Bundle Trust Board Meeting in Public Session 2 November 2021

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 5th October 2021

Chair

Item 5.1 Public Board Minutes October 2021v1.docx

5.2 Matters arising from the previous meeting/action log

Chair

Item 5.2 Public Action log October 2021.docx

6 Chief Executive Horizon Scan

Chief Executive

Item 6 Chief Executive's Report, 021121.docx

7 Patient/Staff Story

Director of Nursing

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

7.1 BREAK

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

8.1 Assurance and Risk Report from the Quality Governance Committee

Chair of Quality Governance Committee

Item 8.1 QGC Upward report October 2021 v2.doc

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

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

Chair of People and Organisational Development Committee

Item 9.1 POD - Upward Report - October 2021.docx

9.2 Establishment Review

Director of Nursing

Item 9.2 Establishment Review 2021 v2.docx

Item 9.2 Appx 1 Establishment Review 2021 V6.pdf

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

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

Chair of Finance, Performance and Estates Committee

Item 10.1 FPEC Upward Report October 2021.docx

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

12 Integrated Performance Report

Director of Finance and Digital

Item 12 IPR Trust Board Front Page Oct 21.docx

Item 12 IPR Trust Board October 2021 v2.docx

13 Risk and Assurance

13.1 Risk Management Report

Director of Nursing

Item 13.1 Strategic Risk Report - November 2021.docx

13.2 Board Assurance Framework

Trust Secretary

Item 13.2 BAF 2021-22 Front Cover November 2021.docx

Item 13.2 BAF 2021-2022 v21.10.2021.xlsx

13.3 Upward Report from Audit and Risk Committee

Chair of Audit Committee

Item 13.3 Audit Committee Upward Report October 21 v1.docx

14 Any Other Notified Items of Urgent Business

15 The next meeting will be held on Tuesday 7th December 2021

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

Minutes of the Trust Board Meeting

Held on 5 October 2021

Via MS Teams Live Stream

Present

Voting Members:
Mrs Elaine Baylis, Chair
Mr Andrew Morgan, Chief Executive
Mrs Liz Libiszewski, Non-Executive Director
Mr Paul Matthew, Director of Finance and Digital
Dr Karen Dunderdale, Director of Nursing
Mrs Sarah Dunnett, Non-Executive Director
Mr David Woodward, Non-Executive Director
Dr Colin Farquharson, Medical Director
Professor Philip Baker, Non-Executive Director

Non-Voting Members:
Mr Simon Evans, Chief Operating Officer
Mrs Alison Dickinson, Associate Non-Executive Director

In attendance:
Mrs Jayne Warner, Trust Secretary
Mrs Karen Willey, Deputy Trust Secretary (Minutes)
Dr Maria Prior, Healthwatch Representative
Mrs Angie Davies, Deputy Director of Nursing (Item 7 only)
Mrs Sarah Hall, Deputy Director of Improvement and Integration

Apologies
Ms Cathy Geddes, Improvement Director, NHSE/I
Dr Chris Gibson, Non-Executive Director

1591/21	**Item 1 Introduction** The Chair welcomed Board members and members of the public who had joined the live stream to the meeting. In line with guidance on Covid-19 the Board continue to hold meetings open to the public through the use of MS Teams live. In line with policy, papers had been published on the Trust website a week ahead of the meeting and the public able to submit questions in the usual manner. The Chair highlighted that although national Covid-19 restrictions were lifted on the 19 July 2021 the NHS continued to operate under the advice of NHS England in regard to Infection Prevention Control measures including the requirement to follow social distancing rules, impacting on the ability to revert to Board meetings in the pre pandemic format. The Trust Board would continue to follow national advice and operate in accordance with procedures that had been implemented during the pandemic.
1592/21	The Chair moved to questions from members of the public. **Item 2 Public Questions** **Q1 from Sue McQuinn**

	The long awaited public consultation on the Acute Services Review is now underway. In relation to the proposals for Grantham Hospital Accident & Emergency Dept., what assurances can you provide that you are genuinely 'open to influence' from the consultation process, that it's not merely a box ticking exercise? **An Urgent Treatment Centre is the ULHT preferred option. If the consultations show a significant number of people are against this, what realistic possibility is there to change the proposals? Would the status quo be an option? Or is it not even take it or leave it, but just 'take it' because a UTC is the only option ULHT will consider?** The Chief Executive responded: The consultation was being led by Lincolnshire Clinical Commissioning Group (CCG) and would be the organisation making the final decision once the consultation was completed. The Trust had been involved in the development of the proposal along with a number of senior clinicians. The tenor of the question was correct in that the Trust supported the proposals contained within the document. The Chief Executive advised that all views expressed during the consultation would be considered and would inform and influence the decision making process. With regard to making the outcome of the consultation as independent as possible the CCG had commissioned an organisation called ORS, a social research company, to produce an independent report at the end of the consultation summarising the process and the feedback from the consultation. The Chief Executive stressed that the consultation was not a vote but an opportunity to listen to what people thought about the situation, challenges, opportunities, options and impact if the proposals were adopted. Also what mitigating actions may be put in place and also the alternative views. As a Lincolnshire NHS System alternative proposals were welcomed however these would need to be both viable and deliverable. The consultation was clear that when the proposals were being developed and considered a shortlisting criteria, relating to quality, access, affordability and deliverability was utilised. This would need to be applied to any other proposals or options put forward. The Chief Executive assured that this was not a tick box exercise and people would be able to put forward alternative options that were viable and deliverable.
1593/21	**Q2 from Jody Clark** **While looking through the public consultation documents, put out by Lincolnshire CCG. They included maps of the conditions of our hospitals. I have included the Grantham Hospital map and would like to ask, as only a couple of areas are Green/of Good Standard, what plans do you have in place to address the Amber and Red areas of Grantham Hospital?** The Chief Operating Officer responded: There were two element firstly on a day to day basis a lot of time was spent managing those areas marked red and areas where there was a need for focused attention in order to maintain safety and ensure the environment was sufficient for both clinical and administrative purposes. This was managed through day to day work across all of the hospital sites.

	The Trust had an estates strategy that was being formed for Board review over the course of the next few years that would describe how the Trust would use investments each year to focus on key areas and improve the quality of the estate across all of the hospital sites. Over the course of the last year the Trust had spent more than £40m on investments to improve the environment, not only at Grantham but also the other sites. A substantial amount of this investment had been to look to improve the amber and red areas. The Trust were looking to carry out a similar level of investment in the current year and the next in order to bring those areas up to standard. Due to the size of the backlog that the Trust had the Trust was keen to make the most of any available capital from national funding streams.
1594/21	**Q3 from Vi King** **Please can I ask what substantive Clinical staff there is at Grantham, not counting bank or Agency. Also, the same question what substantive Clinical staff we have had Lincoln, Louth and Pilgrim, not counting agency or Bank.** **Also, what is the number of substantive clinical staff that have been moved to other sites.** **Can you please give the vacancy rate for clinical staff across all of the Trust.** The Director of Finance and Digital responded: Clinical staff, in full breadth of doctors, nurses and allied health professionals at Grantham Hospital as at 30 September 2021 was 415. There were 2495 at Lincoln Hospital, 66 at Louth County Hospital and 1662 at Pilgrim Hospital. In terms of the staff moved between sites, as the Trust operated as one organisation and staff moves happened as a matter of course in order to run the business this was not something that was recorded and as such could not be answered. The Director of Finance and Digital advised that the vacancy rate across the Trust at the 30 September 2021 was 14%.
1595/21	**Q4 from Charmaine Morgan** **If freedom of information requests (FOIs) are treated separately to Public Questions for the ULHT board, can a 'Log of fois' be added to future board reports with updates/ responses shared in the monthly board reports for transparency/monitoring/scrutiny purposes?** The Director of Finance and Digital responded: For clarity the public Board questions and freedom of information requests are two separate and individual processes. There is no legislative requirement for freedom of information requests to be published and given the volume received of around 50-60 per month it would be impractical to deal with these at the public Board meeting. The Trust are keen to be open and transparent so consideration could be given to determine what could be published on the Trust website in terms of a log of freedom of information

	requests in order to allow people to self-serve what had been asked historically and answered by the Trust.
1596/21	**Item 3 Apologies for Absence** Apologies for absence were received from Dr Chris Gibson, Non-Executive Director and Ms Cathy Geddes, Improvement Director NHSE/I
1597/21	**Item 4 Declarations of Interest** There were no declarations of interest which had not previously been declared.
1598/21	**Item 5.1 Minutes of the meeting held on 7 September 2021 for accuracy** The minutes of the meeting held on 7 September 2021 were agreed as a true and accurate record subject to the spelling correction of Healthwatch on the first page.
1599/21	**Item 5.2 Matters arising from the previous meeting/action log** The Chair noted that all actions due for this meeting had been updated and marked as complete.
1600/21	There were a number of outstanding actions for the People and Organisational Development Directorate which would be reviewed and updated ahead of the November meeting.
1601/21	**Item 6 Chief Executive Horizon Scan including STP** The Chief Executive presented the report to the Board noting the continued pressure on the system including the Trust and that the pressures were becoming visible at the front door, mainly in the emergency departments.
1602/21	The Board were advised that patients were waiting longer than the Trust would want them to including those being brought in by ambulance with long ambulance waits. Staff were working hard through difficult circumstances to address the issues however there were also issues of flow through the hospitals.
1603/21	The Chief Executive noted that delays were being experienced in being able to discharge patients who were medically fit and no longer required acute care. Work was underway with system partners in order to try and resolve these delays as being unable to discharge patients was causing a backlog at the front door as patients could not be admitted to a bed. This would be discussed in detail later on the agenda however the Chief Executive wished to raise the issues with Board members due to the very significant pressures being faced.
1604/21	The Board was advised that further guidance had been received in relation to the Integrated Care Partnership (ICP) and was the NHS and social care partnership of the Integrated Care System. The other half of this was the Integrated Care Board (ICB) that would replace, in part, the CCG once dissolved at the end of March 2022. The Chief Executive noted that the Chair of the ICB was yet to be announced and advised that the recruitment process for the Chief Executive had commenced.
1605/21	The Chief Executive advised that Maz Fosh had been appointed to Lincolnshire Community Health Services NHS Trust as Chief Executive and extend congratulations on her appointment.

1606/21	The Chief Executive noted that the vaccination programme was continuing across the system and that the system public consultation had now commenced in relation to 4 services provided by the NHS.
1607/21	This had previously been referred to as the Acute Services Review however covered more than this however now focused on 4 services these being orthopaedic surgery across Lincolnshire, Urgent and Emergency Care at Grantham, acute medical beds at Grantham and stroke services across Lincolnshire.
1608/21	The consultation launched on 30 September with the Trust present for the launch as the provider of the services. The consultation was CCG led and would run until 23 December 2021 and the Trust and system partners were looking forward to engaging with the public and their representatives over the next 12 weeks.
1609/21	The Chief Executive offered an update on Trust issues noting the financial position at month 5 and the forecast position for H1 which had a slight variance due to the changes in the elective recovery fund (ERF). Had there been no change to the ERF the Trust would have achieved the £1.8m position.
1610/21	The Board was advised that a Director of People and Organisational Development was not appointed following the interviews that had been held. The Trust had gone back out to national advert and it was noted that the Interim Director of People and Organisational Development was no longer with the Trust. The Chief Executive was pleased to advise that the Director of Finance and Digital had agreed to care take the directorate alongside current duties whilst recruitment was undertaken.
1611/21	This would enable leadership, direction and decision making to be in place for the directorate along with support to address vacancy gaps within the team. The Board was advised that interviews for the Deputy Director of Improvement and Integration were due to take place over the next 10 days with a number of candidates for interview.
1612/21	The Chief Executive was delighted to welcome Deborah Elliot to the Trust as the substantive Freedom to Speak Up Guardian.
1613/21	The Chief Executive noted that the expression of interest in the Health Infrastructure Plan had been made as the Trust sought investment in to Lincolnshire to tackle the current premises issues.
1614/21	Mrs Dunnett asked if there was good up take for both the Covid-19 booster vaccine and the winter flu jab.
1615/21	The Director of Finance and Digital noted that as of 4 October 1360 staff had received the flu vaccination and 1530 the Covid-19 booster vaccine and was pleased with the start of the vaccination programmes.
1616/21	Mrs Libiszewski sought to understand the availability of the vaccination slots to ensure staff were able to receive these.
1617/21	The Director of Finance and Digital noted that there were slots available at Grantham currently however work would be undertaken with the vaccination team in order to understand more about this. The Trust were keen to ensure that there was an appropriate level of availability for staff to access the vaccinations and to move through the programme as swiftly as possible. There was a desire to match the 90% flu vaccination rate as had been achieved the previous year.

1618/21	The Chair noted the request from Board members to offer a congratulatory letter to the newly appointed Chief Executive of LCHS asking that this be picked up by the Trust Secretariat. **Action – Trust Secretary, 2 November 2021** The Trust Board: • **Noted the report and significant assurance provided**
1619/21	**Item 7 Patient Story** The Deputy Director of Nursing presented the patient story to the Board advising that the story detailed the introduction of What Matters to You, an initiative to support patient experience.
1620/21	The initiative was introduce by Tommy Whitelaw who was a carer for his Mum Joan who had dementia and he promotes the person centred care principle of What Matters to You. This was about changing the mind-set from what is the matter with you and looks at what the patient would like to support them during their care. Over the past year the Trust had worked with staff and team to consider how this was applied across the Trust.
1621/21	The Deputy Director of Nursing advised that a cohort of volunteers had been identified and this was being linked to the Trusts Quality Improvement Programme in order to implement change within services.
1622/21	The Board watched the video presentation that detailed the initiative that was introduced through the cohort of volunteers at the Hospice in the Hospital, noting the impact that this was having on patients and the experience of those patients who were receiving a quality experience personal to them.
1623/21	The Deputy Director of Nursing noted that the next steps were to identify further cohorts of teams who were interested in implementing What Matters to You across the Trust with a number of teams expressing interest.
1624/21	The Board noted that this was about giving confidence to staff in order to ask patients what would make a difference to them during their care and were advised that the Trust had been cited, through the What Matters to You Annual Network Conference, for the work that had already taken place.
1625/21	Learning had been taken from the initial cohort and it was recognised that there was a need to ensure support was offered to staff in the way of coaching to support them to hold conversations and manage the expectations of patients on what was possible.
1626/21	The Board noted that there had been a pause on the role out due to Covid-19 and operational pressures however this continued to move forward.
1627/21	Mrs Dunnett asked if this would be integrated in to the Trust wide Cultural and Leadership Programme with the Deputy Director of Nursing advising that this was not currently linked it would be possible for this to be implemented.
1628/21	Mrs Libiszewski noted the work that had been undertaken and stated that a number of patients when admitted wanted to know when they would be discharged and asked if this could be built in to the work. The idea being that the discharge date would be owned by the

	patient and would support them to be clear with clinicians about when they would be discharged.
1629/21	The Deputy Director of Nursing noted the suggestion stating that there was work underway to ensure that What Matters to You was improved from a multi-disciplinary perspective so that this was not only nurse or clinician focused. This would push the clinical teams to hear the patient and to work with them.
1630/21	The Chief Executive endorsed the work that was being undertaken the point that this was not just about clinical staff. This was something that all staff should feel they are able to support. This was about normalising some of the conversations being held due to the impact that was seen on patient wellbeing.
1631/21	The Chief Executive noted that this could be linked to the Culture and Leadership Programme but also noted that this was also about what mattered to staff and how their working lives could be made better alongside the patients' experience.
1632/21	The Chair noted that whilst this was a simple initiative it place the patients at the heart of care and was making a difference to the experience received.
1633/21	The Chief Executive offered the support of the Board to the Deputy Director of Nursing noting that the initiative was backed by the Board.
1634/21	The Deputy Director of Nursing noted that the endorsement from the Board was what had been hoped and for the Board support communication across the Trust about the implementation of this. The Trust Board: • **Received the staff story**
	Item 8 Objective 1 To Deliver high quality, safe and responsive patient services, shaped by best practice and our communities
1635/21	**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 21 September Meeting noting that the Committee operated in a limited way due to the third wave of Covid-19 and the Trust operational pressures.
1636/21	Mrs Libiszewski noted that as a result of pressures a number of groups had been stood down however Chair's reports had been received. The Committee noted that the Safeguarding Group continued to pursue work with Lincolnshire Partnership NHS Foundation Trust in relation to restraint and clinical holding training.
1637/21	This was a long standing issue for the Trust and the team were attempting to bring forward an integrated approach to ensure ongoing training for staff.
1638/21	The Patient Safety Group had highlighted and reviewed the most recent never event, the second of the year, to consider actions that were needed. The serious incident investigation process was taking place.
1639/21	The Committee received an upward report regarding the clinical harm and review process, the impact of which was being reviewed by the Committee on a monthly basis. This was also reported to the Board through the performance report and highlighted the issues being faced.

	Mrs Libiszewski noted that the Trust was not an outlier in respect of the current position however this continued to be monitored.
1640/21	The Committee looked in detail at the Quality Impact Assessment (QIA) regarding visiting for patients, particularly due to the arrangements in place and the impact this would have on patients and families. Whilst the Committee had reviewed the QIA visiting arrangements had now been altered and so a request made that the QIA be reviewed to take a more patient centred approach. Whilst this had been taken in to account to some extent it had be, understandably, infection prevention and control focused.
1641/21	Mrs Libiszewski noted that the Committee had received an upward report from the Maternity and Neonatal Oversight Group noting that the updated standards for the Clinical Negligence Scheme for Trusts had been received. As previously the Committee were made aware that the current IT system would hamper the Trusts' ability to submit data and as such this was formally raised to the Board.
1642/21	Whilst it was recognised that some action had been taken this was a national issue that remained. Mrs Libiszewski noted that, as a Board, there was a need to be sighted on the concern that frontline staff were raising in relation to the submission of data.
1643/21	The thematic review of maternity incidents by an external team continued and the report would be presented to the Committee once complete.
1644/21	Mrs Libiszewski noted that the Committee received an update on the national patient survey in to emergency care which, disappointingly, placed the Trust in the bottom 10. Further detail had been requested on the work taking place that would be different and refreshed to try and address the issues. Whilst the Trust were aware that the departments were small and under pressure the outcome was not surprising that patient experience had been impacted by pressures.
1645/21	The Committee received a Chair's report under objective 1c for improving clinical outcomes with the detail being offered through the report.
1646/21	Mrs Libiszewski noted that key issues from the performance report had focused on duty of candour and 12 hour waits in the emergency departments, both remained at a low level of performance due to operational pressures. As the Board were aware the risk relating to emergency care was rated at 25.
1647/21	Mrs Libiszewski reiterated to the Board the issue of escalation being the IT system in maternity services and the impact on data submissions. The Committee had received and reviewed both the risk register and Board Assurance Framework for which there had been no changes made to the assurance ratings.
1648/21	The Chair sought to understand the number of Medical Examiners that had been removed as part of the process for those 5 years post retirement and the process of new Medical Examiners commencing.
1649/21	The Medical Director noted that there had been a number of Medical Examiners removed due to reaching 5 years post retirement however recruitment had taken place and the issue was expected to be resolved by the end of October. Whilst there had been a reduced number of Medical Examiners mitigations had been in place to cover the shortfall.
1650/21	The Director of Finance and Digital noted that the maternity IT system issue had been ongoing for some time and as a result a letter had been sent to the supplier, there had not yet however been a satisfactory response in regard of the next steps. This had been escalated to

	NHS Digital but there remained not turnaround time for this to be resolved. Work was underway with the supplier and with national and regional colleagues although no assurance could be offered.
1651/21	The Chair noted the need to continue to follow up with the supplier as indicated to achieve a resolution. The Trust Board: • **Received the assurance report**
	Item 9 Objective 2 To enable our people to lead, work differently and to feel valued, motivated and proud to work at ULHT
1652/21	**Item 9.1 Assurance and Risk Report People and Organisational Development** The Chair advised the Board that the Director of Finance and Digital had agreed to offer leadership to the People and Organisational Development Directorate whilst the Trust were in the process of making an appointment. The report presented offered a position statement and the Board was advised that the Committee would recommence in October.
1653/21	The Director of Finance and Digital presented the report to the Board advising that the Trust had joined the NHS England/Improvement (NHSE/I) Culture and Leadership Programme and that the Leadership Behaviour Survey had launched in September.
1654/21	The Trust had managed to achieve a higher than average response rate of 16% equating to 1354 staff with response from 92 partner organisations. NHSE/I had commended the Trust on receiving such a high response rate and results were now being analysed. A Cultural Change Team with 50 of the Trusts staff had been formed to support this work.
1655/21	The Board was advised that the Leading Together Forum would launch next week, bringing together 400 staff in leadership roles or those aspiring to be leadership. The event would be run by the Chief Executive and would operate on a regular basis as a vehicle for enabling colleagues to connect with peers and contribute to discussions about the Trust's future and developments.
1656/21	The Director of Finance and Digital noted that the National Staff Survey had launched on 4 October and would close at the end of November with the outcome being offered post November.
1657/21	The Board was advised that the Trust had commenced with phase 3 of the booster vaccination programme with 15,000 staff to vaccination across the system.
1658/21	The Director of Finance and Digital was pleased to welcome the Associate Director of Human Resources and Organisational Development to the Trust who was now in post full time and would be leading this areas and addressing areas of work to make changes and improvements.
1659/21	The Board noted that funding had been secured for a band 7 role that would support the development and delivery of wellbeing in the organisation. A review of the Trust's equality objectives and inclusion strategy would be undertaken by the Associate Director of Human Resources and Organisational Development.
1660/21	The Director of Finance and Digital noted in respect of workforce metrics that mandatory training remained static and that the Trust's absence rate was circa 7% which was

	significantly above the target of 4.5%. It was noted however that this was significantly reduced compared to the peak of absence recorded as 9.4% in wave 2 of the Covid-19 pandemic.
1661/21	Appraisal rates continued to be low and work was underway following the implementation of WorkPal to embed and work through improvements.
1662/21	Mrs Dunnett commented on the amount of support being offered to staff for health and wellbeing and asked that the People and Organisational Development Committee considers how this would be evaluated in order to understand if there had been any impact of the support offered to staff.
1663/21	Mrs Dickinson noted that there was a national campaign with regard to flexible working for staff and asked if the Trust had received many requests and how these were being managed.
1664/21	The Director of Finance and Digital noted that this would be discussed through the People and Organisational Development Committee in terms of the detail however the Trust have a flexible working policy in place that was being managed at a local level. Through the pandemic, for those working remotely, there was a level of flexibility in place. It was recognised however that there was more work to do on how flexible working was accessed by those in roles that needed to be delivered on site.
1665/21	The Director of Nursing noted that there had been a lot of work around recruitment and retention of staff noting there was significant work happening nationally aligned to agenda for change terms and conditions. The Head of Organisational Development was undertaking a specific piece of work to look at how the Trust would implement the national change to agenda for change contracts.
1666/21	The Director of Nursing noted from a nursing perspective that this was traditionally shift based patterns of work and whilst there was a need to offer some flexibility to this there was a need to balance patient safety risks that could occur as a result of multiple flexible shift patterns and multiple staff handover times.
1667/21	The work being undertaken by the Head of Organisational Development would ensure that the Trust was in line with the national requirements to ensure contractual obligations to offer flexible working were met. As work progressed a review of the flexible working policy would be undertaken to ensure that the offer could be made to staff.
1668/21	The Chief Executive noted in relation to the staff wellbeing offer that any evaluation that was undertaken would also need to address the ease of access. This was in part being picked up through the discovery phase of the culture and leadership programme. It was recognised that there was an attractive suite of offers however there was an issue with staff being able to access these at a time that was helpful or convenient to them. When this was overlaid with some of the operational pressures being faced there was added difficulty for people to be released to seek support.
1669/21	The Chair noted, in the role of Wellbeing Guardian, was also hearing that there were concerns as to the ease of access to support. This feedback was being received from the Organisational Development team and there was a need to understand the detail and experience of staff. The Trust Board: • **Received the report noting the limited assurance**

	Item 10 Objective 3 To ensure that service are sustainable, supported by technology and delivered from an improved estate
1670/21	**Item 10.1 Assurance and Risk Report from the Finance, Performance and Estates Committee** The Chair of the Finance, Performance and Estates Committee, Mr Woodward provided the assurances received by the Committee at the 23 September 2021 meeting noting that the Committee worked to a reduced agenda and meeting.
1671/21	Mr Woodward noted that a number of points within the report had been raised as the meeting had taken place and would not repeat these but raised key issues, the first being the estates report and the recognition that a number of risks identified in relation to estates had crystallised in September. There had been a huge effort from the relevant teams in order to address these.
1672/21	As mentioned by the Chief Executive the finance report was received and subject to some technical ERF changes the Trust were on track to deliver the first half plan. It was noted however month 6 would be challenging to deliver.
1673/21	Mr Woodward noted a significant improvement in assurance through the newly designed capital report. There had been a significant effort by the team to produce a detailed paper that covered the plan to delivery through to the year end of the capital programme. The paper had detailed risks in respect of slippage including national supply issues and contingencies had been identified along with actions to progress.
1674/21	The Committee supported the recommendation to the Board for the over commitment of capital between £2 - £5m but not to overspend on the capital limit. This would address the challenges on receiving capital that had been experienced in previous years and would ensure capital was spent effectively and efficiently.
1675/21	Mr Woodward noted that the Information Governance team had moved to the portfolio of the Trust Secretary and there was an intention to Information Governance Group would be strengthened and refocused.
1676/21	The Committee received the Digital Services report that considered cyber risk directly to the organisation and hoped that third party risks would be considered in more detail in future reports.
1677/21	The Committee noted the performance issues that had previously been mentioned in respect of 12 hour trolley waits and the pressures in the emergency departments.
1678/21	Mrs Dunnett noted that there had been a number of challenges in estates, in particular specific challenges in the past few week and asked if the Committee had been assured that these were adequately captured within the risk register.
1679/21	Mr Woodward noted that these had been identified and the challenges had been the mitigations that were long term and required investment. The Chief Operating Officer added that the incidents described within the report were articulated within on or more risks within the risk register. Those impacting electrical and water systems were described as moderate to high across the organisation. Some solutions had managed to address the issues urgently but others would require longer term strategies.
1680/21	These risks were captured and continued to be reviewed to ensure they were adequately articulated along with the level of risk being carried.

	The Trust Board: • **Received the assurance report**
	Item 11 Objective 4 To implement integrated models of care with our partners to improve Lincolnshire's health and wellbeing
1681/21	**Item 11.1 Teaching Hospital Status Update** The Chief Executive presented the report to the Board noting in June 2021 the Board had supported the ambition to apply for University Hospital Teaching status with effect from 1 April 2022.
1682/21	The paper presented to the Board was a joint paper between the Trust and the University of Lincoln who had been supporting the Trust on the proposal. There was close working with the University of Lincoln and the move to University Hospitals Teaching status would see benefit of research, innovation, training and benefits to patient treatments and for the Trust this would support recruitment and retention.
1683/21	The Chief Executive advised that since the last report there had been a change in guidance by the University Hospitals Association (UHA) making it more difficult for the Trust to achieve the status. The biggest changes had been in relation to the number of clinical academics and research capability funding.
1684/21	The Chief Executive noted that the Trust would work with national colleagues at the Department of Health and Social Care (DHSC) in relation to the criteria with DHSC advising that they would like to review the guidance however this would be in the medium term. Both the Trust and the University of Lincoln were keen that the momentum gained was not lost due to the benefits of joint working.
1685/21	The paper set out 6 options that had been considered with option 3, application to become a teaching hospital be submitted and option 6, create a Provider Group Model being the preferred options.
1686/21	The Chief Executive advised that option 3 would see the Trust apply for teaching hospital status as a precursor to, hopefully, move to University Hospital status. Option 6 was a provider model with partners across the health system.
1687/21	Discussions had been held by both the Trust and University at senior level with both management teams preferring options 3. This would offer a number of benefits to the Trust and increase the relationship in place with the University. Whilst the change in guidance was disappointing this had not been viewed as a reason not to continue with option 3 being recommended to the Board.
1688/21	The Chair noted the unfortunate change to the guidance but recognised the desire to progress.
1689/21	Professor Baker had not been aware of the change in guidance and asked if the changes had been confirmed and asked what plans had been in place to fund the consultant posts.
1690/21	The Deputy Director of Improvement and Integration noted that the change in guidance had been confirmed by the UHA however would be keen to seek Professor Baker's view if this differed due to his experience.

1691/21	Professor Baker noted that there would be a need to understand how rigidly the guidance would be applied as this may be flexed.
1692/21	The Deputy Director of Improvement and Integration advised that following conversation with both the University and UHA it had been clear that the guidance would be stringently applied as this was to limit the number of hospitals that became University Hospitals.
1693/21	With regard to the funding for consultant posts, this remained in discussion with the University. 20 consultants would be required and to fulfil the criteria the consultants would need to hold a contract with the University, the funding was yet to be decided.
1694/21	Professor Baker offer support to the process and conversation to be held with the University due to experience of different models across the country.
1695/21	The Chair noted the intention for this to be reported to and monitored through the People and Organisational Development Committee utilising Professor Baker's expertise to add value.
1696/21	The Chair noted that Mrs Dunnett and Mr Woodward had, through the MS Teams chat function, asked about the business case and financial implications as a result of the change in guidance however noted this would be picked up as progress was made.
1697/21	The Chief Executive noted that the comments made by Professor Baker would be explored in relation to how stringent the criteria was. Work would be completed in relation to the business case as it was noted that this would attract extra cost, as built in to the revised guidance.
1698/21	The paper had been presented to the Board in order to ensure there was awareness of the change but also to confirm that the Board wanted to continue and supported recommendation to pursue teaching status prior to University Hospital status. The Chief Executive confirmed that this was the recommendation from both the Trust Executive Team and University Senior Leadership Team. The Trust Board: • **Received the report noting the limited** • **Approved the recommendation to progress option 3 – Teaching Hospital status**
1699/21	**Item 12 Integrated Performance Report** The Director of Finance and Digital presented the report to the Board noting that relevant items for attention of the Board had been raised through the Committee upward reports.
1700/21	The Director of Nursing noted that there had been a significant deterioration in both verbal and written duty of candour from the previous month and that this had been on a downward trend for over the past few months. Discussion had been held by the Quality Governance Committee and Internal Audit had been asked to undertake a review of the governance processes in relation to duty of candour.
1701/21	The Board was advised that the Clinical Governance department and constituent teams had been restructured to a business partner model in order that the clinical governance teams could actively work with the divisions. Implementation of a weekly duty of candour tracker had taken place, aligned to incidents, had taken place at the request of the divisions due to the positive impact of the complaints tracker.
1702/21	Support training had been commissioned for staff through Capsticks in order to ensure staff know when to undertake duty of candour, with who and the timeframe for this to be done.

	This would support the Trusts statutory responsibilities in respect of duty of candour which would continue to be reviewed through the Quality Governance Committee.
1703/21	Mrs Dunnett noted that there was extensive narrative in relation to Summary Hospital-Level Mortality Indicators (SHMI) however there was no data included for Hospital Standardised Mortality Ratios (HSMR) and sought an understanding of this.
1704/21	The Medical Director advised that there was a national data collection issue in relation to HSMR and as such a focus was being given to SHMI due to the relative robustness of the data.
1705/21	Dr Prior noted that there had been a successful recruitment drive earlier in the year for Healthcare Support Workers (HCSW) however it was disappointing to see the increased turnover for these staff.
1706/21	The Director of Nursing noted the proactive and fruitful recruitment to HCSWs advising that these roles had been over recruited at the beginning of the year. The recruitment had included both those new to healthcare and those with previous experience, either in acute, care home or primary care settings. It had been identified that those who had left the Trust were, predominantly, those who had not worked in healthcare previously and this had led to conversations to understand what could have been done differently to help and support those staff in order to retain them.
1707/21	It was noted that the short period of induction prior to working on the wards in hands on care had been traumatic and frightening with those staff having felt ill prepared. Work was now taking place to extend the induction to 3 months along with development of a care camp in order to offer 2 weeks on intensive hands on training covering the fundamentals of care.
1708/21	A focus would be given to those who were new to healthcare to offer support and staff who had left the Trust had been asked if there would be any interest in returning if this was offered, some had been interested.
1709/21	This had been a valuable experience to the Trust and there was a need to ensure access to health and wellbeing for staff and to ensure there was sight of those staff who were struggling. The more structured and intense induction for HCSW, if evaluated well, would be considered wider for anyone new to the Trust in a hands on role. Whilst it was recognised that some of the HCSW appointed were no longer working for the Trust a lot had been learnt from the experience.
1710/21	Mrs Dickinson, noting that the Trust was in the recovery and restoration phase along with managing the elective waiting lists, asked if it would be possible to understand harm for delayed treatment and how this would be reported in future and duty of candour in relation to harm.
1711/21	The Chief Operating Officer advised that clinical harm was reported to the Clinical Harm Oversight Group, co-chaired by the Medical Director and Chief Operating Officer, meeting every 2 weeks.
1712/21	The group reviewed an additional set of processes put in place, over and above the usual incident reporting system to proactively identify where there may be harm to patients in a range of potential harm situations. There were 10 triggers of potential harm with around half in planned care and long waits and 5 focused on urgent care situations that may result in a harm event.

1713/21	The group undertook proactive review of the triggers and identified themes and issues from harm reviews in order to be able to respond and amend the approached being taken. This also factored in the way that the Trust considered risk stratification and the priorities placed on some groups of patients.
1714/21	Articulated through the Finance, Performance and Estates Committee was the way in which the Trust had changed the prioritisation system from time based to a more intuitive, priority bases system, using national guidance issued in wave 2 of the pandemic. The Quality Governance Committee received an upward report from the Clinical Harm Oversight Group in relation to harm reviews. The Trust Board: • **Received the report noting the limited assurance**
	Item 13 Risk, Governance and Assurance
1715/21	**Item 13.1 Risk Management Report** The Chair requested that a specific focus be afforded to risk 4175 during the Board discussion.
1716/21	The Director of Nursing presented the report to the Board noting that this was the monthly report on strategic risks which continued to report the same 3 very high risks as the previous month. These were the impact of Covid-19, capacity to manage emergency demand and workforce engagement, morale and productivity.
1717/21	The Board noted that the report made reference to the scheduled reviews of the risks within the strategic risk register and were advised of the daily reviews undertaken by default through the Gold Command structure that was in place to manage the sites through Covid-19 and operational pressures.
1718/21	The Chief Operating Officer offered background to the situation in which the Trust was currently operating noting that the report articulated the highest level risk within the Trust around the mismatch in capacity, to be able to respond to urgent care demand and the operational pressures within the Trust which were accurately reflecting some of the elements described within the risk register entry.
1719/21	The Board was advised that operationally the demands on hospitals, in terms of numbers of admissions and attendances on urgent care pathways were not excessively above previous year's demands or the volume of patients accessing services in urgent care, nor was it Covid-19 demand in its own right. The Chief Operating Officer advised that the number of patients who were positive with Covid-19 in the Trusts' hospitals was largely as predicted and plateauing at a rate of circa 50% of the demand experienced in the initial wave 1 of Covid-19.
1720/21	What was being experienced was the combination of lower levels of Covid-19 demand, which increased complexity of the services, having to be able to both risk stratify and separate potential infectious from those that were not but also the acuity of patients accessing services.
1721/21	Using the latest data available the Chief Operating Officer advised the Board that those patients who were being triaged as very high acuity, requiring the most urgent response in the emergency departments had increased significantly. At the same time the Trust were also experiencing, in urgent care pathways and accident and emergencies, an increase in exit blocks. This meant that patients were not able to progress

1722/21	through the hospital to be discharged and was resulting in an increase in occupancy within Accident and Emergency.
1723/21	The Trust continued to expand and improve the services offered within the hospital that were having a positive impact and as such a focus was being given to areas such as Same Day Emergency Care, where patients would be treated and discharged the same day without the need for inpatient care or an overnight stay.
1724/21	The Chief Operating Officer noted that the Trust were seeing an increase in the length of stay for patients requiring services outside of hospital and acute care, particularly those who required community or domiciliary care. There had been, on occasions, a doubling of the length of stay of patients who were waiting for those services and had been declared medically optimised.
1725/21	The Chief Operating Officer advised that the combination of the factors described had significantly increased the risk of the Trust's services and contributing to the issues described within the risk register and the delays in care.
1726/21	The Chair noted that the update provided supported the narrative that had been received through the Committee reporting and the Integrated Performance Report.
1727/21	Mrs Libiszewski noted that, if the system was working in the correct way then there would be an increase in the acuity of patients being seen through the emergency departments with lower acuity patients being filter and seen in the most appropriate setting.
1728/21	The Chief Operating Officer confirmed that the Trust would wish to be seeing patients who required acute care and emergency services noting that the proportion of increase was positive. This demonstrated that patients were attending the right places however what had been described was not just acute demand but patients often requiring resuscitation or the highest level of intervention. Overall this placed demand on services, beyond anything that had been seen previously.
1729/21	Mrs Dunnett sought assurance that the Trust were ensuring that those patients who were with the Trust for longer than necessary, particularly the medical outliers, were being kept safe. Mrs Dunnett also noted system working and the shortage of domiciliary care which was causing challenge to the Trust and asked what action was being taken to address this.
1730/21	The Chief Operating Officer noted that the hospitals were designed and staffed in such a way that patients were appropriately cared for using step down levels of care however it was acknowledged that the longer patients remained in an acute setting without requiring acute care risk to the patient increased.
1731/21	The Board was advised that managing outliers was inevitable noting that patient numbers increased when on wards when there was outlier status. Safety net measures were put in place to address this but it was known that the practice of having outlier status wards could increase the length of stay due to the increased complexity of the communications needed. This was monitored closely through daily quality reviews and patient stories were being included in order to understand patient experience.
1732/21	The Chair asked if there were any further mitigations in place in respect of partnership working and the gold calls that were taking place to alleviate pressures.
1733/21	The Chief Operating Officer noted that a number of senior calls were in place with Chief Executives from health and social care coming together to see what was happening. There was a significant challenge within domiciliary care and alternative services were being

	considered along with using other elements of community health and care providers to bridge the gaps.
1734/21	It was noted that this would be complicated due to the number of different services that were coming online however the Critical Response Team would work with community providers in order to ensure patients, who did not require acute care, did not attend the emergency departments and ensure patients received care at home where possible.
1735/21	The Chair noted that the Board understood the challenges being faced and the mitigations in place however there was a need to urge system colleagues to offer support and for this to be in a timely manner.
1736/21	The Chief Executive noted that this position was not unique to Lincolnshire and that there was a need to consider the impact of this level of activity on the workforce. The prime focus was on patients but consideration of what mattered to staff was needed to ensure they could care for patients. There was focus being afforded to this however it was noted that this was exceptional and was adding to the emotional distress of staff.
1737/21	The Chair noted that this was recognised by the Board and there was concern to hear what was happening both locally and nationally. Patients were experiencing challenges in the delivery of care and there was an impact on staff due to this.
1738/21	The Board was satisfied with the mitigations that continued to be enacted and it was hoped that these would be expedited with effective leadership and support from the wider system. The Trust Board: • **Accepted the top risks within the risk register** • **Received the report and noted the moderate assurance**
1739/21	**Item 13.2 Board Assurance Framework** The Trust Secretary presented the report to the Board noting that this had been considered by the Finance, Performance and Estates Committee and Quality Governance Committee during September.
1740/21	The Board were advised that the People and Organisational Development Committee had not met in September and as such the Board Assurance Framework had not been discussed. The Committee would be re-established under Professor Baker's chairmanship in October and a review would be undertaken by the Director of Finance and Digital and the People and Organisational Development Directorate ahead of the Committee.
1741/21	No changes had been made to the assurance ratings presented within the Board Assurance Framework.
1742/21	Mrs Dunnett noted, through the MS Teams chat, that the Audit Committee were due to meet on 11 October where objective 2c would be considered in detail along with the assurance rating.
1743/21	The Chair requested that in light of discussion relating to the University Teaching Hospitals Status that the objective be considered by the People and Organisational Development Committee when it met. The Trust Board: • **Received the report and noted the limited assurance**

1744/21	**Item 13.3 Upward Report from Audit and Risk Committee** The Chair of the Audit and Risk Committee, Mrs Dunnett presented the report to the Board form the extraordinary meeting held on 3 September 2021 noting that this was held to receive the Auditor's report on value for money.
1745/21	Mrs Dunnett noted that the report was part of the 2020/21 external audit reporting cycle and was a new style report written under new guidance, hence the late receipt of the report by the Committee. It was noted however that the receipt of the report at this time was consistent with other Trusts.
1746/21	The report findings were summarised in the narrative of the report for the Board with Mrs Dunnett noting that whilst the Auditor's had seen improvements the Trust continued to face some significant weaknesses in 5 areas. These areas of weakness fell in to required reporting arrangements and were reported to the Board as the current special measures the Trust was in, capital backlog, workforce challenges, financial stability and the outcome of the judicial review process.
1747/21	Mrs Dunnett emphasised that improvements had been seen on previous years and these areas were subject to recommendations which the Auditors were satisfied were captured within the Trust's Board Assurance Framework. This would be monitored through the respective Committees and the Board by way of the monthly governance process that the Trust had in place.
1748/21	Mrs Dunnett noted that this concluded the end of the audit process for the 2020/21 financial year confirming that the audit certificate had been issues and incorporated in to the annual report and accounts. The annual report and accounts had been published and members of the Board had been present at the Annual Public Meeting where these had formally been presented. The Trust Board: • **Received the report noting the moderate assurance**
1749/21	**Item 14 Any Other Notified Items of Urgent Business** No items
1750/21	The next scheduled meeting will be held on Tuesday 2 November 2021, arrangements to be confirmed taking account of national guidance

Voting Members	**6 Oct 2020**	**3 Nov 2020**	**1 Dec 2020**	**2 Feb 2021**	**2 Mar 2021**	**16 Mar 2021**	**6 Apr 2021**	**4 May 2021**	**1 June 2021**	**6 July 2021**	**3 Aug 2021**	**7 Sept 2021**	**5 Oct 2021**
Elaine Baylis	X	X	X	X	X	X	X	X	X	X	X	X	X
Chris Gibson	X	X	X	X	A	X	X	X	X	A	X	X	A

Geoff Hayward	A	A	X	X	X	X	X	A	A	X			
Gill Ponder	X	X	X	X	X	X	X	A					
Neill Hepburn	X	X	X	X	X	X	X	X	X	A			
Sarah Dunnett	X	X	X	X	X	X	A	X	X	X	X	X	X
Elizabeth Libiszewski	X	X	X	X	X	X	X	X	X	X	X	X	X
Paul Matthew	X	X	X	X	X	X	X	X	X	X	X	X	X
Andrew Morgan	X	X	X	X	X	X	X	X	X	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	A	X	X	X	X	X	X
David Woodward									X	A	A	X	X
Philip Baker											X	X	X
Colin Farquharson											X	X	X

PUBLIC TRUST BOARD ACTION LOG

Agenda item: 5.2

Trust Board date	Minute ref	Subject	Explanation	Assigned to	Action due at Board	Completed
4 February 2020	077/20	Assurance and Risk Report Quality Governance Committee	Review of TOM and governance to be presented to the Board	Chief Operating Officer	~~02/11/2021~~ 01/02/2022	Further work commissioned. Report now expected at January Audit Committee
6 April 2021	579/21	Staff survey	Consideration to be given to triangulation of data between staff survey results and quality measures	Int Dir of P&OD	01/06/2021	
6 April 2021	596/21	Smoke Free Policy	Post implementation review following relaunch to be presented to the Board	Int Dir of P&OD	~~02/11/2021~~ 07/12/2021	Newly appointed Associate Dir of HR & OD has picked this up and will bring to Board in Dec.
6 July 2021	994/21	Patient Story	Invitation to Dr Sakthivel and Jody Blow to present and update on the progress of communication training following story at the Board	Trust Secretary	07/12/2021	
6 July 2021	1141/21	Urology Pathway Update	Refreshed site strategies to be presented to the Board	Dir of Imp & Integration	~~05/10/2021~~ 02/11/2021	Private Board agenda. Complete
3 August 2021	1286/21	Assurance and Risk Report People and Organisational Development Committee	Establishment review to be presented back to Committee and Trust Board.	Int Dir People & OD	~~07/09/2021~~ 02/11/2021	Agenda Item Complete
3 August 2021	1301/21	Equality Diversity and Inclusion Annual Report	Equality, Diversity & Inclusion Lead would engage with the People and Organisation and Developmental Team and HR colleagues to	Int Dir of POD	02/11/2021	To be picked up in POD Committee – Complete

			provide further detail on the impact of EU Exit on the Trusts European Workforce.			
3 August 2021	1323/21	Assurance and Risk Report from the Finance, Performance and Estates Committee action	Audit Committee to review the missing outcomes data	Director of Finance & Digital	11/10/2021	Audit Committee meeting 11 October 2021
3 August 2021	1360/21	Urology Service Engagement Output	An update paper on the Urology Service Engagement output to be reported to Board in three Months.	Int Dir of Imp & Integration	~~02/11/2021~~ 07/12/2021	Engagement commenced on 9 August. Three months data not collected until early November. Defer to December Board
7 September 2021	1522/21	Assurance and Risk Report from the Interim Director of People and Organisational Development	Review of OD Team capacity in providing health and wellbeing support to the Trust	Int Dir of People & OD	05/10/2021	Update provided from Int Director October meeting - Complete
5 October 2021	1618/21	Chief Executive Horizon Scan	Congratulatory letter to be sent to the newly appointed Chief Executive of Lincolnshire Community Health Services NHS Trust	Trust Secretary	02/11/2021	Complete

Meeting	*Public Trust Board*
Date of Meeting	*2 November 2021*
Item Number	*Item number 6*
Chief Executive's Report	
Accountable Director	*Andrew Morgan, 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

System Overview

a) All parts of the health system continue to operate under significant demand pressure. This is a combination of service demand (including urgent and emergency care and long-term conditions), the impact of growing numbers of COVID cases, efforts to recover the elective care position and staffing issues. The situation in Lincolnshire is replicated across the country.

b) The vaccination programme is continuing, with the emphasis being on COVID booster jabs, vaccinating 12-15 year olds and winter flu jabs. Additional guidance has been issued about local systems needing to stand up an out of school offer for 12-15 year olds during the October half-term holiday and beyond. This is in addition to the existing School Age Immunisation Service. Further encouragement is also being given to the public to have their COVID booster jab.

c) No appointment was made to the post of Chair Designate of the Lincolnshire Integrated Care Board (ICB), following the recent national recruitment process. Pending an appointment, Elaine Baylis is continuing as Interim Chair of the ICS, alongside her Chair roles at ULHT and LCHS. The recruitment process for the CEO of the ICB is underway, with final interviews taking place at the end of October.

d) The public consultation relating to 4 of Lincolnshire's NHS services has begun. This process was formerly referred to as the Acute Services Review. The four services are countywide Orthopaedic Services, countywide Stroke Services, Urgent and Emergency Care at Grantham and District Hospital and Acute Medical Beds at Grantham and District Hospital. The consultation runs from 30th September to 23rd December. The consultation is led by NHS Lincolnshire CCG.

e) As part of being in System Oversight Framework Level 4 and the national Recovery Support Programme, the health system in Lincolnshire is developing a System Improvement Plan that will inform a longer term Strategic Delivery Plan through to March 2024. The immediate focus of the System Improvement Plan is transforming services relating to care close to home, prescribing and the Musculoskeletal pathway. It is anticipated that there will be a review of progress of the Recovery Support Programme in Lincolnshire with the national team sometime in November.

f) Providers in Lincolnshire, including the statutory NHS Trusts, Lincolnshire County Council, Primary Care Networks, and the voluntary, community and social enterprises sector are continuing to develop their joint working as part of a provider collaborative. This will be known as the Lincolnshire Health and Care Collaborative (LHCC). Providers are expected to lead the transformation of services within an ICS. A Managing Director is being appointed to LHCC through a national recruitment process.

Trust Overview

a) At Month 6 the Trust reported an in-month surplus of £1.4m with a year to date position of a surplus of £1.8m. This means that the trust achieved its H1 plan of a surplus of £1.8m.
b) The CQC conducted an unannounced focussed inspection of the Trust between the 5th and the 8th October, with services being inspected at Pilgrim Hospital Boston on 5th and 6th October and at Lincoln County Hospital on 7th and 8th October. The services inspected at both sites were Urgent and Emergency Care, Medicine, Children and Young People, Maternity. Initial feedback has been received from the CQC but the formal report is not expected until the New Year. This will be following the Well Led Review which is due to take place between 9th and 11th November.
c) The recruitment process for a new Director of People and Organisational Development has recommenced following the unsuccessful process earlier in the year. Pending the appointment of the new Director, Paul Matthew the Trust's Director of Finance and Digital has agreed to be the 'caretaker' Director of People and Organisational Development alongside his existing role. This took effect on 1st October. This ensures that the directorate has executive leadership and decision making over the coming months.
d) A recruitment process has taken place for the secondment opportunity to be the Trust's Director of Improvement and Integration following Mark Brassington's secondment to NHSE/I in the Midlands. A successful candidate has been selected and it is hoped that the details of the appointment can be announced shortly.
e) The Trust's Staff Awards ceremony for 2021 takes place on the evening of 3rd November. The event is being held virtually rather than in-person. The event is being hosted by BBC Radio Lincolnshire presenter Melvyn Prior.
f) The inaugural meeting of the Trust's Leading Together Forum (LTF) has taken place virtually. The LTF brings together c300-400 leaders at all levels from across the Trust. The focus is on developing leadership behaviours and skills in order to create an Outstanding Trust. Feedback from the inaugural meeting, which took place on-line and in two cohorts, was very positive. The LTF will be an integral part of the work to change the Trust's culture as part of the Culture and Leadership Programme.

Report to:	Trust Board
Title of report:	Quality Governance Committee Assurance Report to Board
Date of meeting:	19 October 2021
Chairperson:	Chris Gibson, Non-Executive Director
Author:	Karen Willey, Deputy Trust Secretary

Purpose	This report summarises the assurances received and key decisions made by the Quality Governance Assurance Committee (QGC). The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board's response. This assurance committee meets monthly and takes scheduled reports from all Trust operational groups according to an established work programme. The Committee worked to the 2021/22 objectives. The Trust is responding to the third wave of Covid-19 and as such the meeting was held via Microsoft Teams with a reduced agenda and attendance to focus on key priorities. The Committee were mindful of the pressures being faced by the Trust.
	Assurance in respect of SO 1a Issue: Deliver harm free care **Infection Prevention and Control (IPC) Group Upward Report** The Committee received the report noting the positive progress towards compliance with the Hygiene Code and that 2 policies remained outstanding for approval. The Committee recognised that environmental issues would impact on the ability to become fully compliant. There were, however, plans in place relating to capital spend and significant refurbishments that would support improvements within the environment. The Committee noted that appropriate action had been taken following a national patient safety alert relating to infection risks using FFP3 respirators with leaking valves. The IPC group had reported significant improvements in relation to estates specifically regarding water safety, decontamination and the establishment of a ventilation task group. The Committee was also pleased to be advised that both the production unit and restaurant at Pilgrim Hospital had maintained their 5-star hygiene rating following an Environmental Health Officer inspection. **Patient Safety Group Upward Report** The Committee received the report focusing specifically on the task and finish groups established in respect of Aortic Dissection and Diabetes.

	The Committee noted the positive progress of the Aortic Dissection Task and Finish Group and the involvement of the support group Think Aorta and a relative of a previous patient. The Committee supported the recommendation from the Patient Safety Group that the Diabetes Task and Finish Group should continue to meet to ensure that outcome measures could be reported and assurance offered. **Children and Young People Group Upward Report** The Committee received the report noting the progress that the group had made in recent months including the Get it Right First Time review of paediatric surgery. The Committee noted that whilst there was good assurance in respect of satisfactory governance the issue regarding paediatric radiology provision would be included within a review of general radiology provision. The Committee noted the focus and progress being made in respect of community paediatric services and the significant increase and improvement in reporting and assurance that was being received. The Committee was advised of the work in relation to the paediatric assessment unit and the work underway to consider a similar model at the Lincoln site. However, this was not currently being progressed due to the Acute Services Review. **Maternity and Neonatal Oversight Group Upward Report** The Committee received the report with a number of detailed appendices, noting that the group had reviewed its terms of reference with some minor amendments being made to avoid duplication with the system quality and safety group. The Committee again noted ongoing IT issues with the maternity systems and the action that was being taken in order to address this. The Committee was advised of the impact that Covid-19 was having on staffing within the maternity units alongside the increased birth rate and acuity of caseload. The teams worked to mitigate the impact with a number of strategies in place to address staffing concerns. Progress was noted in the thematic review of all serious incidents and complaints noting that the review panel was due to sit on 5 November. The outcome of which would inform the improvement plan. The Committee noted the NICE guideline deep dive in relation to the induction of labour for women and the impact that this would have on service provision. The Committee were advised of the issues that had been identified by the

	Maternity Independent Advisor in relation to culture and leadership within the service noting that this feedback triangulated with the feedback received by the Maternity Safety Champion Non-Executive Director. **SI Report including Never Events** The Committee received the report noting the number and types of serious incidents that had been declared in month. The Committee noted that all actions in respect of Never Events had now been closed but would remain under review to ensure these remained embedded. **High Profile Cases** The Committee received the report noting the content. **Claims and Inquests** The Committee received the report noting the content from a quality perspective and that financial elements were reported to the Audit Committee. **Clinical Harm Oversight Group Upward Report** The Committee received the report noting that the Divisions had been tasked to develop plans in respect of trajectories for the completion of harm reviews. The Committee noted the imminent implementation of the Artificial Intelligence system that should support the Trust to prioritise patients on the waiting list, and would carefully monitor the outcome.
	Lack of Assurance in respect of SO 1b Issue: Improve Patient Experience **Patient Experience Group Upward Report and National Inpatient Survey – Pre publication report** The Committee received the upward report noting the content and that a number of the groups that reported had been stood down due to operational pressures. The Committee received the national inpatient survey noting the results that remained embargoed until publication on 19 October. Whilst there had been some improvement seen issues remained particularly in regard to discharge and post-hospital care. Once the results were published this would allow for benchmarking to be undertaken of the results with an update being provided to the Committee through the Patient Experience Group.
	Assurance in respect of other areas: **Lincolnshire ICS Quality Committee** The Committee received the first report from this new Committee noting that it incorporates all main providers including those outside of the NHS.

	The Committee was looking to have a collective focus on risk and quality assurance across the system. The Committee noted that there was representation at the meeting through the Director of Nursing and Medical Director and were advised that there wold be clear links to other groups in existence to ensure there was no duplication of work. The Committee was pleased to receive the reporting noting that the forum was evolving to ensure the correct layers of governance were in place. **Integrated Improvement Plan** The Committee received the report noting the improved reporting that had offered a high level overview clearly detailing the strategic objectives, executive leads and the progress of the year 2 programmes of work. The Committee noted that there would be further benefit in the report detailing links to risks and corresponding mitigations. **Committee Performance Dashboard** The Committee noted that an overall increase had been seen in falls during August and September and were advised that a root cause analysis was being undertaken. The Committee were pleased to note the small reduction in grade 2 pressure ulcers and noted that there had been triangulation of data offered to the People and Organisational Development Committee in relation to workforce and quality indicators. The Committee noted that there was no correlation between staffing levels and patient harm. The Committee were advised of the position of duty of candour noting that although a slight improvement was seen from the previous month the overall trend had been adverse since December 2020. The Committee noted the variability in compliance with duty of candour and was advised of a number of actions being taken to ensure improvement. The Committee were pleased to note that HSMR data was once again being reported and the Trust were seeing a recent small downward trend. The Committee noted the work of the Quality Cell and the reviews that were undertaken, specifically in relation to medical outliers and medically fit for discharge patients. The Committee noted the oversight that was in place for this group of patients and that where necessary harm reviews were undertaken. **PRM Upward Report** The Committee received the report noting the improved format and obtained confirmation that the prioritisation categories for patients who were awaiting appointments were consistent across all the divisions.

	The Committee noted that whilst the report had improved there remained disconnect between the issues raised and actions in place to understand how these would be resolved. **Risk Register** The Committee noted the progress on reconfiguration of the risk register and were advised that all risk register confirm and challenge meetings had been scheduled. The Committee noted the intention to further develop the report to ensure that there was information provided on the movement of risks as well as current risks. The Committee noted the specific risks in relation to emergency demand and the growing challenge from Covid-19 levels in the community, and that appropriate mitigations were in place to address these. **Quality Impact Assessments** The Committee received the report noting the improvement of reporting that offered focus and clarity of the progress being made to strengthen the Quality Impact Assessment process. The Committee noted that equality impact assessments were incorporated in the new process. **Internal Audit Report – Review of CQC Actions** The Committee received the reporting noting that all actions were being undertaken. **CQC Update** The Committee were pleased to receive the update and to note that formal notification had been received in respect of the removal and variation of the Section 31 notices. The Committee noted the initial feedback that had been received following an unannounced inspection by the Care Quality Commission to the Trust in October. **Ionising Radiation (Medical Exposure) Regulations Update** The Committee received the report noting the content and positive progress that had been made. A final report is anticipated towards the end of this calendar year.
Issues where assurance remains outstanding for escalation to the Board	No items
Items referred to other Committees for Assurance	

Committee Review of corporate risk register	The Committee noted the risk register and the position of the reconfiguration
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	None

Attendance Summary for rolling 12 month period

Voting Members	O	N	D	J	F	M	A	M	J	J	A	S	O
Elizabeth Libiszewski Non-Executive Director	X	X	X	X	X	X	X	X	X	X	X	X	A
Chris Gibson Non-Executive Director	X	X	X	X	X	X	X	X	X	X	X	A	X
Sarah Dunnett Non-Executive Director					X	X	X	X	X	X	X	A	X
Neill Hepburn Medical Director	X	C	X	X	X	X	X	X	X	X			
Karen Dunderdale Director of Nursing	D	X	A	X	X	X	X	X	X	X	X	X	X
Simon Evans Chief Operating Officer	D	C	C	C	C	C	C	X	D	D	D	D	D
Colin Farquharson Medical Director											X	X	X

X in attendance
A apologies given
D deputy attended
C Director supporting response to Covid-19

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Report to:	Trust Board
Title of report:	People and OD Committee Assurance Report to Board
Date of meeting:	13th October 2021
Chairperson:	Professor Philip Baker, Chair
Author:	Karen Willey, Deputy Trust Secretary

Purpose	This report summarises the assurances received and key decisions made by the People 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 meet for the first time since July under the new Chair of the Committee. The Committee takes monthly and takes scheduled reports according to an established work programme. The Committee worked to the 2021/22 objectives following approval of the BAF by the Board.
Assurances received by the Committee	**Assurance is respect of SO 2a** **Issue: A modern and progressive workforce** **Establishment Review** The Committee received the annual establishment review which detailed the need for an increase in the establishment in order to be able to staff the organisation to the appropriate level. The Committee noted the cost increase that would be seen as a result of this however noted that currently, some positions were being filled by bank and agency staff. Business cases had been written for some areas in response to the review with a number in pipeline for identification and development. The Committee noted that whilst the increase was for both the registered workforce and Healthcare Support Workers the registered workforce would be a combination of level 1 registrants, nursing associates and trainee nurse associates. The Committee raised concern that this appeared to be an increase due to the overall bed base of the Trust which was planned for reduction overtime in line with the system aspiration of care closer to home. It was noted however that this was required at this point in time and future reviews would, when appropriate, support a reduction in the establishment. The Committee approved the report for onward submission to the Trust Board.

	Safer Staffing The Committee received a detailed report noting the level of detail that this offered to the Committee and the difficulties faced in meeting care hours per day and fill rates to ensure staffing levels were met. The Committee noted the mitigations that were in place to ensure that patient safety was not compromised at times of difficult staffing levels. The Trust ensured that ratios were appropriate and where necessary these were amended to support safe staffing. The operational pressures were recognised that were also impacting on staffing due to the need to ensure appropriate levels of staffing, particularly where escalation areas were opened. The Committee noted the Quality Cell that was in place and reporting to Gold Command, the cell reviewed data to ensure that there was no increase in incidents, there had been no increase in incidents of harm or death due to staffing.
	Assurance in respect of SO 2b **Issue: Making ULHT the best place to work** **Upward report from Culture and Leadership Programme** The Committee received the update noting that the programme was in the discovery phase and once complete would continue to progress. The programme was part of the Integrated Improvement Plan of the Trust and was supported through the Project Management Officer with regular project meetings being held. The Committee noted the need for appropriate reporting to the Committee as assurance had not been offered. The Committee noted that the reporting group would be functioning properly with improved reporting due to be in place in November. **Upward report from Equality, Diversity and Inclusion Group** The Committee noted that the EDI Group had not met for some time but that action was in place for this to be reinstated along with reporting to the Committee. **Wellbeing Evaluation** The Committee noted that over the next few months a review of the wellbeing offer would be undertaken and a plan developed for a long term approach and full spectrum of health and wellbeing offers. The Committee noted the comprehensive health and wellbeing offered in place that had been developed to run alongside Covid-19 however an evaluation of this would be informed by the staff survey results.

	It was recognised that work was required on the accessibility to the wellbeing offers in place and support to staff to enable them to take responsibility for accessing the offer. The Committee noted that the Associate Director of HR and OD was deputising the System Wellbeing Board which enabled the Trust to have a presence at system level in respect of wellbeing. **Guardian of Safe Working Quarter 1 Report** The Committee received the report raising concern at the level of bullying and harassment that had been reported. The Committee requested that action be taken to understand the concerns being raised and to determine action that would be taken in order to address this. The Committee requested that this be considered by the relevant Directors in order to ensure that there was appropriate senior focus afforded to the issue. The Committee would receive an update on the actions to be taken at the Committee meeting in November. The Committee further noted the concerns raised in respect of access to hot meals 24/7 for staff and rest areas for Junior Doctors. Action was being taken by the Trust in respect of hot meals with a pilot due to launch imminently.
	Assurance in respect of SO 4b **Issue: To become a University Hospitals Teaching Trust** **Upward Report from University Teaching Hospital meeting** The Committee received the report noting that a meeting was due to take place between the Trust and the University of Lincoln which would focus on relationship building. A further update would be provided to the Committee in November. **Upward Report from Research and Innovation Governance Group** The Committee received the report noting that this offered detail from the meeting held in June. Since the report recruitment to studies had increased significantly placing the Trust 5th in the East Midlands. The Committee noted the intention to combine a number of business cases that had previously been presented, in to a single business case that sat beneath the University Teaching Hospital aspiration. The Committee noted that the Trust had appointed a new Director of Research and Innovation which would support a change in the emphasis and focus of both the group and department. It was hoped that this would strengthen reporting to the Committee.

	Assurance in respect of other areas: **WRES/WDES Action Plans – Lack of Assurance** The Committee received the report noting that this had previously been circulated to the Board where concern had been raised in relation to the number of red actions. The Committee noted that a refresh of the action plan would be undertaken to ensure this had the appropriate focus and to ensure that assurance could be offered to the Board. The Committee were advised that the Black, Asian and Minority Ethnic Network were keen to support the work and offers of support were made by members of the Committee to support and progress the work. The Committee requested that significant improvement and movement was made on the action plan ahead of the Committee meeting in November. **Equality, Diversity and Inclusion Internal Audit Report** The Committee received the reporting noting that action had not yet been taken but that work would be prioritised by the Associate Director of HR and OD. **Board Assurance Framework** The Committee received the Board Assurance Framework noting that this had not received review since July 2021. The Committee considered the assurance ratings within the report following the discussions held during the meeting and agreed that the ratings would remain as reported. The Committee noted that there would be a full review and update of the Board Assurance Framework that would be presented to the Committee in November. **Terms of Reference and Work Programme** The Committee received the terms of reference and work programme noting the intention to review and strengthen the reporting groups to the Committee. A review outside of the Committee would take place for the reporting groups with the terms of references being refreshed to ensure that reporting to the Committee supported assurance. Revised terms of reference for the reporting groups and Committee would be presented back to the Committee.
Issues where assurance remains outstanding	None

for escalation to the Board	
Items referred to other Committees for Assurance	No items referred
Committee Review of corporate risk register	The committee received the risk register noting the current risks presented
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	Department walk around currently suspended.

Attendance Summary for rolling 12 month period

Voting Members	**N**	**D**	**J**	**F**	**M**	**A**	**M**	**J**	**J**	**A**	**S**	**O**
Geoff Hayward (Chair)	X	X	X	A	X	A	X	X	X	Meeting not held		
Philip Baker												X
Sarah Dunnett	X	X	A	X	X	X	X	X	X			X
Karen Dunderdale	C	C	C	C	C	X	A	X	D			X
Paul Matthew												X
Non-Voting Members												
Martin Rayson	X	X	X	X	X	X	X	X	X			
Simon Evans	C	C	C	C	C	C	D	A	D			A
Alison Dickinson												A

X in attendance
A apologies given
D deputy attended
C Director supporting response to Covid-19

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*2 November 2021*
Item Number	*Item 9.2*
Establishment Review	
Accountable Director	*Dr Karen Dunderdale*
Presented by	*Dr Karen Dunderdale*
Author(s)	*Dr Karen Dunderdale*
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	
3a A modern, clean and fit for purpose environment	
3b Efficient use of resources	*X*
3c Enhanced data and digital capability	
4a Establish new evidence based models of care	
4b Advancing professional practice with partners	
4c To become a university hospitals teaching trust	

Risk Assessment	*Insert risk register reference*
Financial Impact Assessment	overall increase in wte of 83.45wte and a funding increase of £2,755,700 full year effect
Quality Impact Assessment	*Completed ahead of implementation*
Equality Impact Assessment	*Completed ahead of implementation*
Assurance Level Assessment	*Insert assurance level* • *Moderate*

Recommendations/ Decision Required	• the board are asked to approve the establishment review and subsequent investment to enable planned recruitment to the posts to commence and therefore break the cycle of agency usage

Executive Summary

The Nurse Establishment Review set out in July-August 2021 to take forward a review of establishments comprehensively reviewed in 2020. In addition, those areas that were not reviewed in 2020 (theatres, Out patients, ED, maternity and Paediatrics) were reviewed.

Each establishment review was undertaken as a table top exercise with the divisional nurse, supported by finance colleagues and the deputy director of nursing who leads on workforce. An objective approach using evidence was taken to ensure consistency of approach and robustness of outcome which stands up to scrutiny.

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

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

This reports an overall increase in funded of 83.45WTE and £2,756k full year effect. ULHT were successful in their Ockenden bid which is funding for 5.25WTE midwives and full year funding of £248,000. This reduces the overall funding required to 78.20WTE and £2,508k. Within the requested additional funding of 83.45WTE; 25.71WTE are for Registered Nursing and 57.74WTE are for Health care support workers (HCSW)

At the time of undertaking the initial financial analysis in August the run rate for nursing in the applicable ward areas was £1,317k and 68 worked WTE above the funded level. On a straight line basis this results in a forecast £3,162k over the funded level by the end of the financial year.

It is worth noting that agency usage for nursing is exclusively in relation to registered nursing. But, even with the significant level of agency spend in August registered nursing reported 42WTE below establishment. Whilst the healthcare support worker position was 110WTE over established, however HCSW includes the international nursing, i.e. a planned over-establishment. The HCSW pressure will reduce as the international Nurses transition to registered nursing posts and reduce the current registered nursing vacancies and / or agency usage.

The financial analysis has been reviewed to reflect September establishment. The position in September; 16.4WTE worked above funded levels inclusive of 12.2WTE under establishment for registered nursing and 28.6WTE over establishment for HCSW. This movement from August will mainly be attributable to the transition of the international nurses from HCSW into Registered Nursing posts, but will also be inclusive of in month attrition.

Utilising the September position to calculate a worst case financial risk to the current rate in 21/22 assuming a 5 month impact;

- Registered Nursing - An additional 37.91WTE Registered Nursing agency = £1,263k. (The 37.91 WTE = 12.2 WTE current under establishment + 25.71WTE additional funding).

- HCSW - 28.6WTE of the 57.74WTE additional funding will offset the current over establishment with the balance of 29.14WTE leading to increased bank and / or substantive costs = £242k.

The reality will be a much smaller financial impact especially in relation to the Registered Nursing Agency usage as demand already exceeds supply constraining the ability to attract additional temporary staff and further transitions of International Nurses will also mitigate the impact.

In the longer term this provides a revised level of funded nurse establishments to recruit to and reduce current agency costs.

If approved and actioned for November reporting this will be a part year funding impact in 2021.22 of £1,045k.

In order to break the cycle of agency usage the board are asked to approve the establishment review and subsequent investment to enable planned recruitment to the posts to commence and therefore break the cycle of agency usage

Nurse Establishment Review 2021

1: Nursing Review Process:

The Nurse Establishment Review set out in July-August 2021 to take forward a table top review of establishments comprehensively reviewed in 2020. In addition, those areas that were not reviewed in 2020 (theatres, Out patients, ED, maternity and Paediatrics) were reviewed.

This process was undertaken for two reasons:

1) To enable the director of nursing to satisfy herself that the current nurse establishments continue to be appropriate for the Trust in light of the recent pandemic.

2) To review the skill mix in the establishments to ensure that nursing establishments and shift arrangements delivered the optimum balance of care quality and efficient use of resources in the context of the recent COVID-19 pandemic.

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

2. Medical In-Patient Wards – Reviewed:

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

- Integrated Assessment Centre
- Acute Cardiac Unit
- AMSS
- Stroke Unit
- Ward 6A
- Ward 6B
- Ward 7B (Respiratory)
- Ward 8A
- Ward 1
- ED

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

- Scampton
- Lancaster
- Burton
- Navenby
- Carlton Coleby
- Stroke Unit
- Johnson
- Dixon
- MEAU
- Neustadt Welton
- Clayton
- ED

The review covers the following areas on the Grantham site:

- EAU

Ward 1 at PBH - the establishment for this area remains unchanged and this area will be subject to a separate business case

Burton – whist this ward was reviewed it will be subject to another establishment review in 3 months due to the changing patient acuity

Navenby – whilst this ward was reviewed it will be subject to a business case due to the change in patient pathways and the Respiratory Support Unit coming on line

Dixon – whilst this ward was reviewed it will be subject to another establishment review in 3 months due to the changing pathways anticipated affecting the ward.

EAU - whilst this ward was reviewed it will be subject to another establishment review in 3 months due it recently being opened.

The Emergency Departments on each site have been reviewed using the Baseline Emergency Staffing Tool (BEST) developed by the RCN Emergency Care Association and the Faculty of Emergency Nursing.
This will be subject of a separate paper which is likely to require a level of investment

Further work with the division of medicine is required and a separate paper will be offered to the board.

3. Surgical In-Patient Wards – Reviewed:

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

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

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

- Greetwell
- Digby
- Hatton
- SEAU
- Shuttleworth
- ICU
- SAL
- Theatres all 4 sites

The review covers the following areas on the Grantham site:

- Combined surgical unit (ward1&2)

Day ward PBH – the establishment for this area remains unchanged and this area will be subject to a separate business case due to the changing nature of the day case and in patient case mix.

Hatton ward – the establishment for this area was reviewed and includes an additional 4 level 1 beds (8 beds in total).

SAL – the establishment for this area remains unchanged and this area will be subject to a separate business case due to the changing nature of the day case and in patient case mix.

Theatres – whilst theatres on all four sites (Lincoln, Boston, Grantham and Louth) were reviewed there was no change to their current establishments. They utilise a combination of shift models and they will be supported to develop and introduce nursing associate roles to be a scrub practitioner. Any investment will be subject to a separate business case due to historic changes in usage and the future developments in the units.

Combine surgical unit - the establishment for this area remains unchanged and this area will be subject to a 3 month review.

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

- Waddington
- Ashby
- Bostonian (previously 7A)
- Outpatients

Waddington & Bostonian – Whilst these wards were reviewed another establishment review will take place in 3 months due to the impact of COVID on the occupancy and case mix of patients.

5 Family Services Wards – Reviewed:

- Neonatal units at LCH and PBH
- Branston
- 1b Womens Health
- Nettleham
- Bardney
- M1
- Labour ward PBH
- Paeds PBH
- Rainforest

Birthrate Plus was used to inform the maternity establishments. Recurrent funding through the Ockenden route has been secured and the variance to support the outcome of the establishment review is presented in this paper to the board.

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

6 Methodology

Each establishment review was undertaken as a table top exercise with the divisional nurse, supported by finance colleagues and the deputy director of nursing who leads

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

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

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

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

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

The calculated establishments include all nursing but exclude ward support functions and ward administration. They do include supernumerary nurse management time tied directly to the ward establishment. This has been apportioned to a 60:40 split reflecting 3 days supernumerary and 2 days clinical supervisory, therefore, legitimising actual practice and in line with the Ward Leaders handbook. The majority of ward leaders offer shifts from their establishments each month to support the site rota and this will be reviewed with the aim of supporting this rota in another way therefore ensuring that ward leaders offer their shifts to their ward area each week.

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

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

Each area had an assessment of their skill mix and adjustments of the numbers of band 6 nurses will be made when there are any movers or leavers in each area concerned.

7. Outcome of the Review:

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

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

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

The reported increase in establishment is a combination of wards currently running higher than their funded establishment due to activity, demand and safety covered in this paper and some wards which need their establishment corrected which will allow for future sustainable recruitment plans.

This reports an overall increase in funded of 83.45WTE and £2,756k full year effect. ULHT were successful in their Ockenden bid which is funding for 5.25WTE midwives and full year funding of £248,000. This reduces the overall funding required to 78.20WTE and £2,508k. Within the requested additional funding of 83.45WTE; 25.71WTE are for Registered Nursing and 57.74WTE are for Health care support workers (HCSW)

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The financial analysis has been reviewed to reflect September establishment. The positon in September; 16.4WTE worked above funded levels inclusive of 12.2WTE under establishment for registered nursing and 28.6WTE over establishment for HCSW. This movement from August will mainly be attributable to the transition of the international nurses from HCSW into Registered Nursing posts, but will also be inclusive of in month attrition.

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The reality will be a much smaller financial impact especially in relation to the Registered Nursing Agency usage as demand already exceeds supply constraining the ability to attract additional temporary staff and further transitions of International Nurses will also mitigate the impact.

In the longer term this provides a revised level of funded nurse establishments to recruit to and reduce current agency costs.

If approved and actioned for November reporting this will be a part year funding impact in 2021.22 of £1,045k.

Division	Ward	New Establishment WTE	New Establishment £	Bank WT	Band	Total New W	Total New	Budget WT	Budget £	Impact WT	Impact £
Medicine	INTEGRATED ASSESSMENT CENTRE	42.87	1,747,700	0.00	0	**42.87**	**1,747,700**	41.07	1,670,500	1.80	77,200
Medicine	ACUTE MEDICAL SHORT STAY UNIT	62.54	2,372,400	0.00	42,700	**62.54**	**2,415,100**	62.54	2,432,700	-0.00	-17,600
Medicine	ACUTE CARDIAC UNIT	24.38	935,400	0.00	5,500	**24.38**	**940,900**	24.38	940,900	0.00	0
Medicine	PILGRIM STROKE UNIT	36.50	1,403,100	0.00	0	**36.50**	**1,403,100**	32.38	1,271,700	4.12	131,400
Medicine	WARD 6A	39.47	1,484,900	0.00	0	**39.48**	**1,484,900**	39.48	1,485,200	0.00	-300
Medicine	WARD 6B	39.47	1,480,400	0.00	0	**39.48**	**1,480,400**	39.48	1,480,700	-0.00	-300
Medicine	WARD 7B RESPIRATORY	39.28	1,526,800	0.00	0	**39.28**	**1,526,800**	40.81	1,569,200	-1.53	-42,400
Medicine	WARD 8A	43.82	1,649,800	0.00	0	**43.82**	**1,649,800**	43.82	1,649,900	-0.00	-100
Medicine	SCAMPTON WARD (OLD HATTON)	28.04	1,023,600	0.00	0	**28.04**	**1,023,600**	28.04	1,023,600	-0.00	0
Medicine	CLAYTON (OLD LANCASTER)	38.56	1,431,800	0.00	0	**38.56**	**1,431,800**	28.04	1,048,900	10.52	382,900
Medicine	DIXON WARD	33.30	1,261,000	0.00	0	**33.30**	**1,261,000**	33.49	1,286,200	-0.19	-25,200
Medicine	NEUSTADT WELTON	54.33	1,959,200	0.00	0	**54.33**	**1,959,200**	35.58	1,311,900	18.75	647,300
Medicine	LANCASTER (FAU)	33.30	1,231,600	0.00	0	**33.30**	**1,231,600**	28.04	1,073,500	5.26	158,100
Medicine	CARLTON COLEBY (DIABETES)	38.56	1,416,300	0.00	0	**38.56**	**1,416,300**	38.56	1,416,400	-0.00	-100
Medicine	LINCOLN STROKE UNIT	51.28	1,978,400	0.00	0	**51.28**	**1,978,400**	47.02	1,827,100	4.26	151,300
Medicine	JOHNSON WARD	70.64	2,901,300	0.00	0	**70.64**	**2,901,300**	70.64	2,901,400	-0.00	-100
Medicine	LIN EMERGENCY ASSESSMENT UNIT	90.01	3,560,100	0.00	0	**90.01**	**3,560,100**	77.88	3,158,000	12.13	402,100
Medicine	WARD 6	28.04	1,018,800	0.00	0	**28.04**	**1,018,800**	26.59	1,006,700	1.45	12,100
Medicine	EAU	38.56	1,438,700	0.00	0	**38.56**	**1,438,700**	34.23	1,349,600	4.33	89,100
Medicine	NAVENBY (RESPIRATORY)	34.67	1,363,500	2.40	108,600	**37.07**	**1,472,100**	37.07	1,472,100	0.00	0
Medicine	BURTON WARD	38.26	1,491,500	0.00	0	**38.26**	**1,491,500**	38.26	1,491,500	0.00	0
Surgery	DAY CASE WARD PHB	19.12	637,500	0.00	0	**19.12**	**637,500**	19.12	637,500	0.00	0
Surgery	SURGICAL ADMISSIONS LOUNGE LCH	18.27	622,400	0.00	0	**18.27**	**622,400**	18.27	622,400	0.00	0
Surgery	WARD 9A	44.96	1,673,600	0.00	0	**44.96**	**1,673,600**	39.25	1,472,000	5.71	201,600
Surgery	WARD 5A	41.76	1,601,900	0.00	0	**41.76**	**1,601,900**	41.76	1,601,900	-0.00	0
Surgery	WARD 5B	36.50	1,361,500	0.00	0	**36.50**	**1,361,500**	36.50	1,361,600	-0.00	-100
Surgery	INTENSIVE CARE UNIT PHB	51.62	2,405,800	0.00	0	**51.62**	**2,405,800**	49.03	2,288,900	2.59	116,900
Surgery	DIGBY WARD	38.10	1,433,400	0.00	0	**38.10**	**1,433,400**	52.34	1,966,200	-14.24	-532,800
Surgery	GREETWELL WARD	33.30	1,302,200	0.00	0	**33.30**	**1,302,200**	33.30	1,302,300	-0.00	-100
Surgery	HATTON WARD (OLD GREETWELL)	41.53	1,638,200	0.00	0	**41.53**	**1,638,200**	33.07	1,341,500	8.46	296,700
Surgery	SEAU	37.32	1,512,000	0.00	0	**37.32**	**1,512,000**	40.39	1,635,500	-3.07	-123,500
Surgery	SHUTTLEWORTH (OLD STOW)	41.76	1,561,600	0.00	0	**41.76**	**1,561,600**	41.76	1,561,700	-0.00	-100
Surgery	INTENSIVE CARE UNIT LCH	78.37	3,691,500	0.00	0	**78.37**	**3,691,500**	80.36	3,755,600	-1.99	-64,100
Surgery	GSU	58.68	2,264,800	0.00	0	**58.68**	**2,264,800**	59.08	2,282,200	-0.40	-17,400
Family Health	BARDNEY	54.99	2,699,600	0.00	0	**54.99**	**2,699,600**	53.53	2,659,600	1.46	40,000
Family Health	NETTLEHAM WARD	41.28	1,873,700	0.17	4,700	**41.45**	**1,878,400**	37.33	1,655,600	4.12	222,800
Family Health	LABOUR WARD	34.59	1,888,000	0.00	0	**34.59**	**1,888,000**	33.25	1,812,300	1.34	75,700
Family Health	WARD M1 MATERNITY	22.16	1,040,300	0.00	18,600	**22.16**	**1,058,900**	21.96	1,047,300	0.20	11,600
Family Health	BRANSTON	27.13	959,600	0.00	0	**27.13**	**959,600**	17.29	666,800	9.84	292,800
Family Health	WARD 1B WOMENS HEALTH	24.38	834,900	0.00	0	**24.38**	**834,900**	16.38	596,900	8.00	238,000
Family Health	NEONATAL SERVICES	46.87	1,961,500	0.00	0	**46.87**	**1,961,500**	46.87	1,961,400	-0.00	100
Family Health	SCBU	24.27	1,031,100	0.00	0	**24.28**	**1,031,100**	24.28	1,031,300	0.00	-200
Family Health	RAINFOREST WARD	46.93	1,850,300	0.00	0	**46.93**	**1,850,300**	42.18	1,611,800	4.75	238,500
Family Health	WARD 4A	34.81	1,353,900	0.00	0	**34.81**	**1,353,900**	43.82	1,690,000	-9.01	-336,100
CSS	WADDINGTON UNIT	41.30	1,607,900	0.00	0	**41.30**	**1,607,900**	41.30	1,607,800	0.00	100
CSS	ASHBY WARD	30.55	1,160,600	0.00	0	**30.55**	**1,160,600**	28.26	1,103,300	2.29	57,300
CSS	BOSTONIAN ONCOLOGY WARD	36.27	1,375,100	0.00	0	**36.27**	**1,375,100**	33.76	1,302,500	2.51	72,600
TOTAL		**1,912.69**	**76,019,200**	**2.57**	**180,100**	**1,915.29**	**76,199,300**	**1,831.84**	**73,443,600**	**83.45**	**2,755,700**
Less Ockenden funding										**5.25**	**248,000**
TOTAL										**78.20**	**2,507,700**

Some ward areas within the list above and separately have been identified as possibly needing increases/ decreases in establishment. These areas will need to follow the governance process through CRIG as a case of need or short form business case, see detail below:

Division	Ward	New Establishment WTE	New Establishment £	Bank WTE	Band £	Total New WTE	Total New £	Budget WTE	Budget £	Impact WTE	Impact £
Medicine	NAVENBY (RESPIRATORY)	53.19	1,978,000	2.40	108,600	**55.59**	**2,086,600**	37.07	1,472,100	18.52	614,500
Medicine	BURTON WARD	30.00	1,128,900	0.00	0	**30.00**	**1,128,900**	38.26	1,491,500	-8.26	-362,600
Medicine	LIN EMERGENCY ASSESSMENT UNIT	38.33	1,407,300	0.00	0	**38.33**	**1,407,300**	38.57	1,519,700	-0.24	-112,400
Surgery	DAY CASE WARD PHB	26.77	937,100	0.00	0	**26.77**	**937,100**	19.12	637,500	7.65	299,600
Surgery	SURGICAL ADMISSIONS LOUNGE LCH	23.47	763,700	0.00	0	**23.47**	**763,700**	18.27	622,400	5.20	141,300
Surgery	THEATRES PHB	123.80	4,541,500	0.00	0	**123.80**	**4,541,500**	122.01	4,460,800	1.79	80,700
Surgery	THEATRES CHL	19.42	699,700	0.00	0	**19.42**	**699,700**	13.67	496,100	5.75	203,600
Surgery	THEATRES LCH	131.34	4,878,600	0.00	0	**131.34**	**4,878,600**	127.33	4,790,600	4.01	88,000
Surgery	THEATRES GDH	71.53	2,033,800	0.00	0	**71.53**	**2,033,800**	52.31	1,591,900	19.22	441,900
TOTAL		**517.85**	**18,368,600**	**2.40**	**108,600**	**520.25**	**18,477,200**	**466.61**	**17,082,600**	**53.64**	**1,394,600**

The table below identifies those areas that have business cases in pipeline through the CRIG process

Description of Business Case	Division	Current Status
Respiratory Modular Unit	MEDICINE	Draft Case of Need in Progress
Pilgrim SDEC (Surgery Bid)	MEDICINE	Draft Case of Need in Progress
Medical SDEC (Medicine Bid)	MEDICINE	Case of Need Submitted to CRIG - referred for further work
Development of the Respiratory Service by recruiting additional Medical Consultants	MEDICINE	Draft Case of Need in Progress
Continuity of Carer - Maternity	FAMILY HEALTH	Draft business case
Oncology Assessment	CSS	Pipeline
Critical Care bids (including Hatton L1 Beds)	SURGERY	Pipeline

7. Workforce Changes:

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

Recruitment actions will include:

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

8. Implementation Plan:

The implementation plan will include the following elements:

Action: Implement roster plan changes within e-rostering system
Date: November 2021

9. Next steps:

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

10. Recommendations:

In order to break the cycle of agency usage the board are asked to approve the establishment review and subsequent investment to enable planned recruitment to the posts to commence and therefore break the cycle of agency usage

Dr Karen Dunderdale, Director of Nursing
Simon Evans, Chief Operating Officer
Paul Matthew, Director of Finance & Digital

October 2021

APPENDIX 1 - NURSING ESTABLISHMENT CONFIRM AND CHALLENGE SUMMARY

	Ward	No. of Beds	Bed Occ.	Acuity	Shift	Current Skill mix RN	Current Skill mix HCA	Existing establishments RN	Existing establishments CSW	Existing establishments Overall	Nursing team proposed RN	Nursing team proposed HCA	WTE Required for Proposed Nursing RN	WTE Required for Proposed Nursing CSW	WTE Required for Proposed Nursing TOTAL
Lincoln	Ashby	18	100%	2	Long Day	3	2				3	3			
					Long night	2	3	15.23	13.03	28.26	2	3	14.32	16.23	30.55
	Burton	20	100%	3	Long Day	4	4				4	4			
					Long night	3	2	18.54	19.72	38.26	3	2	18.54	19.72	38.26
	Carlton Coleby	28	95%	2	Long Day	4	4				4	4			
					Long night	3	3	19.58	18.98	38.56	3	3	19.58	18.98	38.56
	Clayton	28	95%	2	Long Day	4	3				4	4			
					Long night	3	3	14.32	13.72	28.04	3	3	19.58	18.98	38.56
	Digby	28	100%	1	Long Day	4	4				4	3			
					Long night	3	3	30.16	22.18	52.34	3	3	20.95	17.15	38.10
	Dixon	20	100%		Long Day	3	4				3	4			
					Long night	3	2	18.70	14.79	33.49	3	2	16.83	16.46	33.30
	Greetwell	27	95%	1	Long Day	4	3				4	3			
					Long night	3	2	19.58	13.72	33.30	3	2	19.58	13.72	33.30
	Hatton	22	100%	1	Long Day	5	2				5	3			
					Long night	4	2	22.09	10.98	33.07	4	3	25.30	16.23	41.53
	ICU	16 (11 L3)	85%	7	Long Day	13	1				13	1			
					Long night	13	1	72.37	7.99	80.36	13	1	70.37	8.00	78.37
	Johnson	44	90%	5	Long Day	9	4				9	4			
					Long night	8	2	49.15	21.49	70.64	8	3	49.15	21.49	70.64
	Stroke	28	90%	4a	Long Day	6	4				6	4			
					Long night	4	3	28.04	18.98	47.02	5	4	29.79	21.49	51.28
	MEAU	50	100%	4a	Long Day	10	5				10	7			
					Long night	9	5	51.13	26.75	77.88	10	7	52.73	37.27	90.01
	Navenby	18	100%	4	Long Day	3	3				3	3			
					Long night	2	2	20.95	16.12	37.07	2	2	20.95	16.12	37.07
	N/Welton	28	90%	4a	Long Day	6	5				6	5			
					Long night	6	3	20.95	14.63	35.58	5	4	30.10	24.24	54.33
	Scampton	20	95%	1	Long Day	3	3				3	3			
					Long night	2	2	14.32	13.72	28.04	2	2	14.32	13.72	28.04
	SAL	16	100%	3	Long Day	3	2				3	2			
					Long night	2	0	12.91	5.36	18.27	2	0	12.91	5.36	18.27
	SEAU	20	95%	4a	Long Day	4	3				4	3			
					Long night	4	2	24.38	16.01	40.39	4	2	22.32	14.99	37.32
	Lancaster	20	100%	1	Long Day	3	3				3	4			
					Long night	2	2	14.32	13.72	28.04	2	3	14.32	18.98	33.30
	Shuttleworth	28	100%	3a	Long Day	5	4				5	4			
					Long night	4	2	24.84	16.92	41.76	4	2	24.84	16.92	41.76
	Waddington	26	85%	4	Long Day	5	3				5	3			
					Long night	3	3	24.15	17.15	41.30	3	3	24.15	17.15	41.30
Pilgrim	ACU	16	90%	3	Long Day	3	2				3	2			
					Long night	2	2	13.86	10.52	24.38	2	2	13.86	10.52	24.38
	AMSS	48	100%	3	Long Day	7	6				7	6			
					Long night	6	4	35.56	26.98	62.54	6	4	35.56	26.98	62.54
	Day Ward	12	16%	3	Long Day	2	1				2	1			
					Long night	2	1	11.12	8.00	19.12	2	1	11.12	8.00	19.12
	IAC	24	90%	4	Long Day	5	3				5	3			
					Long night	4	3	24.84	16.23	41.07	5	3	26.63	16.23	42.87
	ICU	9	100%	7	Long Day	8	1				8	1			
					Long night	8	1	44.23	4.80	49.03	8	0	45.90	5.72	51.62
	Ward 1	17	85%		Long Day	4	3				3	3			
					Long night	4	3				3	3			0.00
	Stroke	24	87%	3	Long Day	4	3				4	4			
					Long night	3	2	19.12	13.26	32.38	3	2	19.58	16.92	36.50
	Bostonian/ 7A	18	80%	2	Long Day	4	3				4	3			
					Long night	3	2	20.04	13.72	33.76	3	3	19.58	16.69	36.27
	Bevan	12			Long Day	2	1				0	0			
					Long night	2	1			0.00	0	0			0.00
	5A	29	90%	3a	Long Day	5	4				5	4			
					Long night	3	3	22.78	18.98	41.76	3	3	22.78	18.98	41.76
	5B	25	90%	3a	Long Day	5	3				5	3			
					Long night	3	2	22.78	13.72	36.50	3	2	22.78	13.72	36.50
	6A	28	90%	2	Long Day	4	4				4	4			
					Long night	3	3	20.04	19.44	39.48	3	3	20.04	19.44	39.48
	6B	28	90%	2	Long Day	4	4				4	4			
					Long night	3	3	20.04	19.44	39.48	3	3	20.04	19.44	39.48
	7B	24	90%	3a	Long Day	5	3				5	3			
					Long night	4	3	24.58	16.23	40.81	4	2	24.84	14.44	39.28
	8A	29	95%	3a	Long Day	5	4				5	4			
					Long night	4	3	24.84	18.98	43.82	4	3	24.84	18.98	43.82
	9A	32	95%	3	Long Day	5	4				5	5			
					Long night	3	2	22.79	16.46	39.25	4	2	25.30	19.66	44.96
Family Health	Branston	18	90%	2	Long Day	2	1				3	3			
					Long night	2	1	11.57	5.72	17.29	2	2	13.86	13.26	27.13
	1B	12	90%	3	Long Day	2	1				3	2			
					Long night	2	1	11.12	5.26	16.38	2	2	13.41	10.98	24.38
	Neonatal Services	21	68%	4	Long day	6	2				6	2			
					Long night	6	2	33.61	13.26	46.87	6	2	33.61	13.26	46.87
	Nettleham	30			Long day	5	1				5	3			
					Long night	3	2	22.72	14.61	37.33	4	2	26.84	14.61	41.45
	Ward M1 Maternity	15	80%		Long day	3	2				5	2			
					Long night	2	1	13.96	8.00	21.96	2	2	14.16	8.00	22.16
	Labour ward PBH	9			Long Day	4	1				5	1			
					Long night	5	1	27.74	5.51	33.25	5	1	29.33	5.26	34.59
	Bardney				Long Day										
					Long night			43.56	9.97	53.53			43.56	11.43	54.99
	SCBU	12	50%	2	Long day	3	1				3	1			
					Long night	3	1	16.84	7.44	24.28	3	1	16.84	7.44	24.28
	4a	16			Long Day	3	2				4	1			
					Long night	3	2	32.84	10.98	43.82	4	1	27.95	6.86	34.81
	Rainforest	24			Long Day						7	1			
					Long night			32.05	10.13	42.18	7	1	39.67	7.26	46.93
Grantham	Ward 1&2	44	35%	1	Long day	7	5				7	5			
					Long night	4	3	36.90	22.18	59.08	4	3	36.50	22.18	58.68
	Ward 6	22	90%	1	Long day	2	1				3	3			
					Long night	2	1	14.47	12.12	26.59	2	2	14.32	13.72	28.04
	EAU	24		4a	Long day	5	3				5	3			
					Long night	4	2	22.93	11.30	34.23	4	2	24.84	13.72	38.56
TOTAL WARD BASED ESTABLISHMENT (EXCLUDING ENHANCEMENT & SUPERNUMERY POSTS)								1,162.64	669.20	1,831.84			1,188.37	726.93	1,915.29
MOVEMENT FROM CURRENT BASELINE ESTABLISHMENTS													(25.73)	(57.73)	(83.45) (0.00)

SUMMARY

1. Utilisation of the SNCT tool and professional adjustments (largely for side rooms, donning & doffing & the role of the ward leader) results in an increase in RN's of 57.73 wte and HCAs increased by 25.73

2. The 60/40 split for ward leader supervisory /supernumerary time has continued as a standard across the establishments.

3. Assurance is provided that establishments are aligned to SNCT patient acuity and dependency data.

4. Roster templates will provide a flexibility of shift patterns that include a mix of long and short shifts in all areas, this will support the requirement to provide a flexible working pattern.

5. Board can therefore take assurance the current establishment for ward based care matches SNCT required levels and includes professional judgement adjustments therefore offers safe care levels when fully established

Report to:	Trust Board
Title of report:	Finance, Performance and Estates Committee Assurance Report to Board
Date of meeting:	21 October 2021
Chairperson:	David Woodward, Non-Executive Director
Author:	Karen Willey, Deputy 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 groups according to an established work programme. The Committee worked to the 2021/22 objectives. The Trust is responding to the third wave of Covid-19 and as such the meeting was held via Microsoft Teams with a reduced agenda and attendance to focus on key priorities. The Committee were mindful of the pressures being faced by the Trust.
Assurances received by the Committee	**Lack of Assurance** in respect of SO 3a A modern, clean and fit for purpose environment **Estates Statutory Compliance Report** The Committee received the report and were pleased to note that changes had been made and the format of the report reverted from the previous month. A compliance dashboard which would offer a RAG status is planned to be available for the next meeting. The Committee noted the Planned Preventative Maintenance (PPM) backlog risk which remained high however work was underway to review reactive maintenance and increase accuracy of reporting. The Committee noted that PPMs were on a downward trend and were advised of the need for an evaluation of the MICAD system to be undertaken to review the data held and for consideration to be given to the suitability of the system. The Committee noted the progress being made in relation to the helpdesk noting the need to complete recruitment and have staff embedded before further actions to resolve issues could commence. The Ventilation Sub Group was making progress with a meeting having been held to review the terms of reference and ensure appropriate membership. Meetings would take monthly and it was noted that an external design consultancy was in place to review critical ventilation and

	overall theatre environments prior to a procurement process commencing. The Committee noted the continued high number of parking enforcement notices and cancellations being advised that systemic issues had been addressed however there was a need to ensure people followed parking guidelines correctly. The Committee noted the intention for the Estates Strategy to be offered to the Committee in November.
	Assurance in respect of SO 3b Efficient Use of Resources **Finance Report** The Committee received the report noting the forecast for the month end and noting the achievement to deliver a surplus of £1.8m. This had been driven by securing receipt of £400k of prior year pass through funding in addition to £200k of elective recovery funding risk that had been held, these had been released in to the position. The Committee noted the move in to H2 however there was not yet an agreed financial settlement and the H2 submission was not yet due. This would be received by the Committee in November. The Committee noted the potential risk of working to a different set of assumptions prior to receiving the guidance. Agency spend continued to increase despite attempts to reduce the position and the clear actions in place. Work ongoing with medical agency was having an impact but was not showing a rapid downward trend. The Committee were pleased to note that the Family Health Division had succeeded in achieving the 25% target reduction. It was noted however agency nursing was escalating with more beds open in the Trust than a year ago. The Committee noted that the establishment review that would be presented could be achieved within the financial envelope and would impact on agency staffing. The pressures being faced were related to Covid-19 and the increase in inbound admissions. The Committee were pleased to receive the financial bridges that had been presented noting that this offered insight in to the questions being asked. The Committee were offered an update in relation to the CIP discussion held by the Executive Leadership Team noting this had identified how the Trust would deliver the missing CIP. A clear process to identify additional savings and improving the run rate was developed and the process would be managed through the financial review meetings.

	Capital Report The Committee received the report noting the grip and control at operational level of capital is in place and assurance received that the process is in place and working. Work had been undertaken on the over-commitment to capital with service leads providing prioritisation on the mitigation list. The Committee noted the pace at which a step change had been made with decisions being taken earlier in the year on prioritisation which offered a stronger position. The Committee were pleased to be advised of the approval of the full business case for the Medical School and the release of the £1.5m however noted the need to pre-commit ED Resus monies in to next year as it was not possible for this to be brokered. Current year spend would need to be considered to ensure that this was appropriate and offered the right impact. **Cost Improvement Programme Framework** The Committee noted the need to fully embed CIP within the organisation and adjust how this was reflected as business of the Trust. The Committee noted that in order to be successful with CIP delivery a culture change was required in order to ensure staff understood responsibility to achieve productivity, efficiency and financial efficiency. It was noted that the Culture and Leadership Programme would be the foundation for the change in culture with the Committee requesting quarterly progress reports from the People and Organisational Development Committee on the progress of the programme and the impact on CIP. **Establishment Review** The Committee received the establishment review noting the outcome that resulted in the recommendation of a £2.7m increase in the establishment equating to 83.45wte. Ockenden funding had been secured for 5.25wte midwives that would reduce the overall increase in funding required. The Committee noted the current position of the Trust working above plan noting that the approval of the establishment review would ensure safe staffing based on acuity of patients using the safer nursing care tool. The Committee noted the level of confidence in the ability to appoint to the required positions noting that alternative roles would be considered for the registered nursing posts such as nursing associates and trainees. The Committee were advised if the current shortfall in staffing was addressed through the increase of the establishment this would see bank and agency use removed and cost reduction realised.

	The Committee were cognisant of the risk associated with the implementation of the proposed establishment during the transition period where agency would continue to be required whilst substantive posts were recruited to. The Committee recommended the establishment review to the Board for approval subject to the risks being clarified within the paper presented.
	Assurance in respect of SO 3c Enhanced data and digital capability **Digital Hospital Group Upward Report** The Committee received the report noting the content and the need for work to be undertaken in relation to Admissions, Discharges and Transfers (ADTs) as the Trust moved to wholly digital solutions. The Committee were advised of the work relating to the electronic health record within ophthalmology and the need to ensure full adoption of the electronic system. The Committee noted concern in the delay of the electronic health record noting the national and regional challenges being faced due to the level of scrutiny being applied to the outline business case. An opportunity to meet with the Chief Information Officer of NHSX would be taken in order to try and progress.
	Assurance in respect of other areas: **Operational Performance against National Standards** **Urgent Care** The Committee noted the issues that continued regarding ambulance handovers that were both a regional and national concerns. The Trust continued to be an outlier with the position continuing to deteriorate. The Committee noted that exit blocks continued to the main cause of delays. The Committee acknowledged the 12-hour trolley wait position which came as a result of the issues related to flow and discharge of patients. The Committee noted concern of the age range of those experiencing trolley waits with assurance being offered that harm reviews were undertaken for all patients experiencing trolley waits over 12 hours. The Committee noted the need for ongoing and increased system support in order to enable timely discharge of patients no longer requiring acute care. **Cancer Performance** The Committee received the report noting the limited assurance that was being offered in regard to breast cancer services. The increased capacity had been maintained with the service however there had been an increase in demand following 2 high profile cases publicised nationally.

	Further capacity would need to be identified to a level beyond what had been put in place to date to manage the increasing demand. Whilst the backlog had been reduced this was expected to increase again as a result of the demand. The Committee noted concern regarding the 62 day wait backlog that was rising back to levels experienced in the peak of wave 2 of Covid-19. Measures were in place that would come in affect in quarters 3 and 4. The Committee were advised that H2 planning guidance had now been received and the Trust were transitioning to trajectories that would be built in to future reporting. In respect of treatment volumes the Committee noted that the Trust were ranked 8th highest in English hospital demonstrating that the Trust was one of the largest cancer treating Trusts. **Planned Care** The Committee were pleased that the P2 clearance time indicator had been reported however noted that this should see patients treated in a 4 week window, this was not currently being met with patients being treated at 7 weeks. The Trust would need to put in place enhanced recovery capability in order to address delays. The Committee noted that there were some issues with the setting of classifications in line with the new prioritisation of cases with significant variance being seen across the country. The delivery of the C2AI system would support classifications of patients in to the correct P grading. The Committee were advised of the national interest in the 104 week wait patients, the Trust currently had a low number of 104 week waiters however this, in line with trajectories, would see an increase in Q3 before returning to 0 by the end of the year. It was noted however that this would be dependent on the capacity utilised within the independent sector and delivery of new theatres at Grantham Hospital. The Committee noted performance related to referral to treatment however reflected that focus should be afforded to 52 and 104 week wait type measures and P classifications. **Committee Performance Dashboard** The Committee received the report noting the content and the intention for the work to develop the executive scorecard to be complete and reported to the November meeting. **Integrated Improvement Plan** The Committee received the report noting the changes that had been made to the format of the report. It was acknowledged that further work would be required to move this to report assurance however it was anticipated that this would be received at the November meeting.

	The Committee noted the intention for work to be carried out to ensure full alignment to the Integrated Performance Report **Performance Review Meeting Upward report** The Committee received the improved report noting that this now offered actions against issues raised. It was noted that the report would further benefit from outcome measures being demonstrated.
Issues where assurance remains outstanding for escalation to the Board	None
Items referred to other Committees for Assurance	The Committee wished to request quarterly progress reports from the People and Organisational Development Committee on the progress of the culture and leadership programme and the impact this would have on CIP.
Committee Review of corporate risk register	The Committee received the risk register noting the risks presented and the timescale for completion of the reconfiguration
Matters identified which Committee recommend are escalated to SRR/BAF	No items identified
Committee position on assurance of strategic risk areas that align to committee	As above
Areas identified to visit in dept walk rounds	None

Attendance Summary for rolling 12-month period

Voting Members	N	D	J	F	M	A	M	J	J	A	S	O
Gill Ponder, Non-Exec Director	X	X	X	X	X	X						
David Woodward, Non-Exec Director							O	X	X	X	X	X
Geoff Hayward, Non-Exec Director	X	A	X	X	X	A	X	X	A			
Chris Gibson, Non-Exec Director	X	X	X	X	X	X	X	X	X	X	A	X
Director of Finance & Digital	X	X	X	X	X	X	X	X	X	X	X	X
Chief Operating Officer	C	C	X	X	D	X	X	X	X	X	X	X
Director of Improvement & Integration	C	C	C	C	X	X	X	X	X	A		

X in attendance
A apologies given
D deputy attended
C Director supporting response to Covid-19
O Observing

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NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*2 November 2021*
Item Number	*Item 12*
Integrated Performance Report September 2021	
Accountable Director	*Paul Matthew Director of Finance & Digital*
Presented by	*Paul Matthew Director of Finance & Digital*
Author(s)	*Stuart Sage, 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 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 associated actions/escalations where appropriate*

Executive Summary

Quality

Patient Falls

There were 3 falls resulting in severe harm and 1 fall in moderate harm in September 2021. Inpatient falls have increased in numbers over August and September. A number of actions are in place to support the clinical teams including a proposal for Falls Prevention training.

Pressure Ulcers

There was a reduction in category 2 PU at 35 (target of 28.3 month) in September 2021. There are a number of themes currently being observed relating to category 2 pressure ulcers relating to devices, delay in pressure relieving equipment and documentation. The Focus on Fundamentals campaign for November will be skin integrity.

Actions arising from SI Investigations/Departmental

Compliance with closing actions arising from SI investigations was 0% in September compared to a target of 90% and departmental at 25%. Governance processes are being embedded to monitor and support closure of actions.

Medication incidents reported as causing harm

The number of reported incidents causing harm for the month of September has increased to 26.8% more than double the national average of 10.8%. Actions to recover are cited below.

HSMR/SHMI

The Trust is currently at 103.41 for HSMR and 111.83 for SHMI against targets of 100. The Trust has not received Dr Foster data for a four-month period but this has now been resolved. SHMI has increased during the COVID-19 pandemic. The Trust are currently in discussion with the system partners in rolling out the ME service for community deaths and learning can be generated for deaths within 30 days.

Participation in National Clinical Audits

The Trust is participating in 97% of all relevant national clinical audits. The Trust has now registered for the IBD audit which will make us 100% compliant and data collection is due to commence in October 2021.

National Clinical Audit Outliers

There is currently 1 outlier for September 2021for National Bowel Cancer Audit Stoma rate - a case note review is underway to identify reason for none reversal of stoma.

eDD

The Trust achieved 84% with sending eDDs within 24 hours for September 2021 against a target of 95%. eDD compliance has continued to decline for the past three months as there has been considerable pressure on bed capacity.

Sepsis compliance – based on August data

Screening / IVAB inpatient adult – Compliance is at 87.3% and 86.7% respectively for August 2021. Actions to recover can be seen below but of note the sepsis practitioners have revamped the Agency workbook with input from the Oncology/Maternity/Paediatric teams and has undergone a successful pilot in ED.

Screening / IVAB ED / inpatient child - Screening compliance for paediatrics in ED was 86.4% and inpatients at 57%, with the administration of IVAB for paediatrics in ED at 50% in August. Clinical Harm reviews continue and actions to recover can be seen below.

Duty of Candour (DoC)

Verbal compliance for August is at 75% against a 100% target and 50% for written. DoC training has been sourced from an external provider and is booked to be delivered throughout November 2021. The Risk team are currently reviewing compliance and supporting the Divisions on a daily basis.

Operational Performance

A & E and Ambulance Performance

Whilst the summary below pertains to August and September data and performance, the proposed new Urgent Care Constitutional Standards have now been adopted to run in shadow form and performance against these will be described in the supplementary Urgent Care FPEC paper. Amendments to the Urgent Care IPR dashboard have been made for August but these will be refined further as more data becomes available.

4-hour performance for September deteriorated against August's performance of 66.96% being reported at 62.13.%. This is the eleventh time in twelve months the Trust's performance has been below the agreed trajectory.
There were 71 12-hr trolley wait, reported in month. Mismatch of demand versus capacity in inpatients described in risk register entry 4175 was established as the main cause. Whilst mitigation strategies are being deployed they are no sufficient to compensate for the increase in length of stay of patients and therefore the increased demands on inpatient services.

Performance against the 15 min triage target in September demonstrated a deterioration of 5.9% compared with August. 82.60% in August verses 87.98% in July.

Ambulance conveyances for August were, 4381, down by 6.17% against July. There were 629 >59minute handover delays recorded in August, an increase of 294 from August. Delays experienced at LCH and PHB are attributed conveyance pattern/grouped arrival times and increased levels of overcrowding in EDs whilst managing more complex pathways as a result of Covid-19 IPC measures. An increase of >120mins handovers has also been experienced in September because of this (465 in September verses 244 in August.) An Ambulance handover cell has been mobilised to identify additional strategies to mitigate overcrowding and reduce handover delays. System response is also active to reduce delays to discharge, however neither have managed to fully mitigate the issues faced.

Length of Stay

Non-Elective Length of Stay remains of concern and is a major contributor to overcrowding in EDs and the subsequent impact on ambulance handover. Multi agency discharge meetings continue to take place twice daily. All patients on pathways 1, 2 and 3 are reviewed, with a noted increase in discharge of medically optimised patients across the entire week (7days). Pathway 1 capacity (Domiciliary care) has

decreased in availability and is a large contributor to increased LoS. Elective Length of Stay has reduced mainly due to less complex patients accessing surgical pathways that require post-operative care in intensive care.

Referral to Treatment

It is important to view and read this in the context of the current National Covid Restore Agenda, and the move away from a focus on constitutional standards to the expectation of clinical urgency; a clinical risk-based patient selection process as opposed to selection based upon the longest waits. Within this context it is unlikely that there will be complete improvement to statutory RTT performance for some time.

August demonstrated a decreased performance of 2.04% to 56.85%. The Trust reported 1093 797 incomplete 52-week breaches for August end of month compared to 797 in July. The Trust remains in a strong position when compared to other providers.

The Cancer/Elective Cell continued to meet throughout the last three months, with a weekly confirm and challenge meeting with surgical specialities led by senior clinical review and prioritisation cell to ensure capacity across all sites are maximised for the most critical patients. Cancer patients and clinically urgent remain a priority with a continued focus on 62+ day, 104+ days cancer patients and 40+, 52+ and 78+ week patients on the 18-week RTT PTL. As of 3rd October, the Trust has 6 patients waiting longer than 104weeks. These are all currently a choice of patients to delay their treatment.

Waiting Lists

Overall waiting list size had decreased in August to 50,804 but as of 5th October is at 52,585. Work continues between OPD and the CBUs regarding the returning to a standard ‘polling’ approach as part of our restoration plans.

A recovery plan for ASIs has been developed and including a recovery trajectory. As of 3rd October, ASI numbers have decreased to 688 and remains in line with the trajectory.

The Trust reported 5,818 over 40 week waits as at 8th September; an increase of 1,286 from the previous reporting period. The numbers of patients waiting over 26 weeks has increased to a total of 14,633. The longest waiting patients continue to be tracked and discussed weekly with escalation as appropriate and reported bi-weekly to NHSE/I.

DM01

DM01 for August 2021 demonstrated 66.00% compliance against a target of 99.00%. Cardiac echoes have a considerable backlog due to a lack of capacity. The Trust has engaged with an external provider to support recovery in this domain.

Cancelled Ops

Timescales for validated figures were delayed and only received 14th October 2021 post submission time.
Synchronisation of the validation process with submission dates will be rectified for next reporting period.

Cancer

Of the nine cancer standards, ULHT achieved two. Nationally two were met.

58% of the 14 day breach performance was attributed to the Breast Service in respect of the One-stop appointments. A demand verses capacity gap exists and has been previously articulated. This also applies to the Symptomatic Breast service. Although improvements have been made in capacity, demand continues to rise in this service and recent high profile figures publicising awareness campaigns have substantial contributed to increased demand. This has not resulted in impact on the 62day standard yet however impresses the importance of the breast pain pathway improvements to reduce demand on services in future.

The impact of COVID-19 on the delivery of the cancer pathways remains evident for 31 day and 62 day standards.

62 Day pathway backlogs are not reducing – 405 as of 14th October 2021 verses 368 as of 9th September 2021. August 62 day performance: Colorectal = 21.7%, Head & Neck = 25.0%, Gynaecology = 48.1%, Upper GI and Haematology = 52.9%

Workforce

Mandatory Training – The trend for the completion of Core mandatory training, whilst it remains at just under 90% YTD, has decreased in compliance during September. The current Trusts pressures due to increased patient activity, staffing pressures (inc. staff absences) as well as Covid has impacted on staff ability to undertake the training. The appointment of a Learning Support administration post will help the review of core learning and ensure that staff core learning is appropriate and necessary so that the Trust remains compliant to its duty. New training programmes and systems are being used to update the current training packages and review various platforms to deliver the storage and collation of uptake and performance data. A review of core learning is underway to ensure the training that staff are being asked to complete is appropriate and should be mandatory.

Sickness Absence – Sickness has continued to rise in September, this is attributed to the changes in government guidance regarding the wearing of face masks and the return to schools and correlates with an increase in Covid absences. Albeit this is usual for this seasonal time due to the school summer holidays and the inability to take time off and the increased reduction in staffing due to Annual Leave. The negative effect on wellbeing for staff following the impact of the last 20 months and the instability of 'normal' working lives needs to be acknowledged. The rules for isolating have changed therefore we have seen a decrease in those staff needing to isolate. Compliance of the Attendance Management System continues to be embedded and HR/OD staff have been supporting divisions to undertake Call-backs, fill in 'blank reasons' and manages the process to support frontline managers.

Staff Appraisals - The AfC appraisal rate continues to be lower than expected. There has not been the expected improvement as a consequence of the implementation of the WorkPal system. Anecdotal feedback from managers attending WorkPal briefing sessions is that they struggle to adopt a new system in addition to AMS to manage absence (in addition to ESR and Health Roster) and pockets of the organisations have low access to technology. In addition, recurrent hold on non-essential meetings due to operational pressures have had an impact on appraisal conversation planning across the Trust. The fundamental issues remain the extent to which managers have time to spend on appraisal. This will be a focus of Divisions and Directorates during the final 2 quarters of the year. We will be looking at team appraisals and other ways of reducing the administration burden whilst still holding quality conversations with staff.

Agency Spend – The trend on agency spend remains worrying both in downwards, but there will need to be a step change in spend levels across all professions. The interim Director of People has met with Medicine to agree a focus on workforce planning and rotas in order to better understand their workforce need and stop the last minute, expensive spend on agency locums. Stronger governance and planning will be put in place and once the model has been proven to work it will be rolled out to other divisions.

Finance

The Trust exited 2020/21 with a £2.4m surplus; the 2020/21 position was inclusive of £72.1m of planned system support, £4.5m of funding for lost Other Operating Income, and £122.6m of top up block funding totalling over and above the level of funding the Trust would have received on a Payment By Results contract.

The Lincolnshire system resubmitted its financial plan for H1 of 2021/22 to take account of Elective Recovery Funding (ERF).

The revised H1 financial plan for the Trust is inclusive of a £1.8m surplus position, £7.6m ERF, costs of restoration of £5.8m and a requirement for the Trust to deliver cost improvement (CIP) savings of £6.4m.

The Trust has delivered a £1.4m surplus for the month of September (in line with plan) and a £1.8m surplus in H1 (in line with plan).

The month end cash balance is £46.0m which is a reduction of £8.0m against cash at 31 March 2021.

Paul Matthew
Director of Finance & Digital and (interim) People
October 2021

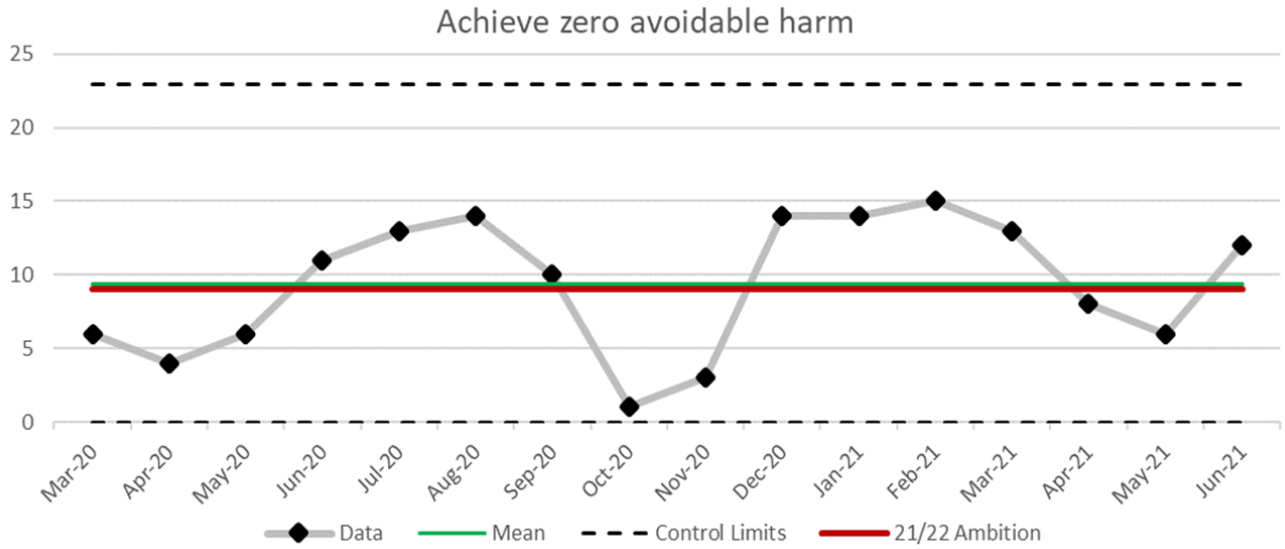
Statistical Process Control Charts

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:



Statistical Process Control Charts

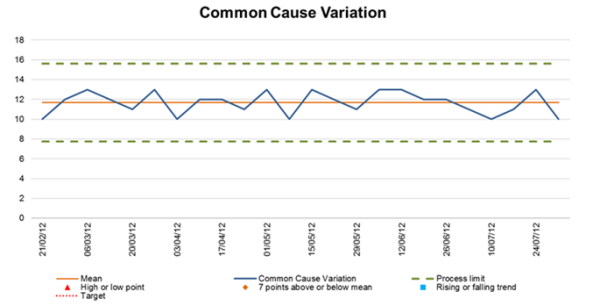
Normal variations in performance across time can occur randomly- without a direct cause, and should not be treated as a concern, or a sign of improvement, and is unlikely to require investigation unless one of the patterns defined below applies.

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

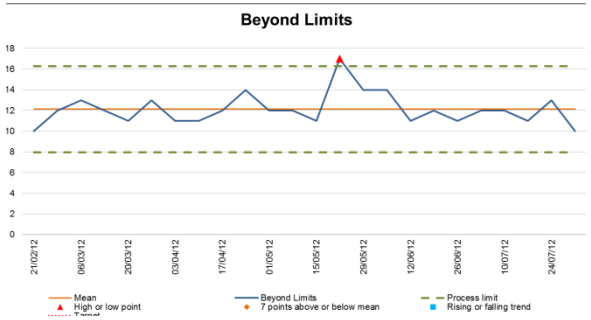
Icons are used throughout this report either complementing or as a substitute for SPC charts. The guidance below describes each icon:

Normal Variation



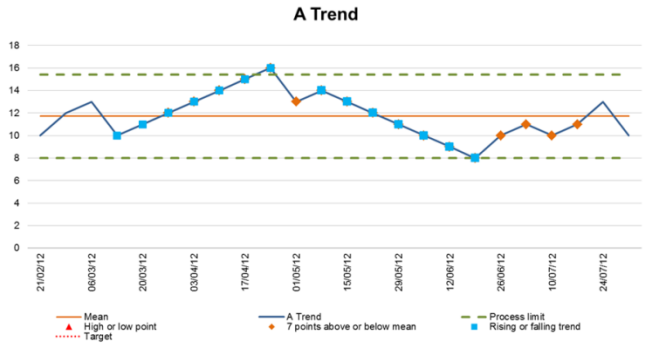
Extreme Values

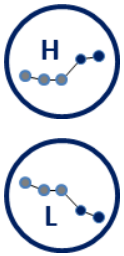
There is no Icon for this scenario.



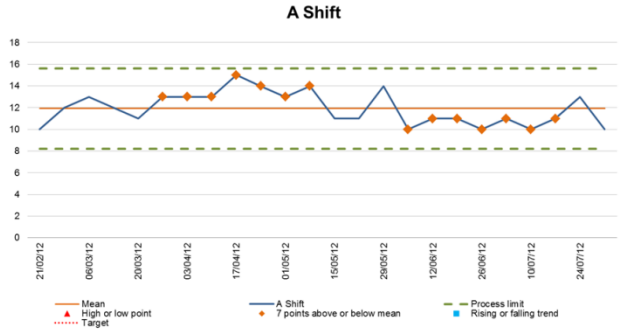
Statistical Process Control Charts

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

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.

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NHS United Lincolnshire Hospitals NHS Trust

EXECUTIVE SCORECARD

								2021/2022				
Strategic Goal	Domain	Measure ID	Measure	Measure Definition	Baseline	21/22 Ambition	£'000	Jul	Aug	Sep	Latest month pass/fail to ambition	Trend variation
Strategic Metrics	Patients	1	Top 25% for acute Trusts for 'Overall' Inpatient experience	This is a monthly Inpatient Friends and Family Test results, w hich are a proxy for annual inpartient experience survery.	4th Quartile	3rd Quartile		4th Quartile Perf. (88.57%) (122nd of 137)	(tbc) Perf. (87.43%) (tbc)		F	
	Patients	2	Achieve zero avoidable harm	Serious incidents (including Never Events) of harm - Moderate, severe and death.	15	9		12	9		P	
	Patients	3	Top 25% for SHMI	Summary Hospital-level Mortality Indicator	4th quartile	4th quartile		4th Quartile (112.55)	4th Quartile (112.88)		P	
	People	4	Top 25% for acute Trusts across all 10 themes in the staff survey	In year monitoring via staff survey on staff morale and leadership.		+10% improvement						
	Partners	26	Deliver 62 day combined cancer standard (77%)	Patients that start a first treatment for cancer w ithin tw o months (62 days) of an urgent GP referral, including NHS cancer screening services.	69.20%	77%		61.50%	63.10%		F	
	Partners	27	Total w ait in Emergency Department over 12 hours (<1% of patients)	Number of Patient ED attendances w aiting more than 12 hours from arrival to transfer, admission or discharge as a percentage of ED attendances.	3.60%	<1%		10.03%	11.45%	15.77%	F	
	Partners	28	Urgent Treatment (P2) treatment turnaround time is less than 4 w eeks	Waiting time from receiving patient referral until treatment is given.	6.7	<4 weeks						
	Partners	29	Deliver Outpatient activity through non-face to face	Increase volume of Outpatients activity for pre-booked telephone and w eb-based sessions, betw een consultant and patient	45.28%	>25%		32.93%	31.77%	32.12%	P	B
	Services	9	Deliver a breakeven revenue position	Financial status - Revenue monthly variance to plan		Breakeven	£'000	£0.00	£1.00	£0.00	P	
	Services	10	Deliver £200m capital plan	Financial status - Capital monthly actual show n cumulatively	£15m	£39m	£'000	£4,049.10	£5,700.60	£7,342.40	F	
Local Projects	Patients	11	No. of medication errors causing harm is <10%	Medication incidents reported as causing harm (low /moderate /severe / death), as a percentage of total medication incidents.	20%	13%		25.63%	23.85%	26.80%	F	A
	Patients	12	Reduce no. of patient fall incidents. (Last 3 month Average)	Number of Falls reported (including no harm)	200	159 (-20.5%)		139.7	145.3	155.7	P	
	People	13	% of staff saying proud to w ork for ULHT	Staff survey on morale and leadership		+10% improvement						
	Partners	14	First non elective admission by 10am	Daily situation reporting before 10am, on unplanned admissions of patients for specific General and Acute w ards.	48%	60%		61.90%	56.57%	59.93%	F	
	Services	15	Reduce agency spend by 25%	Reduction in hospital recruiting to posts as temporary cover (non permanent salaried positions). Agency - cumulative	£44m	£33m (-25%)	£'000	£14,728	£18,515	£22,148	F	
Watch Metrics	Patients	16	Reduce complaints around discharge by 50%	Where patient has been discharged from hospital but is unsatisfied in the w ay the discharge w as handled	n/a							
	Patients	17	Reduce complaints about the experience in A&E by 50%	Patient experience complaints about treatment of A&E	n/a							
	Patients	18	Time to screening and treatment for sepsis (1 hour)	Number of sepsis incidents reported - % of 8 metrics passing to 90%	37.5% (3/8)	62.5% (5/8)		50% (4/8)			F	
	Patients	19	Reduce incidence of pressure ulcers	Number of Pressure Ulcers reported on w ard- Category 2, 3, 4 & Unstageable	58 pcm	45 pcm		54	48	39	P	B
	People	20	% of staff that feel trusted and valued	Staff survey on morale and leadership								
	People	21	No. of managers trained in coaching skills	Staff survey on morale and leadership								
	Partners	22	Increase the proportion of patients seen by a decision maker w ithin one hour	Patient arrival to the time seeing a A&E doctor, w ithin 1 hour.	50%			48.39%	52.22%	44.95%		
	Partners	23	Reduction in the new to follow up ratio	Reduction in the number of follow up outpatient activities undertaken.	1:2.28			1:1.46	1:1.56	1:1.56		
	Partners	24	First OPA w ithin 4 w eeks	Number of outpatients seen w ithin 4 w eeks of their referral to hospital. Includes external referrals only (from GP, Dentist, Optician) for all urgency types (2WW, Urgent, Routine) to consultant led services (non-telephone).	51%			53.11%	47.67%	51.91%		B
	Services	25	Improve CIP performance to a minimum of 4% by 2021/22	Improving the financial performance through proactive monitoring of Cost Improvement Plan (CIP) - monthly variance to CIP plan (H1 £6.412m)	£11.1m	£15.4m	£'000	£1,603.00	-£809.00	£550.00		

(Grey means data unavailable, red is missing)

This executive scorecard will eventually complement the introduction of a new performance routines process, which is currently under development with Divisional executives, alongside the review and development of the IPR report. The new performance routines introduced are deploying new divisional performance scorecards, which eventually will be underpinned by business unit scorecards. All of these scorecards will complement this executive scorecard. Eventually all the reporting performance processes will be realigned to enable consistency of approach on the internal reporting Trust wide.

Quality | Operational Performance | Workforce | Finance

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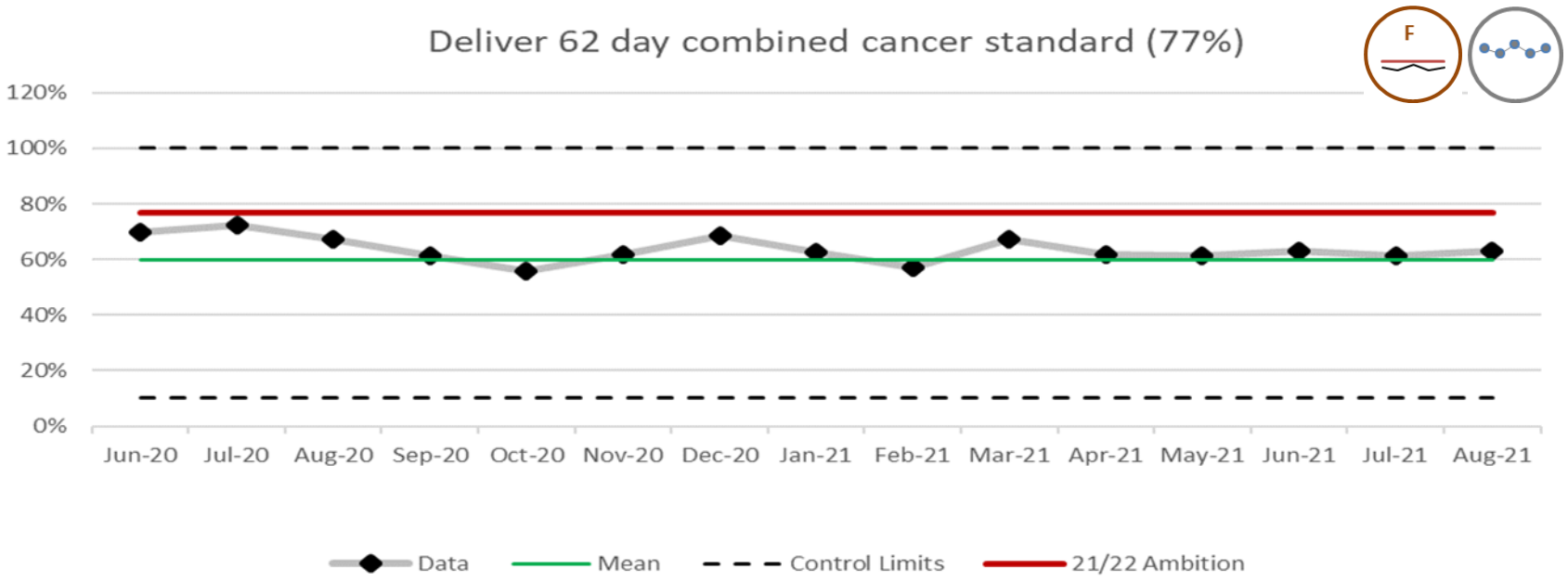


Aug-21
63.1%
Variance Type
Metric is currently experiencing Common Cause Variation
21/22 Ambition
77%
Achievement
Metric is consistently failing to ambition
Executive Lead
Chief Operating Officer

Background:

Patients that start a first treatment for cancer within two months (62 days) of an urgent GP referral, including NHS cancer screening services.

What the chart tells us:

We are currently at 63.1% against a 77% target.

Issues:

Patient engagement in diagnostic process (reluctance to visit hospitals due to perceived COVID-19 risk, including those waiting for vaccines or the 3 week 'effectiveness' period). This is continuing to reduce.

Reduced clinic throughput due to social distancing / IPC requirements, especially in waiting areas. Patient acceptance & compliance with swabbing and self-isolating requirements. Patients not willing to travel to where our service and / or capacity is.

Managing backlogs significantly in excess of pre-COVID levels for Colorectal, Urology, Gynaecology, Lung, and Head & Neck.

Lost treatment capacity due to short notice cancellation of patients (unwell on the day of treatment or day before), not allowing time to swab replacement patients.

Actions:

28 Day standard identified as Trust's cancer performance work stream in the Integrated Improvement Program for 2021-22. Two substantive Medical Oncologists were recruited, one of which was due to start in November 2021, but unfortunately both candidates have withdrawn. Currently, there are 4 Locum Oncologist posts out to advert. Dedicated admin resource has been identified within the Colorectal, Urology, Breast, Gynae, UGI and Lung CBU's to support clinical engagement. Following this model, funding has also been identified a navigator in the Head & Neck CBU whilst a second navigator post within the Colorectal CBU has been identified. The recruitment process is underway.

Endoscopy are in the early stages of undertaking a review around the Bowel Cancer Screening age extension and endoscopy staffing. The intention is to increase the clinical endoscopist workforce with less reliance on consultants and also to increase administrative support by converting fixed term into substantive posts. Work to enhance the early identification of patients requiring Pre-Diagnosis CNS support is ongoing.

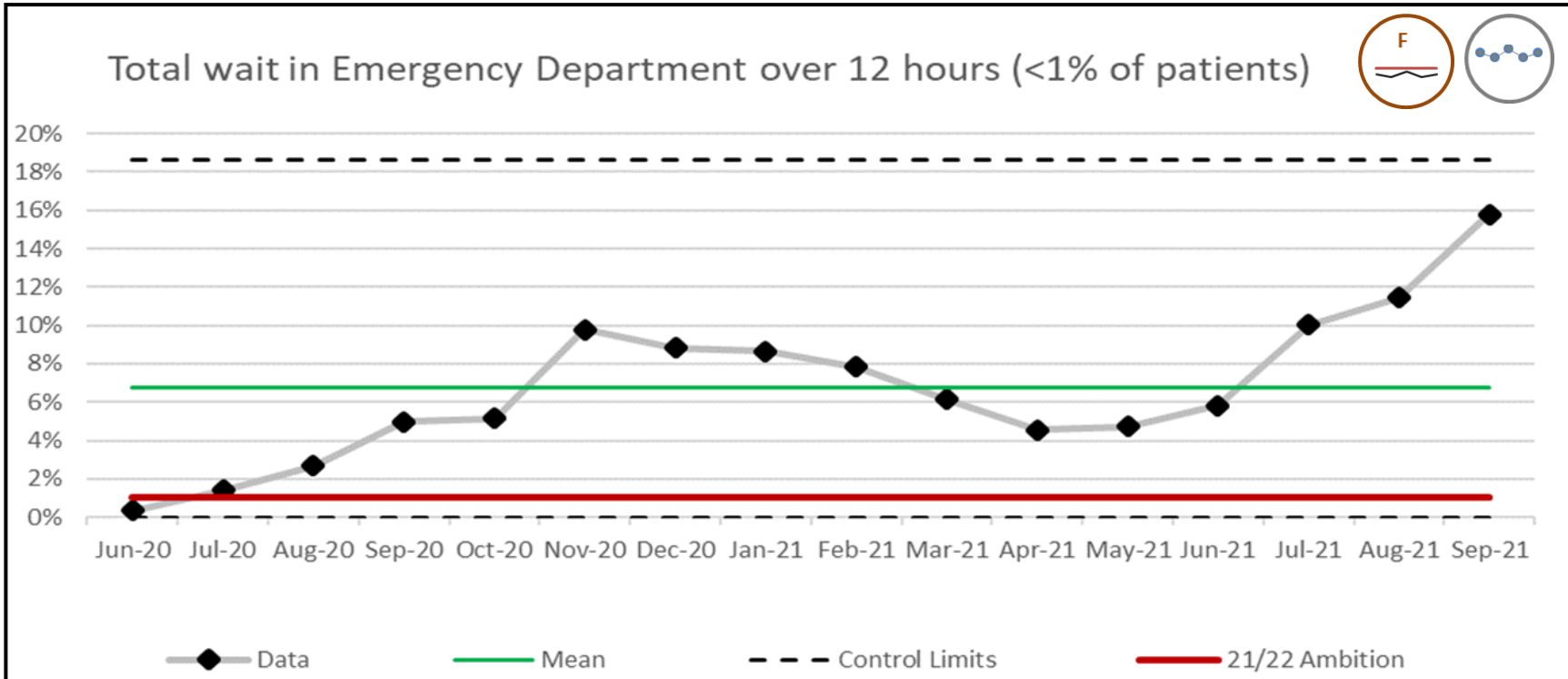
Mitigations:

Theatre capacity is returning to Pre-covid levels. A review of colorectal theatre list scheduling in order to better align with clinician availability continues and Grantham Theatres have now returned to undertaking suitable Level 1 colorectal work. Work continues within the Surgery Division in order to access sufficient HDU post op care via the weekly meetings and to ensure that theatre capacity is fully utilised once full pre-op capacity returns.

Quality | Operational Performance | Workforce | Finance

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Sep-21
15.77%
Variance Type
Metric is currently experiencing Common Cause Variation
21/22 Ambition
1%
Achievement
Metric is consistently failing to ambition
Executive Lead
Chief Operating Officer

Background:

Number of Patient ED attendances waiting more than 12 hours from arrival to transfer, admission or discharge as a percentage of ED attendances.

What the chart tells us:

September experienced an increase in the numbers of patients with an aggregated time of arrival great then 12 hours.15.77% (1466)
of all patients attending the Emergency Department against an agreed target of <1%.

Issues:

The main factor is exit block due to inadequate discharges to meet the demand
Increased number patient experiencing an elongated LOS due to requiring non acute admission but requiring access to an alternative health care setting such transitional care, community hospital and Adult Social Care.
Delays in time to first assessment contribute to the clear formulation pf a treatment plan, especially out of hours.
Onward specialist centre care can also cause delay.

Actions:

Reduce the burden on the Emergency Department through maximising discharges in the morning to create flow and reduce exit block.
Use of alternative pathways such as the UTC, CAS, SDEC, FAU and SAU.
Direct access via EMAS to Community and transitional care facilities
.
The use of the Trust agreed EXiT procedure as part of the Full Capacity Protocol which allow each ward (agreed list) to support the care of an extra patient above their current bed base.

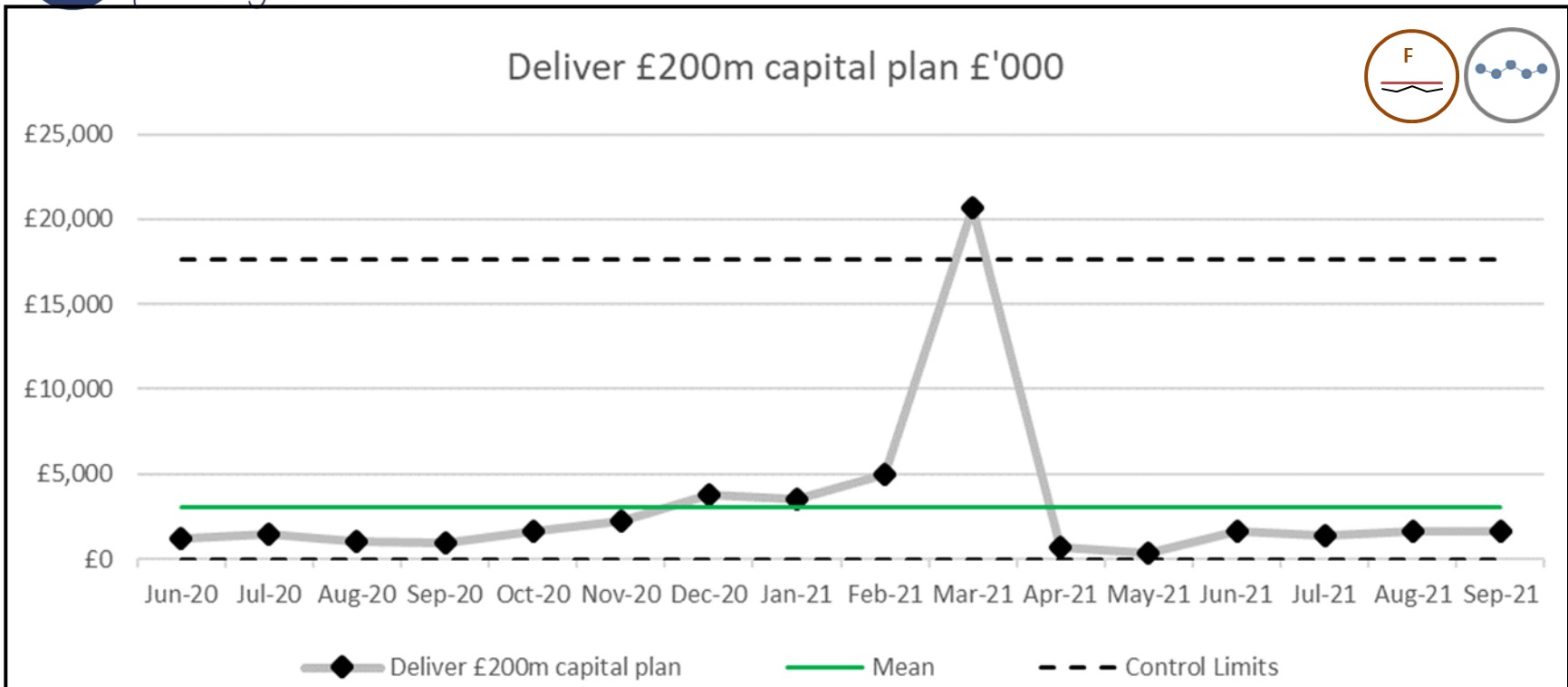
Mitigations:

EMAS have enacted a targeted admission avoidance process.
The Discharge Lounge at LCH and PHB are now operating a 24/7 service provision to release the burden placed on the Emergency Department at in terms of patients awaiting AIR/CIR and transport home.
Increased CAS and 111 support especially out of hours.
Clinical Operational Flow Policy adherence and compliance and Full Capacity Protocol activation. Although the ability to board patients is becoming more problematic.

Quality | Operational Performance | Workforce | Finance

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Sep-21
£1,641,800
Variance Type
Metric is currently experiencing Common Cause Variation
21/22 Ambition
£39 Million for the year
Achievement
Metric is consistently failing to ambition
Executive Lead
Director of Finance

Background:
The Trust has a revised capital programme to deliver of £34.6m, inclusive of £0.9m CDH funds received.

What the chart tells us:
The chart shows that in 2020/21 the majority of the capital programme expenditure was in the final quarter; it shows that expenditure in 2021/22 has similarly started slowly.

Issues:
The Trust has a large capital programme to deliver in 2021/22, and delivery of the programme is at greater risk if the actual expenditure profile is heavily weighted in the final two quarters.
As at the end of September, expenditure YTD of £7.3m is £7.5m behind NHSE&I plan, requiring expenditure of £27.3m in the remainder of 2021/22 to deliver the programme in full.

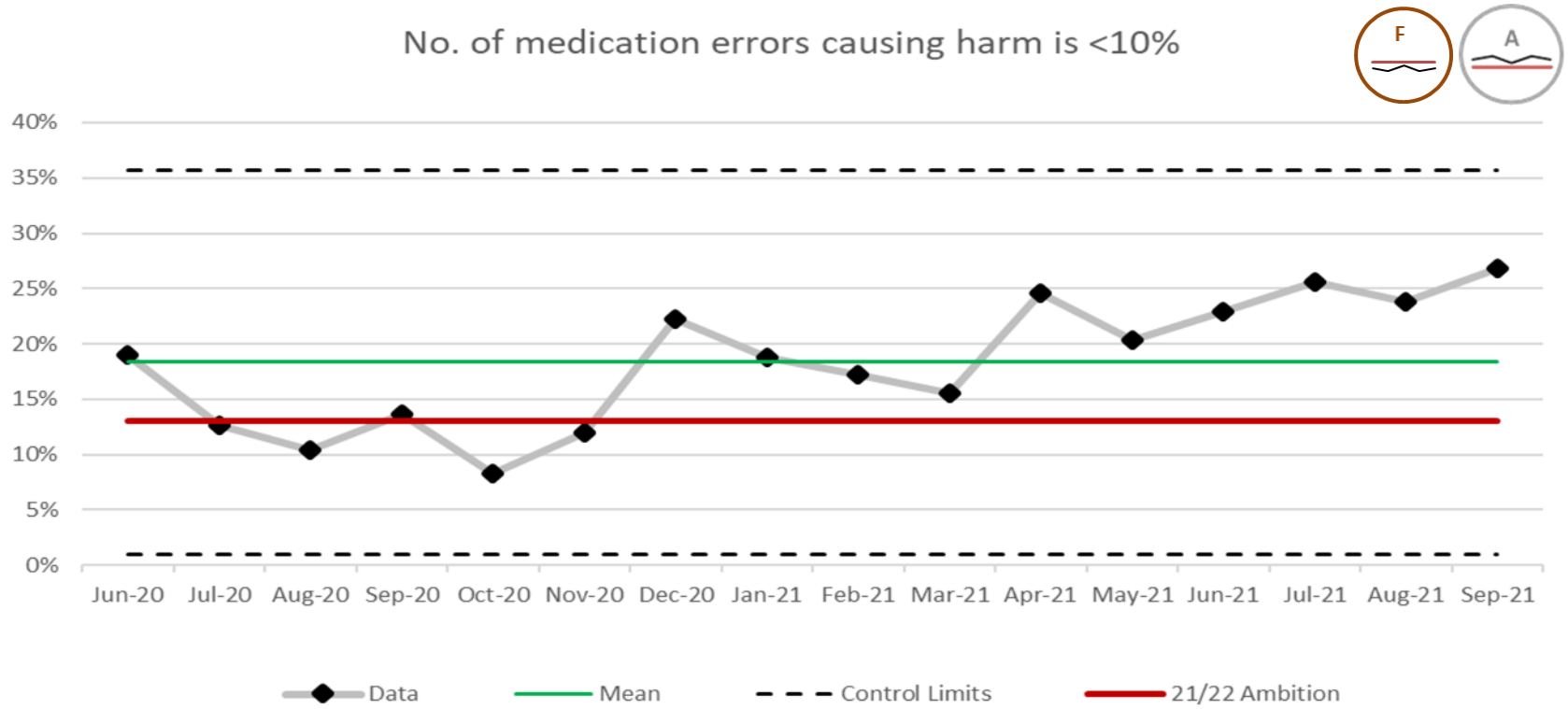
Actions:
To ensure that the capital programme will be delivered in full, the programme is being managed via Capital Delivery Group (CDG). Forecasting meetings were held, as planned, in August/September with scheme leads highlighting areas of slippage, risk and mitigations. Details shared and schemes will be managed through CDG. Updated forecasts to be constantly under review

Mitigations:
Where slippage exists, delegated authority has been provided by Trust Board to DoF and COO. Following this agreement, local decision has been reached to re-allocate based on the 'transition' year agreement at Financial Leadership Group (FLG) for 2021/22. Where this isn't possible, agree the next scheme within the 'System' based on the current known priorities.

Quality | Operational Performance | Workforce | Finance

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Sep-21
26.80%
Variance Type
Metric is currently experiencing Special Cause Variation – above the mean
21/22 Ambition
13%
Achievement
Metric is consistently failing to ambition
Executive Lead
Director of Nursing

Background:
Percentage of medication incidents reported as causing harm (low/moderate/severe or death)

What the chart tells us:
In the month of September, the number of incidents reported was 153. The number of incidents causing some level of harm (low /moderate /severe / death) is 26.8 more than double the national average of 10.8.

Issues:
Medication incidents causing harm is more than double the national average. The majority of incidents are at the point of administration of medication and the main error is omitting medicines.

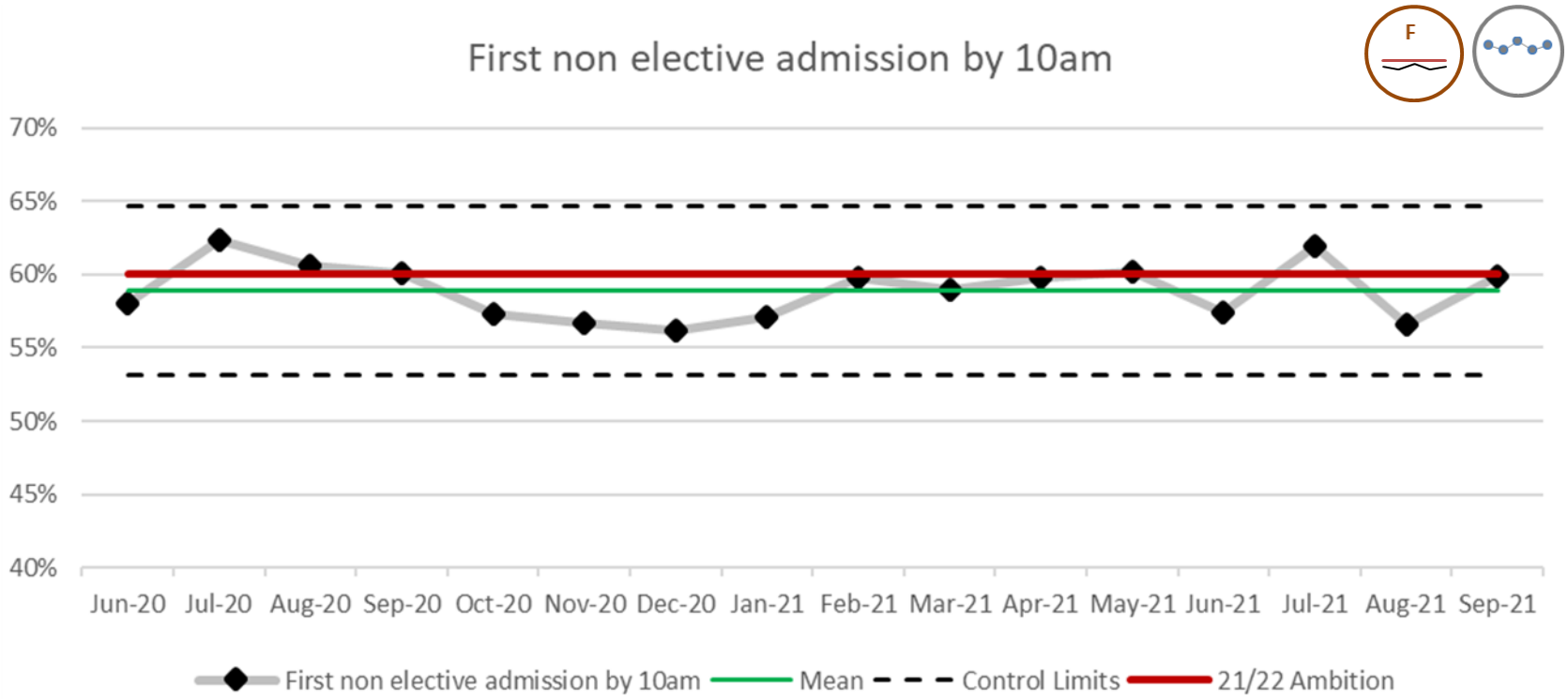
Actions:
A medicines management project group has been set up to tackle on going medicines incidents. This aims to raise the profile of medicines management.

Mitigations:
There is a business case that has been submitted to allow 7 day working for the Pharmacy department and to provide a service to all ULHT wards. Increasing the presence of Pharmacy staff on the wards will reduce risks, improve the safety of care that we provide to patients.

Quality | Operational Performance | Workforce | Finance

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Sep-21
59.93%
Variance Type
Metric is currently experiencing Common Cause Variation
21/22 Ambition
60%
Achievement
Metric is consistently failing to ambition
Executive Lead
Chief Operating Officer

Background:
The Trust target against this standard is 60% of total non-elective admission being admitted before 10am.

What the chart tells us:
September experienced a decrease in the numbers of non-elective admission before 10am.
Compliance was 59.93 against a target of 60% which is.
This equates to 522 patients being admitted before 10am.

Issues:
The main factors causing this deterioration was poor flow the previous day thus leading to increased bed waits in the emergency departments in the mornings, zero compliance against the standard of 10 discharges by 10am and sub optimal use of the discharge lounge before 10am.

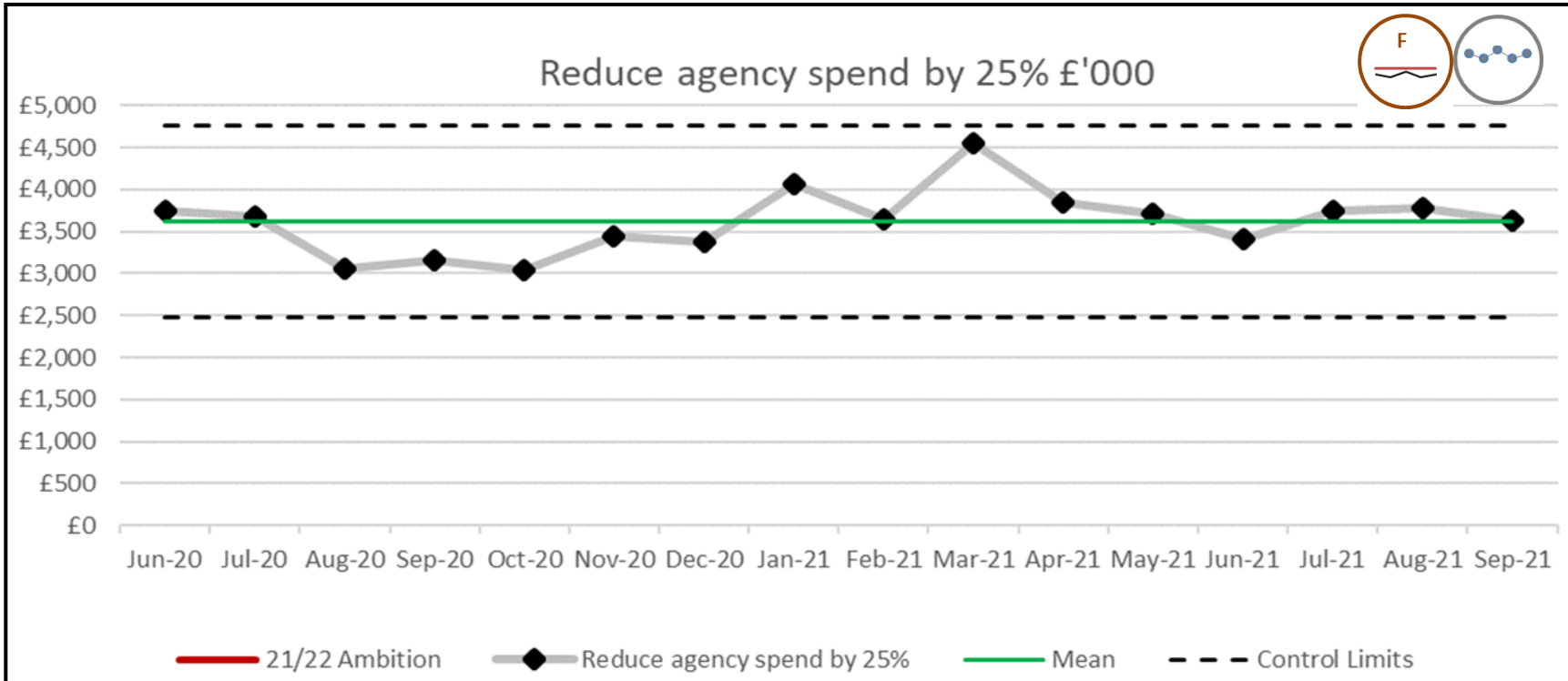
Actions:
Identification of '10 by 10' patients the previous day, ensuring all discharge arrangement are complete and communicated clearly.
Extended opening hours of the discharge lounge incorporating a pull model/in reach to the wards.
Forward look over 72 hours against discharge planning and readiness to leave.
Pull model by system partners to allow exit of all patients on pathway 1, 2 and 3 with a greater then 24hrs LOS post becoming medically optimised.

Mitigations:
Effective use of the reason to reside information to effect more timely morning discharges.
Early use of the discharge lounge for confirmed medically optimised discharges on pathway 1, 2 and 3.
Appropriate use of the full capacity protocol to release assessment unit capacity.

Quality | Operational Performance | Workforce | Finance

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Sep-21
£3,633,000
Variance Type
Metric is currently experiencing Common Cause Variation
21/22 Ambition
£33 Million for the year
Achievement
Metric is consistently failing to ambition
Executive Lead
Director of Finance

Background:
Aim to reduce agency spend by 25% or £11m from £44m in 2019/20 to £33m in 2021/22; the Trust has an Agency Ceiling of £21m.

What the chart tells us:
Agency spend in 2021/22 is around the mean; whereas to achieve the 25% reduction it requires to be lower at an average of £2.75m per month.

Issues:
The Trust has traditionally spent most on Medical and Dental Agency than on any other staff category. However, a continued focus upon a Plan for Every Post has meant that Medical and Dental is £0.4m favourable to the IIP plan.

Increased Agency spend on Nursing and Midwifery & Housekeeping, though, has driven total Agency spend YTD £5.3m above plan.

Actions:
Divisions developing detailed trajectory improvements, including the timeline for supernumerary staff transitioning into substantive roles with agency staff exiting, and agreement of the bed base and establishment to support this.

Alternative roles to fill longstanding vacancies are being reviewed, and exit plans have been requested for admin/managerial roles.

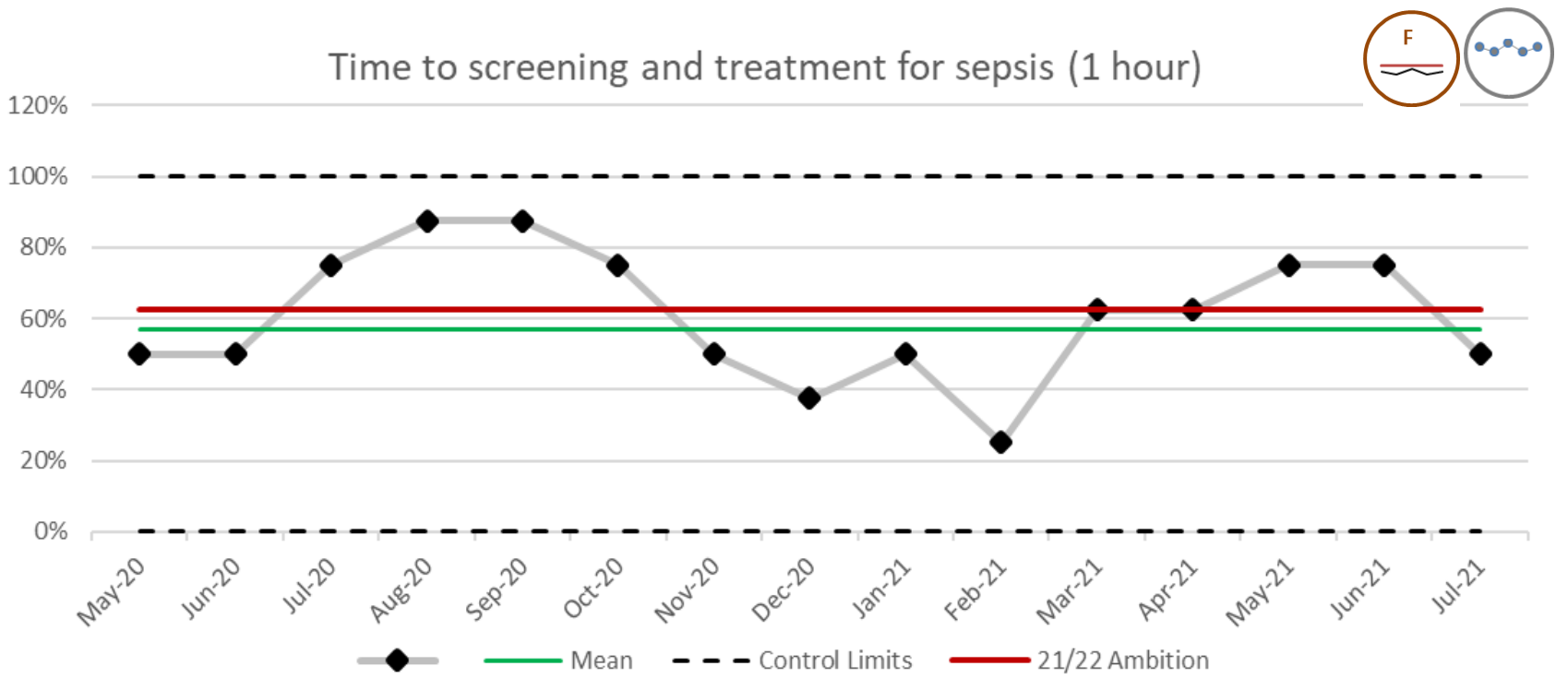
Mitigations:
There remains a continued focus upon Plan for Every post across all staffing categories.

The Trust also continues to review opportunities in the following areas: convert Agency staff to NHS locums; reduce our usage of higher tier agencies; reduce our reliance on Agency staff by increasing the Staff Bank.

Quality | Operational Performance | Workforce | Finance

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Jul-21
50% (4/8)
Variance Type
Metric is currently experiencing Common Cause Variation
21/22 Ambition
62.5% (5/8)
Achievement
Metric has failed to ambition
Executive Lead
Director of Nursing

Background:
% of sepsis metrics achieving the 90% target out of eight metrics in total.

What the chart tells us:
There has been a decline in Paediatric Sepsis compliance and we are currently only achieving our targets in 4 of the 8 Metrics – 50%

Issues:
The decline in compliance has combined with an increased in the amount of children attending and being admitted to our departments as well as an increased acuity among those patients. This is also alongside an increased amount of patient activity within the trust as well as staffing shortages.

Actions:
There is ongoing training happening within departments when workloads allow and there has been Simulation training over both sites. Sepsis practitioners are currently doing walk rounds of areas struggling and offering any support or advice if needed.

Mitigations:
Staff involved in delayed screens or treatment are being involved in carrying out the harm reviews so that lessons can be learned at the time.

Nurses in charge of departments have also been asked to have an oversight of any elevated PEWS scores so they can encourage staff to complete the screens.

Quality | Operational Performance | Workforce | Finance

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

PERFORMANCE OVERVIEW - QUALITY

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target per month	Jul-21	Aug-21	Sep-21	YTD	Pass/Fail	Trend Variation
Deliver Harm Free Care	Clostridioides difficile position	Safe	Patients	Director of Nursing	9	7	3	8	29	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, by reporting acute trust and month using trust per 1000 bed days formula	Safe	Patients	Director of Nursing	TBC	0.03	0.07	0.01	0.06		
	E. coli bacteraemia cases counts and 12-month rolling rates, by reporting acute trust and month using trust per 1000 bed days formula	Safe	Patients	Director of Nursing	TBC	0.17	0.13	0.14	0.13		
	Catheter Associated Urinary Tract Infection	Safe	Patients	Director of Nursing	1	2	0		5	P	
	Falls per 1000 bed days resulting in moderate, severe harm & death	Safe	Patients	Director of Nursing	0.19	0.01	0.07	0.14	0.05	P	
	Pressure Ulcers category 3	Safe	Patients	Director of Nursing	4.3	0	1	0	3	P	B
	Pressure Ulcers category 4	Safe	Patients	Director of Nursing	1.3	0	0	0	1	P	
	Pressure Ulcers - unstageable	Safe	Patients	Director of Nursing	4.4	6	3	4	28	P	
	Venous Thromboembolism (VTE) Risk Assessment	Safe	Patients	Medical Director	95%	95.40%	95.20%	95.93%	96.33%	P	
	Never Events	Safe	Patients	Director of Nursing	0	1	1	0	2	P	
	Reported medication incidents per 1000 occupied bed days	Safe	Patients	Medical Director	4.3	5.29	4.33	5.37	5.03	P	
	Medication incidents reported as causing harm (low /moderate /severe / death)	Safe	Patients	Medical Director	10.7%	25.6%	23.8%	26.8%	24.00%	F	A

OUTSTANDING CARE personally DELIVERED

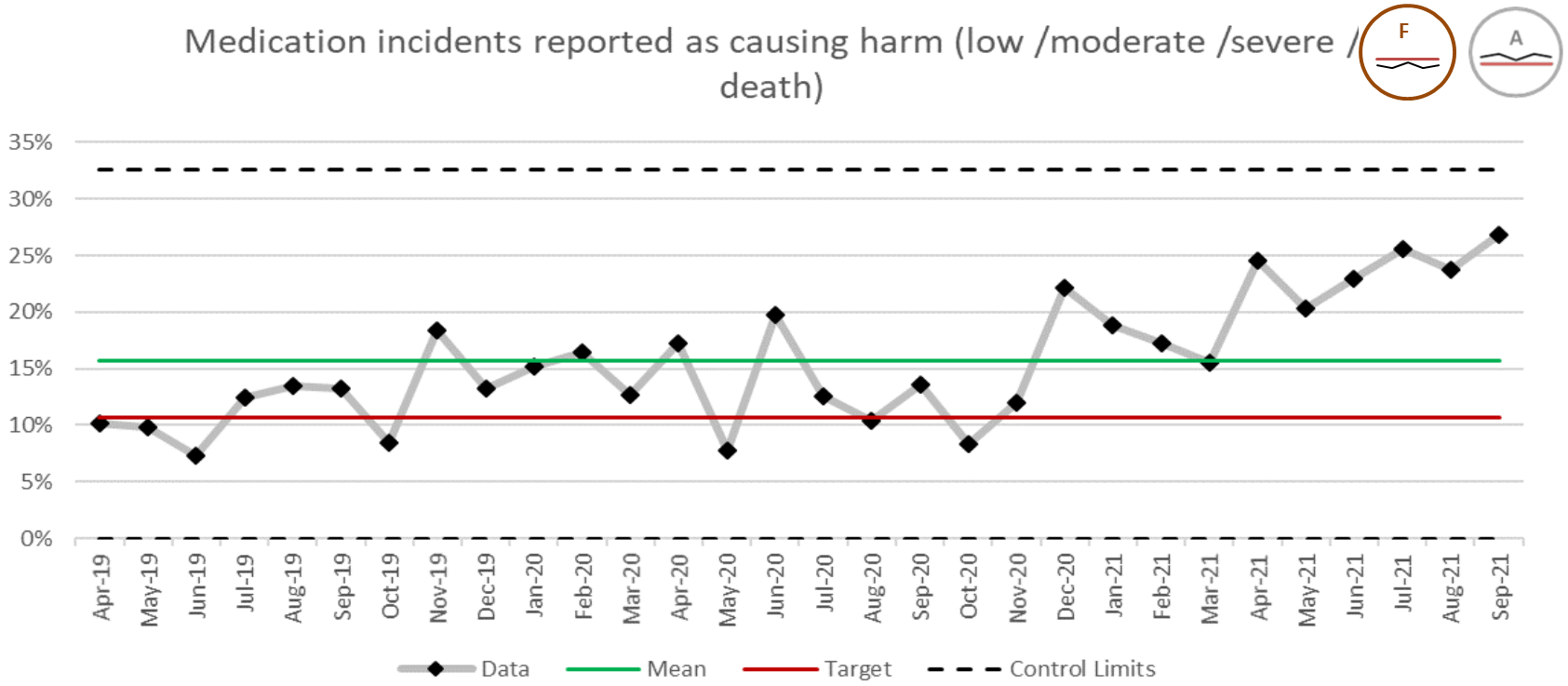
NHS United Lincolnshire Hospitals NHS Trust

PERFORMANCE OVERVIEW - QUALITY

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Jul-21	Aug-21	Sep-21	YTD	Pass/Fail	Trend Variation
Deliver Harm Free Care	Patient Safety Alerts responded to by agreed deadline	Safe	Patients	Medical Director	100%	100%	None issued	100%	66.75%	P	
	Hospital Standardised Mortality Ratio - HSMR (basket of 56 diagnosis groups) (rolling year data 3 month time lag)	Effective	Patients	Medical Director	100	114.30	104.62	103.41	110.97	F	H
	Summary Hospital Mortality Indicator (SHMI) (rolling year data 6 month time lag)	Effective	Patients	Medical Director	100	112.55	112.88	111.83	111.75	F	H
	The Trust participates in all relevant National clinical audits	Effective	Patients	Medical Director	100%	97.00%	97.00%	97.00%	96.00%	F	A
	eDD issued within 24 hours	Effective	Patients	Medical Director	95%	88.70%	87.70%	84.00%	89.70%	F	
	Sepsis screening (bundle) compliance for inpatients (adult)	Safe	Patients	Director of Nursing	90%	90.0%	87.25%		89.75%	F	
	Sepsis screening (bundle) compliance for inpatients (child)	Safe	Patients	Director of Nursing	90%	83.0%	95.58%		88.38%	P	
	IVAB within 1 hour for sepsis for inpatients (adult)	Safe	Patients	Director of Nursing	90%	95.0%	86.66%		92.29%	F	
	IVAB within 1 hour for sepsis for inpatients (child)	Safe	Patients	Director of Nursing	90%	75.0%	57.00%		86.40%	F	
	Sepsis screening (bundle) compliance in A&E (adult)	Safe	Patients	Director of Nursing	90%	90.0%	92.17%		92.51%	P	A
	Sepsis screening (bundle) compliance in A&E (child)	Safe	Patients	Director of Nursing	90%	84.8%	86.35%		86.96%	F	A
	IVAB within 1 hour for sepsis in A&E (adult)	Safe	Patients	Director of Nursing	90%	93.3%	94.30%		94.61%	P	
	IVAB within 1 hour for sepsis in A&E (child)	Safe	Patients	Director of Nursing	90%	50.0%	50.00%		67.50%	F	
	Rate of stillbirth per 1000 births	Safe	Patients	Director of Nursing	4.20	2.66	2.86	3.26	3.02	P	B
Improve Patient Experience	Mixed Sex Accommodation breaches	Caring	Patients	Director of Nursing	0	Submission suspended during Covid					
	Duty of Candour compliance - Verbal	Safe	Patients	Medical Director	100%	45.00%	75.00%	0.00%	60.60%	F	L
	Duty of Candour compliance - Written	Responsive	Patients	Medical Director	100%	18.00%	50.00%		37.40%	F	L

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Sep-21
26.8%
Variance Type
Metric is currently experiencing Special Cause Variation – above the mean
Target
10.7%
Target Achievement
The metric has consistently failed to target
Executive Lead
Medical Director

Background:
Percentage of medication incidents reported as causing harm (low/moderate/severe or death)

What the chart tells us:
In the month of September, the number of incidents reported was 153. The number of incidents causing some level of harm (low /moderate /severe / death) is 26.8 more than double the national average of 10.8.

Issues:
Medication incidents causing harm is more than double the national average. The majority of incidents are at the point of administration of medication and the main error is omitting medicines.

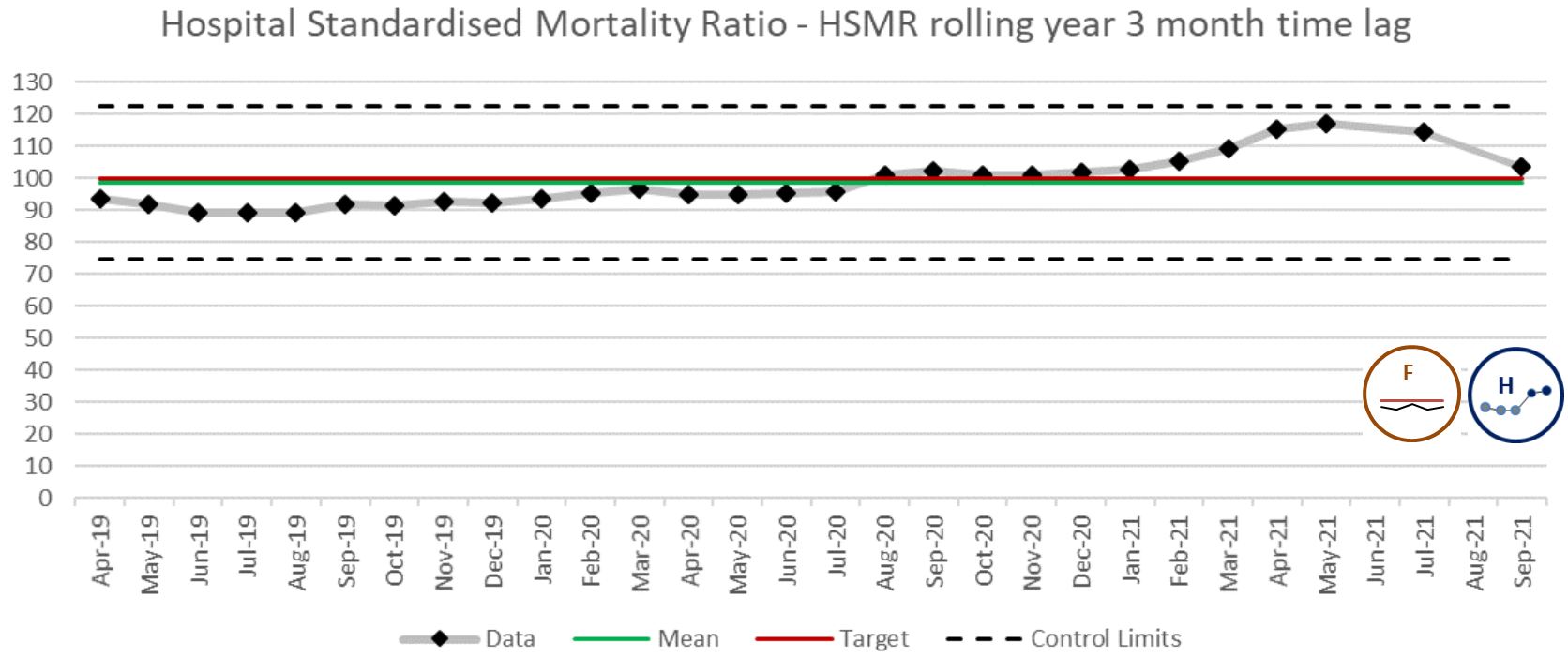
Actions:
A medicines management project group has been set up to tackle on going medicines incidents. This aims to raise the profile of medicines management.

Mitigations:
There is a business case that has been submitted to allow 7 day working for the Pharmacy department and to provide a service to all ULHT wards. Increasing the presence of Pharmacy staff on the wards will reduce risks, improve the safety of care that we provide to patients.

Quality | Operational Performance | Workforce | Finance

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Sep-21
103.41
Variance Type
Metric is currently experiencing Special Cause Variation – high trend
Target
100
Target Achievement
The metric has consistently failed to target
Executive Lead
Medical Director

Background:
The Trusts HSMR increased during the COVID-19 pandemic

What the chart tells us:
The Trust HSMR is decreasing since the peaks seen during the COVID-19 pandemic

Issues:
The Trust did not have any Dr Foster data for the previous 4 months due to a national issue with Dr Foster data.

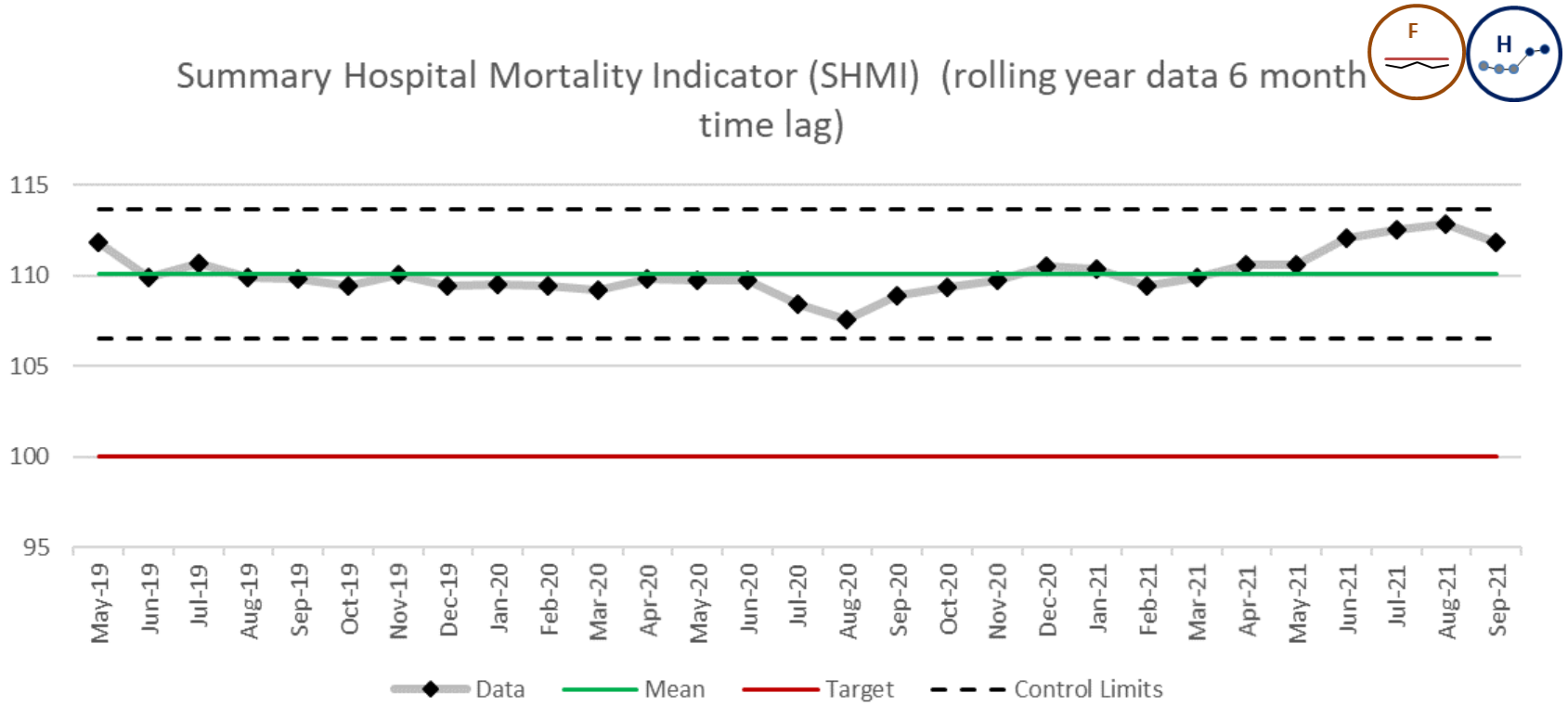
There are a number of alerts which the mortality group will action.

Actions:
A review of all mortality alerts will be discussed at MorALS and a plan implemented.

Mitigations:
All alerts at 3 months have a case note review completed.

The Trust has Medical Examiners who review all deaths.

Divisional mortality reports are produced monthly.



Sep-21
111.83
Variance Type
Metric is currently experiencing Special Cause Variation – high trend
Target
100
Target Achievement
The metric has consistently failed to target
Executive Lead
Medical Director

Background:
SHMI reports on mortality at trust level across the NHS in England using a standard methodology. SHMI also includes deaths within 30 days of discharge.

What the chart tells us:
The Trust's SHMI has increased during the COVID-19 pandemic.

Issues:
The COVID-19 pandemic has impacted on the Trusts SHMI.

The data is 6 months behind.

Actions:
Any diagnosis group alerting is subject to a case note review.

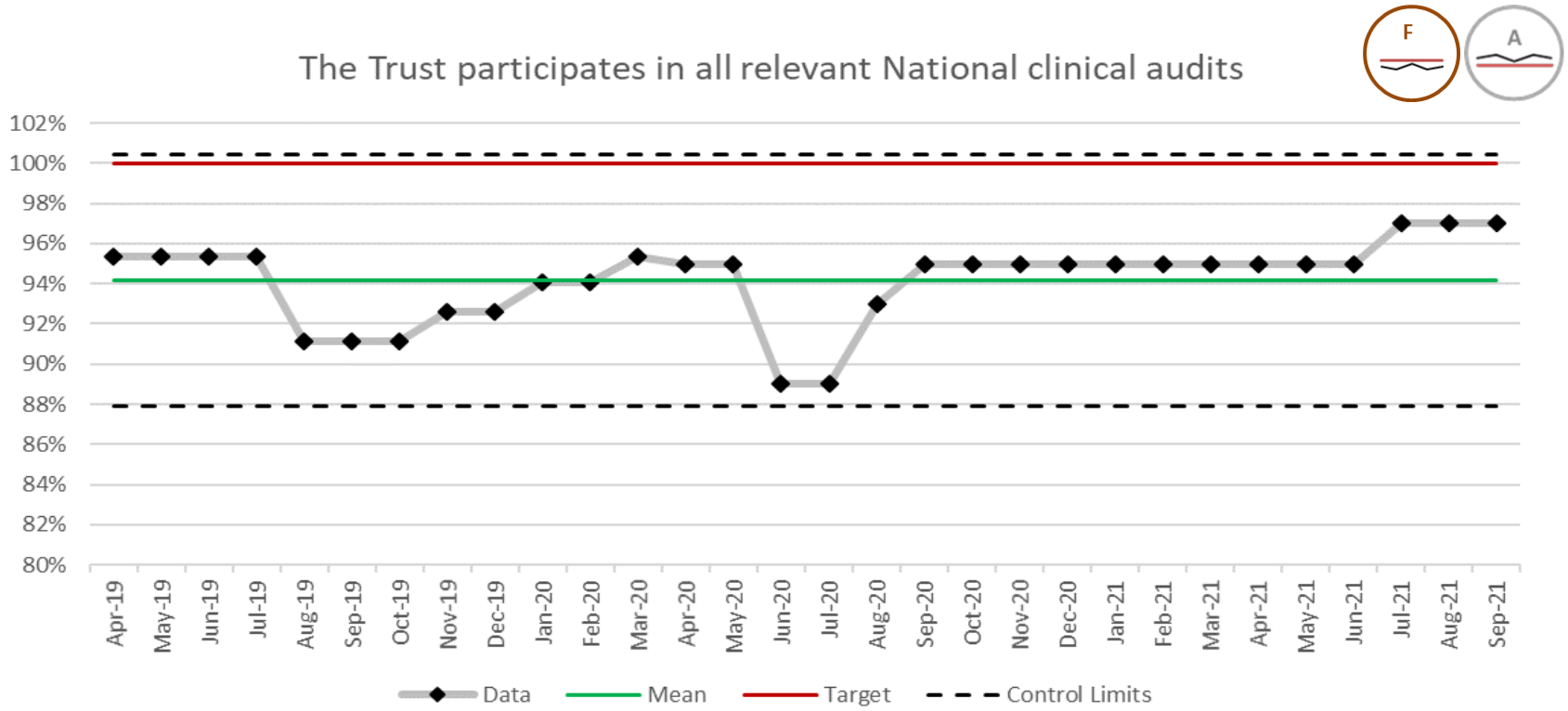
The Trust are currently in discussion with the system partners in rolling out the ME service for community deaths.

Mitigations:
All deaths are reviewed by the Medical Examiner and any deaths were issues are identified are escalated for a structured judgement review or rapid review.

The Trust host the Lincolnshire Mortality Collaborative which is attended by all system partners to share learning.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Sep-21
97%
Variance Type
Metric is currently experiencing Special Cause Variation – above the mean
Target
100%
Target Achievement
The metric has consistently failed to target
Executive Lead
Medical Director

Background:
% participation in relevant National Clinical Audits.

What the chart tells us:
Participation remains at 97% for the month of September 2021.

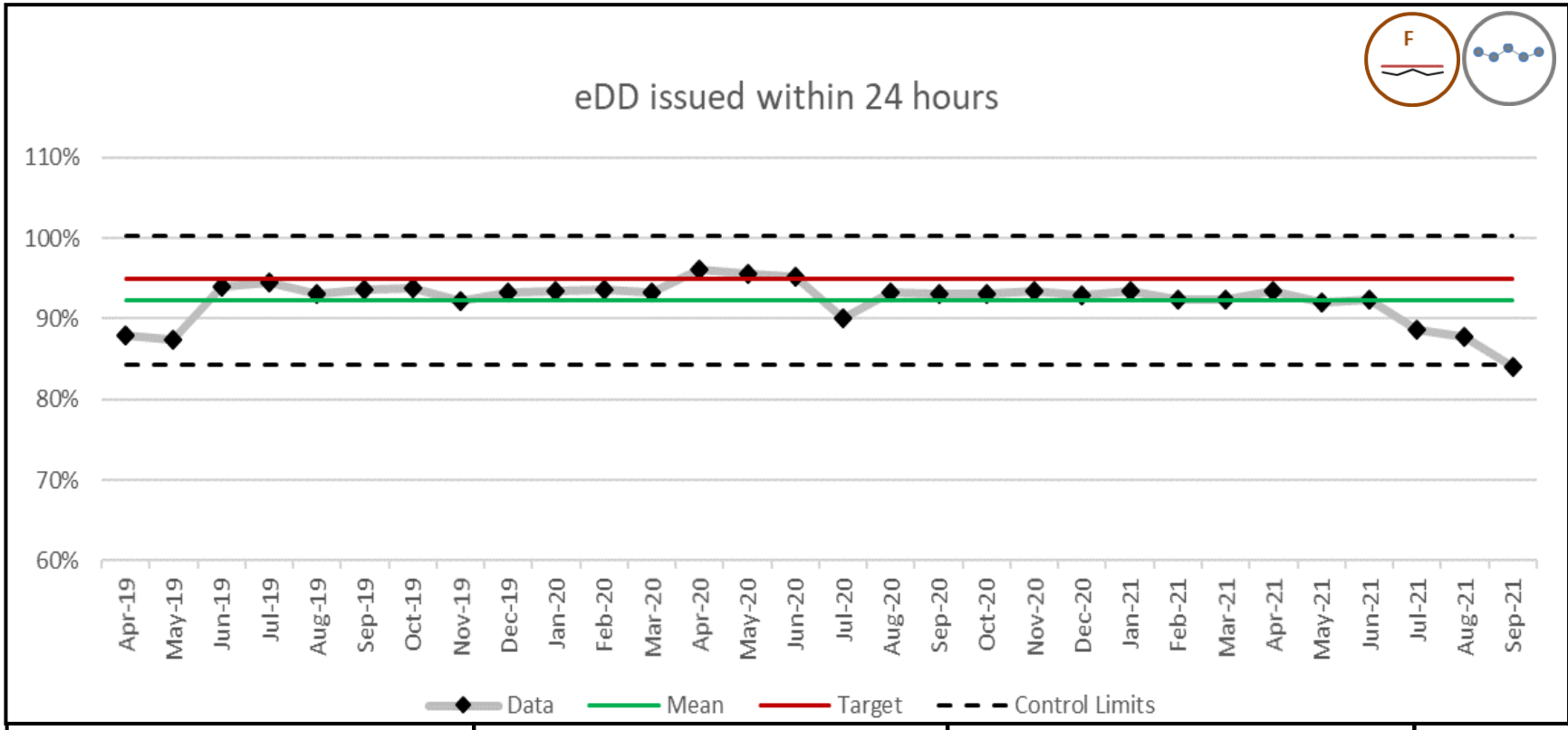
Issues:
None participation in the IBD Audit.

Actions:
Monitored by the Clinical Effectiveness Group.

Mitigations:
IBD participation all relevant data sharing agreements signed off and approved access and logins to the IBD web tool in process to commence data submission October 2021

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Sep-21
84.0%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
95%
Target Achievement
The metric is consistently failing the target
Executive Lead
Medical Director

Background:
eDDs to be sent within 24 hours of a patient's discharge

What the chart tells us:
The Trust is not achieving the 95% target, for September the Trust achieved 84.2%.

Issues:
eDDs not being completed the day prior to the patients discharge.

There have been considerable pressures on bed capacity within the Trust.

Actions:
A dashboard has been developed to highlight ward and consultant compliance.

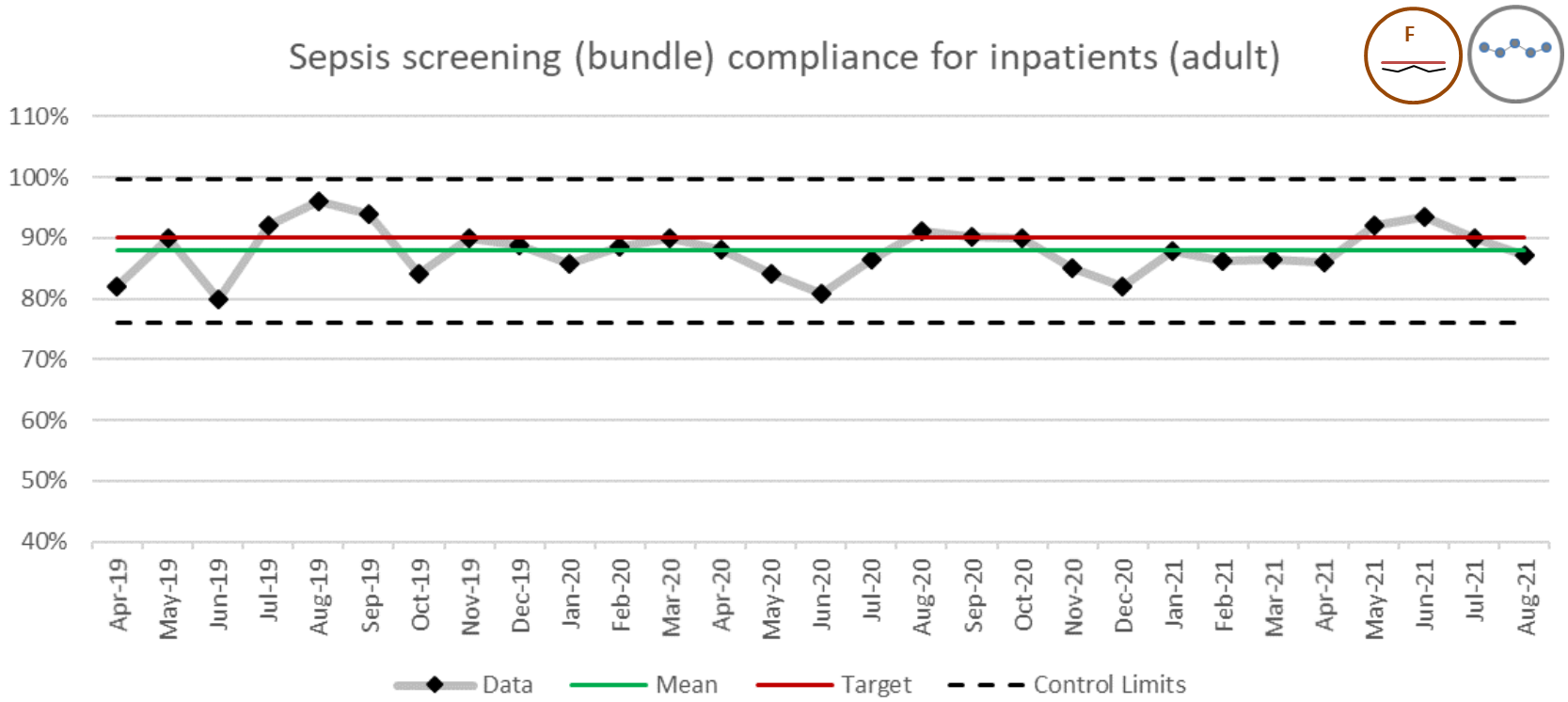
Mitigations:
6 weekly eDD meeting chaired by the Deputy Medical Director.

Streamlined eDD for paediatrics being developed.

95.1% of all eDDs have been sent in the month of September.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Aug-21
87.25%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
The metric is failing the target
Executive Lead
Director of Nursing

Background:
Sepsis screening (bundle) compliance for inpatients (adult).

What the chart tells us:
The compliance for August has declined to 87%.

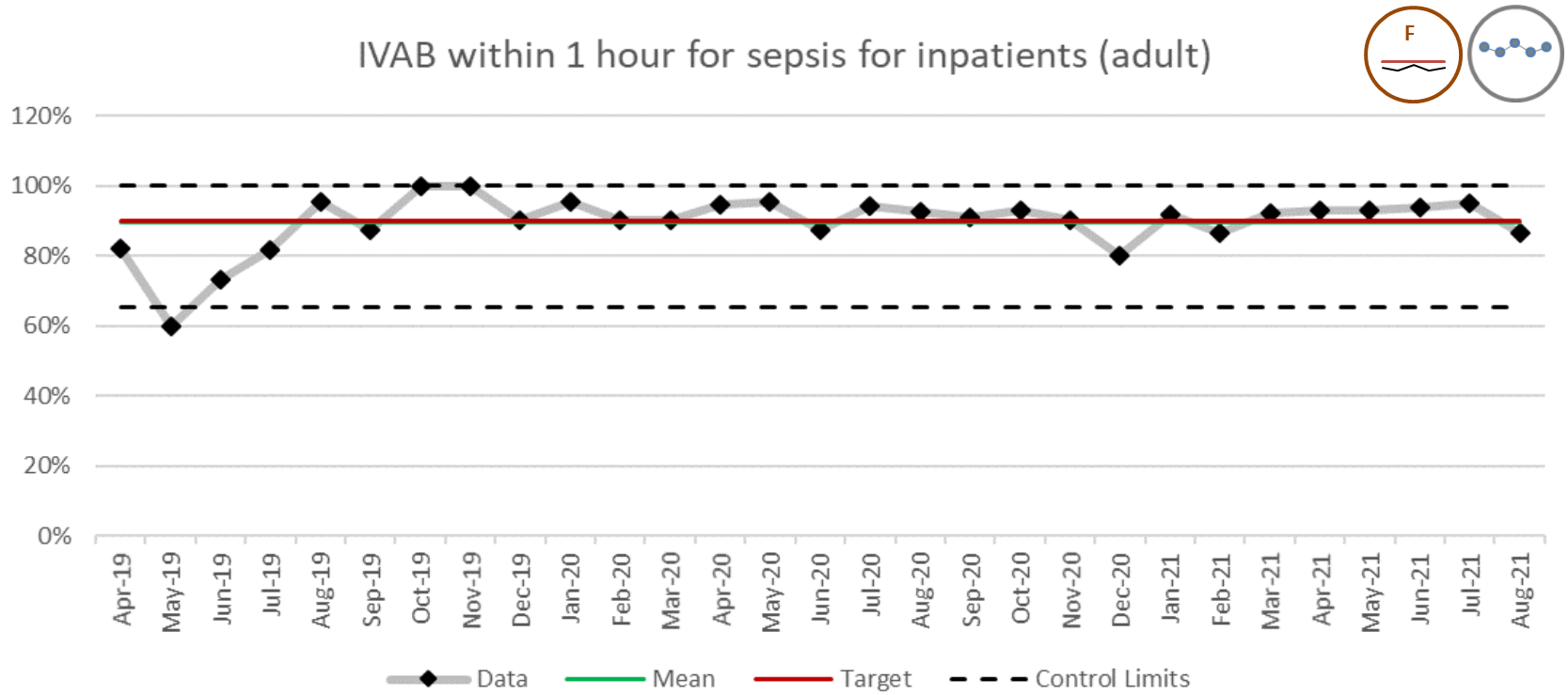
Issues:
The medical wards still face considerable challenges as demand increases and this is reflected in a dip in compliance. The majority of missed screens are for non- infective patients. Missed screens that were attributable to Agency nurses continues to be a theme and probably reflects the staffing challenges as new ward areas open. The majority of screens were acknowledged within the nursing notes with appropriate escalation but without completion on webv.

Actions:
The sepsis practitioners have completely revamped the Agency workbook with input from Oncology and the maternal and paediatric specialists and this has had a successful pilot in ED with increased engagement and compliance. The next stage is to separate the various specialty elements of the workbook so that it can be rolled out to the general ward areas. This will be accompanied by an online quiz which will generate a certificate of compliance to assure ward areas of competency.

Mitigations:
The sepsis practitioners are working closely with the clinical education team to increase teaching for Preceptorship nurses and International nurses. This includes simulation training to provide a more practical approach to the teaching.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Aug-21
86.66%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
The metric is failing the target
Executive Lead
Director of Nursing

Background:
IVAB within 1 hour for sepsis for inpatients (adult).

What the chart tells us:
The compliance for August has declined markedly to 86.66%.

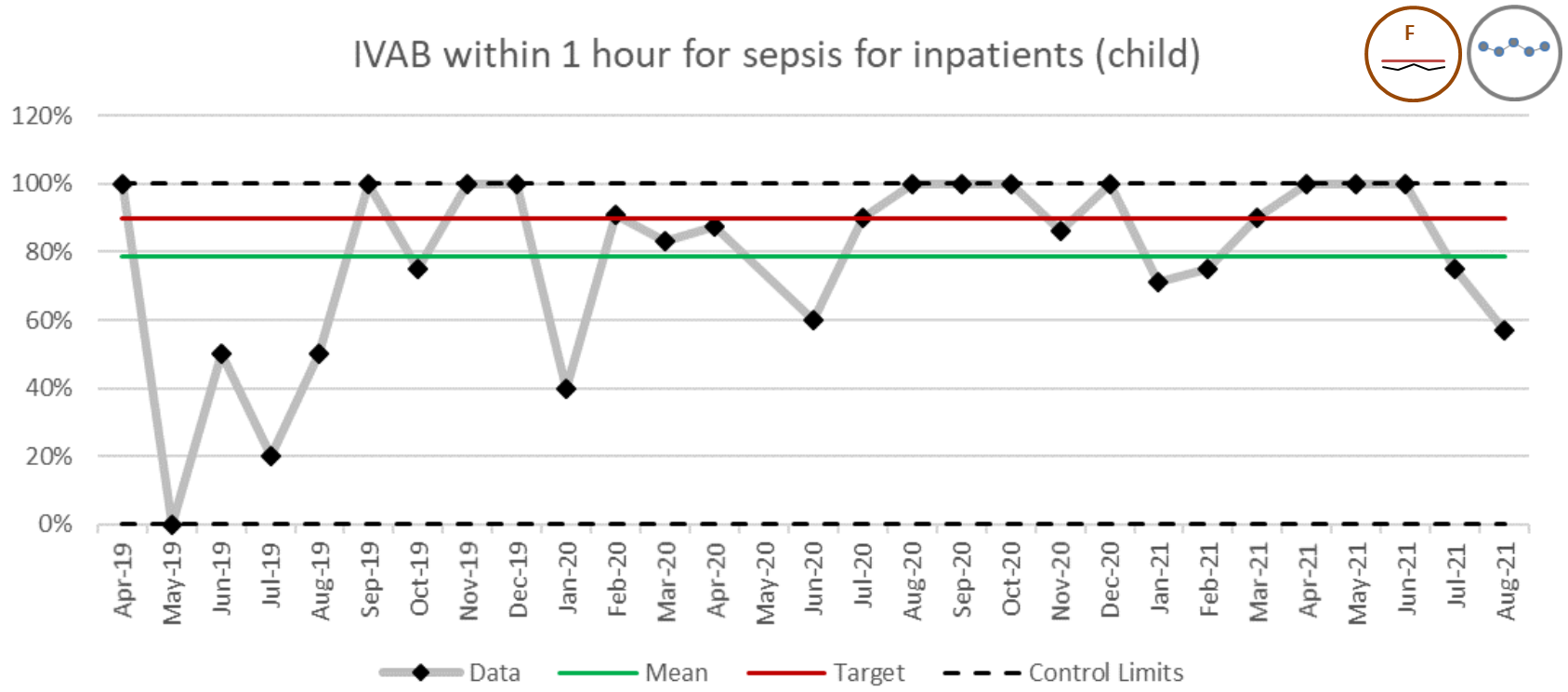
Issues:
The majority of patients were waiting for a clinical decision on prescribing following blood results and X-rays. Documentation in all cases was clear and demonstrated no harm in the harm reviews. The other cases reviewed had detailed compliance to the bundle within 60 minutes but not entered on webv.

Actions:
Ward teaching has now increased and is helping to support the nurses to ensure that all actions including antibiotic administration are performed within 60 minutes. The teaching for medical staff is now on line for easier access and this has been well received and will hopefully emphasise the need for timely clinical decision making.

Mitigations:
The monthly figures do appear to be an anomaly as previous months have shown good compliance and have recovered for the current month. The evidence suggests that actions are being completed in time but not reflected by correctly back timing on web v and this issue can easily be resolved and does not impact patient safety.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Aug-21
57%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
The metric is failing the target
Executive Lead
Director of Nursing

Background:
IVAB within 1 hour for sepsis for inpatients (child)

What the chart tells us:
The compliance for IVAB with the hour for Children's inpatients in August is 57.0% (4 of 7 children). This is well below the 90.0% standard expected.

Issues:
The wards are seeing an increased number of patients and acuity at present. There are also ongoing staffing issues.

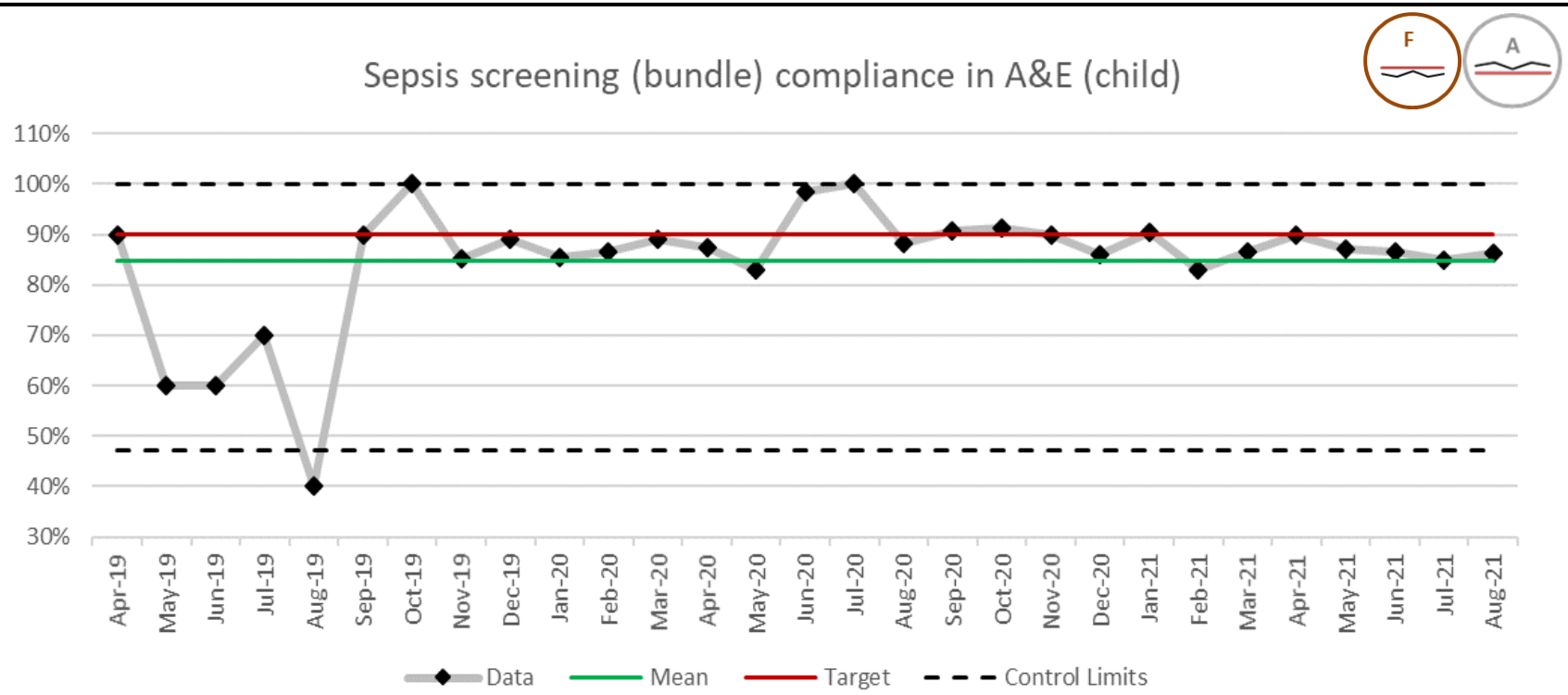
Actions:
Harm reviews are being completed for all children who have delayed treatment, this is carried out by the Nurse/ Dr involved. Scenario training has been organised for the ward and number of these will be around Sepsis, treatment and bundles.

Mitigations:
There is regular contact between the Ward Managers and the Sepsis Practitioners to try to highlight and resolve issues early. The Paeds Sepsis Practitioner regularly visits ward areas to offer support and / or training.

Quality | Operational Performance | Workforce | Finance

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Aug-21
86.35%
Variance Type
Metric is currently experiencing Special Cause Variation – above the mean
Target
90%
Target Achievement
The metric is consistently failing the target
Executive Lead
Director of Nursing

Background:
Sepsis screening (bundle) compliance in A & E (child).

What the chart tells us:
Screening compliance in ED is 86.35% (165 of 191) which is below the 90% target.

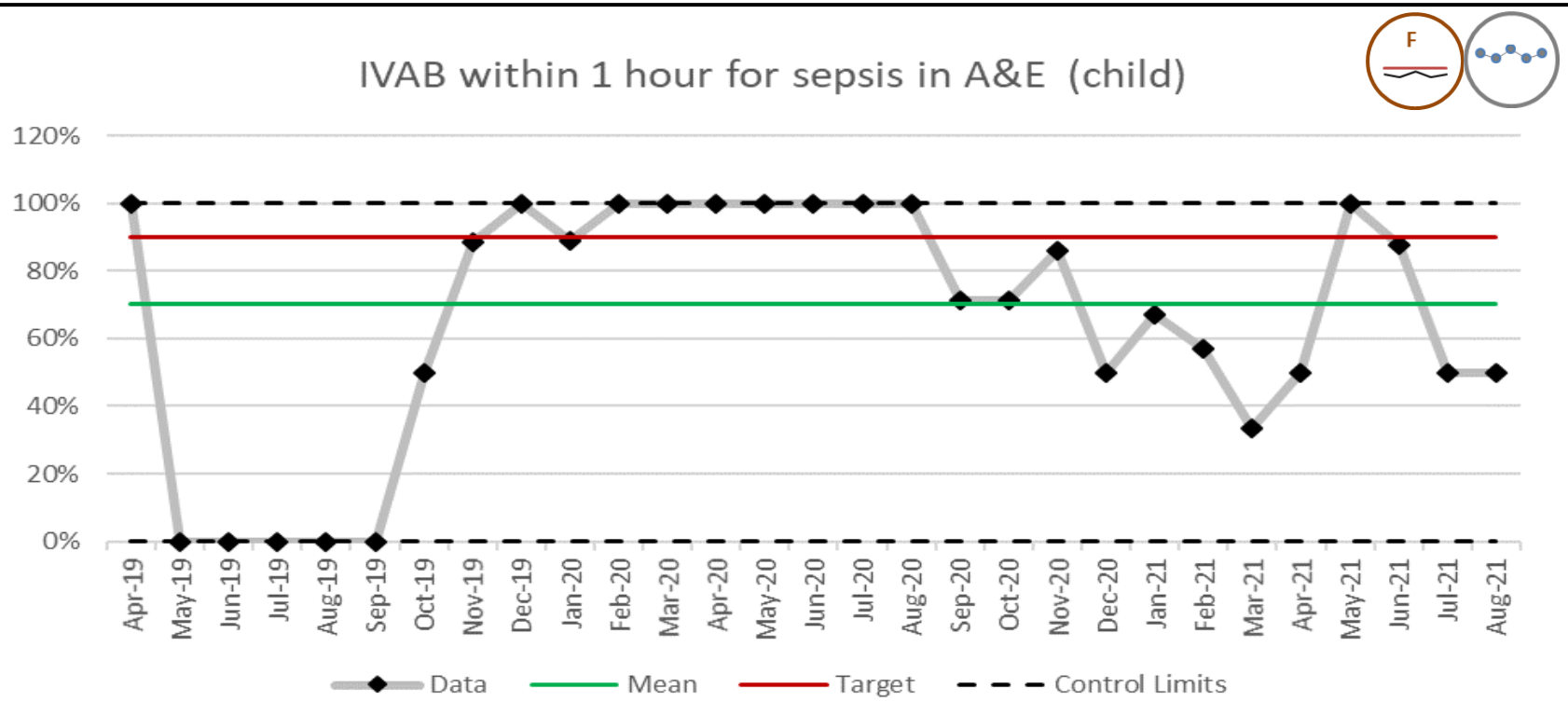
Issues:
ED is seeing a large number of new / Temporary / Agency staff that may still require training. ED is also seeing a large increase in the number of Paediatric patients being seen as well as a higher acuity of patients and this gives them limited time for training etc. Staff have reported that they are struggling with the Paediatric workload as a single Paeds Nurse in the ED department

Actions:
Sepsis Practitioners are currently doing regular walk rounds in the department and offering any assistance if needed. Scenario training is taking place on both sites and has had a good attendance. Harm reviews are being carried out for all delayed / missed screens and ED staff are involved in carrying these out. Sepsis Practitioner will attend morning huddles and ED meetings for support and training.

Mitigations:
There are ongoing fortnightly Sepsis meetings for ED at present, Issues are discussed at these and action plans are put in place quickly to try and assist the department compliance. Previous action plans are also reviewed at these meetings. Issues are discussed at Paediatric Governance.
Paediatric Drs and Nurses from the Ward are supporting the ED when possible.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Aug-21
50%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
The metric is consistently failing the target
Executive Lead
Director of Nursing

Background:
IVAB within 1 hour for sepsis in A&E (child)

What the chart tells us:
The compliance in ED this month for IVAB is 50.0% , 3 out of 6 children received antibiotics within 1 hour.

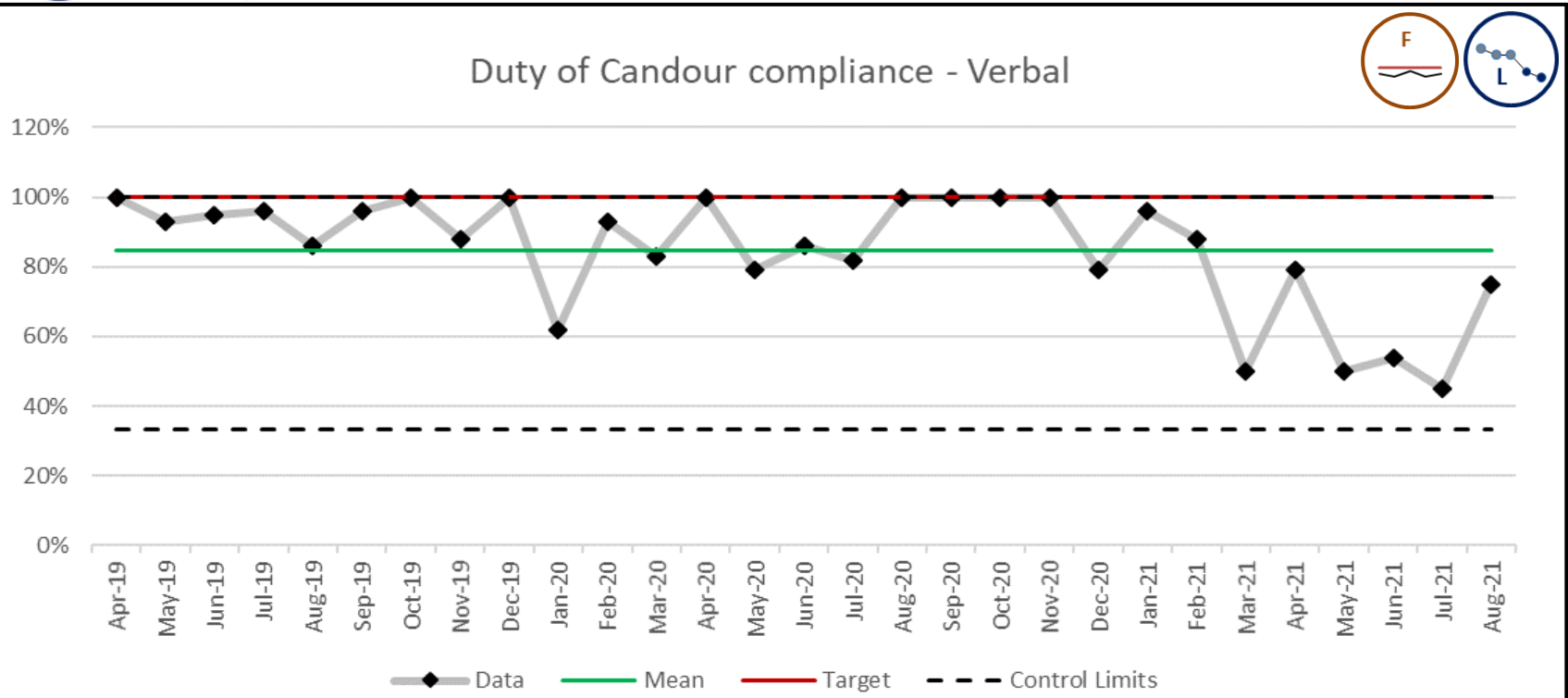
Issues:
The department is currently seeing a large number of children and there are often up to 20 children in the department at one time. This is a huge workload for 1 paeds nurse and a Dr. The staff have reported they are struggling to find time to give these in a timely manner. The ward is also very busy at present and is not always able to offer assistance.

Actions:
Harm reviews are being completed for all children who have delayed antibiotics.
Children are being moved out of the department and to wards as quickly as possible- but this sometimes means antibiotics are not given until being on the ward.

Mitigations:
Discussed at ongoing weekly Sepsis meeting. If ED need assistance with looking after children within the department they are phoning the paediatric wards. Wards are offering help if possible.
The paediatric Sepsis Practitioner is also attending ED regularly to offer support and training.
Data is being pulled every other day in order to detect issues as quickly as possible and try to resolve.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Aug-21
75%
Variance Type
Metric is currently experiencing Special Cause Variation – low trend
Target
100%
Target Achievement
Metric is consistently failing the target
Executive Lead
Medical Director

Background:
Verbal and Written compliance with NHS Duty of candour which applies to all patient safety incidents where harm is moderate or above.

What the chart tells us:
Verbal compliance for August is at 75% against a 100% target.

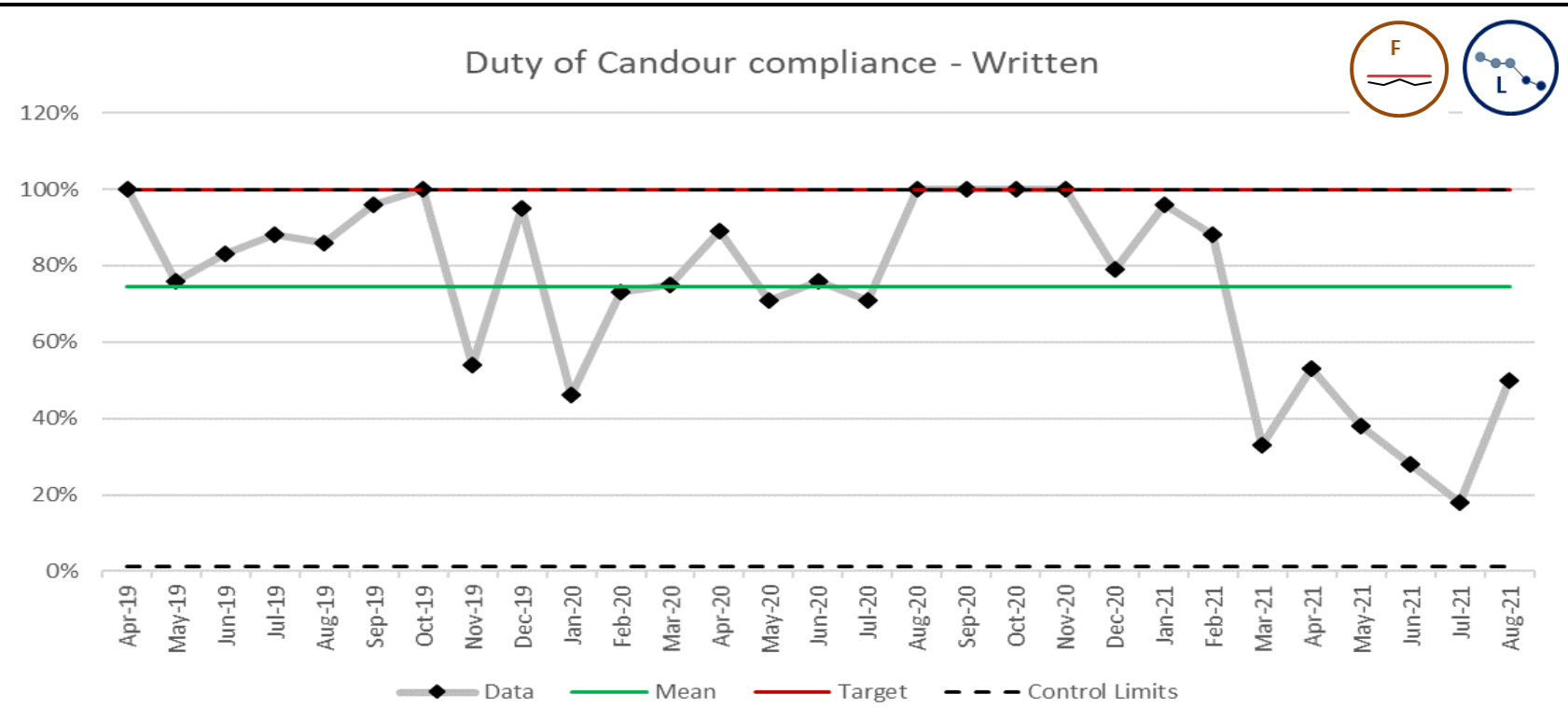
Issues:
Divisions are not recognising when duty of candour applies and should be carried out.
A lack of understanding of the purpose of the Duty of Candour.

Actions:
Central Governance team now notifying clinical teams when a moderate harm or above incident occurs – team sending DoC template letter with notification.
Weekly DOC compliance reports to Divisional Triumvirate

DoC training being sourced from external provider to increase number of trained individuals.

Mitigations:
Audits of DoC compliance to ensure the apologies are given even if the timeframe and therefore compliance has lapsed.

External training for DoC has now been identified and approved to support clinicians better understand the requirements.



Aug-21
50%
Variance Type
Metric is currently experiencing Special Cause Variation – low trend
Target
100%
Target Achievement
Metric is consistently failing the target
Executive Lead
Medical Director

Background:
Verbal and Written compliance with NHS Duty of Candour (DoC) which applies to all patient safety incidents where harm is moderate or above.

What the chart tells us:
Verbal compliance for August 2021 is at 50% against a 100% target.

Issues:
See issues on previous page – Duty of candour compliance – verbal.

Actions:
See actions on previous page – Duty of candour compliance – verbal.

Mitigations:
See mitigations on previous page – Duty of candour compliance – verbal.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

PERFORMANCE OVERVIEW – OPERATIONAL PERFORMANCE

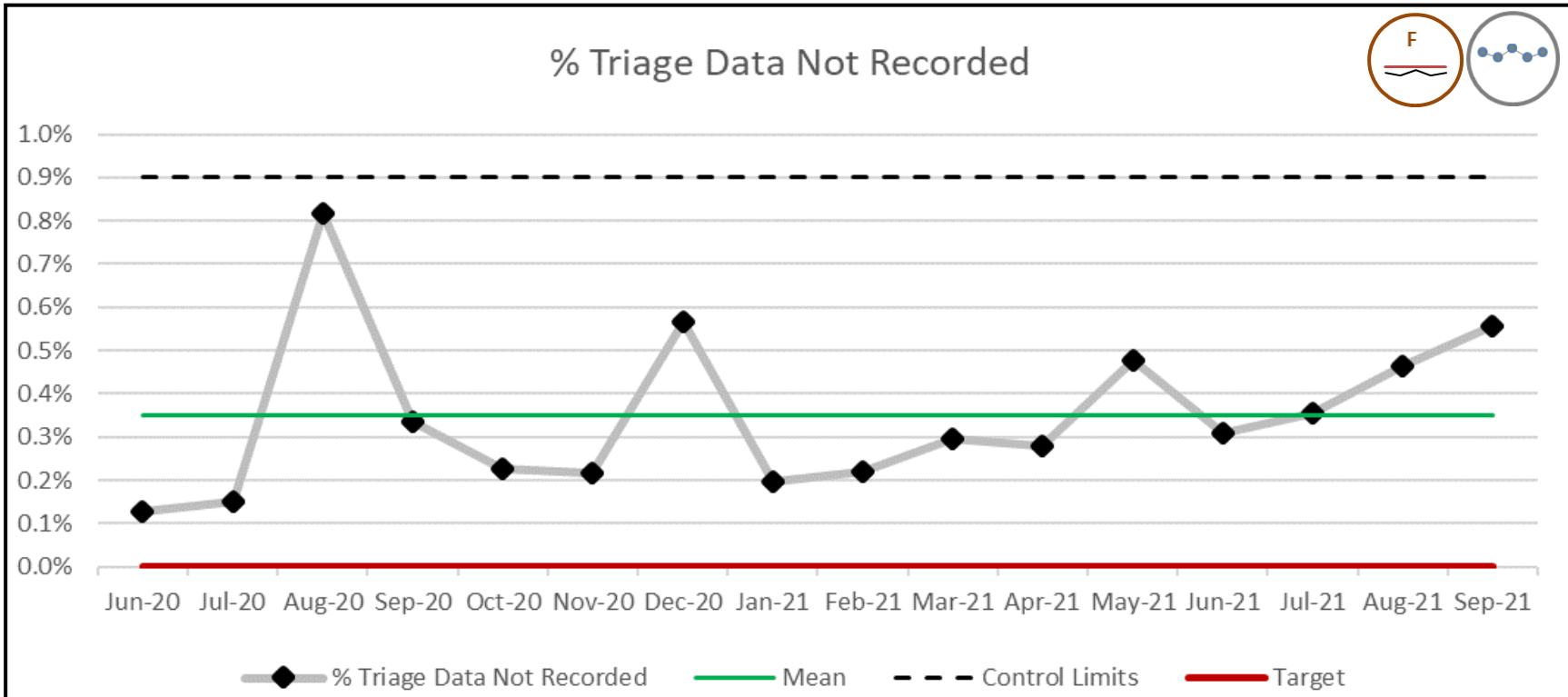
5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	Jul-21	Aug-21	Sep-21	YTD	YTD Trajectory	Latest Month Pass/Fail	Trend Variation	Kitemark
Improve Clinical Outcomes	% Triage Data Not Recorded	Effective	Patients	Chief Operating Officer	0%	0.36%	0.46%	0.56%	0.41%		F		
	4hrs or less in A&E Dept	Responsive	Services	Chief Operating Officer	83.12%	64.93%	66.96%	62.13%	68.59%	83.12%	F	B	
	12+ Trolley waits	Responsive	Services	Chief Operating Officer	0	9	12	71	96	0	F		
	%Triage Achieved under 15 mins	Responsive	Services	Chief Operating Officer	88.5%	83.62%	87.98%	82.60%	86.61%	88.50%	F		
	52 Week Waiters	Responsive	Services	Chief Operating Officer	0	797	1093		5058	0	F	A	
	18 week incompletes	Responsive	Services	Chief Operating Officer	84.1%	58.89%	56.85%		58.93%	84.10%	F		
	Waiting List Size	Responsive	Services	Chief Operating Officer	37,762	50,565	50,804		n/a	n/a	F	H	
	62 day classic	Responsive	Services	Chief Operating Officer	85.4%	60.73%	64.69%		62.82%	85.39%	F		
	2 week wait suspect	Responsive	Services	Chief Operating Officer	93.0%	83.07%	78.70%		79.95%	93.00%	F		
	2 week wait breast symptomatic	Responsive	Services	Chief Operating Officer	93.0%	20.59%	12.74%		11.33%	93.00%	F	B	
	31 day first treatment	Responsive	Services	Chief Operating Officer	96.0%	90.81%	89.36%		91.73%	96.00%	F		
	31 day subsequent drug treatments	Responsive	Services	Chief Operating Officer	98.0%	100.00%	100.00%		99.66%	98.00%	P		
	31 day subsequent surgery treatments	Responsive	Services	Chief Operating Officer	94.0%	77.78%	75.00%		79.65%	94.00%	F		
	31 day subsequent radiotherapy treatments	Responsive	Services	Chief Operating Officer	94.0%	95.24%	95.70%		96.87%	94.00%	P		
	62 day screening	Responsive	Services	Chief Operating Officer	90.0%	76.67%	63.49%		71.76%	90.00%	F	A	

PERFORMANCE OVERVIEW – OPERATIONAL PERFORMANCE

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	Jul-21	Aug-21	Sep-21	YTD	YTD Trajectory	Latest Month Pass/Fail	Trend Variation	Kitemark
Improve Clinical Outcomes	62 day consultant upgrade	Responsive	Services	Chief Operating Officer	85.0%	75.36%	79.07%		78.95%	85.00%	F		
	Diagnostics achieved	Responsive	Services	Chief Operating Officer	99.0%	66.35%			69.17%	99.00%	F	A	
	Cancelled Operations on the day (non clinical)	Responsive	Services	Chief Operating Officer	0.8%				1.57%	0.80%	F		
	Not treated within 28 days. (Breach)	Responsive	Services	Chief Operating Officer	0				24	0	F		
	#NOF 48 hrs	Responsive	Services	Chief Operating Officer	90%	86.36%	94.81%	88.46%	90.35%	90%	F		
	#NOF 36 hrs	Responsive	Services	Chief Operating Officer	TBC	74.24%	74.03%	73.08%	76.59%				
	EMAS Conveyances to ULHT	Responsive	Services	Chief Operating Officer	4,657	4,669	4,381	4,172	4,539	4,657	P		
	EMAS Conveyances Delayed >59 mins	Responsive	Services	Chief Operating Officer	0	568	629	923	494	0	F		
	104+ Day Waiters	Responsive	Services	Chief Operating Officer	10	48	67	0	253	50	P		
	Average LoS - Elective (not including Daycase)	Effective	Services	Chief Operating Officer	2.80	3.21	2.81	2.30	2.76	2.80	P		
	Average LoS - Non Elective	Effective	Services	Chief Operating Officer	4.50	4.43	4.70	4.72	4.44	4.5	F		
	Delayed Transfers of Care	Effective	Services	Chief Operating Officer	3.5%	Submission suspended				3.5%			
	Partial Booking Waiting List	Effective	Services	Chief Operating Officer	4,524	15,193	16,098	16,634	15,634	4,524	F	B	
	Outpatients seen within 15 minutes of appointment	Effective	Services	Chief Operating Officer	70.0%	40.5%	43.0%		42.00%	70.00%	F		
	% discharged within 24hrs of PDD	Effective	Services	Chief Operating Officer	45.0%	39.9%	42.1%		41.83%	45.00%	F		

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Sep-21
0.56%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
0%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:
Percentage of triage data not recorded.

What the chart tells us:
The recording of triage compliance percentage is 0%
September reported 0.56% data not recorded
September demonstrated a 0.10% negative variation compared with August.
This metric is below target

Issues:
- Timely inputting of data.
- Reduced Manchester Triage trained staff (MTS) to consistently operate two triage streams, especially out of hours.
- Adhoc gaps in the provision of Pre-Hospital Practitioners (PHP).
- Increased staffing gaps and skill mix issues
- Increased demand has been cited as a causation factor.
- September experienced IT failures affecting Medway

Actions:
- Increased access to MTS training and time to input data.
- Increased registrant workforce to support 2 triage streams to be in place. Still experiencing some issues.
- To move to a workforce model with Triage dedicated registrants and remove the dual role component.

Mitigations:
- Earlier identification of recording delays via Emergency Care 'Team's chat'.
- Increased nursing workforce following a targeted recruitment campaign has been successful and supernumerary period is coming toan end.
- Twice daily staffing reviews to ensure appropriate allocation of the ED workforce to meet this indicator.
- The Urgent and Emergency Care Clinical Business Unit undertake daily interventions regarding compliance (recording and undertaking).

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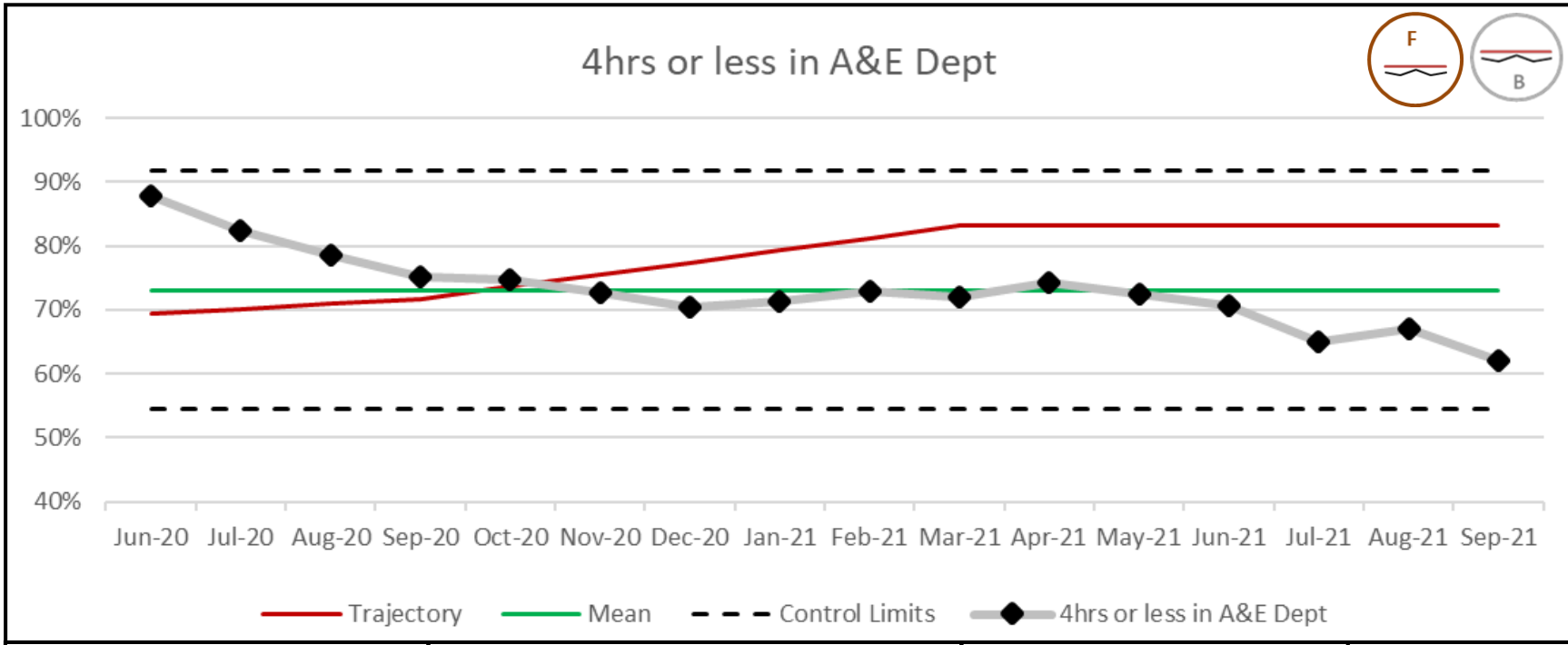
NHS United Lincolnshire Hospitals NHS Trust



Sep-21
62.13%
Variance Type
Metric is currently experiencing Special Cause Variation – below the mean
Target
83.12%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

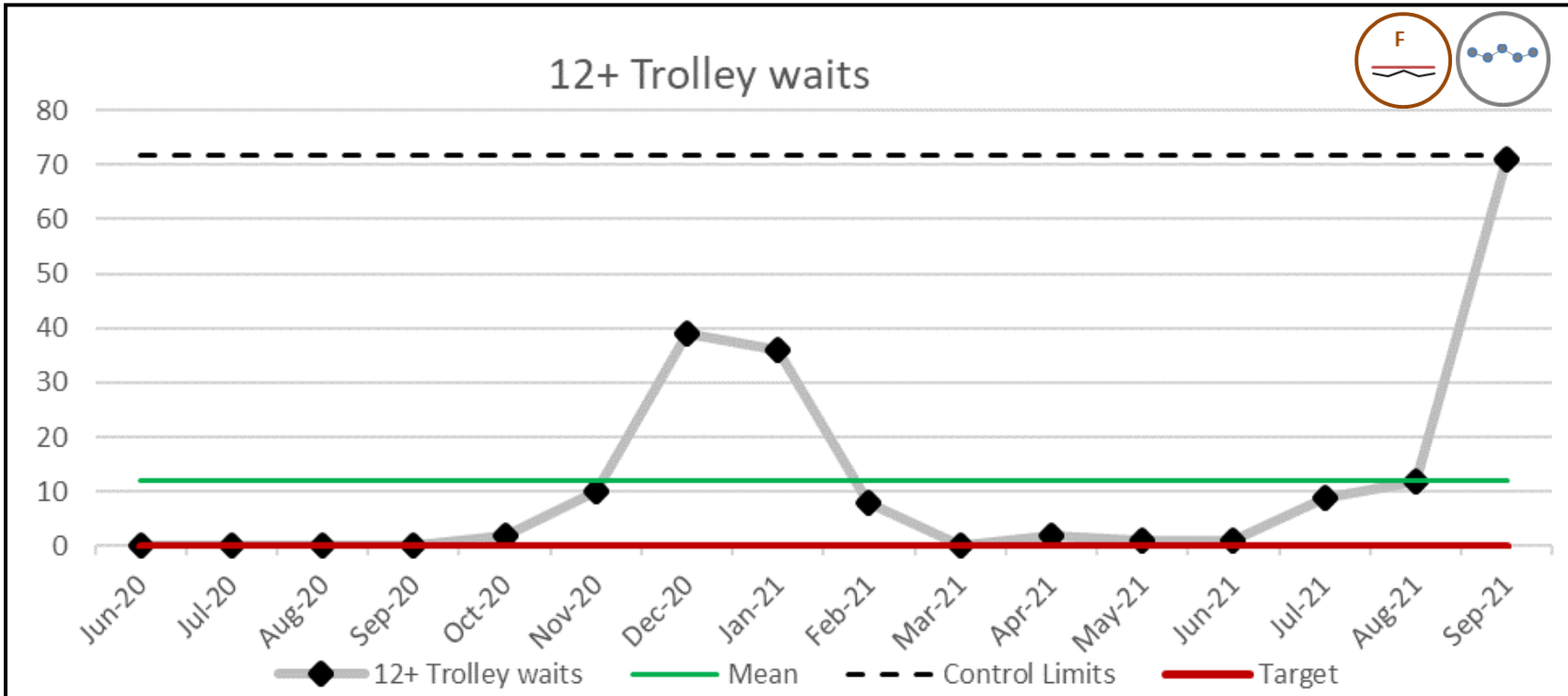
Background:
The national 4-hour standard is set at 95%. The agreed trajectory for compliance for ULHT is set at 83.12%

What the chart tells us:
The current 4-hour transit target performance for September was 62.13% which is 20.99% below the agreed target.
September out turned at 62.13% compared to 66.96% in August. A 4,83% negative variance compared to August.

Issues:
The Emergency Departments saw a 0.18% decrease in attendances in September 2021 (31 patients) compared to August 2021. A comparison to September 2019 denotes an increase of 7.77%. 17,386 combined attendances (ED and UTC) in September compared to 17,417 combined attendances in August.
Inadequate discharges to meet the admission demand remains an issue.
Ongoing medical and nursing gaps that were not Emergency Department specific.
Of the 17,386 recorded attendances for type 1 and type 3 across the Trust, type 1 attendances accounted for 11,688 and type 3 accounted for 5,698. This reduction on type 1 and type 3 attendances is across all 3 acute sites.

Actions:
Reducing the burden placed upon the Emergency Departments further will be though the continued development of Same Day Emergency Care (SDEC).
The re-instating of the Frailty Assessment Unit (FAU) and Surgical Ambulatory Unit (SAU at LCH will support reducing the burden
Maximising the Right to Reside (R2R) information to ensure timely and effective discharges for all pathway zero patients.
A twice daily report is sent to all Divisions. Twice daily System calls are in place to maximise pathway 1, 2, and 3 patients. This is led by the Lead Nurse for Discharge in partnership with System Partners. Work is now in train to apply a zero tolerance to >24hrs exit delays for medically optimised patients.

Mitigations:
The mitigations are repetitive but still relevant.
EMAS have enacted a targeted admission avoidance process.
The Discharge Lounge at LCH and PHB are now operating a 24/7 service provision to release the burden placed on the Emergency Departments in terms of patients awaiting AIR/CIR and also transport home.
Increased CAS and 111 support especially out of hours.
EPIC to Specialty Consultant reviews to ensure DTA applied appropriately. Implementation of STRAP (Short Term Rescue A&E Protocol) on both the LCH and PHB sites to de-escalate.
Clinical Operational Flow Policy adherence and compliance and Full Capacity Protocol activation when OPEL 3 reached.



Sep-21
71
Variance Type
Metric is currently experiencing Common Cause Variation
Target
0
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:

There is a zero tolerance for greater than 12-hour trolley waits. These events are reported locally, regionally and nationally.

What the chart tells us:

September experienced 71 12-hour trolley wait breaches. This equates to 0.6% of all type 1 attendances for September.

Issues:

Sub-optimal discharges to meet the known emergency demand. All reportable 12hr trolleys were either associated with no available beds, patient deterioration or failure to transfer. The 12hr trolleys were anticipated against flow predictions. There remains some complacency in terms of 12hr trolley waits but this is being addressed by the Deputy Chief Operating Officer and Divisions.

Actions:

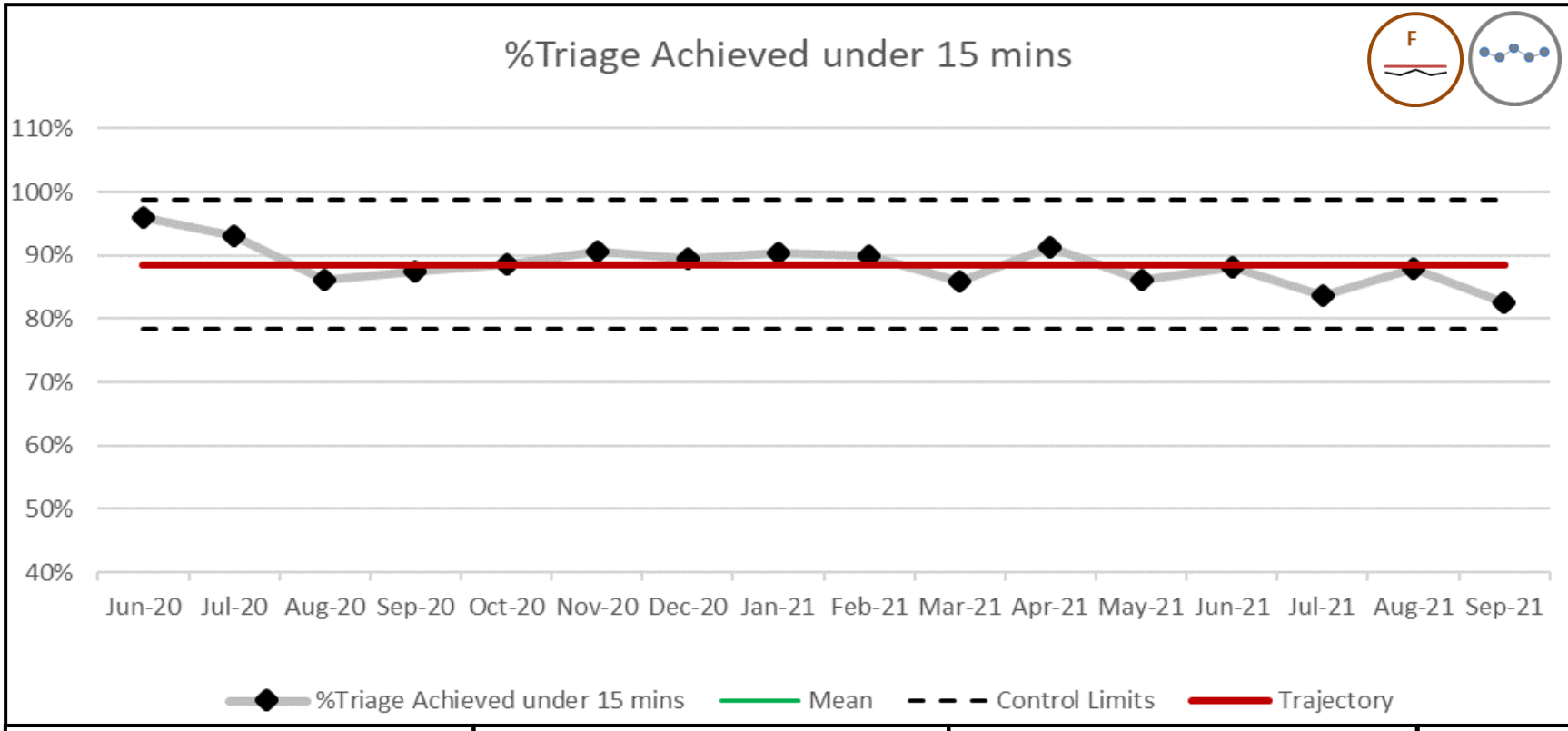
Every reported 12hr trolley wait is subject to an immediate clinical review to ascertain whether it is deemed a 'true' 12hr trolley wait breach and is signed off by the Clinical Lead for ED. The Trust continues to work closely with national regulators in reviewing and reporting these breaches. A timeline for the 12 trolley waits with the greatest total time in ED is submitted to NHSe/i at 11am the next day by the Deputy Chief Operating Officer. A daily review of all potential 12hr trolley waits is in place.
System Partners and Regulators remain actively engaged and offer practical support in situational escalations.
Expectation of securing10 discharges by 10am and 35% of all discharges before midday. All confirmed discharges must go to the discharge lounges unless a clinical exception is agreed.

Mitigations:

All potential DTA risks are escalated at 8hrs to the Deputy Chief Operating Officer/ On Call Manager and rectification plans are agreed with the UEC CBU.
A System agreement is remains in place to staff the Discharge Lounges 24/7 to reduce the number of patients in the Emergency Departments that are deemed 'Medically Optimised' that need onward non acute placement/support. . This has demonstrated a positive impact
All decisions to admit have to be approved by the EPIC (Emergency Physician In Charge) with the relevant On Call Team.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Sep-21
82.60%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
88.5%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:
Percentage of triage achieved under 15 minutes.

What the chart tells us:
The compliance against this target is 88.50%.
September outturn was 82.60% which is 5.9% below the agreed target.
September demonstrated a deterioration of 5.38% compared with August.

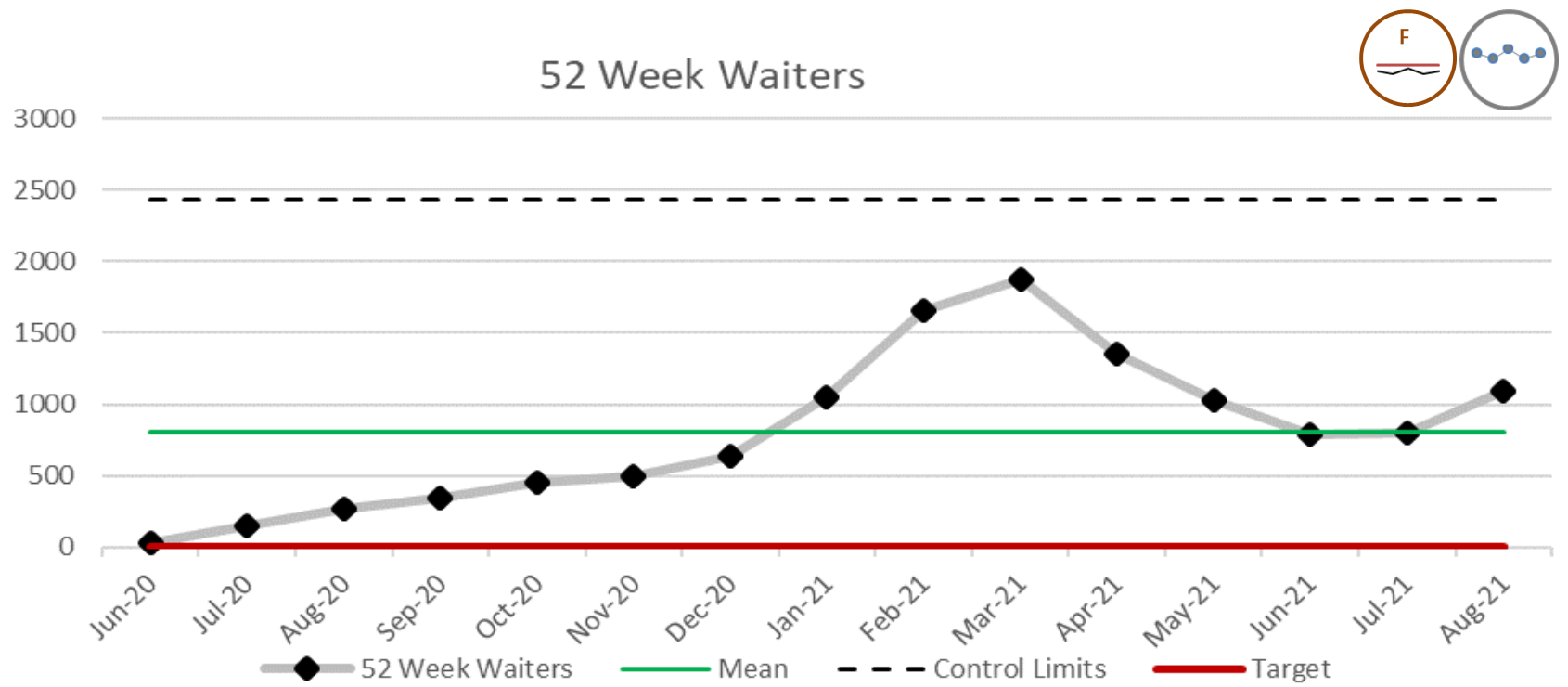
Issues:
- Reduced MTS trained staff available per shift to ensure 2 triage streams in place 24/7.
- Dual department roles. For example, the second triage nurse is also the allocated paediatric trained nurse.
- Inability to maintain agreed staffing template, particularly registrants, due high to sickness and agency cancellations at short notice.
- The ability to effectively maintain two triage streams continues to be mainly out of hours.

Actions:
Increased access to MTS training.
Increased registrant workforce to support 2 triage streams to be in place via Emergency Department recruitment campaign.
To move to a workforce model with Triage dedicated registrants and remove the dual role component.
This metric forms part of the Emergency Department safety indicators and is monitored/scrutinised at 4 x daily Capacity and Performance Meetings.

Mitigations:
The Senior Nurse Leads maintain oversight and support in periods of either high attendance demand or when the second triage stream is compromised due to duality of role issues.
Early escalation and rectification are also managed through the Emergency Department Teams Chat.
A twice daily staffing meeting staffing meeting in in operations 7 days a week and a daily staffing forecast is also in place.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Aug-21
1093
Variance Type
Metric is currently experiencing Special Cause Variation – above the mean
Target
0
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:
Number of patients waiting more than 52 weeks for treatment.

What the chart tells us:
The Trust reported 1093 incomplete 52 week breaches for August. An increase of 296 from July.
The number of 52 week breaches has been steadily reducing since March 2021 but has gone up considerably in August.

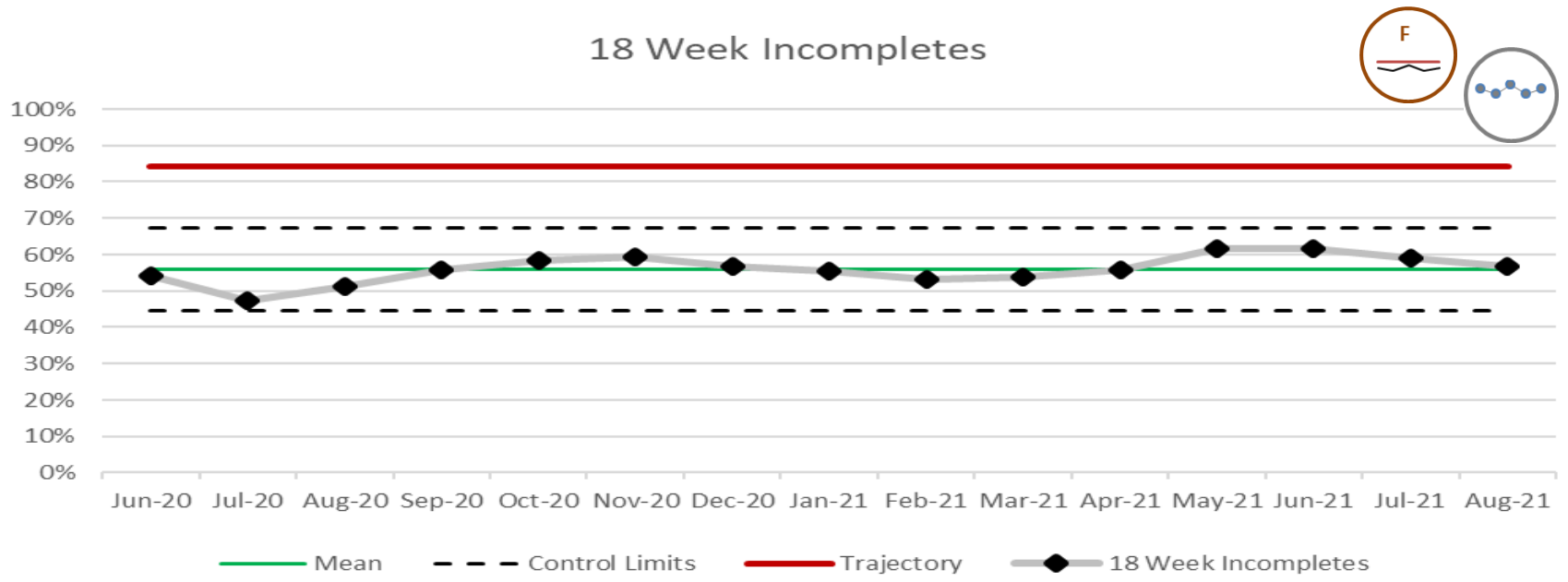
Issues:
Due to capacity challenges, together with a lack of pre-assessment appointments, the admitted position remains challenging. Wave 3 is also impacting on service delivery, which will in turn, detrimentally effect the 52 week position.

Actions:
Pre op assessment service is being reviewed to provide more capacity.
All patients waiting more than 52 weeks are required to have an RCA and harm review completed. The longest waiting patients are treated alongside urgent patients.
The harm reviews are also discussed at the Clinical Harms Oversight Group, chaired by the COO.

Mitigations:
Non admitted patients continue to be reviewed, utilising all available media.
Long waiting patients are reviewed at the weekly PTL meeting.
Patients waiting 78 weeks and above are individually monitored and tracked for their urgency, wait time and priority code.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Aug-21
56.85%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
84.1%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background

Percentage of patients on an incomplete pathway waiting less than 18 weeks.

What the chart tells us:

There is significant backlog of patients on incomplete pathways. August saw RTT performance of 56.85% against a 92% target, which is 2.04% down on July.

Issues:

Performance is currently below trajectory and standard. The five specialties with the highest number of 18 week breaches at the end of the month were:

- ENT – 3479 (increased by 124)
- Ophthalmology – 2731 (reduced by 270)
- Dermatology – 2203 (Increased by 253)
- Gynaecology – 1947 (Increased by 48)
- Maxillo-Facial Surgery + Orthodontics + Oral Surgery -1733 (Increased by 102)

Actions:

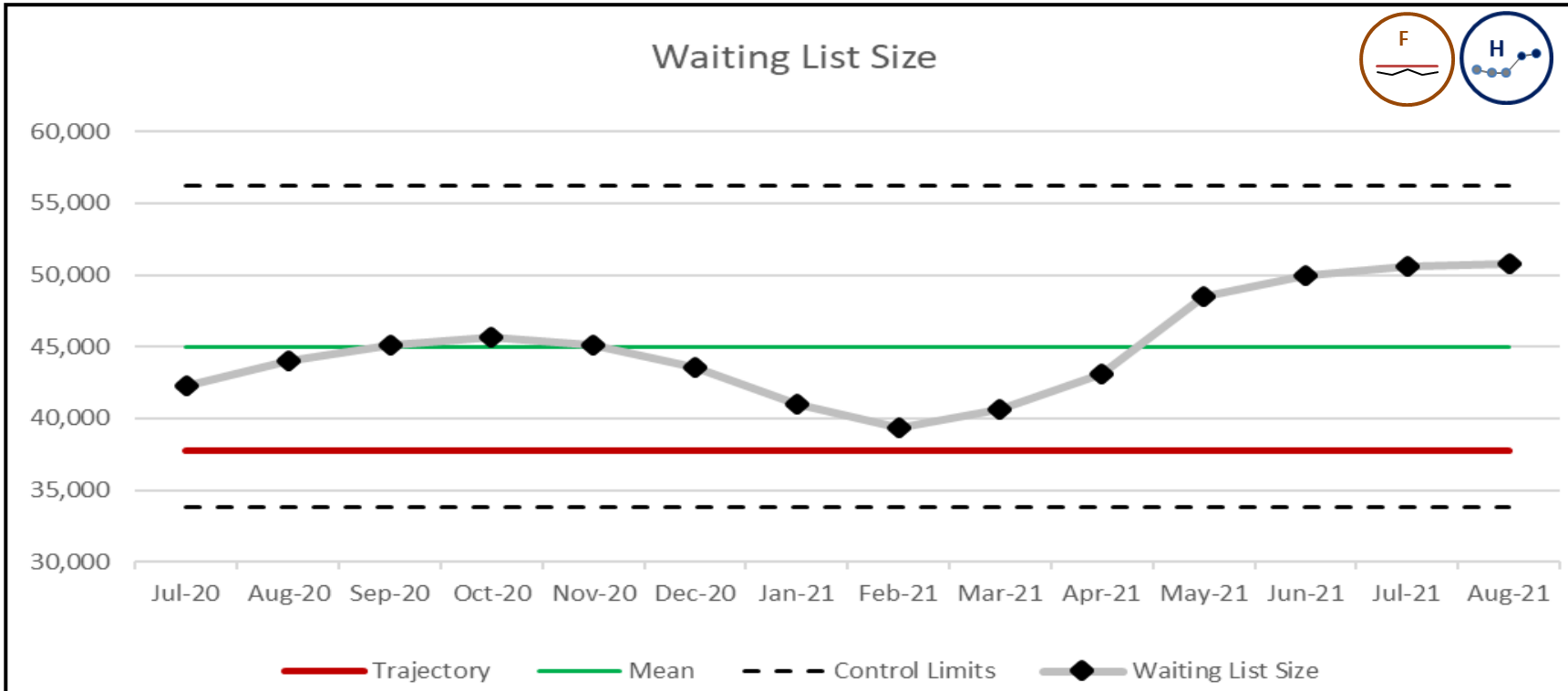
Planned routine elective work remains challenging, with available capacity being focussed on cancer and patients classified as being P2.

Mitigations:

Patient pathways are tracked and discussed at the weekly PTL meeting; which having been stood down due to site pressures, is being reinstated in October.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Aug-21
50,804
Variance Type
Metric is currently experiencing Common Cause Variation
Target
37,762
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:
The number of patients currently on a waiting list.

What the chart tells us:
Overall waiting list size has increased from July, with August showing an increase of 239 to 50,804.
The incomplete position for August 2021 has increased by approximately 12,778 more than the reported pre pandemic size in January 2020.

Issues:
Patients previously on the ASI list have been added to the open referrals list; this caused an increase in the overall waiting list size which will continue to be booked in clinical priority and chronological order.
The top five specialties showing an increase in total incomplete waiting list size from July are:

- ENT +164
- Gastroenterology + 289
- Cardiology + 92
- Dermatology + 95
- Respiratory Medicine +73

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

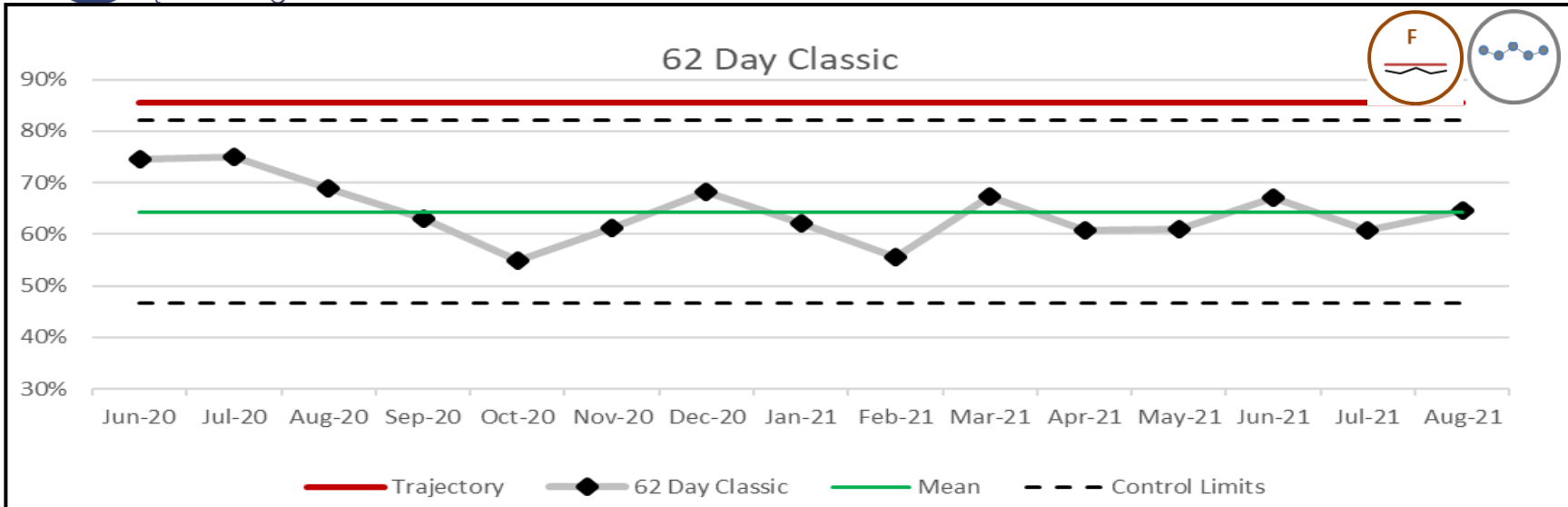
- Trauma & Orthopaedics -264
- Ophthalmology -529
- Community Paediatrics -32
- Nephrology – 47
- Neurology - 59

The Trust reported 5,189 over 40 week waits; an increase of 763 from July. The numbers of patients waiting over 26 weeks increased by 857.

Actions/Mitigations:
The longest waiting patients continue to be monitored and discussed at the weekly PTL meeting, to ascertain if there are any issues preventing the patient from being booked. Capacity issues are also discussed in the RTT Recovery and Delivery meeting, (which alongside the PTL meeting is being reinstated in October) to help find solutions.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Aug-21
64.69%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
85.4%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

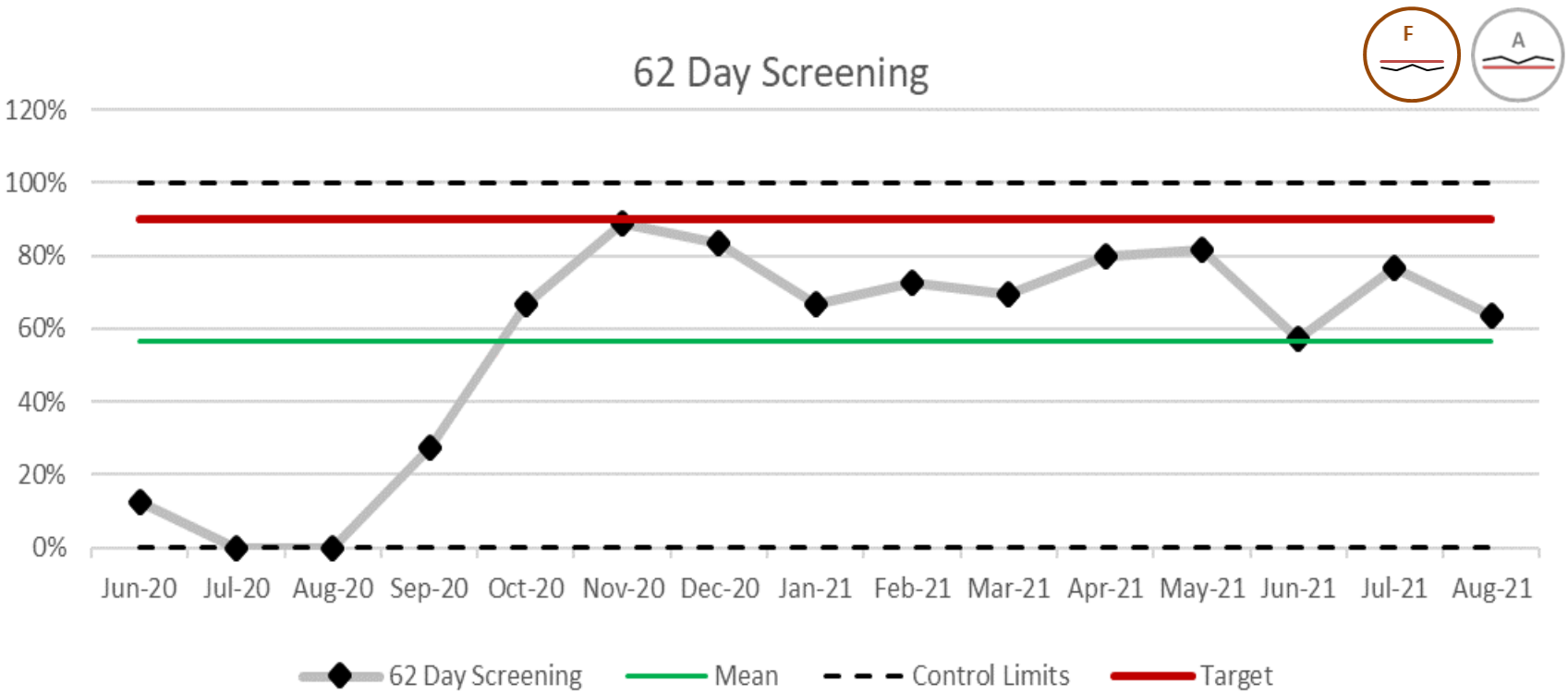
Background:
Percentage of patients to start a first treatment within 62 days of a 2ww GP referral.

What the chart tells us:
We are currently at 64.69% against an 85.4% target.

Issues:
Patient engagement in diagnostic process (reluctance to visit hospitals due to perceived COVID-19 risk, including those waiting for vaccines or the 3 week 'effectiveness' period). This is continuing to reduce.
Reduced clinic throughput due to social distancing / IPC requirements, especially in waiting areas. Patient acceptance & compliance with swabbing and self-isolating requirements. Patients not willing to travel to where our service and / or capacity is.
Managing backlogs significantly in excess of pre-COVID levels for Colorectal, Urology, Gynaecology, Lung, and Head & Neck.
Lost treatment capacity due to short notice cancellation of patients (unwell on the day of treatment or day before), not allowing time to swab replacement patients.

Actions:
28 Day standard identified as Trust's cancer performance work stream in the Integrated Improvement Program for 2021-22. Two substantive Medical Oncologists were recruited, one of which was due to start in November 2021, but unfortunately both candidates have withdrawn. Currently, there are 4 Locum Oncologist posts out to advert.
Dedicated admin resource has been identified within the Colorectal, Urology, Breast, Gynae, UGI and Lung CBU's to support clinical engagement. Following this model, funding has also been identified a navigator in the Head & Neck CBU whilst a second navigator post within the Colorectal CBU has been identified. The recruitment process is underway.
Endoscopy are in the early stages of undertaking a review around the Bowel Cancer Screening age extension and endoscopy staffing. The intention is to increase the clinical endoscopist workforce with less reliance on consultants and also to increase administrative support by converting fixed term into substantive posts. Work to enhance the early identification of patients requiring Pre-Diagnosis CNS support is ongoing.

Mitigations:
Theatre capacity is returning to Pre-covid levels. A review of colorectal theatre list scheduling in order to better align with clinician availability continues and Grantham Theatres have now returned to undertaking suitable Level 1 colorectal work. Work continues within the Surgery Division in order to access sufficient HDU post op care via the weekly meetings and to ensure that theatre capacity is fully utilised once full pre-op capacity returns.



Aug-21
63.49%
Variance Type
Metric is currently experiencing Special Cause Variation – above the mean
Target
90%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

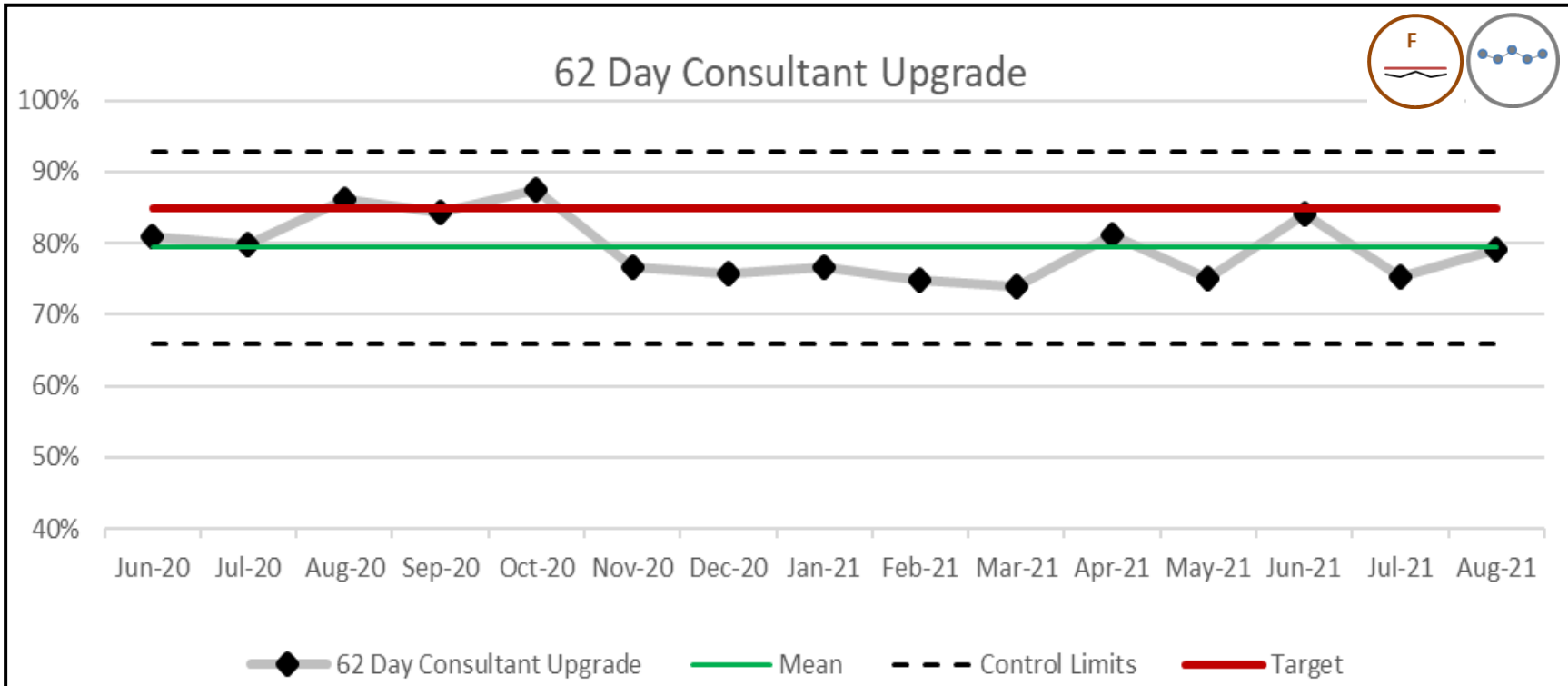
Background:
Percentage of patients to start a first treatment within 62 days of referral from an NHS cancer screening service.

What the chart tells us:
We are currently at 63.49% against a 90% target.

Issues:
See issues on previous page – 62 day classic.

Actions:
See actions on previous page – 62 day classic.

Mitigations:
See mitigations on previous page – 62 day classic.



Aug-21
79.07%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
85%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:
Percentage of patients to start a first treatment within 62 days of a consultant's decision to upgrade their priority.

What the chart tells us:
We are currently at 79.07% against an 85% target.

Issues:
See issues on previous page – 62 day classic.

Actions:
See actions on previous page – 62 day classic.
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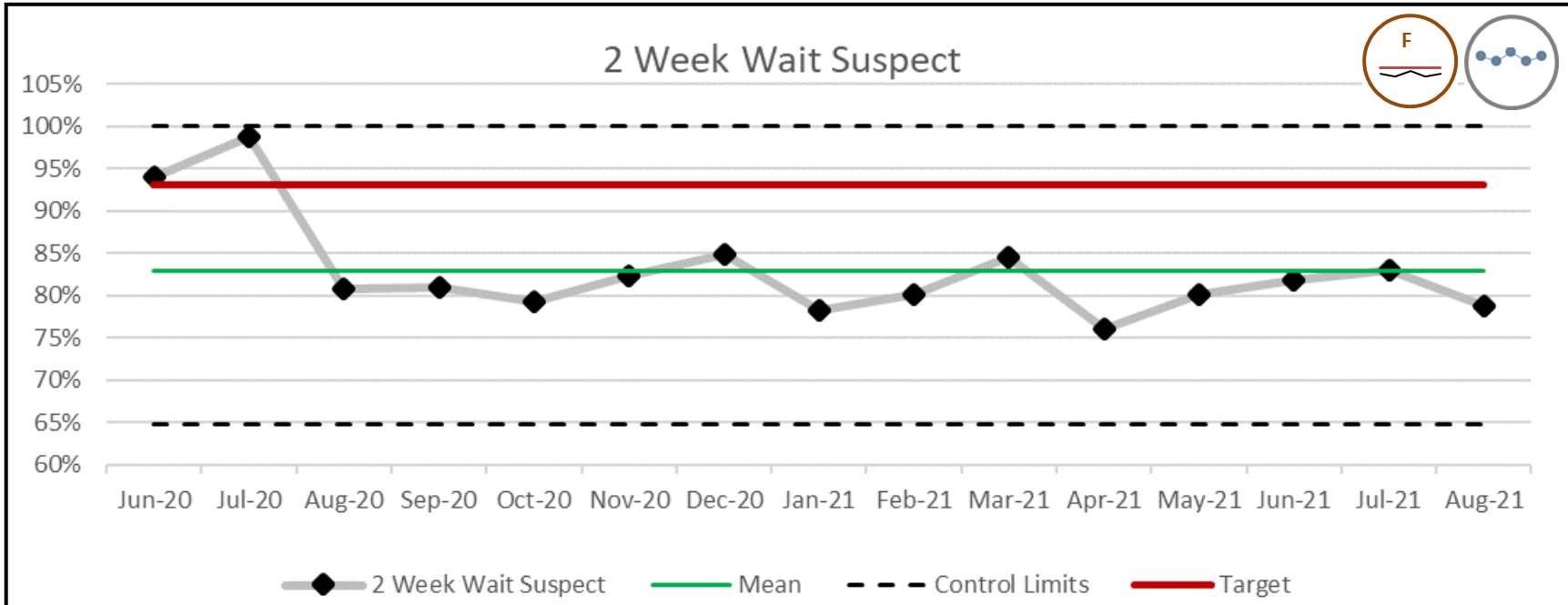
Mitigations:
See mitigations on previous page – 62 day classic.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Aug-21
78.70%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
93%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

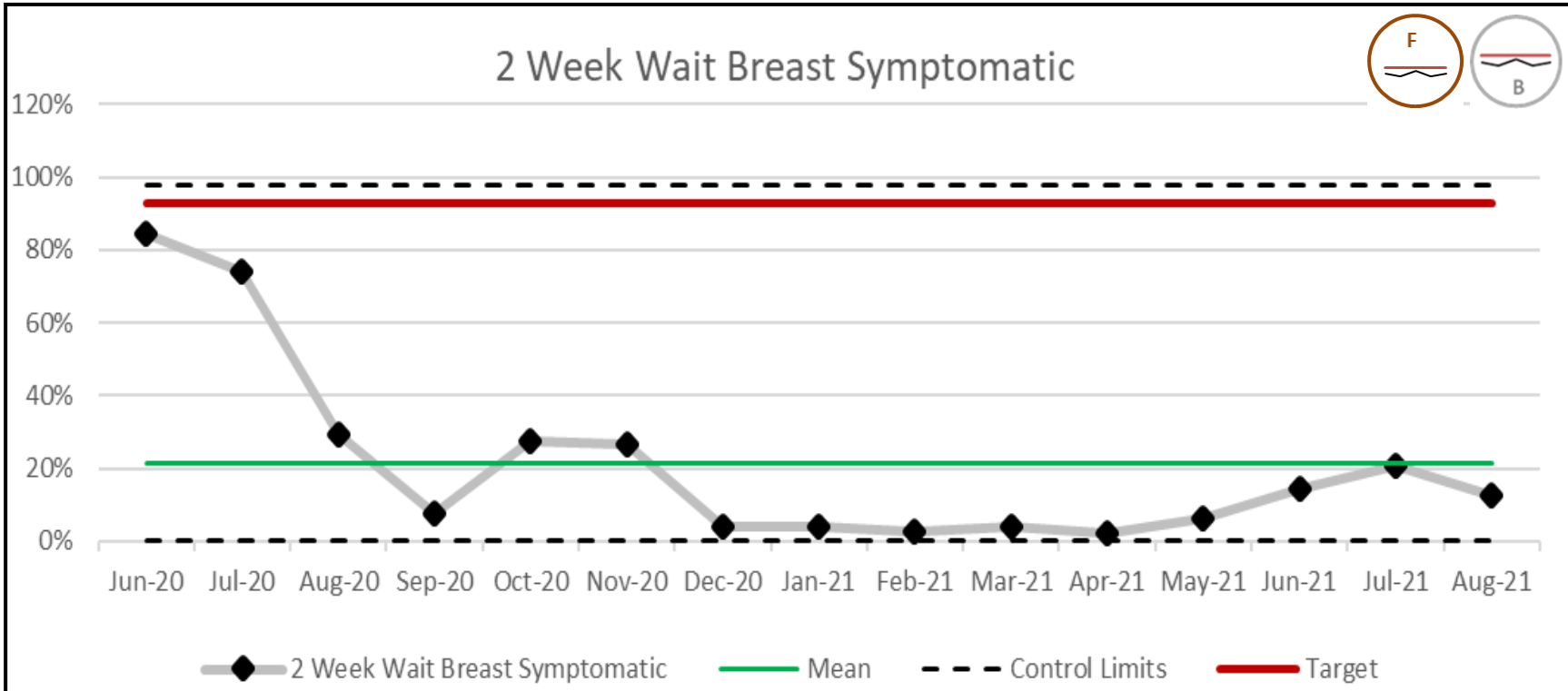
Background:
Percentage of patients seen by a specialist within two weeks of 2ww referral for suspected cancer.

What the chart tells us:
We are currently at 78.70% against a 93% target.

Issues:
The Trust's 14 Day performance continues to be significantly impacted by the current Breast Service One-Stop appointment alignment issues - 58% of the Trust's 14 Day breaches were within that tumour site. The other tumour sites that considerably under-performed include Lung (50%), Gynaecology (52.8%), Urology (83.8%), Upper GI (85.0%), and Head & neck (86.7)%, with Brain only narrowly missing the target (90.9%). All other tumour sites achieved the standard.
Reduced clinic throughput due to social distancing / IPC requirements, especially in waiting areas. Patient acceptance & compliance with swabbing and self-isolating requirements. Patients not willing to travel to where our service and / or capacity is.

Actions:
The Trust is actively seeking to secure the commencement of an Upper GI direct access pathway by the end of December 2021, while a direct access pathway for gynaecology ultrasound is planned is planned to commence pending confirmation and recruitment of SDF posts. A scoping exercise is underway in respect of the bladder and testicular pathway – this includes a direct access pathway and haematuria one stop clinics. Clinical sign-off took place in June and is planned to be in place by the end of October. Recruitment of a new diagnostic ACP is underway to improve capacity in the Urology diagnostic clinics. Work to enhance the early identification of patients requiring Pre-Diagnosis CNS support is ongoing.

Mitigations:
Further respiratory consultant posts will secure lung clinic capacity and support the pilot to appoint lung patients within 48 hours – one Consultant post commenced in August, unfortunately another has withdrawn from the recruitment process.
Breast clinic capacity has now been restored to pre-COVID levels and additional clinics to clear the backlog are being sought and will continue to be until the backlog is cleared. A mastalgia pathway is being worked up with primary care and system partners which has the potential to reduce inbound referrals by circa 15%



Aug-21
12.74%
Variance Type
Metric is currently experiencing Special Cause Variation – below the mean
Target
93%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:
Percentage of patients urgently referred for breast symptoms (where cancer was not initially suspected) seen within two weeks of referral.

What the chart tells us:
We are currently at 12.74% against a 93% target.

Issues:
The 14 Day Breast Symptomatic has been affected by the same impact of the Breast Service One-Stop appointment alignment issues. Reduced clinic throughput due to social distancing / IPC requirements, especially in waiting areas.

Actions:
A comprehensive review of Breast Services is ongoing following the final report issued by NHSI support.

Mitigations:
Breast clinic capacity has now been restored to pre-COVID levels and additional clinics to clear the backlog are being sought and will continue to be until the backlog is cleared. A mastalgia pathway is being worked up with primary care and system partners which has the potential to reduce inbound referrals by circa 15%.

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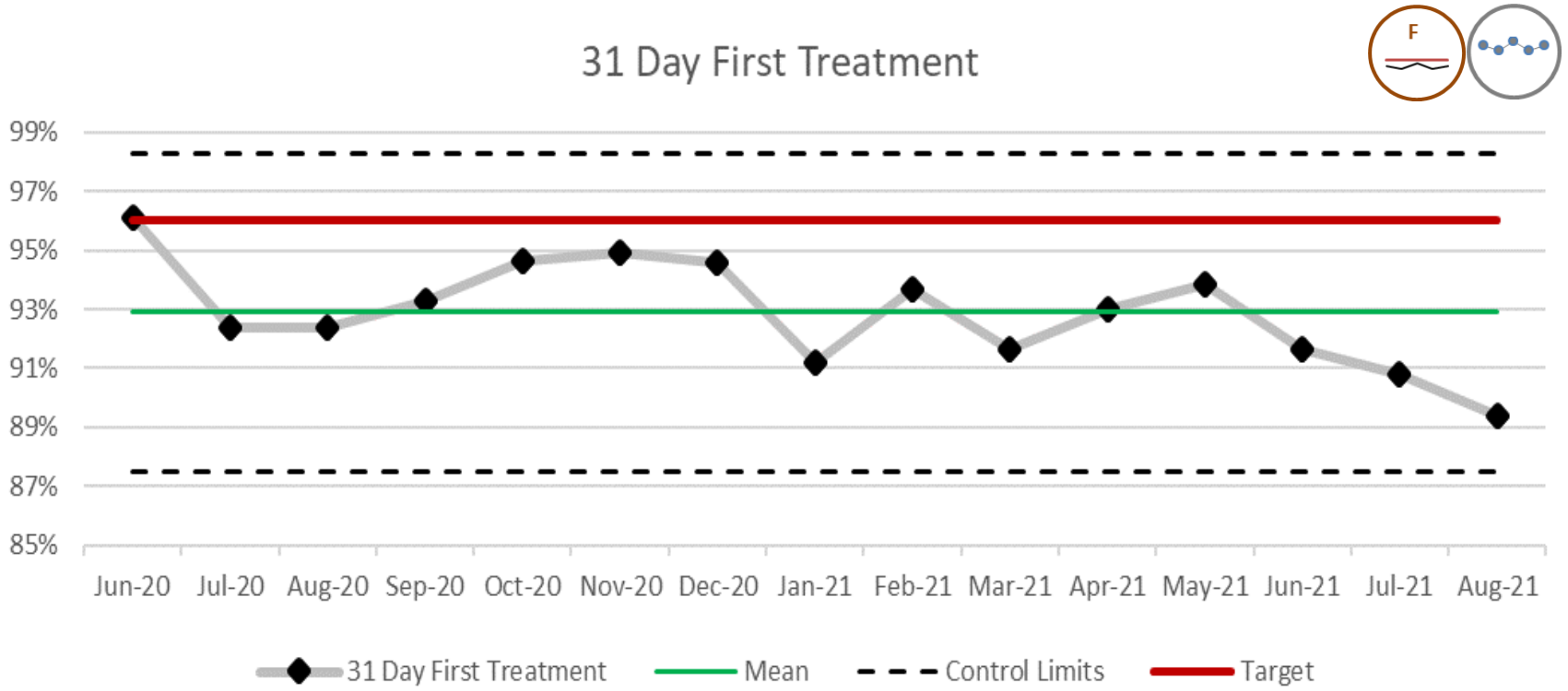

Aug-21
89.36%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
96%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:
Percentage of patients treated who began first definitive treatment within 31 days of a Decision to Treat.

What the chart tells us:
We are currently at 89.36% against a 96% target.

Issues:
The failure of the 31 Day standards was primarily due to the impact of COVID (the reduction in theatre capacity). Reduced theatre capacity across the Trust, all Specialties vying for additional sessions.

Actions:
Two substantive Medical Oncologists were recruited, one of which was due to start in November 2021, but unfortunately both candidates have withdrawn. Currently, there are 4 Locum Oncologist posts out to advert.

Mitigations:
A review of colorectal theatre list scheduling in order to better align with clinician availability continues, and Grantham Theatres have now returned to undertaking suitable Level 1 colorectal work. Work continues within the Surgery Division in order to access sufficient HDU post op care via the weekly meetings and to ensure that theatre capacity is fully utilised once full pre-op capacity returns.

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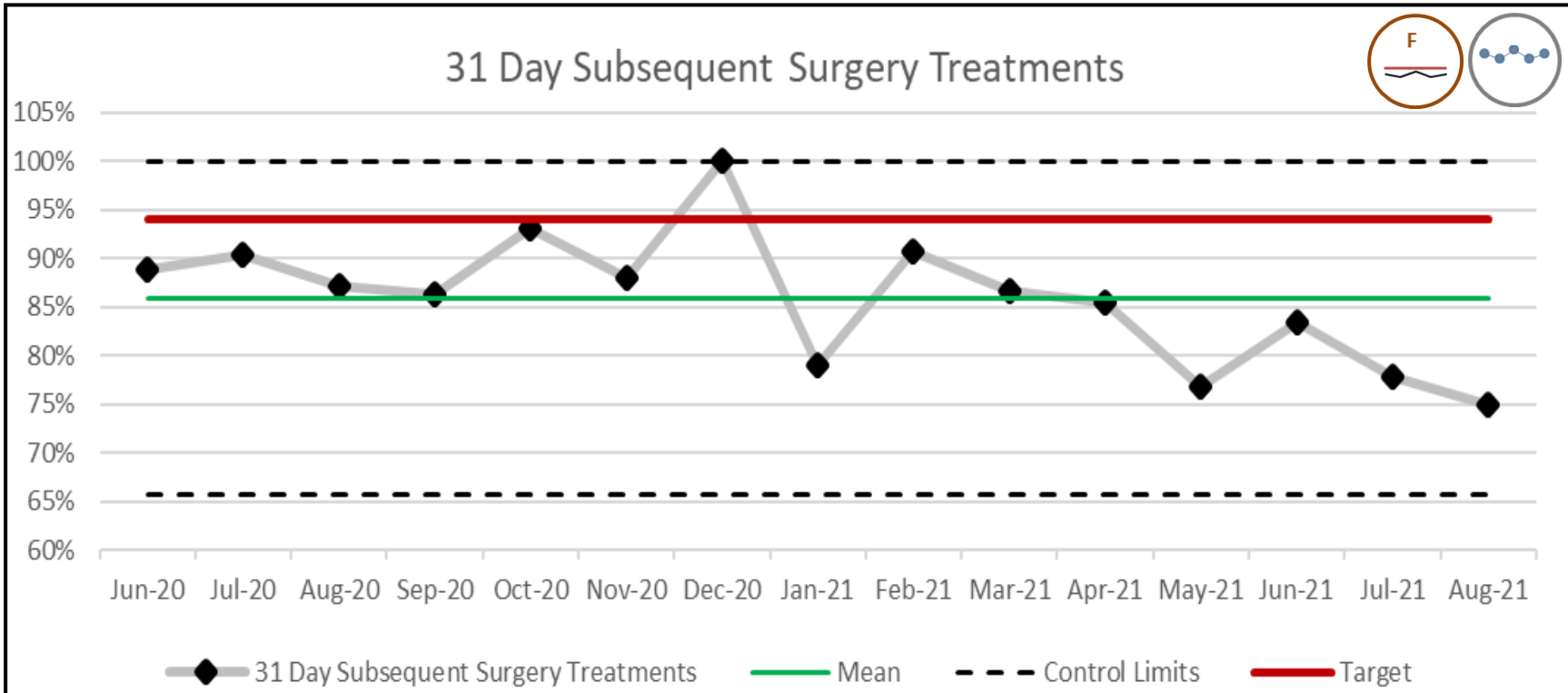

Aug-21
75.00%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
94%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:
Percentage of patients who began treatment within 31 days where the subsequent treatment was surgery.

What the chart tells us:
We are currently at 75.00% against a 94% target.

Issues:
The failure of the 31 Day standards was primarily due to the impact of COVID (the reduction in theatre capacity).
For the subsequent standards the Trust was successful in the Drug and Radiotherapy standards, only failing in the surgery standard.
Reduced theatre capacity across the Trust, all Specialties vying for additional sessions.

Actions:
See actions on previous page – 31 day first treatment.

Mitigations:
See mitigations on previous page – 31 day first treatment.

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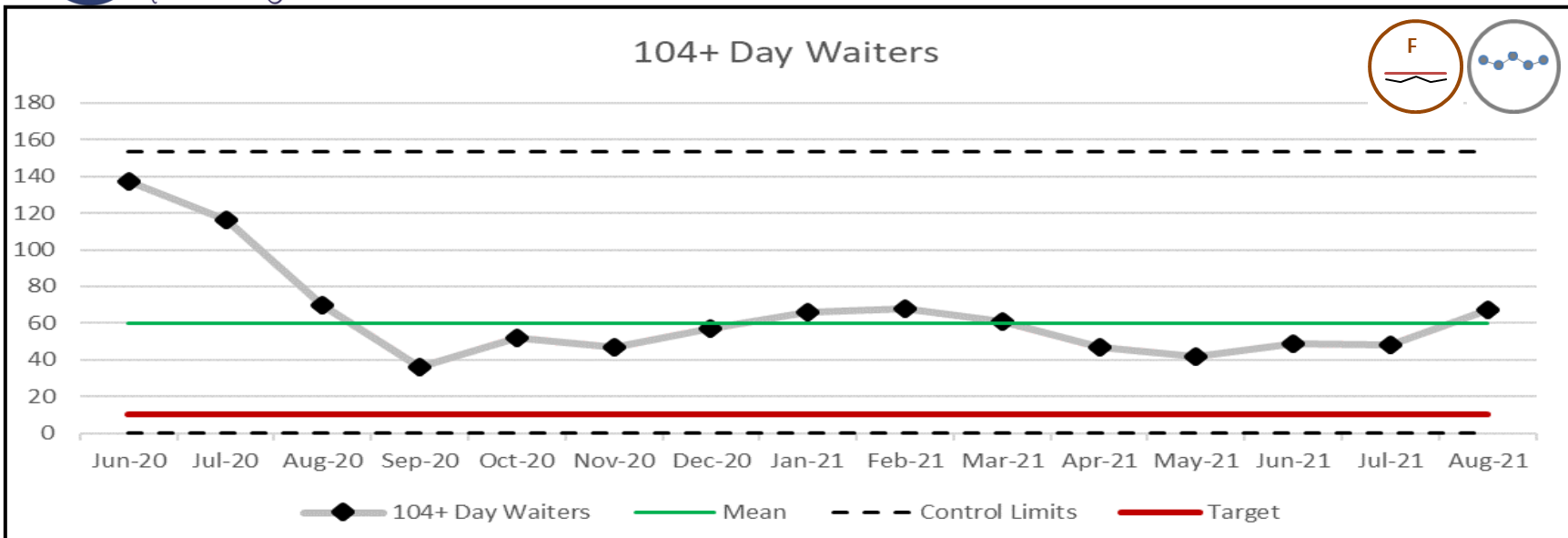

Aug-21
67
Variance Type
Metric is currently experiencing Common Cause Variation
Target
10
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:
Number of cancer patients waiting over 104 days.

What the chart tells us:
As of 8th of October, the 62 Day backlog is at 416 patients. The agreed target is <40.
As of 8th October the 104 Day backlog is at 77 patients. The agreed target is <10.
The current position by tumour site is as follows:-
46 Colorectal, 9 Urology, 6 Head & Neck, 4 each Lung and Upper GI, 3 Gynaecology, 2 each Breast and Haem, 1 Skin

Issues:
Patient engagement in diagnostic process (reluctance to visit hospitals due to perceived COVID-19 risk, including those waiting for vaccines or the 3 week 'effectiveness' period) – this is starting to improve.
Reduced clinic throughput due to social distancing / IPC requirements, especially in waiting areas.
Patient acceptance & compliance with swabbing and self-isolating requirements. Patients not willing to travel to where our service and / or capacity is.
Reduced theatre capacity across the Trust, all Specialties vying for additional sessions. Managing backlogs significantly in excess of pre-COVID levels for Colorectal, Urology, Head & Neck, Lung and Gynaecology. Lost treatment capacity due to short notice cancellation of patients (unwell on the day of treatment or day before), not allowing time to swab replacement patients. Approximately 12% of these patients require support from the Pre-Diagnosis CNS as they have mental or social care needs that have the potential to significantly impact on the length of their pathway.

Actions:
28 Day standard identified as Trust's cancer performance work stream in the Integrated Improvement Program for 2021-22. Two substantive Medical Oncologists were recruited, one of which was due to start in November 2021, but unfortunately both candidates have withdrawn. Currently, there are 4 Locum Oncologist posts out to advert.
Dedicated admin resource has been identified within the Colorectal, Urology, Breast, Gynae, UGI and Lung CBU's to support clinical engagement. Following this model, funding has also been identified a navigator in the Head & Neck CBU whilst a second navigator post within the Colorectal CBU has been identified. The recruitment process is underway.
Endoscopy are in the early stages of undertaking a review around the Bowel Cancer Screening age extension and endoscopy staffing. The intention is to increase the clinical endoscopist workforce with less reliance on consultants and also to increase administrative support by converting fixed term into substantive posts.

Mitigations:
Theatre capacity is returning to Pre-covid levels. A review of colorectal theatre list scheduling in order to better align with clinician availability continues and Grantham Theatres have now returned to undertaking suitable Level 1 colorectal work. Work continues within the Surgery Division in order to access sufficient HDU post op care via the weekly meetings and to ensure that theatre capacity is fully utilised once full pre-op capacity returns.
Work to enhance the early identification of patients requiring Pre-Diagnosis CNS support is ongoing.

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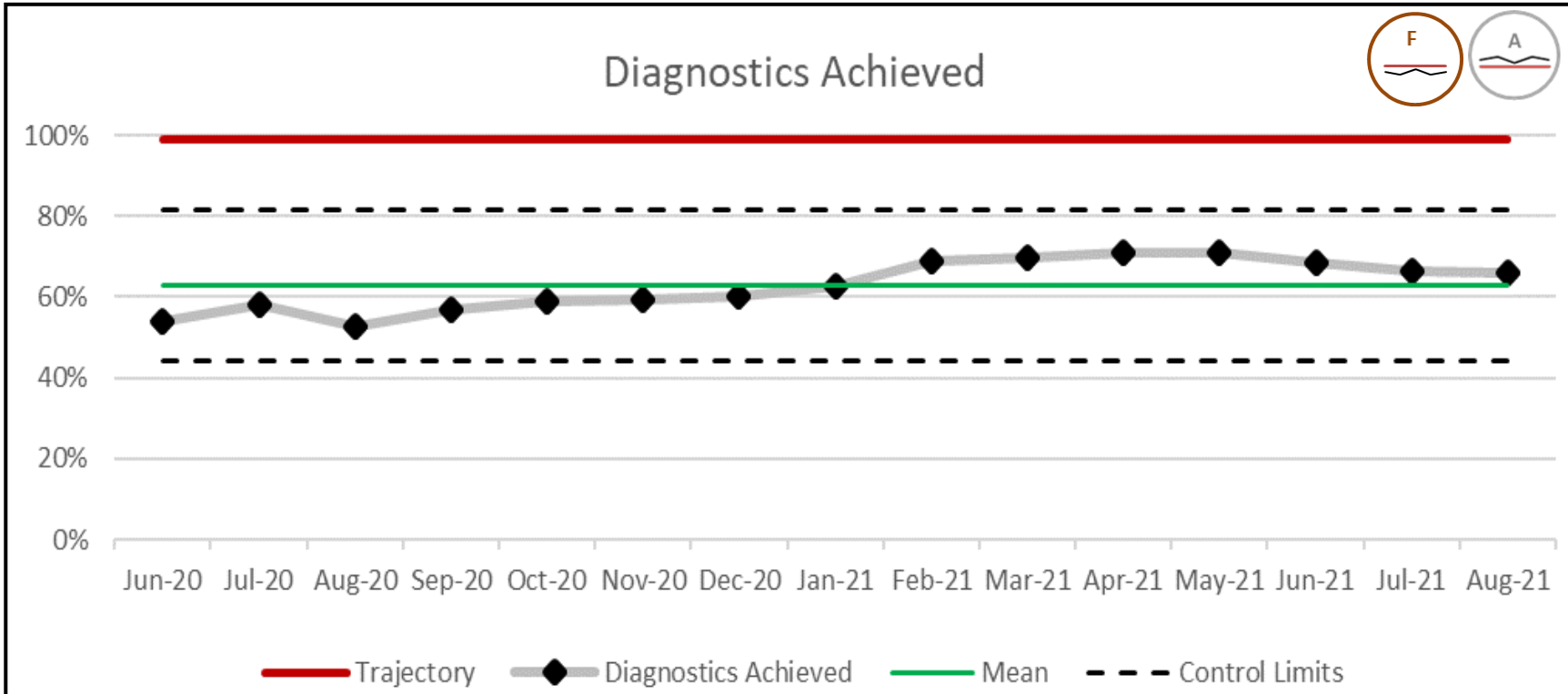

Aug-21
66.00%
Variance Type
Metric is currently experiencing Special Cause Variation – above the mean
Target
99%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:

Diagnostics achieved in under 6 weeks.

What the chart tells us:

We are currently at 66.00% for August 2021 against the 99.00% target.

Issues:

- All areas have lost capacity due to social distancing, demand is still higher than capacity for some procedures so causing increased backlogs for some specialities and increasing the number of breaches declared each month for those specialities.
- Increase demand in Ultrasound due to Mediscan being stopped by the CQC this has caused an additional 2000 scans a month from AQP, Cardiac Echoes have a considerable backlog due to lack of capacity

Actions:

Where demand out strips capacity additional resource is being sort, but this is proving difficult to obtain in cardiology echoes, additional US list are happening but not enough to deal with the additional 2000 scans.

Mitigations:

All waiting lists are being monitored and where 50% of the waiting list is over 6 weeks, we are being asked to complete a clinical validation for each patient and assign a D code to that patient. Going forward every new referral will have a D code assign to that patient. This will make sure all patients are seen in clinical urgency.

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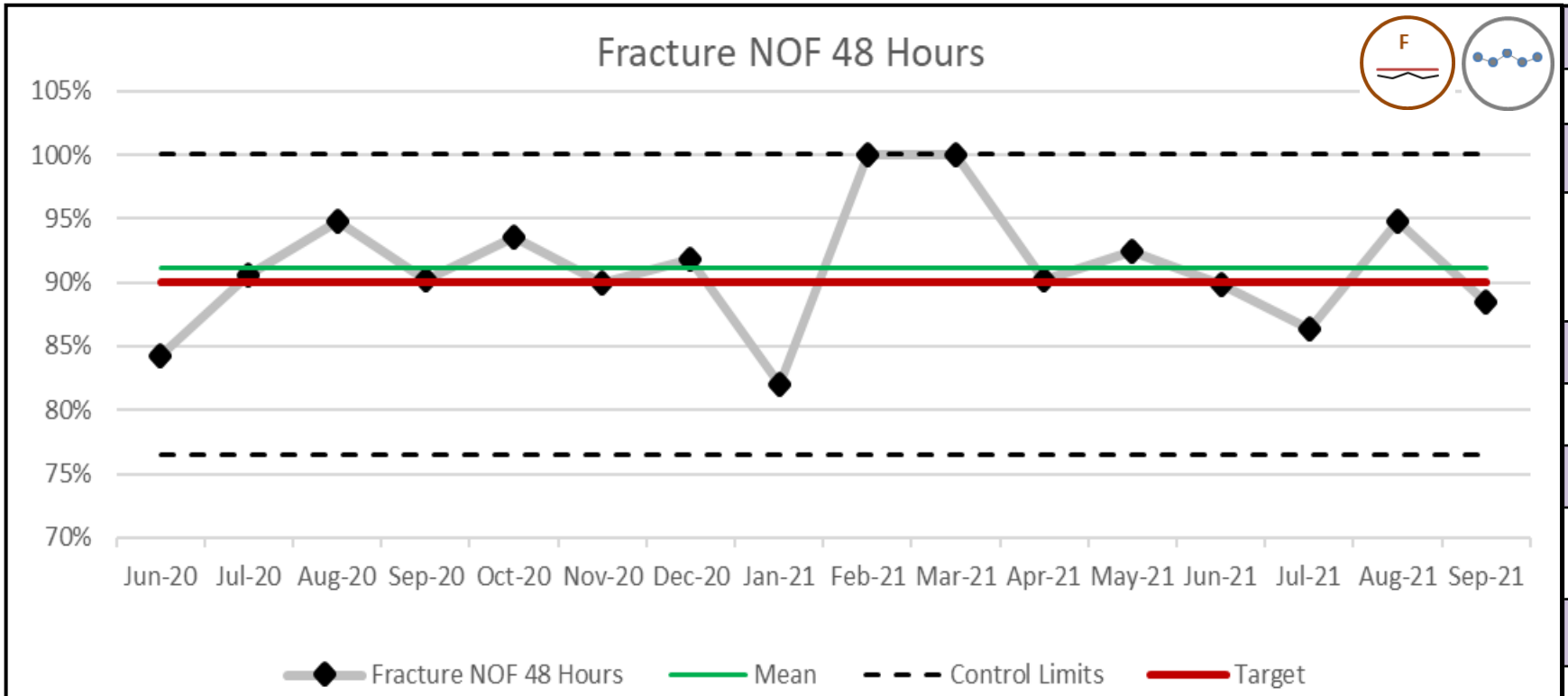

Sep-21
88.46%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:
Percentage of fracture neck of femur patients time to theatre within 48 hours.

What the chart tells us:
In Aug 21 performance was 95% with a slight dip in Sept performance of 88.46%

A marginal reduction in NOF time to theatre performance has been seen. The performance of this metric is variable due to trauma demand and the health of patients which can cause delays in surgery.

Issues:

- Increase in trauma demand.
- High vacancy rate in theatres which limits capacity for additional theatres.
- Due to increase in trauma demand and the types of injuries seen, certain procedures have been clinically prioritised ahead of NOF patients.
- Delays for NOF's included reduced theatre capacity, patients medically unfit to proceed and the need for specialist surgeon availability.

Actions:

- NOF pathway project ongoing to ensure pathway from EMAS response through to patient discharge post-surgery being fully optimised and responsibilities/protocols are clear.
- Forward planning of theatre lists required based on historical peaks in activity seen.
- 'Golden patient' initiative to be fully implemented.
- Ensure robust processes in place to utilise Trust wide trauma capacity and beds.

Mitigations:

- Ensure trauma lists are fully optimised.
- Reduce 'on the day' change in order of the trauma list where clinically appropriate.
- Daily attendance at the trauma meeting by the clinical business unit to improve communication, visibility of current position and increased support for theatre utilisation and extra capacity needed

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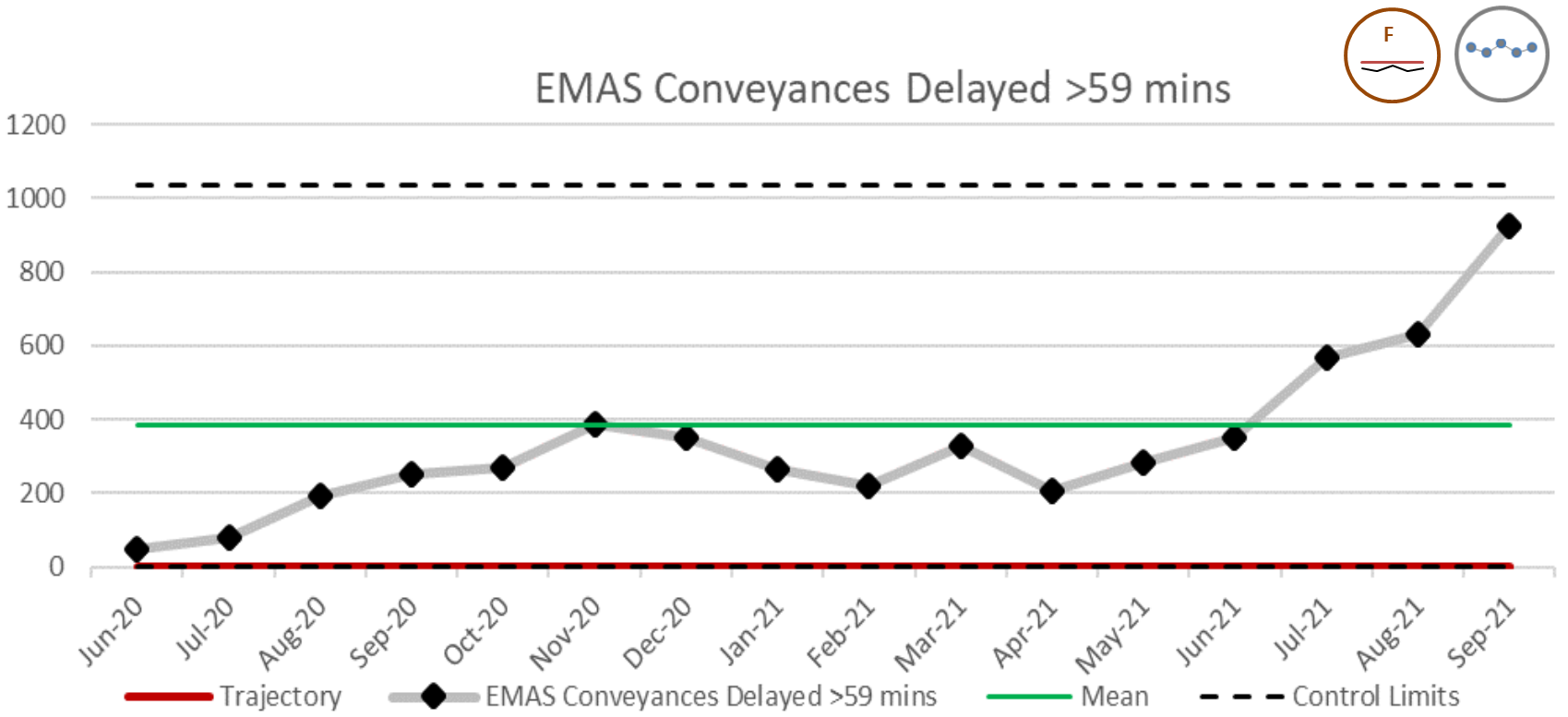

Sep-21
923
Variance Type
Metric is currently experiencing Common Cause Variation
Target
0
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:
Delays in offloading patients following a conveyance has a known impact on the ability of EMAS to respond to outstanding calls. Any delays greater than 59 minutes is reportable to the CCG. There is local and national Ambulance handover delay escalation protocol

What the chart tells us:
September experienced an increase in greater than 59 minutes' handover delays. 923 in September compared to 629 in August. This represents a 31.86% increase.
What the chart does not tell us is the increase of >4hrs and >3hrs in September 2021 both LCH and PHB experienced significant increases in terms of >120 mins.

Issues:
The pattern of conveyance and prioritisation of clinical need contributes to the delays.
Increased conveyances continue to profile into the late afternoon and evening coincides with increased 'walk in' attendances causing a reduce footprint to respond to timely handover.
Poor flow and discharges continue to result in the emergency departments being unable to de-escalate due to an increase number of patients waiting for admission.
A more detailed account of >59-minute handover delays are featured in the UEC FPEC report.

Actions:
All ambulances approaching 30 minutes without a plan to off load are escalated to the Clinical Site Manager and the in hours Operational Silver Commander to secure a resolution and plans to resolve are feedback to the DOM
Daily messages to EMAS crews to sign post to alternative pathways and reduce conveyances to the acute setting.
Active monitoring of the EMAS inbound screen to ensure the departments are ready to respond.
A pilot is due commence using a 'front door' Clinical Site Manager to monitor and challenge inappropriate conveyance.

Mitigations:
Early intelligence of increasing EMAS demand has allowed for planning and preparedness to receive and escalate. Contact points throughout the day and night with the Clinical Site Manager and Silver Commander to appreciate EMAS on scene and calls waiting by district and potential conveyance by site.

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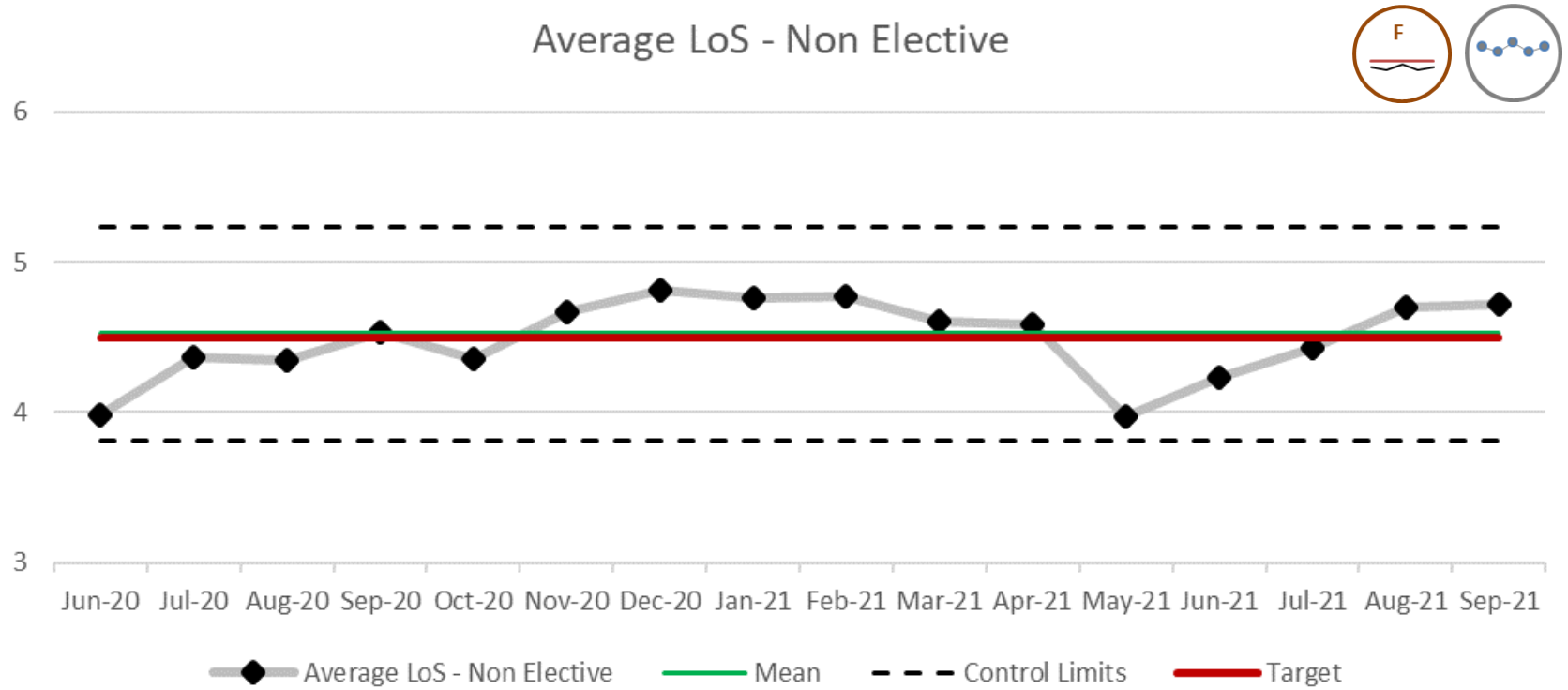

Sep-21
4.72
Variance Type
Metric is currently experiencing Common Cause Variation
Target
4.5
Target Achievement
Metric is failing the target
Executive Lead
Chief Operating Officer

Background:

Average length of stay for Non-Elective inpatients.

What the chart tells us:

The agreed target is 4.5 days verses the actual of 4.72 days in September.
This is an increase of 0.2 days compared with August.
This is a 0.22 variance against the agreed target.

Issues:

Increasing numbers of stranded (213) and super stranded (69) patients.
PCR turnaround delays impacting on the discharge of pathway 1, 2 and 3 patients due to equipment failure.
Increasing length of stay of all pathways 1-3
The most significant increase in volume of bed days is Pathway 1 Domiciliary care.
Reluctance of Care Homes to admit at the weekends
Higher acuity of patients requiring a longer period of recovery.
Increased medical outliers leading to delays in senior reviews.

Actions:

Focused discharge profile through right to reside data.
Cancellation of elective activity and SPA time to allow for daily consultant review of all patients.
Medically optimised patients discussed twice daily 7 days a week with system partners to ensure plans in place and a zero tolerance of >24hrs delay
Use of rapid PCRs to ensure no delay once social care plans are secured.
Maximise use of all community and transitional care beds.

Mitigations:

Divisional Bronze Lead continues to support the escalation of exit delays to the relevant Divisions and Clinical Business Units.
Continued reduction in corporate and divisional meetings to allow a more proactive focus on increasing daily discharges. However, this is not sustainable.
A daily site update message is now sent at 6am alerting Key Leaders to ED position and flow.

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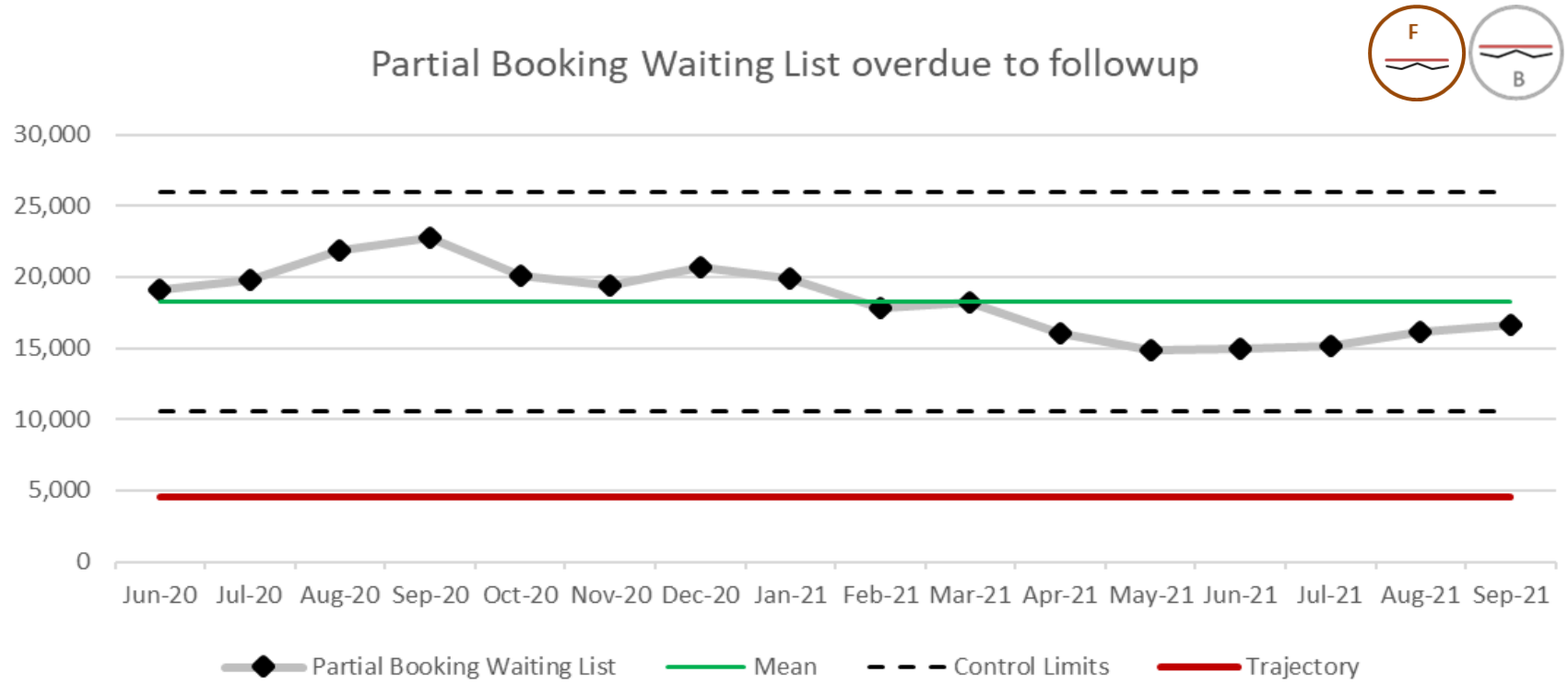

Sep-21
16,634
Variance Type
Metric is currently experiencing Special Cause Variation – low trend
Target
4,524
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:
The number of patients more than 6 weeks overdue for a follow up appointment.

What the chart tells us:
We are currently at 16,634 against a target of 4,524.
Due to Covid the number of patients overdue significantly increased.
Recovery work took place and reduced the number of patients overdue but this has started to increase on an upward trend since July 2021.

Issues:
The organisation is pressured in a number of areas especially in urgent / emergency care that has taken priority over outpatients. The issues include conflicting priorities, increasing demand on resources, space, aligning requirements.

Actions:
Service recovery plans produced and updated regularly. Meetings stepped down due to site pressures. Where possible, specialities are continuing with validation, clinical triage and exploring technological solutions.
642 meeting in place to challenge short notice clinic cancellations but recently been stepped down due to patient flow pressures.

Mitigations:
Supporting organisational priorities taking individual outpatient clinics down, if support required across the sites (site/patient flow and theatres).

PERFORMANCE OVERVIEW - WORKFORCE

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	Jul-21	Aug-21	Sep-21	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%	90.89%	90.39%	87.80%	89.65%		F		
	Number of Vacancies	Well-Led	People	Director of HR & OD	12%	11.57%	12.13%	11.93%	10.84%		P		
	Sickness Absence	Well-Led	People	Director of HR & OD	4.5%	5.05%	5.09%	5.18%	5.04%		F		
	Staff Turnover	Well-Led	People	Director of HR & OD	12%	12.01%	12.46%	13.04%	11.88%		F		
	Staff Appraisals	Well-Led	People	Director of HR & OD	90%	67.95%	62.79%	56.84%	68.52%		F		
					£'000	£'000			£'000				
	Agency Spend	Well-Led	People	Director of HR & OD	-£2,757	-£3,745	-£3,787	-£3,633	-£22,148		F		

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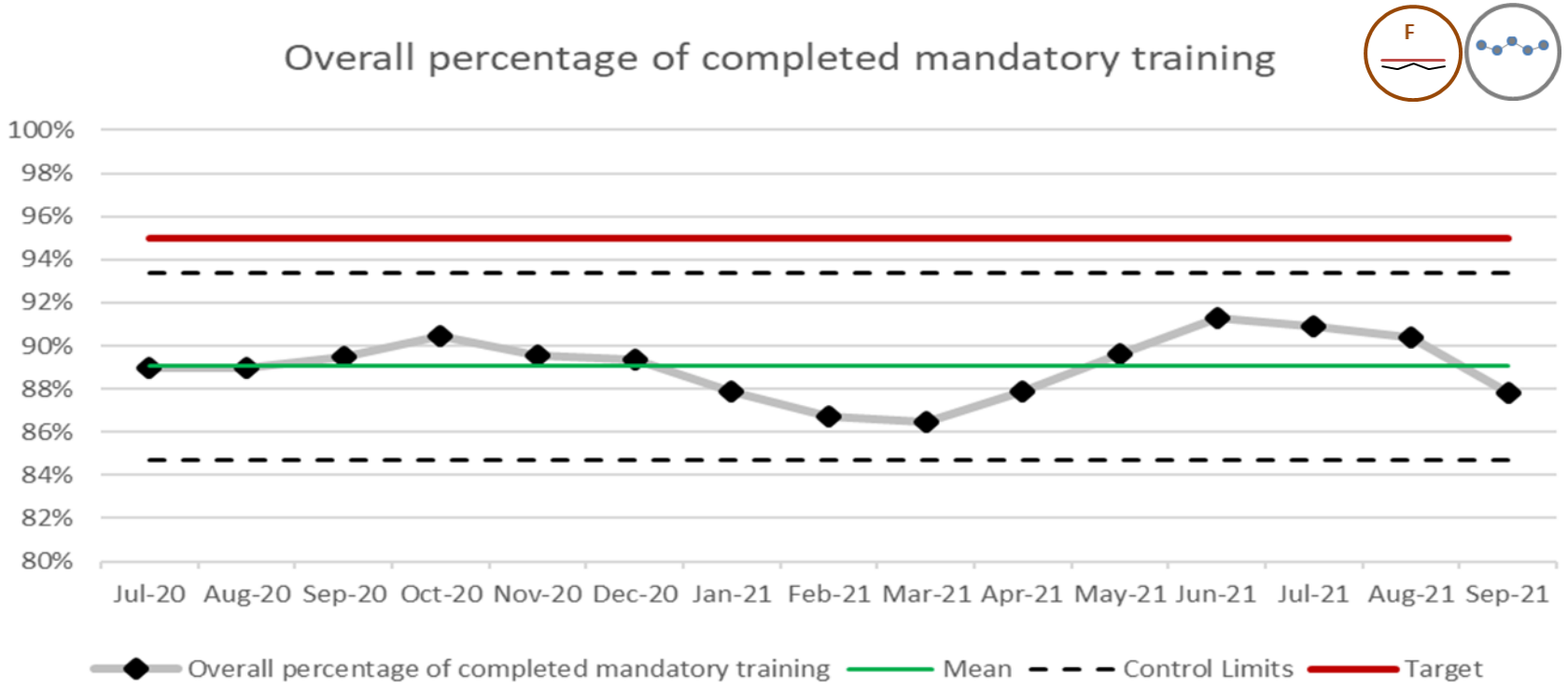

Sep-21
87.80%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
95%
Target Achievement
Metric is consistently failing to target
Executive Lead
Director of HR & OD

Background:
Overall percentage of completed mandatory training.

What the chart tells us:
Compliance with mandatory training is still high but has reduced due to staffing pressures, higher absence levels, an increase in patient activity and operational pressures.

Issues:
- Front line staffing face an increased difficulty in ensuring protected time due to current pandemic
- Higher levels of absence also prevent staff to access their ESR which becomes overdue
- All Training currently stood down due to the Major Critical Incident of the Trust.

Actions:
- The appointment of Learning support position will support the ongoing review into what training is required by who and at what level.
- Communications of the link with core learning and pay progression.

Mitigations:
See actions

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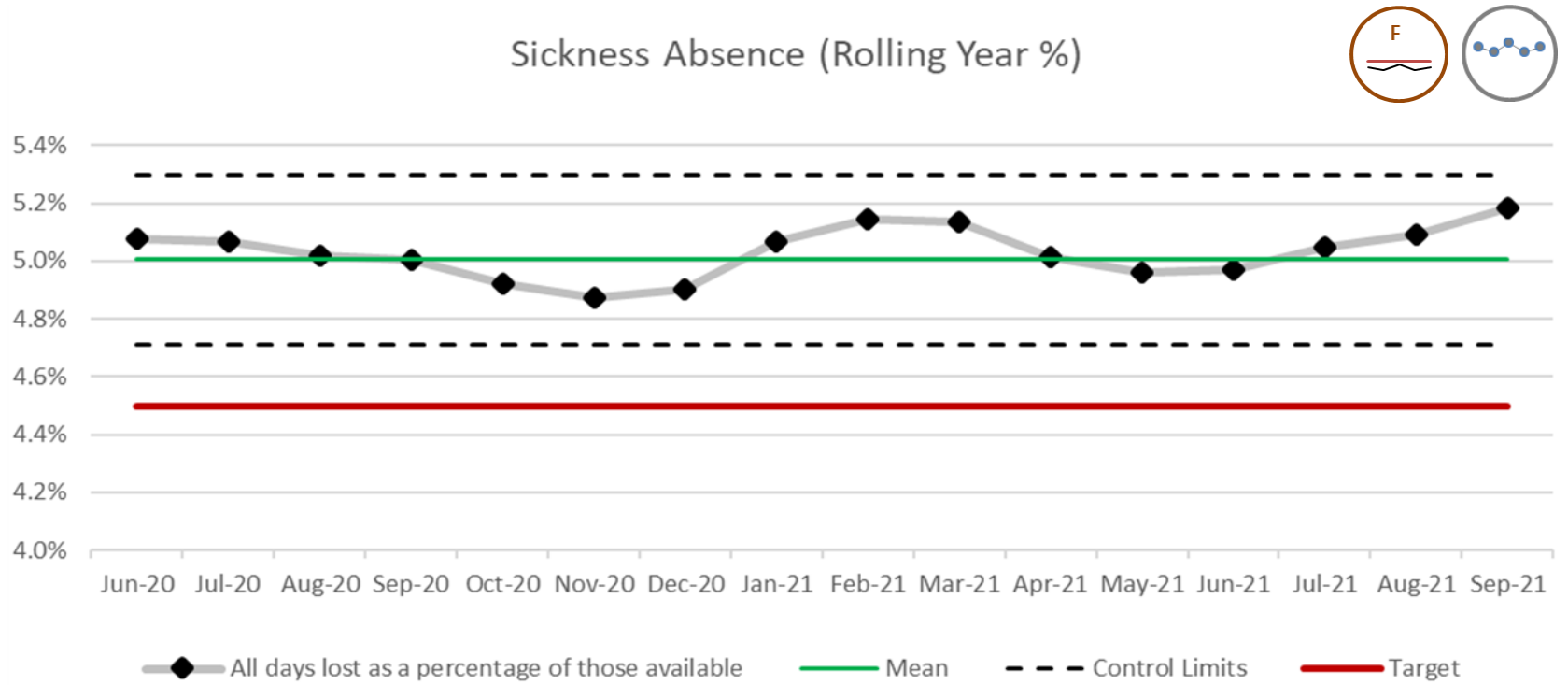

Sep-21
5.18%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
4.5%
Target Achievement
Metric is consistently failing to target
Executive Lead
Director of HR & OD

Background:
% of sickness absence rolling year.

What the chart tells us:
The Chart shows us that sickness absence has increased to its highest level since June 2020.

Issues:

- As we move into Wave 4, COVID absences increase in numbers of staff absent and patient numbers.
- The increases in absence correlates to the wearing of face masks not being mandatory and children returning to school.
- Managers not accurately reporting absences timely impacts on accuracy of live real time data.

Actions:

- Current review of risk assessment process to ensure staff are returning to wok safely and timely.
- A review continues of absence data to cleanse and update
- HR continue to do Wellbeing calls to staff to support timely referrals and support.

Mitigations:
See Actions.

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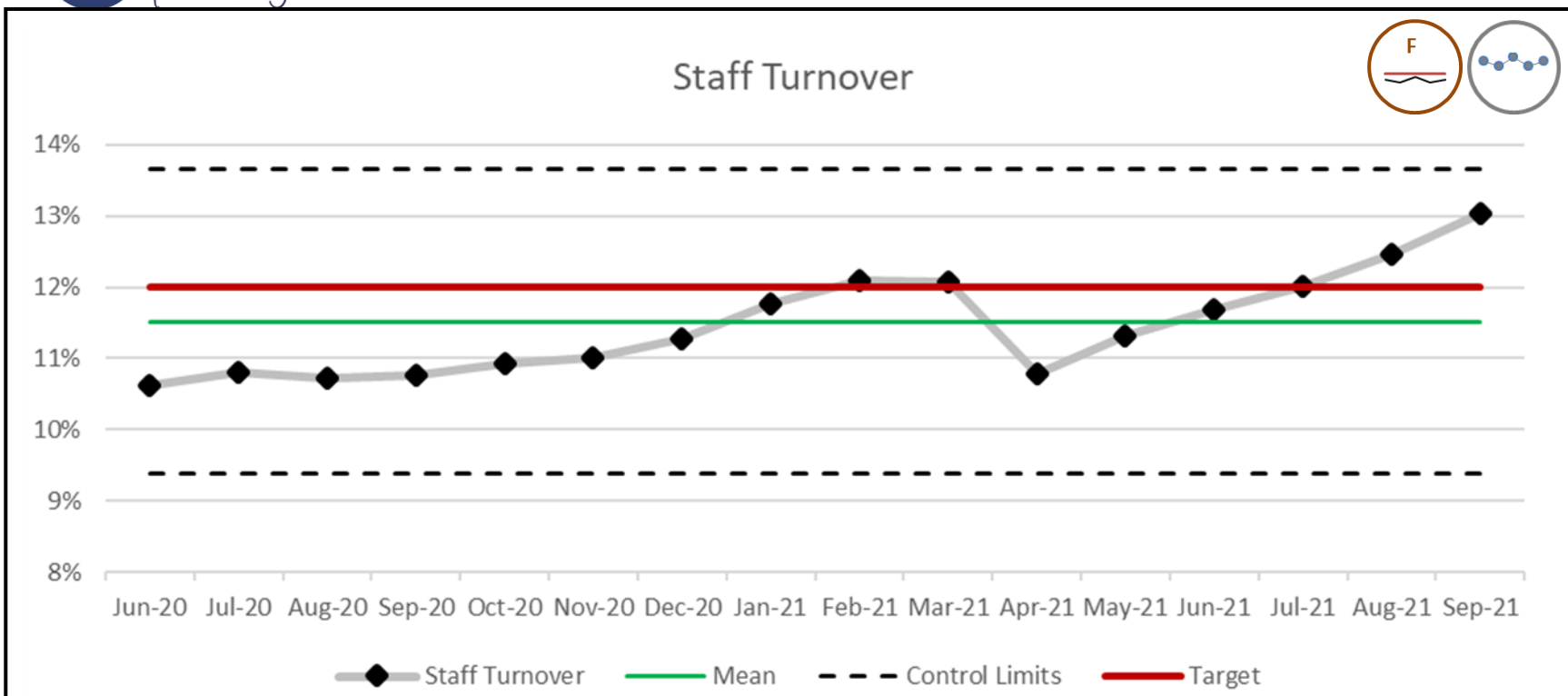

Sep-21
13.04%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
12%
Target Achievement
Metric is failing to target
Executive Lead
Director of HR & OD

Background:
% of turnover over a rolling 12-month period

What the chart tells us:
As expected, turnover rates continue to steadily creep up. The pressures of working in an acute trust environment for the past 18 months is having an impact on people.

Issues:
- An increasing % of nurses at retirement age are looking to secure flexible work arrangements to return to.
- More choose to leave when reaching end of contract / tenure due to pressured environment
- Low retention from HCSW recruitment drive done earlier in 2021

Actions:
The flexible working policy is published in October. Flexible working is now a contractual entitlement for staff.

Turnover as a result of 'challenging behaviours' is to be expected as a consequence of the work being done through the Culture and Leadership Programme.

Mitigations:
See actions

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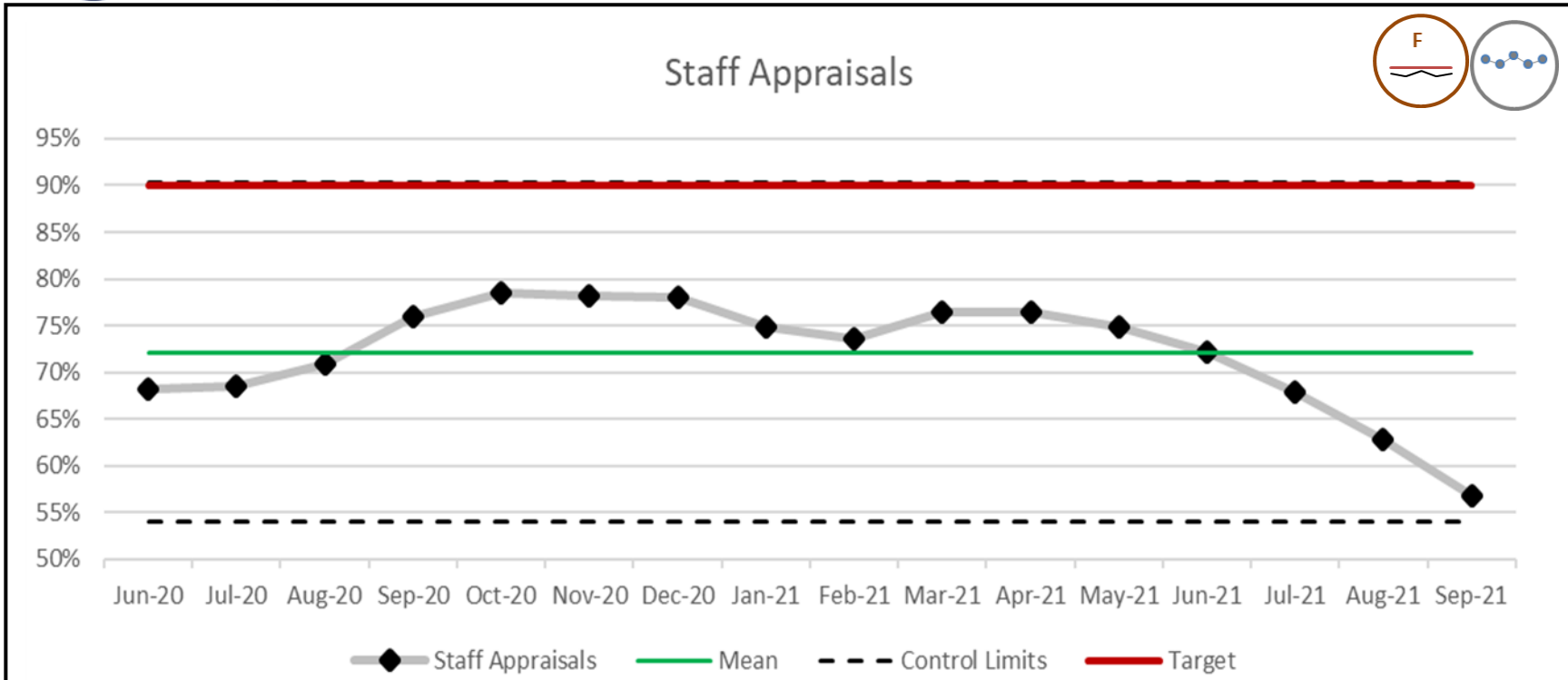


Sep-21
56.84%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
Metric is consistently failing to target
Executive Lead
Director of HR & OD

Background:
% completion is currently 56.84%.

What the chart tells us:
The gap to achieve the target completion rate for appraisal is widening. While there is a systemic issue around completion of appraisals, wave 3 has had a significant impact on the completion of appraisals.

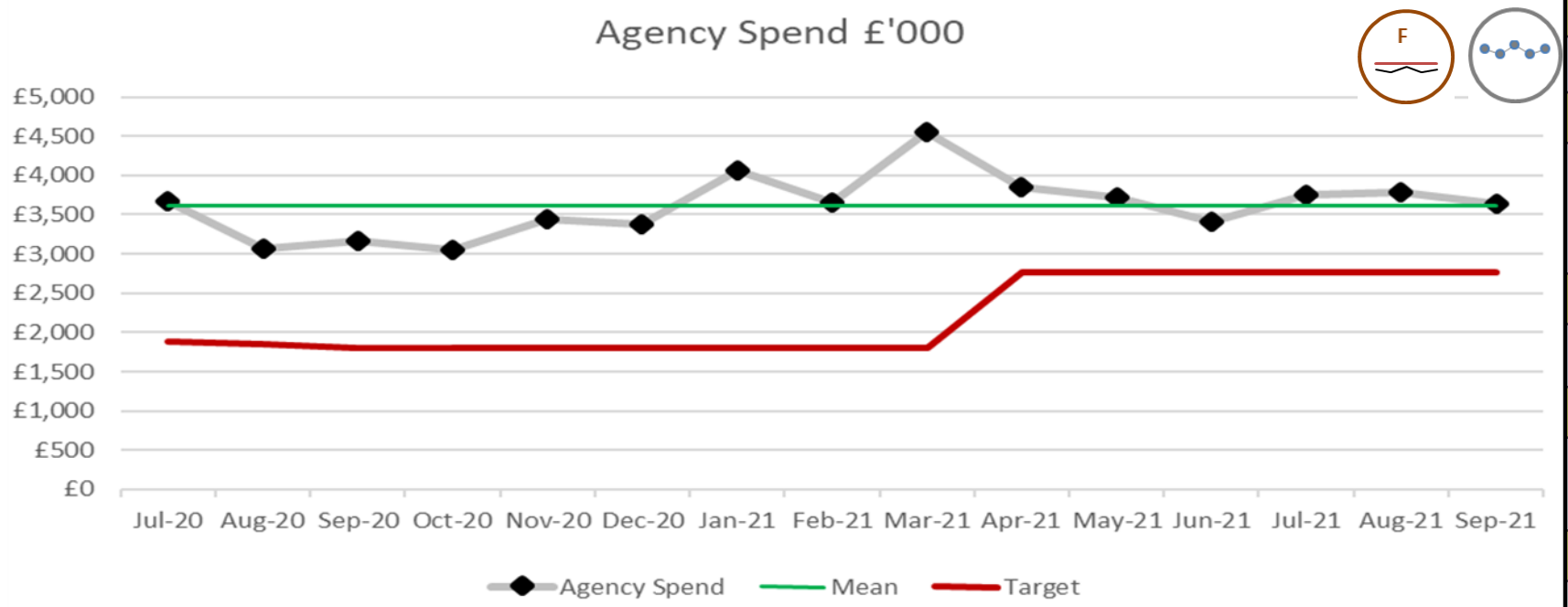
Issues:
- Impact of Covid – Wave 3 caused a backlog
- Appraisal completion seen as redundant activity for managers.
- WorkPal system adoption rates increased month on month- but slow
- Appraisal completion directly linked to pay progression. If appraisal is not completed, then the individual is not eligible to pay progression. Individual's manager is also not eligible.

Actions:
- Divisions have included completion of appraisals in their IIP major projects and scorecards
- Appraisals to be the norm as part of leader/staff through Culture and Leadership Programme.
- Appraisal completion to be focussed through the divisions regardless of operational pressures.

Mitigations:
- Trust to consider an appraisal cycle – 3 months of the year when everyone in the Trust completes appraisals. The appraisal training calendar can also be aligned to this cycle.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Sep-21
£3,633,000
Variance Type
Metric is currently experiencing Common Cause Variation
Target
£2,757,000
Target Achievement
Metric is consistently failing to target
Executive Lead
Director of HR & OD

Background:

Agency spend £'000

What the chart tells us:

Agency spend continues above target spend as it has done for the last 12 months.

Issues:

Medical

- Staff absences are high at present due to sickness
- High sickness in rota coordination across medicine and Issues affect full grip and control.
- Ongoing Issues around good rota design for medical staff.
- Number of IMT3s in shadowing period creating additional gaps.

Nursing

- Continued additional capacity creates an ongoing additional demand.
- Sickness and vacancies create a need to fill shifts via temporary staffing

Actions:

Medical

- Focus of workforce groups on grip and control.
- Expedited recruitment of trust grade doctors.
- Increased Medical bank rates

Nursing

- Weekly monitoring of Agency use and spend
- Strengthened controls through 2x daily staffing meetings
- Ongoing recruitment
- All booking reasons scrutinised
- Weekly nursing staffing solutions meeting and scrutiny back in place.

Mitigations:

Medical

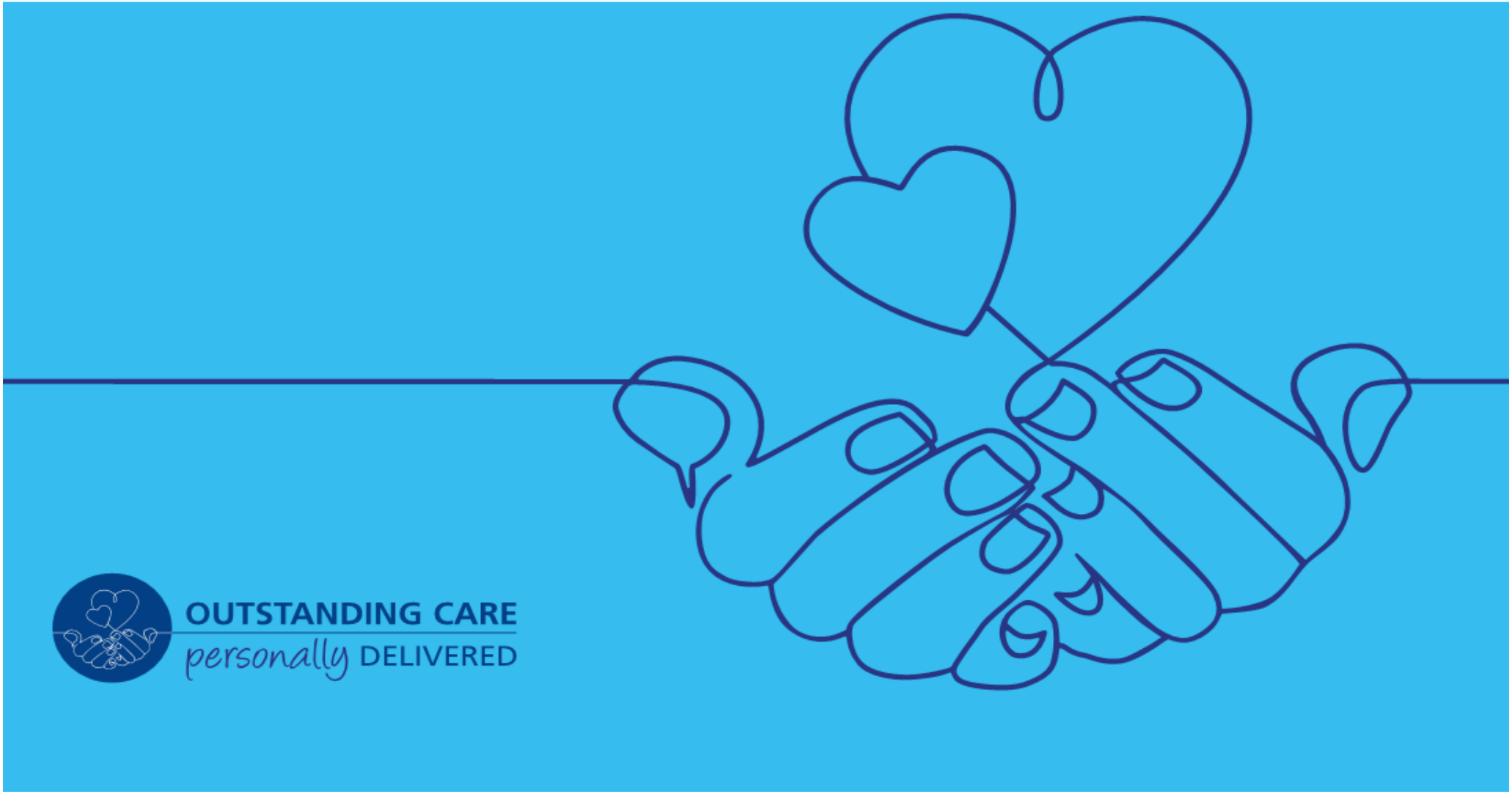
- Refocusing of nursing and medical workforce transformation groups on short-term issues around agency spend.

Nursing

- Nursing and therapy Workforce Transformation Group meeting delayed but will start from October
- Plan for every post across Divisions
- Nursing Workforce plan being drafted.

Financial Position Month 6 (2021/22)
Finance Report
5 Year Priority – Efficient Use of Resources

NHS
United Lincolnshire Hospitals
NHS Trust



Quality | Operational Performance | Workforce | Finance

Finance Spotlight Report

NHS
United Lincolnshire Hospitals
NHS Trust

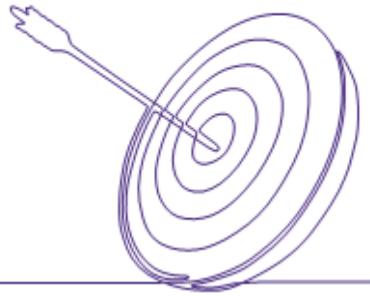
	Current Month			Year To Date		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
Operating income from patient care activities	50,106	55,261	5,155	303,741	306,667	2,926
Other operating income	2,519	2,782	263	15,380	16,407	1,027
Employee expenses	(33,750)	(39,364)	(5,614)	(206,821)	(214,118)	(7,297)
Operating expenses excluding employee expenses	(16,824)	(16,692)	132	(106,730)	(103,790)	2,940
Net Finance Costs	(639)	(638)	1	(3,807)	(3,807)	(0)
Other gains/(losses) including disposal of assets	0	11	11	0	103	103
Surplus/(Deficit) For The Period/Year	1,411	1,360	(51)	1,764	1,462	(302)
Remove capital donations/grants I&E impact	6	56	50	36	338	302
Adjusted financial performance surplus/(deficit)	**1,417**	**1,416**	**(1)**	**1,800**	**1,800**	**0**

- The above table shows that in line with plan the Trust has delivered a £1.4m surplus for the month of September and a £1.8m surplus in H1.

- The Trust had forecast to be £0.6m adverse to plan at the end of H1 primarily due to the operational pressures in the Trust leading to non-substantive cost pressures and the reduction in the Trust capacity to deliver restore plans and attract the associated Elective Recovery Fund (ERF) income.

- However, **the Trust has been able to deliver its planned £1.8m surplus** as a result of the receipt of £0.4m of prior year pass through funding and £0.2m of ERF risk which did not mature.

Finance Spotlight Report (background)

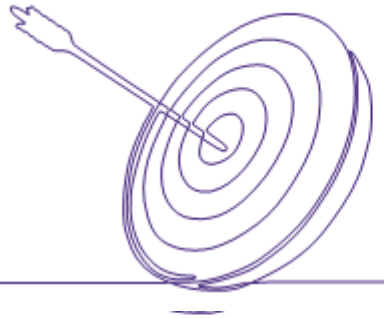


United Lincolnshire Hospitals NHS Trust

- The Trust exited 2020/21 with a £2.4m surplus; the 2020/21 position was inclusive of £72.1m of planned system support, £4.5m of funding for lost Other Operating Income, and £122.6m of top up block funding totalling over and above the level of funding the Trust would have received on a Payment By Results contract.
- The Lincolnshire system resubmitted its financial plan for H1 of 2021/22 to take account of Elective Recovery Funding (ERF). The revised H1 financial plan for the Trust is inclusive of a £1.8m surplus position, £7.6m ERF, costs of restoration of £5.8m and a requirement for the Trust to deliver cost improvement (CIP) savings of £6.4m.
- While the Trust's financial plan for H1 is a £1.8m surplus, this is comprised of a deficit in the first quarter and a surplus in the second quarter, illustrated by the monthly planned financial values in the table below, with the requirement to deliver the majority of the CIP in Q2 (aligned to the national planning expectations) driving the improving monthly position.

Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Half Year Ending 30 Sept 2021
(921)	(867)	688	507	976	1,417	1,800

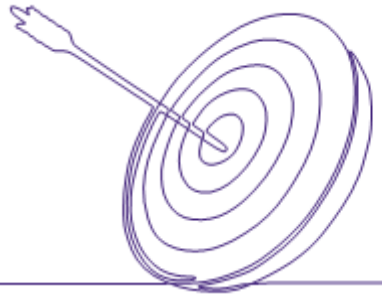
Finance Spotlight Report (Key areas of focus - Income)



United Lincolnshire Hospitals NHS Trust

- The overall Income position in H1 is £4.0m favourable to plan:
  - **£4.2m adverse movement re ERF** – This movement reflects lower than planned achievement of ERF income; an accrual of £0.2m for ERF risk was released in September as the final nationally calculated Q1 freeze value has been confirmed; the financial plan for H1 assumed ERF income of £7.6m and that £3.4m of this would be brokered to the CCG, but given the Trust only achieved £3.4m of ERF income this brokerage was not possible.
  - **£4.5m favourable movement re Pay award** - As per national guidance, the Trust has accrued income from our Lead Commissioner to match the cost of the pay award paid for A4C and medical staff in September; Provider Trusts will receive cash in October based upon centre's estimate of the cost of the pay award.
  - **£2.6m favourable movement re other Patient Care Income** – This movement comprises £1.8m re pass through income, £0.4m one-off benefit re prior year pass through income, £0.3m re additional block funding allocations not known at the time of plan submission, and £0.1m over performance on other variable income streams such as CRU and Private Patients.
  - **£1.0m favourable movement re Other Operating Income** – made up of £0.4m of additional top up funding (in relation to Covid), and £0.6m in relation to variable income streams such as non patient care recharges, car parking income and catering income.
- Shadow monitoring of activity on a Tariff basis determined that actual activity of £34.5m was delivered in the current month, such that actual activity delivered is £14.9m lower than the income the Trust received; however, the income is inclusive of COVID, Top Up, Restore & BAU allocations.

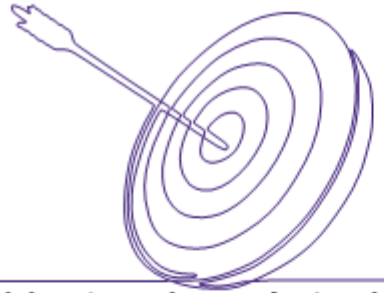
Finance Spotlight Report (Key areas of focus - Pay)



NHS
United Lincolnshire Hospitals
NHS Trust

- The overall Pay position in H1 is £7.3m adverse to plan:
  - **£4.5m adverse movement re pay award** - The in-month pay position included £4.5m in relation to the pay award paid to A4C and medical staff in September; as per national guidance, no accrual was previously made for the pay award has been included on the advice of NHSE/I, and the cost of the pay award in September has been matched by an additional income accrual.
  - **£1.8m adverse movement re Pay CIP delivery** – Recurrent delivery of Pay savings is £2.4m lower than planned, and non recurrent savings of £0.6m have only mitigated part of the slippage in H1.
  - **£1.1m adverse movement re Restore and Covid** – The additional costs of Covid (including the cost of bank incentive rates) are £2.0m higher than planned; this pressure is mitigated in part by £0.9m lower than planned costs in relation to Restore.
  - **Other adverse movements have been offset within the position** – An adverse movement of £1.0m has been mitigated by other upsides in Pay; these pressures include £0.6m re investment (beds), £0.2m re prior year commitments, and £0.2m re expenditure for which the Trust receives top up funding (e.g. Covid vaccination programme).
- Excluding the pay award, Pay in September was £0.7m lower than in August; this reduction included £0.3m re bank holiday enhancements and £0.3m re incentive bank rates.
- The IIP priorities included a 25% (or £11m) reduction in Agency expenditure compared to 2019/20, and Agency expenditure in H1 was £5.6m higher than the level required to deliver this target.

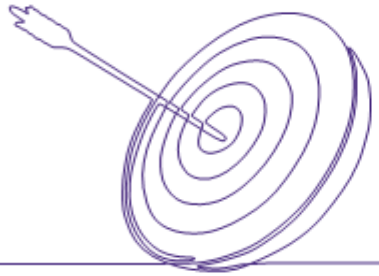
Finance Spotlight Report (Key areas of focus - Other)



United Lincolnshire Hospitals NHS Trust

- The overall Non Pay position in H1 is £2.9m favourable to plan. Actual Non Pay expenditure in September was £0.2m higher than in August; the net increase is driven by £1.0m increase in expenditure on drugs and clinical supplies and services (reflecting higher activity volumes) and £0.8m increase in technical savings.
- CIP of £6.2m has been delivered in H1 in relation to 2021/22 savings schemes; while delivery of savings overall is only £0.2m adverse to plan, £5.2m of the savings made (86.5%) are non recurrent.
- Capital funding levels for 2021/22 agreed through Trust Board & FPEC, showed a plan of c£33.7m. This has been increased to c£34.6m in M6 due to confirmation of Community Discharge Hub (CDH) funds of £0.9m.
- The capital plan submitted to NHSE/I has a year-to-date plan at M6 of c£14.9m. Spend incurred at M6 equated to c£7.3m, therefore schemes are behind plan by c£7.5m externally. A detailed capital forecast – agreed with all scheme leads - has created an 'Internal Plan' for monitoring purposes also and this shows that schemes are £0.9m behind plan.
- The month end cash balance is £46.0m which is a reduction of £8.0m against cash at 31 March 2021.
- BPPC performance is 91% / 88% by value / volume of invoices paid for the six months to September. (In month performance 93%/ 87% by value / volume). Work has been undertaken and options identified for consideration to further improve performance.

Finance Dashboard



NHS
United Lincolnshire Hospitals
NHS Trust

NHSI's Use of Resources assessments aim to help patients, providers and regulators understand how effectively trusts are using their resources to provide high quality, efficient and sustainable care. The assessment is in 5 resource areas;

Clinical Services
People
Clinical Support Services
Corporate Services, Procurement, Estates and Facilities
Finance

Metric	Rating Boundary			
	1	2	3	4
Capital servicing capacity	2.5	1.75	1.25	<1.25
Liquidity ratio (days)	0	-7	-14	<-14
I&E Margin	1%	0%	-1%	<=-1
I&E margin distance from plan	0%	-1%	-2%	<=-2%
Agency	0%	25%	50%	>=50%

The finance assessment seeks to answer the question: ***How effectively is the trust managing its financial resources to deliver high quality, sustainable services for patients?*** It does this at a high level using the 5 key indicators and each of which is rated 1 to 4 [which represent Outstanding, Good, Requires Improvement and Inadequate]. The rating boundaries are contained in the table above and ULHT absolute metric and rating for the last two full financial years and the current 2020/21 position are as follows

Finance and use of resources rating	Full Year 31/03/2019	Full Year 31/03/2020	Full Year 31/03/2021	Actual YTD SEP 2021	Forecast 31/03/2022
Capital service cover metric	(10.40)	(1.73)	0.06	1.83	3.18
Capital service cover rating	4	4	4	2	1
Liquidity metric	(98.73)	(128.28)	3.71	4.12	2.64
Liquidity rating	4	4	1	1	1
I&E margin metric	(19.71%)	(7.62%)	0.38%	0.56%	0.28%
I&E margin rating	4	4	2	2	2
Agency metric	77.00%	110.00%	113.00%	111.00%	111.00%
Agency rating	4	4	4	4	4
I&E margin: distance from financial plan - metric	(2.80%)	0.70%	n/a	0.00%	0.00%
I&E margin: distance from financial plan - rating	4	1	n/a	1	1

Balance Sheet

United Lincolnshire Hospitals NHS Trust

	31 March 2021	30 September 2021	
		Plan	Actual
	£000	£000	£000
Intangible assets	4,600	3,692	3,659
Property, plant and equipment	247,119	255,383	247,912
Receivables	2,790	2,781	2,763
Total non-current assets	**254,509**	**261,856**	**254,334**
Inventories	6,510	6,728	6,907
Receivables	25,935	14,892	24,947
Cash and cash equivalents	54,042	43,377	46,036
Total current assets	**86,487**	**64,997**	**77,890**
Trade and other payables	(69,643)	(53,493)	(58,104)
Borrowings	(402)	(555)	(555)
Provisions	(2,056)	(2,178)	(2,234)
Other liabilities	(1,587)	(2,943)	(3,093)
Total current liabilities	**(73,688)**	**(59,169)**	**(63,986)**
Total assets less current liabilities	**267,308**	**267,684**	**268,238**
Borrowings	(3,624)	(4,231)	(3,471)
Provisions	(4,069)	(4,132)	(3,941)
Other liabilities	(12,075)	(11,823)	(11,824)
Total non-current liabilities	**(19,768)**	**(20,186)**	**(19,236)**
Total assets employed	**247,540**	**247,498**	**249,002**
Financed by			
Public dividend capital	677,570	677,570	677,570
Revaluation reserve	27,522	27,174	27,173
Other reserves	190	190	190
Income and expenditure reserve	(457,742)	(457,436)	(455,931)
Total taxpayers' equity	**247,540**	**247,498**	**249,002**

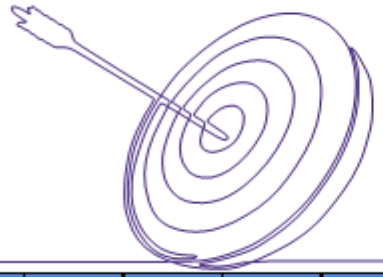
Note 1: The revised H1 financial plan submitted in May did not include a full monthly balance sheet and cashflow. The plan presented here, whilst not submitted, underpinned the actual submission.

Note 2: Trade and other receivables continue to be supressed at pre-pandemic levels with the continuation of block contract payments for the first half of 2021/22.
Funding of £4.5m covering Apr-Sept Pay Award arrears due from CCGs has been accrued.

Note 3: Cash balances remain significantly increased on 2019/20 levels. Whilst Trusts are no longer paid one month in advance, the continued block payment regime means cash balances remain high. Coupled with this the Trust received payments in March to cover future outgoings associated with accrued annual leave. During September, pay award arrears (£4.5m) and the Flowers liability (£1.3m) were paid out.

Note 4: Trade Payables remain below pre-pandemic levels with the Trust continuing to pay suppliers well within the 30 day target. Staff related creditors are however at higher levels than historically seen, with increases due to annual leave (£8.1m).
Capital creditors have dropped from March (£13.0m) and are now at £2.7m.
BPPC for September was 93% / 87% as measured by value / volume of invoices paid.

Receipts & Payments – April 2021 - March 2022



NHS United Lincolnshire Hospitals NHS Trust

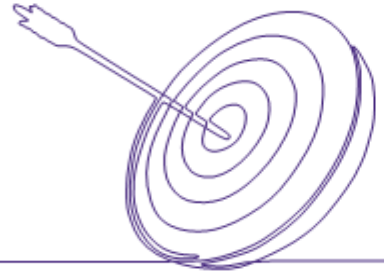
	Apr-21 £m	May-21 £m	Jun-21 £m	Jul-21 £m	Aug-21 £m	Sep-21 £m	Oct-21 £m	Nov-21 £m	Dec-21 £m	Jan-22 £m	Feb-22 £m	Mar-22 £m
Cash at Bank b'f	**54.0**	**50.5**	**53.1**	**44.0**	**47.8**	**52.4**	**46.0**	**52.8**	**46.6**	**41.2**	**40.0**	**42.5**
NHS England	6.4	6.5	6.5	8.0	6.8	8.3	6.7	6.5	6.5	6.5	6.5	6.5
Clinical commissioning groups	42.0	43.6	42.6	42.6	42.6	42.7	51.0	40.4	40.4	40.4	40.4	40.4
Other Patient related income	0.2	0.3	0.7	0.7	0.4	0.2	0.4	0.4	0.4	0.4	0.4	0.4
Patient related Income	**48.6**	**50.5**	**49.9**	**51.3**	**49.8**	**51.1**	**58.0**	**47.3**	**47.3**	**47.3**	**47.3**	**47.2**
Non-pat care services to other Govt bodies	1.1	0.8	1.2	(0.0)	0.8	0.2	1.0	1.0	1.0	1.0	1.0	1.0
Education & Training	8.4	-	0.1	4.4	0.0	0.1	1.4	1.4	1.4	1.4	1.4	1.4
Research & Development	0.0	0.0	0.2	0.2	0.1	0.0	0.1	0.1	0.1	0.1	0.1	0.1
Pay Recharges	0.4	0.1	0.3	0.2	0.2	0.3	0.4	0.4	0.4	0.4	0.4	0.4
Leasing Income	0.0	0.2	0.3	0.1	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1
Other Income	0.4	0.6	0.6	0.3	5.1	0.4	0.7	0.7	0.7	0.7	0.7	0.7
Other Operating Income	**10.4**	**1.7**	**2.7**	**5.2**	**6.3**	**1.1**	**3.7**	**3.7**	**3.7**	**3.7**	**3.7**	**3.7**
Income Total	**59.0**	**52.2**	**52.5**	**56.5**	**56.1**	**52.2**	**61.7**	**51.0**	**51.0**	**51.0**	**51.0**	**50.9**
Payroll: Weekly / Monthly	(18.1)	(17.5)	(17.7)	(17.7)	(17.8)	(21.0)	(18.2)	(18.2)	(18.2)	(18.2)	(18.2)	(18.2)
Payroll: Tax / NI	(8.2)	(8.2)	(8.1)	(8.4)	(8.0)	(8.0)	(8.3)	(8.3)	(8.3)	(8.3)	(8.3)	(8.3)
Payroll: Pensions	(4.6)	(4.7)	(4.7)	(4.7)	(4.7)	(4.7)	(4.7)	(4.7)	(4.7)	(4.7)	(4.7)	(4.7)
Agency	(7.2)	(2.7)	(5.3)	(4.7)	(3.3)	(1.7)	(3.4)	(3.4)	(3.4)	(3.4)	(3.4)	(3.4)
Non Pay: NHSLA	(2.4)	(2.4)	(2.4)	(2.4)	(2.4)	(2.4)	(2.4)	(2.4)	(2.4)	(2.4)	-	-
Non Pay Other	(17.4)	(10.8)	(21.8)	(15.1)	(16.4)	(18.5)	(16.8)	(16.8)	(16.7)	(16.7)	(16.5)	(16.5)
Non Pay - VAT Reclaim	1.3	-	0.8	1.5	3.0	0.7	0.7	0.7	0.7	0.7	0.7	0.7
Operating Expenses Total	**(56.5)**	**(46.2)**	**(59.1)**	**(51.4)**	**(49.5)**	**(55.5)**	**(53.0)**	**(53.0)**	**(52.9)**	**(52.9)**	**(50.4)**	**(50.4)**
PDC dividends payable/refundable	-	-	-	-	-	(3.1)	-	-	-	-	-	(3.8)
Finance Costs Total	**-**	**-**	**-**	**-**	**-**	**(3.1)**	**-**	**-**	**-**	**-**	**-**	**(3.8)**
Revenue Cash movement in Month	**2.4**	**5.9**	**(6.5)**	**5.1**	**6.6**	**(6.4)**	**8.7**	**(2.0)**	**(1.9)**	**(1.9)**	**0.6**	**(3.3)**
Capital cash spent: Internally Funded	(5.9)	(3.2)	(2.5)	(1.1)	(1.0)	-	(0.5)	(2.9)	(1.1)	(1.8)	(0.3)	2.2
Capital cash spent: PDC Funded	(0.0)	(0.0)	(0.1)	(0.3)	(1.0)	-	(1.5)	(1.4)	(2.3)	(2.5)	(2.8)	(5.3)
Capital PDC received	-	-	-	-	-	-	-	-	-	5.0	5.0	7.7
Total External Financing & Capital	**(5.9)**	**(3.2)**	**(2.6)**	**(1.3)**	**(1.9)**	**-**	**(1.9)**	**(4.3)**	**(3.5)**	**0.7**	**1.9**	**4.7**
TOTAL CASH AT BANK c'f	**50.5**	**53.1**	**44.0**	**47.8**	**52.4**	**46.0**	**52.8**	**46.6**	**41.2**	**40.0**	**42.5**	**43.8**

Note 1: Cash balances remain significantly increased on 2019/20 levels. Whilst Trusts are no longer paid one month in advance, the continued block payment regime means cash balances remain high. Coupled with this the Trust received payments in March to cover future outgoings associated with accrued annual leave.

Note 2: The cash position has remained relatively steady since March, the only notable movement being a reduction in capital creditors from £13.1m to £2.7m.
The level of trade creditors has also reduced from £16.5m in March to £8.1m.

Note 3: As at the end of September, taking into account the capital cash underspend from 2020/21, capital creditors and internally generated resource (depreciation) £7.6m of the cash held relates to capital.

Cashflow reconciliation– April - Sept 2021 (H1)



United Lincolnshire Hospitals NHS Trust

	Full Year 2020/21	30 September 2021	
		Plan	Actual
	£000	£000	£000
Operating surplus / (deficit)	8,778	3,777	5,166
Depreciation and amortisation	13,674	7,803	7,484
Impairments and reversals	3,121	-	-
Income recognised in respect of capital donations	(3,923)	(300)	-
Amortisation of PFI deferred credit	(503)	(252)	(251)
(Increase) / decrease in receivables and other assets	16,119	11,052	1,015
(Increase) / decrease in inventories	527	(218)	(397)
Increase/(decrease) in trade and other payables	16,987	(7,499)	(1,954)
Increase/(decrease) in other liabilities	(2,085)	1,356	1,506
Increase / (decrease) in provisions	1,556	214	78
Net cash flows from / (used in) operating activities	**54,251**	**15,932**	**12,647**
Interest received	12	-	-
Purchase of intangible assets	(1,245)	-	-
Purchase of property, plant and equipment	(39,483)	(23,522)	(17,645)
Proceeds from sales of property, plant and equipment	625	-	109
Net cash flows from / (used in) investing activities	(40,091)	(23,522)	(17,536)
Public dividend capital received	409,664	-	-
Loans from Department of Health and Social Care - repaid	(377,859)	-	-
Other loans received	2,544	760	-
Interest paid	(2,522)	-	-
PDC dividend (paid)/refunded	(5,662)	(3,836)	(3,117)
Net cash flows from / (used in) financing activities	26,165	(3,076)	(3,117)
Increase / (decrease) in cash and cash equivalents	**40,325**	**(10,665)**	**(8,006)**
Cash and cash equivalents at 1 April - brought forward	13,717	54,042	54,042
Cash and cash equivalents at period end	**54,042**	**43,377**	**46,036**

Note 1: The Cashflow reconciliation presents the same information as the preceding Receipts and Payments slide, but does so by analysing the various balance sheet classifications.

Note 2: The cash position is broadly as expected at £46.0m against plan £43.4m.

Note 3: The working capital position is broadly in line with expectations with movements in payables / receivables broadly netting off.

Note 4: The principle reason for the cash variance to plan is a shortfall of £5.9m against planned capital payments. This is linked to delays in the capital programme.

Meeting	*Trust Board*
Date of Meeting	*2 November 2021*
Item Number	*Item number allocated by admin*
Strategic Risk Report	
Accountable Director	*Dr Karen Dunderdale, Director of Nursing*
Presented by	*Dr Karen Dunderdale, Director of Nursing*
Author(s)	*Matt Hulley, Risk & Incident 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	*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 of strategic risk requiring further action*

Executive Summary

- This Strategic Risk Report focuses on the highest priority risks currently being managed within the Trust.
- Key risk indicators for all Very high risks (those rated 20-25) have been updated with available data, as evidence of the current extent of risk exposure
- The effect of the 'Delta Variant' on ULH services requires careful monitoring
- Of note 52% of all strategic risks are overdue their review a decrease from 87% in September 2021. This is being addressed as part of the ongoing roll out and review of the Risk Register reconfiguration.
- In addition to the scheduled review, risks are also discussed at the Gold meetings and relevant cells daily during this ongoing period of increased pressure.

Purpose

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

- Review the management of significant strategic risks.
- Evaluate the effectiveness of the Trust's risk management processes.

1. Introduction

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

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

1.2 This report is focussed on those strategic risks with a current rating of very high risk (a score of 20-25). A summary of the full strategic risk register is also provided for reference. Of note 52% of all strategic risks are now overdue their review date. This is being addressed as part of the ongoing roll out and review of the Risk Register reconfiguration.

1.3 In addition to the scheduled review, risks are also discussed at the Gold meetings and relevant cells daily during this period of increased pressure.

2. Strategic Risk Profile

2.1 There are 2 strategic quality & safety risks with a current rating of Very high risk:

Risk title (ID)	Local impact of the global coronavirus (Covid-19) pandemic (4558)		
Current risk rating	Very high (25)	**Risk lead**	Natalie Vaughan
Lead group	Infection Prevention & Control Group		

Key Risk Indicators (KRIs):

- Total number of Covid-19 inpatient admissions – as of 22 October there had been 3,655 Covid-19 inpatient cases within ULHT; this is an increase of 138 since 27 September.
- Number of current inpatient admissions due to Covid-19 – 26 at Lincoln and 24 at Pilgrim as of 22 October; previous figures were 18 at Lincoln and 18 at Pilgrim as of 27 September 2021.
- Patient deaths due to Covid-19 – total of 916 as of 22 October, compared with 892 as of 27 September 2021.
- Serious Incidents where the pandemic response is a contributory factor – to the end of June 2021 there were 30 completed SI investigations that cited the pandemic response; an average of 3.5 incidents per month between March and July 2020; an average of 1 per month between August and December 2020 with a declining average of 0.5 incidents per month within 2021.
- In line with guidance the Trust has now declared a thematic SI looking into hospital acquired probable and definite Covid-19 cases – in line with this the number of SIs will no longer be a KPI utilised to monitor this risk.

Gaps in control & mitigating actions:

- England Covid alert level is at Level 3 (epidemic is in general circulation)
- Cases of COVID-19 are increasing across the country and the situation is being monitored closely.
- Intensive care capacity to be increased to 200% if required
- 3 vaccines have now been approved by the MHRA and are being rolled out across the country; there are several approved treatments for Covid-19 symptoms that are now in use.
- Operational Gold Command in place to manage the ULHT response – control protocols are used for site access; PPE use; social distancing; patient admissions & discharges; staff rapid testing; use of essential equipment & oxygen
- Essential information to all staff is now being provided to staff through the weekly ULHT Bulletin which has replaced the SBAR

Risk title (ID)	Timely provision of Non-Invasive Ventilation (NIV) (4041)		
Current risk rating	Very high (20)	**Risk lead**	Linda Keddie
Lead group	Patient Safety Group		

Key Risk Indicators (KRIs):

- Completion of the NIV Pathway project as part of the Respiratory Improvement Plan
- Incidents involving NIV related care are now being addressed by the ULH NIV Group
- Findings from this group will be fed back into the risk register as assurance and reported in this risk report going forward.

Gaps in control & mitigating actions:

- Evidence of ongoing incidents and concerns around the recognition of Type 2 Respiratory Failure, which then impacts onto the timely commencement of NIV therapy in accordance with national standards.

2.2 There is 1 strategic finance, performance or estates risk with a current rating of Very high risk:

Risk title (ID)	Capacity to manage emergency demand (4175)		
Current risk rating	Very high (25)	**Risk lead**	Simon Evans
Lead group	Trust Gold Recovery and Restoration Meetings. Emergency Care Clinical Standards Forum. Divisional Performance Review Meetings (PRMs)		

Key Risk Indicators (KRIs):

KPI	In Month Target (%)	July (%)	August (%)	September (%)	YTD (%)	Last month Pass/Fail	Trend Variation
A&E waiting times	83.12	64.93	66.96	62.13	68.59%		
Ambulance Conveyances Delayed >59 minutes	0	568	629	923	494		

- A&E waiting times against the constitutional standard – 4-hour performance for September was 62.13% a decrease from August and below the target of 83.12%.
- Ambulance conveyances for September was 923 an increase from August. Delays experienced at LCH and PHB are attributed to volume and conveyance pattern as the emergency pathway comes under further pressure.

Gaps in control & mitigating actions:

- The trust has met with NHSEi regional executive team to review gaps and mitigations on two occasions.
- It is recognised that across the region the combination of pressure to recover backlogs, increased urgent care admissions above expected levels, increased Covid presentations (although below Wave 1 and 2) coupled with workforce availability issues have created a particularly challenging environment for acute trusts to operate safely in.
- Improvement measures and the U&EC improvement plan whilst will help alleviate some pressures currently do not fully address the combined issues of demand vs capacity and workforce availability.
- In Wave 1 and Wave 2 of the Covid-19 response the Trust identified a Risk Score of 25 for Covid-19 pandemic impact. Although many of the elements of this risk are the same as those described in the Covid-19 score 25 risk, this risk Capacity to manage emergency demand (4175) more accurately describes the main risk the Trust is experiencing.
- Specific concerns relate to ambulance handover delays, increased non-elective admissions, stranded and super-stranded patients
- Lincoln site reconfiguration plans & business case for investment on Pilgrim site (with government funding)
- The U&EC improvement programme has undertaken an internal review of process, key stakeholders and original milestones where off track clear rectification plans are now in place
- Partnership working within the system will support a more proactive response and delivery to system need. U&EC Partnership Board currently leads the system response to the risk described.
- Harm reviews are being carried out for all patients affected by waiting more than 12 hours in A&E following a decision to admit and ambulance handover delays of more than 2 hours

2.3 There is 1 strategic people & organisational development risks with a current rating of Very high risk:

Risk title (ID)	Workforce engagement, morale & productivity (4083)		
Current risk rating	Very high (20)	**Executive lead**	TBC
Lead group	Workforce Strategy Group		

KPI	In Month Target (%)	Jun 21 (%)	Jul 21 (%)	August (%)	YTD (%)	Last month Pass/Fail	Trend Variation
Staff Appraisal Rates	90	72.19	67.95	62.79	70.86		

Key Risk Indicators (KRIs):

- Staff appraisal rates were 62.79% in August, below the target of 90%.
- People Pulse survey results – almost 900 staff completed the first survey (in July 2020), a response rate of around 12%; 85% of staff felt informed (+0.6 vs NHS overall); 63% felt confident in local leaders (equal to NHS overall); 61% felt supported (-5.7 vs NHS overall); 59% felt they had a good work-life balance (-2.5 vs NHS overall).
- NHS National Staff Survey (NSS) results – some improvement in results of 2019 staff survey across two thirds of the questions, still below average for acute trusts; less than 50% of staff would recommend ULHT as a place to work; the Trust's score for the bullying & harassment theme in the NSS stayed relatively unchanged in 2019 at 7.6 against a national average of 7.9.

Gaps in control and mitigating actions:

- Work on morale is part of the Integrated Improvement Plan and a number of work-streams within it, including introduction of an individual performance management/appraisal e-learning programme from November & implementation of new WorkPal online appraisal system, which has been deferred to the New Year.
- New approaches to interacting with staff during Covid response; feedback has been positive and was reflected in results from the NHS Pulse Survey.

2.5 A summary of all current strategic risks is included as **Appendix 1**.

3. Conclusions & recommendations

3.1 The highest priority risks at present continue to relate to the Covid-19 pandemic and the potential impact on patients; staff; visitors and the continued provision of a full range of clinical services. There remains considerable uncertainty as to the future course of the pandemic and the risk posed to the Trust. The effect of the 'Delta Variant' on ULH services requires careful monitoring

3.2 The Trust Board is invited to review the report and advise of any further action required at this time to improve the management of strategic risks or to strengthen the Trust's risk management framework.

Appendix 1 - Summary of all risks recorded on the Strategic Risk Register:

ID	Title	Clinical Business Unit	Risk Type	Rating (current)	Risk level (current)	Review date
4175	Capacity to manage emergency demand	Urgent & Emergency Care CBU	Service disruption	25	Very high risk	13/09/2021
4558	Local impact of the global coronavirus (Covid-19) pandemic	Operations	Harm (physical or psychological)	25	Very high risk	31/12/2021
4041	Timely provision of Non-Invasive Ventilation (NIV)	Specialty Medicine CBU	Harm (physical or psychological)	20	Very high risk	30/06/2021
4083	Workforce engagement, morale & productivity	Human Resources & Organisation Development	Reputation / compliance	20	Very high risk	30/06/2021
4403	Compliance with electrical safety regulations & standards	Estates & Facilities	Reputation / compliance	16	High risk	31/03/2021
4404	Major fire safety incident	Estates & Facilities	Harm (physical or psychological)	16	High risk	31/12/2021
4480	Safe management of emergency demand	Urgent & Emergency Care CBU	Harm (physical or psychological)	16	High risk	31/12/2020
4383	Substantial unplanned expenditure or financial penalties	Finance & Digital	Finance	16	High risk	31/12/2021
4300	Availability of medical devices & equipment	Medical Directorate	Medical equipment	16	High risk	31/12/2021
4156	Safe management of medicines	Pharmacy CBU	Harm (physical or psychological)	16	High risk	30/09/2021
4144	Uncontrolled outbreak of serious infectious disease	Nursing Directorate	Patient safety (physical or psychological harm)	16	High risk	31/12/2021
4142	Delivery of harm free nursing care	Nursing Directorate	Patient safety (physical or psychological harm)	16	High risk	31/12/2021
4044	Compliance with information governance regulations & standards	Corporate Services	Reputation / compliance	16	High risk	30/06/2021
3690	Compliance with water safety regulations & standards	Estates & Facilities	Reputation / compliance	16	High risk	31/03/2021
3720	Critical failure of the electrical infrastructure	Estates & Facilities	Service disruption	16	High risk	31/12/2021
3688	Quality of the hospital environment	Estates & Facilities	Reputation / compliance	16	High risk	31/03/2021
4003	Major security incident	Estates & Facilities	Harm (physical or psychological)	16	High risk	31/03/2022

4593	Lincoln Mortuary Building	Path Links (Pathology)	Service disruption	16	High risk	16/06/2021
4556	Safe management of demand for outpatient appointments	Outpatients CBU	Harm (physical or psychological)	12	High risk	31/12/2021
4581	Heating (Trust Wide)	Estates & Facilities	Harm (physical or psychological)	12	High risk	31/03/2021
3520	Compliance with fire safety regulations & standards	Estates & Facilities	Reputation / compliance	12	High risk	31/12/2021
4081	Quality of patient experience	Nursing Directorate	Patient experience	12	High risk	31/12/2021
4082	Workforce planning process	Human Resources & Organisation Development	Service disruption	12	High risk	31/03/2021
3689	Compliance with asbestos management regulations & standards	Estates & Facilities	Reputation / compliance	12	High risk	31/03/2021
4043	Compliance with clinical governance regulations & standards	Nursing Directorate	Regulatory compliance & standards (including performance targets)	12	High risk	31/12/2021
4145	Compliance with safeguarding regulations & standards	Nursing Directorate	Regulatory compliance & standards (including performance targets)	12	High risk	31/03/2021
4146	Effectiveness of safeguarding practice	Nursing Directorate	Patient safety (physical or psychological harm)	12	High risk	31/03/2021
4157	Compliance with medicines management regulations & standards	Pharmacy CBU	Reputation / compliance	12	High risk	30/06/2021
4181	Significant breach of confidentiality	Corporate Services	Reputation / compliance	12	High risk	31/12/2020
4179	Major cyber security attack	Finance & Digital	Information Governance: Data confidentiality & integrity	12	High risk	31/12/2021
4176	Management of demand for planned care		Service disruption	12	High risk	31/12/2020
4362	Workforce capacity & capability (recruitment, retention & skills)	Human Resources & Organisation Development	Service disruption	12	High risk	30/06/2021
4481	Availability & integrity of patient information	Finance & Digital	Service disruption	12	High risk	31/01/2022
4401	Safety of the hospital environment	Estates & Facilities	Harm (physical or psychological)	12	High risk	31/03/2021

4402	Compliance with regulations and standards for mechanical infrastructure	Estates & Facilities	Reputation / compliance	12	High risk	31/03/2021
4405	Critical infrastructure failure disrupting aseptic pharmacy services	Pharmacy CBU	Service disruption	12	High risk	30/09/2021
4406	Critical failure of the medicines supply chain	Pharmacy CBU	Service disruption	12	High risk	31/12/2021
4423	Working in partnership with the wider healthcare system	Improvement & Integration Directorate	Service disruption	12	High risk	31/12/2020
4437	Critical failure of the water supply	Estates & Facilities	Service disruption	12	High risk	31/12/2021
4497	Contamination of aseptic products	Pharmacy CBU	Harm (physical or psychological)	10	Moderate risk	30/06/2021
4384	Substantial unplanned income reduction or missed opportunities	Finance & Digital	Finance	8	Moderate risk	31/12/2021
4441	Compliance with radiation protection regulations & standards	Diagnostics CBU	Reputation / compliance	8	Moderate risk	31/03/2022
4389	Compliance with corporate governance regulations & standards	Chief Executive	Reputation / compliance	8	Moderate risk	31/12/2020
4397	Exposure to asbestos	Estates & Facilities	Harm (physical or psychological)	8	Moderate risk	31/03/2021
4398	Compliance with environmental and energy management regulations & standards	Estates & Facilities	Reputation / compliance	8	Moderate risk	31/03/2021
4399	Compliance with health & safety regulations & standards	Estates & Facilities	Reputation / compliance	8	Moderate risk	30/09/2021
4351	Compliance with equalities and human rights regulations, standards & contractual requirements	Human Resources & Organisation Development	Reputation / compliance	8	Moderate risk	31/03/2021
4352	Public consultation & engagement	Chief Executive	Reputation / compliance	8	Moderate risk	31/12/2020
4353	Safe use of medical devices & equipment	Medical Directorate	Patient safety (physical or psychological harm)	8	Moderate risk	31/12/2021
4363	Compliance with HR regulations & standards	Human Resources & Organisation Development	Reputation / compliance	8	Moderate risk	31/03/2021
4368	Efficient and effective management of demand for outpatient appointments	Outpatients CBU	Reputation / compliance	8	Moderate risk	30/09/2021

4382	Delivery of the Financial Recovery Programme	Finance & Digital	Finance	8	Moderate risk	31/12/2020
4182	Compliance with ICT regulations & standards	Finance & Digital	Reputation / compliance	8	Moderate risk	20/12/2021
4177	Critical ICT infrastructure failure	Finance & Digital	Service disruption	8	Moderate risk	31/12/2021
4180	Reduction in data quality	Finance & Digital	Reputation / compliance	8	Moderate risk	31/12/2020
4138	Patient mortality rates	Medical Directorate	Reputation / compliance	8	Moderate risk	31/12/2021
4141	Compliance with infection prevention & control regulations & standards	Nursing Directorate	Regulatory compliance & standards (including performance targets)	8	Moderate risk	31/12/2021
4143	Nursing profession staffing levels	Nursing Directorate	Workforce (including capacity & capability, engagement & morale, health & well-being etc.)	8	Moderate risk	31/12/2021
3503	Sustainable paediatric services at Pilgrim Hospital, Boston	Children & Young Persons CBU	Patient safety (physical or psychological harm)	8	Moderate risk	01/11/2021
3687	Implementation of an Estates Strategy aligned to clinical services	Estates & Facilities	Service disruption	8	Moderate risk	31/03/2021
3721	Critical failure of the mechanical infrastructure	Estates & Facilities	Service disruption	8	Moderate risk	31/12/2021
3722	Energy performance and sustainability	Estates & Facilities	Finance	8	Moderate risk	31/03/2021
3951	Compliance with regulations & standards for aseptic pharmacy services	Pharmacy CBU	Reputation / compliance	8	Moderate risk	30/09/2021
4579	Delivery of the new Medical Education Centre	Improvement & Integration Directorate	Reputation / compliance	8	Moderate risk	31/12/2020
4486	Clinical outcomes for patients	Medical Directorate	Harm (physical or psychological)	8	Moderate risk	31/12/2021
4502	Compliance with regulations & standards for medical device management	Medical Directorate	Regulatory compliance & standards (including performance targets)	8	Moderate risk	31/12/2021
4526	Internal corporate communications	Chief Executive	Reputation / compliance	8	Moderate risk	31/12/2020

4528	Minor fire safety incident	Estates & Facilities	Harm (physical or psychological)	8	Moderate risk	31/12/2021
4553	Failure to appropriately manage land and property	Estates & Facilities	Finance	8	Moderate risk	31/03/2021
4400	Safety of working practices	Estates & Facilities	Harm (physical or psychological)	6	Low risk	30/09/2021
4061	Financial loss due to fraud	Finance & Digital	Finance	4	Low risk	31/12/2021
4277	Adverse media or social media coverage	Chief Executive	Reputation / compliance	4	Low risk	31/12/2020
4385	Compliance with financial regulations, standards & contractual obligations	Finance & Digital	Reputation / compliance	4	Low risk	31/12/2021
4386	Critical failure of a contracted service	Finance & Digital	Service disruption	4	Low risk	31/12/2021
4387	Critical supply chain failure	Finance & Digital	Service disruption	4	Low risk	31/12/2021
4388	Compliance with procurement regulations & standards	Finance & Digital	Reputation / compliance	4	Low risk	31/12/2020
4438	Severe weather or climatic event	Corporate Services	Service disruption	4	Low risk	31/12/2021
4439	Industrial action	Corporate Services	Service disruption	4	Low risk	31/12/2021
4440	Compliance with emergency planning regulations & standards	Corporate Services	Reputation / compliance	4	Low risk	31/12/2021
4469	Compliance with blood safety & quality regulations & standards	Cancer Services CBU	Regulatory compliance & standards (including performance targets)	4	Low risk	31/12/2021
4482	Safe use of blood and blood products	Cancer Services CBU	Patient safety (physical or psychological harm)	4	Low risk	31/12/2021
4483	Safe use of radiation (Trust-wide)	Diagnostics CBU	Harm (physical or psychological)	4	Low risk	31/03/2022
4567	Working Safely during the COVID -19 pandemic (HM Government Guidance)	Estates & Facilities	Reputation / compliance	4	Low risk	05/01/2022

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*2 November 2021*
Item Number	*Item 13.2*
Board Assurance Framework (BAF) 2021/22	
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 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 2021/22 BAF were presented to all Committees during October and the Board are asked to note the updates provided within the BAF.

Assurance ratings have been provided for all objectives and have been confirmed by the Assurance Committees and also the Audit and Risk Committee.

The Board are asked to note that the People and Organisational Development Committee met during October with the new Non-Executive Director Chair in place. The Committee noted the need for a full review of objectives 2a and 2b which would be completed and presented to the November Committee.

The Audit Committee noted the need for a full review of objective 2c which will be completed and presented to the Committee when it meets in January.

The following assurance ratings have been identified:

Objective		Rating at start of 2021/20	Previous month (September)	Assurance Rating (October)
1a	Deliver harm free care	R	A	A
1b	Improve patient experience	R	R	R
1c	Improve clinical outcomes	R	R	R
2a	A modern and progressive workforce	A	A	A
2b	Making ULHT the best place to work	R	R	R
2c	Well led services	A	A	A
3a	A modern, clean and fit for purpose environment	R	R	R
3b	Efficient use of resources	G	R	R
3c	Enhanced data and digital capability	A	A	A
4a	Establish new evidence based models of care	R	A	A
4b	To become a University Hospitals Teaching Trust	R	R	R

Board Assurance Framework (BAF) 2021/22 - October 2021

Strategic Objective	Board Committee
Patients: To deliver high quality, safe and responsive **patient** services, shaped by best practice and our communities	Quality Governance Committee
People: To enable our **people** to lead, work differently and to feel valued, motivated and proud to work at ULHT	People and Organisational Development Committee
Services: To ensure that **services** are sustainable, supported by technology and delivered from an improved estate	Finance, Performance and Estates Committee
Partners: To implement integrated models of care with our **partners** to improve Lincolnshire's health and well-being	Trust Board

Ref	Objective	Exec Lead	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Control Gaps	How identified control gaps are being managed	Source of assurance	Assurance Gaps - where are we not getting effective evidence	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**												
						Developing a Safety Culture - Group, lead & plan in place to support the delivery of an improved patient safety culture (PSG)	Human Factors training delayed due to Covid-19 Definition of Safety Culture Ambition Operational pressures have meant that meetings have not taken place.	External Safety Culture company engaged to deliver focus groups at all levels through the organisation and support development of safety culture ambition Project lead continues to review project and complete highlight reports as appropriate.	Safety Culture Surveys Action plans from focus groups and Pascal survey findings Update reports to the Patient Safety Group and upwardly reported to QGC	Due to operational pressures culture surveys have not been taking place.	Where possible, safety conversations have been taking place with staff.		
						Robust Quality Governance Committee, which is a sub-group of the Trust Board, in operation with appropriate reporting from sub-groups. (CG)	Operational pressures have meant that QGC meeting has been reduced.	All papers have been considered and discussed by exception. Assurances provided to QGC include feedback from gold and relevant cells as outlined below.	Upward reports from QGC sub-groups 6 month review of sub-group function				
						Effective sub-group structure and reporting to QGC in place	Due to operational pressures, not all sub-groups have met and others have had a reduced agenda.	All papers have either been discussed by exception or a chair/vice chaire upward report completed following review of the papers.	Sub-Group upward reports to QGC				
						IPC policies and procedures are in place in line with the requirements of The Health and Social Care Act (2008). Code of Practice on the prevention and control of infections and related guidance "Hygiene Code" (IPCG)	Policies not in line with the requirements of the Hygiene Code and some have not been reviewed and updated.	Planned programme of IPC policy development and update in line with Hygiene Code requirements.	IPC programmes of surveillance and audit are in place to monitor policy requirements. Divisional audit processes with progress and exception reporting to IPCG, IPC Site meetings and IPC related Divisional forums. Associated action and development plan documentation. Very good progress with monthly IPC ratification. Work on decontamimnation-related policies. This will lead to compliance of policy aspects of the Hygiene Code	Some aspects of reporting require further development.	Reporting to and monitoring by IPCG and other related forums, e.g. Site meetings.		

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)	Control Gaps	How identified control gaps are being managed	Source of assurance	Assurance Gaps - where are we not getting effective evidence	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating
1a	Deliver Harm Free Care	Director of Nursing/Medical Director	Failure to manage demand safely Failure to provide safe care Failure to provide timely care Failure to use medical devices and equipment safely Failure to use medicines safely Failure to control the spread of infections Failure to safeguard vulnerable adults and children Failure to manage blood and blood products safely Failure to manage radiation safely Failure to deliver planned improvements to quality and safety of care Failure to provide a safe hospital environment Failure to maintain the integrity and availability of patient information Failure to prevent Nosocomial	4558 4480 4142 4353 4146 4556 4481	CQC Safe	Process in place to monitor delivery of and compliance with The Health and Social Care Act (2008). Code of Practice on the prevention and control of infections and related guidance (IPCG). Infection Prevention and Control BAF in place and reviewed monthly (IPCG)	Non-compliance with some aspects of the Hygiene Code.	Premises and facilities Premises Assurance Model (PAM) - 21/22 - take forward as a sub project led by (E&F). Gap Analysis to be compiled and presented quarterly to the IPCG and QGC. IPC policies to be updated / developed / written in line with the timetable. •Recruited into Estates and Facilities/Decontamination Lead post commenced in post July 2021 • Good progress with achieving and sustaining standards of environmental cleanliness. Potential to remain at amber due to infrastructure concerns & requirement to achieve compliance with new National Standards of Cleanliness directive. Task and Finish Group feeds into IPCG. Good progress • Provision of suitable hand hygiene facilities work under the remit of ward enhancement, capital and tap replacement programmes.	IPC programmes of surveillance and audit are in place to monitor policy requirements. Divisional audit processes with progress and exception reporting to IPCG, IPC Site meetings and IPC related Divisional forums. Associated action and development plan documentation	Some aspects of reporting require further development.	Reporting to and monitoring by IPCG and other related forums, e.g. Site meetings.	Quality Governance Committee	A
						Monthly mortality report in place to track achievement of SHMI/Mortality targets (Maintaining our HSMR and improving our SHMI) (PSG) reporting in to monthly mortality group and upwardly to PSG	Gaps in the number of structured judgement reviews undertaken Impact of Covid-19 on coding triangles	Funding available to train an additional 40 members of staff to undertake structured judgement reviews by the end of March 2021	National Clinical Audits Dr Foster alerts HSMR and SHMI data	Due to national issues, Dr Foster data has not been available.	Local data sources are used where possible.		
						Robust policies and procedures for incident investigations, harm reviews and assurance of learning (PSG)	Clinical harm review processes not all documented & aligned with incident reporting	Task and finish group in place to agree required changes to harm review processes and documentation Appointment of a Clinical Harm and Mortality Manager	Incident Management Report Quarterly harm report to PSG Bi-weekly executive level Serious Incident meeting Learning to Improve Newsletters Patient Safety Briefings Divisional Integrated Governance reports				
						Process in place to ensure safe use of surgical procedures (NatSIPs/LocSIPs) (PSG)	Lack of assurance regarding progress of implementing NatSIPs/LocSIPs within the Trust although progress is being made within CSS, Family Health and Surgery Divisions. Operational pressures is impacting on delivery in medicine.	Working Group set up and meeting as per the ToR, divisional representation; quarterly reporting to PSG Additional support provided to medicine from the Safety Culture Team.	Audit of compliance	Audit of compliance not currently in place	Review will occur through the Task & Finish group and reported upwards to PSG		

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			spread of Covid-19			Medication safety Group in operation (Reduce medication errors) (Improving the safety of medicines management) (Review of Pharmacy model and service) (PSG)	Lack of e-prescribing leading to increase in patient safety incidents	Replacement of manual prescribing processes with an electronic prescribing system; improvements to medication storage facilities; strengthening of Pharmacy involvement in discharge processes	Upward Report of the: Medicines Quality Group				

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						Appropriate policies and procedures in place to ensure medical device safety (PSG)	Lack of assurance regarding staff training on the medical devices	Implementation of a central database of medical device user training records					
						Appropriate policies and procedures in place to recognise and treat the deteriorating patient, reported to deteriorating patient group and upwardly to PSG and QGC. (Ensuring early detection and treatment of deteriorating patients) (PSG)	Number of incidents occurring regarding lack of recognition of the deteriorating patient Maturity of some of the sub-groups of DPG not yet realised Observation policy has now been reviewed and is out for approval.	Deteriorating Patient Group set up as a sub group of the Patient Safety Group to identify actions taken to improve; has its own sub-groups covering NIV; AKI; sepsis; VTE;DKA Observation policy under review with expected update to the next DPG in July	Audit of response to triage, NEWS, MEWS and PEWS Sepsis Six compliance data Audit of compliance for all cardiac arrests Upward reports into DPG from all areas				
						Ensuring a robust safeguarding framework is in place to protect vulnerable patients and staff (Ensuring a robust safeguarding framework is in a place to protect vulnerable patients and staff) (SVOG)	New funding needed to continue restraint training delivery. Business case being developed in conjunction with conflict resolution team and will be presented to QGC within next 2 months. Further work has taken place with LPFT to consider a joint approach to training - awaiting options paper from LPFT	Updated policy & training in use of chemical restraint / sedation; strengthening of pathways & training to support patients with mental health issues	Upward reporting from Mental Health/ Learning Disability and Autism Oversight Group				
						Appropriate policies in place to ensure CAS alerts and Field Safety Notices are implemented as appropriate.	Gap in current policy identified meaning that not all responses from divisions are received / recorded.	Task and Finish Group set up to review processes and improve compliance. This has led to improvement in compliance, however further work still required. Any relevant alerts are also discussed at gold as appropriate.	Quarterly report to PSG with escalation to QGC as necessary. Compliance included in the integrated governance report for Divisions.				
						Appropriate policies and procedures in place to reduce the prevalence of pressure ulcers, including a Skin Integrity Group (NMAAF)							
						Formal governance processes in place within divisions, including regular meetings and reporting, supported by a central governance team (CG)	Training provision for Divisional Clinical Governance Leads No formal job description of roles and responsibilities for Clinical Governance Leads	Role based TNA being devised for Clinical Governance leads Draft role description for a Clinical Governance Lead developed for consultation.	Minutes of Divisional Clinical Governance meetings with upward reporting within the Division Divisional Integrated Governance Report Support Offer in place from the central CG team for the Divisions	Minutes demonstrate some Divisional Clinical Governance meetings need strengthening	Implementation of standard ToR, agendas and reporting		
						Robust process in place to monitor delivery against the CQC Must Do and Should Do actions and regulatory notices (Delivering on all CQC Must Do actions and regulatory notices) (CG)			Monthly report to QGC and Trust Board on Must and Should dos				

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1b	Improve patient experience	Director of Nursing	Failure to provide a caring, compassionate service to patients and their families Failure to provide a suitable quality of hospital environment	3688 4081	CQC Caring	Patient Experience Group, which is a sub-group of the Quality Governance Committee, in place meeting monthly Robust Complaints and PALS process in place (PEG)	Patient Experience Group reinstated in its new format and ToR, the group needs to develop its maturity Meeting stood down due to operational pressures.	The group meets monthly, has developed a work reporting plan Papers reviewed and Chair's report provided. Any risks to quality and safety are discussed at the relevant cell meeting, eg, quality cell and issues escalated to gold as appropriate. Quality Impact Assessments undertaken as part of the response to operational pressures are discussed at the quality cell.	Upward reports to QGC monthly and responds to feedback Review of ToR in July 2021 Quarterly Complaints reports identifying themes and trends presented at the Patient Experience Group Patient Experience Group upward report	Divisional assurance reports to PEG providing limited assurance; further work needed to improve this. Will be monitored through PEG.	Head of Pt Experience revising divisional assurance report template and have discussions with divisional clinical leads re: requirements for the reports.	Quality Governance Committee	R
						Patient Experience & Carer plan 2019-2023	Number of objectives in the plan paused due to Covid Pandemic; this means the plan need a full review.	Objectives being reviewed with updated timeframes going forward for inclusion in the IIP and other improvement plans at Directorate level. Patient & Carers Experience Plan to be reviewed by end Sept 21 and present to Oct PEG	Patient Experience & Carer Plan progress report to Patient Experience Group and IIP Support and Challenge meetings with monthly highlight reports.	Limited assurance until the plan is reviewed.			
						Quality Accreditation and assurance programme which includes section on patient experience.	Lack of alignment of findings in accreditation data to patient experience plans. Accreditation visits paused due to operational pressures.	Head of pt experience to have access to accreditation data. Deep dives into areas of concern as identified in quality meetings and accreditation reports. Update reports to PEG and QGC as required. Matrons audits continue to take place. Any risks to quality and safety identified are discussed at the quality cell and issues escalated to gold as appropriate.	Reports to PEG and upwardly to QGC	Visits are cancelled when the organisation is in surge leading to delays in reporting.	Scheduled visits for the year. Pt Experience team to have sight of hotspots / concerns and can inreach to provide support.		
						Redesign our communication and engagement approaches to broaden and maximise involvement with patients and carers (PEG)	Reaching out project (Hard to Reach groups) still in development; diversity of current patient representatives and panel members is narrow; 15 new panel members recruited; contact still to be made with some community groups. Experts by Experience group slow to gain traction and engagement.	Patient Panel has agenda and representatives that attend Patient Experience group to feedback and ensure continuity of messaging Sensory Loss group upwardly reports to Patient Panel.	Upward reports and minutes to the Patient Experience Group IIP reporting to Support & Challenge group.	Diversity of patient engagement and involvement.	CCG colleagues exploring development of a Health Inequalities cell to combine efforts in reaching out. Experts by Experience to be championed by Cancer Board. Breast Mastalgia expert patient group to be developed for pathway design.		
						Care after death / last offices Procedure & Guidelines Sharing information with relatives Visiting Procedure Patient information	Inconsistency in applying end of life visiting exceptions.	Swan resource boxes distributed to all areas Wedding boxes created for a number of key wards and within Chaplaincy services. Exceptions guidance re-issued. Monitor through complaints & PALs.	Report to PEG through cmplaints & PALs reports; upward reports from Visiting Review working group.	Visiting experience section within complaints & PALs reports.	Complaints/PALs reports to include visiting concerns; divisional assurance reports to include visiting related issues.		

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						Inclusion Strategy in place (PEG)	Lack of diversity in patient feedback and engagement	Equality, Diversity and Inclusion Lead is member of Patient Experience Group.	EDI 1/4rly report to PEG;	EDI Reports not being received by PEG	Head of Pt Experience to discuss with EDI lead to agree a way forward.		
						Robust process in place for annual PLACE inspection accompanied by PLACE LITE (PEG)	PLACE Lite Process needs to be embedded as Business as Usual	PLACE Lite visits are being scheduled for the year across the organisation.	PLACE report to go to Patient Experience Group quarterly and upwardly reported to QGC	National PLACE programme currently paused due to pandemic;	PLACE Lite continues & reports to PEG.		
1c	Improve clinical outcomes	Medical Director	Failure to provide effective and timely diagnosis and treatment that deliver positive patient outcomes	4558	CQC Responsive CQC Effective	Getting it Right First Time Programme in place with upward reports to CEG and QGC (CEG)	Due to Covid there is a delay in implementing GIRFT recommendations although some visits have started to take place again.	Quarterly reports to Clinical Effectiveness Group GIRFT project Manager in post	Upward reports to QGC and its sub-groups KPIs in the integrated governance report	Divisions not having oversight of their workstreams	Workstreams to be presented at PRMs	Quality Governance Committee	R
						Clinical Effectiveness Group as a sub group of QGC and meets monthly (CEG)	Some issues with quaoracy due to operational pressures however attendance has improved Prevous two meetings cancelled due to operational pressures.	September papers reviewed and upward report produced for QGC by the chair/vice chair. Any risks to quality and safety are discussed at the relevant cell meeting, eg, quality cell and issues escalated to gold as appropriate. Quality Impact Assessments	Effective upward reporting to QGC				
						Clinical Audit Group in place and meets monthly (CEG) with quarterly reports to QGC	There are outstanding actions from local audits Due to operational pressures, quoracy has been an issue.	Audit Leads present compliance with their local audit plan and actions. Support being provided from central team to close outstanding overdue actions	Reports generated for Clinical Audit group and CEG detailing status of local audits and number of open actions	Clinical Audit Leads may not attend to present their updates	Rolling attendance in progress and names of Clinical Audit Leads not attending will be escalated to the Triumvirate		
						National and Local Audit programme in place and agreed (CEG) - signed off by QGC	Audit findings do not always demonstrate the necessary improvements	Increased focus on reporting outcomes from audit Revision of Clinical Audit Policy to strengthen	Reports from the National Audit Programmes including outlier status where identified as such Relevant internal audit reports				
						Process for monitoring the implementation of NICE guidance and national publications in place (CEG) and upwardly reported through QGC	Guidance relating to completion of baseline asssessment not always followed for clinical guidelines.	Increased resources to help clear backlog of NICE clinical guidelines and technical appraisal assessments	Reports on compliance with NICE / Tas demonstrating improved compliance.				
						Process in place for taking part in the Patient Related Outcome Measures (PROMs) project (CEG)			Quarterly reports to CEG and upwardly reported to QGC	Business Units not sighted on their performance due to no reporting during COVID-19	National reports to be presented at Governance Meetings once produced		
						Quarterly Learning Lessons Newsletter in place at both Division and Trust wide level (CEG)	Staff may not access emails to review newsletters						

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SO2	**To enable our 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	Vacancy rates rises Turnover increases Sickness absence rises Under-investment in education & learning Failure to engage organisation in continuous improvement Failure to transform the medical & nursing workforce	4362	CQC Safe CQC Responsive CQC Effective	NHS people plan & system people plan & four themes:- - Looking after our people - Belonging in the NHS - New ways of working & delivering care - Growing for the future	Awaiting sign off of system people plan		Reported progress on the implementation of the NHS People Plan and the Lincolnshire System Workforce Plan NB New indicators being developed for the 21/22 financial year			People and Organisational Development Committee	**A**
						Workforce planning and workforce plans	Overall vacancy rate declining but increasing for clinical roles.	IIP Project - Embed robust workforce planning and development of new roles					
						Recruitment to agreed roles - plan for every post		Pipeline report shows future vacancy position International nurse recruitment & cohort recruitment	Internal Audit - Recruitment follow up				
						Focus on retention of staff - creating positive working environments		IIP Projects - appraisal, mandatory training, talent management	Modern Employer targets Rates of appraisal/mandatory training compliance				
						Embed continuous improvement methodology across the Trust		Training in continous improvement for staff	Staff survey feedback				
						Reducing sickness absence	Sickness absence rate higher than average	Embedding of AMS	Sickness/absence data Turnover rates Vacancy rates				
						Ensuring access to the personal and professional development that enables people to deliver outstanding care and ensures ULHT becomes known as a learning organisation	IIP projects in early stage of delivery	IIP projects - education and learning	Reported progress on the implementation of the NHS People Plan and the Lincolnshire System Workforce Plan NB New indicators being developed for the 21/22 financial year				
						NHS People Plan & System People Plan & four themes:- - Looking after our people - Belonging in the NHS - New ways of working & delivering care Growing for the future	Awaiting sign off of system people plan Delivery of IIP projects in early stage of delivery	Delivery of IIP projects as set out in controls					
						Trust values & staff charter - Resetting our Culture & Leadership programme	Poor staff survey results in 2020 (although in pulse survey more positive)	Creation of Learning Together Forum					

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2b	Making ULHT the best place to work	Director of People and Organisational Development	Further decline in demand Failure to address examples bullying & poor behaviour Lack of investment or engagement in leadership & management training Perceived lack of listening to staff voice Under-investing in staff engagement with wellbeing programme Failure to respond to GMC survey Ineffectiveness of key roles Staff networks not strong	4083	CQC Well Led	Effective communication mechanisms with our staff - ELT Live, managers cascade, intranet etc.		Reviewing the way in which we communicate with staff and involve them in shaping our plans	Staff survey feedback - engagement score, recommend as place to work			People and Organisational Development Committee	R
						Leadership & Management training. (Improving the consistency and quality of leadership and line management across ULHT)		Continue to implement new leadership programme e.g training on well-being conversations	Pulse surveys - " Have your say" Number of staff attending leadership courses				
						Perception of fairness and equity in the way staff are treated		IIP Project - Address the concerns around equity of treatment and opportunity within ULHT so that the Trust is seen to be an inclusive and fair organisation	WRES/ WDES Data Internal Audit - Equality, Diversity and Inclusion				
						Staff networks	Some staff networks stronger than others	Continued work to embed the networks and provide them with effective support	Protect our staff from bullying, violence and harassment - measure through National Staff Survey				
						Demonstate that we care and are concerned about staff health and wellbeing		Embed programme focused on staff wellbeing	Reports on progress in implementing the NHS People Plan and the Lincolnshire System Workforce Plan Number of Schwartz rounds completed (once implemented)				
						Focus on junior doctor experience key roles:- - Freedom to speak up Guardian - Guardian of safe working - Well-being Guardian	Identified FTSU capacity in Trust as insufficient	Budget identified for post and recruitment exercise commenced for full time FTSU Guardian Junior doctor forum	GMC junior doctor survey				
2c	Well led services	Chief Executive	Current risk register configuration not fully reflective of organisations risk profile Current systems and processes for policy management are inadequate resulting in failure to review out of date or policies which are not fit for purpose	4277 4389	CQC Well Lead	Delivery of risk management training programmes	Training delayed due to Covid-19	Corporate support offer made to divisions	Third party assessment of well led domains Internal Audit assessments Risk Management HOIA Opinion received and Audit Committee considered in June noting 'partial assurance with improvement required can be given on the overall adequacy and effectiveness of the Trust's framework of governance, risk management and control. Completeness of risk registers Annual Governance Statement			Audit Committee	A

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						Shared Decision making framework	Councils suspended due to Covid-19		Number of Shared decision making councils in place	8 councils established. Target for 2021 was 6	Feedback tools to review progress/success		
						Implementing a robust policy management system		Review of document management processes New document management system - SharePoint Single process for polices	Numbers of in date policies	Movement on policies still not fast enough	Clinical and Corporate Policies and Guidelines now managed through single process by Trust Secretary Report to Audit Committee quarterly Report to ELT fortnightly		
						Ensure system alignment with improvement activity							
SO3	**To ensure that services are sustainable, supported by technology and delivered from an improved estate**												
						Develop business case to demonstrate capital requirement	Business Case is not fully signed off and articulates a level of capital development that cannot be rectified in any single year.	Interim case for £9.6M of CIR has been reviewed and approved by NHSE with the majority of schemes due to deliver in 2020/21 Capital Delivery Group has oversight of the delivery of key capital schemes.	Capital Delivery Group Highlight Reports	Infrastructure case has tackled £9.6M of the overall £100m+ backlog.	Estates improvement and Estates Group review compliance and key statutory areas. Development of 2021/22 Capital Programme will continue to ensure progress against remaining backlog of critical infrastructure. Capital Delivery Group will monitor the delivery of key capital programmes and ensure robust programme governance.		
						Delivering environmental improvements in line with Estates Strategy		Estates improvement forum and improvement team monitor progress through and has restarted now Wave 2 Covid has passed.		Collation of Audits across all areas during Covid are partial due to availability of high viral load areas.			
			Longer term impact on supplier			Continual improvement towards meeting PLACE assessment outcomes	PLACE assessments have been suspended and delayed for a period during COVID		PLACE assessments	PLACE Assessments have been reduced to PLACE/light in lieu of access and staffing restrictions during Covid.			

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3a	A modern, clean and fit for purpose environment	Chief Operating Officer	services (including raw materials) 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	Review and improve the quality and value for money of Facility services including catering and housekeeping	Value for Money schemes have been delayed during COVID		MiC4C cleaning inspections Staff and user surveys 6 Facet Surveys	6 Facet Survey are not recent and require updating.	IPC Cell/Group and upward reporting of cleanliness is reported through to QGC. Water Safety and Fire Safety Groups will report through alongside Health and Safety Groups to relevant sub-committees and provide a more comprehensive view offering assurance were it is possible and describing improvement where it is not. The appointment of Authorised engineers in key statutory areas will give responsible person/Executive arms length oversight of assurance gaps to fill.	Finance, Performance and Estates Committee	R
						Continued progress on improving infrastructure to meet statutory Health and Safety compliance		Water/Fire safety meetings are in place and review of controls are part of external validation from authorised engineers.	Reports from authorised engineers 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				
						Delivering £6.4m CIP programme in H1 21/22 and estimated full Year 21/22 CIP value of £15.4m.	Operational ownership and delivery of efficiency schemes	Divisional Financial Review Meetings - paused due to COVID - reinstated from May 21. Request to all Divisions to provide detailed CIP recovery plans.	Delivery of revised CIP Achievement of both ULHT and STP financial Plan	Model Hospital Benchmarking/Reporting - paused due to COVID - reinstated from May 21 (update brought to FPEC in May)	Gaps are being reviewed monthly with Divisions through FRMs		
						Delivering financial plan aligned to the Trust and Lincolnshire STP financial plan / forecast for 2021/22	Urgent and unplanned Restore and Covid related costs	Lincolnshire STP financial plan Lincolnshire STP collective management of financial risk Savings plan, monitoring and reporting.	Delivery of the Trust and System financial plans for H1	Granular detailed CIP implementation plans.	Internally through FRMs and upwards into FPEC, externally through the STP reporting structure including Finance Leadership Group upwards to the Executive Leadership Group.		
			Efficiency schemes do not cover extent of savings required. Continued reliance on agency and locum staff and use of			Reduce agency spend by 25% from the 19/20 baseline as per IIP priority	Reliance on temporary staff to maintain services, at increased cost	Centralised agency & bank team	Delivery of the IIP 25% agency reduction target.	Granular detailed plan for every post plans.	Through the Medical and Nursing Workforce Transformation Groups and through FRMs upward into FPEC		

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3b	Efficient use of our resources	Director of Finance and Digital	and locum staff and use of enhanced bank rates to maintain services at substantially increased cost Failure to achieve recruitment targets increases workforce costs Unplanned expenditure (as a result of unforeseen events) National requirements and Trust response to Restoration and Recovery and third COVID wave.	4382 4383 4384	CQC Well Led CQC Use of Resources	Utilising Model Hospital, Service Line Reporting and Patient Level Costing data to drive focussed improvements to be restarted from Q2	Lack of up-to-date and robust benchmarking information due to the usefulness of the 20/21 cost collection exercise being reduced related to COVID.	Refresh of internal costing and SLR information for roll out in the Trust in Q2 21/22.	SLR and PLICs information	CQC Use of Resources - paused due to COVID	Improvement in the CQC Use of Resources is part of the Trust 21/22 IIP	Finance, Performance and Estates Committee	R
						Implementing the CQC Use of Resources Report recommendations	Lack of up-to-date and robust benchmarking information due to the usefulness of the 20/21 cost collection exercise being reduced related to COVID.	Refresh of internal costing and SLR information for roll out in the Trust in Q2 21/22.	SLR and PLICs information	CQC Use of Resources - paused due to COVID	Improvement in the CQC Use of Resources Trust scoring is part of the Trust 21/22 IIP and performance is reported through PMO upward reports.		
						Working with system partners to deliver the Lincolnshire financial plan for H1 and H2 21/22.	Urgent and unplanned Restore and Covid related costs	Lincolnshire STP financial plan Lincolnshire STP collective management of financial risk Savings plan, monitoring and reporting.	Delivery of the Trust and System financial plans for H1 and H2	Granular detailed CIP implementation plans.	Internally through FRMs and upwards into FPEC, externally through the STP reporting structure including Finance Leadership Group upwards to the Executive Leadership Group.		
						Detailed activity modelling aligned to resource requirements to support Trust and System Restoration.	Impact of Wave 3 and increasing acuity of NEL patients creating bed and staffing resource pressures to deliver restoration plan.	Trust Restoration plan and through Restoration and Recovery daily Trust meetings. Lincolnshire STP activity plan Lincolnshire STP collective management of restoration of planned care activity	Reporting against the Trust and System Restoration plan and national Trajectories.				
3c	Enhanced data and digital capability	Director of Finance and Digital	Tender for Electronic Health Record is delayed or unsuccessful 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 -	Cyber Security and enhancing core infrastructure to ensure network resilience. .	Digital Services Steering Group Digital Hospital Group Operational Excellence Programme Outpatient Redesign Group	Number of staff using care portal	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 as impact of Wave 2 reduces. Nationally mandated ICS Minimum Viable Product shared record must be in place by September 2021. Some ongoing work with partner organisations to ensure their data is within the Care Portal. IG sharing issues resolved but some technical ones remain.	Finance, Performance and Estates Committee	A
						Commence implementation of the electronic health record	Roll-out IT equipment to enable agile user base Redeployment of staff as a result of Trust response to Covid-19.	Digital Services Steering Group Digital Hospital Group e-HR Programme Steering Group	Delivery of 20/21 e HR plan		EPR OBC to be approved by NHSE/I OBC requirments being worked thorugh with NHSE/I		
						Undertake review of business intelligence platform to better support decision making			Delivering improved information and reports Implement a refreshed IPR	IPR refresh being completed in July 2021 for June 2021 reporting.	Steady implementation of PowerBI through specific bespoke dashboards and requests.		

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						Implement robotic process automation	Lack of expert knowledge available within and to the Trust (experts in short supply nationally) Business case under development						
						Improve end user utilisation of electronic systems	Business case for additional staff under development						
						Complete roll out of Data Quality kite mark			Ensuring every IPR metric has an associated Data Quality Kite Mark	Information improvements aligned to reporting needs of Covid-19.	A number of metrics have had a review and these are awaiting formal sign off. They will then appear in the IPR. Remaining metrics have a work plan and deadlines associated with completion.		
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	Failure of specialty teams to design and adopt new pathways of care Failure to support system working Failure to design and implement improvement methodology		CQC Caring CQC Responsive CQC Well Led	Supporting the implementation of new models of care across a range of specialties	Specialty strategies not in place	Requirement for specialty strategies now part of strategy deployment and will commence August 2021	Reports -ELT / TLT -Committees -Board -System -Region	Impact of specialty changes	New performance framework will address and the upward report regarding IIP	Finance, Performance and Estates Committee	**A**
						Improvement programmes for cancer, outpatients and urgent care in progress	Recovery post COVID and risk of further waves Urgent Care Transformation team not yet established	Outpatient Improvement Group Cancer Improvement Board Urgent and Emergency Care Board.	Improvement against strategic metrics % of patients in Emergency Department >12 hrs (Total Time) Delivery against 62 day combined standard Urgent Treatment (P2) turnaround time Deliver outpatient activity non face to face		Reporting via FPEC		
						Development and Implementation of new pathways for paediatric services - in progress, included in 21/22 plans.	Engagement exercise required to seek further views regarding the proposed revised model	CYP Group re-established	Board report July 2021				
						Urology Transformational change programme	Engagement exercise required to seek further views regarding the proposed revised model	Urology steering group in place reporting through IIP	Board report July 2021				
						Pre op Assessment Modernisation							

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						Support Creation of ICS - Lincolnshire designation 1st April 2021	Delay to review and adoption of legislation	Weekly ICS meetings Provider Collaborative Steering Group	SLB reports and upward reports by CEO / Chair				
						Support the consultation for Acute Service Review (ASR) Phase 1 - PCBC with national team	Awaiting CCG to review and sign off approach to consultation	Weekly ASR meetings	SLB reports and upward reports by CEO / Chair				
						Implementing the Outstanding Care Together Programme to support the Organisation to focus on high priority improvements - in progress	Disruption due to COVID has resulted in a less mature approach to strategy deployment, broad understanding across the organisation, progress on building capacity and capability.	OCTP Exec led pillar meetings continue ELT/TLT oversight Board / system reporting	Weekly ELT updates Monthly TLT updates Quarterly board reports Quarterly board development sessions				
4b	To become a University Hospitals Teaching Trust	Director of Improvement and Integration	Failure to develop research and innovation programme Failure to develop relationship with university of Lincoln and University of Nottingham Failure to become member of university hospital association		CQC Caring CQC Responsive CQC Well Led	University Hospital Teaching Trust Status Developing a business case to support the case for change			Progress with application for University Hospital Trust status			People and Organisational Development Committee	R
						Increasing the number of Clinical Academic posts			Numbers of Clinical Academic posts RD&I Strategy and implementation plan agreed by Trust Board				
						Improve the training environment for students			GMC training survey Stock check against checklist Internal Auidt - Education Funding				
						Developing an MOU with the University of Lincoln			RD&I Strategy and implementation plan agreed by Trust Board				
						Develop a portfolio of evidence to apply for membership to the University Hospitals Association							

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)	Control Gaps	How identified control gaps are being managed	Source of assurance	Assurance Gaps - where are we not getting effective evidence	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating

The BAF management process

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

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

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

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

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

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

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

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

Meeting	*Trust Board*
Date of Meeting	*2 November 2021*
Item Number	*Item 13.3*
Audit Committee Upward Report	
Accountable Director	*Sarah Dunnett, Audit Committee Chair*
Presented by	*Sarah Dunnett, Audit Committee Chair*
Author(s)	*Jayne Warner, Trust Secretary*
Report previously considered at	*N/A*

How the report supports the delivery of the priorities within the Board Assurance Framework	
1a Deliver harm free care	
1b Improve patient experience	
1c Improve clinical outcomes	
2a A modern and progressive workforce	
2b Making ULHT the best place to work	
2c Well Led Services	*X*
3a A modern, clean and fit for purpose environment	
3b Efficient use of resources	
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	*Assurance level* • *Moderate*

Recommendations/ Decision Required	• *Ask the Board to note the upward report and the actions being taken by the Committee to provide assurance to the Board on strategic objective 2c*

Executive Summary

The Audit Committee met via MS Teams on the 11th October 2021, the Committee considered the following items:

Internal Audit
The Committee received a progress report from the Trust Internal Auditor providers noting that progress during the second quarter had been slower than anticipated due to operational pressures and capacity.

A number of planned audit dates had been postponed however it was noted that the Internal Audit provider was confident of the ability to deliver the totality of the 2021/22 programme, including audits bought forward from 2020/21. The Committee however noted concern regarding the size of the programme and current Trust pressures that could impact on the ability of the Trust to support the programme with further assurance sought.

The Trust Internal Auditor Providers confirmed that a further two final reports had been issued since the last meeting, IIP CQC Outcomes report and Equality, Diversity and Inclusion, both of which offered partial assurance.

The Committee received a comprehensive update from the Trust's Chief Operating Officer on implementing recommendations to strengthen controls contained within the Internal Audit Estates Report. The Audit Committee will continue to seek assurance on implementation of the agreed action plan and its impact on issues highlighted within the review.

The Committee noted that there were 78 outstanding audit actions with 6 high risk, 17 medium risk and 14 low risk, with progress on implementing agreed recommendations slower than anticipated. The Committee would continue to seek assurance on the level of grip and control over progressing agreed actions and was seeking further assurance on those related to the workforce agenda.

The Committee also asked that the Board collectively seek further assurance on those outstanding in relation to Medicines Management.

Finance Ledger Implementation
The Committee received an update on the system wide implementation of the new finance system, with a go live date of 1st December 2021. The Committee noted the work underway for implementation and that work would be reviewed by both internal and external audit as part of the 2021/22 audit programmes. Internal and external audit are currently liaising on approach to the review.

External Audit
The Committee received the External Auditors Progress Report and confirmed the 2021/22 audit fee. The External Auditors have commenced planning work for the year with the Audit Strategy Memorandum due to be presented at the January Committee meeting, together with a progress report on prior year recommendations.

Counter Fraud
The Committee reviewed and approved the Local Counter Fraud Specialists Progress report.

The Committee noted that 961 responses had been received to the Annual Fraud Awareness Survey, a 10 % increase on prior year. 88.9% respondents said the Trust took allegations seriously, 90.3% said nothing would prevent them from reporting a fraud, and staff knew where and how to report. Actions to increase awareness are being targeted throughout November 2021, including a specific Fraud Awareness Week, commencing 14 November 2021.

Training rates were remained slightly behind target at 93.86% however there was continued momentum as this remained part of the Trust's core training offer.

Action on areas of the Counter Fraud Functional Standard Return that were rated red (2) and amber (3) were progressing and on track for an overall green rating for 2021/22, consistent with prior year. A focus was being given to the alignment of fraud risk assessments to Trust policies, development of outcome based metrics and roll-out of the Counter Fraud Champion role.

Compliance Report
The Committee received the regular report on compliance noting that this covered the period from July 2021 to September 2021. Oversight of regulatory notices and enforcement actions was noted including the removal and variations of S31 notices and improvement notices.

The Committee noted levels of staff over payments and pharmacy stock losses both showing improving positions on the previous year and requested that updates be provided in future reports to demonstrate progress.

The committee noted improving position in relation to waivers with 13 requested and 2 refused, this reflected significant improvements in processes that had been made.

The Committee noted the need for additional communications to be shared in to the organisation in respect of Standards of Business Conduct and Gifts and Hospitality in order to improve reporting.

Risk management and revision of risk register
The Committee have continued to request assurance on actions being taken to strengthen controls over risks and received a progress report on the risk register reconfiguration to support improvement, including an update on implementation of recommendations made by Internal Audit.

The Committee noted the status of the revision of the risk register that was due to be completed within a shortened timeline. The Committee noted the delivery of risk management training and work progressing through the divisions and oversight through monthly divisional governance of the risk register.

Policies Update
The Committee received an update in relation to the Year 2 IIP major project of a robust policy management system that offered limited assurance.

The Committee noted the resource that was in place and improved progress, offering a clearer understanding of the position. The Committee noted the continued fortnightly scrutiny by the Executive Leadership Team and the ongoing review of documentation management and control, along with policy approval processes. Work had commenced on the alignment and divisional review of documents.

The Committee sought further assurance on the review at divisional level. The Committee have requested future reports to quantify numbers outstanding.

Board Assurance Framework
The Committee confirmed that the Board Assurance Framework remained relevant and effective for the Trust with focus on the appropriate risks. The Committee noted the limited assurance.

Particular reference was made to Objectives 2a and 2b with the Committee requesting that the People and Organisational Development Committee undertake review of these objectives due to the Committee not having met due to the transitioning to a new Chair and interim Executive Director.

Objective 2c – Well Led Services was the remit of the Audit Committee and the amber rating for the objective was confirmed. The Committee requested that the BAF was populated to reflect assurance reports presented to the Committee, including the latest policy position, risk management updates, action on Estates management and losses, findings from internal audit reports, shared decision-making council implementation and removal of enforcement notices and conditions.

The follow-up of internal audit recommendations remained a concern.