS Trust

OUTSTANDING CARE
personally DELIVERED

REVIEW OF QUALITY PERFORMANCE

PATIENT SAFETY

The safety of our patients is central to everything we want to achieve as a provider of healthcare. We are committed to continuously improving the safety of our services, and will focus on avoiding and preventing harm to patients from the care, treatment and support that is intended to help them. We will do this by successfully implementing proactive patient safety improvement programmes and by working to better understand and improve our safety culture. We will also continue to conduct thorough investigations and analyses when things go wrong, identifying and sharing learning, and making improvements to prevent or reduce the risk of a recurrence. We will be open and honest with patients and their families when they have been subject to a patient safety incident, and will strive to eliminate avoidable harm as a consequence of care we have provided.

Coronavirus (COVID-19)

During March 2020, a global outbreak of Coronavirus (COVID-19) initiated a national incident across the UK. For Lincolnshire's hospitals this meant the Trust had to implement a range of measures to ensure we were prepared for a potential surge in the number of patients we might see.

We continue to work closely with national health bodies to inform our plans and ensure that both our patients and staff remain safe and well-cared for, following Public Health England guidance at all times around the appropriate use of PPE.

Patient pathways were reviewed to consider what impact a surge in patients may have had on services. Some areas in our hospitals were segregated, outpatient appointments and non-urgent operations were cancelled to ensure that plenty of capacity was created in our hospitals.

For our patients we introduced the use of video consultations for a number of services. This meant that patients were still able to attend appointments and access medical care.

The Trust had to make the difficult decision to suspend visiting to help protect staff and patients from any increased risk of exposure to the virus. This applied to all areas apart from in specific circumstances. As part of our response to this, we created a Family Liaison Team to ensure that patients were able to keep in touch with loved ones and receive items they needed.

For staff we have also been able to secure a free meal per day for staff, as well as free parking. For patients, free parking and TV services and phone calls have been provided to help support them during the pandemic.

As the pandemic progresses, we will continue to monitor the situation and react accordingly to ensure that our patients continue to receive the best quality care in Lincolnshire. Within the 2020-21 Quality Account there will be a narrative detailing the changes and learning that occurred.

Never Events

It was very disappointing that we had ten Never Events this year. We are committed to ensuring that we create safe systems and processes in order to protect our staff and patients from Never Events occurring. We will ensure we support staff across the organisation to implement learning from these events, as set out in the action plans, and provide assurances that this has been completed.

Never Events are a specific type of Serious Incident defined by NHS Improvements as “patient safety incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers”.

The Trust declared 10 Never Events in the 2019-20 financial year, in the following categories:

- 4 Wrong-site surgery (3 in Theatres; 1 in Outpatients)
- 1 Wrong implant / prosthesis (Theatres)
- 1 Wrong route administration of IV medication (A&E)
- 2 Retained foreign object post-procedure (1 in Theatres; 1 in Labour Ward)
- 2 Mis-placed naso-gastric tube (Medical Wards)

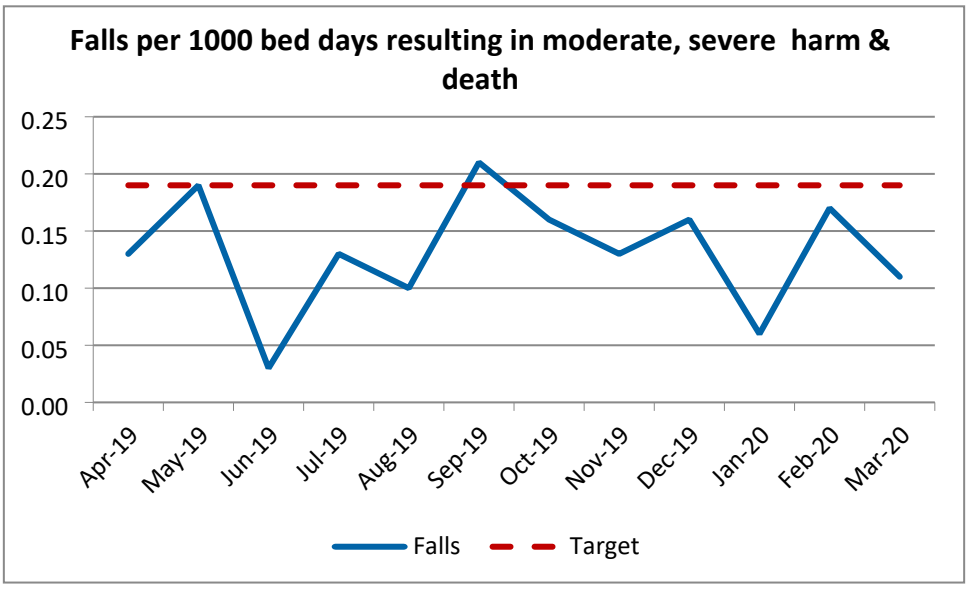
As a result of lessons learned from investigating these Never Events, some of the improvements the Trust has made include:

- Amendments to the surgical safety checklist used for dental extractions and introduction of a new mouth diagram form
- Tighter controls over the management of surgical equipment when used for Obstetric procedures in operating theatres
- Competency checks for agency nursing staff in the management of nasogastric tubes
- Strengthened medicines management practice in all Emergency Departments
- Additional safety checks when undertaking implant surgery
- Inclusion of a diagram in the safety checklist for facial surgery

Reducing harm from our Falls

Falls are the most common cause of injury in a hospital and result in both psychological and physical harm including, bleeding, fractures, or even death in vulnerable patients. Falls have an annual cost to the NHS of £2.3 billion, with an average cost of £2,600 per fall. Annually there are over 200,000 falls reported to the National Reporting and Learning System (NRLS) across the health economy. Falls have a significant and lasting impact for patients and those resulting in harm are more likely to occur in acute Trusts.

Falls resulting in moderate, severe harm and death April 2019 – March 2020



The national average for falls resulting in moderate, severe harm and death is 0.19. The Trust has been below average for eleven of the twelve month for 2019/20.

The Trust has commenced a dedicated falls incident review panel which meets recurrently with senior nursing, medical, Allied Health Professional and CCG representation to review incidents when a patient has experienced harm as a result of a fall in order to identify lessons to be learnt and shared to help reduce recurrence.

There is a Trust Wide Frailty Clinical Nurse Specialist in post who will support wards in caring for our frailer patients and provide an additional focus on Falls improvement within the organisation.

We have started conducting Focus on Falls Safety Support visits by the Frailty Nurse Specialist, Frailty Consultant Nurse and Senior Nurse on wards and departments within the organisation. Working with the ward teams to review falls safety specific to their area and help to develop falls safety learning plans and share areas of good practice identified.

'FaLLS -Focus and Lessons Learned Sharing' safety messages and newsletter have been developed to support wider sharing.

The Frailty Clinical Nurse Specialist has commenced monthly site drop-in clinics for falls link nurses.

A staff educational passport for frailty has been developed, a schedule of regular training sessions will be available on all aspects of frailty including falls prevention.

We have introduced a standardised Falls Grab Pack across the Trust with all documentation and guidance to follow if a patient falls.

We now have a dedicated Frailty team of trainee Advanced Care Practitioners working predominantly in our Emergency Departments who incorporate Falls assessments routinely into their comprehensive geriatric assessments this then proactively benefits patients being admitted as triggers for falls are considered at the start of their admission.

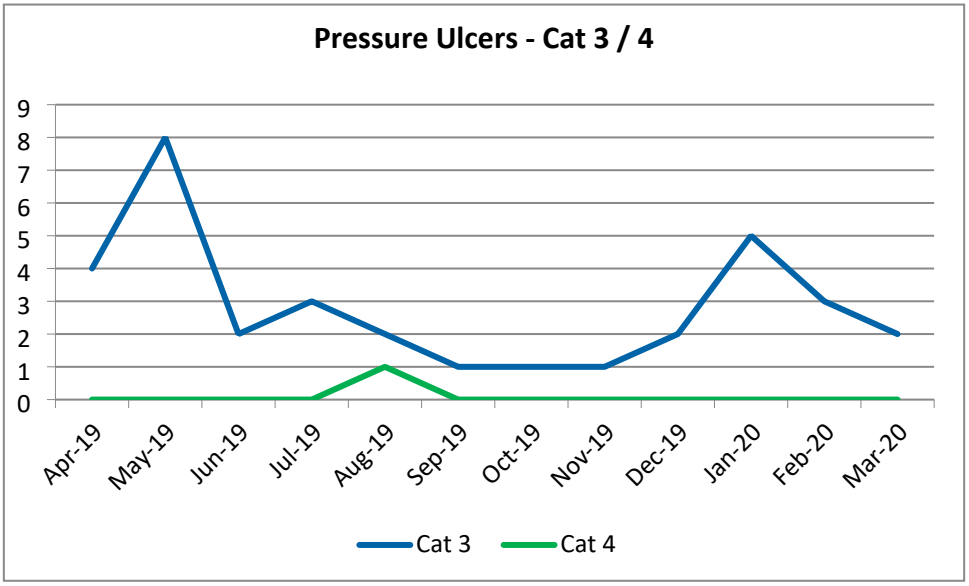
We have been actively involved at the first meeting of a Lincolnshire wide Falls Stakeholder collaboration and will continue to look at ways we can work together with partner agencies to support people at risk of falling in and out of hospital.

The Trust has introduced a Lying and Standing blood pressure sticker for easy identification in medical notes when a patient's blood pressure may put them at an increased risk of falling and requires a medical review.

Reducing our harm from Pressure Ulcers

It is estimated that 80-95% of all pressure ulcers are avoidable. Pressure ulcers (also known as pressure sores or bedsores) are injuries to the skin and underlying tissue, primarily caused by prolonged pressure on the skin. They can happen to anyone, but usually affect people confined to bed or who sit in a chair or wheelchair for long periods of time.

Category 3 and 4 pressure ulcers April 2019 – March 2020



The Trust had 34 category 3 pressure ulcers compared to a benchmark of 51 or less
The Trust had 1 category 4 pressure ulcer compared to a benchmark of 16 or less.
There is no national benchmark for reduction of pressure ulcers.

The Trust continues to hold a regular pressure ulcer incident review panel which meets regularly with tissue viability specialist, senior nursing, allied health professional and CCG representation. The team review the care provided for patients who have developed a pressure ulcer to identify areas that require improvement and lessons that require wider sharing.

The tissue viability clinical nurse specialist team utilise the electronic referral and Datix incident reporting systems to review and validate all categories of pressure ulcers and moisture damage that have developed. This supports a conversation with staff to check what actions have already been taken and prompt them to do any additional care actions that would help prevent deterioration.

Link Nurses from across hospital sites have attended Trust-wide tissue viability study days to encourage networking and increased opportunities for sharing. The study days have provided education and training on a range of tissue viability focus areas including pressure ulcer prevention and wound care.

Tissue Viability training has been reviewed and a new e-learning package has been developed and will be launched soon. Tissue viability sessions continue to be delivered for newly registered nurses and new health care support workers.

The Tissue Viability team have been working collaboratively with community colleagues to share practice and have developed a new joint wound formulary. A study day is being planned to launch the joint wound formulary.

CLINICAL EFFECTIVENESS

We will ensure that each patient receives the right care, according to scientific knowledge and evidence-based assessment, at the right time in the right place, with the best outcome.

Understanding, measuring and reducing patient mortality

NHS England uses two different measures called Hospital Standardised Mortality Rate (HSMR) and Summary of Hospital Level Mortality Indicator (SHMI) to measure mortality rates across NHS providers. Each is a subjective measure which needs to be interpreted with caution. SHMI and HSMR are risk-adjusted indicators which measure whether mortality associated with hospitalisation and post-discharge are in line with predictions.

This provides greater clarity in the understanding and monitoring of mortality. The HSMR and SHMI are available monthly and SHMI includes deaths 30 days after discharge. Hospitals need to monitor their data and understand variation. A statistically higher than expected mortality may

indicate problems with the quality of care provided and should be investigated further using a robust and reliable method of evaluation and analysis.
Due to the current global pandemic of COVID-19, the Trust is unsure of what impact this will have on our mortality rates. The Trust has appointed interim Medical Examiners as our substantive Medical Examiners have been redeployed back into their clinical specialities. The legislation changed during the pandemic to allow the interim Medical Examiners to complete the Medical Certificate of Cause of Death (MCCD). Case note reviews have been conducted on all deaths to identify if there were any care delivery issues, and if identified these would be investigated through the standard Trust processes. The outputs from the case note reviews during this pandemic will be presented at Patient Safety Group and Quality Governance Committee.

The Trust has developed a 2018-2021 Mortality Reduction Strategy, to ensure there is an effective mortality review programme in place that identifies areas for improvement, and an effective governance structure that monitors the delivery of improvements.

The Mortality Reduction Strategy states that:

- All cases where patients have died are reviewed by the Medical Examiner and if there are concerns the cases are escalated for an in-depth review or investigation
- Mortality rates are monitored to identify trends and areas of emerging concern
- Findings from all mortality reviews are shared for learning at the appropriate level to ensure risks are identified and acted upon
- Where mortality reviews have shown that care falls short of the agreed standard, focused actions are identified to improve care and service delivery
- Processes are in place to support accurate and thorough clinical documentation and coding
- Staff are adhering to the completion of care bundles for specific conditions
- There is appropriate escalation and rescue of the deteriorating patient

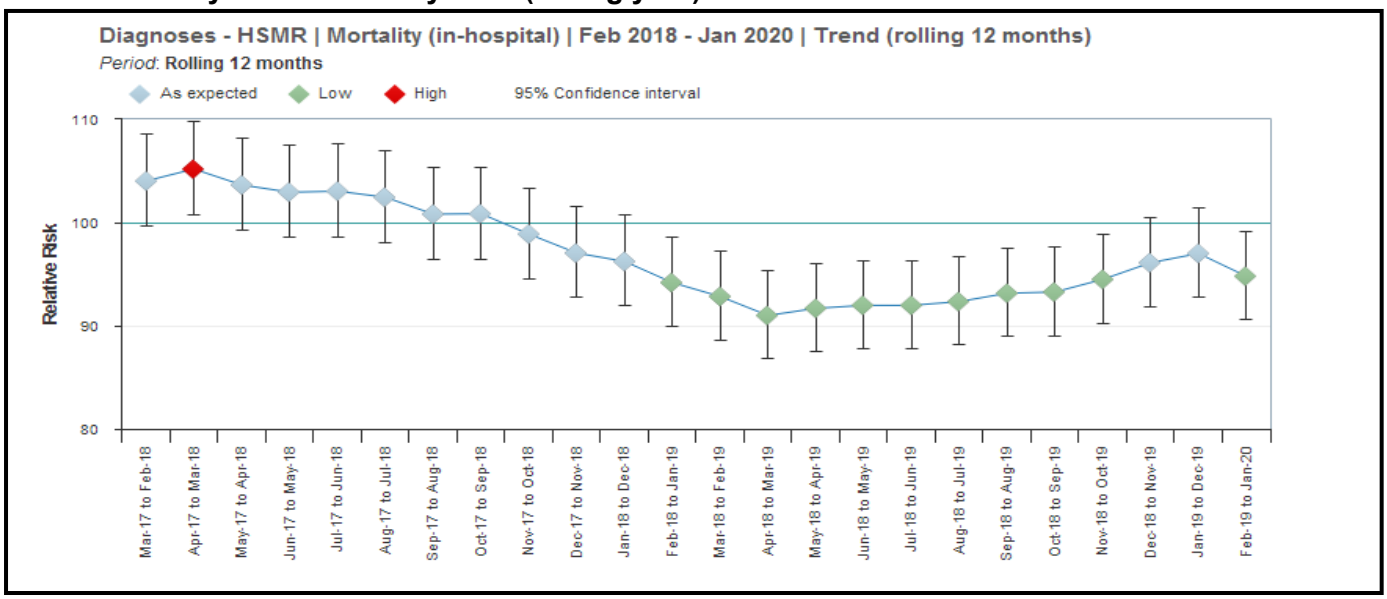
HSMR compares an organisation’s actual number of deaths with their expected number of deaths. The prediction calculation takes into consideration the following criteria:

- Age of the patient
- Gender
- Primary Diagnosis
- Mode and method of admission
- Admission for the previous 12-month period
- Palliative Care

- Co-Morbidities

Standardisation of the ratio allows a valid comparison between different hospitals.

HSMR February 2018 – January 2020 (rolling year)



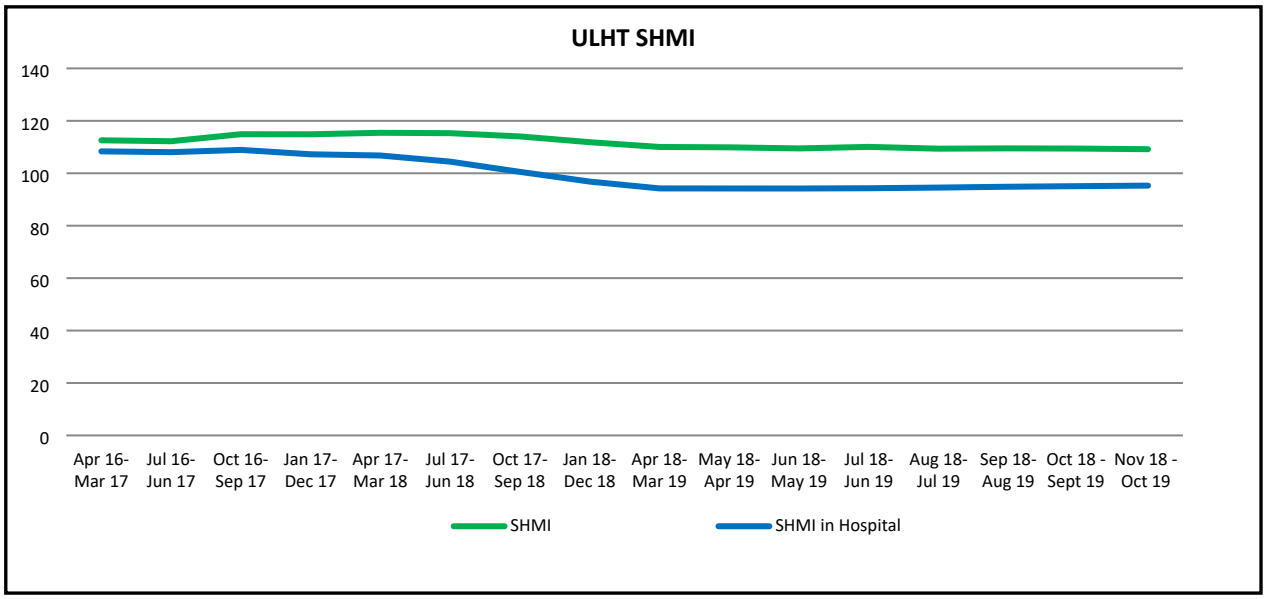
From October 2018 the Trust has been consistently below the national standard of 100. The data is published with a 3-month time delay.

SHMI reports on the number of deaths and covers all deaths reported of patients who were admitted to non-specialist acute Trust in England and either die while in hospital or within 30 days of discharge. The data can be separated into in-hospital and out of hospital (within 30 days) to enable detailed analysis of the Trust.

The expected number of deaths is calculated from a risk-adjusted model developed for each diagnosis group that accounts for the following:

- Age
- Gender
- Primary Diagnosis
- Method of admission
- Co-Morbidities

SHMI April 2016 – October 2019 (rolling year)



The data is published with a 6-month time delay.

In hospital SHMI is 95.29, however, reviewing SHMI as a whole the Trusts score is 109.18 from November 2018 – October 2019.

The Trust is liaising with the Clinical Commissioning Group (CCG) within Lincolnshire to explore the reasons for the higher SHMI out of hospital.

Seven Day Services

ULHT is committed to delivering high-quality services that ensure equity of access for all patients 24 hours a day, seven days a week. The Trust has been participating in the national audits for seven-day hospital services against the four clinical priority standards:

Priority Clinical Standards	• **Standard 2: Time to Consultant Review** • **Standard 5: Diagnostics** • **Standard 6: Consultant Directed Interventions** • **Standard 8: On-going Daily Consultant Directed Review**

Standard 2	Standard 5	Standard 6	Standard 8
All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital	Access to Consultant-directed Diagnostics within one hour if critical, 12 hours if urgent and 24 hours for non-urgent patients • Within 1 hour for critical patients • Within 12 hours for urgent patients	Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols	Patients with high dependency needs should be seen and reviewed by a consultant twice daily (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least once every 24 hours

The Trust had to submit a Board Assurance Framework (BAF) detailing their compliance with the four clinical priority standards. The BAF is presented at Quality Governance Committee and upwardly reported to Trust Board prior to being submitted nationally.

The Trust has made improvements since commencing the audits, however, the Trust is not achieving the 90% standard for clinical standards 2, 6 or 8.

We continue to face challenges in achieving these standards, however benchmarking across the East Midlands and the country shows that we are within national and regional parameters.

The Trust currently has multiple work-streams dedicated to the delivery of improved patient flow through the organisation. Whilst many services are delivered on a seven-day basis, in other services there remains a differential between week days and weekends. There is however clear clinical commitment to move towards seven-day services within our Divisions.

GETTING IT RIGHT FIRST TIME (GIRFT)

Getting It Right First Time (GIRFT) is a National NHS improvement programme that began in 2016, it is delivered in partnership with the Royal National Orthopaedic Hospital NHS Trust. The programme is designed to improve the quality of care within the NHS by reducing unwarranted variations through sharing best practice between Acute Hospital Trusts and standardising services across the NHS system. The programme identifies where changes are required to improve patient care, outcomes and experience. Also identifying areas to improve efficiencies, reduce unnecessary procedures and appropriately reduce cost.

The programme is led by Clinicians that have been identified as experts in their fields. There are currently 45 live work streams nationally; 40 Surgical and Medical work streams with 5 that have been identified as cross-cutting schemes that impact on all services. The National team engages with each Trust and organises visits at Specialty level known as “Deep Dive Visits”, they provide local data packs prior to the visit using the NHS Improvement, Hospital Episode Statistics and Model Hospital data to help identify areas for improvement within the Trust.

The Trust has engaged in the programme since it’s infancy with the first of our visits being General Surgery and Orthopaedics in 2016. To date ULHT has had 19 deep dive visits across Surgical and Medical Specialties and 4 cross-cutting schemes.

The deep dive visits are attended by National GIRFT Team members, ULHT’s Clinicians, Nursing, Finance, Clinical Coding, Executive representation, Clinical and administration support staff across the specialty. The visits provoke discussion and understanding and provides the Trust with an opportunity to advise the National Team of any improvements in outcomes since the data pack was published. The interactive discussion at these deep dive visits also provides an opportunity to identify and discuss further opportunities for improvement in our services.

Following the deep dive visits, the National Team compile a comprehensive local improvement recommendation plan that the Trust has to implement to ensure compliance with the GIRFT recommendations. Once the National Team has visited 90% of Trusts for a specific clinical or cross-cutting specialty a national report is produced encompassing the learning and recommendations gathered from all local visits. The Trust is asked to incorporate all national

recommendations into their local GIRFT action plan. The Trust updates the National GIRFT Team frequently with progress against delivery of the GIRFT action plan.

ULHT has so far fully implemented / completed 20% of recommendations provided by the GIRFT programme, with 51% of actions in progress across the Trust and 29% pending national and local agreement.

PATIENT EXPERIENCE

Complaints

Patients and carers can raise a concern in a number of ways. One way is via the Patient Advice and Liaison Service (PALS). They will try to resolve any issues. If this is not successful, or the concern is too complex, PALS will pass this on to the Complaints Department. The other way patients can raise concerns is by directly contacting the Complaints Team. The complaint will be passed on to the relevant Division to respond. Once received, individual Divisions work closely with the complaints team to resolve those concerns which do not require a full formal investigation. A formal complaint is one in which the complainant asks for an investigation and written response.

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

It is imperative that complainants feel that they are treated with respect and receive an open, honest and timely response to their concerns. Complaints response times are monitored by the Complaints Department and the Executive Team. All complaints are allocated a 35 working day response timescale including the cases that are referred back for further investigation. This is to ensure that the processes stay aligned and so that we acknowledge, investigate and respond to the complaints within a timely manner. However, should it become apparent that the investigation may take longer we will contact the complainant and explain the reasons for the delay and a further date will be agreed.

Learning from complaints takes place at a number of levels. The service, department or specialty identifies any immediate learning and actions that can be taken locally.

A quarterly report identifies themes, trends and suggestions for improvement based on a variety of feedback. This report is discussed at our Patient Safety Group and Quality Governance Committee.

Complaint data is triangulated with other information such as incidents, serious incidents, inquest conclusions and claims information to ensure a full picture of emerging and persistent issues is recognised and described. Learning from complaints is shared with staff at a variety of meetings.

To help improve the management of all complaints we have further reviewed and streamlined the process. The improvements for the response rates will be seen in 2020-21. The table below provides a summary of the key complaints performance indicators monitored within the Trust:

Measure	Target	2019-20	2018-19
New complaints received	N/A	721	739
Acknowledged all complaints within 3 days	95%	100%	95%
Response Rates	35 days	40%	56%

Parliamentary and Health Service Ombudsman (PHSO)

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

A total number of 18 complaints were referred to the Ombudsman during 2019-20 compared to 24 complaints during 2018-19. The numbers broken down across hospital sites equate to

- 10 from Lincoln
- 8 from Pilgrim
- 0 from Grantham

Of the 18 complaints, 3 have been identified for formal investigation, 2 cases are still being assessed and 13 have been rejected by the Ombudsman. This equates to 72% of all cases

referred to the Ombudsman during 2019-20 being rejected. The cases were either referred back to the Trust to undertake further work at local resolution (2 cases) with the remaining 11 not meeting the Ombudsman's criteria for investigation as the Trust had adequately addressed and resolved the concerns raised. The increase in cases rejected by the Ombudsman indicates that the quality of the response sent to complainants has improved and reflects the hard work that has been undertaken by the complaints team to ensure that all the concerns raised have been addressed to a high standard.

When we examine the 18 cases referred to the Ombudsman, there is no specific pattern in terms of speciality area. Cases include Orthopaedics, Care of the Elderly, Stroke, Dermatology, ENT, Rehabilitation and Paediatrics. Complaint themes continue to centre around medical care including delay in diagnosis, poor communication (with patients and other NHS organisations) nutritional decisions, end of life care, radiology reporting standards and decisions around discharge planning.

In addition to the 18 new cases referred to the Ombudsman an additional 9 cases were closed. These cases were referred to the Ombudsman the previous year but closed during 2019-20. Of these 9 cases, 1 case was upheld, 5 were partly upheld, 2 were not upheld and 1 case was referred back to local resolution.

If the Ombudsman considers that there has been injustice as a result of the care/treatment provided to an individual the Ombudsman will consider whether it would be appropriate to recommend a financial remedy payment. Financial Remedy Payments made to complainants during 2019-20 totalled £3,850.

Improving complaint handling

The Complaints Team are constantly reviewing their processes to ensure timely and quality responses are sent. The Complaints Team have:

- Complaint responses are now in letter formats with the complainant's questions and the Trusts responses clearly documented.
- Responses are quality checked prior to being signed off by the Executive Team

- A review of the complaint process for re-opened complaints, which has now been successfully implemented to ensure high quality timely responses.
- Continue to promote local resolution of complaints as they arise. Encourage meetings with complainants at an early stage of investigations, as beneficial method of sensitively addressing concerns.

One of the main drivers in investigating complaints is to identify opportunities for learning and changes in practice to improve services for patients. Actions and improvements are an integral component of the investigation process. Complaints are discussed at specialty governance meetings.

Examples of learning and actions identified following complaint investigations:
Clinical Support Services:

Following a medicine dispensing error, an action plan has been put in place to ensure that all staff involved have their competencies reassessed. They have also been asked to complete a reflective piece of learning regarding accuracy checking and medication dispensing.

Family Health:

Delay in treatment/procedure regarding post-partum bleeding.
Following the complaint, there has been a review of the guidelines for the management of postpartum bleeding to ensure that a second scan is considered even if the previous scan has been normal. A training programme is also being implemented.

Medicine:

Delay in diagnosing amyloidosis
It has been acknowledged that this is a very difficult condition to diagnose. As a result of the complaint, all cardiologists have undertaken a teaching session to learn more about the amyloidosis to raise awareness of the condition.

Poor documentation of fluid and intake monitoring.
As a result, the Trust has introduced a mandatory fluid balance core training for all staff and the introduction of a fluid balance policy. The purpose of the policy is to ensure that staff are

aware of the importance of fluid balance monitoring. This will also enable all staff to commence, complete and discontinue fluid balance monitoring competently and effectively

Surgery:

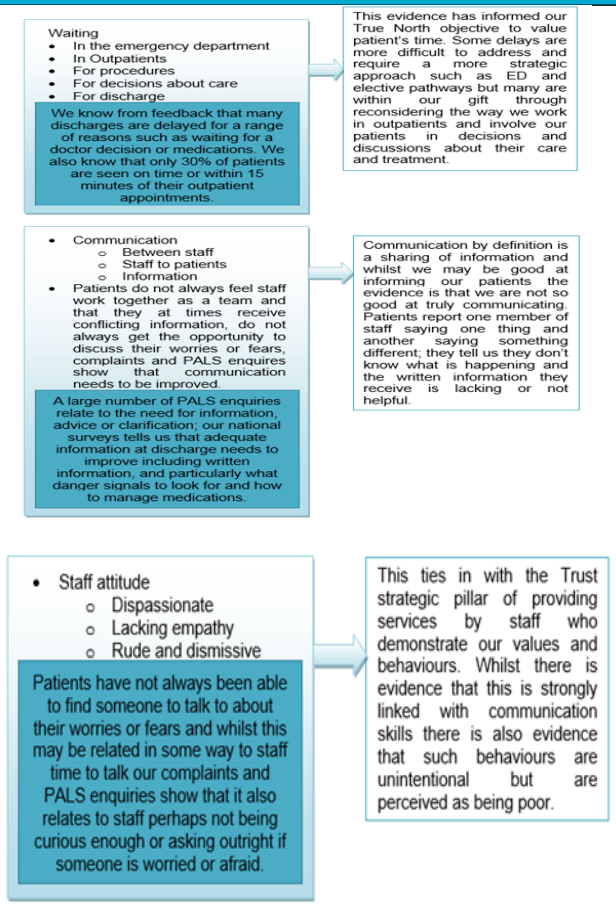
Injury sustained during treatment.

Poor communication with the family, who were not made aware that during the procedure there is a risk of a skin tear even where precautions have been taken. The family or patient were not made aware that this had happened.

As a result, the orthopaedic team have changed their emergency cover to allow the same surgeons to follow up their own patients care post operatively.

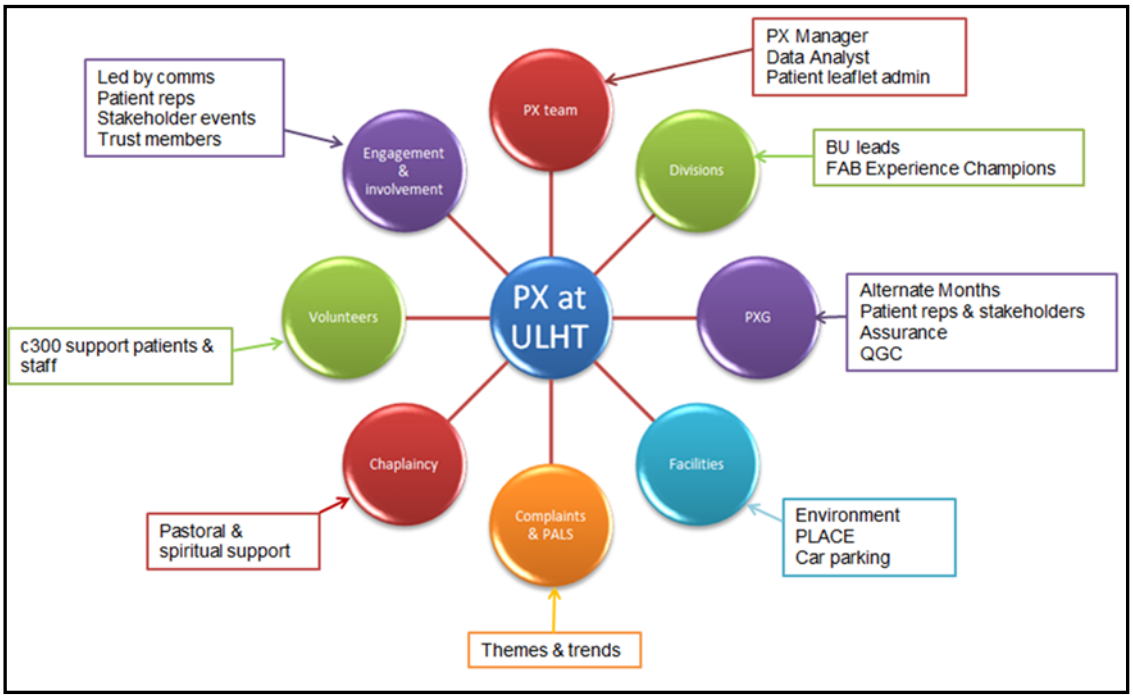
Patient Experience Plan

The 2016-2019 Patient Experience Strategy has been reviewed and a new 3 year Patient and Carer Experience Plan developed. The objectives for this have been drawn from what our patients are telling us.

FFT, national surveys, PALS and complaints:	National survey at a more granular level:
	• Privacy in ED - this relates particularly to corridor waits and a crowded department. • Length of time on the waiting list for admission and whether admission date was changed • Help to eat meals and to wash and keep clean. • Level of confidence and trust in our doctors and that doctors and nurses in some cases talk over patients as if they weren't there. • Keeping patients informed and up to date on their care and treatment; patients are too frequently moved to different wards and this can cause concern and delay discussions and decisions about care. • Discharge concerns relate particularly to being involved in decisions and having written information on what to do post-discharge. • Asking patients about the quality of care during their hospital stay.

Addressing these 5 principles have been developed:

1. Staff engagement and experience – recognising that to achieve a patient centred approach we must also address staff experience
2. Engaging patients, carers and staff – embedding a culture of genuine involvement and engagement; welcoming patients and carers as expert partners and using their experience to drive improvements and developments
3. Meaningful measurement – measuring well, measuring relentlessly, measuring the right things and acting swiftly on the intelligence is key to meaningful data
4. Turning data into intelligence and action – it is important to triangulate our data alongside other metrics such as staffing and safety indicators; the data itself isn't the objective it's turning it into improvement and innovation
5. Realising our potential – working with leaders across the organisation to unlock their teams' potential



This new plan has drawn on national and local imperatives and provides the blueprint for Patient Experience over the next 3 years and the following illustrations demonstrate some of this year's achievements.

Academy of FAB NHS Stuff

ULHT became the first Academy of FAB Stuff Accredited Trust. This is in recognition of an organisation that is committed to the overarching values and ambitions, specifically in relation to leadership and actively supporting this is an improvement philosophy encouraging everyone to share best practice. The Academy principles encourage staff to own change for the benefit of patients and staff. The Trust has won 2 national FAB awards and been finalists for others.

The Trust has launched the following as part of the FAB stuff:

- Caring for Carers
- Swan Scheme patient jewellery pouches
- Spiritual care boxes
- Lincoln Care Home Service (joint submission)
- Ward information placemats
- We have woven FAB principles into our QI programmes

The Trust has held four highly successful FAB-Change days with hundreds of staff pledges and project ‘shares’ and three Patient Experience conferences where FAB has been a pivotal feature. The FAB concept has motivated and enthused staff and encouraged them to seek out what is working well elsewhere but also to celebrate their local improvements such as those shown above shared nationally by our staff alongside many more.

Development of FAB Experience Champions

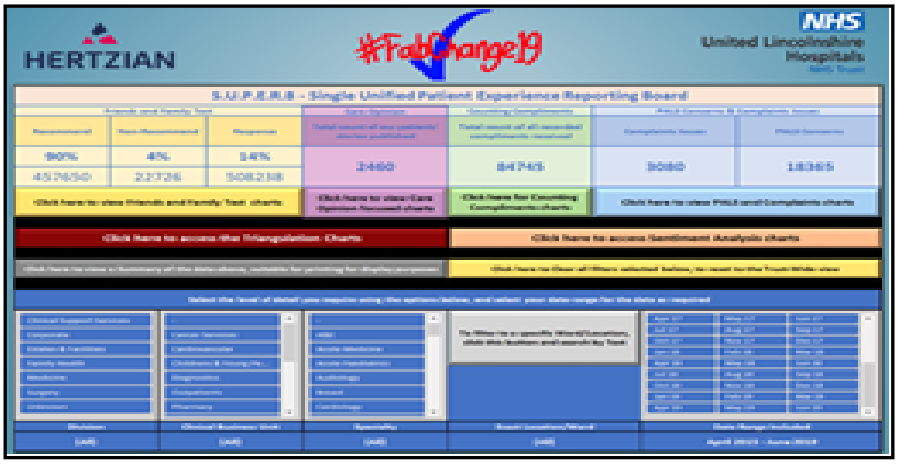
Designed to provide a link in to clinical teams the champion's network 'recruited' 73 staff since its launch in the early summer of 2019. The role of the champion is to seek out, listen and respond to the voice of the patient and carers at service level and to be the champion for that team. A full support package for champions was developed which included guides and resources and training and wards have stepped up to the challenge with development of local patient experience improvements such as a Carers Corner, patient information noticeboards, post discharge follow up contact, development of 'Grab Packs' for patients with Autism, development of Georges Garden and local patient surveys and forum events with actions to address issues raised.

Launch of the Single Unified Patient Experience Reporting Board – SUPERB

SUPERB has become the 'go-to' interactive dashboard for our patient experience metrics and enables comparisons and triangulation across FFT, PALS and complaints and Care Opinion with national surveys data looking to be incorporated in the coming months. Explorative work was undertaken with an external company called Hertzian to include semantic and sentiment analysis which will be further developed in 2020-2021. SUPERB was showcased at the #GIANT19 event in October and the work was a finalist at the Lincolnshire 2019 Health Awards.

We know that SUPERB is beginning to become socialised within our services now, for example matrons have discussed how it has been used within team meetings to look at what patients are saying and discuss collectively how to address any issues raised. There have been links established with the Quality Matrons and the accreditation programme to draw out hot spots and hot topics to then create action plans to support wards. SUPERB and other Patient

Experience Metrics have been used as part of the local improvement and service development projects within Pilgrim ED and paediatrics with the data being used to measure and monitor progress and impact.



Development of real-time surveying

With the aim to provide teams with timely, triangulated, meaningful and accessible intelligence the real-time surveying project has progressed well with the launch paused only due to COVID-19. The process will be run by a team of specially recruited team of Patient Experience Surveyors and data input directly into iPads, collated and manipulated and then sent directly to team leaders. The team are ready to launch once the Trust exits COVID restrictions.

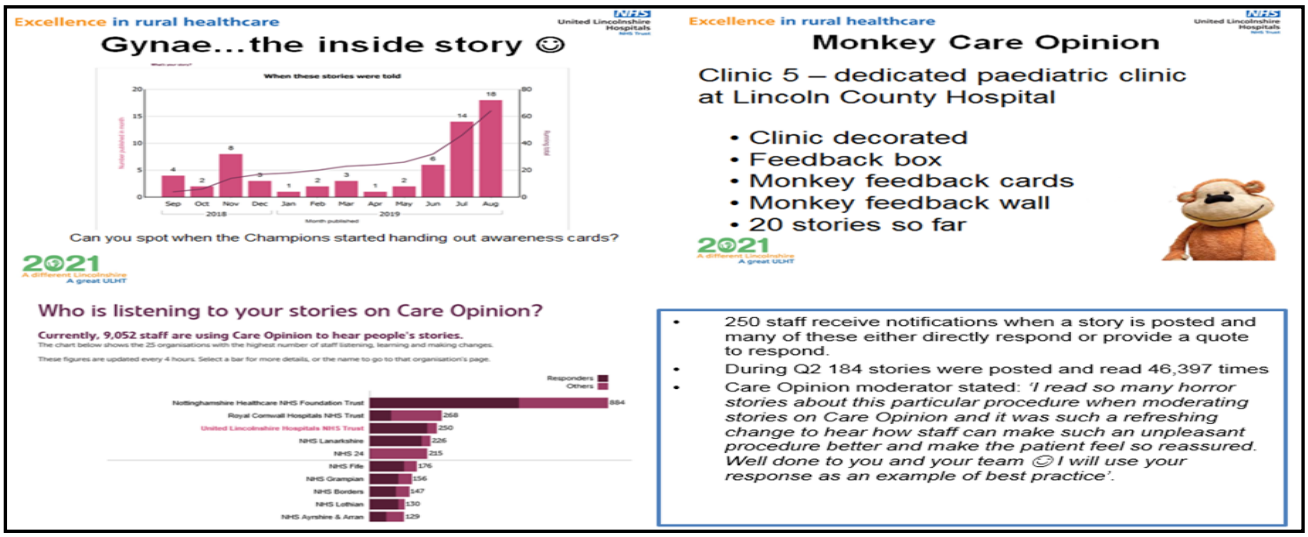
Widening involvement of patients and carers to hear their stories and voices

A number of initiatives have been developed but their April launch dates have been paused due to the onset of the Coronavirus: COVID-19; these include:

- The Gift of a Story – putting our patient stories into a digital format enabling sharing and longevity of their use
- Empathy museum – development of a library of staff and patient stories to focus on empathy; understanding others perspectives
- Schwartz Rounding – funding and project plan well developed and ready to restart once current restrictions are eased.

Presentation to national Care Opinion conference

ULHT presented at the Care Opinion national conference to showcase the Trusts process for seeking, listening and responding to patients stories. ULHT are in the top 3 ranking of Trusts using Care Opinion and offer support to other Trusts. 250 staff receive direct notifications of stories being posted and are able to directly respond and they share the stories with the team. Negative or critical stories prompt direct contact and response to patients and teams use these to make improvements. Examples included the introduction of a new approach to toast at breakfast to the introduction of placements which detail ward routine and how to contact medical teams.



Patient Experience Conference 2019

This year's conference focused on empathy and communication and had presentations from patients and staff. The conference overall was evaluated as excellent from the over 120 staff who attended. Patient representatives told their stories and one in particular led to the patient revisiting the ward and working alongside matron and ward staff to instigate small but impactful changes to the environment and how day appointments are handled. This patient also used her story in teaching sessions.

FAB Change Day 2019

In 2017 The Academy of FAB NHS Stuff took over the running of NHS Change Days and here at ULHT we have celebrated and supported them every year. In 2019 we had a range of initiatives including:

- Randomised Coffee Trial – with over 200 people taking part
- High Fives – the giving of simple High Five 'handprints to reward and recognise colleagues and say well done
- Search and Share – encouraging staff to check out the FAB Academy, search for what others are doing and to adapt and adopt quality improvements – and equally to share the great work happening at ULHT. We tied this in with the ULHT QIP and QSIR programmes
- Developed a beginner's guide to Twitter to inspire staff to join up and communicate with healthcare colleagues across the country
- Quizzes and fun events and many random acts of kindness throughout the week that culminated in our appearance at the #GIANT19 event in front of a global audience and being awarded Academy accreditation by Simon Stevens

FAB Change Day is embraced each year with fun, inspiration and motivation for staff. It is an opportunity for staff to look inwards as well as see what other Trusts are doing as often staff can feel they are not perhaps making that much of a difference or have anything to celebrate – a fact that is more than often totally untrue. From the Coffee Trial relationships have continued such as between a healthcare assistant and a senior manager who keep in touch and share each other's work worlds and perspectives.

Excellence in rural healthcare

The Academy of Fabulous Stuff

#FabChange19

NHS United Lincolnshire Hospitals NHS Trust

#FabChange19

Tuesday 15th October – #FabChange19 fun and games!

At the Academy we are all about having fun and spreading inspiration, positivity, motivation and passion! Here are just three of the things we have lined up for you!

Randomised Coffee Trial (RCT).
Over a hundred people signed up to join this year's RCT and have now been randomly paired with people from across the Trust to spend a few minutes getting to know each other over a cuppa.
Benefits of RCTs include:

- They are a really good way of creating links within the organisation and encouraging us to collaborate.
- People discover amazing connections with people that they are matched to – we call this the transformational power of serendipity!
- They give permission and opportunity to meet colleagues who are not necessarily involved in our day to day work.
- People enjoy the experience and it contributes to feelings of motivation and being inspired.
- They support wellbeing: providing an opportunity to step outside of our work, take a break and pause while we learn more about our colleagues.
- RCTs offer the chance to make time to talk to the people we should be talking to anyway and to meet people who we won't be directly working with but it's nice to know who they are!

High Five!
Recognising and appreciating our colleagues is incredibly motivating; giving a High Five could be for having done a great piece of work, landed a project that is showing results, coming up with a great idea – but equally it doesn't have to be for something huge or monumental; it can be for being a great co-worker, for being there for you, for giving their best, for being great to work with.....it's the gesture and the appreciation that makes a real difference.

So why not send a High Five to someone you know – to say well done or thanks. Cards have been sent to lots of people around the Trust or you can email jennie.negus@ulh.nhs.uk or sharon.kidd@ulh.nhs.uk for a few – or you can make your own (though ours have clever QR codes on them that take you to the websites!)

Mental Health, Learning Disability and Autism

Whilst strategically sitting within the Safeguarding agenda this work has its core in patient experience and there have been a number of achievements across the last 12 months including:

Mental Health Q1 achievements

- Greater Trust awareness about MH issues & care
- All policies up to date.; including new Close Observation Policy.
- All MHA pathways reviewed with LPFT.
- Ligature risk assessments up to date in all areas & new review schedule agreed.
- Adult MH risk assessment designed and being rolled out.
- Core Plus MHLD&A awareness training from July 1st.
- Clinical Holding training progressing well now with support from PMO.
- 360 assurance action plan completed.
- Training sessions held with Gold & Silver commanders & SDMs

New core plus training commenced 1st July 2019.

Learning Disability – Q1 achievements

- Completed appraisal against NHSI LD Improvement Standards & actions identified.
- Close working with LPFT LD liaison team.
- Access to LPFT Experts by Experience.
- Core Plus MHLD&A awareness training from July 1st.
- Signed up to Treat Me Well (TMW) campaign & two very successful workshops held in May.
- New TMW steering group convened to meet in August & lead LD improvement work. Membership includes patients, experts by experience, carers and care providers.
- LD Bundle developed and launched.
- TMW focus for #LDWeek19

Learning from case reviews considers patient and staff experience as well as clinical or operational decisions & actions

Very successful start to Treat Me Well campaign & ULHT led multi-agency action group convened.

Autism – Q1 achievements

- Lincolnshire Strategy presented to 2021 Board & Trust signed commitment statement.
- Very active ULHT Steering Group with x 2 experts by experience.
- Close Observation Policy includes specific needs for Autistic patients.
- First 3 services identified for undertaking Reasonable Adjustment mark:
  - LCH OT
  - Navenby Ward
  - Recruitment team

#LDWeek19 week long campaign a huge success

Launch of LD Bundle; MHA bundle due for release in August.

Integrated Improvement Plan (IIP)

The Integrated Improvement Plan (IIP) is our 5-year Improvement Plan. It identifies the key priorities for the Trust over the next 5 years 2020-2025 ensuring we are focused on the right things for both our patients and our staff. The Trust is now seeking to move from a short term, reactive approach to quality and safety to a more comprehensive and planned approach. This streamlined approach will help to make a real difference for our patients and support our staff to deliver the high standards of care to which we all aspire. Effective partnerships across the Lincolnshire health community are vital for achieving our overall goals and we are committed to working as one health and care system.

Within the Trust IIP the strategic framework 2020-2025 provides our future direction:

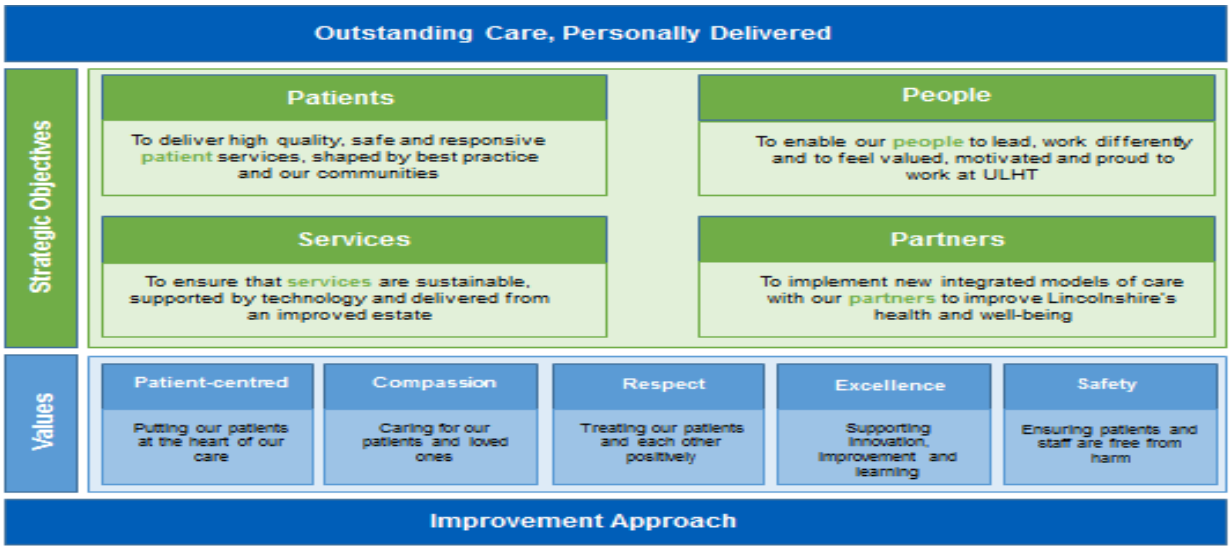
Patients - To deliver high quality, safe and responsive patient services, shaped by best practice and our communities.

People - To enable our people to lead, work differently and to feel valued, motivated and proud to work at ULHT.

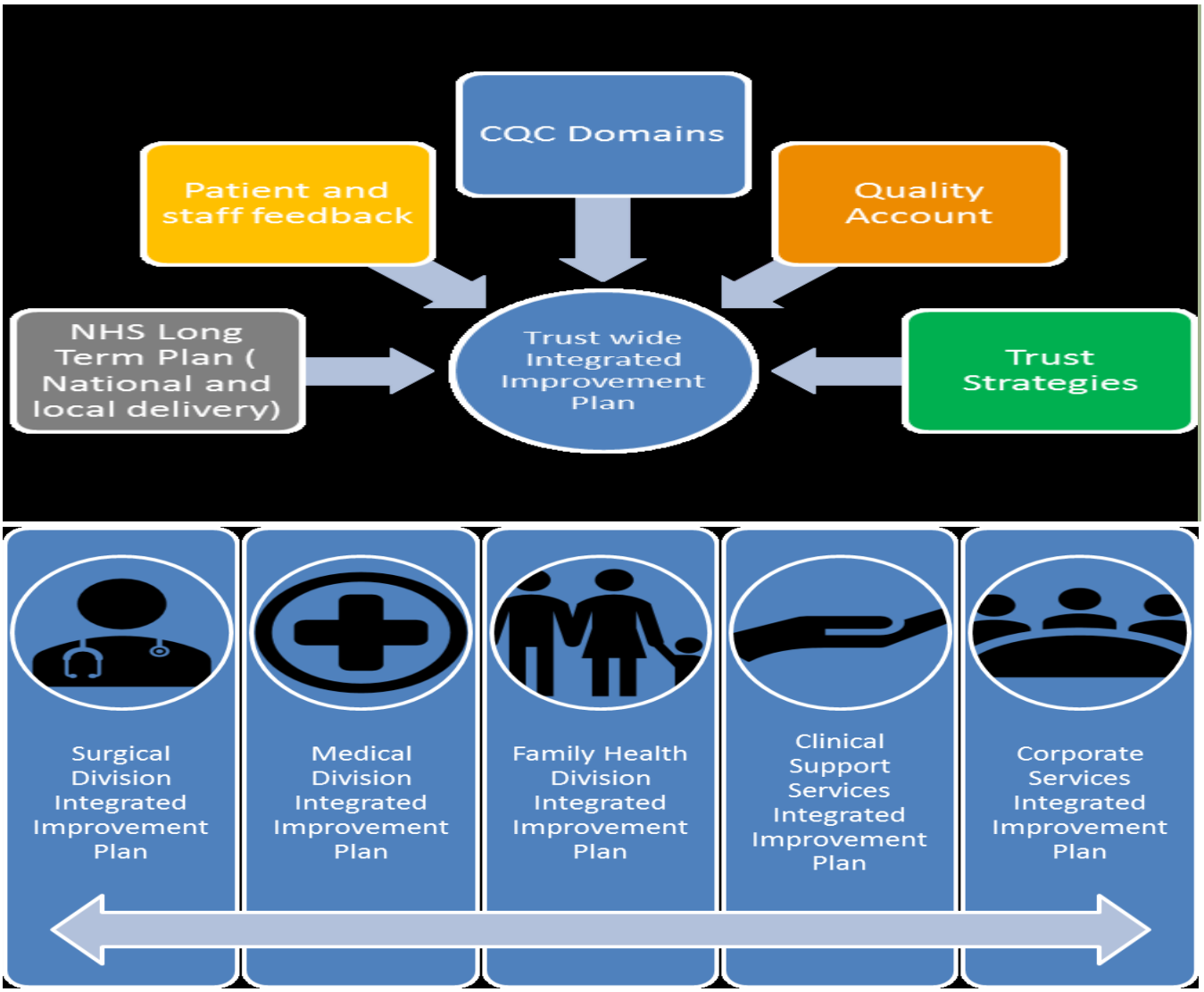
Services - To ensure that services are sustainable supported by technology and delivered from an improved state.

Partners - To implement new integrated models of care with our partners to improve Lincolnshire health and well-being.

Our strategic framework 2020-2025 provides our future direction:



Our Trust Integrated Improvement Plan will be at the centre of all we do, supported by our Trust values



Strategic Objectives	**Patients** To deliver high quality, safe and responsive **patient** services, shaped by best practice and our communities	**People** To enable our **people** to lead, work differently and to feel valued, motivated and proud to work at ULHT	**Services** To ensure that **services** are sustainable, supported by technology and delivered from an improved estate.	**Partners** To implement new integrated models of care with our **partners** to improve Lincolnshire's health and well-being.
Our 5 year priorities	Deliver Harm Free Care Improve patient experience Improve clinical outcomes	A modern and progressive workforce Making ULHT the best place to work Well-led services	Modern, clean and fit for purpose environment Efficient use of our resources Enhanced data and digital capability	Establish new evidence-based models of care Advancing professional practice with partners To become a University Hospitals Teaching Trust

Our Outcomes	HSMR and SHMI are within the top quartile nationally Patient Surveys in top quartile Top quartile for national clinical audits and benchmarking To meet all of our regulatory requirements	Top quartile for vacancy and turnover rates Staff Survey results in top quartile Rated outstanding for Well-led	Capital funding secured to deliver trust strategies Financial Plan delivered Staff will have access to real time-data via electronic systems	All nationally required access standards delivered A full partner in a functioning ICS Reduced activity delivered in acute setting Acute Service Review delivered in partnership To be a University Hospitals Teaching Trust

Equality Diversity and Inclusion

As a Trust, we value equality and human rights in everything we do, and are committed to working with our stakeholders to reduce health inequalities and value equality and diversity within our services and across the health community. We aim to ensure that the services we deliver meet the needs of the population we serve regardless of their age, disability, gender, race, religion/ belief, sexual orientation, marriage and civil partnerships, transgender and pregnancy/maternity.

We aim to continually develop and ensure that equality is incorporated into everything we do, as 'the golden thread' to all our activity. We value equality, diversity and inclusion and have set out our approach in our policies and practices with the aim of ensuring dignity and respect for all. Since 2018 the Trust has an inclusion strategy which includes our equality objectives for the duration of the strategy 2018-2021. Our inclusion strategy can be accessed on the Trust website: https://www.ulh.nhs.uk/about/equality-diversity/equality-objectives/

The Trust also produces an equality, diversity and inclusion annual report which provides an update on the progress we have made in relation to equality, diversity and inclusion for patients and service users and also for our staff. This is published on our ULHT website.

Celebrations and recognition of dedicated hospital staff

Around 200 patients, volunteers and staff members from across the Trust, came together to celebrate at the annual ULHT Staff Awards which recognises and celebrates the dedication and hard work of staff. This year more than 600 nominations were received for staff in a wide range of job roles, all showcasing the fantastic quality of care that is given to patients and colleagues in Lincolnshire's hospital.

At the ceremony, held on Thursday 2nd May 2019 at the EPIC Centre at Lincolnshire Showground, there were 12 award categories including awards for outstanding leader, unsung hero, research and innovation, and great patient experience.

Freedom to speak up

In October 2016 the Trust complied with the NHS Contract requirement to nominate a Freedom to Speak Up Guardian. As an organisation, we are committed to investigating and taking appropriate action where concerns are raised with us, and have arrangements, including the Guardian to ensure staff who raise concerns are fully supported to do so. The Trust Freedom to Speak Up Guardian has lead responsibility to ensure that the appropriate handling of concerns is in place and the effectiveness of the local systems is considered by the board. The Trust has a Freedom

to Speak Up Policy which describes the different ways staff can speak up and assures them that staff who speak up will not suffer detriment. The opportunity to feedback is given through a feedback question offered when a speaking up matter is concluded.

How does the Trust support staff to speak up:

- Through its Voicing Your Concerns Policy.
- Through the Freedom to Speak Up Guardian.
- Through the 13 Freedom to Speak Up Champions who have been engaged to support speaking up across all staff groups and geographical sites.
- Through the commitment of the Board to champion the importance of raising concerns. The Board receives a quarterly report on speaking up and has completed the self-assessment
- The FTSU Guardian meets regularly with the Trust Chief Executive and Non-Executive Champion for Speaking Up.

What should staff do if they have a concern:

- Where possible speak to their line manager.
- Contact anyone named in the Voicing Your Concerns Policy.
- Contact the Trust Freedom to Speak Up Guardian through the dedicated confidential email. address freedomtospeakguardian@ulh.nhs.uk
- Make use of one of the national whistleblowing helplines for advice.

Guardians of Safe Working

All organisations employing 10 or more trainee doctor trainees are required to appoint a Guardian of Safe Working. This principle was agreed as part of the negotiations around the 2016 junior doctor contract. The role sits independently from the management structure, with a primary aim to represent and resolve issues related to working hours for the junior doctors employed by the Trust. The guardian role provides assurance to the employer that issues of compliance with safe working hours will be addressed, as they arise. The Trust has appointed a Guardian of Safe Working, one who has this responsibility for junior doctors employed across the Trust. He is supported by an Human Resources Manager.

The office of the Guardian has established regular pan Trust Junior Doctor Forums that run every 6 weeks. The forums ensure that issues and concerns are highlighted and resolved with

management involvement. This relationship also ensures that the patients receive safe, high quality care from junior doctors, supported by the Guardians of Safe Working. Where junior doctors experience challenges to their contract, examples would be through working longer hours or insufficient time prescribed to educational supervision, then junior doctors are required to submit an Exception Report to their appointed Guardian of Safe Working. The purpose of this Exception Report is to highlight and patterns or trends which need to be addressed with particular specialities to ensure that safe working practices are achieved.

Performance information is currently being collected against the number of Exception Reports submitted, by specialty, by site and by reason. The Guardians report regularly to the Board through the Workforce and Organisational Development Committee, within their reports include details of the numbers of exception report and they draw out themes which we use to improve the experience of junior doctors at the Trust.

The Resourcing Team are working closely with the clinical leads to fully understand the requirements of the different grades of doctors in training within each discipline in order that a targeted approach to reducing rota gaps can be planned. Further work to review current processes, ensuring they are fit for purpose and aligned to provide the necessary expertise to support the Divisions and the Post Graduate Education Teams with the starters, leavers and rotations for doctor in training grades. The Resourcing Team will continue to respond to requests for support in reducing rota gaps and continue pursuing alternative solutions. The Trust will also be undertaking a review of the agency usage for doctor in training grades with the aim of implementing solutions to reduce the need for agency workers, which will include, effective rota co-ordination and the option of rotational posts to fill rota gaps.

PERFORMANCE AGAINST NATIONAL PRIORITIES AND ACCESS STANDARDS

NHS Improvement's Single Oversight Framework (SOF) has four performance metrics:

- Accident and Emergency (A&E) 4-hour waiting standard
- 62-day GP cancer standard
- Referral to Treatment (RTT) incomplete pathways standard
- 6-week diagnostic waiting times standard

The national standards are:

- 95% for A&E 4 hour waits
- 85% for 62-day GP Cancer
- 92% for RTT incomplete pathways
- 99% for 6-week diagnostic waiting times

Access Key Performance Indicators		Quarter 1			Quarter 2			Quarter 3			Quarter 4			2019-20	2018-19
		Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20		
A&E 4 hours	Actual %	66.36	68.22	72.44	67.05	69.24	73.07	64.22	62.04	64.71	67.00	68.42	73.87	68.05	69.75
	Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
62 day GP Cancer	Actual Classic %	77.31	65.52	79.08	73.42	65.60	72.86	65.70	65.70	63.30	54.94	67.13	77.04	68.97	73
	Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%
	Actual Screening %	100	92.11	90.16	82.10	86.57	64.52	68.10	83.33	81.10	67.57	70.59	81.4	80.63	87
	Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
RTT	Actual %	84.16	84.48	83.16	83.20	82.64	82.27	82.92	83.52	82.75	83.52	82.23	79.25	82.84	83.69
	Target	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%
6 week diagnostic	Actual %	96.71	96.03	97.09	94.53	94.15	96.59	97.65	96.55	94.13	95.35	99.08	91.94	95.82	97.53
	Target	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%
Clostridioides difficile	Actual	5	4	4	3	6	9	10	10	4	3	4	4	66	57
	Target	9	9	9	9	9	9	9	9	9	9	9	9	108	59
VTE	Actual %	96.15	97.21	96.57	97.53	97.16	96.98	97.60	97.60	97.43	97.89	98.18	96.42	97.23	96.66
	Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

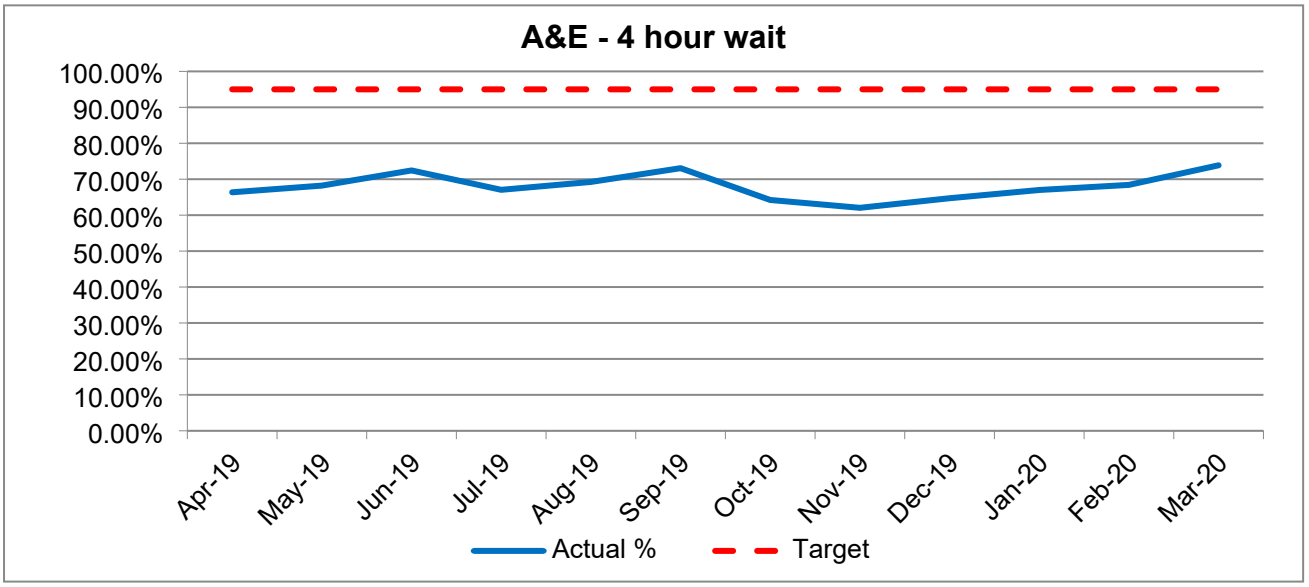
Not Achieved

Achieved

Accident and Emergency (A&E) 4-hour waiting standard

The performance for the 4 hour A&E standard for April 2019 – March 2020 was 68.05%.

A&E 4 hour performance April 19 – March 20



The performance for the 4 hour A&E standard for 2018-19 was 69.75%.

Actions undertaken to improve performance

In the early part of 2019-20 the Trust embarked upon the largest improvement programme of its kind in the Trust, an Urgent and Emergency Care Programme (UEC). The Programme consisted of seven work-streams all aimed at improving patient quality, performance and the experience of staff. The work-streams focussed on the emergency pathway from attendance through to discharge and included actions to improve triage, ambulance handover, medical staffing, primary care streaming, ambulatory care, ward processes, discharge and reconfiguration. The model for Improvement used by the UEC Programme is that promoted by the NHS Academy, 'Quality Service Improvement and Redesign' or QSIR. Part of the success of the UEC Programme was that it became an established and recognisable improvement programme within the system. The Emergency Care Intensive Support Team (ECIST) continued to provide support to the Trust throughout the year sharing good practice.

Areas that have seen the greatest improvement and contribution towards achieving improved 4-hour improvement are as follows:

Triage is an assessment that takes place when patients first attend the department to ensure unwell patients are identified sooner. Trusts are expected to perform at 100% against this target and whilst this has fluctuated during the year, by March 2020 Triage was performing at 96%. This is due to there being more trained staff than in the previous year

Another area that has seen significant improvement is primary care streaming. This is a service co-located within the emergency department that reviews patients who do not need to be seen through an emergency pathway. The aim was to achieve 20% of emergency attendances through this stream and this has been successfully delivered through some great partnership working with our community partners Lincolnshire Community Healthcare Services. With out of hours' care included in this metric for primary care streaming, the service has been able to deliver closer to 30%.

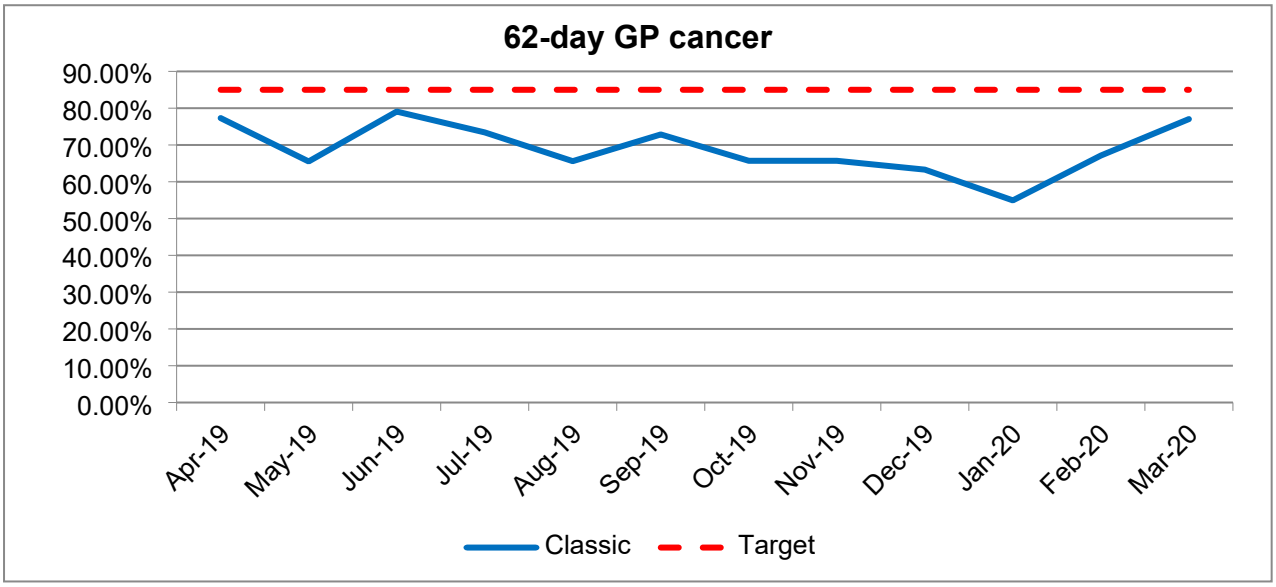
Whilst medical staffing continued to be challenging during the earlier part of the year, demand and capacity modelling and a staffing options appraisal presented to Board later in the year which was approved have enabled further recruitment to take place and a new staffing model to be implemented. This is a significant step towards sustained improvement in emergency care, with the time to first assessment, a well- documented key metric in achieving overall 4-hour performance, beginning to see a month-on-month improvement.

Being able to take handover for patients on ambulances within expected timescales has continued to prove challenging. Whilst some improvement has been seen, this has not been sustained. Delaying an ambulance handover impacts on EMAS's ability to be able to respond to urgent calls within the community, and we are continuing to work with our EMAS partners to look at solutions to improve this metric.

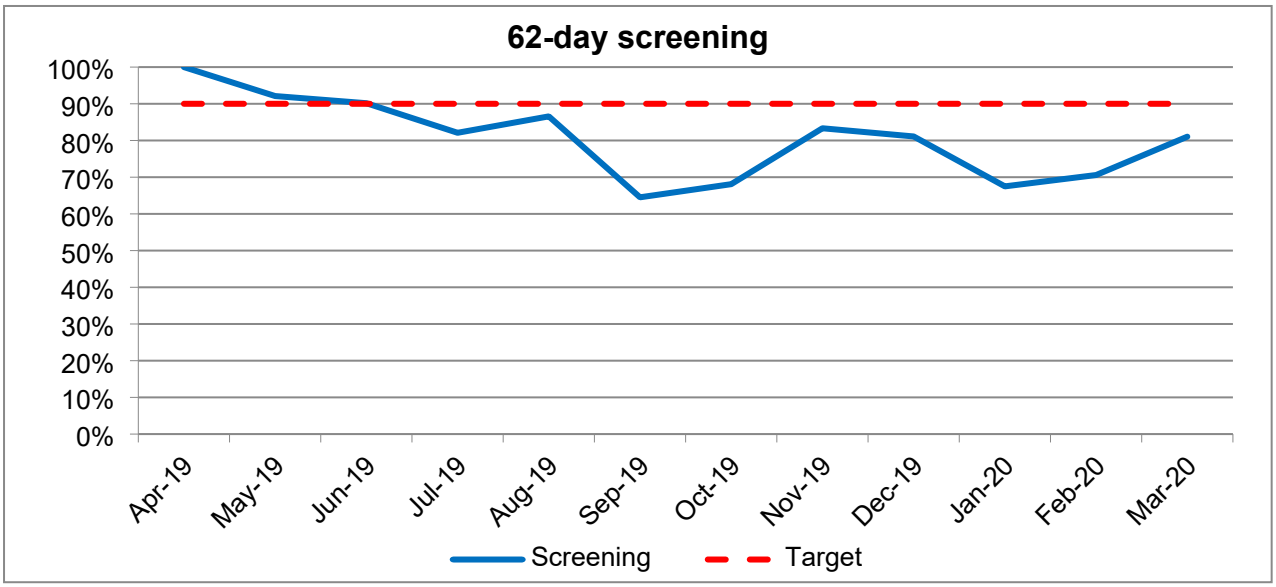
Cancer 62 day waits

Performance for 2019-20 has been consistently poor and we have not achieved the national targets which were expected in March 2020.

Cancer compliance April 2019 – March 2020



The performance for cancer 62-day classic for 2018-19 was 73%.



The performance for cancer 62-day screening for 2018-19 was 87%.

Actions undertaken to improve performance

In December 2019 it was agreed across the system that the Trust would adopt an Improvement Methodology approach to support the Division's to deliver the cancer standards. A more structured, simplified, metric led improvement approach would enable greater transparency of delivery and therefore improve lines of accountability and relations between the commissioners and ULHT.

The improvement approach is to provide a simplified plan, data-driven, and testing areas to ensure optimum pathway improvement. The framework is made up of five key speciality areas and cross-cutting themes with key milestones and metrics attached.

Tumour site-specific pathway improvement work streams:
Broken down to detail actions to improve time to diagnosis and actions to improve time to treatment

Cross-cutting work streams, including:

- Operational governance including booking and scheduling
- Oncology
- Diagnostic turnaround – imaging, endoscopy, pathology
- MDT Review and effectiveness
- Tertiary partnerships and collaboration

5 High impact actions were identified, these were identified through monitoring the number of 62 Day patients treated and the number of breaches. Further analysis work for each speciality area is being considered to further scope the service using the NHSI pathway analyser tool as this analysis will look at patients treated in the last 30/ 60 days depending on treatment numbers. The aim of this further analysis work is to support and understand the areas of concern and broaden the deep dive of each specialty areas to ensure they are correct.

The High impact action plans are all uploaded on to Aspyre the Sustainability and Transformation Partnership (STP) Programme and Project planning tool. Each speciality area has a Quality, Service Improvement and Redesign (QSIR) Scoping Brief. Each Speciality area has a project team to support the improvement plan and key metrics.

The 5 areas include;

1. Urology
2. Colorectal
3. Upper Gastrointestinal
4. Lung
5. Gynaecology

For the period of time from January to March 2020 the above areas were scoped and improvement plans were identified and work continued to take place improving aspects of the pathways.

18 weeks – Referral to Treatment (RTT)

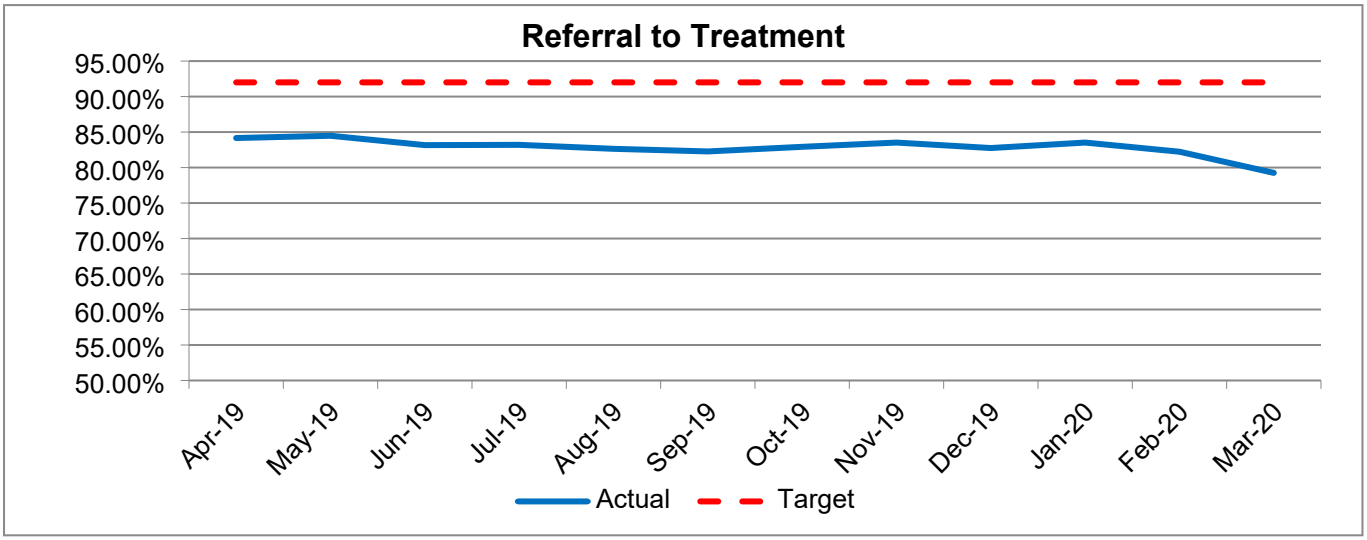
During 2019-20 in addition to the 92% Referral to Treatment (RTT) standard national and regional focus has been on elimination of waits in excess of 52 weeks and reduction of the overall waiting list size.

ULHT RTT performance has maintained an average of just above 83% with variation within control limits.

The Trust had eight RTT 52 week breaches April to September 2019. There were zero 52-week breaches in quarters 3 and 4.

The overall waiting list reduced in size and achieved the agreed target of 37,761 by 31st March 2020.

RTT compliance April 2019 – March 2020



The performance for RTT for 2018-19 was 83.69%

Actions undertaken to improve performance:

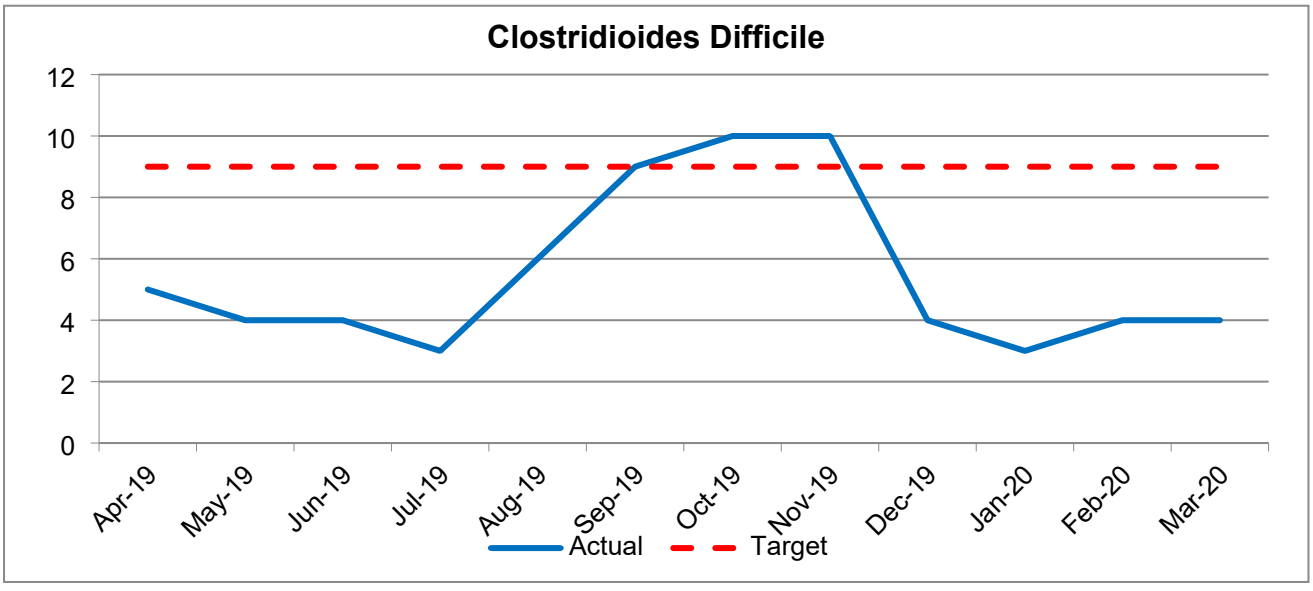
- Deputy Chief Operating Officer post established to lead Planned Care performance improvement
- NHSE/I Intensive Support Team (IST) review and recommendations regarding RTT pathway management embedded
- External validation capacity funded to validate pathways
- System improvement programme focused on challenged specialties, with particular success in neurology

Clostridioides Difficile Infection

The acute provider objectives for 2019-20 has been changed to include the two categories:

- Hospital-onset healthcare-associated: cases that are detected in the hospital two or more days after admission
- community onset healthcare-associated: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the Trust reporting the case in the previous four weeks.

Clostridioides difficile rates April 2019 – March 2020



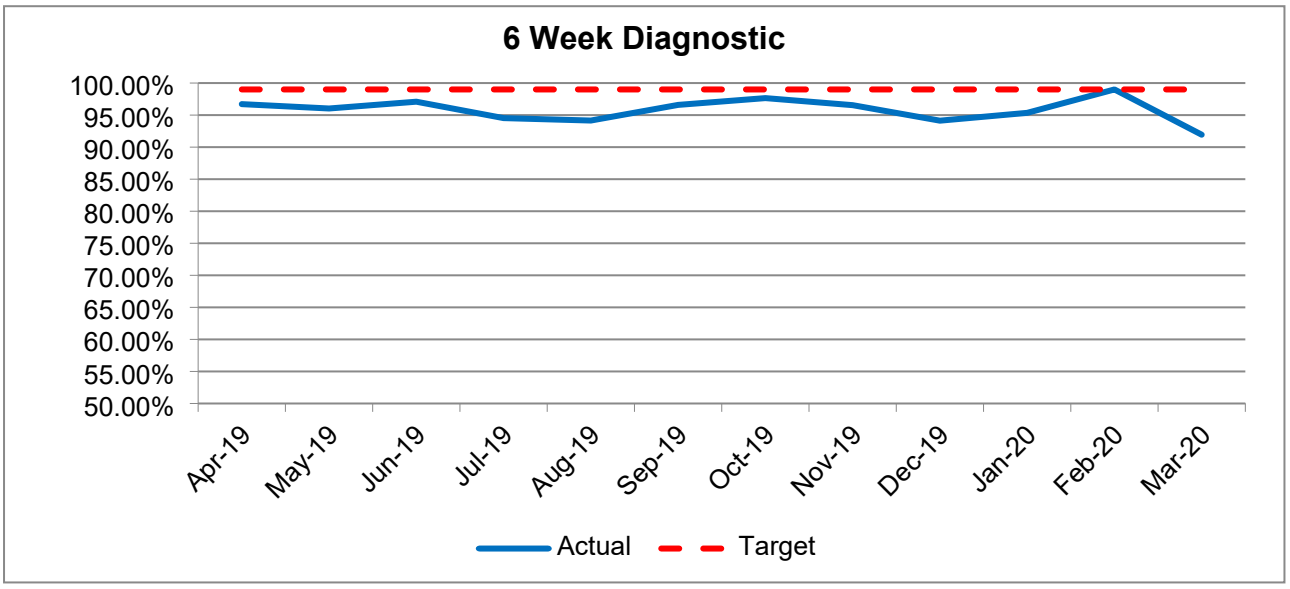
The performance for Clostridioides difficile for 2018-19 was 57 cases.

The Trust was under the allocated number for Clostridioides difficile infection.

6-week wait diagnostic procedures

This standard covers the top 15 high volume diagnostic tests. The expectation is that, at each month-end, 99% of patients waiting for these tests should have been waiting for less than six weeks.

6 Week diagnostic compliance April 2019 – March 2020



The performance for diagnostics for 2018-19 was 97.53%.

In February 2020 the Trust achieved the 99% target, however, due to COVID-19 the performance dropped in March 2020.

Actions undertaken to improve performance:

- Cardiac echoes utilised additional capacity to keep breaches to a minimum
- Urodynamics outsourced some of the procedures to the private hospital (BM)I and used the capacity across the Trust and divisions
- Urology utilised additional capacity to bring down their month-end breaches
- Neurophysiology utilised additional capacity and outsourced to reduce their month-end breaches

NHS
United Lincolnshire Hospitals
NHS Trust

ANNEX 1

OUTSTANDING CARE
personally DELIVERED

STAKEHOLDER COMMENTS

NHS Lincolnshire Clinical Commissioning Group (Lead Commissioner)

NHS Lincolnshire Clinical Commissioning Group (the commissioners) welcomes the opportunity to review and comment on the United Lincolnshire Hospitals NHS Trust (the trust) Annual Quality Account 2019 – 20.

The Quality Account provides very comprehensive information on the quality priorities that the trust has focussed on during the year including delivering a sustained reduction in HSMR (Hospital Standardised Mortality Rate). HSMR compares an organisation's actual number of deaths with their expected number of deaths, the systems implemented for reviewing mortality has enabled the trust to be in the top 25% performing trusts nationally.

Looking forward to the 2020 – 21 Quality Priorities the commissioner is pleased that the approach of maintaining a focus on patient safety is continuing whilst at the same time aligning a number of these priorities to the Lincolnshire System Quality Priorities, these include:

- The safe discharge of patients will enable the trust to support the Emergency Department by improving patient flow throughout the hospital. The trust is regularly delivering care at 92% of hospital capacity and often more than this figure in winter periods, NHSE advises that the optimum is 85%.
- Identification of the need to deliver harm free care in a repeatable way across the trust to all patients but particularly identifying deteriorating patients. The clinical management of sepsis, fluid management, compliance with the World Health Organisations Surgical Safety Checklist and communicating effectively between teams shall have a particular focus.
- Infection Prevention and Control is a building block of good healthcare and the trust is committed to achieving the hygiene code and demonstrating this compliance

The Quality Account has numerous examples of the good work undertaken by the organisation over the past year but the commissioner believes the trust launch of the Single Unified Patient Experience Reporting Board (SUPERB) which triangulates a range of patient experience metrics is particularly noteworthy.

The trust has been subject to two Care Quality Commission inspections over the past year the first inspection rated the organisation as "Requires Improvement" and the second inspection rated the Emergency Department as "Inadequate".

Whilst commissioners' are concerned at these ratings the CCG will continue to support and work with the trust to address the required improvements.

The commissioners would like to thank United Lincolnshire Hospitals NHS Trust who have worked very hard with partners in the Lincolnshire Health System during the COVID-19 pandemic to ensure patients' needs are met in this challenging time.

NHS Lincolnshire CCG looks forward to working with the trust over the coming year to further improve the quality of services available for our population in order to deliver better outcomes and the best possible patient experience.

Elizabeth Ball
Associate Director of Nursing & Quality
NHS Lincolnshire Clinical Commissioning Group

Healthwatch Lincolnshire

United Lincolnshire Hospital Trust Quality Account Statement 2019/20

Healthwatch Lincolnshire Quality Account working group: Dean Odell (Contract Coordinator), Maria Prior (Board Chair), Pauline Mountain (Steering Group Chair), Brian Wookey (Trustee), Lyndy Moulder (Trustee).

Healthwatch Lincolnshire would like to thank Bernie Gallen and Sally Seeley for presenting the ULHT Quality Account and meeting with our representatives.

Healthwatch Lincolnshire share all relevant patient experiences we receive with ULHT and thank you for responding which is generally within 20 working days. Your responses are shared in turn with the patient, carer or service user who raised the issue where possible, in many cases providing them with a level of closure they may not otherwise receive. We believe learning through patient feedback and experiences is an essential part of any service improvement.

Commentary relating to the previous year's Quality Accounts

Priority 1 – *Patient and Carer Experience*. Friends and Family Test results were not aligned with national averages, but the comments are being used to implement improvements in services. Healthwatch Lincolnshire would encourage the trust to embed a culture of using patient experience to drive improvement.

Priority 2 – *Recommended as a place to work*. We recognise this priority was suspended and superseded by the launch of the Integrated Improvement Plan (IIP).

Priority 3 – *Ensuring Effective Systems for Reviewing Mortality*. This priority was met, and we welcome the initiation of the Mortality Assurance Learning Strategy (MorALS) Group once the Trust begins the recovery stage.

Priority 4 - *Cared For In The Right Place At The Right Time*. Respiratory Patients – This priority met 5 out of the 6 areas. It did not meet the target of Non-Invasive Ventilation (NIV), however, the Trust has included the NIV pathway within this year's priorities and we hope learning from last year has been taken on board.

Priorities and challenges for the forthcoming year

Priority 1 – *Care of Respiratory Patients*. the current measures of success include the review of a number of processes and clinical pathways. Healthwatch Lincolnshire would like to see the inclusion of more outcome focused measures of success for this priority.

Priority 2 – *Safe discharge of our patients*. Over the last few years Healthwatch Lincolnshire has highlighted safe discharge as an area of concern and we are aware that this is something ULHT have been working on improving for some time but with limited effect. Improved system working across health and social will be required to meet this priority. Healthwatch as a national network are looking to focus some work into hospital discharge this year, and as the local Healthwatch we will feed information gathered into this initiative both locally and nationally.

Priority 3 – *Care of the deteriorating patient*. We welcome the recognition that the current care is sub-optimal but there is little detail around how this will be achieved in practice.

Priority 4 – *Delivering harm free care*. Considering the high number of Never Events in 2019/20, we welcome the inclusion of this priority. However, there is not much evidence as to how success will be achieved. We would also urge the Trust to include zero Never Events as a desired outcome for this priority in these Quality Accounts. We would also encourage the inclusion of 'always' events, things that should always be done 100% of the time.

Priority 5 - *Infection Prevention and Control*. There are 150 items on IPC list. Have we assurances that there will be compliance for each one? We welcome the inclusion of your action plan with monthly milestones.

Healthwatch Lincolnshire, in our Watchdog role, plan to benchmark your five 2020/21 priorities during the coming year against patient and carer feedback. As part of this process we will be inviting ULHT to provide periodic performance updates against them. We believe this approach will help to bring more relevance and support to our involvement in responding to future Quality Accounts.

We welcome the various work streams and priorities for 2020/21 and see the potential for much improved partner working across many of the priorities, including 'Safe Discharge of Patients' and increasing implementation of the ReSPECT process. We strongly believe that partnership working with other providers such as patient transport, primary care and care homes can only improve the quality of care for patients across the whole of health and social care.

Healthwatch Themes and Trends for ULHT – The last 12 months

The sentiments below are shared to give example of service-related comments.

- General lack of communications in relation to: -
  - Appointments being cancelled without reason
  - Results not being sent to patients GP surgeries, either in a timely manner or at all, patients having to chase these
  - Medication changes not being sent to GP surgeries, resulting in delays in patients getting new medication
  - Lack of communication between departments (information not passed on resulting in anxiety for patients/families)

- Patients told us about their mixed experiences with A&E, many commented they felt they were treated with respect and found the staff most helpful, however others experienced the opposite.

- There were also several comments that stated patients felt well cared for during their stay in a ULHT hospital in different departments.

- During the COVID-19 outbreak many patients felt there could be more information provided around their appointments being cancelled. Patients understand the necessity for this but feel they have been left with little or no further communication. A helpline would be useful for each speciality so patients could make contact should they need any advice or guidance in their situation.

Healthwatch Lincolnshire appreciates and supports the honesty in the Quality Accounts where the Trust identifies there is still much more work that needs to be done as they remain in quality and financial special measures. Healthwatch Lincolnshire continue to have concerns around cancer services and A& E performance. Healthwatch Lincolnshire is here to support these improvements with the inclusion of learning from patient experience.

Finally, we consider our relationship with ULHT is very positive and look forward to continued engagement with the Trust in the coming year.

Lincolnshire COUNTY COUNCIL Working for a better future	HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE

Statement on United Lincolnshire Hospitals NHS Trust's *Quality Account* for 2019/20

This statement has been prepared by the Health Scrutiny Committee for Lincolnshire.

Covid-19

The impact of covid-19 on the whole Trust is of course unprecedented, although the peak of activity was after the end of the quality account year. The Committee would like to record its thanks to all the staff, who have continued to provide services during the most challenging period in the history of the NHS. The Trust is to be commended in ensuring that stocks of personal protective equipment have remained available for staff during the pandemic.

Progress on Priorities for Improvement for 2019-20

The Committee welcomes the Trust's progress on the four priorities for improvement for 2019-20, which are considered in turn: -

- *Priority 1 – Patient and Care Experience* – Six of the seven actions have been achieved, which is welcome and the continued work to improve patient feedback data is noted.
- *Priority 2 – Organisation as a Place to Work and be Treated* – All actions have been achieved, which is commended, and the consolidation of this work in the integrated improvement plan is noted.
- *Priority 3 – Effective Systems for Reviewing Mortality* – All actions have been again been achieved. The planned launch of the mortality assurance learning strategy group during the Trust's recovery phase is noted.
- *Priority 4 – Improving Care and Treatment for Respiratory Patients* – Five of the six actions have been achieved and the inclusion of the non-invasive ventilation pathway in the 2020-21 priorities is supported.

Priorities for Improvement for 2020-2021

We support the selection of the five priorities for 2020/21.

- *Priority 1 – Care of Respiratory Patients* – The Committee understands this priority applies to all patients, including those affected by covid-19 and will build in previous work in response to the *Getting It Right First Time* improvements.
- *Priority 2 – Safe Patient Discharge* – The rationale for focusing on the safe discharge of patients, including improving 'patient flow' through the hospitals, is accepted, and progress on this priority would be welcome.
- *Priority 3 - Care of the Deteriorating Patient* - Prompt diagnosis and treatment of sepsis is key to delivering improved care for patients in this category.
- *Priority 4 – Harm Free Care* – Ten 'never events' during 2019-20 is much higher than usual, so all actions to eliminate never events are a key priority.
- *Priority 5 – Infection Prevention and Control* – Improving compliance against the hygiene code is supported.

Care Quality Commission

The Care Quality Commission (CQC) suspended most of its inspection activities in March 2020 and it is not yet known when these will fully resume. There are some outstanding actions for the Trust from previous CQC reports, and again the Committee is unsure when the CQC will begin its follow-up activities. As noted previously, poor CQC ratings can impacts on staff morale; and recruitment and retention. The Trust's continued status of being in special measures for its care, as well as for its finances, will be considered by the Committee in the coming year, as part of updates on the Trust's progress with its integrated improvement plan.

Reducing Harm from Pressure Ulcers

The Committee congratulates the Trust on the significant reductions in the number of category three and four pressure ulcers, with only one of the latter recorded during 2019/20.

Engagement with the Health Scrutiny Committee for Lincolnshire

During 2019-20, frequent engagement with the Health Scrutiny Committee for Lincolnshire has continued. This has included during the summer of 2019 attendance by clinicians at the Committee as part of the presentations on the *Healthy Conversation 2019* engagement exercise, which provided the Committee with a deeper understanding of the rationale for each preferred option.

We look forward to continued engagement with the Trust's senior managers in the coming year. This will be particularly important as the Trust, together with the rest of the local NHS,

balances the challenges of responding to covid-19 with restoring care and treatment to non-covid-19 patients.

Workforce Challenges

The Committee understands that recruiting and retaining staff is continuing to be an issue for the Trust. There are also challenges with the staff being transferred from one hospital to another to support the restoration of services. Communication with staff is paramount so that they are involved in developments, whether long term or temporary.

Grantham Accident and Emergency

The closure of Grantham A&E overnight from August 2016 has been a longstanding concern for the Committee. During the last year, the Committee has sought information on the impact of this continued closure on the waiting times at other A&Es, for example at Lincoln County Hospital, as this will need to be taken into account in the eventual consultation on its future.

Although outside the quality account year, the conversion of Grantham A&E into an urgent treatment centre in June 2020 on a 'temporary' basis has led to further concern. The Committee's position is that consultation on the long term future of Grantham A&E should take place as soon as possible.

Presentation of the Document

We are again pleased to see a clear indication as to whether the success measures for each action supporting each priority have been achieved. We also welcomed the opportunity to provide direct feedback on the presentation of information in the draft quality account, particularly on how the priorities for 2020/21 are set out.

Conclusion

The Committee is grateful for the opportunity to make a statement on the draft Quality Account. The Committee looks forward to progress with the five quality improvement priorities in the coming year and will continue to seek to engage the Trust at its meetings.

Explanation of changes from stakeholder feedback

Summary of changes made in receipt from NHS Lincolnshire East Clinical Commissioning Group (Lead Commissioner)

No changes required

Summary of changes made in receipt from Health Scrutiny Committee for Healthwatch Lincolnshire

Respiratory priority: Outcome measures have been included within this priority.

Care of the deteriorating patient: Greater detail has been added to this priority.

Delivering harm free care priority – there was a request to have zero surgical Never Events, which has been included.

Summary of changes made in receipt from Health Scrutiny Committee for Lincolnshire

The Committee requested design changes to the 2020-2021 priorities which were made.

NHS
United Lincolnshire Hospitals
NHS Trust

ANNEX 2

OUTSTANDING CARE
personally DELIVERED

STATEMENT OF DIRECTORS' RESPONSIBILITIES

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS trust boards on the form and content of annual quality account (which incorporate the above legal requirements) and on the arrangements that NHS trust boards should put in place to support the data quality for the preparation of the quality account.

In preparing the quality account, directors are required to take steps to satisfy themselves that:

- The content of the quality account meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2019-20 and supporting guidance; Detailed requirements for quality account 2019-20;
- The content of the quality account is not inconsistent with internal and external sources of information including;
- Board minutes for the financial year, April 2019 and up to 4th June 2020 ("the period");
- Papers relating to quality reported to the Board over the period April 2019 to the date of signing this statement;
- Feedback from the Commissioners Lincolnshire East Clinical Commissioning Group on behalf of the Lincolnshire Federated Quality Function dated 9th July 2020;
- Feedback from local Healthwatch organisations Healthwatch Lincolnshire dated 24th July 2020;
- Feedback from the Overview and Scrutiny Committee, Lincolnshire County Council Health Scrutiny Committee dated 14th July 2020
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 2018-19;
- The latest national patient survey, CQC Survey Coordination Centre Maternity Care Pathway Reports: antenatal care, dated January 2019;
- The latest national patient survey, CQC Survey Coordination Centre Maternity Care Pathway Reports: labour and birth, dated 2019;
- The latest national patient survey, CQC Survey Coordination Centre Maternity Care Pathway Reports: postnatal care, dated 2019;

- The latest national patient survey, CQC Survey Coordination Centre Patient Survey Report, dated 2019;

- NHS England National Cancer Patient Experience Survey, published 25th June 2020;

- The latest national and staff survey, Survey Coordination Centre, United Lincolnshire Hospitals NHS Trust, NHS Staff Survey Benchmark Report dated 2019;

- Care Quality Commission inspection, CQC Pilgrim Hospital Quality Report, Inspection dated 17th October 2019.;

- Care Quality Commission United Lincolnshire Hospitals NHS Trust Inspection Report, dated 17th October 2019;

- The Head of Internal Audit's draft annual opinion over the Trust's control environment dated 16th June 2020; and

- Minutes of the Quality Governance Committee Meetings May & September 2020;

- The quality account presents a balanced picture of the NHS Trust's performance over the period covered;

- The performance information reported in the quality account is reliable and accurate;

- There are proper internal controls over the collection and reporting of the measures of performance included in the quality account, and these controls are subject to review to confirm that they are working effectively in practice;

- The data underpinning the measures of performance reported in the quality account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and

- The quality account has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the quality account.

- The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality account.

By order of the board

Andrew Morgan

.....
Chief Executive Officer

Elaine Baylis

.....
Chair, Trust Board

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

Purpose	This report summarises the assurances received and key decisions made by the Workforce and OD Assurance Committee. The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board. This assurance committee meets monthly and takes scheduled reports according to an established work programme. The Committee worked to the 2020/21 objectives. The Trust are in the 'Restore' phase in response to Covid-19, the meeting was held via Microsoft Teams with a reduced agenda to focus on key priorities.
Assurances received by the Committee	**Assurance in respect of SO 2a** **Issue: A modern and progressive workforce** **Workforce Strategy Group** The Committee received a verbal update regarding the group and the intent for the group to be integrated with the Committee Performance Dashboard in order to review the data, consider issues of variance and risk in order to upward report to the Committee and provide assurance. The Committee were advised that the group would be reinstated following the reduction of the incident level and groups established during Covid-19 would be reviewed. The group would seek to address workforce issues arising from recovery planning and would lead in to the planning for 2021/22. Reporting to the Committee would commence in September and would reflect the concerns and issues raised by the Committee regarding the performance dashboard.

	Safe Staffing The Committee received the new report and noted the continued increase of temporary staffing, there had been consistent Bank Staff use throughout Covid-19 however an increase in agency usage had been seen. Establishment reviews were well underway with three quarters completed. There had been some success in negotiating a reduction in agency costs and adjustments to tiers had been made. Nursing fill rates remained lower than required and the Committee were advised that the Trust should be working to a 95% fill rate. Staffing levels would be triangulated with serious incidents and red flags in order to identify how workforce triangulated with patient safety risks. **Implementation of the Doctor Support Role during Covid-19** The Committee were advised of the innovation from Covid-19 due to the use of medical students within new and innovative roles within the Trust. Students had been employed at a Band 2 in to a Doctor support role which allowed the development of skills and confidence. Positive feedback had been received from those students who had taken up the role. Due to the positive feedback the Trust were now considering how a role could be established that would provide a route in to a medical profession. This would require building in to the Trust's workforce plan. The Committee supported the recommendation to develop the pilot further due to the positive impact of the role, noting that this also supported the Trust's objective to achieve teaching hospital status. **Band 4 and TNA top up** The Band 4 and TNA top up was presented to the Committee to seek support for onward presentation to the Trust Leadership Team. The Trust were looking to support Band 4 members of staff within the Trust who wished to further develop their careers. Staff would be supported through an apprenticeship framework and as such would

	need to remain employed and supported by the Trust. The preferred options proposed ensured that there would be no financial disincentive to staff to progress. A commitment had been made through the Trusts workforce planning to support staff through the development pathway. These options had been supported by the Nursing, Midwifery and AHP forum. The Committee raised concerns regarding the impact on divisional finances as these posts would be funded from divisional budgets. The Committee questioned if it would be possible to 'lock' staff in to the Trust for a period of time post completion of training to ensure that benefits were realised. The Committee supported the recommendations made for onward reporting to the Trust Leadership Team to seek approval.
	Assurance in respect of SO 2b **Issue: Making ULHT the best place to work** **NHS People Plan** A gap analysis for the NHS Plan compared to the Trusts Integrated Improvement Plan (IIP) had been presented, and the identified gaps were to be considered by the Executive Team for inclusion in the current or future years IIP as appropriate. There had been a number of changes since the draft plan had been received including shortened timescales. The Committee were advised that the themes remained the same however there had been a marked change to reflect experiences through Covid-19 and strengthened inclusivity. A gap analysis of the Trust's existing plan would be undertaken and where required development of the plan would take place. The Committee noted areas requiring further detail including flexible working and retire and return. The Committee noted the intention to add to the People Promise and to set the context of programmes of work through the Integrated Improvement Plan.

	The Committee welcomed the analysis of the plan and work due to be undertaken.
	Assurance in respect of other areas: **Board Assurance Framework** The Committee received the BAF noting the content and RAG ratings that had been provided. The Committee had reviewed the narrative and ratings within the BAF against the discussions held, agreeing that the content of the BAF was an accurate reflection of the current position. **Committee Performance Dashboard** The Committee received the performance dashboard noting the improvement of the vacancy rate position, this had however not yet impacted on agency spend. The sickness position of the Trust had been complicated due to Covid-19 due to the significant number of staff off work due to Covid-19 related reasons. The Trust were working through bringing staff back to work. The launch of the attendance management system was expected to allow improved reporting for sickens and to support managers to hold better conversations with staff. The Committee noted the risks within the report and requested that an exception report for the top areas of risks be provided to the Committee.
Issues where assurance remains outstanding for escalation to the Board	None
Items referred to other Committees for Assurance	None
Committee Review of corporate risk register	The committee received the risk register noting the risk of numbers of EU staff who had resigned from the Trust. Further work was being undertaken to support staff with the settlement scheme as a result of

	Brexit. The Committee noted that most risks were driven at a divisional level and would be explored through Performance Review and Financial Review meetings to provide better scrutiny.
Matters identified which Committee recommend are escalated to SRR/BAF	No areas identified
Committee position on assurance of strategic risk areas that align to committee	No areas identified
Areas identified to visit in ward walk rounds	No areas identified

Attendance Summary for rolling 12 month period

Voting Members	**A**	**S**	**N**	**D**	**J**	**F**	**M**	**A**	**M**	**J**	**J**	**A**
Geoff Hayward (Chair)	No meeting	X	X	X	X	A	A	No meetings held due to Covid-19			X	X
Sarah Dunnett		X	X	A	X	X	X				X	X
Non-Voting Members												
Martin Rayson		X	X	X	X	X	X				X	X
Matthew Dolling		A	A									
Debrah Bates												
Simon Evans		X	X	A	A	A	D				X	D
Victoria Bagshaw		X	X	X	X	X						
Karen Dunderdale							A				X	X

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*1st September 2020*
Item Number	*Item 9.2*
Director of Nursing Safe Staffing Report	
Accountable Director	*Dr Karen Dunderdale, Director of Nursing*
Presented by	*Dr Karen Dunderdale*
Author(s)	*Debrah Bates, Deputy Director of Nursing*
Report previously considered at	*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	
3b Efficient use of resources	X
3c Enhanced data and digital capability	
4a Establish new evidence based models of care	X
4b Advancing professional practice with partners	
4c To become a university hospitals teaching trust	

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

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

Executive Summary

June has been a challenging month in respect of staffing due to a number of factors including a staged reintroduction of normal elective activity whilst continuing to manage patients affected by the COVID Pandemic, the need to introduce both green and blue pathways of clinical care across our two main hospital sites, the temporary change of the Grantham Hospital activity to that of a green site and a continued vacancy position overlaid with sickness.

This resulted in an increase in the usage of temporary staffing levels to that of pre-Pandemic levels. This has been the continued focus of the twice daily workforce safeguard meetings which was introduced throughout the Pandemic which takes an overall view of staffing across sites and services in order to provide the necessary actions and assurance that nursing levels are safe across our areas.

Recruitment figures have remained static in recent months, which could be in part, down to the Pandemic. Overseas recruitment has recommenced in July, and the first cohort of overseas nurses are due to land in the UK at the end of August.

The extended clinical placements offered to our student nurses who are due to qualify in August/ September have continued. 80 students have accepted jobs within the Trust when they register with the NMC.

MONTHLY NURSE STAFFING and WORKFORCE REPORT

1. PURPOSE OF REPORT

This is the newly developed monthly report which will be reported to the People and OD Committee. The report is being presented at a time when wards and departments are returning back to business as usual following significant changes that have been invoked through the COVID19 Pandemic. As such, this inaugural report will make reference to some trend analysis but only time will tell to what the full impact of the Pandemic will have on services going forward.

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

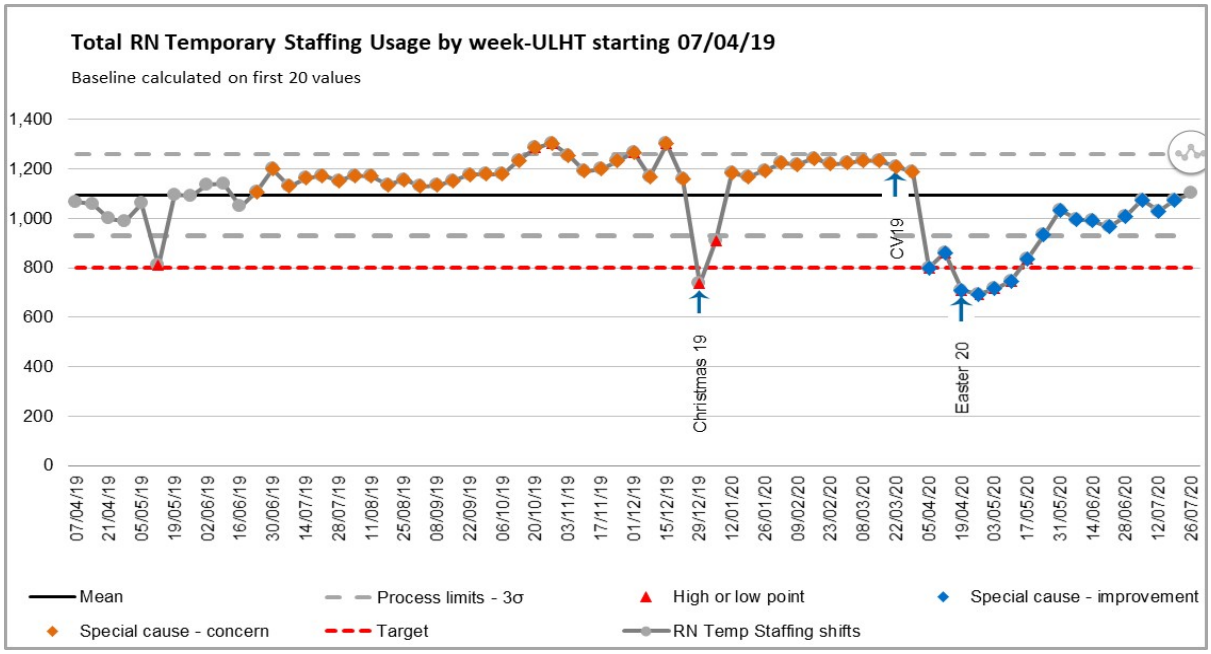
The Trust is committed to providing safe, effective, caring, responsive and well led care that meets the needs of our patients. It is recognised that decisions in relation to safe clinical staffing require a triangulated approach which consider Care Hours per Patient Day (CHPPD) together with staffing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

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

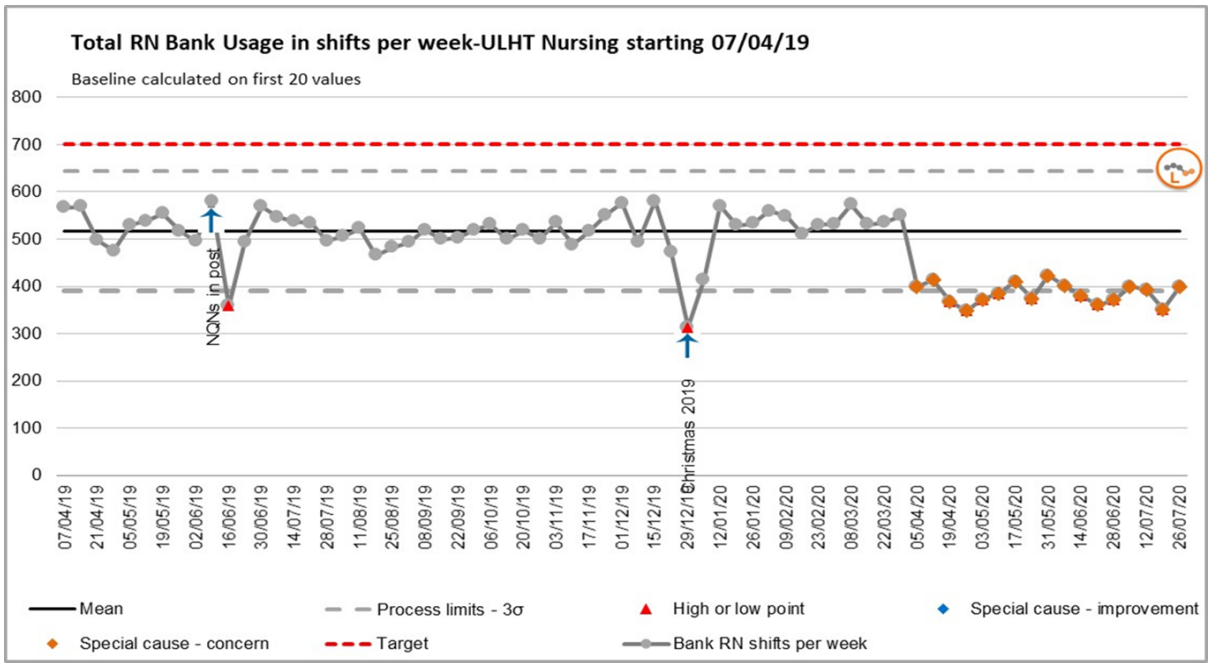
2. PROGRESS UPDATE

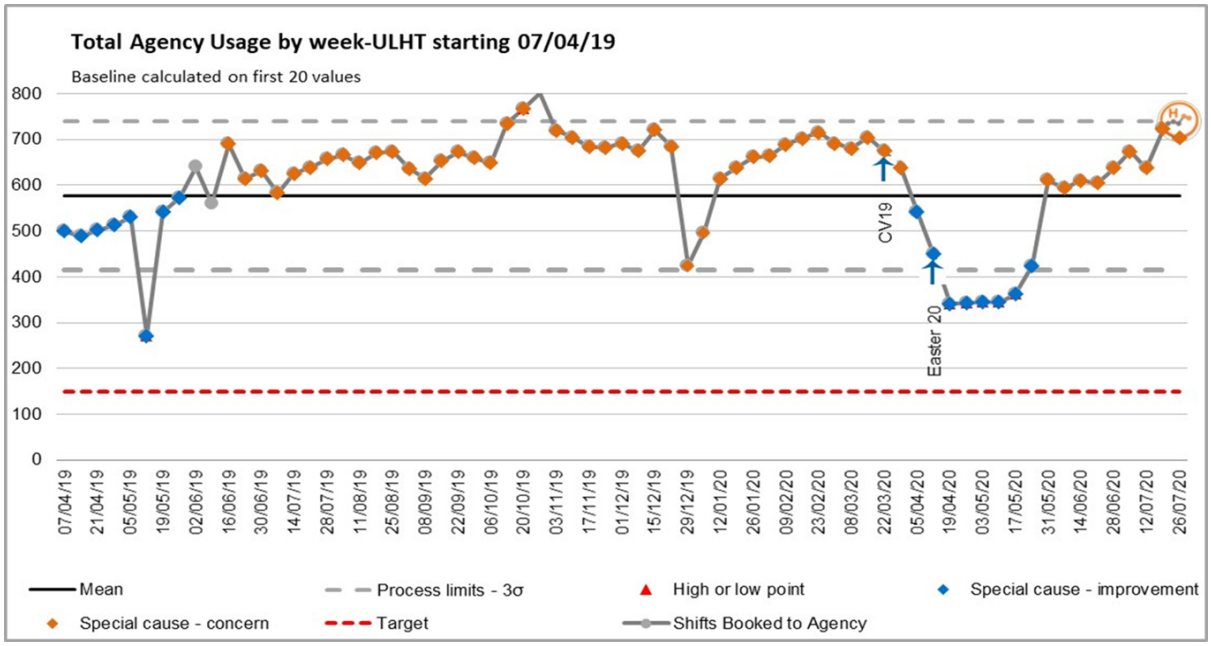
2.1 Temporary Staffing

The use of temporary staffing to maintain safe staffing levels across the Trust has continued to increase significantly since the lowest usage rates which were seen at the height of the Pandemic in April 2020, and is nearing pre-Pandemic levels. This is being addressed with high priority through the Nursing Workforce Transformation Programme (NWTP) and at the twice daily staffing safeguards meetings that have been introduced since the outset of the Pandemic. At both of the forums, Divisions are rigorously challenged on their agency usage and are required to take accountability of other actions that increase agency usage, such as efficient rostering practice and robust recruitment plans.



Temporary staffing is made up of both bank and agency staff. In reviewing the temporary staffing figures further, it is clear that the use of bank has remained low and more static both pre and throughout the Pandemic, whilst agency usage has continued to climb.





The ratio of bank to agency usage continues to be around 40%:60%, a position that has not changed since May 2019 and as such cannot be attributed to the Pandemic. With this in mind, the Bank systems and processes are currently under review and are expected to be refreshed and relaunched in September 2020. The bank incentive schemes are also currently under review, with the aim of looking to attract more staff to join the bank and book shifts, which would ultimately replace the need for the more expensive use of agency nurses. The aim being to flip the current ratio of bank to agency staff usage to that of 60% of temporary staffing shifts being booked through bank and 40% through agency.

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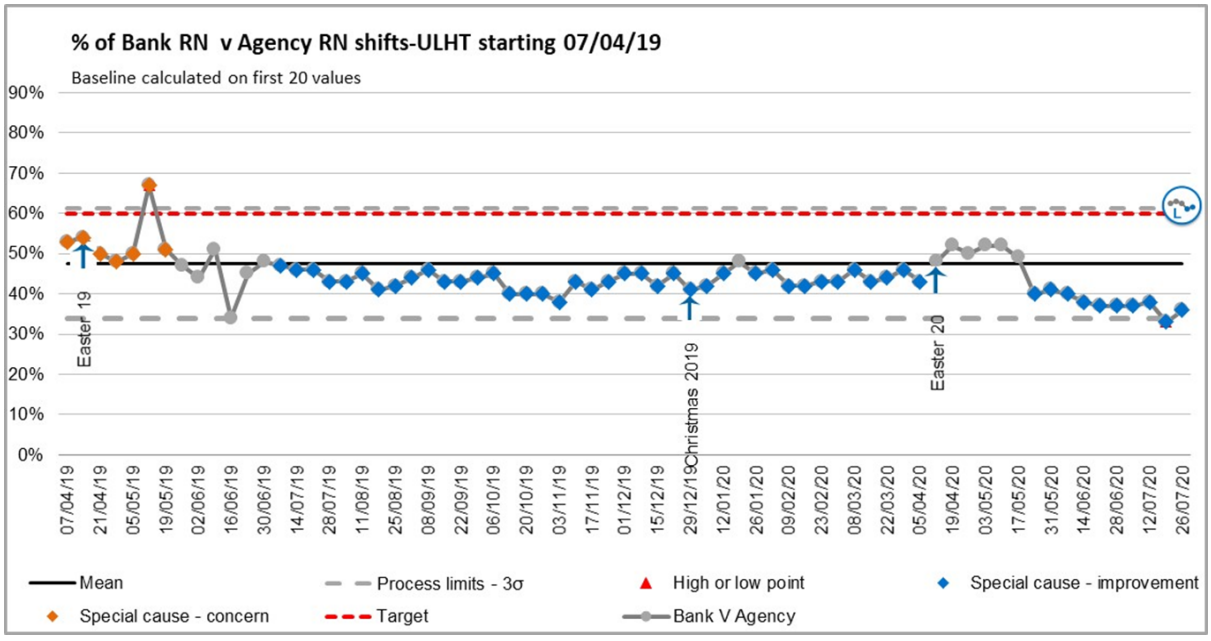
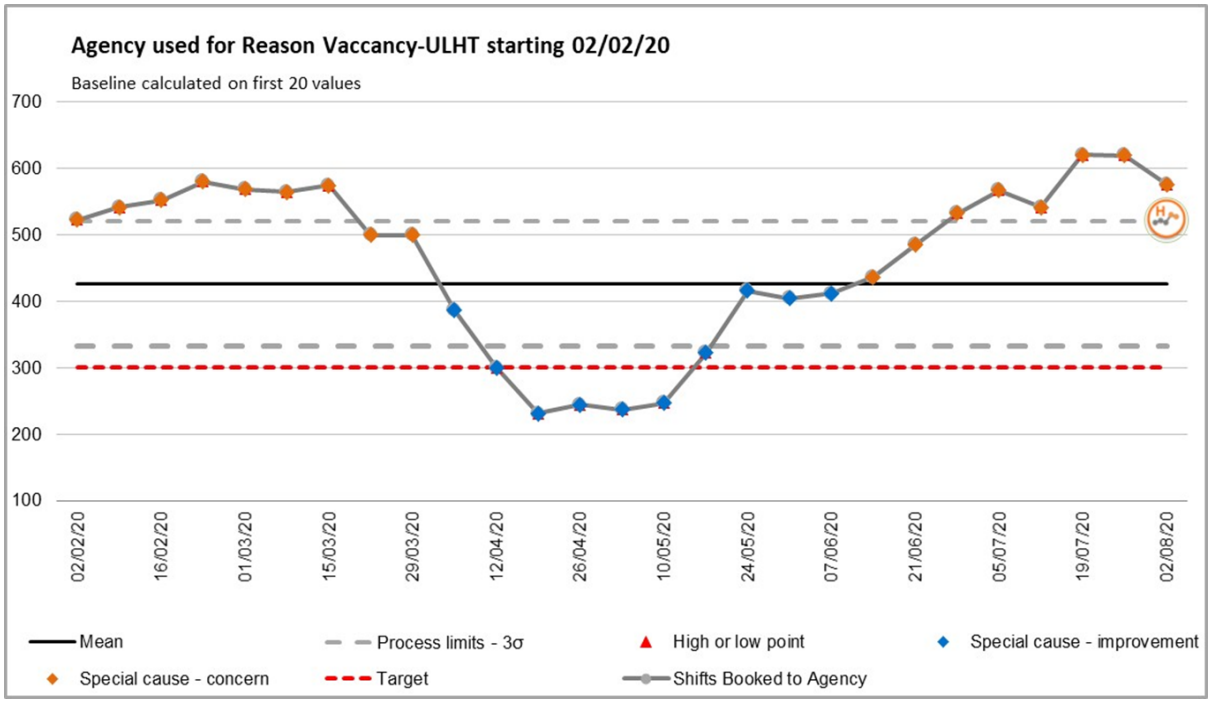


The top four reasons for temporary staffing usage during July 2020 were;

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

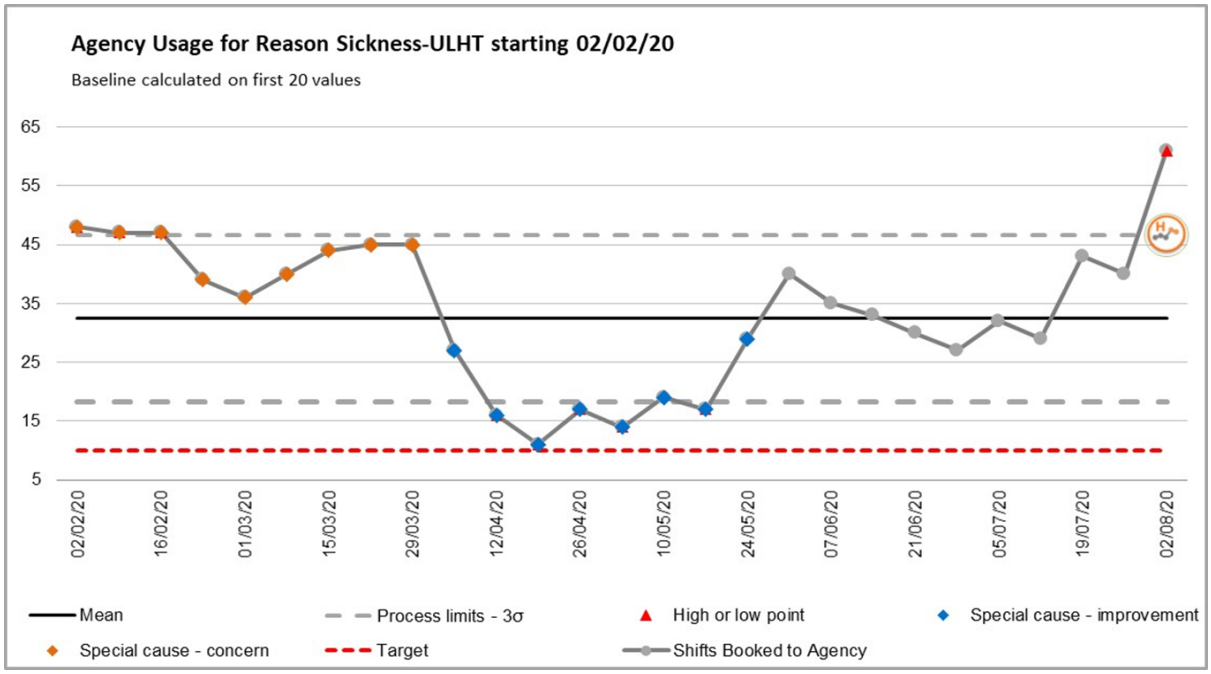
However, the trend of agency usage attributed to vacancy as a reason for usage appears to have increased since May 2020, yet the vacancy rate does not appear to have increased by the same margin. This suggests that some of the agency attributed to vacancy, may not be the correct reason identified.

It is worth noting that the number of agency shifts booked for the purpose of covering vacancy, should decrease once the student nurses gain their NMC registration.



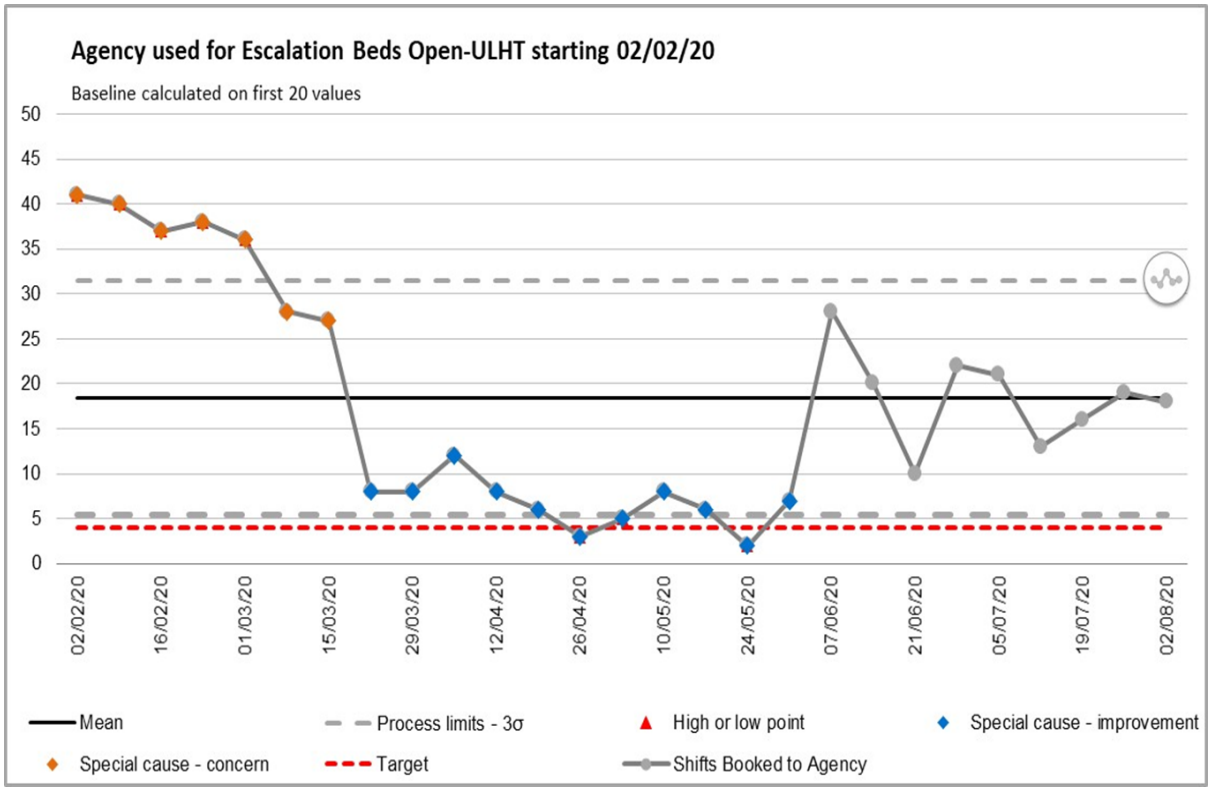
The use of agency bookings attributed to sickness as a reason, is increasing. This may be indicative of a workforce that is suffering the consequences of the Pandemic.

It is also noted that some areas need to be reminded that 4% sickness is built into budgeted establishments. This means that areas where sickness is less than 4% could be able to absorb shifts without the need for temporary staffing. This is another issue that will be picked up through a focus on rostering practice which is an action coming out of the discussions at the NWTP.



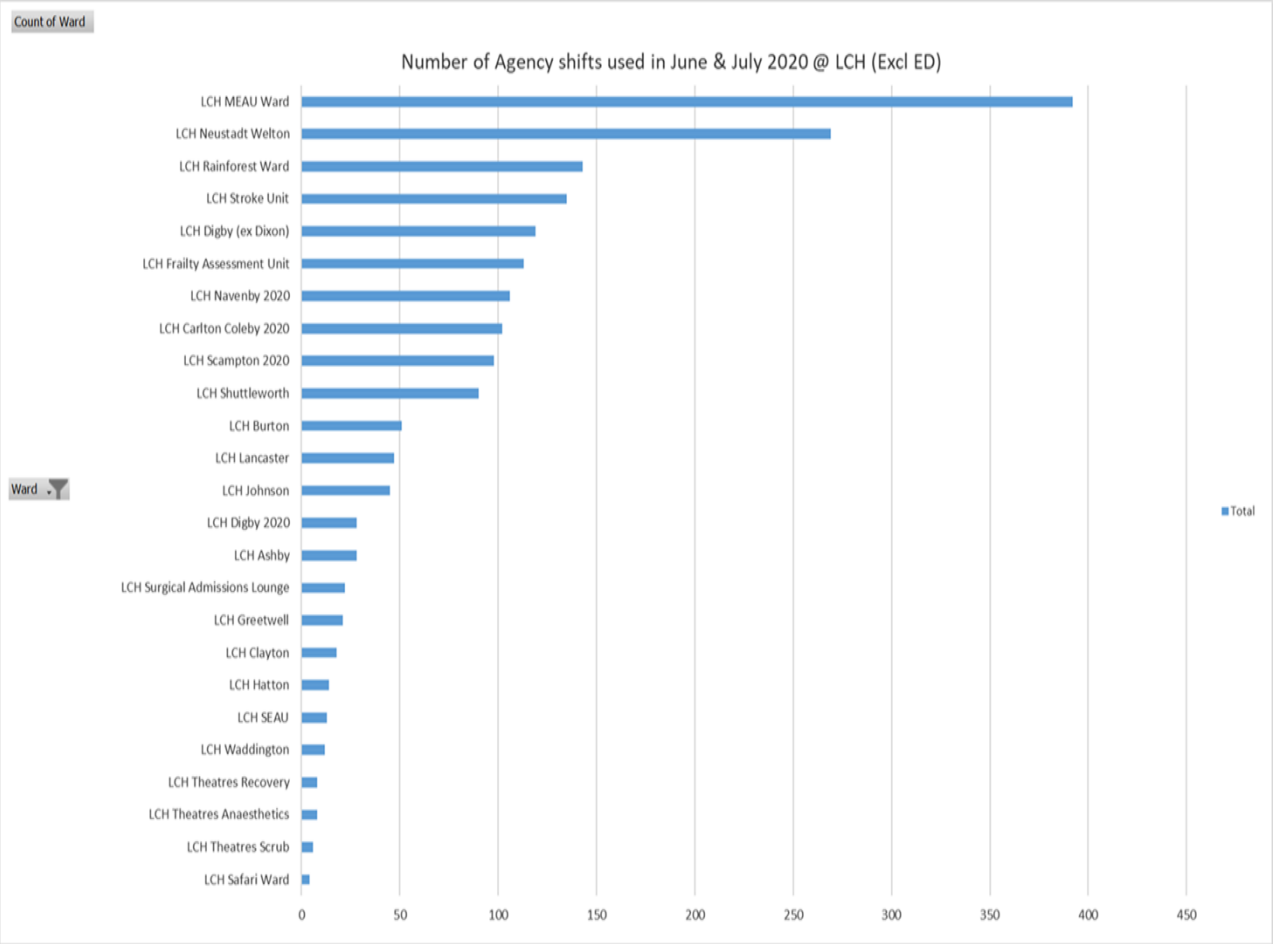
The use of agency shifts for staffing escalation beds fell to low levels at the height of the Pandemic, in line with the overall reduction in bed occupancy that was noted throughout the Trust at the height of the Pandemic.

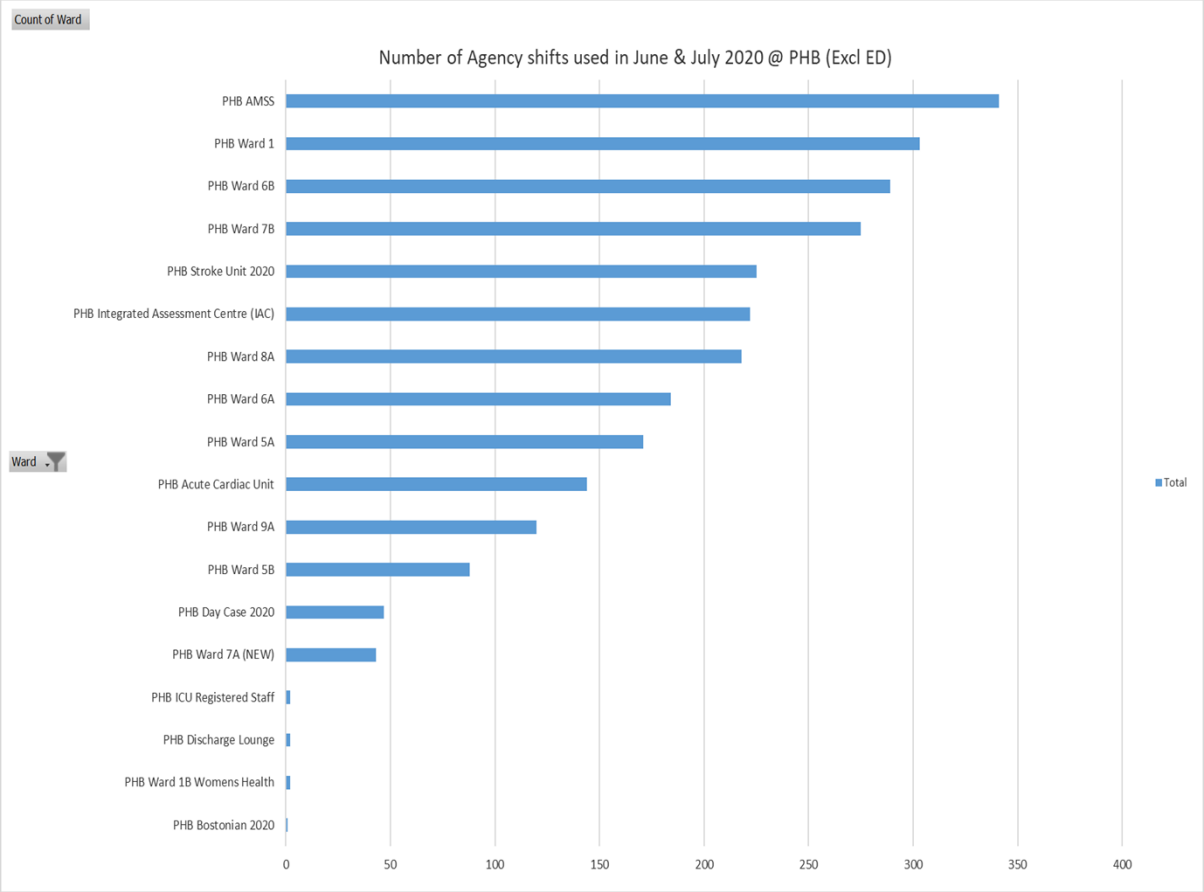
However, this has seen an increase since June, and may be attributed to the re-introduction of green pathways and the need to open escalation beds to ensure the green pathways are adequately staffed and patients protected.



The highest users of agency nursing across the Trust are both Emergency Departments at Lincoln and Pilgrim, this is a direct result of high vacancy levels in both departments. The other high agency users are listed below for both Lincoln and Pilgrim sites.

Grantham has been an agency free site since the onset of the Pandemic.





As well as reducing the volume of agency nurse shifts being booked, significant effort has been taken to reduce the hourly rate of pay for an agency nurse, avoiding at all costs, the most expensive off –framework agency shifts where ever possible.

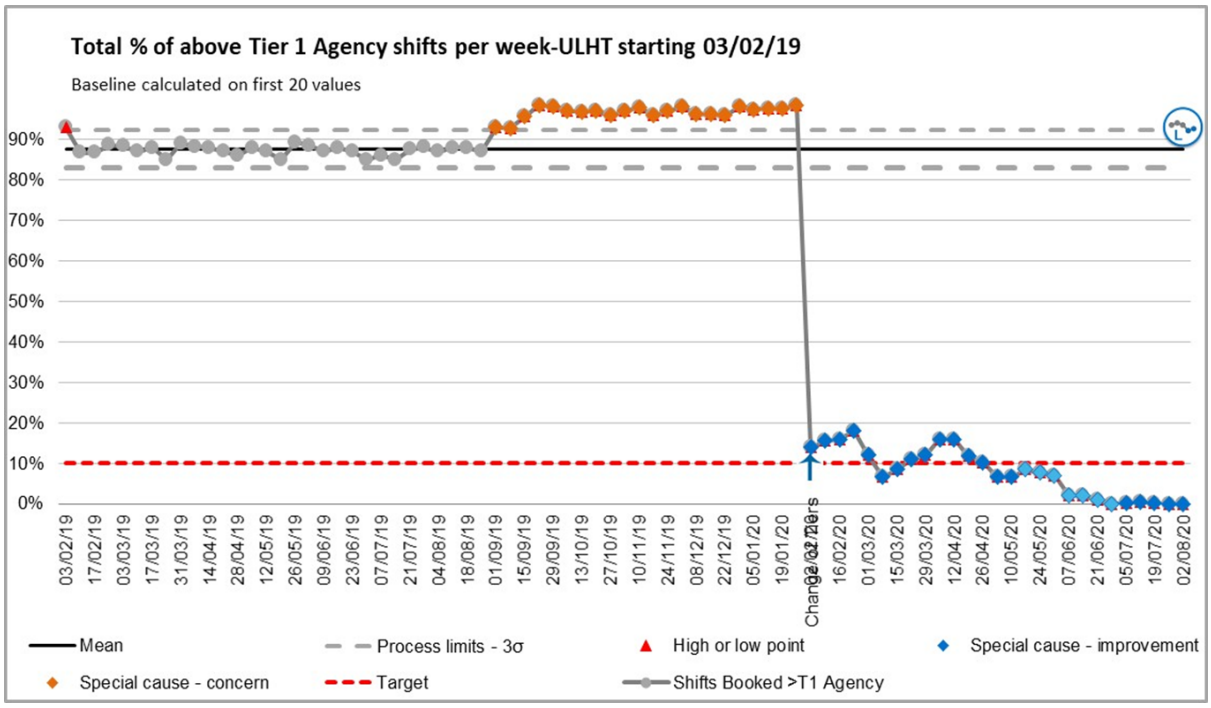
The Trust has been successful in negotiated a rate reduction from 3 of our volume suppliers from the 3rd August with an agreement in principle to further reduce in October 2020. This has led to the following

- Creation of a new Tier1 (which is not exclusive to these 3 suppliers) for any of our current suppliers who are willing to drop their rate in line with the above.
- A move from 21 days' notice on shifts to 24 days' notice for new Tier1 suppliers with the aim of giving them the competitive advantage over any agency who does not agree to the rate reduction. These will be considered Tier2.
- Some level of protection from cancelations for Tier1 suppliers as a focus will be made on cancelling Tier2 agency shifts and above as appropriate
- All supplier who do not agree to a rate reduction will move to the Tier2 list and will remain on 21 days' notice.

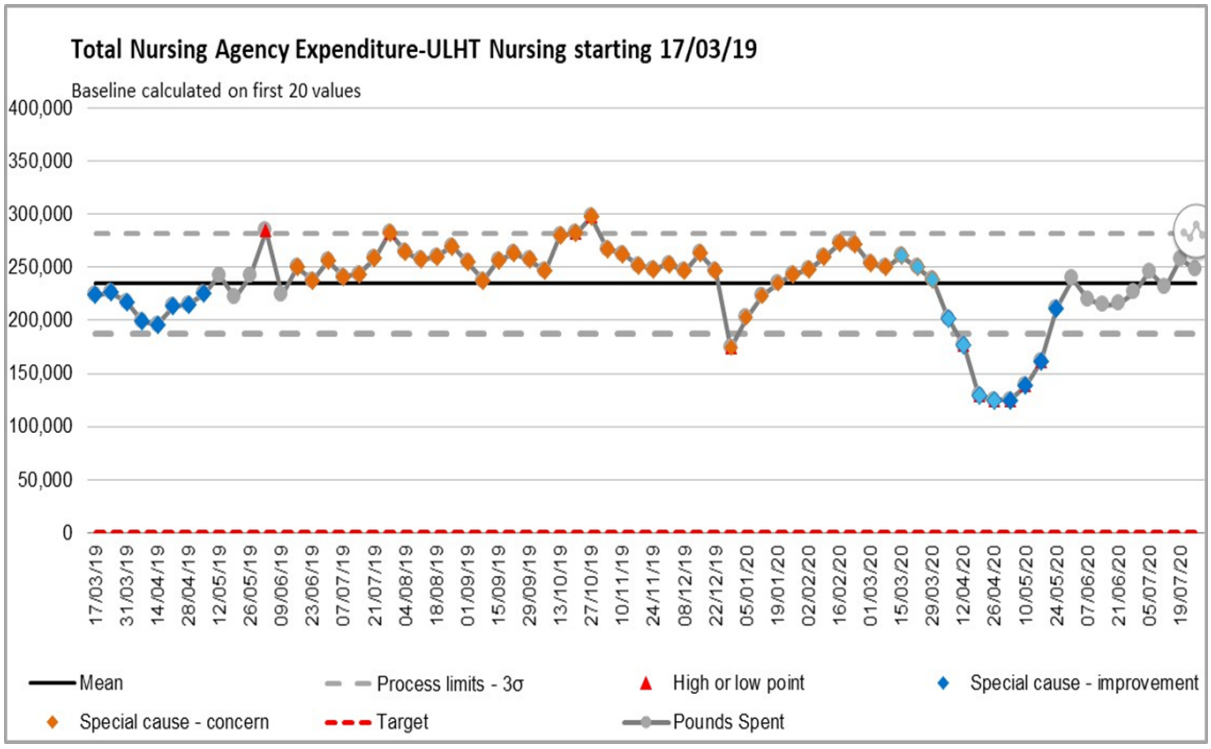
This alone has the potential to yield the following results

Approximate Weekly Saving based on Current supply					
Shifts	Hours	Adv Rate Reduction	Weekly Saving	Monthly Saving	Projected Yearly Saving
300	3600	£1.24	£4,464.00	£17,856.00	£214,272.00

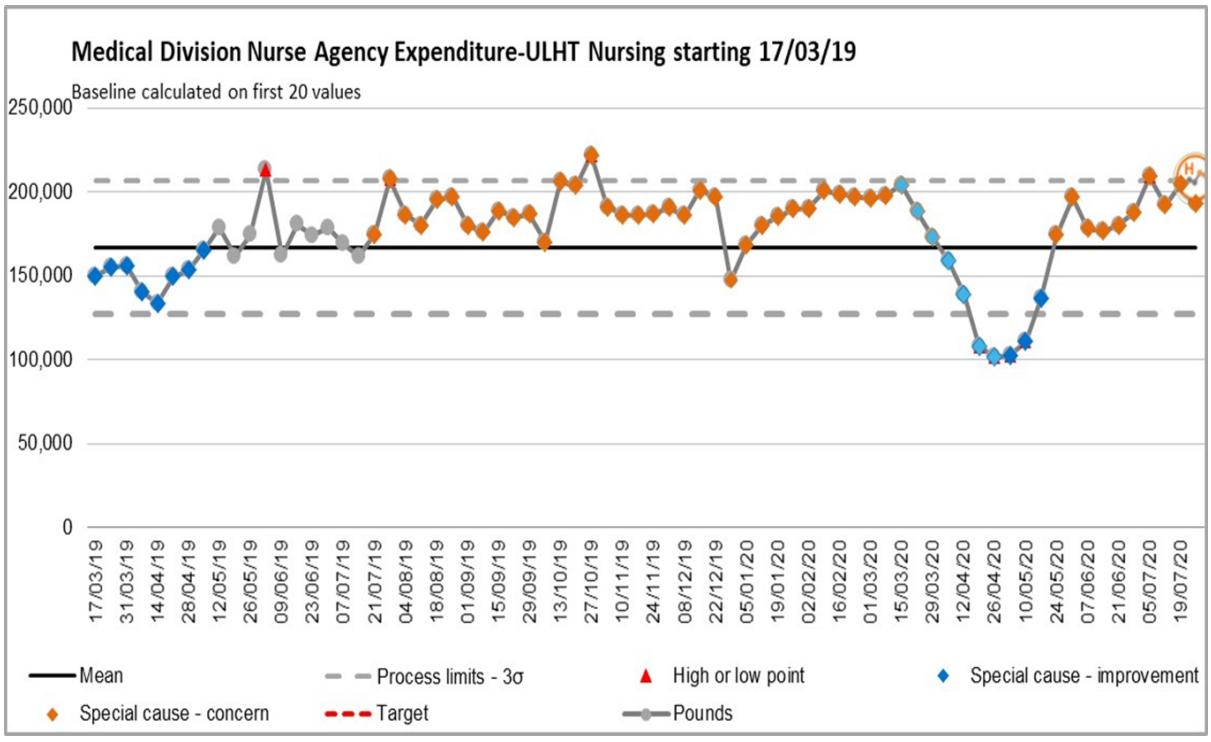
The agency usage by tier demonstrates a positive trend in reducing the percentage of shifts that are being used from Tier 2 agency and can be seen below.



The overall agency bill has seen a massive reduction through the Pandemic, as both volume and cost was reduced. This now appears to be increasing again which is cause for concern and is being closely monitored through the NWTP and plans to mitigate this developed.

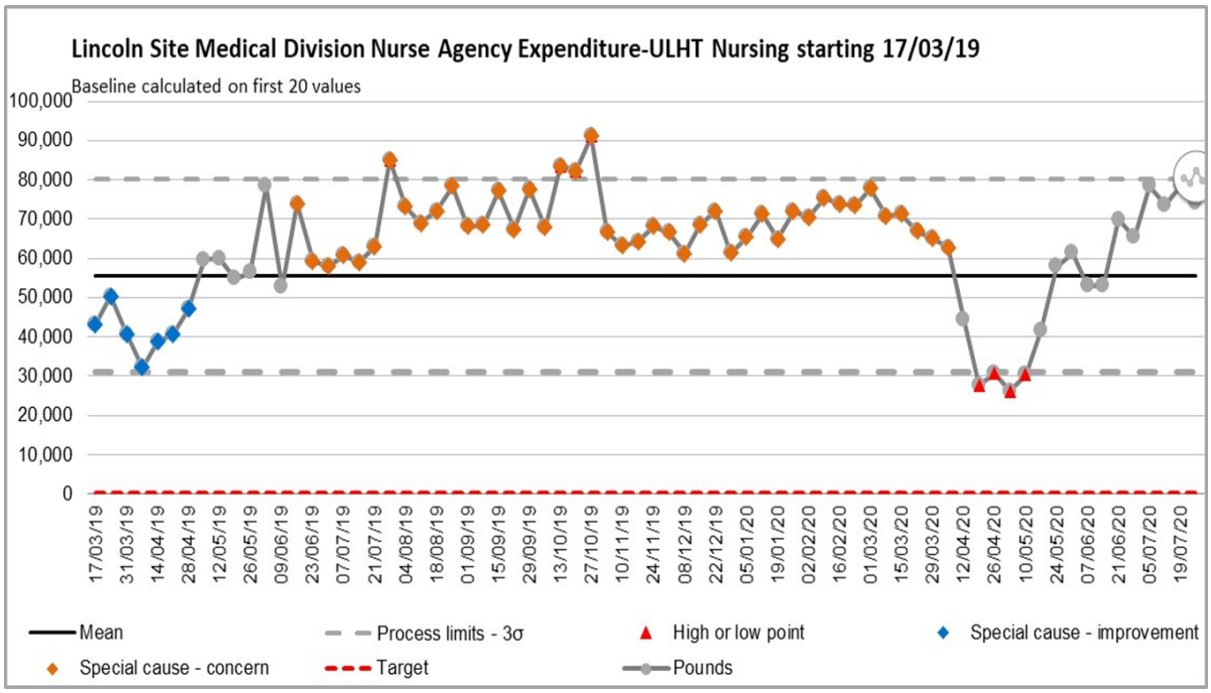


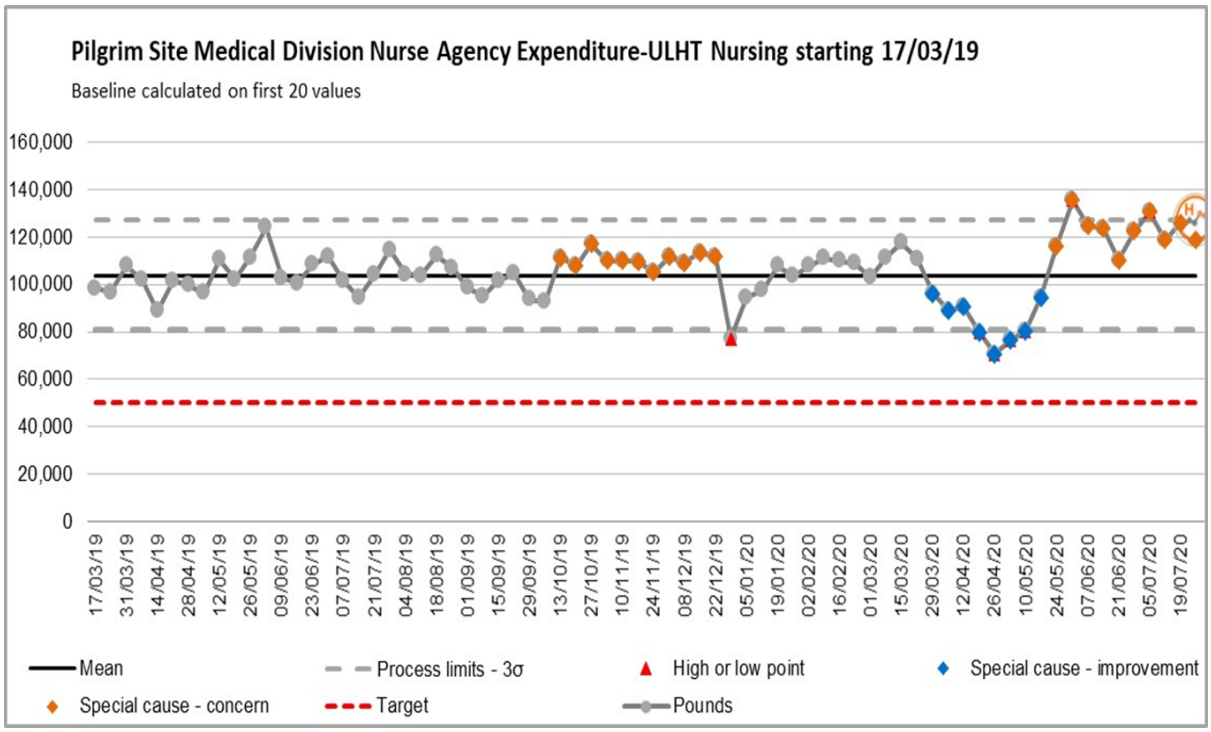
A closer view of where the increase is happening is apparent when evaluating the data split by Division with Medicine being the largest user of agency. Unfortunately, the Division of Medicine also has the highest agency spend which is reflective of the need to use both Tier 2 and on occasions, off-framework agency within the Division as often the skills that are required to fill shifts within the medical areas, require specially trained nurses who are only available through the most expensive agencies, for example, nurses trained in the Emergency Department and in acute respiratory areas.



Further analysis also shows that agency usage in the Division of Medicine is higher at the Pilgrim site than at Lincoln.

This corresponds to a higher vacancy rate across the Pilgrim site, which is a point of challenge replayed to the Division in considering any recruitment strategy in the future.





2.1.2 Shift Fill

Shift fill rates data is no longer a mandatory reporting requirement of Trusts, as it has been replaced by Care Hours Per Patient Day (CHPPD) as a metrics for comparison. However, both the planned and actual fill rate is still a point of discussion within the NWTP, and as can be seen Appendix 1, there is still an amount of variance that is worthy of discussion. Also of note is that there has been a move in July for all ward areas to plan for a 95% fill rate overall, rather than 100%.

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

- 61.69% registered, 71.94% unregistered for day shifts
- 63.93% registered, 71.17% Unregistered for night shifts

The overall Trust fill rate for June 2020 was 65.28% which is reflective of the clinical areas that were closed or modified with reduced bed occupancy as a result of the Pandemic.

2.1.3 CHPPD

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

The data below demonstrates the CHPPD for June across the Trust

Hospital	CHPPD Rates for Staffing					
	Registered		Unregistered		Total (Includes Others)	
	Planned CHPPD	Actual CHPPD	Planned CHPPD	Actual CHPPD	Planned CHPPD	Actual CHPPD
Grantham	20.7	6.6	12.2	3.7	33.0	10.3
Lincoln	9.0	5.4	4.6	3.8	13.9	9.2
Pilgrim	7.6	5.6	5.5	3.7	13.3	9.4
Trust	8.8	5.5	5.2	3.7	14.3	9.3

The full NHS Digital upload information is presented in Appendix 1.

Evidence shows that safe staffing levels have a direct impact on outcomes for patients. For all wards are subjected to scrutiny with the aim of identifying any correlating harm to patients through reported incidents and poor patient experience.

2.1.5 Daily staffing Reviews

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

The Matrons attend the meeting have made progress in their approach to prioritising shifts within their own ward and Divisional areas, but there is more progress to be made in relation to rostering practice.

The daily staffing meetings will continue to be supported by the Nursing Directorate until a level of confidence in the Matrons execution of wider cross site thinking is embedded.

2.2 Rostering

Rostering metrics have been included in the NWTP, and divisions have been asked to develop specific action plans to address any shortfalls.

This process is in its infancy, but has already produced themes that include poor compliance with the Key performance indicators relating to rostering practice.

As a result, monthly Roster Clinics will commence in August which will be supportive confirm and challenge meetings held between the Nursing Directorate and Divisional Nurses from Roster Creators to the Matrons who sign the rosters off as compliant prior to publication.

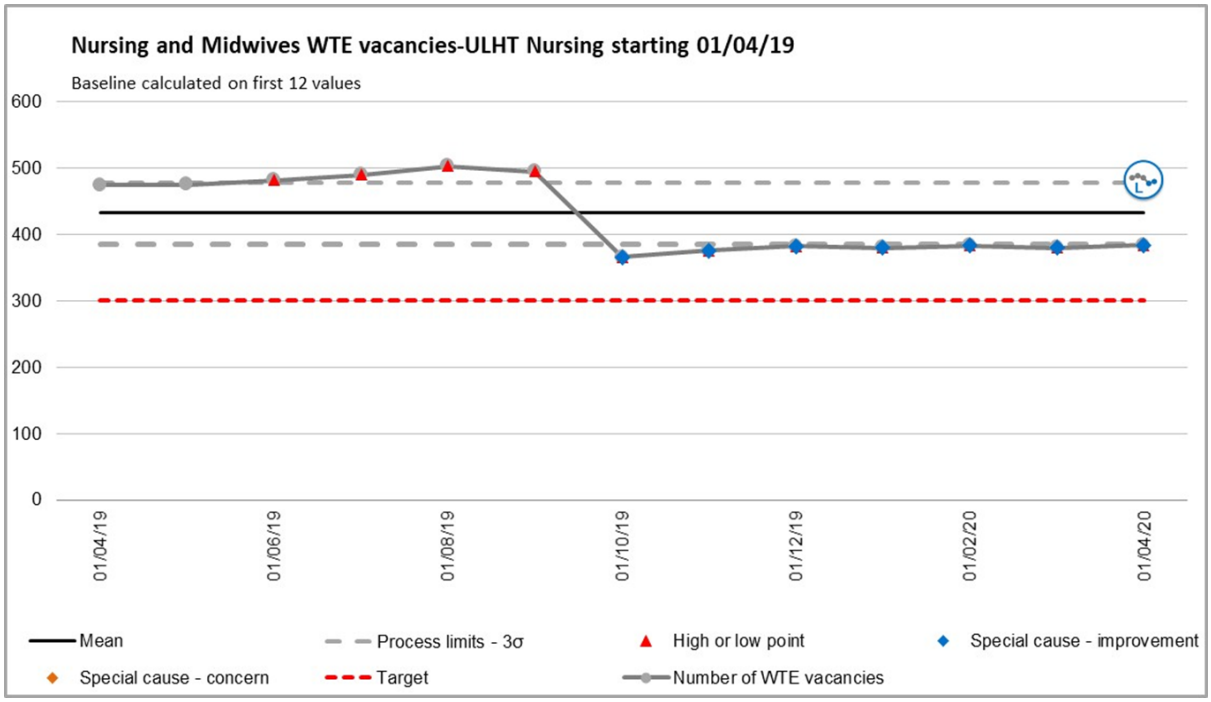
This will also be supported with further development sessions to be led by Allocate and the Head of Nursing informatics to ensure that staff are conversant with good rostering practice.

3 Recruitment and retention

3.1 Vacancies

The current vacancy position continues to be a main focus and challenge in delivering the staffing needs of the wards and departments. The latest vacancies rates are detailed below.

The impact made on these figures by the newly qualified nurses will be evident in next month's report. We have offered 66 students from the University of Lincolnshire contracts, this equates to 48% of the full cohort of students who will qualify from Lincoln in September. We have also offered 14 students from other universities contracts, hence the expectation is to have 80 newly qualified Registered Nurses from September 2020.



3.2 Recruitment

The overseas recruitment project that started in January 2020 has also been affected by the Pandemic, as overseas candidates have been prevented from travelling, applying for Visa's and also the OSCE test centres in the UK have been closed.

However, we are expecting the first cohort of overseas nurses arriving within the Trust at the end of August, travel permitting. These nurses will be subject to quarantine measures for 14 days, as per national guidance. They have all been booked to take their OSCE exams in November 2020.

The interviewing of overseas candidates has recommenced in June with the aim of recruiting 15 overseas nurses per month.

The majority of nurses already recruited have been offered positions at Pilgrim hospital, in the Division of Medicine.

Recruitment will be discussed at length through the establishment review process, and new roles will be encouraged where it is appropriate to do so.

The next cohort of Trainee Nursing Associates due to complete their programme will register in September and have been offered substantive contracts within the organisation. We are expecting 6 to gain their registration from this cohort. This will leave 36 trainees in post from this date.

Further cohorts of trainee nursing associates have been planned to start in October 2020 and January 2021 which should see numbers increase by 25 per cohort.

3.3 Establishments

The nursing establishment review will complete in August 2020 and will be presented to the Trust Board in September/ October.

4.0 RECOMMENDATIONS

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

5.0 CONCLUSIONS

The report is presented to the Committee to reflect the on-going challenges that are faced within Nursing, and to reference the work that is being undertaken through the Nursing Workforce Transformation Programme. It will, as it develops in the future, continue to reflect the progress being made and the improvements in grip and control across temporary staffing and rosters in particular but enhanced by workforce developments and agreed safe establishments according to national guidance and best practice.

Appendix 1: Digital Data submission June 2020

Safe Staffing Performance Dashboard - Jun-20																	
	CHPPD Rates for Staffing						Fill Rates				Nurse Sensitive Quality Indicators						
	Registered		Unregistered		Total		Total Day		Total Night								
SITE/ Ward	Planned CHPPD	Actual CHPPD	Planned CHPPD	Actual CHPPD	Planned CHPPD	Actual CHPPD	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Staffing Red Flags for Month	Falls with harm	Grade 3/4 Pressure Ulcers	Medication errors	Appraisals	Sickness %	Core Learning
GRANTHAM HOSPITAL																	
Ward 1	14.98	4.11	11.00	3.61	26.21	7.73	23.7%	30.6%	38.0%	39.2%	0	0	0	0	93%	5%	94%
Ward 2	154.35	1.78	77.30	1.63	231.65	3.41	1.8%	3.4%	0.0%	0.0%	0	0	0	0	96%	14%	94%
Ward 6	-	-	-	-	-	-	11.4%	5.5%	16.7%	5.0%	0	0	0	1	59%	2%	93%
EAU	8.98	5.61	4.97	4.00	13.95	9.60	52.5%	74.6%	83.4%	89.8%	0	0	0	1	88%	5%	88%
Acute Care Unit	42.38	27.00	8.13	1.89	50.51	28.88	58.7%	23.5%	70.0%	13.6%	0	0	0	1	91%	17%	91%
LINCOLN COUNTY HOSPITAL																	
Ashby	3.56	3.22	3.17	3.37	6.72	6.59	85.7%	113.2%	100.0%	99.9%	0	0	0	0	88%	4%	92%
Bardney	12.75	12.42	8.15	12.13	24.49	27.40	93.0%	159.2%	103.4%	135.6%	0	0	0	0	91%	1%	88%
Branston	23.76	17.55	10.07	6.74	35.75	26.12	64.1%	90.0%	94.2%	29.4%	0	0	0	0	92%	6%	98%
Burton	3.34	3.15	2.98	3.68	6.32	6.83	90.2%	124.5%	101.7%	122.3%	2	0	0	5	89%	1%	97%
Carlton Coleby	3.44	3.07	2.60	2.49	6.04	5.76	82.7%	93.3%	100.7%	100.0%	11	0	0	1	69%	4%	87%
Clayton	4.54	3.78	2.90	3.21	7.43	7.00	75.6%	117.2%	96.7%	100.8%	3	0	0	0	96%	1%	96%
Dixon	-	-	-	-	-	-	-	-	-	-	0	0	0	0	58%	6%	81%
Frailty Assessment Unit	3.84	3.19	3.23	4.46	7.07	7.65	91.4%	153.0%	74.0%	114.2%	2	0	0	3	79%	6%	86%
Greetwell	3.87	3.42	2.75	2.91	7.10	6.55	82.7%	99.6%	98.1%	117.4%	0	1	0	2	100%	7%	97%
Hatton	6.92	4.98	2.16	3.30	9.09	8.29	69.4%	134.2%	75.2%	200.0%	3	0	0	2	100%	5%	91%
ICU	153.56	30.22	40.49	6.58	205.67	36.84	20.2%	18.1%	19.1%	13.6%	0	0	0	3	67%	4%	80%
Johnson	10.13	9.13	3.66	4.87	13.79	14.00	91.5%	126.2%	88.3%	148.4%	1	1	0	0	94%	4%	92%
Lancaster	7.01	6.28	6.29	7.47	13.30	13.77	85.1%	111.2%	96.7%	132.4%	6	0	0	3	83%	17%	81%
MEAU	7.46	6.76	4.25	4.12	11.71	10.89	89.8%	99.5%	92.2%	94.0%	4	0	0	2	90%	1%	84%
Navenby	5.74	4.75	5.37	3.73	11.11	8.76	76.2%	67.0%	92.5%	74.9%	0	0	0	2	88%	6%	88%
Nettleham	1.54	1.45	3.93	3.52	5.47	4.98	88.2%	84.1%	102.9%	100.2%	0	0	0	0	92%	3%	88%
Neustadt Welton	6.92	6.20	4.85	4.79	11.77	10.99	81.6%	91.5%	100.4%	109.0%	0	0	0	1	100%	5%	90%
Neonatal (SCBU)	16.98	15.43	7.25	5.21	24.23	20.64	86.0%	74.2%	97.0%	67.7%	0	0	0	0	88%	2%	91%
Rainforest	9.37	12.93	4.20	6.81	13.57	19.74	129.1%	149.9%	151.1%	190.0%	0	0	0	2	58%	1%	88%
Scampton	3.93	3.59	3.32	3.98	7.25	7.57	87.6%	117.2%	96.1%	125.3%	1	0	0	3	75%	24%	84%
SEAU & SAU	7.97	6.17	4.54	3.94	12.51	10.11	76.5%	81.6%	79.0%	96.7%	0	0	0	0	77%	5%	91%
Shuttleworth	4.83	4.31	3.04	2.99	7.87	7.30	86.7%	93.0%	92.8%	111.0%	0	0	0	4	97%	1%	90%
Stroke Unit	6.39	4.69	3.56	3.76	9.95	8.46	74.8%	105.5%	79.6%	106.0%	2	0	0	23	62%	12%	87%
Waddington Unit	5.14	4.88	2.54	2.96	7.67	7.84	88.7%	100.4%	105.8%	175.6%	2	0	0	2	97%	7%	95%
PILGRIM HOSPITAL, BOSTON																	
Acute Cardiac Unit	5.64	4.74	2.43	2.46	8.08	7.20	84.1%	94.6%	83.9%	114.8%	1	0	0	0	93%	12%	93%
Acute Medical Short Stay	3.51	3.27	3.22	3.24	6.85	6.63	87.2%	105.7%	101.5%	94.2%	0	1	0	1	98%	7%	94%
Bevan Ward	-	-	-	-	-	-	-	-	-	-	0	0	0	0	0%	0%	0%
IAC	9.43	7.56	5.47	4.92	18.58	13.56	74.0%	94.0%	88.4%	84.7%	0	0	0	1	75%	8%	91%
ICU	68.11	33.09	54.20	5.56	123.32	39.38	51.7%	14.2%	44.9%	4.3%	0	0	0	0	52%	8%	89%
Labour Ward	32.31	32.00	6.33	5.84	38.64	37.84	99.7%	89.0%	98.3%	96.1%	0	0	0	0	92%	8%	91%
Neonatal Unit (SCBU)	14.79	14.12	7.45	6.23	22.23	20.36	93.5%	76.3%	97.8%	100.0%	0	0	0	0	93%	0%	96%
Stroke Unit	6.05	3.89	4.86	3.33	10.92	7.22	66.0%	85.7%	62.0%	46.7%	0	0	0	3	91%	5%	94%
1B	177.89	20.83	123.00	11.22	300.89	32.06	10.6%	10.2%	13.3%	6.7%	0	0	0	0	88%	16%	95%
5A	4.13	4.26	3.29	3.12	7.42	7.38	106.0%	94.2%	98.0%	96.2%	0	0	0	2	97%	13%	86%
5B	6.71	5.23	4.18	4.33	10.90	9.56	68.7%	113.0%	97.4%	85.3%	0	0	0	1	70%	10%	93%
6A	11.91	5.37	10.52	4.21	22.43	9.58	42.3%	44.6%	49.6%	34.2%	2	0	0	3	86%	17%	86%
6B	4.73	3.55	3.78	3.26	8.52	6.81	84.4%	85.2%	63.3%	87.3%	0	0	1	2	71%	18%	94%
7A	4.50	1.96	2.71	1.21	7.21	3.17	23.7%	38.2%	49.9%	56.8%	0	0	0	0	0%	0%	0%
7B	5.39	5.25	4.10	4.30	9.49	9.55	87.7%	98.2%	117.4%	122.1%	7	0	1	3	88%	11%	88%
8A	8.30	7.07	7.22	6.37	15.55	13.46	82.4%	85.4%	90.3%	93.0%	10	0	0	1	93%	10%	91%
9A (formerly 3B)	3.85	3.59	2.85	2.87	6.71	6.63	86.0%	98.3%	106.4%	105.2%	3	0	0	0	100%	1%	91%
M1	8.97	8.88	5.93	5.66	14.89	14.53	98.0%	93.5%	100.6%	100.0%	0	0	0	0	100%	4%	95%
Bostonian	6.96	6.19	4.57	4.07	11.53	10.27	74.8%	85.4%	99.1%	96.5%	0	0	0	3	96%	7%	93%
Ward 1	9.46	7.46	8.51	5.90	17.97	13.36	76.9%	62.0%	81.2%	81.9%	0	0	0	2	50%	9%	90%

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Public Board Meeting*
Date of Meeting	*1st September 2020*
Item Number	*Item 9.3*
Accountable Director	*Martin Rayson, Director of People & OD*
Presented by	*Martin Rayson, Director of People & OD*
Author(s)	*Stephen Kelly, Head of Occupational Health & Wellbeing Service*
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	*X*
2a A modern and progressive workforce	*X*
2b Making ULHT the best place to work	*X*
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	*4142*
Financial Impact Assessment	*The cost of the flu campaign is fully funded*
Quality Impact Assessment	*Achieving a take-up rate of 100% among ULHT's front-line workers will protect our patient from the risk of acquiring flu whilst in hospital*
Equality Impact Assessment	*The vaccine is available to all. Two types of vaccine are available to ensure all groups and all faiths can have the vaccine at ULHT*
Assurance Level Assessment	*Insert assurance level* • *Moderate – see risks to be addressed*

Recommendations/ Decision Required	• *To approve the self-assessment at Appendix 1, based on the evidence provided*
	• *To ask the People & OD Committee to oversee delivery of the Flu Plan and to give assurance to the Board around delivery of the plan and the100% target for frontline staff*

Executive Summary

On 4th August the Department of Health and Social Care and Public Health England published a letter giving further details on the 2020/21 flu vaccination programme.

The letter includes the following paragraph:

All frontline health and social care workers should receive a vaccination this season. This should be provided by their employer, in order to meet their responsibility to protect their staff and patients and ensure the overall safe running of services. ***Employers should commission a service which makes access easy to the vaccine for all frontline staff, encourage staff to get vaccinated, and monitor the delivery of their programmes.***

Our CQUIN target is 90%, but the letter indicates that 100% of all frontline workers in the Trust should be vaccinated. In 2019/20 we achieved 85% take-up. We have already started planning for the campaign this year and a detailed flu plan (including a communications plan) will be considered by the Executive Leadership Team on 3rd September. The plan will build on our successful campaigns to date and will address the issues arising from the campaign last year, which had a slow start. These were:

- The availability of vaccines
- The availability of peer to peer vaccinators

There are still a proportion of frontline staff who take a purposeful decision not to have the vaccine. The plan this year, particularly the communications plan, will focus on reaching out to those groups and emphasising the expectation that staff will have the vaccine to protect patients.

The experience of COVID influences our plan for 2020/21. With the expectation of a COVID vaccine becoming available, we have the potential to build on this flu plan to deliver any COVID vaccine to ULHT frontline staff.

The 4th August Flu Letter also advises that:

NHS Trusts should complete a self-assessment against a best practice checklist which has been developed based on five key components of developing an effective flu vaccination programme. The completed checklist should be published in public board papers at the start of the flu season.

The checklist is included at Appendix A. Board should note that against the majority of the criteria, we have self-assessed “green”. Where the RAG rating of “amber” are given, the actions to turn to green, with timescales, are included. Where criteria are “red”, there are no timescales for resolution, but urgent action is underway.

The self-assessment has been used to identify the key risks to the campaign. These are:

- Flu Vaccine order 2020 /2021 not sufficient to vaccinate 100% of all staff, sufficient to vaccinate all frontline staff – Amber
- Lack of Peers to Peers to vaccinate staff – Amber
- Cold chain storage of vaccines - risk of loss of vaccines – Red
- No drop in clinics locations – need central point on both main sites for clinics – Red

Our preparations for flu are in a good place to achieve the 100% target. It may be difficult to overcome all resistance to have a flu vaccine. However, our communications plan will build up and increasingly focus on those areas and staff where take-up is lower.

We will report back progress regularly to the People & OD Committee and then to the Board.

United Lincolnshire Hospitals NHS Trust
Healthcare Worker Flu Vaccination Best Practice Management Checklist 2020-2021

For Public Assurance Via Trust Boards by December 2020

	Committed Leadership	RAG	Trust Self-Assessment
A1	Board record commitment to achieving the ambition of vaccinating all frontline healthcare workers		The Board commitment to the flu programme will be made at the meeting on 1st September and will be evidenced in the minutes. Detailed flu plan will be considered by Executive Leadership Team (ELT) on 3rd September. The Trust will publish in its regular SBAR to all staff, the commitment to the seasonal flu vaccine.
A2	Trust has ordered and provided a quadrivalent (QIV) flu vaccine for healthcare workers		Completed. We have two vaccine supplies for the 2020/21 campaign: 1. Seqirus, Flucelvax Tetra Quadrivalent cell grown vaccine - for pregnant women, aged 65 and over with a confirmed allergy 2. Sanofi Pasteur, Quadrivalent Influenza Vaccine (split virion, inactivated) Staggered delivery dates throughout September & October due to the Trust capacity to store vaccines. The flu vaccine delivery schedule will be included in the detailed plan, which will go to ELT.
A3	Board receive an evaluation of the flu programme 2019/20, including data, successes, challenges and lessons learnt		In 2019/20, we achieved a vaccination rate of frontline staff of 85% The two main issues were the availability of vaccines and limited availability of peer to peer vaccinators. There are groups of staff who continue to decline the vaccine. We started flu planning in June this year and will be meeting monthly from

			Sept 2020 through to Mar 2021. There is greater certainty around supply in 2020/21 and we have started to recruit the peer vaccinators earlier. We aim to have one in every ward or department, with two in larger wards and departments Regular clinics in key central points in the main sites will supplement this and ensure easy access to the vaccine for all frontline staff. OH staff will be supplemented by trained bank vaccinators. Two main groups of clinical staff, medics and nurses, had lower than expected uptake last year. Targeting these two groups will be a key aim of this year's plan. We will also be targeting BAME other "at risk staff". We will adapt our communications plan, being developed with the Comms plan, to emphasise the risk (linking to COVID) and responsibility of our staff. We will target particular staff groups.
A4	Agree on a board champion for flu campaign		Martin Rayson, Director of People and OD
A5	All board members receive flu vaccination and publicise this		We will plan to vaccinate the Board in mid-September, when the first delivery of flu vaccines are received. This will be publicised as part of our communications plan.
A6	Flu team formed with representatives from all directorates, staff groups and trade union representatives		Team is in place to oversee flu campaign. We will also engage through existing forums, such as staffside, Trust Leadership Team, MACs and nursing forums. This is planned to begin through September and October, but is not yet delivered
A7	Flu team to meet regularly from September 2020		The group has met and regular meetings are scheduled from September 2020 to February 2021
Communication Plan			
B1	Rationale for the flu vaccination programme and facts to be published – sponsored by senior clinical leaders and trades unions		This is part of the flu plan and will be published in letters to all staff from Cx, Director of Nursing and Medical Director. Staffside will be asked to endorse the messaging. We will publish in SBAR and through other staff

			communication tools.
B2	Drop in clinics and mobile vaccination schedule to be published electronically, on social media and on paper		Drop-in clinics are more difficult to provide in the present because of COVID 19 restrictions in respect of social distancing. However they will be available to supplement the peer to peer vaccinators. Details will be published. We will use the ULHT Together Facebook pages to publish details.
B3	Board and senior managers having their vaccinations to be publicised		This is planned for mid-September when the first vaccines arrive and we will publicise as part of the communications plan
B4	Flu vaccination programme and access to vaccination on induction programmes		The dates for all induction programmes, meetings where training takes place for groups of staff including doctors.
B5	Programme to be publicised on screensavers, posters and social media		A detailed communications plan is being developed, embracing the tools identified. This will be reviewed by ELT on 3rd September
B6	Weekly feedback on percentage uptake for directorates, teams and professional groups		Occupational health maintains a database of those who have had the vaccine and will supply weekly reports to ELT and others covering the uptake of the flu vaccine by all trust staff, hospital sites, staff groups, divisions, directorates.
Flexible Access to Flu Vaccine			
C1	Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered		We have recruited to date 130 flu vaccinators. This is a better position than in 2019. However, we still do not have a designated peer to peer flu vaccinator in all clinical areas. We will explore the potential of a “buddy” system if we are not able to identify vaccinators in all areas. Aim to complete by mid-September, following up with Divisions where we have issues.
C2	Schedule for easy access drop in clinics agreed		We have identified locations on the Pilgrim and Grantham sites, but not yet at Lincoln. We are pursuing this urgently with Estates and Facilities and may be able to update at the Board meeting
C3	Schedule for 24 hour mobile vaccinations to be agreed		Peer-to-peer vaccinators will be available through a 24 hour period to vaccinate staff from other wards and departments across a range of shifts. We will publicise this, so that all staff are aware.
Incentives			

D1	Board to agree on incentives and how to publicise this		Occupational health has not used incentives to encourage staff to have the flu vaccines for the past three years. Our judgement is that we should focus on the messaging and the commitment to protecting our patients. This consistent message allowed us to achieve a compliance rate of 88% in 2018/19 and 85% in 2019/20.
D2	Success to be celebrated weekly		Communication plan envisages weekly updates on progress, We will use a dashboard to report progress, by staff group, including our Jab-O-Meter.

Outstanding Actions and Risks for 2020/2021 Flu Campaign.

	Risk	RAG	Comment
1	Flu Vaccine order 2020 /2021 not sufficient to vaccinate 100% of all staff, sufficient to vaccinate all frontline staff.		Order agreed and confirmed, we have increased the order as the demand is expected to be higher. There are no more vaccines available but Pharmacy continue to look to source more. The NHS nationally have indicated that the supply of vaccines should not be a problem.
2	Lack of Peers to Peers to vaccinate staff		We have made good progress in recruiting peer-to-peer vaccinators. The aim is to have a peer-to-peer vaccinator for every frontline area and two for larger wards departments. We will need continued support from senior leaders to achieve this. We will follow up on this at meetings of ELT and the Trust Leadership Team in the next two weeks.
3	Cold chain storage of Vaccines, Risk loss of vaccines,		No location on both main sites for flu fridges with back-up power supply. We continue to rely on fridges in OH locations, without the back up. Continuing to work with Estates and Facilities to resolve this.
4	No drop in clinics locations, central point on both main sites for clinics		No central locations/accommodation identified on the Pilgrim site at present. Continuing to work with Estates and Facilities to progress

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Report to:	Trust Board
Title of report:	Finance, Performance and Estates Committee Assurance Report to Board
Date of meeting:	20 August 2020
Chairperson:	Gill Ponder, Non-Executive Director
Author:	Karen Willey, Trust Secretary

Purpose	This report summarises the assurances received and key decisions made by the Finance, Performance and Estates Committee (FPEC). The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board's response. This assurance committee meets monthly and takes scheduled reports from all Trust operational committees according to an established work programme. The Committee worked to the 2020/21 objectives. The Trust are in the 'Restore' phase in response to Covid-19 and as such the meeting was held via Microsoft Teams with a reduced agenda to focus on key priorities
Assurances received by the Committee	**Lack of Assurance** in respect of SO 3a A modern, clean and fit for purpose environment **Issue: Assurance/Exception Report Health and Safety Group** The Committee received the upward report from the Health and Safety Group noting that there remained an issue with representation from Staffside. The Committee requested that this be escalated to the Executive Leadership Team for resolution. The Committee expressed disappointment that the report was not fit for purpose as sufficient assurance had not been provided to the Committee and areas such as the significant challenges posed by the pandemic had been omitted. As such the Committee felt unable to discharge its duty of upward assurance to the Board. The Committee would conduct a comprehensive review of the group's terms of reference and work programme in order to ensure that effective reporting to the Committee could be achieved. **Issue: Assurance/Exception Report Emergency Planning Group** The Committee received the upward report noting that there was a lack of assurance relating to the key messages reported to the Committee as timescales and monitoring of achievement had not been reported. Concern was raised regarding the investigation relating to break glass call points being disabled at Pilgrim Hospital. There had been no indication

	to the Committee that a comprehensive investigation had been conducted or that actions had been taken to prevent a recurrence. The Committee requested further information on the actions and timescales of the key items that had been reported.
	Lack of Assurance in respect of SO 3b Efficient Use of Resources **Issue: Finance Report** The Committee received the report noting that the Trust had maintained a breakeven position at the end of Month 4 in line with the financial regime in place as a result of Covid-19. The Trust had undertaken a forecast for the impact of Covid-19 for the period April – July with an expectation of requiring £3.4m additional funding over and above the block payment received. At the end of July the position was £0.7m adverse to this with the top-up required being £4.1m. Payment had been received for April to June with July monies outstanding. A thorough check and challenge is undertaken internally as well as by NHSE/I on a monthly basis. It was noted that income relating to car parking and catering had fallen as a result of Covid-19 by £1.1m over the first 4 months of the financial year. The Committee noted that agency pay remained unchanged in July at £3.7m and Bank pay had increased by £1.1m, driven by additional surge rota costs. The overall pay position had increased by £0.1m due to substantive pay falling by £0.9m as a result of reduced Covid-19 response costs and the Medical and Dental pay award confirmation. The Committee were advised that the Director of Finance & Digital is working with the Medical Director and Director of People & OD to create a medical workforce transformation programme following on from the nursing workforce transformation programme in order to provide further control of medical workforce spend. The Committee were advised that non-pay continued at an acceptable rate aligned with the reduction in planned activity and supported by service line reporting. Costs would start to rise as the recovery programme is implemented. The Trust is yet to receive a formal update on the level of funding to be made available to cover the period October to March. The Committee noted that there had not been any further movement with capital following the August Board meeting.

	Issue: Covid-19 Financial Governance The Committee received a comprehensive report noting the detailed governance arrangements that were in place for both the initial Covid-19 response and the restoration/recovery phases. The Committee were assured that the Trust were maintaining grip and control of the Covid-19 spend and that appropriate bids for funding were being pursued.
	Assurance in respect of other areas: **Committee Annual Report 2019/20** The Committee received the updated annual report noting that further work was required to develop the report in order to detail the achievements of the Committee during the year. **Committee observation action plan** The Committee received the updated action plan noting the progress that had been made with 2 of the original 15 actions yet to be fully completed. **Committee Performance Dashboard** The Committee received the dashboard noting that A&E performance was positive however demand was increasing as patient confidence to use services returned. It was noted that build monies available to the Trust would support improvement within the A&E departments. Disappointment was noted regarding theatre utilisation and the cancer backlog performance; however this was being addressed through increased utilisation of the Grantham Green Site as part of the restoration plan. Concern was raised by the Committee regarding the expected increase in 2ww referrals from Primary Care. The Committee noted that the dashboard required alignment to the Integrated Improvement Plan and were advised that this would be supported by the work being conducted in relation to Operational Excellence. **Performance Review Meeting upward report** The Committee received the first upward report from the Performance Review meetings noting that this would be further developed to ensure that the Committee were presented with a divisional breakdown. The Committee were advised that the intent was to provide update reports to the relevant Committees of the Board ensuring that each Committee received appropriate oversight.

	Integrated Improvement Plan Report The Committee received the draft Integrated Improvement Plan report. Feedback was sought form the Committee on the layout of the report to ensure that this would provide the assurance required. The Committee requested improvement trajectories, with timescales which would enable the Committee to gain assurance on progress towards meeting constitutional standards as the Trust progressed with recovery actions post Covid. The Integrated Performance Report was received by the Committee.
Issues where assurance remains outstanding for escalation to the Board	No additional items to raise.
Items referred to other Committees for Assurance	PRM escalation from Clinical Support Services in relation to Liver Biopsies.
Committee Review of corporate risk register	The Committee reviewed the risk register however requested that further detail be provided in future reports.
Matters identified which Committee recommend are escalated to SRR/BAF	The Committee was assured that the BAF was reflective of the key risks in respect of the strategic objectives of the organisation with the addition of Covid-19.
Committee position on assurance of strategic risk areas that align to committee	As above
Areas identified to visit in dept walk rounds	None

Attendance Summary for rolling 12 month period

Voting Members	S	O	N	D	J	F	M	A	M	J	J	A
Gill Ponder, Non-Exec Director	X	X	X	X	A	X	X	No meetings held due to Covid-19			X	X
Geoff Hayward, Non-Exec Director	X	X	X	X	X	X	X				X	X
Chris Gibson, Non-Exec Director	A	X	A	X	X	A	X				X	X
Director of Finance & Digital	X	D	X	D	X	X	X				X	X
Chief Operating Officer	X	D	X	X	X	D	A				A	D
Director of Estates and Facilities	X	X	D	X	D	X						

X in attendance A apologies given D deputy attended

Meeting	Trust Board
Date of Meeting	1st September 2020
Item Number	Item 12
Integrated Performance Report for July 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 the full suite of metrics as agreed by the Committee rather than the reduced set which were agreed and reported during the COVID-19 pandemic response. The dashboard contains the most recent data available (July 2020) where this is available at the point of production.

Medication Incidents causing harm
Although the performance reported of 12.6% exceeds the national average of 10.7%, the Trust is below peer average which is 15.1% in the same period.

Mortality
SHMI
Although SHMI is above the 100 target at 108.42 based on the most recent period available (March 2019 to February 2020), it has decrease from the previous reporting period and is now 'within expected limits'. SHMI includes both deaths in-hospital and within 30 days of discharge but will not be including COVID-19 deaths. In hospital SHMI is 95.8 and the exception report details the work being undertaken with system partners to reduce mortality within 30 days of discharge.

Clinical Audit and Effectiveness
National Audit Participation Rate
Performance against this metric has been impacted by COVID-19 and the resulting changes to national data collections and cancellation of elective procedures. The July performance of 89% relates to the audits detailed in the exception report (national IBD, elective procedures and asthma audits).

eDD issued within 24 hours
The 94.23% compliance was caused by an IT system failure over one weekend in the month. Immediate action was taken to rectify the problem so that it does not reoccur.

Sepsis
1.Bundle Compliance (Adult inpatient)
July performance against this metric has improved to 86.5%. Targeted harm reviews are being undertaken by ward leads and the sepsis practitioners to identify and address areas of and reasons for non- compliance or common themes.

2.Bundle Compliance (Paediatric inpatient)
July performance against this metric is static at 86%. As detailed in the exception report, the missed screens are predominantly on the Lincoln site and targeted work is being undertaken by the paediatric resuscitation and sepsis practitioner who is now in post.

Duty of Candour
Performance is 86% (verbal) and 76% (written) for July with 2 incidents not demonstrating verbal and 3 written duty of candour compliance. In month monitoring and reminders to both individuals and divisional teams continues and a review of compliance at the Patient Safety Group with divisional representatives to discuss performance and actions needed has been introduced.

Operational Performance

On 5th March 2020, in response to the Covid-19 pandemic, the Trust enacted the Pandemic Flu plan and elements of the Major Incident Plan and put in place Command and Control systems. This response continued until 1st August when nationally the national Emergency Response Level was reduced to Level 3. This signified the start of the Recovery Phase of the response to Covid-19 pandemic.

Operational performance for the periods of June-July where data is available reflects the Restore phase where services were being reinstated, but not recovered. From August 1st this recovery will start with ambitions to returning to pre-Covid-19 levels of waiting lists, response times and constitutional standards.

4-hour performance for July was 82.15%, achieved despite a third month of increased ED attendances (14% higher than June and the greatest increase in demand since the pandemic began). The Trust is performing above the pre-Covid-19 target trajectory and has done for the last three months. Performance remains stronger than 2019 levels at 8% better position. A&E triage performance continues to be better than trajectory as does 60 minute time to treatment standard.

During July there were 81 >59-minute ambulance handover delays across the Trust, reflecting the first month of conveyance numbers returning to above trajectory levels since the pandemic started. Amongst load sharing strategies handover and alternative pathway discussions have started to prevent further deterioration and to restore previous performance levels. In addition to this the Trust us undertaking a number of capital developments to ensure environments are fit for purpose and safely deliver care in socially distanced spaces.

RTT performance for June was 54.08%. The Trust reported 34 incomplete 52 week breaches for June end of month. Root cause analysis and harm reviews have not indicated any concerns with patients coming to harm, however as the number of delays increases risk stratification and prioritisation will becomes more and more important. Regionally ULHT have proportionately few 52 week delays representing the work undertaken by teams with telephone and e-consultations, however this number is likely to continue to rise until recovery plans start to take full effect in September.

In a similar way to RTT performance waiting list size has increased from May into June with the total waiting list increasing by 1005 to 39,032. Original trajectories forecasting the impact of Covid-19 forecast a much greater increase, and so in future months with some services being Restored and the impact of the Recovery plans in September this figure will likely start to slow in July and start to reduce at the end of August/September. New trajectories will be developed in line with the Recovery phase.

Diagnostics access performance for June has shown the second month of improvement largely as a result of Restoration of Endoscopy and Imaging capacity. This should continue to improve although other modalities and diagnostic services are not expected to fully Recover until much later in the year as focus remains on Urgent Care and clinically urgent patients.

May Cancer 62 Day Classic performance was 74.5%, which was an improvement of 7% against the previous month. 2 Week Wait performance was 94.1% (against a 93% target) which marks a further improvement and Trust's best performance since October 2017 against this standard. This represents the increase of access to 2ww services which were available throughout Covid-19 phases 1 and 2, as well as managing increased demand as patients have gained confidence in accessing hospital services.

Overall backlog number of patients waiting more than 62 and 104 days remain a priority and are part of Covid-19 Restore and Recovery phases. July has shown a reduction in both, but it is expected that August will be the point where patients waiting more than 104 days will return to pre-Covid levels, and 62 day backlog will at that point have reduced by only 20% for Covid-19 peak backlog levels in June. This backlog reduction and improvement in waiting times will initially have a very significant impact on 62day performance which calculates treated patients waiting times. Therefore in August and September 62day classic performance standard particularly will reduce.

Workforce

M4 Pay is adverse to plan with much of this resulting from direct COVID expenditure. However, there is a notable variance in substantive fte to plan YTD driven by reduced turnover and stronger than planned recruitment. Whilst this is on the whole positive, a lack of a corresponding reduction in bank and agency staffing costs presents a risk.

Whole Trust vacancy rate has continued to improve in months three and four of 2020/21 and is now below target with 12 month turnover also below target for three consecutive month. Strong improvement in medical vacancy rate is particular pleasing with a 7 percentage point improvement in the last 12 months. Nursing vacancy rate is also better than plan YTD with stronger than anticipated recruitment despite delay to international starts which are now planned for later this month. Further improvement is also anticipated by end of Q2.

Absence rate has been significantly affected by COVID related absence and the wider availability of staff but rolling 12 month rate remains of concern.

Staff Appraisal Rate remains low and Core learning has dropped to below 90% both likely due to the distraction of COVID. We are considering requiring all staff to have a conversation with their manager during September/October to cover:

- Their role in Recovery
- Issues about their well-being and resilience.

This would meet an expectation in the NHS National People Plan, ensure there is alignment around our objectives for the remaining months of the year and we can legitimately record as an appraisal conversation. This will be discussed further with ELT next week.

The number of unresolved Employee relations cases has increased to 94 (excluding Appeals).

Paul Matthew
Director of Finance & Digital
August 2020

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

PERFORMANCE OVERVIEW

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	May-20	Jun-20	Jul-20	YTD		Latest Month Pass/Fail	Trend Variation	Kitemark
Deliver Harm Free Care	Clostridioides difficile position	Safe	Patients	Director of Nursing	9	4	6	6	26		P		
	MRSA bacteraemia	Safe	Patients	Director of Nursing	0	1	0	0	1		P		
	MSSA bacteraemia cases counts and 12-month rolling rates of hospital-onset, using trust per 1000 bed days formula	Safe	Patients	Director of Nursing	TBC	0.08	0.04	0.04	0.07				
	E. coli bacteraemia cases counts and 12-month rolling rates, per 1000 bed days formula	Safe	Patients	Director of Nursing	TBC	0.01	0.13	0.04	0.06				
	Never Events	Safe	Patients	Medical Director	0	0	0	0	0		P		Timeliness, Completeness, Validation, Process
	New Harm Free Care	Safe	Patients	Director of Nursing	99%								Timeliness, Completeness, Validation, Process
	Pressure Ulcers category 3	Safe	Patients	Director of Nursing	4.3	1	1	3	5		P		
	Pressure Ulcers category 4	Safe	Patients	Director of Nursing	1.3	1	0	0	1		P		Timeliness, Completeness, Validation, Process
	Pressure Ulcers - unstageable	Safe	Patients	Director of Nursing	19/20 will be used as a benchmark	5	3	9	19				
	Summary Hospital Mortality Indicator (SHMI) (rolling year data 6 month time lag)	Effective	Patients	Medical Director	100	109.73	109.73	108.42	109.43		F		
	Hospital Standardised Mortality Ratio - HSMR (rolling year data 3 month time lag)	Effective	Patients	Medical Director	100	95.00	95.50	95.73	95.26		P	B	
	Sepsis screening (bundle) compliance for inpatients (adult)	Safe	Patients	Director of Nursing	90%	84.20%	80.90%	86.50%	84.90%		F		
	Sepsis screening (bundle) compliance for inpatients (child)	Safe	Patients	Director of Nursing	90%	84.00%	86.10%	86.30%	86.60%		F		
	IVAB within 1 hour for sepsis for inpatients (adult)	Safe	Patients	Director of Nursing	90%	95.20%	87.40%	94.00%	92.75%		P	A	
	IVAB within 1 hour for sepsis for inpatients (child)	Safe	Patients	Director of Nursing	90%	No positive screens in sample	60.00%	90.00%	79.17%		P		

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PERFORMANCE OVERVIEW

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	May-20	Jun-20	Jul-20	YTD		Latest Month Pass/Fail	Trend Variation	Kitemark
Deliver Harm Free Care	Sepsis screening (bundle) compliance in A&E (adult)	Safe	Patients	Director of Nursing	90%	93.00%	92.50%	94.11%	93.03%		P	A	
	Sepsis screening (bundle) compliance in A&E (child)	Safe	Patients	Director of Nursing	90%	83.00%	98.40%	100.00%	92.18%		P	A	
	IVAB within 1 hour for sepsis in A&E (adult)	Safe	Patients	Director of Nursing	90%	96.00%	95.70%	97.30%	96.08%		P	A	
	IVAB within 1 hour for sepsis in A&E (child)	Safe	Patients	Director of Nursing	90%	100.00%	100.00%	100.00%	100.00%		P	A	
	Rate of stillbirth per 1000 births	Safe	Patients	Director of Nursing	4.20	1.93	1.72	2.59	2.04		P	L	
	Number of Serious Incidents (including never events) reported on StEIS	Safe	Patients	Medical Director	14	10	16	14	47		P		Timeliness, Completeness, Validation, Process
	Catheter Associated Urinary Tract Infection	Safe	Patients	Director of Nursing	1				0				
	Falls per 1000 bed days resulting in moderate, severe harm & death	Safe	Patients	Director of Nursing	0.19	0.18	0.08	0.15	0.15		P		Timeliness, Completeness, Validation, Process
	Reported medication incidents per 1000 occupied bed days	Safe	Patients	Medical Director	4	4.63	4.68	5.10	4.76		P	L	
	Medication incidents reported as causing harm (low /moderate /severe / death)	Safe	Patients	Medical Director	10%	7.80%	19.80%	12.60%	14.38%		F		
	Potential under reporting of patient safety incidents / Reported incidents (all harms) per 1,000 bed days	Safe	Patients	Medical Director	30	35.48	38.20	37.80	37.07		P	A	
	Patient Safety Alert compliance (number open beyond deadline)	Safe	Patients	Medical Director	0	2	0	0	2		P		
	National Clinical audit participation rate	Effective	Patients	Medical Director	98%	95.00%	89.00%	89.00%	92.00%		F		
	7 day Services Clinical Standard 2 (all patients have a Consultant review within 14 hours of admission)	Effective	Patients	Medical Director	90%	Not Collected audit done twice a year							
	7 day Services Clinical Standard 8 (ongoing review)	Effective	Patients	Medical Director	90%	Not Collected audit done twice a year							
	Venous Thromboembolism (VTE) Risk Assessment	Safe	Patients	Medical Director	95%	96.52%	97.90%	98.30%	96.77%		P		
	eDD issued within 24 hours	Effective	Patients	Medical Director	95%	95.50%	95.30%	90.00%	94.23%		F	A	

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PERFORMANCE OVERVIEW

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	May-20	Jun-20	Jul-20	YTD	YTD Trajectory	Latest Month Pass/Fail	Trend Variation	Kitemark
A Modern and Progressive Workforce	Overall percentage of completed mandatory training	Safe	People	Director of HR & OD	95%	88.80%	88.16%	88.95%	88.90%		F		
	Number of Vacancies	Well-Led	People	Director of HR & OD	12%	12.52%	12.20%	11.88%	12.47%		P	L	
	Sickness Absence	Well-Led	People	Director of HR & OD	4.5%	4.99%	5.08%	5.07%	5.02%		F	A	
	Staff Turnover	Well-Led	People	Director of HR & OD	12%	11.00%	10.62%	10.80%	10.97%		P		
	Staff Appraisals	Well-Led	People	Director of HR & OD	90%	69.48%	68.27%	68.52%	69.14%		F		
					£'000	£'000	£'000	£'000	£'000				
	Agency Spend	Well-Led	People	Director of HR & OD	TBC	-£3,200	-£3,743	-£3,674	-£13,695		F		
Improve Patient Experience	Mixed Sex Accommodation breaches	Caring	Patients	Director of Nursing	0	0	0	0	0		P		Timeliness, Completeness, Validation, Process
	% Triage Data Not Recorded	Effective	Patients	Chief Operating Officer	0%	0.18%	0.13%	0.15%	0.18%		F		
	Duty of Candour compliance - Verbal	Safe	Patients	Medical Director	100%	79.00%	86.00%		88.33%		F		
	Duty of Candour compliance - Written	Responsive	Patients	Medical Director	100%	71.00%	76.00%		78.67%		F		

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PERFORMANCE OVERVIEW

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	May-20	Jun-20	Jul-20	YTD	YTD Trajectory	Latest Month Pass/Fail	Trend Variation	Kitemark
Improve Clinical Outcomes	4hrs or less in A&E Dept	Responsive	Services	Chief Operating Officer	70.9%	88.70%	88.15%	82.37%	87.12%	68.92%	P		
	12+ Trolley waits	Responsive	Services	Chief Operating Officer	0	0	0	0	0	0	P		
	%Triage Achieved under 15 mins	Responsive	Services	Chief Operating Officer	88.5%	94.70%	96.01%	93.03%	94.88%	88.50%	P		
	52 Week Waiters	Responsive	Services	Chief Operating Officer	0	31	34		68	0	F		
	18 week incompletes	Responsive	Services	Chief Operating Officer	84.1%	63.25%	54.08%		62.86%	84.10%	F	L	
	Waiting List Size	Responsive	Services	Chief Operating Officer	37,762	38,576	39,581		n/a	n/a	F		
	62 day classic	Responsive	Services	Chief Operating Officer	85.4%	66.97%	74.52%		69.20%	85.39%	F		
	2 week wait suspect	Responsive	Services	Chief Operating Officer	93.0%	92.51%	94.08%		90.42%	93.00%	P		
	2 week wait breast symptomatic	Responsive	Services	Chief Operating Officer	93.0%	94.05%	84.48%		82.53%	93.00%	F		
	31 day first treatment	Responsive	Services	Chief Operating Officer	96.0%	97.17%	96.11%		96.60%	96.00%	P		
	31 day subsequent drug treatments	Responsive	Services	Chief Operating Officer	98.0%	98.46%	95.24%		97.90%	98.00%	F		
	31 day subsequent surgery treatments	Responsive	Services	Chief Operating Officer	94.0%	82.05%	88.89%		86.91%	94.00%	F		
	31 day subsequent radiotherapy treatments	Responsive	Services	Chief Operating Officer	94.0%	98.75%	89.89%		94.67%	94.00%	F		
	62 day screening	Responsive	Services	Chief Operating Officer	90.0%	0.00%	12.50%		31.25%	90.00%	F		

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

PERFORMANCE OVERVIEW

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	May-20	Jun-20	Jul-20	YTD	YTD Trajectory	Latest Month Pass/Fail	Trend Variation	Kitemark
Improve Clinical Outcomes	62 day consultant upgrade	Responsive	Services	Chief Operating Officer	85.0%	83.57%	80.92%		79.31%	85.00%	F		
	Diagnostics achieved	Responsive	Services	Chief Operating Officer	99.0%	44.96%	53.96%		45.53%	99.00%	F		
	Cancelled Operations on the day (non clinical)	Responsive	Services	Chief Operating Officer	0.8%	1.40%	0.54%		1.33%	0.80%	P	L	
	Not treated within 28 days. (Breach)	Responsive	Services	Chief Operating Officer	0	19	1		56	0	F		
	#NOF 48 hrs	Responsive	Services	Chief Operating Officer	90%	87.14%	84.21%	90.63%	86.20%	90%	P		
	#NOF 36 hrs	Responsive	Services	Chief Operating Officer	TBC	72.86%	70.18%	78.13%	72.09%				
	EMAS Conveyances to ULHT	Responsive	Services	Chief Operating Officer	4,657	4,357	4,218	4,700	4,258	4,657	F		
	EMAS Conveyances Delayed >59 mins	Responsive	Services	Chief Operating Officer	0	27	49	81	55	0	F	L	
	104+ Day Waiters	Responsive	Services	Chief Operating Officer	5	45	137	116	323	20	F		
	Average LoS - Elective (not including Daycase)	Effective	Services	Chief Operating Officer	2.80	3.51	2.57	3.38	3.16	2.80	F		
	Average LoS - Non Elective	Effective	Services	Chief Operating Officer	4.50	3.47	3.98	4.37	3.88	4.5	P		
	Delayed Transfers of Care	Effective	Services	Chief Operating Officer	3.5%	Submission suspended			3.13%	3.5%			
	Partial Booking Waiting List	Effective	Services	Chief Operating Officer	4,524	18,154	19,106	19,789	18,785	4,524	F	H	
	Outpatients seen within 15 minutes of appointment	Effective	Services	Chief Operating Officer	70.0%	32.7%	38.0%	33.3%	35.76%	70.00%	F		
	% discharged within 24hrs of PDD	Effective	Services	Chief Operating Officer	45.0%	36.0%	36.2%	37.0%	37.34%	45.00%	F		

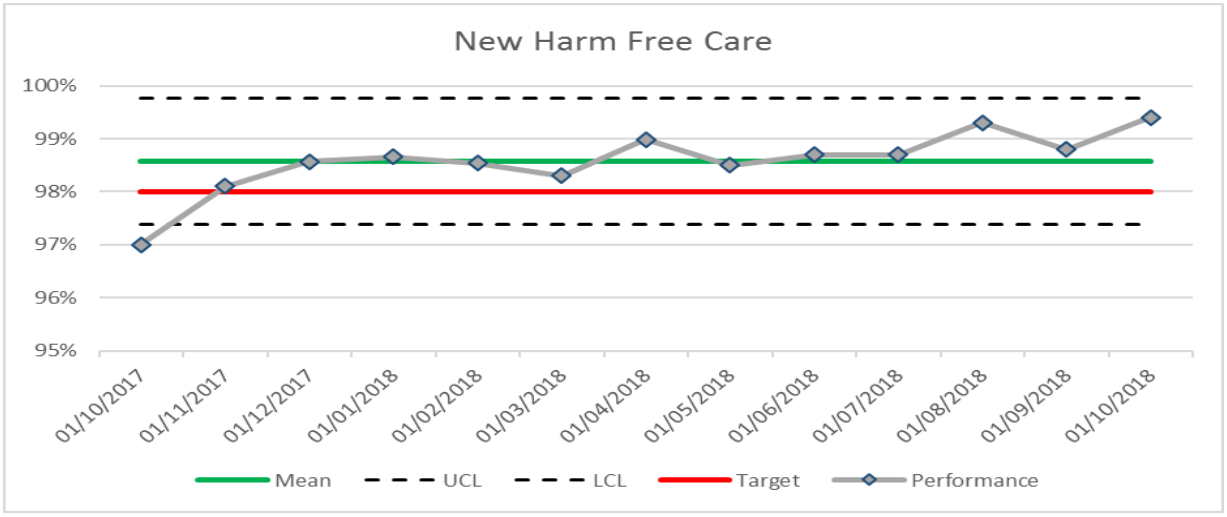
STATISTICAL PROCESS CONTROL CHARTS

Statistical Process Control (SPC) charts are an analytical tool that plot data over time. They help us understand variation which guides us to make appropriate decisions.

SPC charts look like a traditional run chart but consist of:

- A line graph showing the data across a time series. The data can be in months, weeks, or days- but it is always best to ensure there are at least 15 data points in order to ensure the accurate identification of patterns, trends, anomalies (causes for concern) and random variations.
- A horizontal line showing the Mean. This is the sum of the outcomes, divided by the amount of values. This is used in determining if there is a statistically significant trend or pattern.
- Two horizontal lines either side of the Mean- called the upper and lower control limits. Any data points on the line graph outside these limits, are 'extreme values' and is not within the expected 'normal variation'.
- A horizontal line showing the Target. In order for this target to be achievable, it should sit within the control limits. Any target set that is not within the control limits will not be reached without dramatic changes to the process involved in reaching the outcomes.

An example chart is below:



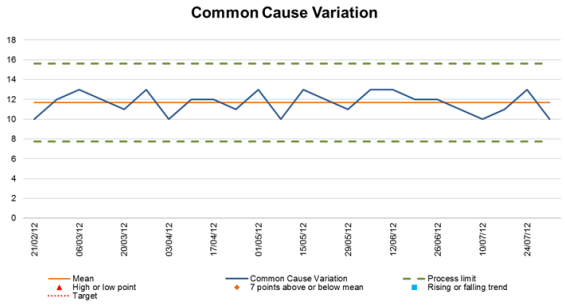
Normal variations in performance across time can occur randomly- without a direct cause, and should not be treated as a concern, or a sign of improvement, and is unlikely to require investigation unless one of the patterns defined below applies.

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

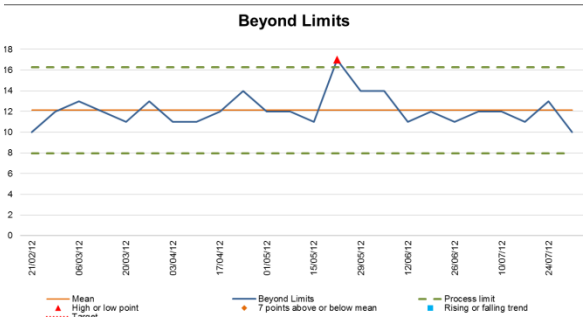
- Normal variation – (common cause) fluctuations in data points that sit between the upper and lower control limits
- Extreme values – (special cause) any value on the line graph that falls outside of the control limits. These are very unlikely to occur and where they do, it is likely a reason or handful of reasons outside the control of the process behind the extreme value
- A trend – may be identified where there are 7 consecutive points in either a patter that could be; a downward trend, an upward trend, or a string of data points that are all above, or all below the mean. A trend would indicate that there has been a change in process resulting in a change in outcome

Icons are used throughout this report either complementing or as a substitute for SPC charts. The guidance below describes each icon:

Normal Variation

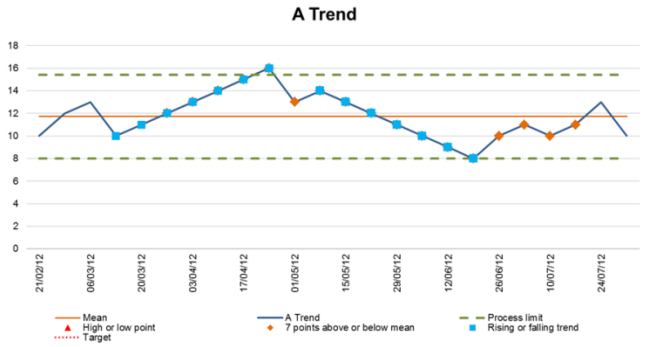


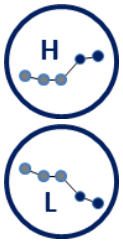
Extreme Values



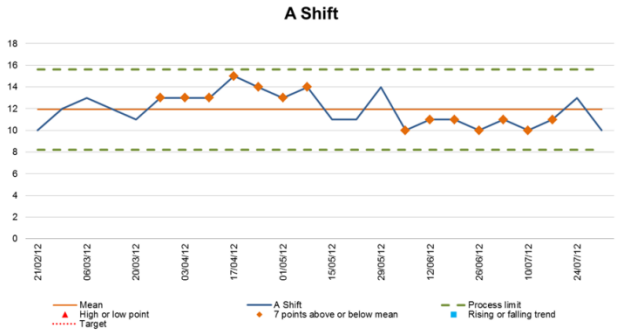
There is no Icon for this scenario.

A Trend (upward or downward)





A Trend (a run above or below the mean)



Where a target has been met consistently

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

Where a target has been missed consistently

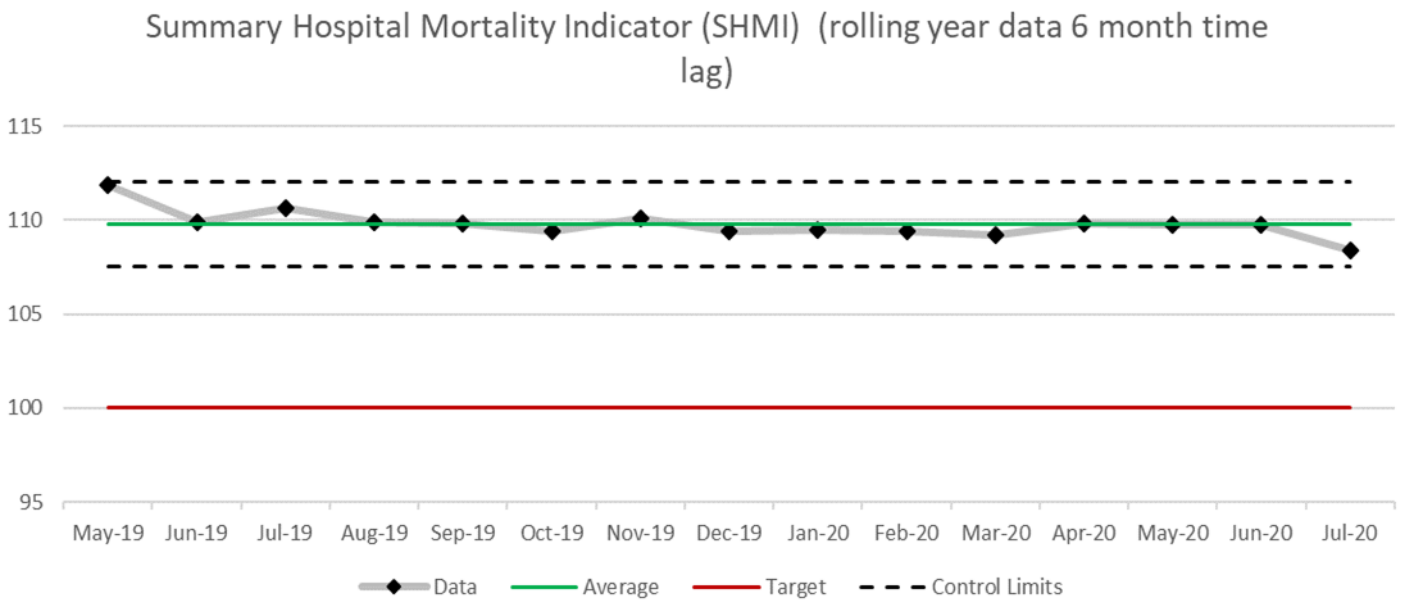
Where the target has been missed for at least 3 of the most recent data points in a row, or in a string of 7 of the most recent data points, at least 5 out of the 7 data points have missed.

DELIVER HARM FREE CARE - MORTALITY

Executive Lead: Medical Director

CQC Domain: Effective

Strategic Objective: Patients



Challenges/Successes

SHMI (March 2019 to February 2020) is 108.42 'within expected limits' this is a slight decrease from the previous reporting period. SHMI includes both deaths in-hospital and within 30 days of discharge. SHMI's current in-hospital SHMI is 95.8. SHMI will not be including COVID-19 deaths within their analysis.

Actions in place to recover

The Lincolnshire Collaborative has been re-established, however, the function of this group is being reviewed by ULHT and our system partners.

The Mortality Assurance Learning Strategy (MorALS) Group has commenced and Clinical Governance are currently liaising with the Clinical Business Units to ensure we have robust mortality processes in place.

Substantive Medical Examiners (MEs) have recommenced in post with effect from 03 August 2020. The Trust has also increased the number of ME PAs to 13PAs to enable 100% of deaths being reviewed by the ME.

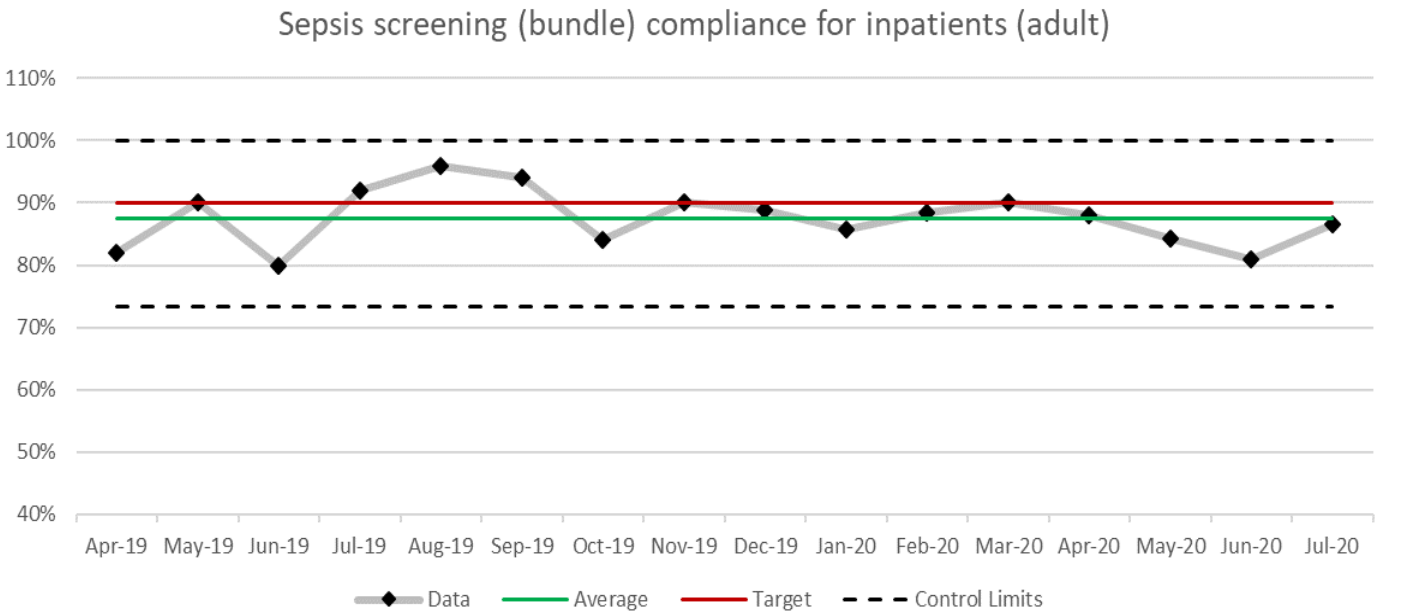
A thematic analysis of the deaths reviewed during the COVID-19 pandemic will be presented in August 2020.

DELIVER HARM FREE CARE – SEPSIS SCREENING

Executive Lead: Director of Nursing

CQC Domain: Safe

Strategic Objective: Patients



Challenges/Successes

Sepsis screening compliance for Adult Inpatients has improved in July to 86.5% although has not achieved the 90% target.

Actions in place to recover:

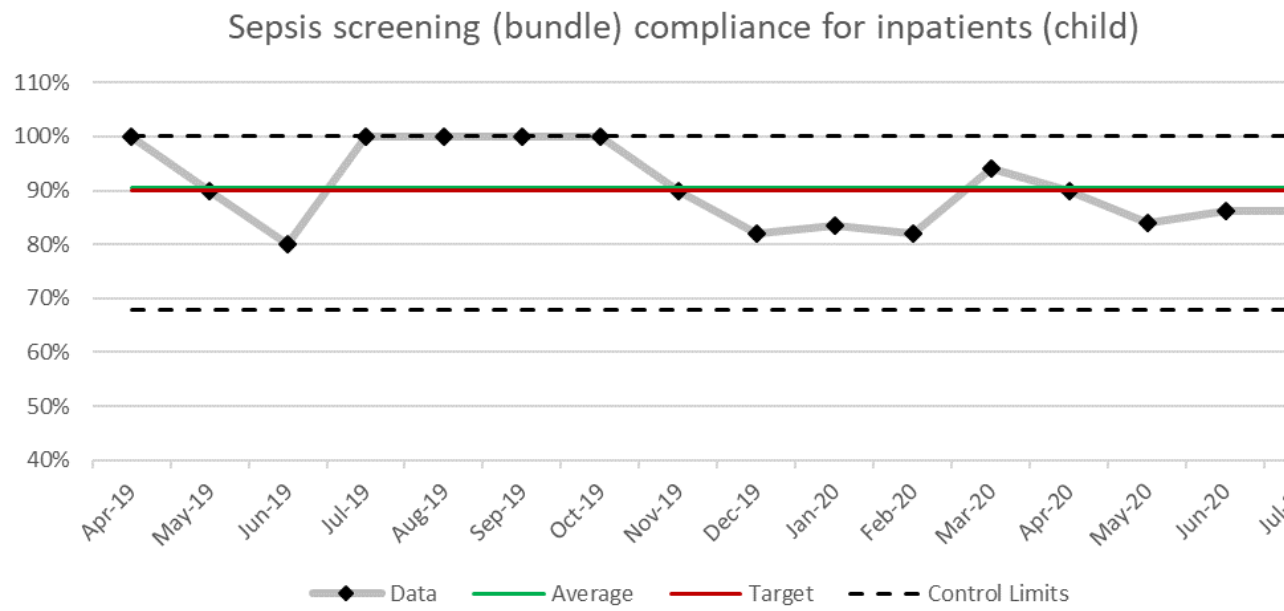
- Sepsis Practitioners are undertaking harm reviews in partnership with Ward Leaders to identify current themes for noncompliance and support required improvements.
- Sepsis Practitioners delivering 'Tea Trolley' teaching sessions in targeted areas alongside Clinical Education team.
- Lessons learned from reviews shared through clinical governance forums.
- Review of sepsis workbook utilisation by Agency staff is to be undertaken.
- Continuing to develop the Train the Trainer programme.
- Sepsis will be included in September during first month of the new 'Focus on Fundamentals' education and awareness programme.

DELIVER HARM FREE CARE – SEPSIS SCREENING continued

Executive Lead: Director of Nursing

CQC Domain: Safe

Strategic Objective: Patients



Challenges/Successes

Sepsis screening compliance for inpatient (child) has remained static at 86% and therefore not achieved the 90% target.

Where a delay in screening has been identified cases have been reviewed and it was confirmed that no patients were diagnosed with sepsis and received timely treatment in line with their individual requirements.

Actions in place to recover:

The designated Paediatric Resuscitation and Sepsis Practitioner now in post will undertake this month's harm reviews in conjunction with the ward lead in order to better understand the reasons for noncompliance and identify bespoke training accordingly.

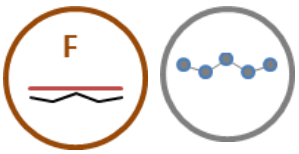
The Paediatric Resuscitation and Sepsis Practitioner will attend the ward safety huddles to improve focus on identifying sepsis and screening within 60 minutes.

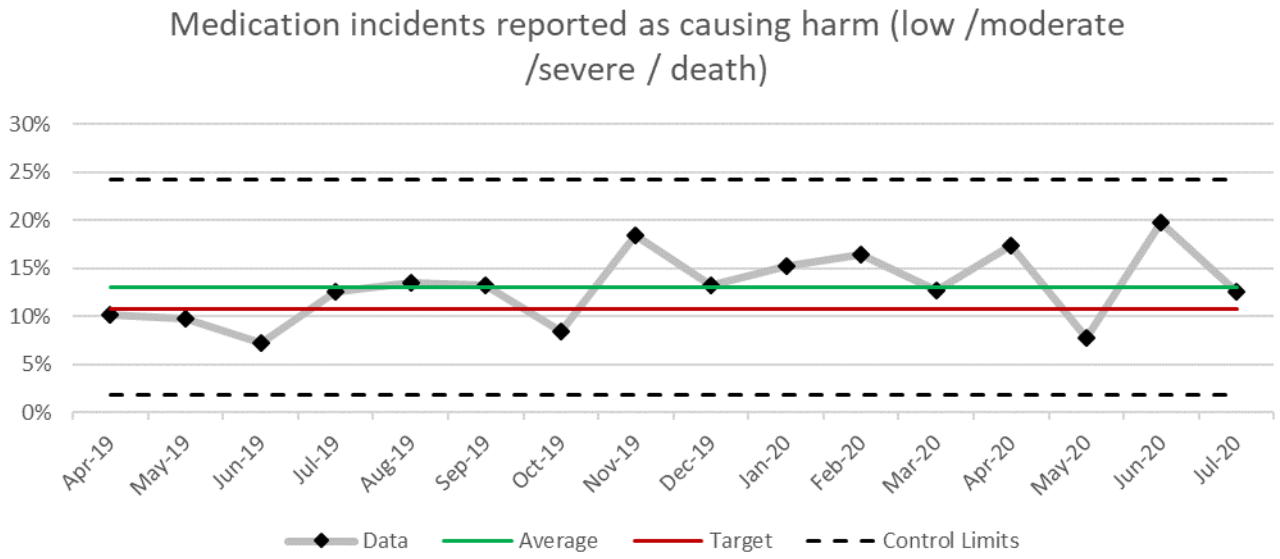
DELIVER HARM FREE CARE – MEDICATION INCIDENTS

Executive Lead: Medical Director

CQC Domain: Safe

Strategic Objective: Patients





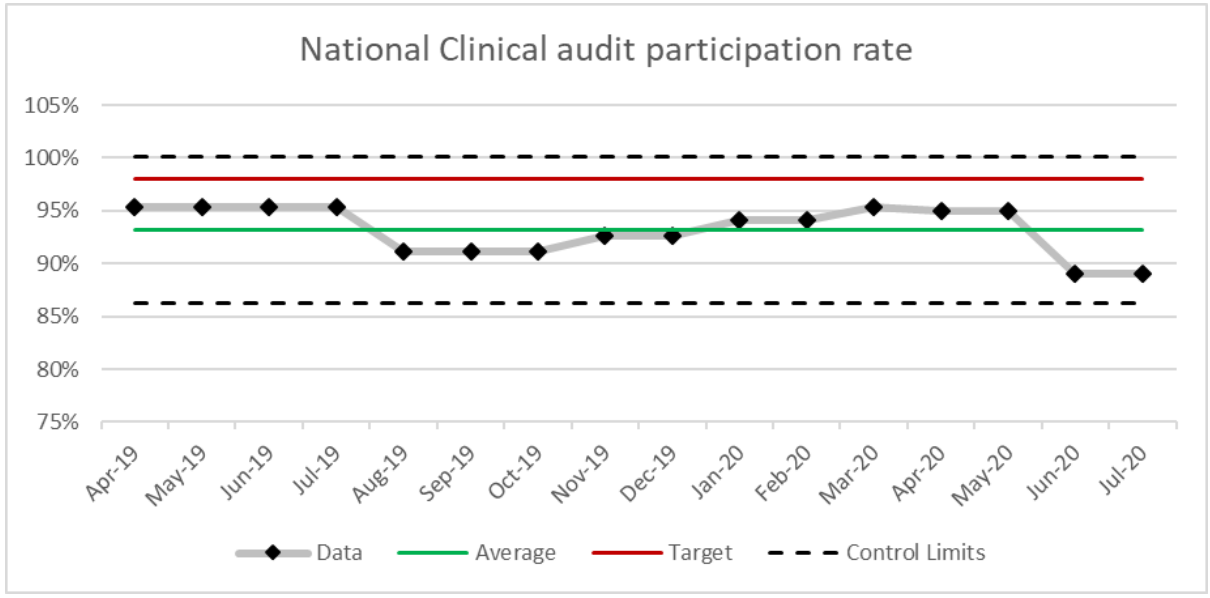
Although the performance reported of 12.6% exceeds the national average of 10.7%, it is in line with the average for the Trust and is below peer average which is 15.1% in the same period.

DELIVER HARM FREE CARE – NATIONAL CLINICAL AUDIT RATE

Executive Lead: Medical Director

CQC Domain: Effective

Strategic Objective: Patients



Challenges/Successes

The % participation National Clinical Audit rate has remained at 89% for the month of July 2020 compared to a target of >98% as the following audits are not compliant with data submissions;

Actions in place to recover:

- Non Participation in the National IBD audit to be clarified with the Gastroenterologists as the latest National report lists all other eligible Trusts are participating, however there is a participation fee to be paid by each Trust and it is not clear if this is the reason for our non-participation. This is being clarified with the service
- National Adult Asthma Audit from 1st April 2020 new data set being introduced delayed due to COVID-19 there will be a backlog to work through once the new dataset is launched which will align to BPT due to commence August 2020

Elective procedures cancelled in line with NHS England Guidance

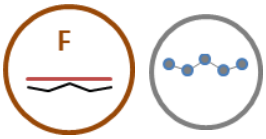
- Procedures now taking place this should improve participation submissions with the Green site.

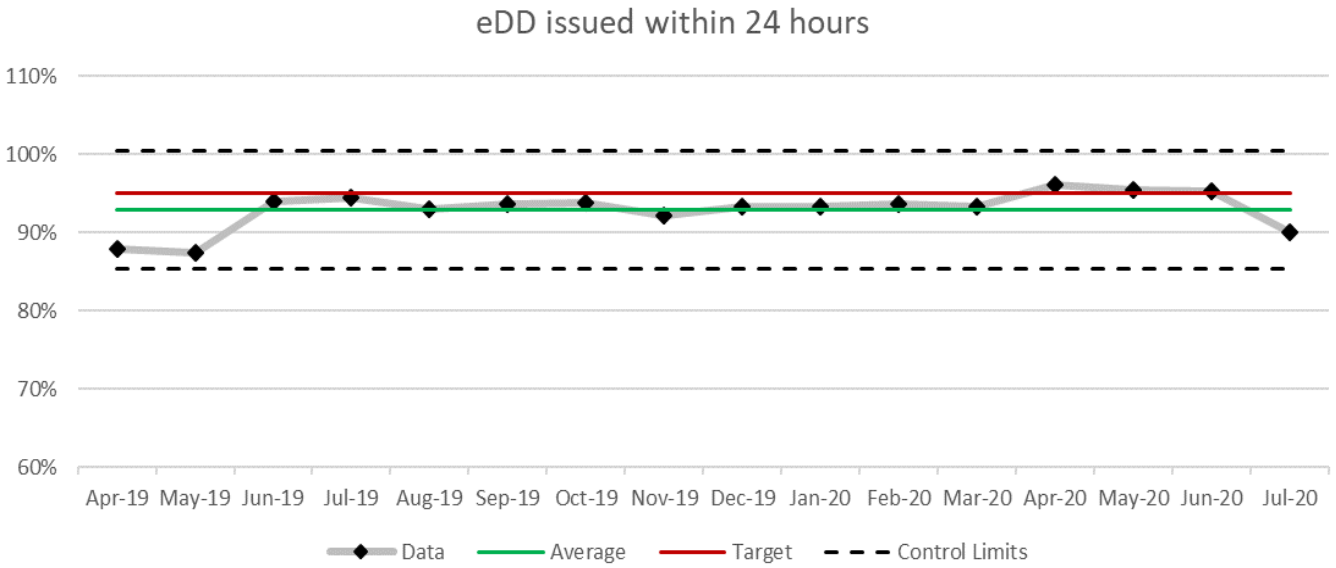
DELIVER HARM FREE CARE – eDD ISSUED WITHIN 24 HOURS

Executive Lead: Medical Director

CQC Domain: Effective

Strategic Objective: Patients





Challenges/Successes

The decline in performance is due to a IT system error which prevented the eDDs being sent over one weekend in the month.

Actions in place to recover:

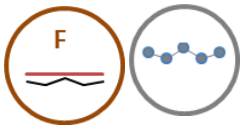
The issue was identified, investigated and resolved on the next working day. If this had not have occurred performance would have been above the benchmark.

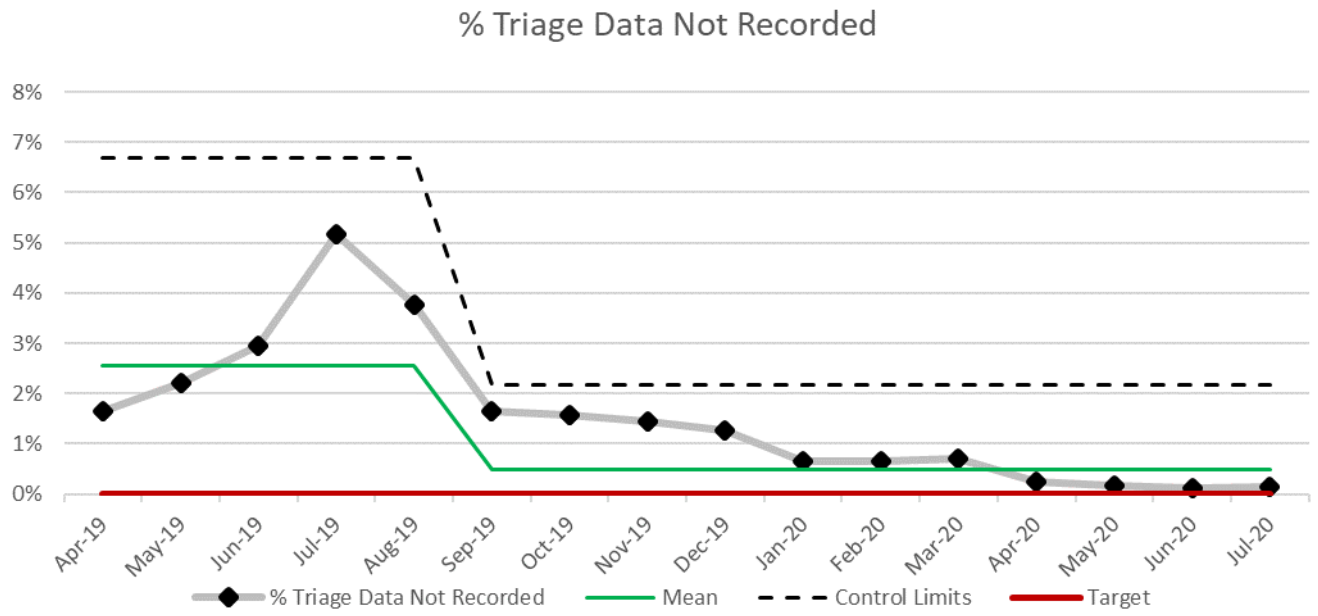
IMPROVE PATIENT EXPERIENCE – % TRIAGE DATA NOT RECORDED

Executive Lead: Chief Operating Officer

CQC Domain: Effective

Strategic Objective: Patients





Challenges/Successes

- July demonstrated a 0.02% negative variation in performance compared with June 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.
- The CQC recommendations to, where possible, replace the Pre-Hospital Practitioner role with a registrant caused disruption but it appears to be less of an issue currently.
- Some short notice sickness and agency cancellation has resulted in the inability to provide two triage streams at peak times of attendances.

Actions in place to recover:

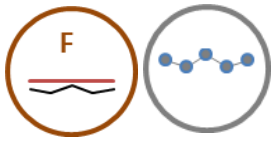
- The actions against this metric are repetitive but still valid.
- The Deputy Divisional Director of Nursing/Lead Nurse, Urgent and Emergency Care (UEC) ensures increased compliance and maintenance against this target and improvements continue to be realised.
- The Divisional UEC Operational Leads (DGM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

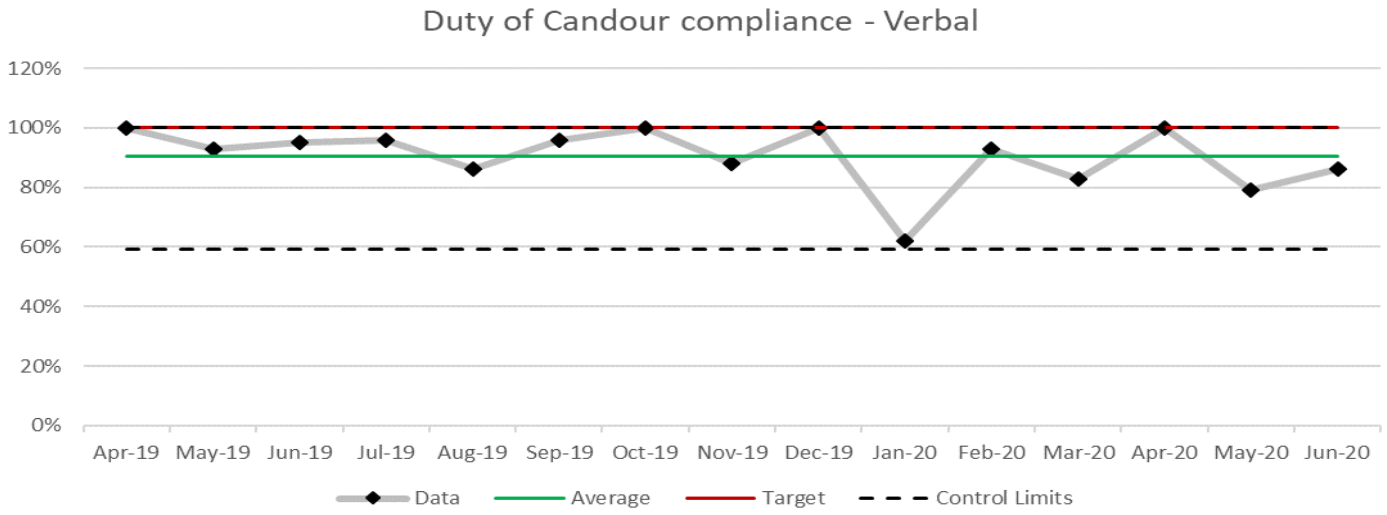
IMPROVE PATIENT EXPERIENCE – DUTY OF CANDOUR

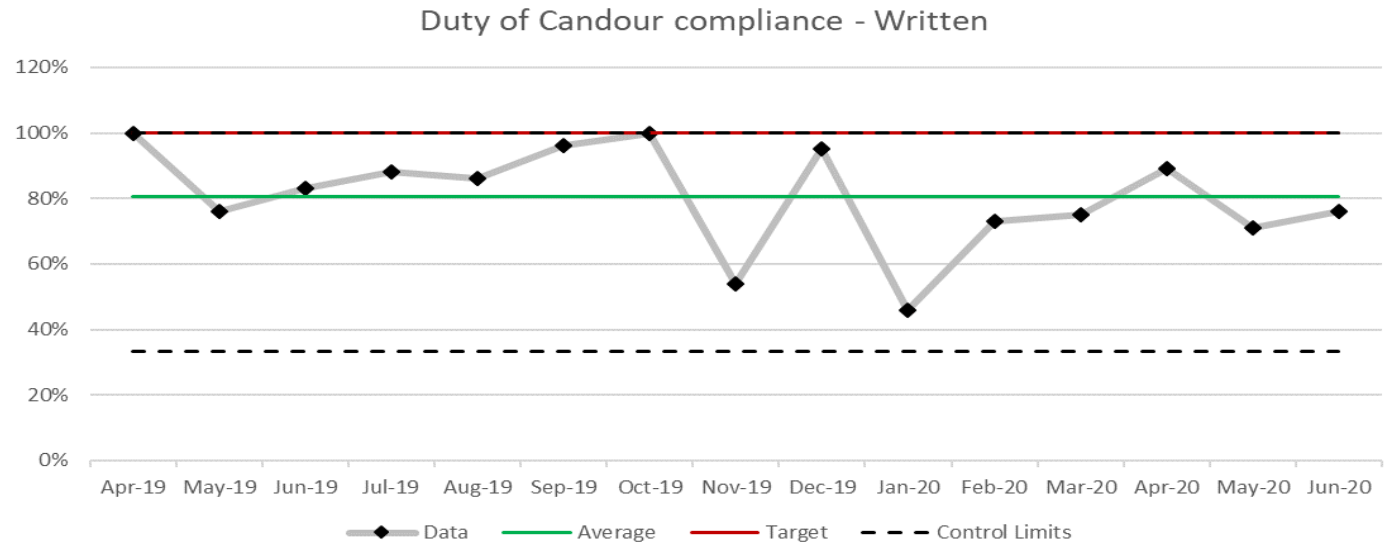
Executive Lead: Medical Director

CQC Domain: Safe/Responsive

Strategic Objective: Patients







Challenges/Successes

- The Trust attained 86% compliance with verbal duty of candour in July and 76% of written duty of candour
- Of the 19 notifiable incidents requiring Duty of Candour in June, the Trust achieved 89% compliance for 'in person' notification (2 non-compliant incidents, 1 in Urgent & Emergency Care CBU, 1 in Surgery CBU); and 84% for 'written follow-up' (1 additional incident non-compliant in Specialty Medicine CBU).

Actions in place to recover:

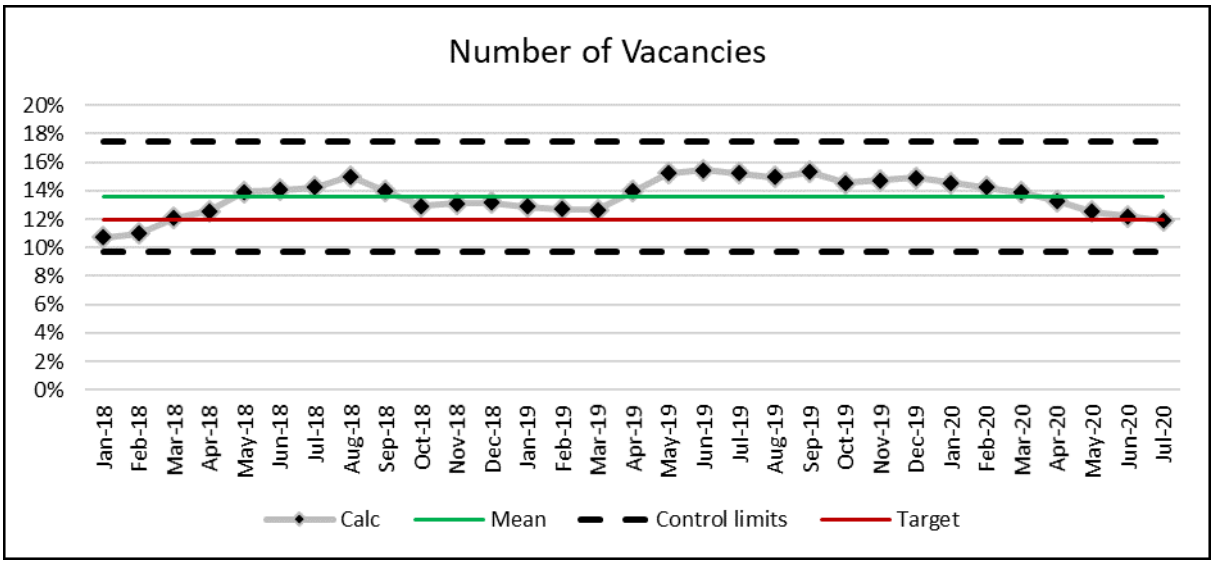
- Duty of Candour compliance is reviewed every month at the Patient Safety Group, where performance concerns and required actions are discussed and agreed with divisional representatives.
- This is in addition to in-month monitoring and escalations to individuals and divisional teams

A MODERN AND PROGRESSIVE WORKFORCE – VACANCY RATES

Executive Lead: Director of HR & OD

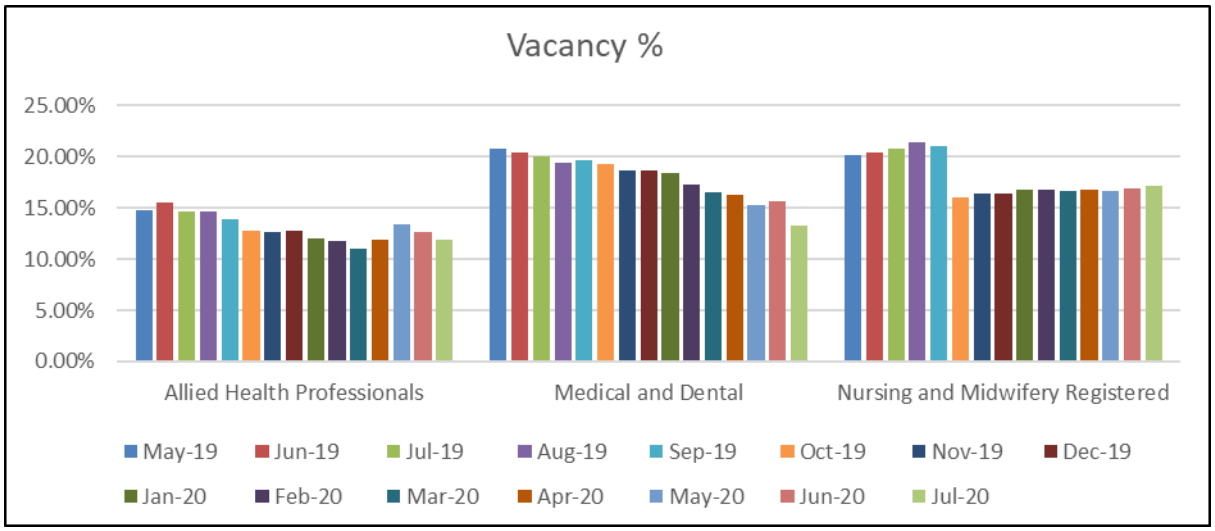
CQC Domain: Well-Led

Strategic Objective: People



Challenges/Successes

Whole Trust vacancy rate has continued to improve in months three and four of 2020/21, with 12 month turnover also below target for three consecutive months. It is likely that the COVID pandemic has impacted on both the delayed movement of staff within the NHS and individual decisions to retire.

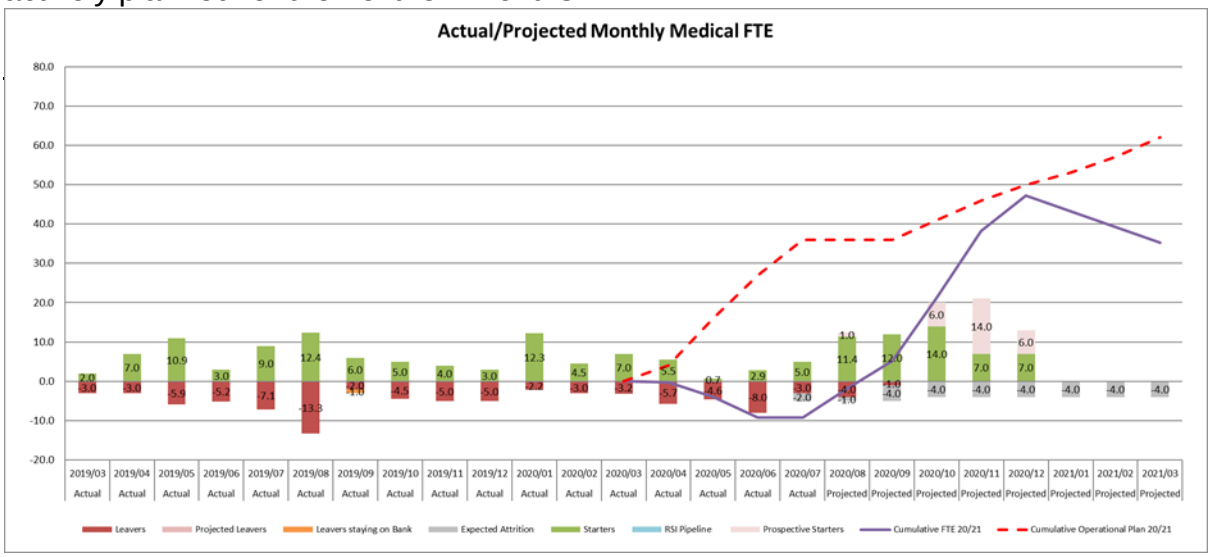


Staff Group	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20
Allied Health Professionals	14.60%	13.94%	12.76%	12.68%	12.82%	12.00%	11.71%	11.02%	11.93%	13.33%	12.66%	11.90%
Medical and Dental	19.38%	19.60%	19.24%	18.64%	18.62%	18.43%	17.31%	16.58%	16.27%	15.31%	15.66%	13.21%
Nursing and Midwifery Registered	21.37%	21.04%	16.06%	16.40%	16.40%	16.74%	16.82%	16.67%	16.75%	16.69%	16.87%	17.08%

Medical Staff Vacancy Rate

Improvement in the vacancy rate for medical staff continues with a marked 7 percentage point improvement over the last twelve months, whilst a 1% improvement in turnover over has contributed to this improvement, much of this improvement has been driven by a greater level of resourcing activity (consultant and SAS doctors) by Divisions strongly supported by the Resourcing Team and the international recruitment partnership and a higher Deanery fill rate for Doctors in Training. Improvement will also be seen with the planned start of Trust Grade doctors to address DiT HEEM rotational gaps this month.

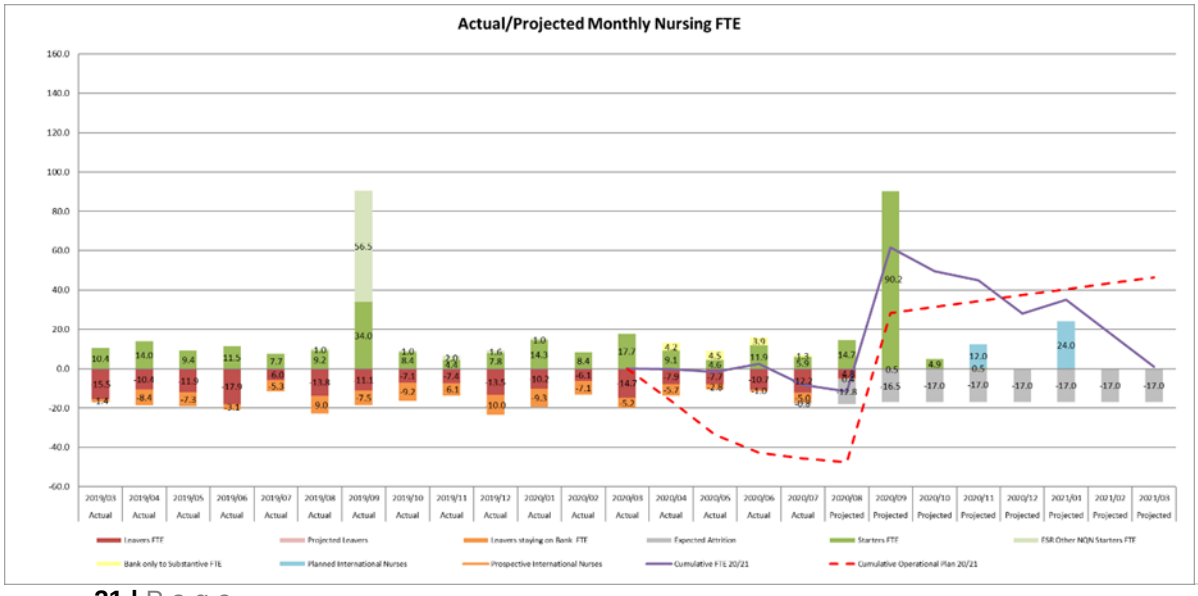
Further improvement in consultant and SAS Doctor Vacancy Rates are built into the 2020/21 Operational Plan (red dotted line), however the timeline for this planned improvement has shifted to the right with the impact of the COVID pandemic on international starts but are now starting to be actively planned for the next few months.



Graph as at 3 Aug 2020

Nursing Vacancy Rate

Improvement in the vacancy rate for nursing also continues with a 4.3 percentage point improvement over the last twelve months, with a 2.3% improvement in annual turnover a much stronger contributory factor and remains ahead of 2020/21 Operational Plan (red dotted line), resulting from reduced turnover and stronger than planned domestic recruitment including the conversion of some bank only staff to substantive (yellow on the waterfall chart). Further improvement is expected with planned NQN starts in August and September. The pipeline below reflects updated plans for international starts which have been reduced for year one and significantly delayed due to COVID, however the first international cohort will join the Trust later this month.

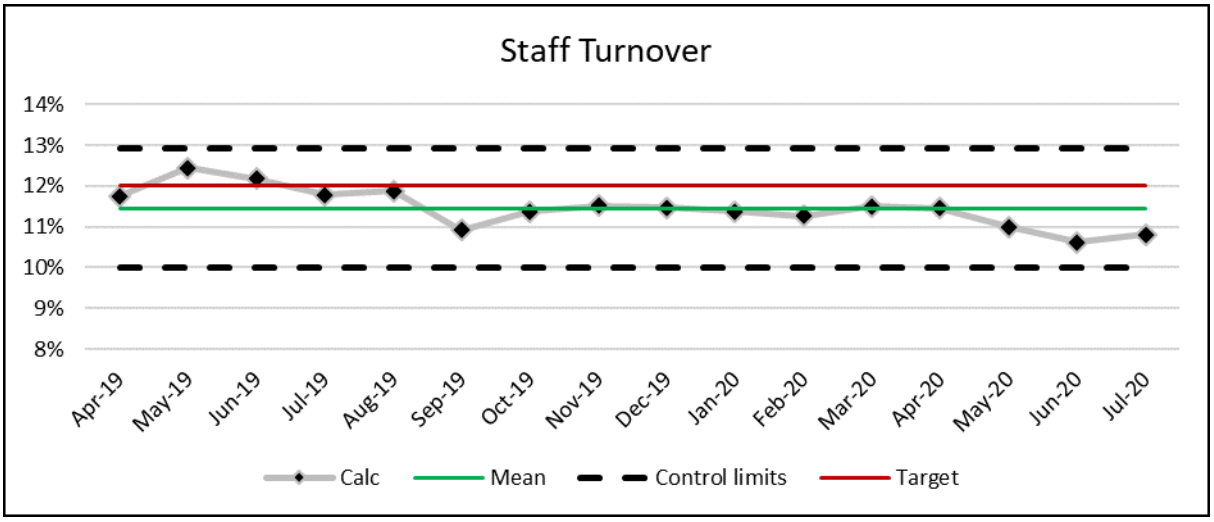


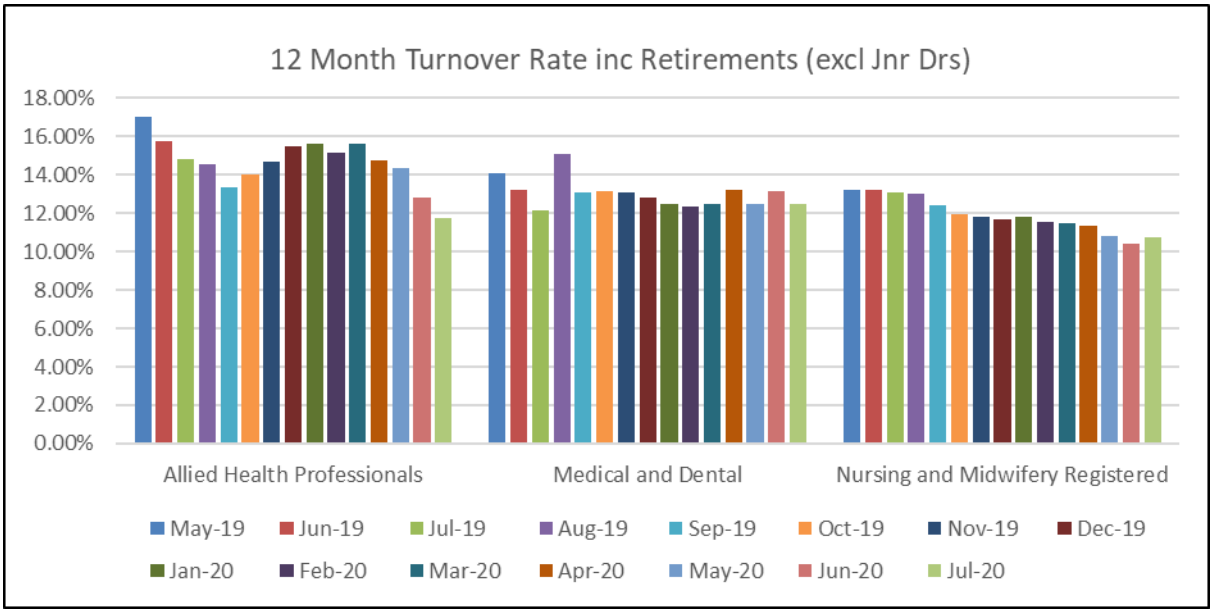
A MODERN AND PROGRESSIVE WORKFORCE – VOLUNTARY TURNOVER

Executive Lead: Director of HR & OD

CQC Domain: Well-Led

Strategic Objective: People





Staff Group	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20
Allied Health Professionals	14.53%	13.36%	14.02%	14.69%	15.46%	15.60%	15.16%	15.64%	14.73%	14.37%	12.79%	11.74%
Medical and Dental	15.10%	13.07%	13.11%	13.04%	12.78%	12.46%	12.36%	12.44%	13.21%	12.49%	13.14%	12.49%
Nursing and Midwifery Registered	12.99%	12.43%	11.96%	11.81%	11.70%	11.82%	11.56%	11.50%	11.32%	10.80%	10.42%	10.71%

Challenges/Successes

Longer-term trends for turnover remain positive, with the nursing rate close to national median rates. AHP turnover rate has reduced in the last 3 consecutive months and vacancy rate is now below 12% for the first time in many months.

Vacancy Rate / Turnover – Assurance, Actions In Place To Improve and Risks

For Assurance

- 12 month trend of improvement in KPIs
- Continued strong pipeline for Consultant and SAS recruitment
- Divisions continue to use the 'plan for ever post' approach to all vacant posts and there is greater triangulation with associated agency costs. (Nearly all consultant and SAS vacancies are actively being progressed).
- High number of AACs planned for 20/21 with an increasing standard on the bar to be met for appointment as a ULHT consultant.
- International strategic partnership fully mobilised with further Divisional engagement events to take place.
- Recruitment plan in place for a high number of DiT August rotational gaps
- Clinical Leads Forum (for medical leaders) and a SAS Forum (for Speciality doctors). We have also appointed a SAS Tutor in January and published a complete development calendar for SAS doctors.
- International nursing recruitment through strategic partner in progress.
- Fully engaged with HEE GLP programme
- First International nursing cohorts planned
- Strong engagement with student nurses and guaranteed employment offers
- International radiographers landed.
- Positive HCSW recruitment campaign with now minimal vacancies.
- Recruitment times have reduced from around 90 days, to around 60 days

Further Improvement

- Increased focus on staff engagement to reduce turnover. We are now looking at different initiatives for identified staff groups – Nursing, AHP's and Doctors. Exit data shows that the reasons for leaving are very different for the three groups.
- With the Integrated Improvement Plan being signed off there are a number of initiatives identified within that which will specifically focus on retention of staff. We are now in discussion to launch an AHP forum that will focus on an education strategy, workforce strategy, career development strategy and retention strategy for AHP's. All streams of work will be led by members of staff themselves.
- Widen 'plan for every post' to Nursing and AHP vacancies.
- A number of digital media recruitment campaigns planned.
- Further improvement on progressing known leavers is required.
- Plan to move to single position numbers in ESR to further support triangulation of associated agency costs with vacant posts.
- Risk to medical pipeline from an historical agency addressed.
- The improvement plan related to the recruitment process has been delayed due to COVID and is being re-profiled. It is essential that it is delivered to ensure sustained improvement.

Risks

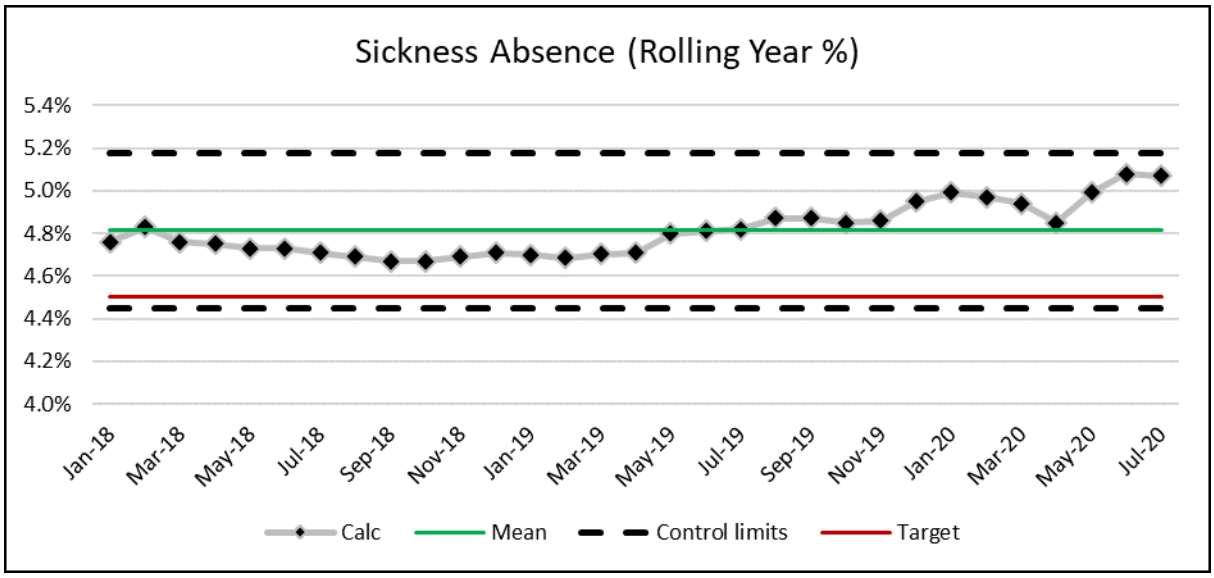
- Continued delay in international starts due to COVID and increased risk of attrition of international recruits from offer to start
- Divisional timely processing of known leavers and lost opportunity for early planning of local intelligence of anticipated staff moves.
- Translation of improvement in substantive vacancy rate into reduction in temporary staffing costs.
- Period of higher ‘risk of retirement’ numbers.
- OSCE capability for paediatric nursing
- Continued distraction from COVID Recovery phase.
- AHP retention and attraction.

A MODERN AND PROGRESSIVE WORKFORCE – SICKNESS

Executive Lead: Director of HR & OD

CQC Domain: Well-Led

Strategic Objective: People



Challenges/Successes

The 12 month rolling absence figure is 5.1% for July.

Sickness Absence – Assurance, Actions In Place To Improve and Risks

Points for Assurance

- The number of staff absent due to COVID reasons has significantly reduced.
- All Line Managers have been contacted to arrange any formal sickness meetings that may have not taken place during the COVID pandemic.
- Meetings have been taking place via Teams to avoid any further delays where possible.
- The ER Team will continue to contact those employees who are showing new symptoms and provide support to managers who are anxious about returning to work.

Actions being taken to improve performance

- Some meetings have not taken place due to availability of Union Representatives during the COVID pandemic.
- There are currently 95 open sickness cases relating to Stress and Anxiety. The ER team continue to support Line Managers to contact those people also to offer them support, to ensure all health and wellbeing avenues are being explored fully.
- The ER Team are now focussing on setting up a number of formal hearings for Disciplinary, Capability, Grievance and Appeal which may be impacting upon absence.

- The majority of staff who were shielding have now returned to work. However there are still a number of staff absent due to COVID reasons including those shielding. The ER Advisors are working closely with Line Managers to ascertain individual circumstances and to ensure a supportive return to work plan is agreed following a risk assessment. This will continue to reduce these absences further.
- The introduction of the Attendance Management System is our key response around levels of absence. More detail is given below

Update on the Attendance Management System

- Since go live (in Corporate Services) on the 3rd August, there has been 10 existing long term sickness cases that have transferred across and there has been 7 new short term absences recorded and being managed through the system.
- There are a total of 153 managers who have been trained in the first initial tranche of 427 Corporate staff not using Health roster.
- The ER team are currently contacting managers who have not been completing their call backs to ensure that the trust has full engagement with the system and the absence management process as per our policy.
- There is ongoing preparation for the next tranche, possibly ICT, following the news that the Healthroster integration should be active sooner than initially discussed which will enable the Trust, circumstances allowing, to complete the full roll out across the Trust earlier than we had planned.
- Lead Administrator now in place to support the project.
- The ER Advisors to support line managers with the implementation of the new Attendance Management System to manage attendance effectively.

Risks

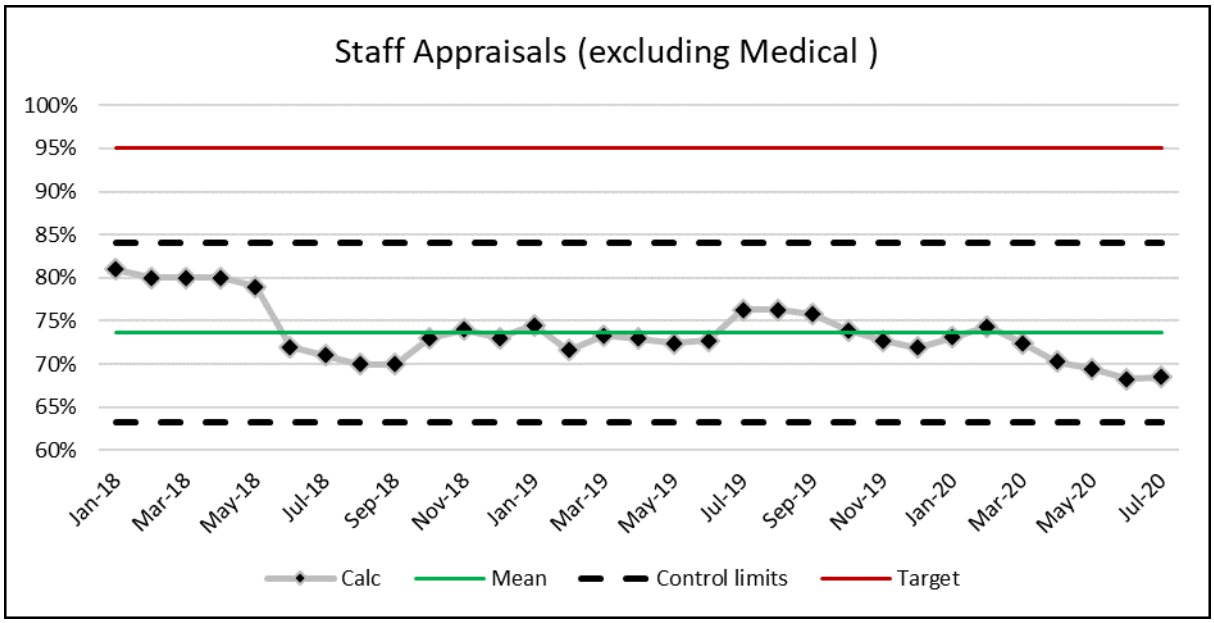
- A second spike of COVID, alongside summer annual leave or winter pressures.
- The ability to bring staff back to work or to WFH when they are not willing due to anxieties. The lack of accurate or timely recording by managers.

A MODERN AND PROGRESSIVE WORKFORCE – APPRAISALS

Executive Lead: Director of HR & OD

CQC Domain: Well-Led

Strategic Objective: People



Appraisal – Assurance, Actions In Place To Improve and Risks

Points for assurance

- E&F – OD work has been commissioned to identify and address the underpinning issues within E&F and where these impact on appraisal quality and completions.
- FH – completion levels have remained stable throughout the Covid period; Appraisal remains an area of focus and attention for continued improvement.
- Medicine – a proposed three week rolling programme of Workforce Performance Reviews with key managers/leaders, which will include oversight/remedial action relevant to appraisals.

Actions being taken to improve performance

- NHS People Plan (August 2020) requires that from September 2020 every member of the NHS should have a health and wellbeing conversation and develop a PDP reviewed annually
- We are considering requiring all staff to have a conversation with their manager during September/October to cover:
- Their role in Recovery
- Issues about their well-being and resilience.
- This would meet an expectation in the NHS National People Plan, ensure there is alignment around our objectives for the remaining months of the year and we can legitimately record as an appraisal conversation. This will be discussed further with ELT next week.

Risks

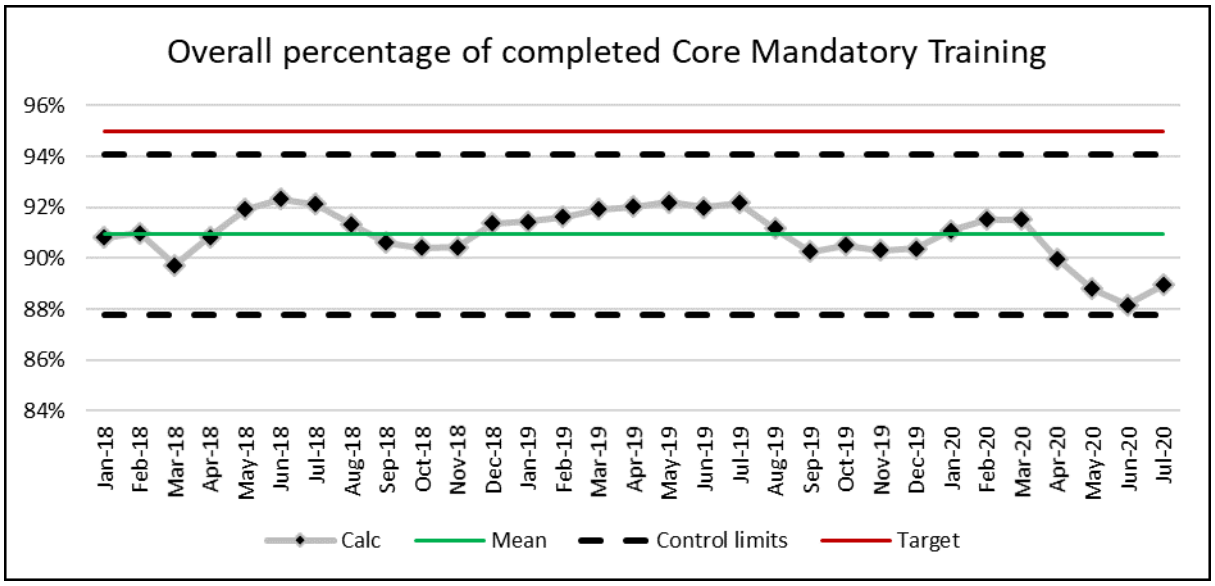
- Appraisal rates continue to fall as a result of COVID

A MODERN AND PROGRESSIVE WORKFORCE – CORE LEARNING

Executive Lead: Director of HR & OD

CQC Domain: Well-Led

Strategic Objective: People



Challenges/Successes

Compliance rate for Core Learning showed a consistent pattern of over 90% compliance through to the start of COVID. Data from Lincolnshire Partnership Foundation Trust (LPFT) and Lincolnshire Community Health Services (LCHS) show that their compliance rates are in the same overall range.

Discussions are ongoing within the STP to consider the possible benefits of sharing approaches to Core Learning with other Trusts in the Lincolnshire Healthcare community and the potential of this to increase Core Learning compliance even further. In addition, HR Business Partners and specialist trainers such as those in the Resuscitation Department are working actively with senior managers to continue to improve compliance.

New starters are now able to complete some of their Core Learning before commencing with the Trust. A complete e-learning Induction course is now in place due to Coronavirus outbreak.

Continued focus on IG training compliance to enable the Trust to achieve accreditation.

Core Learning – Assurance, Actions In Place To Improve and Risks

Points For Assurance

- Core learning is consistently running at around 90-92%
- All face to face activity ceased with a number of topics becoming E-learning packages
- Induction continued through COVID as an E-learning induction
- E-induction commenced in March 2020

Actions Being Taken To Improve Performance

- Socially distanced classroom training is being reintroduced where possible while ensuring that social distancing is maintained.
- Topic Specialists are now looking at other ways of delivering training
- The Fire Safety Team are shortly trialling delivering their Core Fire Safety training through Microsoft Teams
- The Safeguarding team are looking at new e-learning packages
- Core learning to become a performance target and is reviewed through PRMs
- Establishment of additional venues, such as the restaurant at Lincoln, giving access to Trust computers to make it easier for staff to complete e-learning courses.

Risks

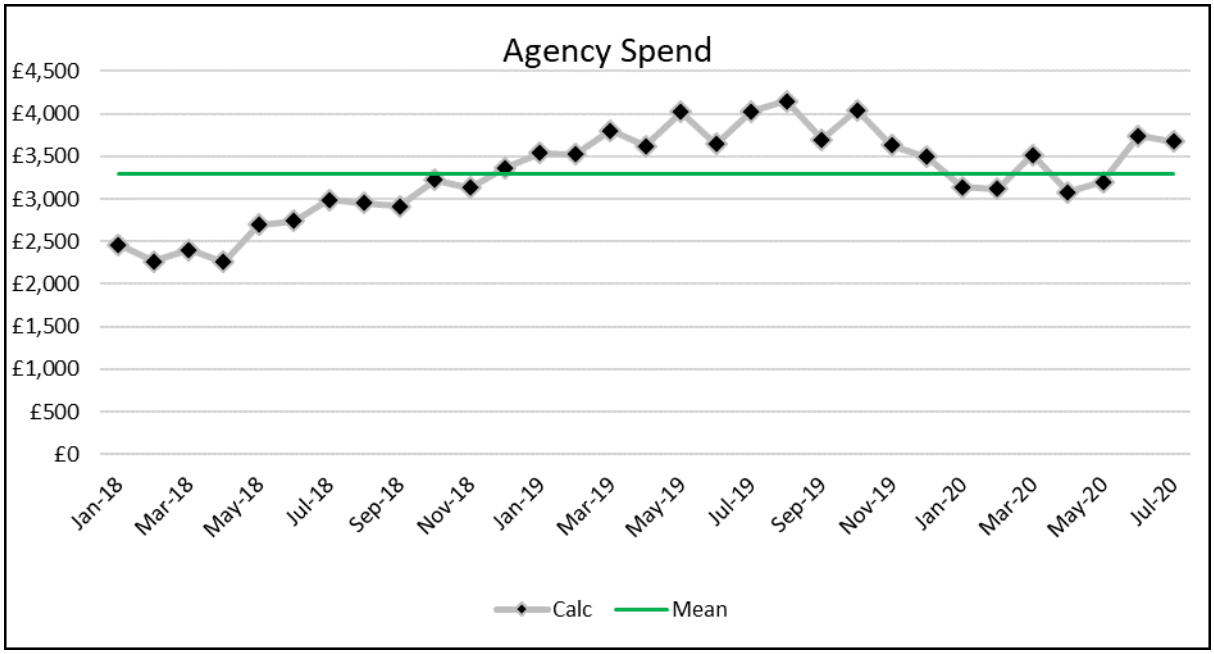
- Managers not releasing staff to undertake training as part of the restoration/recovery phase
- Failure of social distancing in classroom setting leading to potential social isolation requirement for larger numbers of staff, as occurred recently at Hillingdon Hospital.
- A second spike in Cornavirus
- Lack of staff access to E-learning
- Specialities not replacing face to face ongoing without alternatives

EFFICIENT USE OF OUR RESOURCES – AGENCY SPEND

Executive Lead: Director of HR & OD

CQC Domain: Well-Led

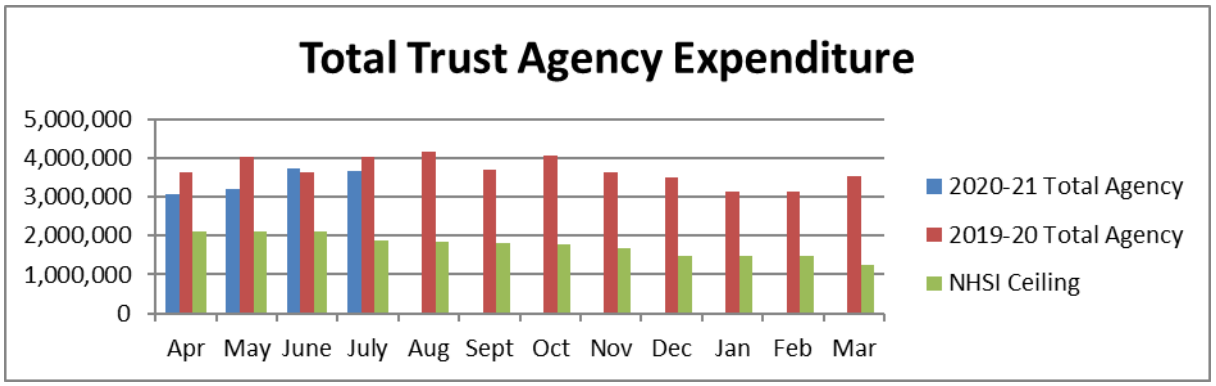
Strategic Objective: People



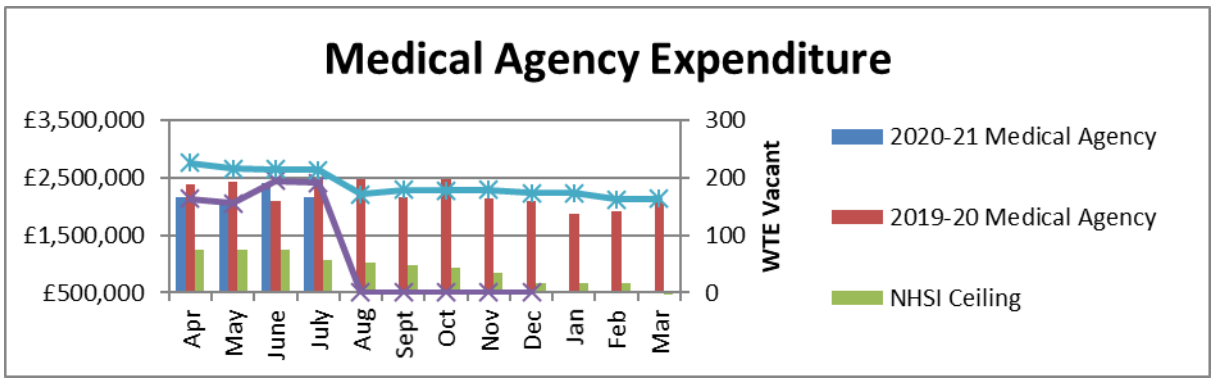
Challenges/Successes

Pay is £11.2M adverse to plan including (at M3) £4.9m of additional Pay costs in relation to Covid and £3.9m of notional expenditure in relation to additional employers' pension contributions which NHS England did not take into account when setting the Block payment.

However, there is notable adverse variance in substantive staffing which is being driven by a marked difference in actual substantive staff in post to plan at M4. Whilst this is on the whole positive, a lack of a corresponding reduction in bank and agency staffing costs presents a risk.



The monthly run rate for total agency spend in both June (M3) and July (M4) has increased to comparable levels with 19/20 with July costs understated due to a financial correction.



The medical agency spend for July was £2,472,385 (gross of adjustment) only slightly down from June which was £2,475,550. The continued increase is primarily driven by additional Covid shifts. Excluding all Covid related shifts for 19/20 comparison the agency total would have been £2,195,495, this still would have been slightly higher than pre Covid months and the increase is driven by the increased headcount in Emergency medicine (which is mainly being covered by agency) evidenced by Medicine requests categorised against vacancies, the average over the previous year was circa 1400 per month , it is now around 1865, the increase is driven by UEC.

Currently the agency forecast for august is £1,637,173 with significantly less Covid related shifts, better denary fill rate, more cost effective ways of resourcing such as trust grade roles and long term bank and regional bank doctors.

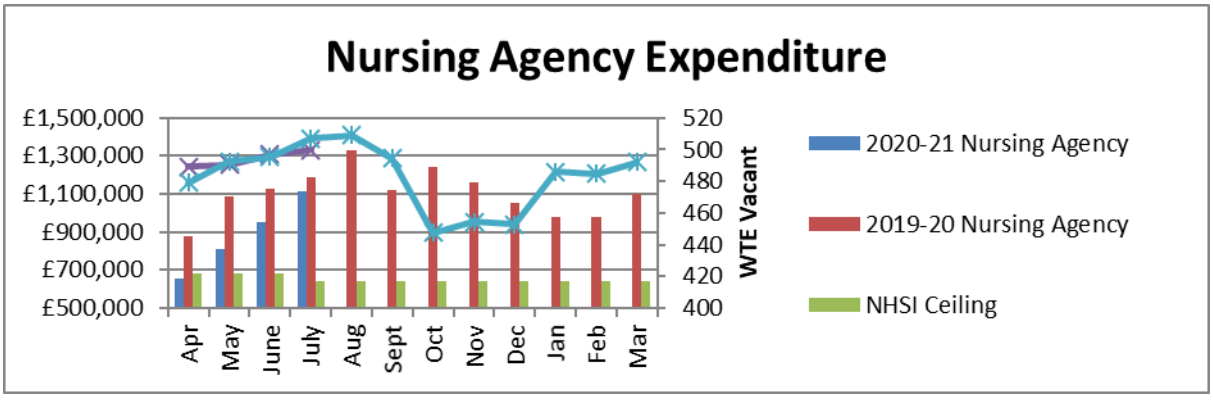
Rates remain fairly static and regionally in line with other trusts with the exception of junior rates which are below regional average.

As expected with the high volumes we were able to save a further £8,442 in reduced commissions, in the last 12 months, we have paid £131,190 less than the framework commission levels.

The DE efficiency was at 99.0% with only 32 shifts (3 Drs) being VAT applicable. This is the most VAT efficient month ever, the last 4 months have been at 98%+ which is exceptional.

The new managed bank continues to improve, with 28% of requested shifts through bank. We are in a much improved position in terms of prospective shifts versus retrospective shifts.

Agency to Bank ratio for July was 18:7 with 24.7% from Internal Bank and 1.7% from Regional Bank.



Nursing agency costs for M3 and M4 have increased steeply as NEL activity and bed occupancy levels have increased. However, off- framework nursing agency use has been significantly reduced and Thornbury use has only been used in exceptional circumstances.

Pay Costs – Assurance, Actions In Place To Improve and Risks

For Assurance

- Divisional MI information for medical agency is to a high standard and is increasingly being used.
- Nursing agency costs were controlled during lower bed occupancy levels.
- Trend of reducing off-framework nursing agency use
- The Director of Nursing has commissioned a refreshed forum for transforming the nursing workforce with an early focus on nursing agency use and cost.
- Scientific, AHP and other agency costs continue on downward trend.

Further Improvement

- Recruitment Improvement – see Vacancy Rate Section.
- Medical agency master vend currently undergoing collaborative procurement and will further support the positive work on contractual commission levels.
- Plan to move to single position numbers in ESR to further support triangulation of associated agency costs with vacant posts.
- Capitalising on benefits of managed and collaborative Medical Bank.
- A number nursing agency improvement work streams are in train including enhanced divisional MI, new SoP for Agency use, full review of rostering practice, review of overtime and bank, increasing lower tier framework nurse agency volumes to further reduce reliance on off frame work agency use and longer term temporary nursing staffing plans in place to avoid higher premiums of shorter lead time requests.

Risks

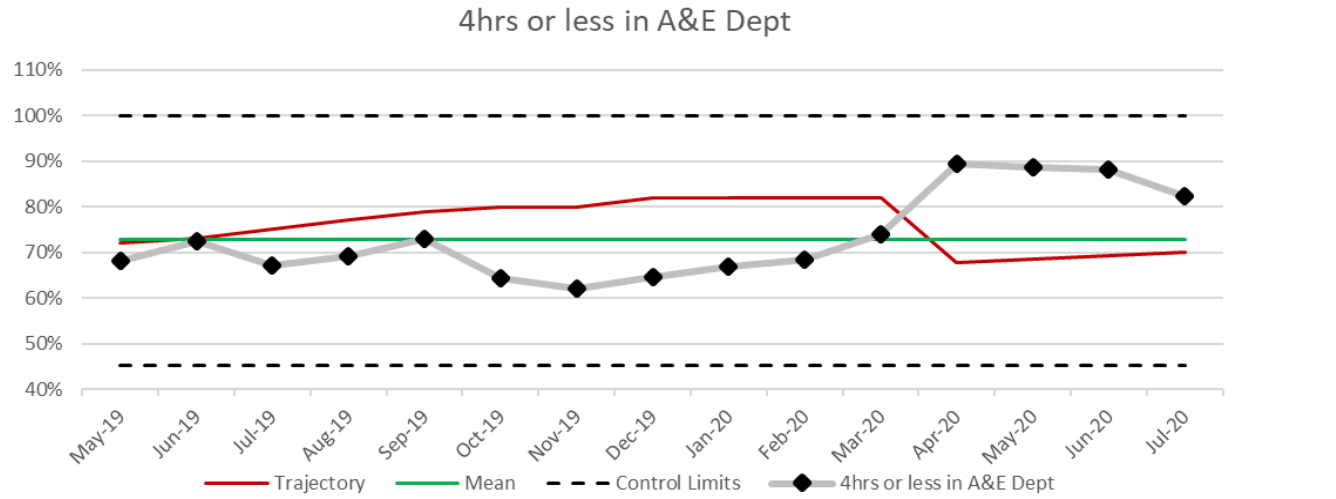
- Continued delay in international starts due to COVID.
- Direct COVID activity and expenditure is continued.
- Current run rate will breach NHSE/I cap by greater than 150% limiting UoR Assessment Rating

IMPROVE CLINICAL OUTCOMES – A&E 4 HOUR WAIT

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services



Challenges/Successes

- The NHS remained on a Level 4 COVID19 Pandemic incident response until 31st July, when notice was given that a de-escalation to Level 3 was to be instigated on 1st August 2020.
- A campaign to encourage the public to seek urgent medical care via Urgent Care Centres and Emergency Departments continued throughout July leading to further increases in attendances.
- Grantham transitioned from and Emergency Department to a 24 hours Urgent Care Treatment Centre on 22nd June 2020, thus reducing type 1 activity but increasing type 3 activity. July treated 1887 attendances compared to 1508 in June. This represents an increase of 379 attendances
- July ED type 1 and streaming was 15,269 attendances verses 13,075 in June. This represents a 14.73% increase. By site LCH experienced a 11.72% increase in attendances, PHB saw an increase of 16.94%. GDH also experienced an increase in attendances of 20.09% The GDH increase needs to be seen within the context extended opening hours.
- July overall outturn for A&E type 1 and primary care streaming delivered 82.37% against an agreed trajectory of 70.12%.
- This demonstrates a deterioration of 5.78% compared with June outturn, although this is still an improvement against trajectory of 12.25%.
- By site, for July, LCH delivered 76.80%, an 8.23% deterioration on June's performance, PHB delivered 84.41%, a deterioration of 4.01%. GDH achieved 99.15% which was an improvement of 1.07% compared to June. The highest days of delivery by the Emergency Departments was 27th July when PHB delivered 90.83% and 5th July when LCH achieved 81.03%. Conversely, the lowest days of delivery by Emergency Department was 31st July when LCH only achieved 56.42% and on 14th July when PHB only achieved 60.80%. A full analysis is in train, but likely attributors are a continued blue vs green demand mismatch, acuity and ambulance conveyances.
- Streaming at PHB experienced a deterioration in performance, 92.10% in July compared to 97.56% in June
- This deterioration should be seen in the context of increased non-elective admissions and a reduced available bed base.

Actions in place to recover:

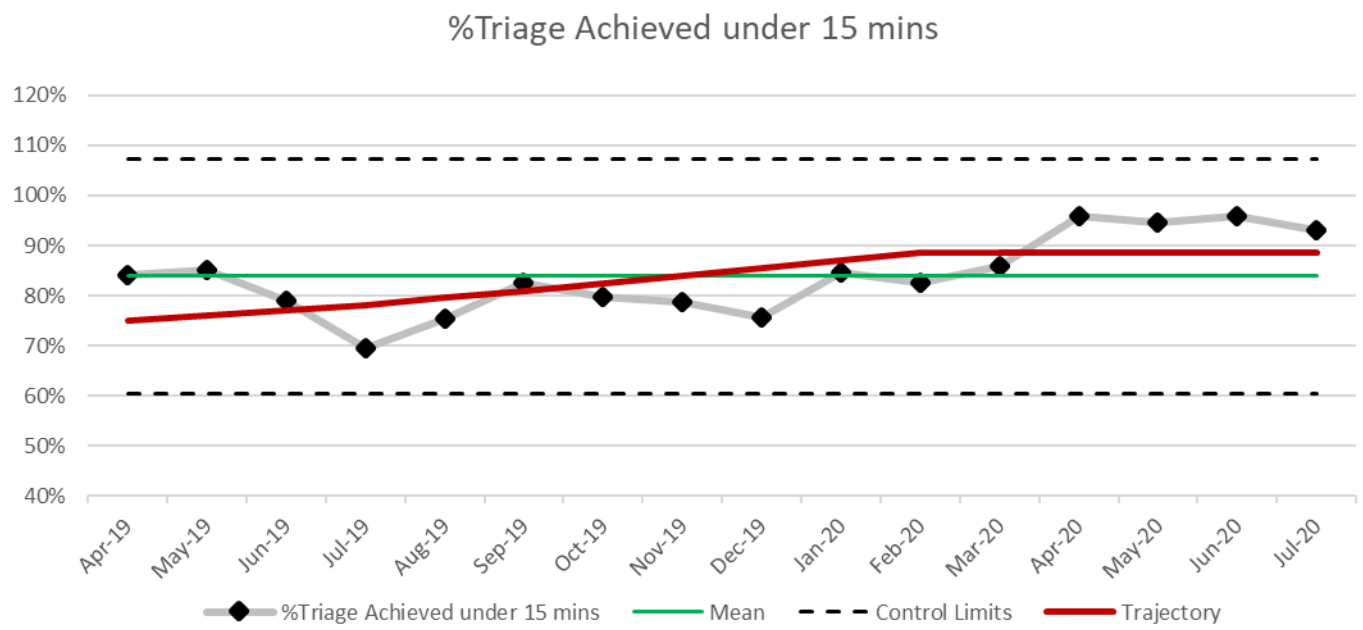
- Those process improvements, not affected by volume, have been reflected in the Restore phase of COVID management and where identified as more transformational, they have been further developed through a re-energised local improvement and delivery structure.
- The ability to respond dynamically in all urgent and emergency care access areas will support patients to be seen by the right person in the right service.
- As part of recovery, a bid for NHSe/i capital monies was submitted and approval to proceed obtained. This will see an increased ED footprint and the extension of primary care streaming.

IMPROVE CLINICAL OUTCOMES – %TRIAGE ACHIEVED UNDER 15

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services



Challenges/Successes

- Triage under 15 minutes deteriorated by 2.98% in July position. 93.03% in July verses 96.01% in June. The balance between managing the blue pathway and green pathway continues to be problematic, especially at times of increased volume of patients in the departments
- Measures are in place to ensure this key metric continues to achieve its improvement trajectory toward 100%.
- This metric is also captured as part of the daily and weekly CQC assurance reporting and performance is discussed daily by clinicians as part of the ED safety huddles.

Actions in place to recover:

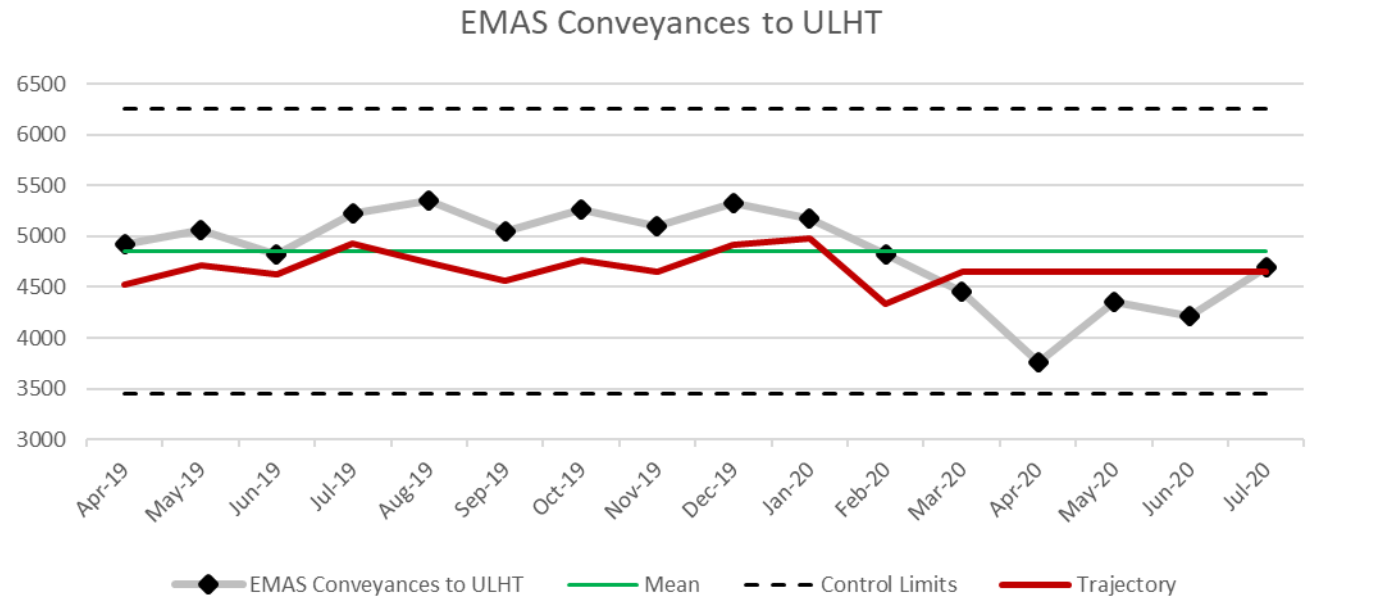
- A return to levels more in line with Pre Covid attendances, the focus must remain on achievement. This will be monitored and actioned locally by the newly appointed band 8a ED Performance Managers and the recent appointments of 2 x 8a Clinical Leads (Nursing).

IMPROVE CLINICAL OUTCOMES – AMBULANCE CONVEYANCES

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services



Challenges/Successes

- Ambulance conveyances for July were 4700 compared to 4218 in June. This represents a 10.26% increase in conveyances across all sites.
- By site, LCH conveyances were 2835 in July compared with 2492 in June, a 12.10% increase, PHB was 1821 in July compared with 1606 in June, a 11.81% increase. GDH continued to experience a reduction in conveyance 44 in July compared to 120 in June, a 63.34% reduction.
- The continued challenge, as we move from restore and into recovery, whilst maintaining the segregated pathways, will be managing our overall conveyances. July has seen record numbers of conveyances to LCH. We are working with the System to reduce our overall attendances and conveyances by ensuring all admission avoidance pathways are robust and communicated clearly. It is also evident that LCH is receiving a largest proportion of those conveyances that would have attended GDH.

Actions in place to recover

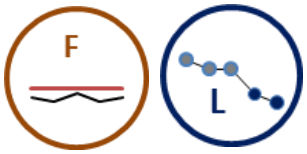
- Restore plans being put in place by the Trust for urgent and emergency care (UEC) include patients being appropriately clinically managed through alternative streams to avoid large numbers of patients in the emergency department leading to possible delays in handover.
- An increase to the overall footprint of our Emergency Departments is currently underway with secured funding.
- Key to delivering this and the Trusts UEC Restore plan is the understanding and transparency of the Restore plans being developed and agreed by our partners in EMAS, LPFT, ASC and LCHS.
- Load sharing is now in place between LCH and PHB for all clinical transfers from GDH

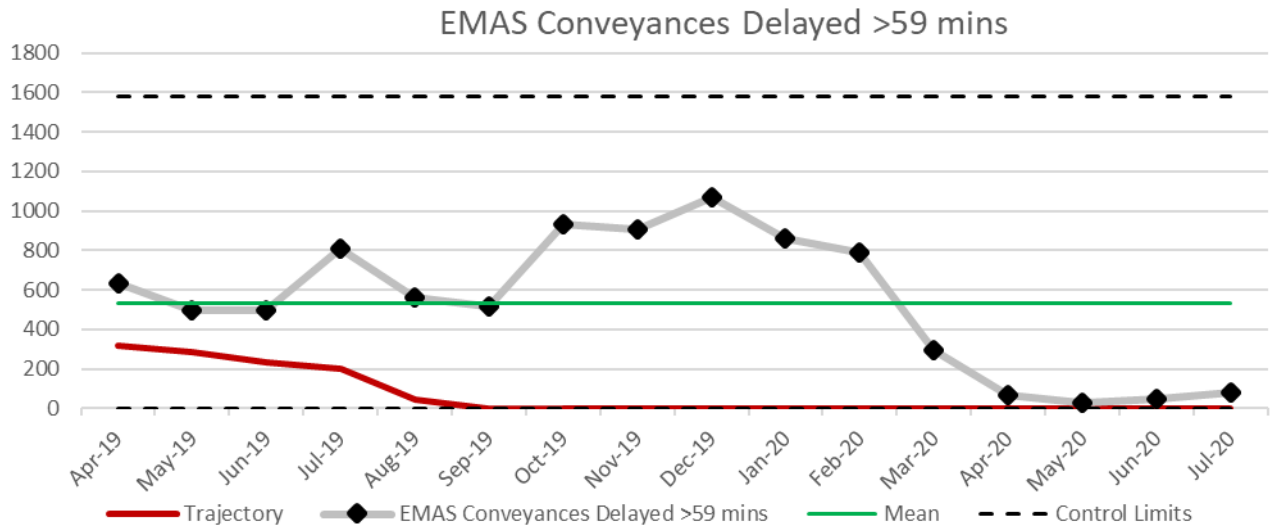
IMPROVE CLINICAL OUTCOMES – AMBULANCE HANDOVER >59

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services





Challenges/Successes

- During July there were 81 >59-minute ambulance handover delays. This is an increase of 32 compared to June. This represents a 39.51% increase in >59-minute ambulance handover delays. A focus has been applied to understanding this. NHSe/i are supporting local enquiries and improvement strategies.
- LCH had 63 >59-minute ambulance conveyances in July compared with 25 in June. This represents a 60.32% increase in July compared to June. PHB had 18 >59-minute ambulance conveyances in July compared with 24 in June. This represents a 25% reduction.
- Delays experienced at LCH and PHB are, in the main, as a result of an inability to 'flex' the segregated pathways more proactively and the pattern of conveyance.

Actions in place to recover

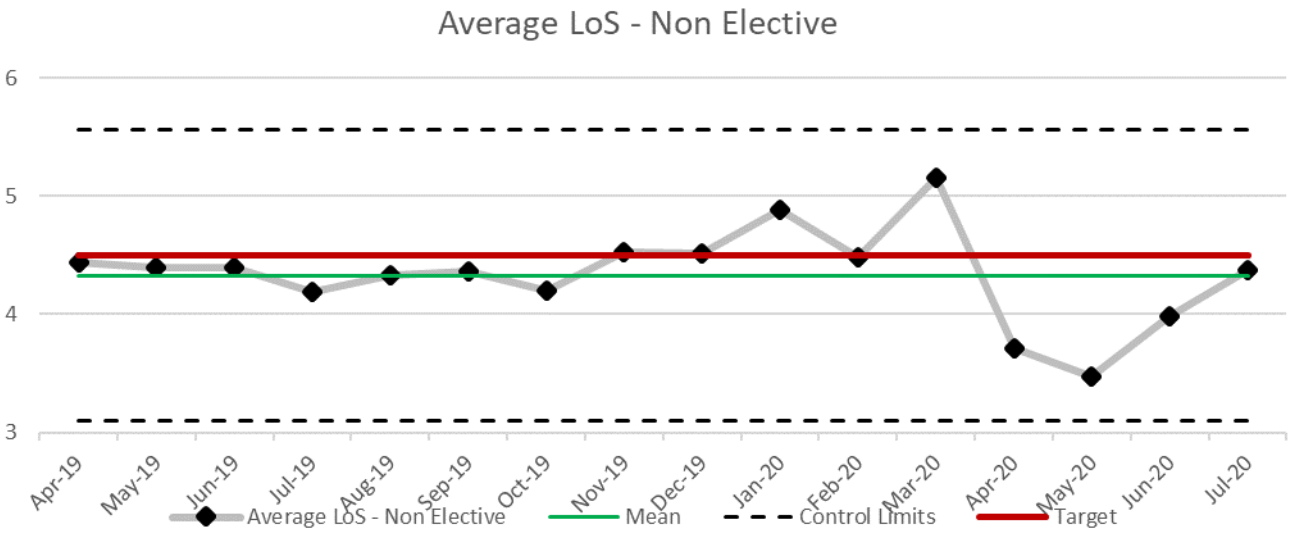
- RAT has been reinstated as well as maintaining a level of segregation for suspected COVID patients.
- A bid has been submitted and accepted to increase the footprint of both the Emergency Departments (LCH and PHB), specifically to allow an increased ability to respond to the timely and safe Ambulance handovers
- Work is in train within the System to reduce the overall ambulance conveyances to ULHT through implementing robust alternative pathways. A webinar is planned on 12th August.

IMPROVE CLINICAL OUTCOMES – AVERAGE LOS NON-ELECTIVE

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services



Challenges/Successes

- Average LOS for non-elective admissions saw further deterioration during July, delivering 4.37 ALOS compared to 3.98 compared in June. This represents a negative variation of 0.39 days.
- During July the numbers of patients with a LLOS decreased from 82 in June to 78 in July. A decrease of 4 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 in the manage phase. However, the introduction of a local patient swabbing agreement for all patients requiring on going care within Adult Social Care, discharge delays of >72 hours are increasing. This is under constant review as the ULHT G&A core beds can no longer support this process.
- Non elective admissions increase slightly in July by 3.35%. 2898 in July compared to 2801 in June

Actions in place to recover

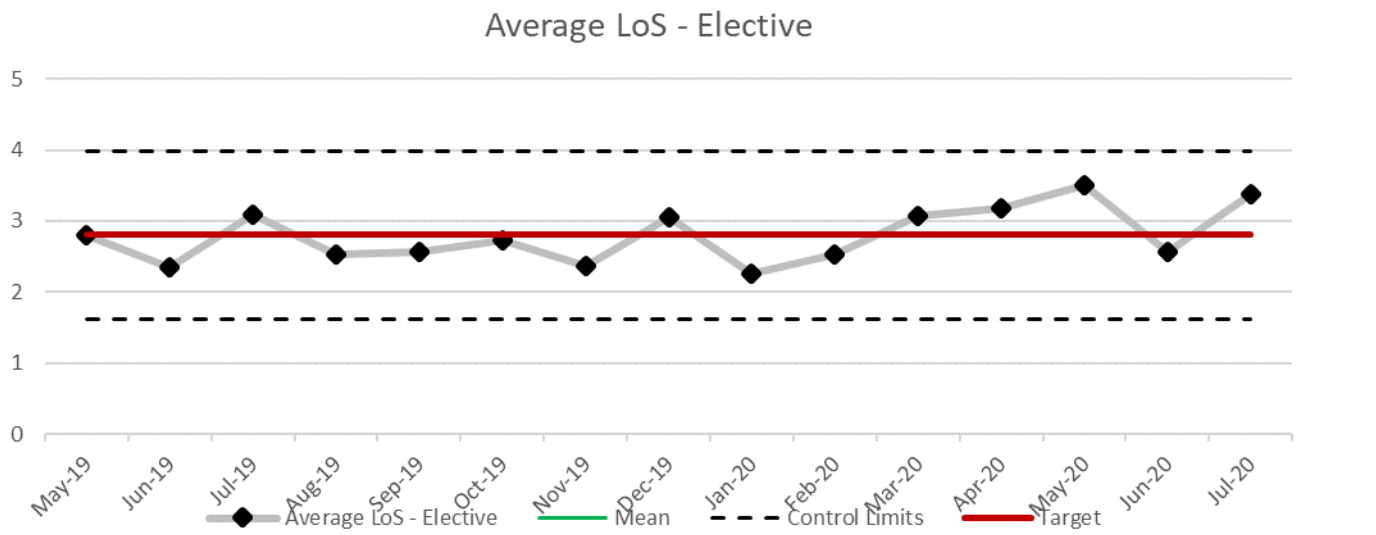
- Multi-agency discharge meetings take place once daily, seven days a week. Line by line reviews take place against each patient on pathway 1,2 and 3. Discharge plans are scrutinised. Clear expectations are agreed within the System to protect agreed discharge plans.
- Weekly multi-agency long length of stay meetings for each hospital site in place to support more complex patients through their discharge pathway.
- Patient swabbing agreement being reviewed to allow more flexibility in terms of valid swab result timescales to reduce >72-hour delays to discharge.
- System wide discussion and agreement has been reached to secure the multi-agency Discharge Cell continues through restore and recovery.

IMPROVE CLINICAL OUTCOMES – AVERAGE LOS ELECTIVE

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services

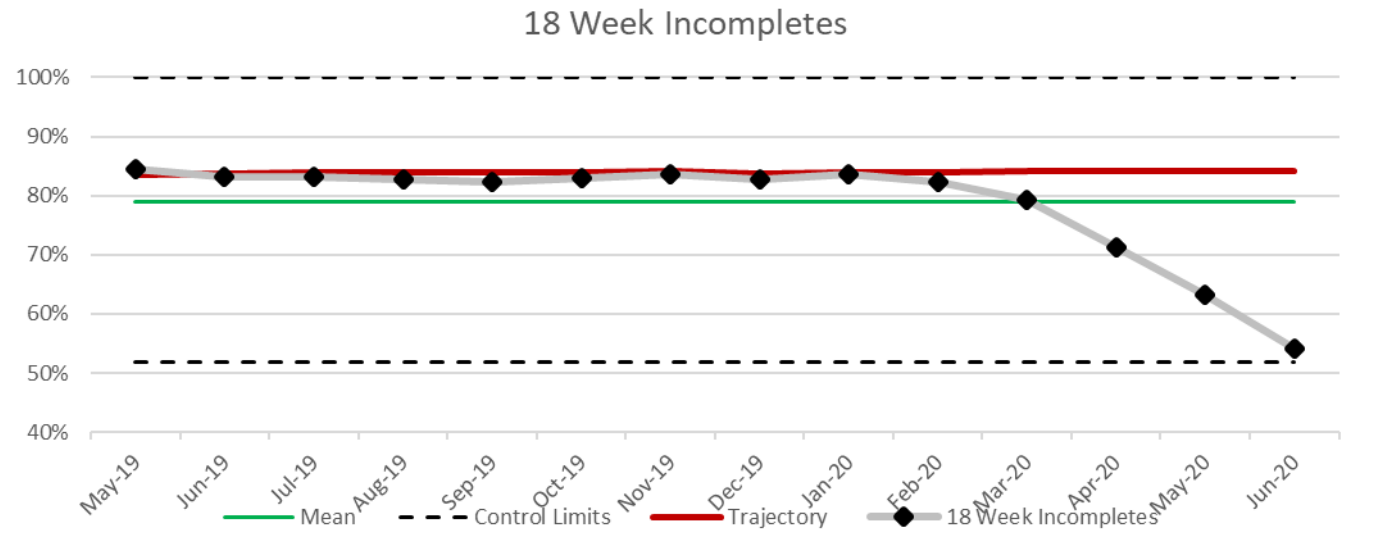


IMPROVE CLINICAL OUTCOMES - RTT 18 WEEKS INCOMPLETES

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services



Challenges/Successes

RTT performance is currently below trajectory and standard.

June saw RTT performance of 54.08%, -9.18% worse than May.

Diagnostic Imaging (14.29%) is the lowest performing specialty, from 50% last month (-35.71%). Neurology has deteriorated this month with a 9.23% decrease from 60.57% last month to 51.33% in June.

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

- Ophthalmology - 3148 (Increased by 1095)
- Maxillo-Facial Surgery + Orthodontics + Oral Surgery - 1880 (Increased by 260)
- ENT - 1839 (Increased by 126)
- Gastroenterology - 1562 (Increased by 172)
- Trauma & Orthopaedics - 1465 (Increased by 570)

Actions in place to recover:

As detailed above, performance across all specialties continues to decline. Ophthalmology, Maxillo-Facial, and Trauma & Orthopaedics have seen the largest decrease in performance.

The re-introduction of routine elective work for both admitted and non-admitted is now being progressed in line with recovery plans.

One of the largest detrimental impacts on General Surgery and Gastroenterology performance is the standing down of the Endoscopy service for routine patients. The Endoscopy service re-opened on 6th July, with the exception of services at Louth, which is scheduled to re-open on 7th September, and is

currently working on the backlog of Cancer patients. It is anticipated that Cancer performance will be recovered by the end of August. The service is currently running at approx 50% capacity but, by September this should be at about 80%. Endoscopy will be extending to 7 days service provision on all sites, enabling routine activity to be started in September. This will then start to improve performance in the specialities dependant on this service. The recovery trajectory shows that, assuming all plans come to fruition, Endoscopy will be back to preCOVID performance by end of November for both cancer and non-cancer patients.

Specialties achieving the 18 week standard for June were:

- Clinical Oncology 94.78%
- Medical Oncology 100%

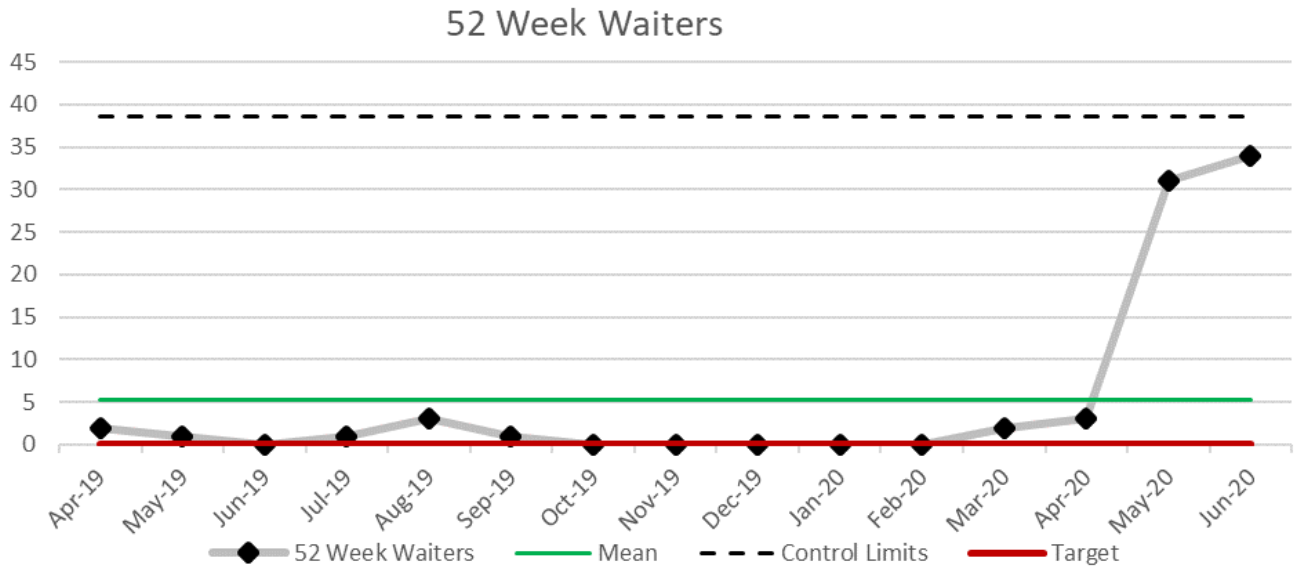
This is due to the continuation of Cancer services throughout the pandemic.

IMPROVE CLINICAL OUTCOMES – 52 WEEK WAITERS

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services



Challenges/Successes

The Trust reported thirty-four incomplete 52 week breaches for June end of month. Twenty seven of these were due to stopping service provision and seven due to incorrect data entry.

Root cause analysis and harm reviews will be completed by the relevant division for each patient. Where required, discussions around the incorrect data entry will be had with relevant staff and necessary actions implemented.

Due to the COVID19 pandemic necessitating the standing down of routine services, and also the reduction in capacity due to social distancing as services have started to recommence, it is anticipated that there will be an increased number of breaches declared each month.

Actions in place to recover

Work is continuing within services for Cancer and Urgent patients.
Recovery plans continue to be discussed and revised; accounting for a changing environment.
Divisions are reviewing pathways to look at ways to enable provision of routine services.
Across the Trust outpatient services continue to use all available media to consult with patients.
Data for June is below.

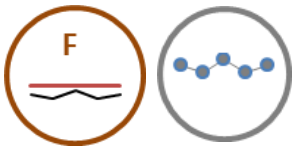
Start W/c	01/06/2020	
End before W/c	06/07/2020	
Average Appointments per week (all media)	9282.2	
Face to Face	4117.2	44%
Telephone	5099	55%
Telemedicine (Video)	66	1%

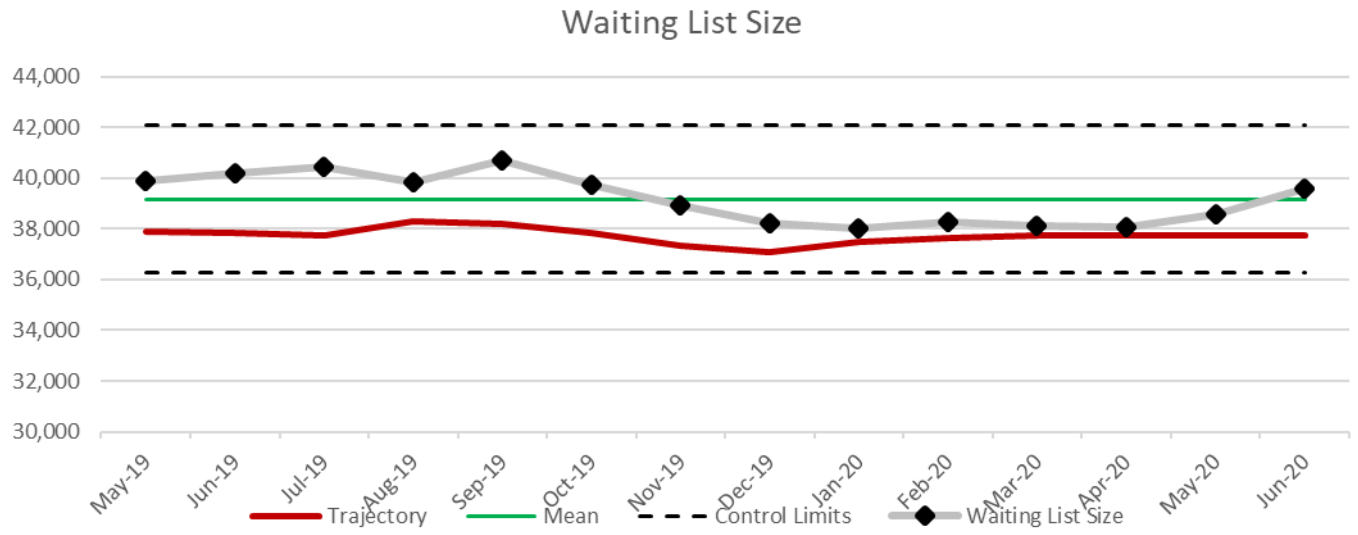
IMPROVE CLINICAL OUTCOMES – WAITING LIST SIZE

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services





Challenges/Successes

Overall waiting list size has increased from May, with June total waiting list increasing by 1005 to 39,581. The incompletes position for June is now approx. 549 more than the March 2018 (39,032) target.

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

- Trauma & Orthopaedics + 272
- Ophthalmology + 232
- Urology + 191
- Colorectal Surgery+ 146
- Cardiology + 130

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

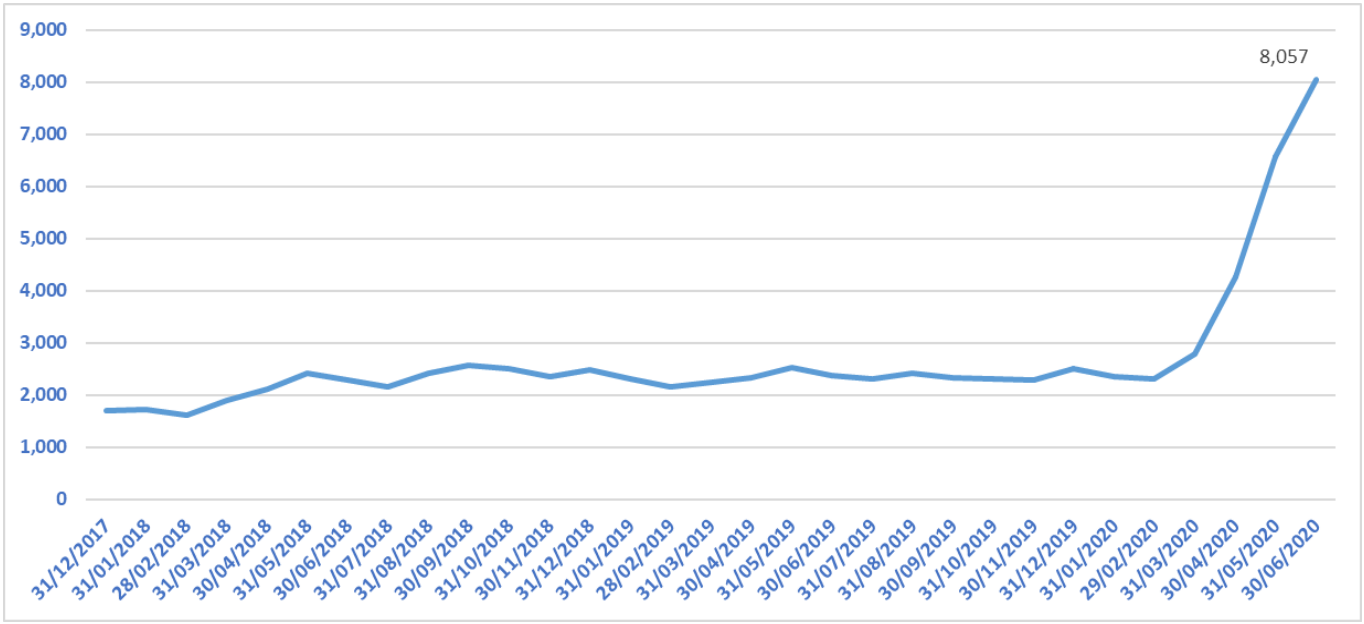
- Maxillo-Facial Surgery + Orthodontics + Oral Surgery - 180
- Paediatrics - 108
- ENT - 86
- Endocrinology- 68
- Respiratory Physiology - 53

Actions in place to recover

May to June saw an increase of patients waiting over 40 weeks, +223, with General Surgery (+77) showing the largest increase. 7 specialties reduced their position compared to last month, with Endocrinology showing the best improvement of -24 patients from last month.

The chart below shows progress up to 30th June, with an increase of 1480 patients from May. The largest increase was seen in Ophthalmology, +527. The largest decrease of -154, being in ENT.

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

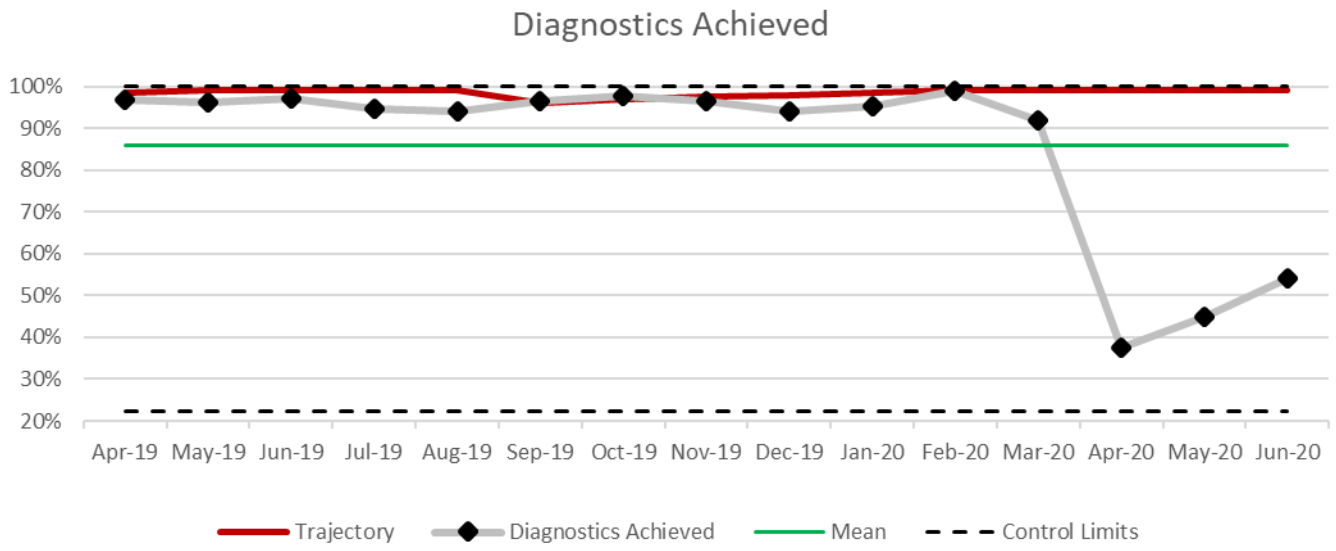


IMPROVE CLINICAL OUTCOMES – DIAGNOSTICS

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services



Challenges/Successes:

June performance was 53.96% which was an improvement on May 44.96%, this is mainly due to the waiting list growing in numbers below 6 weeks and an increase in activity.

Actions in place to recover:

July has seen most routine services being approved to turn back on by Gold. This will allow for patients on the routine back log to be booked in addition to cancer and urgent patients where capacity will allow.

Endoscopy is undertaking a recovery project where we are looking to maximise are capacity on all sites whilst still working within safe guidelines. This has already had a great effect on the cancer patient backlog and when cancer at backlog has been dealt with routine patients will be booked.

Audiology are in negotiation with Specsavers in securing capacity within their shop to see patients that would normally be seen by United Lincolnshire hospitals, this will massively reduce the backlog within audiology if Specsavers are able to support us.

The National return for diagnostics is being completed weekly. And an activity, backlog and total waiting list tracker will be added to the diagnostic restore cell on teams.

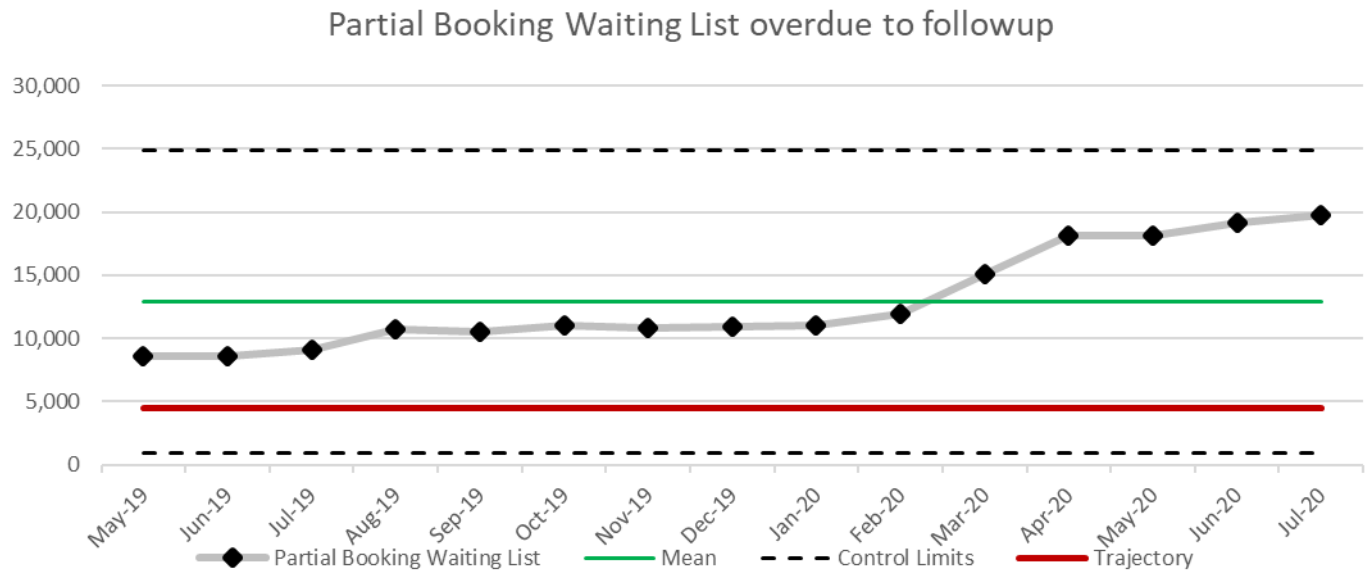
Capacity across all diagnostics still remains an issues due to social distancing and IPC.

IMPROVE CLINICAL OUTCOMES – PARTIAL BOOKING WAITING

Executive Lead: Chief Operating Officer

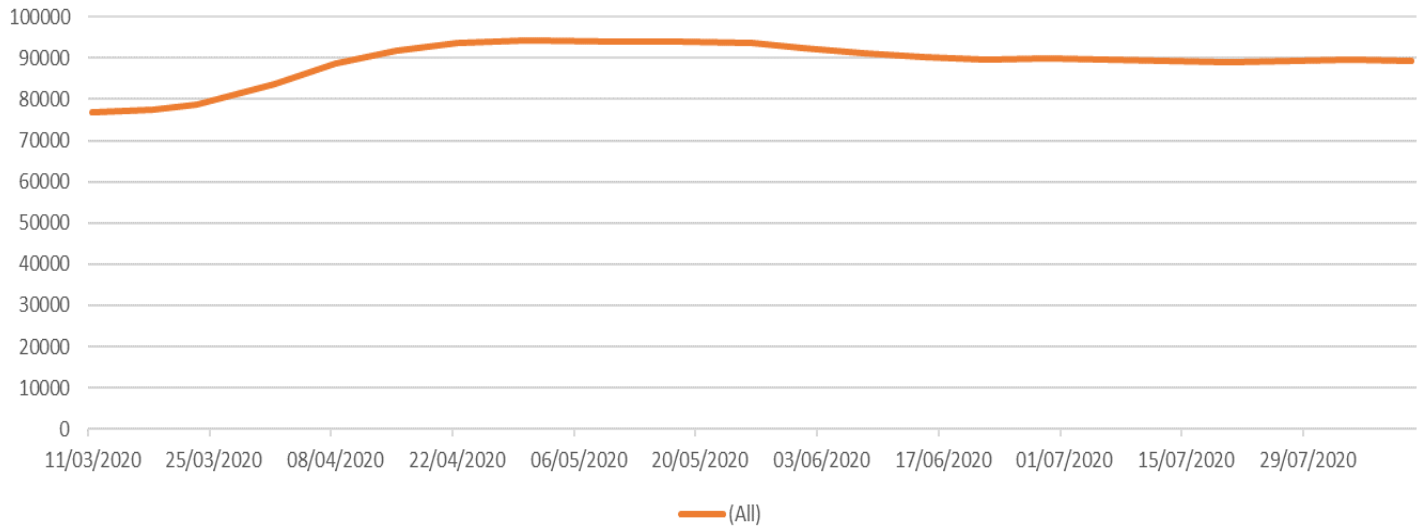
CQC Domain: Responsive

Strategic Objective: Services



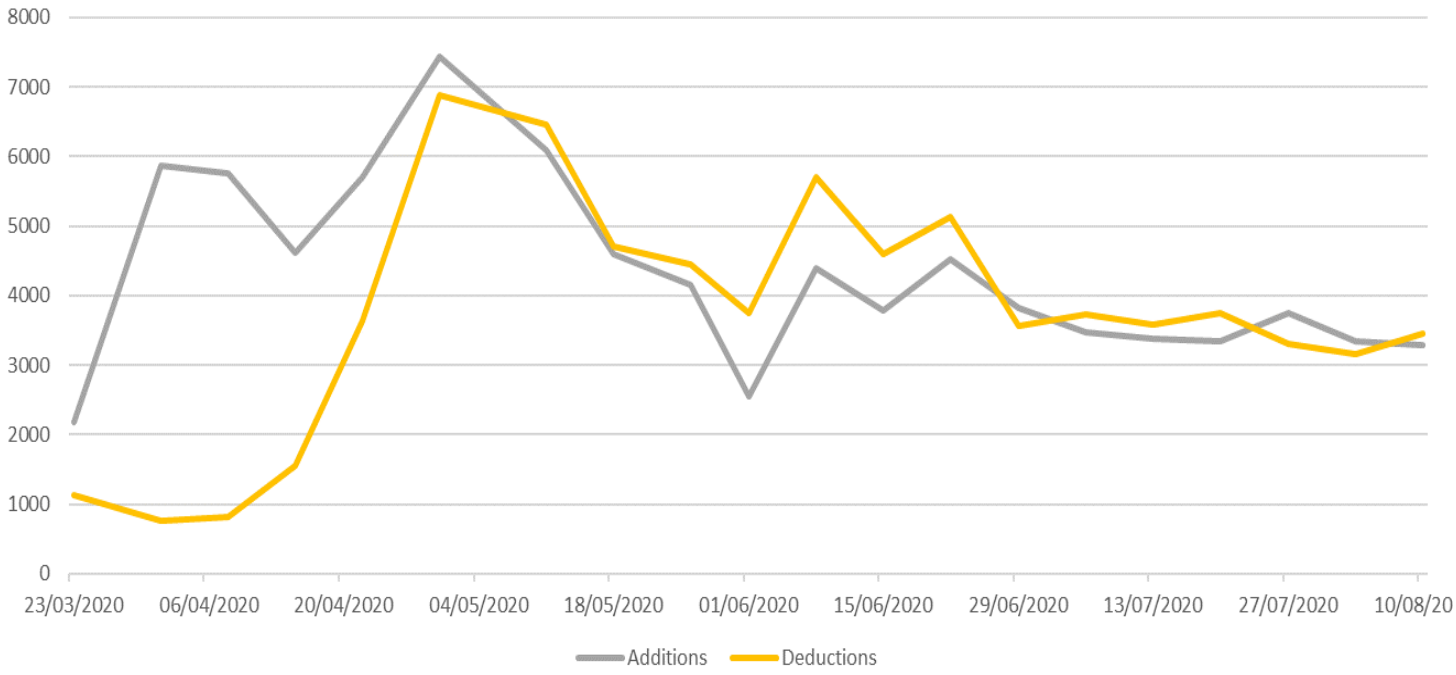
Challenges/Successes:

Following a period of growth through March to May due to a significant reduction in routine outpatient activity because of the Trust's response to COVID-19, the overall partial booking waiting list size has continued to reduce since the beginning of June at a rate of circa. 900 per week, as illustrated in the chart below. However appointments overdue to follow up on the waiting list have grown since last month, albeit at a reduced scale, this is due to a large number of patients being reviewed (virtually and by phone) at the beginning of covid were put on a 3 month period review. We are now seeing these patients becoming overdue again.



Actions in place to recover:

Our recovery actions include administrative validation, clinical triage and the scaling up of technology enabled care. The actions are challenged at a weekly PBWL review meeting. As a result of these actions waiting list deductions have outrun additions, leading to the reduction in overall waiting list size.

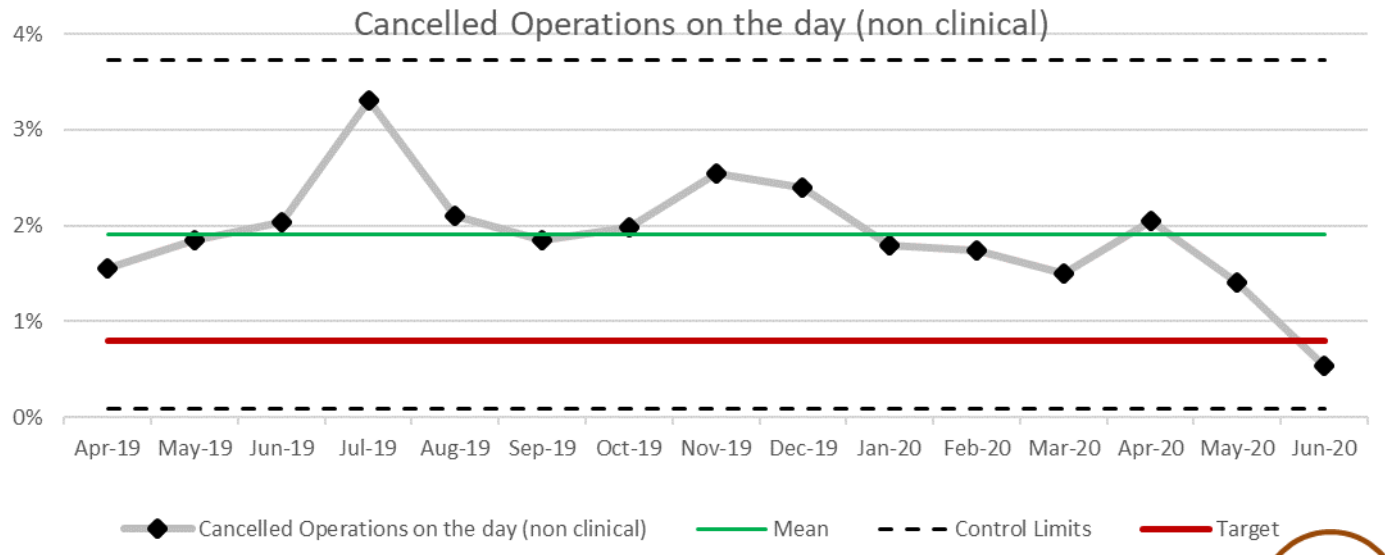


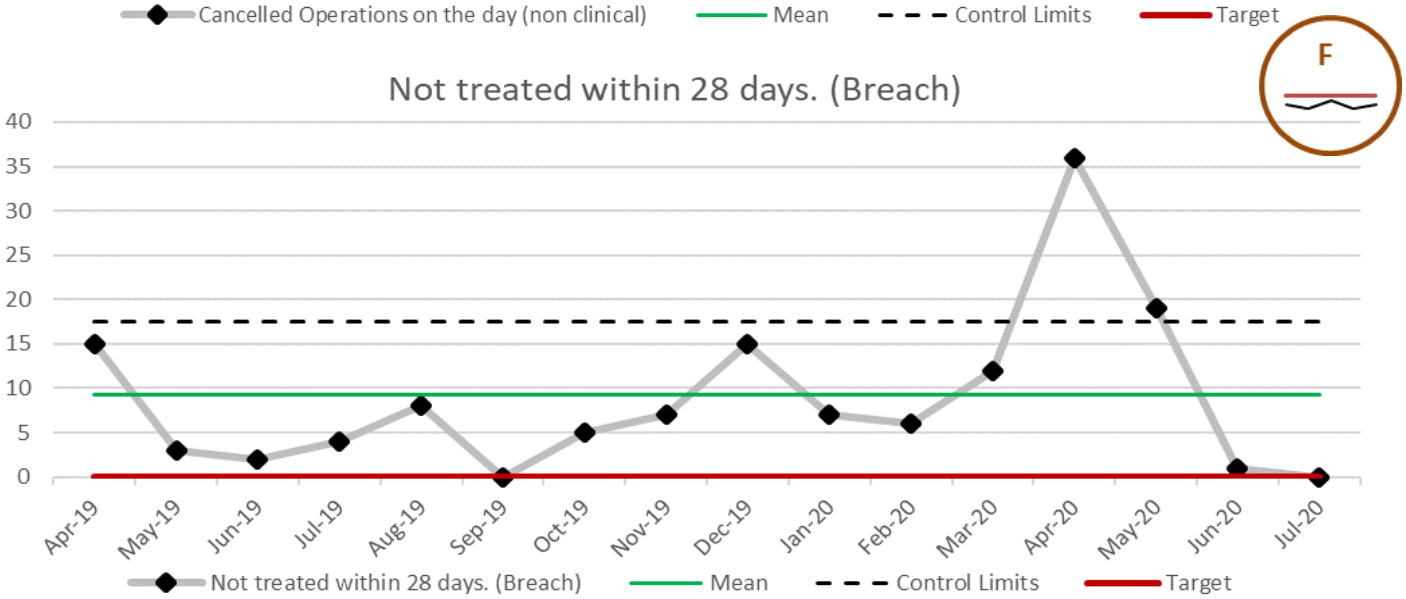
IMPROVE CLINICAL OUTCOMES – CANCELLED OPS

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services





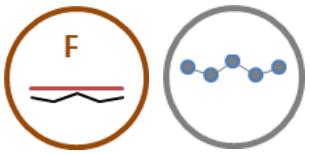
There has been a reduction in the numbers of on the day cancellations. The core reasons for the cancellations are attributable ICU staffing challenges for surgery that requires level 2/3 provision. Arrangements are in place to secure the required resources to mitigate non clinical cancellations on the day.

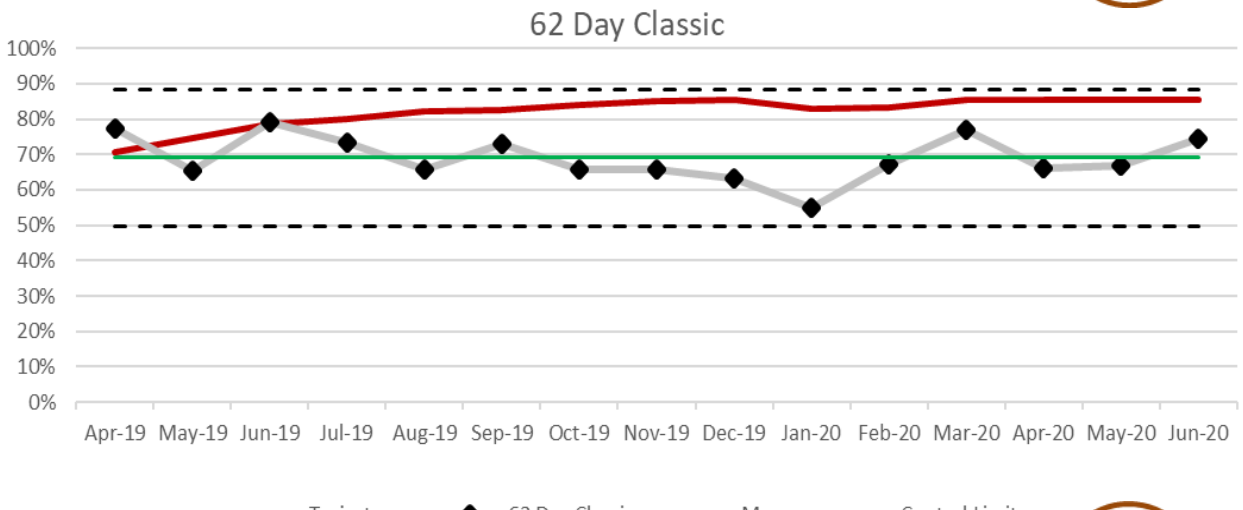
IMPROVE CLINICAL OUTCOMES – CANCER 62 DAY

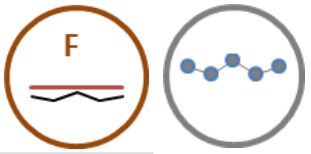
Executive Lead: Chief Operating Officer

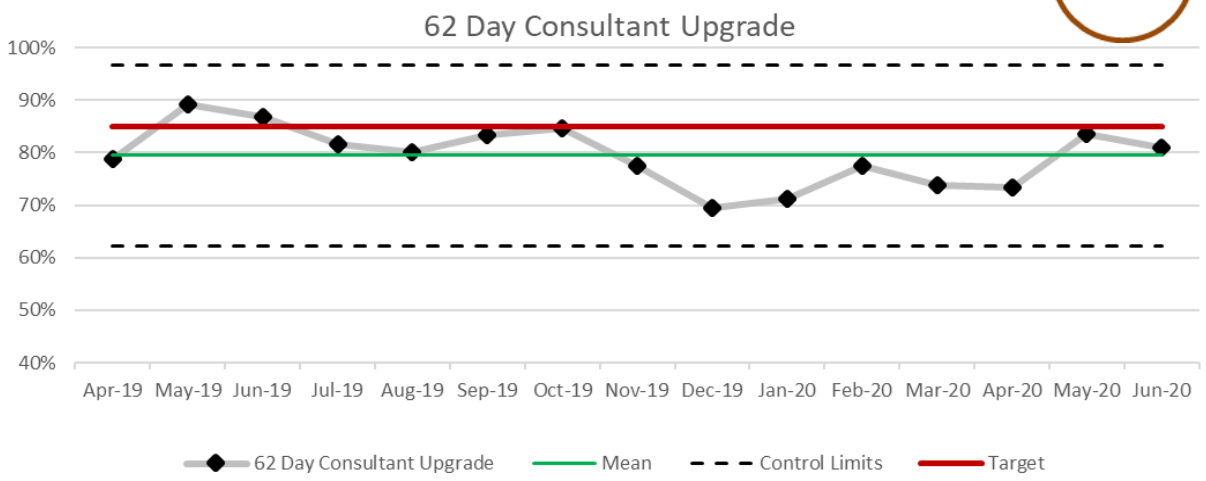
CQC Domain: Responsive

Strategic Objective: Services









Challenges/Successes

In June we saw an improvement (+7.4%) in the 62 Day Classic performance compared to May, at 74.5% and putting us in line with the national average.

Early indications are that our July 62 Day Classic performance will be circa 70%.

The impact of COVID-19 on our cancer pathways is clearly visible through the increase in number of patients over day 62 and 104. These backlogs will impact on the Trust's future performance, but how much will depend on the volume that convert to a cancer diagnosis and when their treatments commence (ie focussed in one month or spread over many).

The instruction from NHSE/I, on 9th July, has stipulated all patients waiting 104 days and over are to be seen by the 21st August 2020 and that the number of patients waiting over 62 days should be reduced by 20% by that date, with a trajectory in place for full recovery.

Actions in place to recover:

Daily meeting to review patients over 104 days, led by the CSS Managing Director and attended by senior Divisional staff.

The Grantham Green Site is now running 4 theatres for 5 days a week with a view to increasing this to 6-7 days; Lincoln is working with 2 theatre lists per day for 5 days a week and Pilgrim with 1 theatre lists per day, 5 days per week.

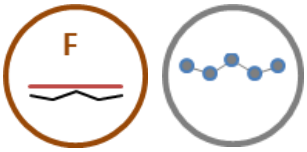
The NHSE/I letter has supporting information for Endoscopy Units as these has been identified as key in the recovery. Work is underway to increase the volume of patients being seen in our Endoscopy, with priority being given to clinically urgent and long-waiting patients (ie over 62 days).

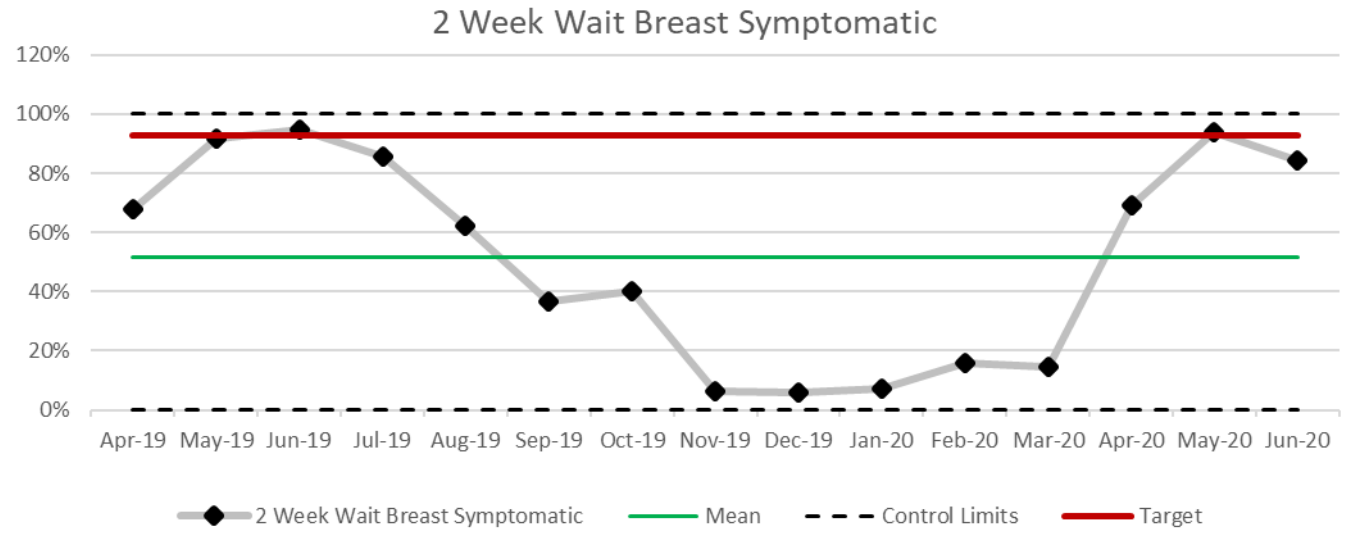
IMPROVE CLINICAL OUTCOMES – CANCER 2 WEEK WAIT

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services





Challenges/Successes

The 14 Day Breast Symptomatic, though not as high as May's performance was still significantly up on recent months

Actions in place to recover:

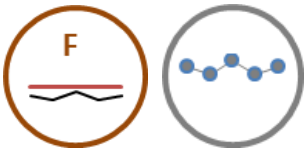
Review of Imaging services (including Breast Radiology provision) being undertaken by Meridion, results awaited.

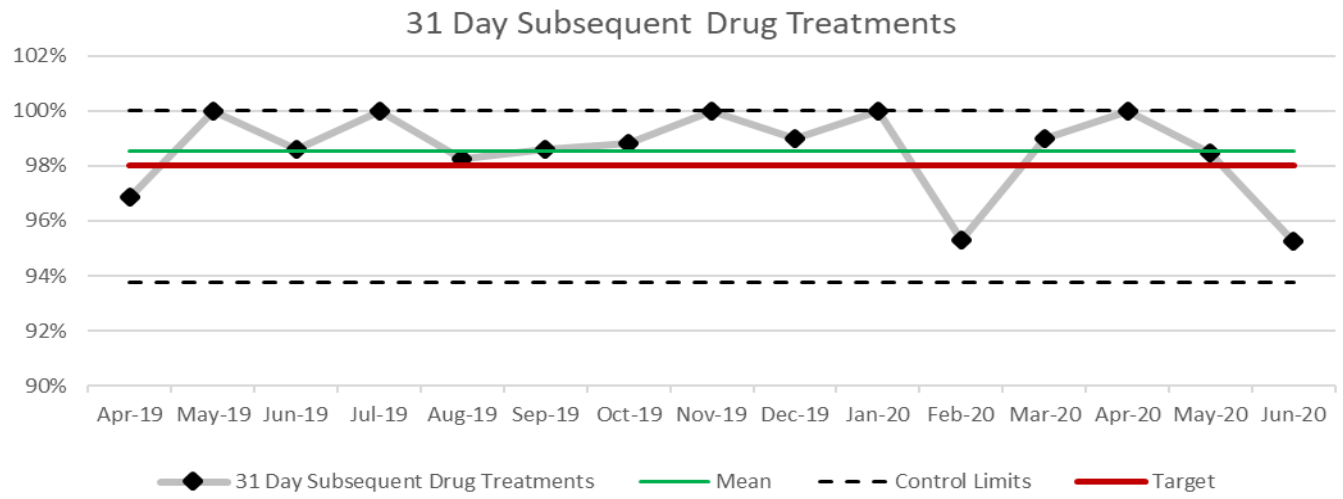
IMPROVE CLINICAL OUTCOMES – 31 DAY

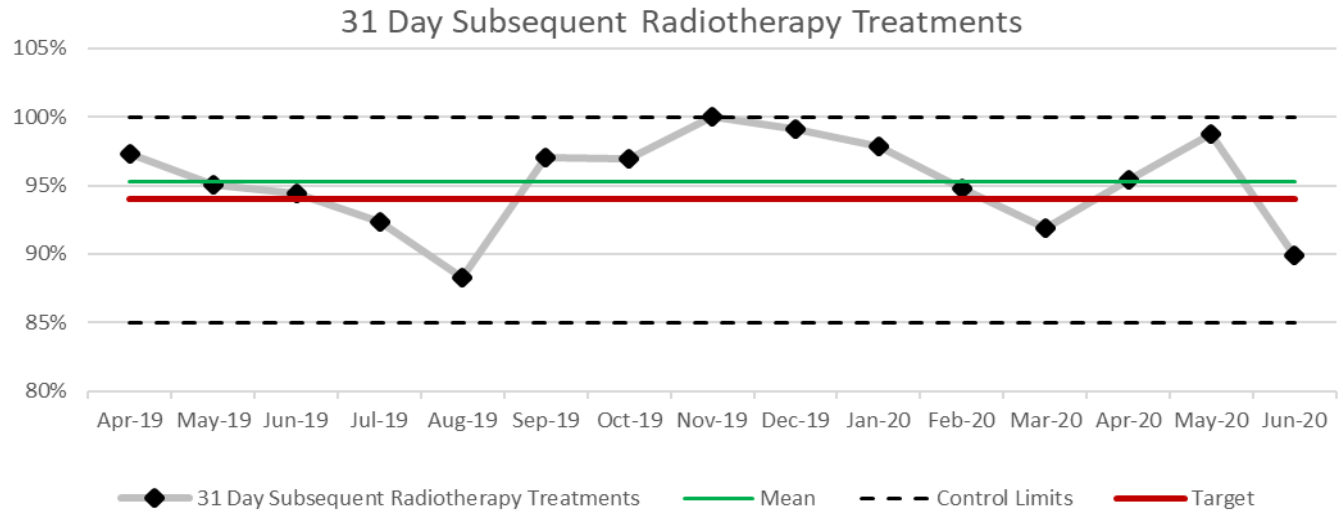
Executive Lead: Chief Operating Officer

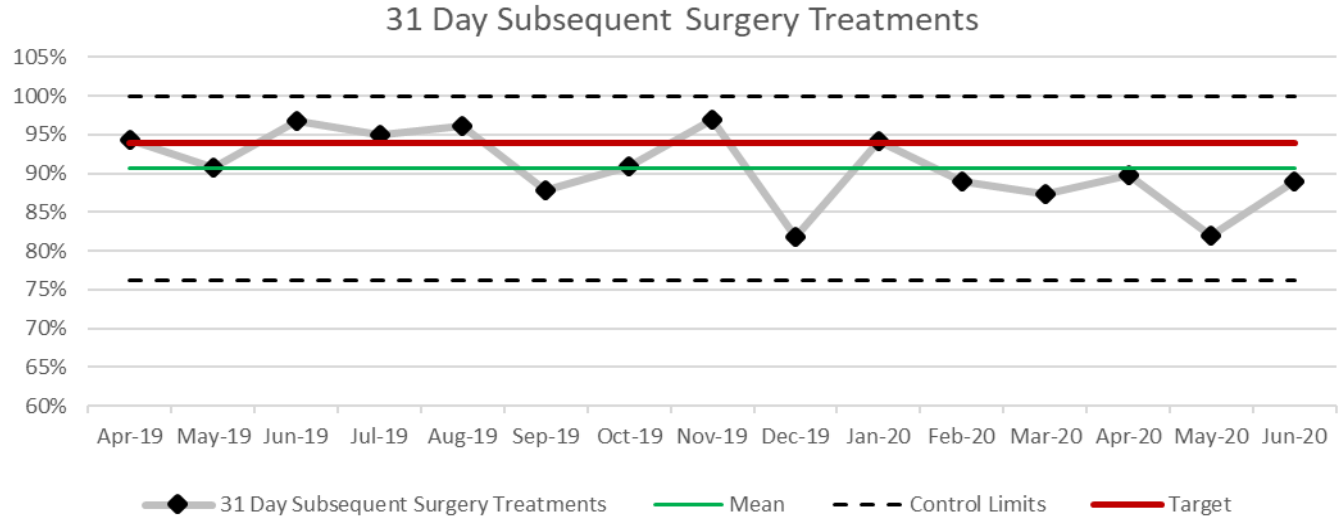
CQC Domain: Responsive

Strategic Objective: Services









Challenges/Successes

The 31 Day Subsequent standards were missed primarily due to the impact of COVID: the reduction in capacity and patient reluctance to attend hospitals.

Actions in place to recover:

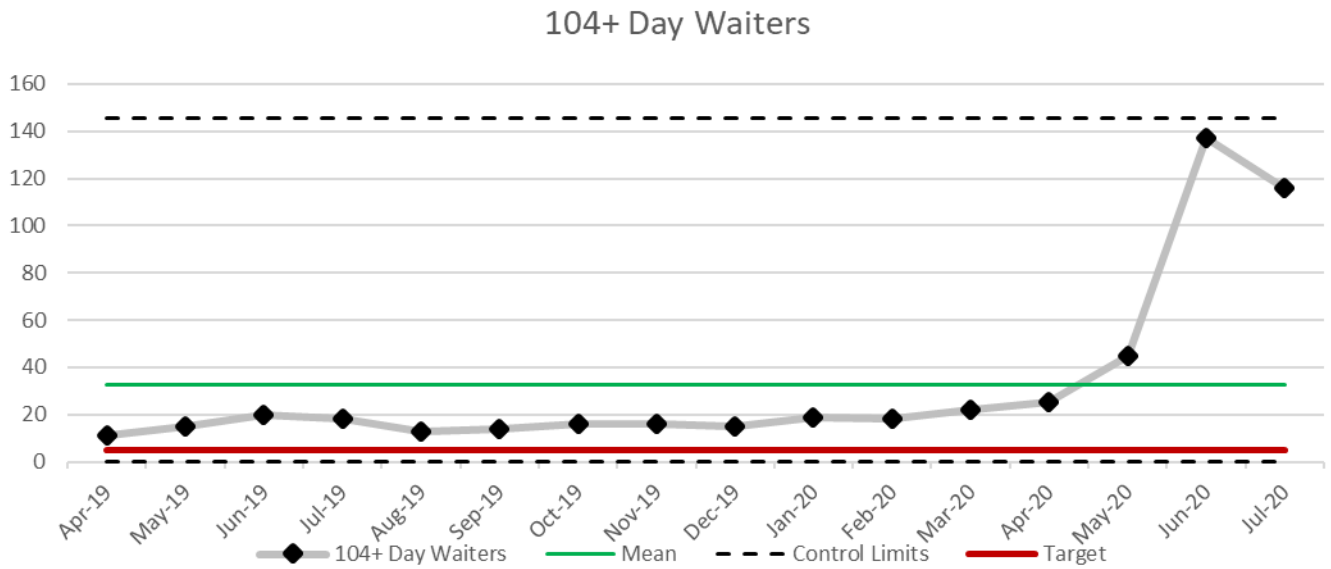
Although all theatre activity initially stopped in the run-up to COVID-19, the Grantham Green Site is now running 4 theatres for 5 days a week with a view to increasing this to 6-7 days; Lincoln is working with 2 theatre lists per day for 5 days a week and Pilgrim with 1 theatre lists per day, 5 days per week. The new model started in July and will contribute significantly to the delivery of 31-day subsequent surgery.

IMPROVE CLINICAL OUTCOMES – 104+ DAY WAITERS

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services



Challenges/Successes

The 104+ Day backlog was stabilising week-on-week pre-COVID but the crisis temporarily stopped diagnostics and treatments, both at ULHT and tertiary centres, and this has had a significant impact on these numbers. As of 12th August there were 104 patients waiting over 104 days, significantly above the target of 10 patients. Of these patients 76% 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.

The impact of COVID-19 on our cancer pathways is clearly visible through the increase in number of patients over day 104.

Actions in place to recover:

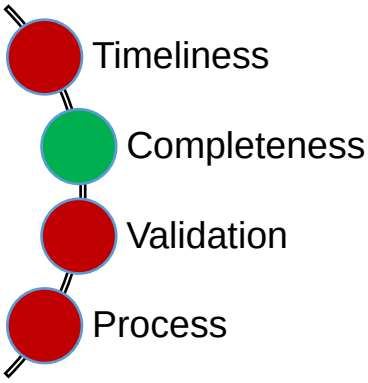
The instruction from NHSE/I, on 9th July, has stipulated all patients waiting 104 days and over are to be seen by the 21st August 2020 and to support this reduction there is a daily meeting to review patients over 104 days, led by the CSS Managing Director and attended by senior Divisional staff.

There is a weekly review of all patients over 104 days with the Cancer Lead Clinician.

The Grantham Green Site is now running 4 theatres for 5 days a week with a view to increasing this to 6-7 days; Lincoln is working with 2 theatre lists per day for 5 days a week and Pilgrim with 1 theatre lists per day, 5 days per week.

APPENDIX A – KITEMARK

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



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

Meeting	*Trust Board*
Date of Meeting	*Tuesday 1st September 2020*
Item Number	*Item 13.1*
Strategic Risk Report	
Accountable Director	*Dr Karen Dunderdale, Director of Nursing*
Presented by	*Dr Karen Dunderdale, Director of Nursing*
Author(s)	*Paul White, Risk & Incident Lead*
Report previously considered at	*N/A*

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

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

Recommendations/ Decision Required	*Trust Board is invited to review the report and identify any areas requiring further action*

Executive Summary

- 39 out of 82 strategic risks recorded on Datix are currently rated as Very high or High (48% of the total)
- Aseptic pharmacy services are now at reduced risk as interim controls are in place whilst the agreed long term plan is implemented
- Of the 28 strategic quality and safety risks currently recorded, 1 has a rating of Very high risk (25); 3 have a rating of High risk (16); 12 are High risk (12)
- Evaluating the current level of risk in relating to the Covid-19 pandemic is challenging due the high level of uncertainty
- Of the 43 strategic finance, performance & estates risks currently recorded, 17 are rated High risk (12-16) and 3 are rated Very high risk (20-25)
- An outline business case has been prepared for improving Pilgrim A&E
- Financial controls and governance arrangements are in place to manage delivery of the Financial Recovery Programme
- Workforce capacity, capability and morale risks remain very high and are a focus for the Trust's Integrated Improvement Plan (IIP)

Purpose

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

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

Key messages

Introduction

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

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

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

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

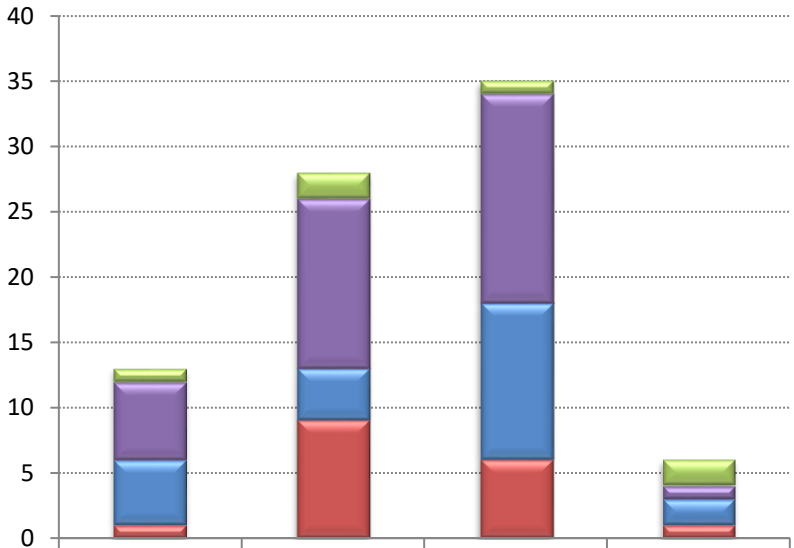
4.4 Strategic and operational risk registers consist of two types of risk:

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

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

Strategic Risk Profile

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



	Low risk	Moderate risk	High risk	Very high risk
Finances	1	2	1	2
Reputation / compliance	6	13	16	1
Service disruption	5	4	12	2
Harm (physical or psychological)	1	9	6	1

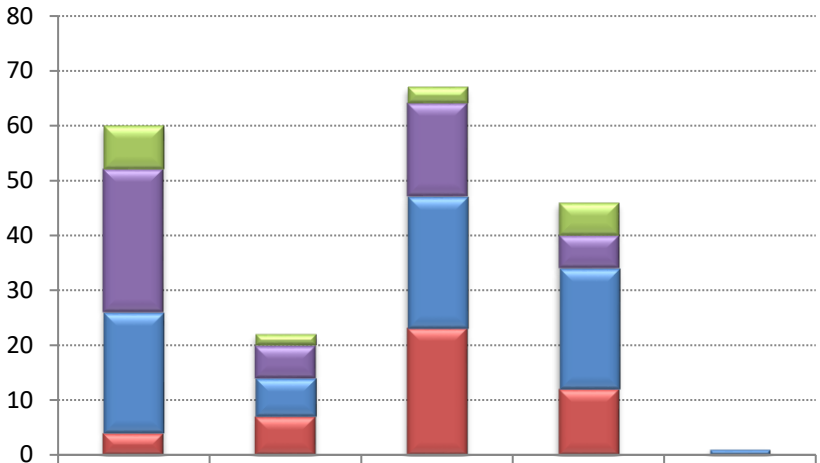
4.7 39 out of 82 strategic risks recorded on Datix are currently rated as Very high or High (48% of the total). Three strategic risks have reduced in rating since July 2020, all relating to aseptic pharmacy services where the reduced risk is reflective of interim controls that are now in place whilst the agreed long term plan for a sustainable service is implemented:

- Critical infrastructure failure has reduced from High risk (16) to High risk (12), due to the continued use of a temporary facility whilst Lincoln and Pilgrim facilities remain closed
- Contamination of aseptic products has reduced from High risk (15) to Moderate risk (10)
- Compliance with aseptic regulations has reduced from High risk (12) to Moderate risk (8)

4.8 A summary of all risks recorded on the Strategic Risk Register is attached as **Appendix I.**

Operational Risk Profile

4.9 **Chart 2** shows the number of operational (divisional business unit) risks by current (residual) risk rating:



	Very low risk	Low risk	Moderate risk	High risk	Very high risk
Finances	8	2	3	6	0
Reputation / compliance	26	6	17	6	0
Service disruption	22	7	24	22	1
Harm (physical or psychological)	4	7	23	12	0

4.10 Of the 196 risks recorded on divisional business unit risk registers, 47 (23%) are currently rated as High or Very high. A summary of these risks is attached as **Appendix II.**

4.11 There is one operational High risk specifically relating to the Covid-19 pandemic:

- Safety impact in TACC CBU, due to potential shortages of fluids and disposables for CVVH (Continuous Veno-Venous Hemofiltration), PPE and some medicines

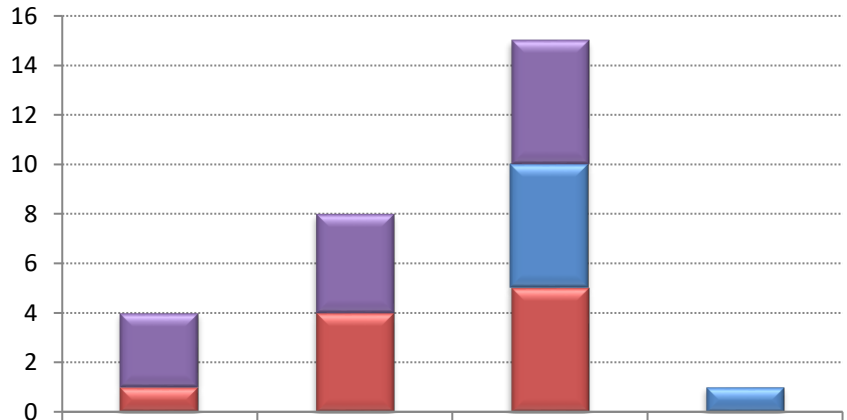
4.12 The health, safety and security risk in Surgery CBU has increased to High risk (15) on review, due to the lack of functioning emergency buzzers on Wards 5a and 5b at Pilgrim Hospital. Interim safety measures are in place to enable staff to communicate in the event of an emergency, whilst plans are developed to replace the faulty buzzers.

4.13 The workforce risk in Cancer Services CBU has increased from High risk (12) to High risk (15) on review. This is due to issues with consultant staffing capacity in Haematology and Oncology. A risk summit is scheduled for October to plan a way forward.

Quality & Safety Risk Profile

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

4.15 There are 28 quality and safety risks recorded on the strategic risk register. **Chart 3** shows a breakdown of these risks by current risk rating and type:



	Low risk	Moderate risk	High risk	Very high risk
Finances	0	0	0	0
Reputation / compliance	3	4	5	0
Service disruption	0	0	5	1
Harm (physical or psychological)	1	4	5	0

4.16 There have been no material changes to the strategic quality and safety risk profile since the last report. All of these risks were due for quarterly review in July, however it is likely that some updates were still progressing through divisional governance arrangements at the time of reporting.

4.17 Of the 28 strategic quality and safety risks currently recorded, 1 has a rating of Very high risk (25); 3 have a rating of High risk (16); 12 are High risk (12).

4.18 Key points for the Trust Board to note in relation to these risks are as follows:

Local impact of the global Covid-19 pandemic (Risk ID 4558)

- Current risk rating Very high (25)
- The East Midlands has been one of the least affected areas of the country
- Evidence of significantly reduced impact in recent weeks; effective risk mitigation plan in place

- Potential for a second wave across the UK is a cause of on-going uncertainty regarding the current level of risk

Safe management of emergency demand (Risk ID 4480)

- Current risk rating High (16)
- Issues with A&E capacity; ward bed availability; and levels of demand leading to over-crowding and delays at both Lincoln and Pilgrim hospitals
- Lincoln A&E included in reconfiguration project
- Business case developed for substantial investment in Pilgrim A&E
- Analysis of incidents reported this financial year to date compared to 2019/20 suggests that the level of patient safety risk within A&E departments has not reduced measurably as yet

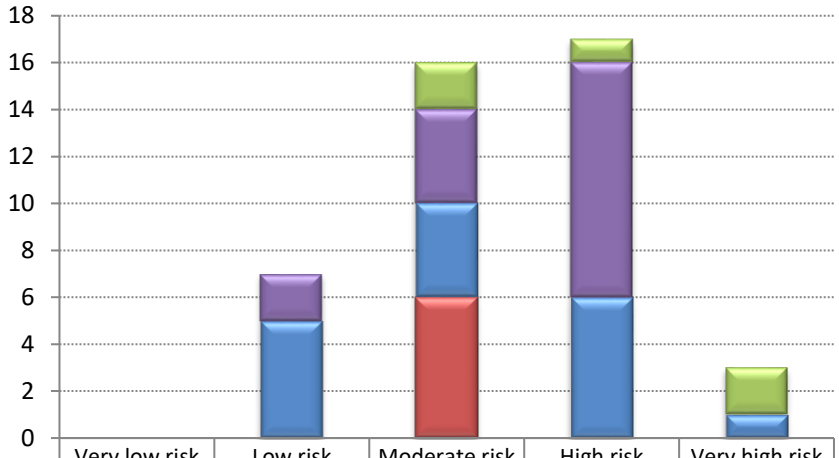
Safe management of medicines (Risk ID 4156)

- Current risk rating High (16)
- The most significant risk factor remains the current reliance upon a manual prescribing process across all sites; as it is vulnerable to human error
- The planned implementation of electronic prescribing will address many of the risk factors associated with manual prescribing
- Insufficient involvement of Pharmacy in the discharge process and medicines reconciliation increases the potential for medication errors
- Mitigating action for Pharmacy to introduce routine monitoring of compliance with the electronic discharge documentation (eDD) policy; progress in reducing the risk is due to be reviewed and evaluated this quarter
- Analysis of medication incidents reported this financial year to date compared to 2019/20 suggests that the level of patient safety risk relating to medication has not yet begun to reduce

Finance, performance and estates risk profile

4.19 The Finance, Performance and Estates Committee (FPEC) is the lead assurance committee responsible for oversight of the Finance, Performance and Estates Risk Profile. FPEC did not meet regularly during the earlier stages of the Covid-19 pandemic response, but reconvened from July.

4.20 **Chart 4** shows a breakdown of the 43 strategic finance, performance and estates risks by current risk rating and type:



	Very low risk	Low risk	Moderate risk	High risk	Very high risk
Finances	0	0	2	1	2
Reputation / compliance	0	2	4	10	0
Service disruption	0	5	4	6	1
Harm (physical or psychological)	0	0	6	0	0

4.21 Of the 43 strategic finance, performance & estates risks currently recorded, 17 are rated High risk (12-16) and 3 are rated Very high risk (20-25).

4.22 Key points for the Trust Board to note in relation to these risk are as follows:

Capacity to manage emergency demand (Risk ID 4175)

- Current rating Very high risk (20)
- The system has matured over the last 12 months and confidence exists to challenge each part of our system
- The risk remains as highlighted to Trust Board (ULHT) and UCB that the volume of emergency demand continues to pose a significant threat to delivery
- Specific concerns relate to ambulance handover delays, increased non-elective admissions, stranded and super-stranded patients
- Further mitigation exists within the Lincoln site reconfiguration to minimise the impact of the projected circa -120 bed deficit trust wide

Substantial unplanned expenditure or financial penalties (Risk ID 4383)

- Current rating Very high risk (20)
- Continued reliance upon a large number of temporary agency and locum staff to maintain the safety and continuity of clinical services across the Trust, at substantially increased cost
- Mitigation through delivery of the Financial Recovery Programme; maintaining grip & control on expenditure; use of PRM process to hold divisions to account and develop mitigating schemes where needed

Delivery of the Financial Recovery Programme (Risk ID 4382)

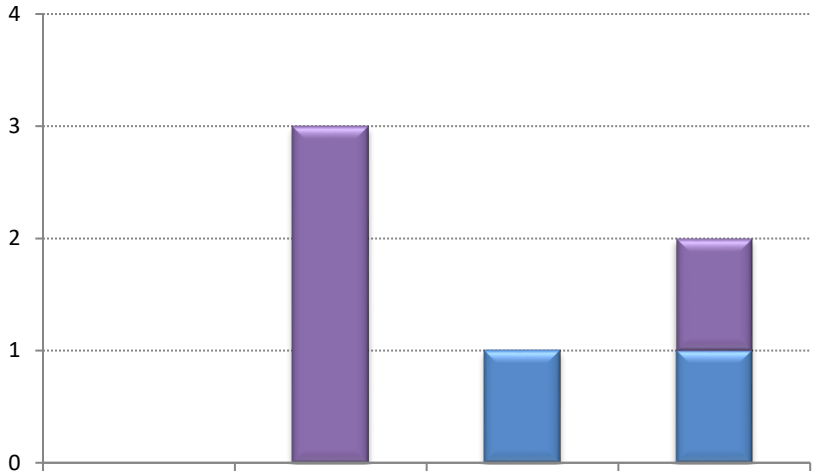
- Current rating Very high risk (20)
- Identification of schemes to cover the level of efficiency required
- If assumptions are inaccurate; or if there are capacity & capability issues with delivery; it may result in failure to deliver these schemes
- The Finance PMO team works with divisions to manage planned schemes and identify mitigating schemes

4.23 Clinical Engineering are currently working on a revised approach to managing medical device availability risk, which will involve providing divisions with regular up to date information regarding the replacement programme and funding gaps to support prioritisation decisions. This type of risk is particularly high within diagnostic and surgical specialties.

Workforce risk profile

4.24 The People & Organisational Development Committee (PODC) is the lead assurance committee responsible for oversight of the Workforce Risk Profile. The PODC did not meet regularly during earlier stages of the Covid-19 pandemic response but reconvened from July.

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

4.26 There have been no material changes to the strategic workforce risk profile since the last report.

4.27 Key points for the Trust Board to note in relation to these risk are as follows:

Workforce capacity & capability (recruitment, retention & skills) (Risk ID 4362)

- Current risk rating Very high (20)
- Substantial challenge to recruiting and retaining sufficient numbers of Registered Nurses; the Director of Nursing has introduced a Nursing Transformation Programme to look into demand and supply issues
- High vacancy rates for consultants and middle grade doctors Trust-wide; a plan is in place for all medical posts and vacancy rates are reducing
- Both areas are a focus for the Integrated Improvement Plan (IIP)

Workforce engagement, morale & productivity (risk ID 4083)

- Current risk rating Very high (20)
- Impact of the cost reduction programme & organisational change on staff morale
- Some improvement in the results of the 2019 staff survey across two thirds of the questions
- A number of IIP work-streams address morale issues
- Introduction of new NHSE/I Pulse Check from August

4.28 Of the 13 Clinical Business Units (CBUs) within the Trust, 9 are now showing a workforce risk that is rated as High (12). The risk has reduced in the following areas:

- Urgent & Emergency Care CBU
- Urology, Trauma & Orthopaedics and Ophthalmology CBU
- Theatres, Anaesthetics & Critical Care CBU

Strategic communication and engagement risks

4.29 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)

4.30 There has been no change in these risks since the last report.

Appendix 1 - Summary of all risks recorded on the Strategic Risk Register:

ID	Title	Division	Risk Type	Rating (current)	Risk level (current)
4558	Local impact of the global coronavirus (Covid-19) pandemic	Corporate	Harm (physical / psychological)	25	Very high risk
4175	Capacity to manage emergency demand	Medicine	Service disruption	20	Very high risk
4362	Workforce capacity & capability (recruitment, retention & skills)	Corporate	Service disruption	20	Very high risk
4083	Workforce engagement, morale & productivity	Corporate	Reputation / compliance	20	Very high risk
4382	Delivery of the Financial Recovery Programme	Corporate	Finances	20	Very high risk
4383	Substantial unplanned expenditure or financial penalties	Corporate	Finances	20	Very high risk
4480	Safe management of emergency demand	Medicine	Harm (physical / psychological)	16	High risk
4437	Critical failure of the water supply	Corporate	Service disruption	16	High risk
4403	Compliance with electrical safety regulations & standards	Corporate	Reputation / compliance	16	High risk
4384	Substantial unplanned income reduction or missed opportunities	Corporate	Finances	16	High risk
4144	Uncontrolled outbreak of serious infectious disease	Corporate	Service disruption	16	High risk
3520	Compliance with fire safety regulations & standards	Corporate	Reputation / compliance	16	High risk
3688	Quality of the hospital environment	Corporate	Reputation / compliance	16	High risk
3690	Compliance with water safety regulations & standards	Corporate	Reputation / compliance	16	High risk
3720	Critical failure of the electrical infrastructure	Corporate	Service disruption	16	High risk
4156	Safe management of medicines	Clinical Support	Harm (physical / psychological)	16	High risk
4044	Compliance with information governance regulations & standards	Corporate	Reputation / compliance	16	High risk
4405	Critical infrastructure failure disrupting aseptic pharmacy services	Clinical Support	Service disruption	12	High risk
4481	Availability of patient information	Corporate	Service disruption	12	High risk

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

ID	Title	Division	Risk Type	Rating (current)	Risk level (current)
4476	Compliance with clinical effectiveness regulations & standards	Corporate	Reputation / compliance	12	High risk
4497	Contamination of aseptic products	Clinical Support	Harm (physical / psychological)	10	Moderate risk
4567	Working Safely during the COVID -19 pandemic (HM Government Guidance)	Corporate	Reputation / compliance	9	Moderate risk
3951	Compliance with regulations & standards for aseptic pharmacy services	Clinical Support	Reputation / compliance	8	Moderate risk
4526	Internal corporate communications	Corporate	Reputation / compliance	8	Moderate risk
4528	Minor fire safety incident	Corporate	Harm (physical / psychological)	8	Moderate risk
4553	Failure to appropriately manage land and property	Corporate	Finances	8	Moderate risk
4483	Safe use of radiation	Clinical Support	Harm (physical / psychological)	8	Moderate risk
4486	Clinical outcomes for patients	Corporate	Harm (physical / psychological)	8	Moderate risk
4424	Delivery of planned improvements to quality & safety of patient care	Corporate	Reputation / compliance	8	Moderate risk
4467	Impact of a 'no deal' EU Exit scenario	Corporate	Service disruption	8	Moderate risk
4404	Major fire safety incident	Corporate	Harm (physical / psychological)	8	Moderate risk
4389	Compliance with corporate governance regulations & standards	Corporate	Reputation / compliance	8	Moderate risk
4397	Exposure to asbestos	Corporate	Harm (physical / psychological)	8	Moderate risk
4398	Compliance with environmental and energy management regulations & standards	Corporate	Reputation / compliance	8	Moderate risk
4399	Compliance with health & safety regulations & standards	Corporate	Reputation / compliance	8	Moderate risk
4400	Safety of working practices	Corporate	Harm (physical / psychological)	8	Moderate risk
4401	Safety of the hospital environment	Corporate	Harm (physical / psychological)	8	Moderate risk
4363	Compliance with HR regulations & standards	Corporate	Reputation / compliance	8	Moderate risk

ID	Title	Division	Risk Type	Rating (current)	Risk level (current)
4138	Patient mortality rates	Corporate	Reputation / compliance	8	Moderate risk
4141	Compliance with infection prevention & control regulations & standards	Corporate	Reputation / compliance	8	Moderate risk
3687	Implementation of an Estates Strategy aligned to clinical services	Corporate	Service disruption	8	Moderate risk
3721	Critical failure of the mechanical infrastructure	Corporate	Service disruption	8	Moderate risk
3722	Energy performance and sustainability	Corporate	Finances	8	Moderate risk
4003	Major security incident	Corporate	Harm (physical / psychological)	8	Moderate risk
4177	Critical ICT infrastructure failure	Corporate	Service disruption	8	Moderate risk
4180	Reduction in data quality	Corporate	Reputation / compliance	8	Moderate risk
4182	Compliance with ICT regulations & standards	Corporate	Reputation / compliance	8	Moderate risk
4351	Compliance with equalities and human rights regulations, standards & contractual requirements	Corporate	Reputation / compliance	8	Moderate risk
4352	Public consultation & engagement	Corporate	Reputation / compliance	8	Moderate risk
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

ID	Title	Division	Risk Type	Rating (current)	Risk level (current)
4440	Compliance with emergency planning regulations & standards	Corporate	Reputation / compliance	4	Low risk
4441	Compliance with radiation protection regulations & standards	Clinical Support	Reputation / compliance	4	Low risk
4469	Compliance with blood safety & quality regulations & standards	Clinical Support	Reputation / compliance	4	Low risk
4482	Safe use of blood and blood products	Clinical Support	Harm (physical / psychological)	4	Low risk
4502	Compliance with regulations & standards for medical device management	Corporate	Reputation / compliance	4	Low risk
4514	Hospital @ Night management	Corporate	Service disruption	4	Low risk

Appendix 2 – Summary of all High and Very high operational risks recorded on divisional business unit risk registers:

ID	Title	Division	Risk Type	Rating (current)	Risk level (current)
4426	Availability of essential equipment & supplies (Diagnostics CBU)	Clinical Support Services	Service disruption	20	Very high risk
4193	Health, safety & security of staff, patients and visitors (Surgery CBU)	Surgery	Harm (physical or psychological)	15	High risk
4340	Workforce capacity & capability (Cancer Services CBU)	Clinical Support Services	Service disruption	15	High risk
4194	Delayed patient diagnosis or treatment (Surgery CBU)	Surgery	Harm (physical or psychological)	12	High risk
4196	Workforce capacity & capability (Surgery CBU)	Surgery	Service disruption	12	High risk
4201	Compliance with regulations & standards (Surgery CBU)	Surgery	Reputation / compliance	12	High risk
4262	Availability of essential equipment & supplies (Urology, T&O and Ophthalmology CBU)	Surgery	Service disruption	12	High risk
4287	Access to essential areas of the estate (Therapies & Rehabilitation)	Clinical Support Services	Service disruption	12	High risk
4289	Exceeding annual budget (Therapies & Rehabilitation)	Clinical Support Services	Finances	12	High risk
4297	Workforce capacity & capability (Therapies & Rehabilitation)	Clinical Support Services	Service disruption	12	High risk
4302	Workforce capacity & capability (Specialty Medicine CBU)	Medicine	Service disruption	12	High risk
4303	Safety & effectiveness of patient care (Specialty Medicine CBU)	Medicine	Harm (physical or psychological)	12	High risk
4304	Health, safety & security of staff, patients and visitors (Specialty Medicine CBU)	Medicine	Harm (physical or psychological)	12	High risk
4305	Exceeding annual budget (Specialty Medicine CBU)	Medicine	Finances	12	High risk
4311	Access to essential areas of the estate (Specialty Medicine CBU)	Medicine	Service disruption	12	High risk
4315	Delayed patient diagnosis or treatment (Cardiovascular CBU)	Medicine	Harm (physical or psychological)	12	High risk
4317	Exceeding annual budget (Cardiovascular CBU)	Medicine	Finances	12	High risk

ID	Title	Division	Risk Type	Rating (current)	Risk level (current)
4320	Workforce capacity & capability (Cardiovascular CBU)	Medicine	Service disruption	12	High risk
4322	Safety & effectiveness of patient care (Cardiovascular CBU)	Medicine	Harm (physical or psychological)	12	High risk
4324	Access to essential areas of the estate (Cardiovascular CBU)	Medicine	Service disruption	12	High risk
4327	Delayed patient diagnosis or treatment (Urgent & Emergency Care CBU)	Medicine	Harm (physical or psychological)	12	High risk
4328	Quality of patient experience (Urgent & Emergency Care CBU)	Medicine	Reputation / compliance	12	High risk
4331	Exceeding annual budget (Urgent & Emergency Care CBU)	Medicine	Finances	12	High risk
4333	Delayed patient discharge or transfer of care (Urgent & Emergency Care CBU)	Medicine	Reputation / compliance	12	High risk
4334	Access to essential areas of the estate (Urgent & Emergency Care CBU)	Medicine	Service disruption	12	High risk
4335	Compliance with regulations & standards (Urgent & Emergency Care CBU)	Medicine	Reputation / compliance	12	High risk
4372	Compliance with regulations & standards (Outpatient Services)	Clinical Support Services	Reputation / compliance	12	High risk
4391	Health, safety & security of staff, patients and visitors (Estates & Facilities)	Corporate	Harm (physical or psychological)	12	High risk
4392	Availability of essential equipment & supplies (Estates & Facilities)	Corporate	Service disruption	12	High risk
4394	Access to essential areas of the estate (maintained by Estates & Facilities)	Corporate	Service disruption	12	High risk
4396	Exceeding annual budget (Estates & Facilities)	Corporate	Finances	12	High risk
4409	Health, safety & security of staff, patients and visitors (Children & Young Persons CBU)	Family Health	Harm (physical or psychological)	12	High risk
4415	Exceeding annual budget (Children & Young Persons CBU)	Family Health	Finances	12	High risk
4416	Delayed patient diagnosis or treatment (Children & Young Persons CBU)	Family Health	Harm (physical or psychological)	12	High risk
4420	Workforce capacity & capability (Children & Young Persons CBU)	Family Health	Service disruption	12	High risk
4425	Workforce capacity & capability (Diagnostics CBU)	Clinical Support Services	Service disruption	12	High risk

ID	Title	Division	Risk Type	Rating (current)	Risk level (current)
4116	Availability of essential equipment & supplies (TACC CBU)	Surgery	Service disruption	12	High risk
4168	Availability of essential equipment & supplies (Pharmacy)	Clinical Support Services	Service disruption	12	High risk
4169	Availability of essential information (Pharmacy)	Clinical Support Services	Service disruption	12	High risk
4170	Workforce capacity & capability (Pharmacy)	Clinical Support Services	Service disruption	12	High risk
4191	Availability of essential equipment & supplies (Surgery CBU)	Surgery	Service disruption	12	High risk
4429	Availability of essential information (Diagnostics CBU)	Clinical Support Services	Service disruption	12	High risk
4435	Access to essential areas of the estate (Diagnostics CBU)	Clinical Support Services	Service disruption	12	High risk
4452	Compliance with regulations & standards (Women's Health & Breast Services CBU)	Family Health	Reputation / compliance	12	High risk
4460	Workforce capacity & capability (Women's Health & Breast Services CBU)	Family Health	Service disruption	12	High risk
4461	Safety & effectiveness of patient care (Women's Health & Breast Services CBU)	Family Health	Harm (physical or psychological)	12	High risk
4565	Safety impact during the Covid-19 pandemic response (TACC CBU)	Surgery	Harm (physical or psychological)	12	High risk

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*1 September 2020*
Item Number	*Item 13.2*
Board Assurance Framework (BAF) 2020/21	
Accountable Director	*Andrew Morgan Chief Executive*
Presented by	*Jayne Warner, Trust Secretary*
Author(s)	*Karen Willey, Deputy Trust Secretary*
Report previously considered at	*N/A*

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

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

Recommendations/ Decision Required	• *Board to consider assurances provided in respect of Trust objectives noting that framework has been reviewed through committee structure*

Executive Summary

The relevant objectives of the 2020/21 BAF were presented to all Committees during August.

A number of updates have been made to the BAF including:

- additional elements that may prevent the Trust from meeting its objectives
- management of control gaps during Covid-19
- sources of assurance

Assurance ratings have been provided for all objectives and have been confirmed by the Committees.

The following assurance ratings have been identified:

Objective		Previous month	Assurance Rating
1a	Deliver harm free care	R	R
1b	Improve patient experience	R	R
1c	Improve clinical outcomes	R	R
2a	A modern and progressive workforce	R	R
2b	Making ULHT the best place to work	R	R
2c	Well led services	A	A
3a	A modern, clean and fit for purpose environment	R	R
3b	Efficient use of resources	R	R
3c	Enhanced data and digital capability	A	A
4a	Establish new evidence based models of care	R	R
4b	Advancing professional practice with partners	G	G
4c	To become a University Hospitals Teaching Trust	A	A

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

Strategic Objective	Board Committee
Patients: To deliver high quality, safe and responsive **patient** services, shaped by best practice and our communities	Quality Governance Committee
People: To enable our **people** to lead, work differently and to feel valued, motivated and proud to work at ULHT	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 manage safely and effectively the care of patients due to staffing capacity and capability and estate and equipment constraints If the Trust is unable to manage the backlog of patients who require time critical treatments recovering from the COVID response	4558	CQC Safe	Developing a safety culture 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 Ensuring continued incident investigations, harm reviews and assurance of learning	Level 4 EPRR stepped down to Level 3 incident throughout the UK with regional NHSE/I command and control. Gold Recovery Steering Group established Continued review and monitoring of HSMR and SHMI by QGC CQC actions monitored through QGC meeting during Covid 19 streamlined governance arrangements IPC Team part of Trust Covid response National guidance followed on PPE/ Infection Prevention methods Pandemic Flu Plan initiated Separate care pathway for urgent and planned care to aim to eliminate risk of nosocomial infection Reduce the risk of nosocomial transmission when care cannot be delayed and testing status not known Elective care patients assessed by test and symptoms to be Covid-19 risk minimised Urgent and emergency care in a defined zone	Control gaps identified and reported through to Gold Command Structure. Reviews of the Incident Management Structure are Conducted at the end of each phase and include any gaps in controls. Audits of changes are carried out internally and externally as part of NHSE change processes. Tracking learning actions from incidents and reviews	Trust Wide Accreditation Programme National and Local Harm Free Care indicators Safeguarding, DoLS and MCA training Safety Culture Surveys Sepsis Six compliance data HSMR and SHMI data Flu vaccination rates Audit of response to triage, NEWS, MEWS and PEWS CQC Ratings Monitoring nosocomial infection rates	Assurance received through daily/weekly briefing processes with Chair/CEO/ Execs	Assurance gaps to be identified through Trust Board streamlined governance process and Quality Governance Committee	Quality Governance Committee	R

Ref	Objective	Exec Lead	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Controls in place during Covid	How identified control gaps are being managed	Source of assurance	Assurances in place during Covid	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating
1b	Improve patient experience	Director of Nursing	If the Trust is unable to manage safely and effectively the care of patients presenting with severe symptoms of covid 19 caused by the absence of an effective treatment, issues with availability of equipment (including PPE) or the required staffing capacity to manage the level of demand	4558	CQC Safe	Greater involvement in the co-design of services working closely with Healthwatch and patient groups Greater involvement in decisions about care Deliver Year 3 objectives of our Inclusion Strategy Redesign our communication and engagement approaches to broaden and maximise involvement with patients and carers	Level 4 EPRR stepped down to Level 3 incident throughout the UK with regional NHSE/I command and control. Gold Recovery Steering Group established CQC actions monitored through QGC meeting during Covid 19 streamlined governance arrangements Pandemic Flu Plan initiated Informed consent re risks Agreement to comply with requirements Access controlled by exemplary IPC and PPE compliance Access controls maintain equitable access to healthcare	Control gaps identified and reported through to Gold Command Structure. Reviews of the Incident Management Structure are Conducted at the end of each phase and include any gaps in controls. Audits of changes are carried out internally and externally as part of NHSE change processes.	Getting real time patient and carer feedback Hold 6 listening events Thematic reviews of complaints and compliments User involvement numbers National patient surveys Number of locally implemented changes as a result of patient feedback	Assurance received through daily/weekly briefing processes with Chair/CEO/ Execs	Assurance gaps to be identified through Trust Board streamlined governance process and Quality Governance Committee	Quality Governance Committee	R

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 manage safely and effectively the care of patients due to staffing capacity and capability and estate and equipment constraints If the Trust is unable to manage the backlog of patients who require time critical treatments recovering from the COVID response	4558	CQC Safe CQC Responsive CQC Effective	Ensuring our Respiratory patients receive timely care from appropriately trained staff in the correct location Ensuring recommendations from Get it Right First Time (GIRFT) Reviews are implemented Ensuring compliance with local and national clinical audit reports Review of pharmacy model and service	Level 4 EPRR stepped down to Level 3 incident throughout the UK with regional NHSE/I command and control. Gold Recovery Steering Group established CQC actions monitored through QGC meeting during Covid 19 streamlined governance arrangements Pandemic Flu Plan initiated	Control gaps identified and reported through to Gold Command Structure. Monitoring incident reports and investigations	Numbers of NIV patients receiving timely care Numbers of unplanned ITU admission numbers Monitoring the implementation of GIRFT recommendations Implementation of recommendations with local and national clinical audit reports	Assurance received through daily/weekly briefing processes with Chair/CEO/ Execs	Assurance gaps to be identified through Trust Board streamlined governance process and Quality Governance Committee	Quality Governance Committee	R
SO2	**To enable out people to lead, work differently and to feel valued, motivated and proud to work at ULHT**												
2a	A modern and progressive workforce	Director of People and Organisational Development	The response to the COVID incident through the manage and restore phases, has delayed the projects in our Integrated Improvement Plan related to "People". There have been positives in our response to COVID, such as staff communication and engagement and management of risks to staff. We will progress the IIP through the recovery phase	4362	CQC Safe CQC Responsive CQC Effective	Embed Robust workforce planning and development of new roles Targeted recruitment campaigns to include overseas recruitment Delivery of annual appraisals and mandatory training Creating a framework for people to achieve their full potential Embed continuous improvement methodology across the Trust Reducing absence management Deliver Personal and Professional development	Declared as a level 4 incident throughout the UK. NHSE to coordinate NHS response. Major incident (Gold Command Structure) CQC actions monitored through QGC meeting during Covid 19 streamlined governance arrangements Pandemic Flu Plan initiated We are now starting to reintroduce at some pace key IIP projects, including international recruitment, absence management, appraisals and mandatory training and talent management. Workforce planning will be a key part of the COVID Recovery Plan and planning for 2021/22. We will reprofile action plans and reset PI improvement for the year	Covid Command and decision making structure alongside Board agreed lean governance arrangements have been in place during the COVID incident. During August we will re-restablish the Workforce Strategy Group, who will oversee delivery of the People workstreams of the IIP and give assurance to the Workforce and OD Committee, highlighlighting actions to manage control gaps. The Operational Equality and Diversity Group will undertake a similar role for workforce equality and diversity issues.	Vacancy rates Turnover rates Rates of appraisal/mandatory training compliance Learning days per staff member Staff survey feedback Sickness/absence data Reported progress on the implementation of the NHS People Plan and the Lincolnshire System Workforce Plan	Assurance received through daily/weekly briefing processes with Chair/CEO/ Execs	Assurance gaps to be identified through Trust Board streamlined governance process and People and Organisational Development Committee	People and Organisational Development Committee	R

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	The response to the COVID incident through the manage and restore phases, has delayed the projects in our Integrated Improvement Plan related to "People". There have been positives in our response to COVID, such as staff communication and engagement and management of risks to staff. We will progress the IIP through the recovery phase	4083	CQC Well Led	Embedding our values and behaviours Reviewing the way in which we communicate with staff and involve them in shaping our plans Adapting our responsibility framework and leadership programmes in line with the NHS Leadership Compact Revise our diversity action plan for 2021/22 to ensure concerns around equity of treatment and opportunity are tackled Agree and promote the core offer of ULHT, so our staff feel valued, supported and cared for Implementing Schwartz Rounds Embed Freedom to Speak Up and Guardian of safe Working Celebrate year of the Nurse/Midwife	We are now starting to reintroduce at some pace key IIP projects, including international recruitment, absence management, appraisals and mandatory training and talent management. Workforce planning will be a key part of the COVID Recovery Plan and planning for 2021/22. We will reprofile action plans and reset PI improvement for the year. We will embrace enhancements introduced during COVID, such as the more regular meetings with staffside, the revised Staff Engagement Group and the ELT Live sessions on Facebook and Teams	Covid Command and decision making structure alongside Board agreed lean governance arrangements have been in place during the COVID incident. During August we will re-establish the Workforce Strategy Group, who will oversee delivery of the People workstreams of the IIP and give assurance to the Workforce and OD Committee, highlighlighting actions to manage control gaps. The Operational Equality and Diversity Group will undertake a similar role for workforce equality and diversity issues.	WRES/ WDES Data Staff survey feedback - engagement score, recommend as place to work Number of staff attending leadership courses Number of Schwartz rounds completed (once implemented) Protect our staff from bullying, violence and harassment - measure through National Staff Survey Reports on progress inimplementing the NHS People Plan and the Lincolnshire System Workforce Plan Use of NHSI Covid pulse survey			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
SO3	**To ensure that services are sustainable, supported by technology and delivered from an improved estate**												

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
3a	A modern, clean and fit for purpose environment	Chief Operating Officer	Covid-19 impact on supplier services who are supporting the improvement, development, and maintenance of our environments. Availability of funding to support the necessary improvement of environments (capital and revenue)	3720 3520 3688 4403 3690	CQC Safe	Develop business case to demonstrate capital requirement Delivering environmental improvements in line with Estates Strategy Continual improvement towards meeting PLACE assessment outcomes Review and improve the quality and value for money of Facility services including catering and housekeeping Continued progress on improving infrastructure to meet statutory Health and Safety compliance	Declared as a level 4 incident throughout the UK. NHSE nationally and then regionally coordinate NHS response through a command and control process. Major incident (Gold Command Structure) employed locally. Estates and Facilities Cell reviews the key elements of environmental conditions to support the increasing demands on IPC, and complex infection control measures required. Health & Safety conditions are reviewed in the context of Estates and Facilities Cell and are reviewed by Silver Incident command and then subsequently Gold sign off.	Control gaps identified and reported through to Gold Command Structure where Covid related. Water/Fire safety meetings are in place and review of controls are part of external validation from authorised engineers. Now that additional capital funding has been secured for critical infrastructure a new Forum will be created to capture progress and feed back into governance systems how risks are mitigated and alleviated. Audits of changes are carried out internally and externally as part of NHSE change processes as well as contained within internal reviews.	PLACE assessments 6 Facet Surveys Reports from authorised engineers Staff and user surveys MiC4C cleaning inspections Response times to urgent estates requests Estates led condition inspections of the environment Response times for reactive estates repair requests Progress towards removal of enforcement notices	Assurance received through daily/weekly briefing processes with Chair/CEO/ Execs Monthly and where necessary extraordinary board meetings review the response to Covid which include measures required to ensure environments are suitable/fit for purpose in the context of Covid. Business Cases for deployment of emergency capital bids and feedback on delivery against those deployment plans. Datasets and additional reporting measures are in place that describe key environmental issues (supply of oxygen in wards as an example) to NHSE in addition to local usage for assurance purposes.	Assurance gaps identified are addressed through the command structure governance process, and mitigation steps taken. Additional reporting by exception is put in place to provide evidence and contribute to assurance process. No Covid-19 related gaps identified are escalated through estates and facilities group as part of upward reporting and where urgent or significant impact to Exec Leadership Team, where immediate actions can be taken.	Finance, Performance and Estates Committee	R
3b	Efficient use of our resources	Director of Finance and Digital	Efficiency schemes do not cover extent of savings required - £27.0m Continued reliance on agency and locum staff to maintain services at substantially increased cost Failure to achieve recruitment targets increases workforce costs Unplanned expenditure (as a result of unforeseen events) or financial penalties Failure to secure all income linked to coding or data quality issues National requirements and Trust response to Phase 3 - Recovery.	4382 4383 4384	CQC Well Led CQC Use of Resources	Delivering £27m CIP programme in 20/21 Delivering financial plan Utilising Model Hospital, Service Line Reporting and Patient Level Costing data to drive focussed improvements Implementing the CQC Use of Resources Report recommendations Working with system partners to deliver the Lincolnshire Plan. Detailed activity modelling aligned to resource requirements to support Trust and System response to Phase 3.	Deliver a monthly break-even position after taking Coivd-19 (including Restore and Recovery) costs into account.	Divisional Financial Review Meetings Centralised agency & bank team Financial Strategy and Annual Financial Plan Performance Management Framework System wide savings plan Internal Audit: Integrated Improvement Plan - Q2 Temporary Staffing - Q1 Education Funding - Q3 Estates Management - Q4 Workforce Planning - Q2	Delivery of CIP Achievement of Financial Plan Closing the Model Hospital opportunity gap Improve service line profitability	Financial Reporting to Board Covid-19 financial governance process Suspension of national financial regime	Management of control gaps being reintroduced in a phased way from July 2020. Continue to await national guidance.	Finance, Performance and Estates Committee	R

Ref	Objective	Exec Lead	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Controls in place during Covid	How identified control gaps are being managed	Source of assurance	Assurances in place during Covid	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating
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
SO4	**To implement integrated models of care with our partners to improve Lincolnshire's health and well-being**												
4a	Establish new evidence based models of care	Director of Improvement and Integration	Specifiic projects paused during the Covid 19 manage phase, specific projects are now progressing with delivery throughout the Covid Recovery Phase		CQC Caring CQC Responsive CQC Well Led	Supporting the implementation of new models of care across a range of specialties - in progress Support Creation of ICS - commencing Support the development of an Integrated Community Care programme - on hold Support the consultation for Acute Service Review (ASR) Phase 1 - in progress Improvement programmes for cancer, outpatients and urgent care in progress, programme for theatres is on hold Development and Implementation of new pathways for paediatric services - in progress	Declared as a level 4 incident throughout the UK from March 2020. Now NHSE are coordinating phase 3 of the recovery phase, returning urgent and non-urgent services back to capacity and provision as it was pre-covid. During this period of recovery, work is in progress on specific projects to introduce new evidence based models of care as highlighted in column G. In addition, benefits from service changes made as a result of the need to change due to Covid will be locked in for the future, at the same time as addressing any impact on equality for patients who may have poorer clinical outcomes.	Control gaps identified and reported through to Gold Command Structure Delivery of service transformation aligned to the IIP overseen by the Trust Leadership Team.	Numbers of new models of care established Delivery of ASR Year 1 objectives Improvement in health and wellbeing metrics	Assurance received through daily/weekly briefing processes with Chair/CEO/Execs COVID reporting to Trust Board monthly		Finance, Performance and Estates Committee	R

Ref	Objective	Exec Lead	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Controls in place during Covid	How identified control gaps are being managed	Source of assurance	Assurances in place during Covid	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating
4b	Advancing professional practice with partners	Director of Nursing	Specific projects paused during Covid 19 response		CQC Caring CQC Responsive CQC Well Led	Supporting the expansion of medical training posts Support widening access to Nursing and Midwifery and AHP Support expansion of Paediatric nursing programme Developing System wide rotational posts Scope framework to support staff to work to the full potential of their licence Ensure best use of extended clinical roles and our future requirement	Nursing, Midwifery and AHPs have been feeding into the practice placement offers as coordinated by Health Education England, and have employed students who have opted in to extended clinical placements throughout the COVID pandemic. This includes all branches of nursing and midwifery.	Students who are on placement have been allowed to choose where they wish to work and have been supported in their request. There is a formal route of raising any concern via HEE, HEIs and locally. Any issues have been managed in a timely manner	Increase in training post numbers Numbers on Apprenticeship pathways Numbers of dual registrants Numbers of joint posts and non medical Consultant posts Numbers of pre-reg and RN child	Feedback has been sought from the students in practice and the Assistant Director of Nursing has engaged in the weekly strategic calls hosted by HEE	The Medical Director would be required to add information around medical staffing		G
4c	To become a University Hospitals Teaching Trust	Medical Director	Specific projects paused during Covid 19 response			Developing a business case to support the case for change 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:

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

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

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

OUTSTANDING CARE
personally DELIVERED

NHS
United Lincolnshire Hospitals
NHS Trust

Trust Board Forward Planner

	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug
Standing Items													
Chief Executive Horizon Scan													
Patient/ Staff Story													
Integrated Performance Report													
Board Assurance Framework													
Declaration of Interests													
Governance													
Audit Committee Report													
Strategic Objectives for 2019/2020													
BAF Sign off for 2019/20													
Annual Accounts, Annual Report and Annual Governance Statement Approval													
Quality Account													
Strategic Risk Register													
NHS Provider Licence Self Certification													
NHSI Board Observation Actions													
Strategic Objective 1 –To deliver high quality, safe and responsive patient services, shaped by best practice and our communities													
Quality Governance Committee Assurance and Risk Report													
Safer Staffing Report	TBC												
Safeguarding Annual Report	TBC												
Annual Report from DIPC	TBC												

	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug
Strategic Objective 2 – To enable our people to lead, work differently and to feel valued, motivated and proud to work at ULHT													
Workforce, OD and Transformation Committee Assurance and Risk Report													
Staff Survey Results													
Freedom to Speak Up Report													
Report from Guardian of Safe Working	TBC												
WRES/WDES Annual Submission													
Strategic Objective 3 – To ensure that services are sustainable, supported by technology and delivered from an improved estate													
Finance, Performance and Estates Committee Assurance and Risk Report													
Financial Plan and Budgets													
Clinical Strategy Update													
Operational Plan Update													
Emergency Preparedness, Resilience and Response (EPRR) NHS Core Standards													
Strategic Objective 4 - To implement integrated models of care with our partners to improve Lincolnshire's health and well-being													