Bundle Trust Board Meeting in Public Session 2 February 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 1 December 2020
Chair
Item 5.1 Public Board Minutes December 2020v1.docx

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

6 Chief Executive Horizon Scan Including STP
Chief Executive
Item 6 Chief Executive's Report 020221 FINAL.docx

6.1 Green Site Quarterly Review
Chief Operating Officer
Item 6.1 2nd Grantham Quarterly Review 22nd Jan v6.docx

6.2 Temporary Green Site Recommendations
Item 6.2 Grantham Green Site Temporary Changes Recommendations Trust Board 020221 v5.docx

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

7.1 Assurance and Risk Report from the Quality Governance Committee
Chair of Quality Governance Committee
Item 7.1 QGC Upward Report December 2020 v2.doc
Item 7.1 QGC Upward Report January 2021 v2.doc

7.2 Ockenden Review
Director of Nursing
Item 7.2 Ockenden and Reporting 21 01 21 v4.docx
Item 7.2 Ockenden Actions.docx
Item 7.2 First Ockenden Response - Urgent Actions Final 21 12 2020 211220.docx
Item 7.2 Second Ockenden Response.docx

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

8.1 Assurance and Risk Report from the People and Organisational Development Committee
Chair of People & OD Committee
Item 8.1 POD - Upward Report - December 2020v1.doc
Item 8.1 POD - Upward Report - January 2021.doc

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

9.1 Assurance and Risk Report from the Finance, Performance and Estates Committee
Chair of Finance, Performance and Estates Committee
Item 9.1 FPEC Upward Report December 2020.docx
Item 9.1 FPEC Upward Report January 2021 v2.doc

10	Strategic Objective 4 To implement integrated models of care with our partners to improve Lincolnshire's health and wellbeing
11	Integrated Performance Report
	Item 11 Integrated Performance Report - Trust Board Final V2.pdf
12	Risk and Assurance
12.1	Audit Committee Upward Report
	Chair of Audit Committee
	Item 12.1 Audit Committee Upward Report.docx
12.2	Risk Management Report
	Director of Nursing
	Item 12.2 Strategic Risk Report - February 2021.pdf
12.3	Board Assurance Framework
	Trust Secretary
	Item 12.3 BAF 2020-21 Front Cover January 2021.docx
	Item 12.3 BAF 2020-2021 v25.01.2021.xlsx
13	Any Other Notified Items of Urgent Business
14	The next meeting will be held on Tuesday 2 March 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 1 December 2020

Via MS Teams Live Stream

Present

Voting Members:
Mrs Elaine Baylis, Chair
Mrs Sarah Dunnett, Non-Executive Director
Dr Karen Dunderdale, Director of Nursing
Mrs Gill Ponder, Non-Executive Director
Mr Andrew Morgan, Chief Executive
Dr Neill Hepburn, Medical Director
Mr Mark Brassington, Director of Improvement and Integration/Deputy Chief Executive
Mrs Liz Libiszewski, Non-Executive Director
Mr Paul Matthew, Director of Finance and Digital
Dr Chris Gibson, Non-Executive Director
Mr Geoff Hayward, Non-Executive Director

Non-Voting Members:
Mr Simon Evans, Chief Operating Officer

In attendance:
Mrs Jayne Warner, Trust Secretary
Mrs Karen Willey, Deputy Trust Secretary (Minutes)
Mrs Anna Richards, Associate Director of Communications
Ms Cathy Geddes, Improvement Director, NHSE/I
Dr Maria Prior, Healthwatch Representative
Mr Mike Oko, BAME Network Chair (Item 8.2)
Mrs Saumya Hebbar, BAME Network Vice Chair (Item 8.2)
Mr Tim Couchman, Equality, Diversity and Inclusion Lead (Item 8.2)

Apologies
Mr Martin Rayson, Director of People &OD

1759/20	**Item 1 Introduction** The Chair welcomed Board members and members of the public who had joined the live stream to the meeting. In line with guidance on Covid-19 the Board continue to hold meetings 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.
1760/20	The Chair moved to questions from members of the public. **Item 2 Public Questions** **Q1 from Richard Rawlins**

	'Given ULHNHST's declaration in respect of clinical effectiveness that: **"All care needs to reflect clinical best practice and meet national guidelines to ensure that patients get the right treatment at the right time, every time"** **- please may I have sight of any and all evidence that is in the hands of ULH NHST's CEO; the Medical Director and/or the Trust's Ethics Committee, and in any patient consent literature - as to any benefit or harm caused by energies generated by Reiki therapists, and which are expected to benefit patients if applied at ULH NHST by an appointee to this advertised post?'** **I appreciate that presently there are more pressing issues for ULH, yet as the answer to this question is very simple and does not require metaphysical wriggling.** **Answering should be the work of but a moment.** **Please provide the evidence on the basis of which this post was devised, advertised and appointed.** The Medical Director responded: The evidence requested is available within the House of Lords Select Committee report on the use of complementary therapies dated 2000. The report has been shared with the Trust Secretary who would be able to send on to Dr Rawlins. The post had been withdrawn from the Trust and the Charities who fund the post were working with St Barnabas Hospice, who offer services on a different paradigm to ensure patients derive benefit. Events had moved on from the initial advertising of the post. **Q2 from Colin Musson** **With the release of 3 good vaccines and the Prime Minister saying that life could back to normal by April, when will ULHT start to recruit all levels of Staff from Consultants ,Doctors, Junior Doctors, Registrars and Nurses.to enable Grantham Hospital to re-open.** The Chief Operating Officer responded: Grantham Hospital remains very much open and continues to deliver critical services during the difficult times of the response to Covid-19. The site has provided many thousands of treatments for cancer and urgent care patients and is offering urgent treatment care services with partners Lincolnshire Community Health Services NHS Trust. The Chief Operating Officer was pleased to see the developments in the vaccines however stated that this had not stopped the Trust recruiting. The Trust had been able to continue to recruit all grades of Doctors throughout Covid-19 by utilising Microsoft Teams and other digital platforms. There had been successful recruitment of a number of good quality Doctors and Nurses throughout Covid-19. **Q3 from Jody Clark** **I firstly want to thank everyone in our Lincolnshire NHS for continuing to care for our community during such a difficult time.** **It was good to see that the Cancer care is continuing at Grantham Hospital and elective surgery. I hope this can continue during winter. I just wanted to ask, with the mention of the CT blue pathway proposed for Grantham. Can you please explain how that would work due to the green, covid safe measures?**

	The Chief Operating Officer responded: The Trust continued to attempt to expand provision of services at Grantham and the CT pathway, along with other diagnostic modalities and imaging, looked to increase what was offered at the offsite premises at the Gonerby Road, Health and Treatment Centre. It was hoped, through this provision to develop a regional diagnostic centre that would support blue pathway patients. Providing CT services at this site would support other services at Grantham such as the Urgent Treatment Centre as well as preventing patients travelling to Lincoln or Pilgrim unnecessarily. It was hoped that this development would be one amongst a number at the Gonerby Road site. **Q4 from Nicola Farrington-Rowlands** **I am aware that patients have tested positive for covid whilst on wards in the Trust. These patients have caught the virus in the place where they should have been safest. What is going on and why is infection prevention and control failing so direly in the hospital? How can patients get out of the endless covid cycle where they come into hospital because they need a procedure but can't have it because they are then covid positive? Transmission in hospital is preventing serious operations taking place.** The Director of Nursing responded: Community acquisition of Covid-19 is high and therefore the numbers within the hospitals reflect activity in the community. Daily monitoring of patients whose swabs return as positive are undertaken and as the Director of Infection, Prevention and Control and Director of Nursing these are reviewed at least three times during each day. The majority of patients are admitted with Covid-19 during the 5-7 incubation period of the virus however some patients test negative on admissions. All patients are tested on admissions and subsequently tested on day 3 of admission. These can also be negative with subsequent tests providing a positive result, these would be known as nosocomial transmissions. Due to the contagious nature of the virus it is difficult to identify who transmitted it but it is known that the virus spreads through cough droplets and the virus landing on hard surfaces. It is also known that a number of people are asymptomatic, both patients and staff, which leads to the virus spreading without knowledge. For this reason, across the NHS, self-testing has been rolled out with the Trust issuing over 4000 testing kits for frontline staff. This adds to the level of confidence and robustness of asymptomatic individuals. The Trust had taken a number of actions to reduce the risk of the spread of infection when staff or patients are in hospital. This included the use of personal protective equipment (PPE), so staff reduce the risk of transmission and daily audits for compliance. Any issues identified are promptly actioned however the Trust are seeing sustained use of PPE through the audits being conducted. Hand sanitisation is also being used by staff who are observed in their use, along with social distancing in both ward and non-ward areas in order to maintain infection, prevention and control (IPC) excellence. Robust cleaning is in place and where Covid-19 positive patients and staff are this is increased to reduce risk. Spot check audits are conducted to ensure cleaning is of the right standard and is maintained.

	The Trust has clear guidance in place for patients regarding mask wearing in order to stop patient to patient or patient to staff transmission. There has also been clear communication on sharing of items between patients such as books and magazines. Where patients have a medical condition resulting in difficulties wearing a facemask a number of interventions are in place to support those patients. The movement of staff across wards to support care and treatment has been reduced along with measures such as restricted visiting in order to reduce footfall. Designated Covid-19 wards and ward areas have also been established to contain the virus. Given the actions being taken by the Trust it is not felt that IPC practices are failing. The Trust have been testing all patients who are due to attend for a procedure before this takes place with the added advantage of the green site at Grantham undertaking a large proportion of elective activity. With the number of Covid-19 patients increasing in hospitals and putting a strain on services, there may be a need to cancel elective procedures in order to take care of critically ill patients. Regarding the point made about the endless Covid-19 cycle, once patients have tested positive, if they are not well enough to leave hospital, once they are past the 14 day period, symptoms have subsided or there is no deterioration related to Covid-19 the Trust would look to undertake the procedure. If however the patients condition was life threatening the procedure would be undertaken to save the life of the patient. This would be done in a way that protected staff and reduce the risk of transmission. IPC practices are taken very seriously by the Trust. The Chair thanked Ms Farrington-Rowlands for the question noting that the concern raised was understood. It was hoped that the public would appreciate from the answer to the question how seriously this was being taken and what measures the Trust had in place to prevent transmission. The Chair advised that the agenda for the meeting was truncated due to the significant pressure the Trust was under. As such a different format of reporting from the Chief Executive and Executive Directors would be presented.
1761/20	**Item 3 Apologies for Absence** Apologies for absence, due to being Covid Gold Commander, were received from Martin Rayson, Director of People and Organisational Development
1762/20	**Item 4 Declarations of Interest** There were no declarations of interest which had not previously been declared.
1763/20	**Item 5.1 Minutes of the meeting held on 3 November 2020 for accuracy** The minutes of the meeting held on 3 November 2020 were agreed as a true and accurate record subject to the following amendments 1560/20 – Should read – the Committee welcomed this support 1561/20 – Should read – had rather

1764/20	**Item 5.2 Matters arising from the previous meeting/action log** The Chair had reviewed the action log noting that this was up to date and no actions required the attention of the Board.
1765/20	**Item 6 Chief Executive and Executive Director's Organisational Update** The Chief Executive presented the report to the Board noting that the report also included updates from the Executive Directors.
1766/20	The Chief Executive provided a System and Trust update to the Board noting that there was media coverage regarding the Covid-19 vaccination. Planning was underway for the roll out of the vaccination however national approval had not yet been received.
1767/20	The flu vaccination programme for the Trust continued with 70% of frontline staff having been vaccinated. Additional doses of the vaccine had been received allowing the programme to continue. There had been a national drive to vaccinate staff to ensure sufficient time was left between receiving the flu vaccine and the Covid-19 vaccine, once approved.
1768/20	The System winter preparedness review had gone well and the formal write up was awaited. This had covered all issues related to winter, GPs, community, mental health and acute care. There were some follow up action to be focused on however the summary of the review was positive. It was hoped that this would be reflected in the formal response. Colleagues from NHS England had stressed that great team work had been seen along with support across the system.
1769/20	The Chief Executive noted that the outcome of the Acute Services Review panel was not yet known however the review of the pre-consultation business case had taken place and a letter, confirming progress to the national panel, was awaited. The system had provided good responses to the key lines of enquiry during the review and it was hoped that this would proceed to the national panel.
1770/20	As mentioned in the response to the public question, lateral flow testing kits had been received for staff and were being distributed to allow staff to undertake tests twice weekly and report results.
1771/20	The Chief Executive extended congratulations to Simon Evans who, following a national recruitment process, had been appointed substantively as the Chief Operating Officer. The post for the Medical Director vacancy had received 19 applicants with a strong field. The Chair and Chief Executive would be involved in the interview process.
1772/20	The Chief Executive had hoped to include within the report, updated guidance on maternity visiting however, this had not been received in time for inclusion. The Director of Nursing was asked to provide a verbal update.
1773/20	The Director of Nursing noted that the national guidance was awaited in relation to the expectation of visiting for parents across all areas of maternity services, known as green access. The Trust were working on the basis that access would need to be provided to a number of areas including date scans, 20 week and foetal medicines scan, induction of labour pathway, early and established labour and some antenatal clinic appointments.
1774/20	The Trust currently allowed partners to accompany women to all of the situations described, the Trust were confident that if the suggestions for green access were made in the guidance that the Trust would be compliant. The Trust had been clear that there had been a desire to

	maintain this as the importance of partners being with expectant mums throughout the pathway was understood.
1775/20	The Chief Operating Officer provided an incident and operational update in relation to Covid-19 advising that the NHS had returned to a level 4 incident on 5th November. This was due to the recognised increase in prevalence nationally and returned the NHS to a command and control approach with NHS England directing the response. The Trust had moved back to the manage phase of the incident and had already developed plans in line with the potential for a second wave.
1776/20	The report described the differences between wave 1 and 2 and it was noted that, whilst the Trust had received a significant number of Covid-19 patients in wave one, this was less so than some other Trusts. The Trust had learnt from wave 1 in how to respond and many of the actions taken in wave one were now in place for wave 2. There was however some significant differences that posed a significant challenge.
1777/20	Unlike wave 1 where non-Covid-19 emergency demand had reduced by up to 60% this was not the case for wave 2. The Trust was seeing significantly more Covid-19 cases both in and out of hospital in Lincolnshire and the implications of this were being experienced as explained by the Director of Nursing in response to the public question.
1778/20	As a result of the increased prevalence, the Trust were seeing an increase in the number of staff absent due to Covid-19 or due to family contacts. This was reducing the Trusts ability to respond to wave 2.
1779/20	Unlike the first wave, the Grantham green site model would provide an important response in maintaining cancer services, clinically urgent elective care and green services. This would continue but at a slightly lower level of activity, recognising the increased level of absenteeism of staff.
1780/20	The current position had been more challenging over the past week and the Trust had moved to critical incident in the past 24 hours. This response was part of the Trusts' emergency preparedness, resilience and response (EPRR) and was a planned response should the Trust be faced with the level of challenge seen. Support could be drawn from System partners in order to recover and reinstate all services.
1781/20	Delays had been seen in the emergency departments and access to urgent care. Some of this had been part of the response to try and protect IPC measures which would ensure patients were not admitted to high risk areas, where there would be an increased likelihood of contracting Covid-19. Some of the delays were deliberate in order to manage the risk of patients and maintain the highest levels of safety.
1782/20	The Chief Executive provided an update to the Board in relation to staff absence, keeping our staff safe, well-being and increasing supply.
1783/20	There were key issues in both staffing levels but also the well-being of colleagues and this was clearly reflected across the NHS. The Trust currently had an absence level of 11% of a headcount of 8000. Half of absences were Covid-19 related and were as a result of staff having Covid-19 or needing to isolate due to being in contact or living with someone who had contracted Covid-19.
1784/20	The level of absence had a bearing on the Trusts ability to provide a full range of services and flagged up the need for the well-being of the workforce to be looked after. Measures were in place to support staff well-being including risk assessments, twice daily health checks on site,

	lateral flow testing, flu vaccination, in additional to the well-being offer in place for staff and well-being hubs having been introduced recently at Pilgrim and Lincoln.
1785/20	The System was working well to supply workforce to the Trust, considerable support had been in place for a number of weeks and the Chief Executive thanked system partners for their support.
1786/20	In order to increase supply of staffing that Trust had undertaken a huge effort to redeploy clinical staff and support staff. The Chief Executive paid tribute to colleagues for their flexibility to redeploy, it had been incredibly difficult to move staff between wards and sites whilst respecting IPC requirements.
1787/20	The Director of Finance and Digital provided an update to the Board on the financial aspects of the Trust noting that for the first half of the year a break even position had been achieved each month. The second half of the year was following a national financial regime.
1788/20	The financial envelope was defined at Sustainability and Transformation Partnership and Integrated Care System level across the country resulting in Lincolnshire receiving £87m of funding in addition to the original base income allocation.
1789/20	This would cover the ability to continue to break even, as had been done in the first half of the year, and included growth funding costs for the changes in activity and inflations. This had also provided an assumption of the cost impact of Covid-19 for the last half of the year.
1790/20	At month 7, October, the Trust had reported a small surplus of £145k against the block allocation of £11.9m that had been received from the £87m system allocation.
1791/20	The underlying reason for the surplus had been due to £400k less than planned being spent on pay, mainly due to the inability to achieve the level of agency staffing expected. In the main this had offset the pressures in non-pay, particularly with an electrical and energy infrastructure failure that had resulted in a one off cost of repair and some other utilities costs. It was expected that this would reduce at the end of November.
1792/20	A further £700k of costs had been incurred due to Covid-19, bringing the total spend to £15.2m year to date (YTD). A further £600k of costs had been incurred on restoring services bringing costs to £3.3m.
1793/20	Capital spend YTD was £7.3m being £10m behind plan although the Trust were on track to spend all of the allocation by the end of March 2021. The Capital Delivery Group had successfully been put in place to oversee capital spend. A number of tenders were out to market and work was underway, amongst Covid-19, although an element of risk remained to delivery.
1794/20	The Lincolnshire System had submitted a financial plan inclusive of a £4m deficit that would sit solely with Lincolnshire Clinical Commissioning Group, with the expectation that each of the providers would break even. At month 7 there was a system deficit of £16k reported however the overall position of the system was £500k favourable to plan, driven in part by the Trusts favourable month 7 position.
1795/20	Dr Gibson noted the positive development of the use of lateral flow testing but stated that there had been some concern regarding false positive results and staff isolating unnecessarily. Dr Gibson asked if the Trust were able to provide gold standard PCR testing promptly for staff who had received a positive lateral flow test.

1796/20	The Chief Operating Officer advised that as part of the plan for lateral flow testing, which was known not to be as accurate as conventional PCR tests, an approach was put in place which would follow on from the lateral test. This would provide a rapid turnaround for staff, currently 24 hours, for PCR testing. The Trust may lose a day of a staff members time in terms of the overall process, this was not resulting in long periods of time.
1797/20	Dr Gibson also noted that there had been public debate regarding the vaccination process and hoped that the Trust plans for this included an element of communication planning. If the vaccine was approved by the Medicines and Healthcare products Regulatory Agency (MHRA) it was hoped that Trust staff would confidently set an example to the rest of the community in taking up the vaccine.
1798/20	The Chief Operating Officer noted that if had been difficult to identify timescales and information for vaccine planning however a short turnaround time in terms of notification to commence was expected. Planning had been in place for some time in terms of the overall process and mechanisms were being set up that would come online from December. Key communication messages had been drafted and were ready to use however, details of delivery and the site were not yet confirmed. Learning from the roll out of lateral flow testing had been applied to the communications for the vaccination.
1799/20	Mrs Ponder asked, given the importance of annual leave on staff wellbeing and the bigger impact of the second wave of Covid-19, how were the Trust enabling staff to have leave without compromising patient safety.
1780/20	The Director of Nursing stated that the Trust always tried to balance service and patient needs but also maintaining staff needs for health and wellbeing. This was difficult to balance however as a principle there was a desire to ensure staff took leave and were enabled to do so.
1781/20	At this point in the year staff should have taken half of their leave entitlement and the situation was being reviewed. In current circumstances, due to the critical incident, staff were being asked to step forward and give up some leave on the understanding that this was done through a risk assessment process. Where staff had a need to take leave for wellbeing the Trust were supportive of this however if some staff could give up leave without compromising their wellbeing they would be asked to do so.
1782/20	The Chair was grateful for the comprehensive report noting that the Trust was facing significant operational challenges. Unlike wave 1 higher levels of Covid-19 were being seen along with activity levels in urgent care.
1783/20	The Chair offered her sincere thanks for the huge effort to continue to deliver services, support staff and continue to keep patients safe. The Trust Board: • **Noted the update and significant assurance provided**
	Item 7 Objective 1 To Deliver high quality, safe and responsive patient services, shaped by best practice and our communities
1784/20	**Item 7.1 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 17th November meeting noting that there had been both

	reduced attendance and agenda due to being in a critical incident when the meeting took place.
1785/20	Despite this position the Committee had covered a significant amount of normal reporting and the Committee were pleased to advise the Board that a significant number of actions associated with Never Events had now been closed. Improvement continued to be seen in the work taking place across the governance team.
1786/20	The Committee had received the first report outlining the Trusts approach to Safety Culture. Work would commence in the operating theatres and it was understood that the first survey had now commenced. It was noted that these had seen some delay due to Covid-19 but key roles were being put in place to ensure work was taken forward.
1787/20	The Committee were suggesting to the Board that an update on Safety Culture work was received directly due to the breadth of work and responsibility of all Board members in ensuring that this was embedded in to practice across the organisation.
1788/20	The Committee had received a significant update in relation to infection, prevention and control that had been covered by the Director of Nursing in the response to the public question. The Committee had been updated on the issues associated with outbreaks, personal protective equipment availability and flu vaccinations.
1789/20	An update had been received in relation to key issues learnt from serious incident, particularly in relation to the recruitment of a thrombolysis nurse who would be taking forward key actions in this area.
1790/20	Open actions from complaints had been updated to the Committee with a plan in place to address the issues highlighted along with the implementation of a robust process going forward. The Committee would continue to regularly monitor complaint actions to ensure historical actions were closed and the process for future complaint actions embedded.
1791/20	The Committee received an update on the submission of the clinical audit to surgical site infections and the actions to be taken, particularly in light of the absence of key guidelines. The Committee were assured actions were being put in place and monitored.
1792/20	National reporting in to stroke and stroke outcomes, along with benchmarking data had been received. The interim pathway had been reviewed and altered with a memorandum of understanding put in place with an alternative organisation for service provision. The Committee intended to continue to monitor the outcomes to patients but had also requested that the Finance, Performance and Estates Committee consider if the performance measures in place ensured the pathway remained safe.
1793/20	The Chair noted that a Safety Culture upward would be received by the Board in due course and was pleased to see that the Committee had sight of harm reviews, quality impact assessments and mortality data.
1794/20	The Chair recognised that the Stroke Service was fragile noting that this formed part of the Acute Services Review. In the interim, the Committee would need to ensure close monitoring of the quality of the service provided. The Trust Board: • **Received the assurance report**

	Item 8 Objective 2 To enable our people to lead, work differently and to feel valued, motivated and proud to work at ULHT
1795/20	**Item 8.1 Assurance and Risk Report People and Organisational Development Committee** The Chair of the People and Organisational Development Committee, Mr Hayward provided the assurances received by the Committee at the 12th November 2020 meeting.
1796/20	The Committee had noted continued improvements in recruitment and appraisal rates, which were now at their highest since May 2018. It was noted however that the ability to maintain the position was being impacted by Covid-19.
1797/20	Mr Hayward also noted the continued progress in relation to the Trust becoming a University Hospitals Teaching Trust. This was a long term project but progress was being made. The Trust Board: • **Received the assurance report**
1798/20	**Item 8.2 BAME Network update – presentation** The Chair introduced the Black, Asian, Minority Ethnic (BAME) Network update and welcomed the Chair Mr Mike Oko, Vice Chair Mrs Saumya Hebbar of the network and Mr Tim Couchman, Equality, Diversity and Inclusion Lead had also joined the meeting.
1799/20	The relationship with staff networks was important at any time but particularly BAME issues in the current environment, as such the Board sought to focus further attention to this.
1800/20	Mr Oko provided a presentation to the Board noting that there was a desire to further develop the relationship with BAME staff who were fundamental to the running of the Trust.
1801/20	Area 1: Protection and Safety, the Trust had done well to support staff to be redeployed during the pandemic and had been noted in the British Medical Journal. The network were also exploring dedicated time in the first year of appointment to the Trust for medical staff in order to allow for time to adjust to the Trust environment and the UK.
1802/20	Both the BAME Chair and Vice Chair had expressed their intention to become Freedom to Speak Up Champions however training had been paused due to Covid-19.
1803/20	The Alama risk assessment had been released which when completed identified a Covid-19 age which should then be acted on to reduce risk. All staff should have a culturally appropriate risk assessment in place.
1804/20	Area 2: Recovery and Redesign, the network were trying to ensure there were representatives in place for the identified work streams and it also felt that this would be a good time for the Trust to actively recruit staff and sell the Trust better. The development of the medical school offered a good opportunity to attract good quality Doctors to Lincolnshire.
1805/20	44% of the medical school were from a BAME background and in 4 years would be working in the organisations. There was a need to continue learning and have a realistic timeline to progress.

1806/20	Area 3: Decision Making, there was a need to consider the impact on BAME staff in decision making processes, this responsibility would sit with the Board where there was a need to ensure clear and effective communication.
1807/20	The Chair and Vice Chair were now able to attend Gold meetings in order to provide representation. This provided useful insight and it was hoped that this could progress for staff being involved regularly.
1808/20	The creation of a monthly dashboard was awaited that would offer a pulse check of issues within the organisation.
1809/20	Area 4: Engagement, funding had been arranged for the Chair of the network and support of time off in lieu for the Vice Chair. The reverse mentoring programme had commences and was progressing reasonably well.
1810/20	Support was sought for each division to have and equality, diversity and inclusion lead in place who could support proactive engagement.
1811/20	Area 5: Media and Communication, the network were hoping to foster a sense of family within the organisation. There was money being spent on locum staff that, if the Trust recruited, did not need to be spent. This was an ideal time to recruit and sell Lincolnshire if the Trust were willing to be proactive.
1812/20	The network had secured £50k of monies from Sir Tom Moore fundraising and some of this would be used to build the relationship with the medical school, development of and App to support training. This would fit with the long-term development of the medical school.
1813/20	The Board were advised from the presentation that the new cohort of Doctors knew what they would like to receive from the Trust with this primarily to be treated fairly.
1814/20	The Chair thanked Mr Oko for the presentation noting that it was pleasing to see the progress being made by the network.
1815/20	Mrs Hebbar noted that due to Covid-19 work and discussion were not progressing as fast as would be liked however it had been possible to continue network calls and engagement. Staff were able to join the calls in order to share concerns and highlight issues.
1816/20	Mr Couchman thanked the Board for the opportunity to share comments noting that it was important that lessons learnt through wave 1 and in to wave 2 were acted on with a focus on completing equality impact assessments. Support was in place for the equality, diversity and inclusion team with an additional appointment that would allow a focus on supporting staff networks. It was felt that it would be important to ensure that all staff networks could connect and this had been an important step forward.
1817/20	The Director of Improvement and Integration, as the Executive Sponsor for the network, thanked Mr Oko, Mrs Hebbar and Mr Couchman for the work being done to support the network. This had grown and broadened significantly to support colleagues across the organisation.
1818/20	There had been significant changes to the way in which the network was functioning with the Chair and Vice Chair spending time working across the system with other chairs. This offered power in numbers and was an important point that could not be lost.

1819/20	Good links were being developed with the medical school and support was being offered to medical students from BAME backgrounds in respect of training and transition in to first roles within the NHS. Support to other professional groups was also being explored.
1820/20	The network was also working across the region and with national teams which was providing a good profile for the work being done in Lincolnshire to support colleagues during Covid-19. The Director of Improvement and Integration noted that there remained more to be done however during the extremely challenging times momentum had been maintained.
1821/20	The Chief Executive expressed thanks for the presentation noting the great work that was being done, noting positive involvement with a reverse mentoring role with a BAME colleague. The Chief Executive asked, as a BAME ally with considerable positional authority, what could be done to help progress the delivery of the action plan.
1822/20	Mr Oko noted that progress would take time but that the Chief Executive had the power to lead change, knowing when things were not right and had the ability to change this.
1823/20	The Director of Nursing would be interested in supporting the BAME network due to previously working in a Trust with a high number of BAME colleagues but would also be interested in working together across the networks, as the executive sponsor for the women's network. There was clear alignment of the objectives across the networks that the Executive Directors wished to support.
1824/20	Mrs Hebbar referred back to the question from the Chief Executive stating that from the point of view of the network that biggest thing that could be done would be to ensure the level of passion and enthusiasm shown was pushed down to the next level of leaders. The dashboard would support this by highlighting key figures and would be shared with all managers at band 8 and above. The metrics would need to be taken seriously and there needed to be a way to take the leaders on the journey and find more allies.
1825/20	Mr Oko stated that a timeline from the Chief Executive on when things could change would be useful. The medical students would be arriving in 4 years and this could be the starting point to lay out a timeline of where the Trust wanted to be.
1826/20	Mr Couchman advised that the dashboard was being developed and that this would be tested at a divisional level and at clinical business unit in some areas, so that senior managers had access to patient and workforce data. Whilst the current commitment was positive, this needed to continue and the support of the Trust Board in relation to reverse mentoring was appreciated. A framework had been agreed in order embed the offer.
1827/20	Mr Couchman noted that the cultural intelligence work had been delayed due to Covid-19 however this could have a big impact across the system once introduced. Continued support and strengthening of the staff networks was needed however this was underway.
1829/20	The Chief Executive welcomed the practical nature of the points raised by the Chair and Vice Chair of the network noting that this was about the ownership below executive level and active involvement and delivery of the agenda. The Chief Executive would consider the request and present some ideas back to the network in due course.
1830/20	The Chair sensed that there was a step change in inclusion, particularly for BAME colleagues, language was changing and whilst this was in the early stages of the journey there was a sense that this was on the right path.
1831/20	The list of requests from medical students presented was reasonable and something that could be achieved. The Chair had offered to meet with the Chair and Vice Chair of the

	network following the Board meeting and invited the Chief Executive to be part of the discussions. **Action – Chair/Chief Executive, 2nd February 2021**
1832/20	The Chair offered assurance of the continued support to the network and to the intention to change the profile of how BAME colleagues were treated within the organisation. A further report would be received by the Board in 3 months. The Trust Board: • **Received the BAME Network update**
	Item 9 Objective 3 To ensure that service are sustainable, supported by technology and delivered from an improved estate
1833/20	**Item 9.1 Assurance and Risk Report from the Finance, Performance and Estates Committee** The Chair of the Finance, Performance and Estates Committee, Mrs Ponder provided the assurances received by the Committee at the 19th November 2020 meeting noting that there had been a lean agenda in view of covid pressures.
1834/20	There continued to be a lack of assurance on a number of estates areas and additional assurances had been requested. The Committee sought assurance on the delivery of action plans that were stated to be in place but provided no assurance of delivery.
1835/20	Further assurance had been sought around baseline date on which to measure outcomes and follow up activities after cleanliness audits, along with continued compliance with enforcement notices.
1836/20	Mrs Ponder highlighted to the Board that the Trust had achieved a small surplus, as detailed in the update from the Director of Finance and Digital, which was a unique position for the Trust.
1837/20	The Committee noted that an area of concern had been identified in relation to missing outcomes, not only due to the financial impact but also due to the potential impact on patients. A plan would be developed to provide focus.
1838/20	Concern had also been raised regarding the clearance of 104 day waits, these had been on track to clear by November however had slipped due to Covid-19. There was concern about the impact this could have on patients and the Committee asked that the Quality Governance Committee consider if the harm review process in place was working effectively to review any potential harm to patients.
1839/20	The Chair asked that the Chairs of the Finance, Performance and Estates Committee and Quality Governance Committee met to discuss the approach to harm reviews from the perspective of both Committee to ensure that the right Executive Directors were tied in to the process.
1840/20	Mrs Libiszewski noted that the harm review process was due at the Quality Governance Committee however the action would be taken forward to ensure this was covered appropriately. **Action – Mrs Ponder/Mrs Libiszewski, 2nd February 2021**

	The Trust Board: • **Received the assurance report**
	Item 10 Objective 4 To implement integrated models of care with our partners to improve Lincolnshire's health and wellbeing
1841/20	**Item 10.1 Lincolnshire System Priorities 2020/21 – Status update** The Chief Executive presented the report noting that this was a new report from the System that would be presented to all Boards across Lincolnshire.
1842/20	The report detailed the 13 priority topics that the Lincolnshire NHS System had set itself at the beginning of the year. It was noted that whilst it had not been a typical year due to Covid-19 it had felt appropriate to pursue, as much as possible, the priorities set.
1843/20	The Chief Executive advised that different organisations were leading on different priorities with the Trust leading on Access Waiting Times and Cancer. The Trust provided assurance both to the Trust Board, through performance and Committee reports, and other Boards within the system.
1844/20	In addition to the summary report received by all Boards, additional detailed reporting was being considered as to what individual Boards required on these topics. Working on the principle that if reports were being produced this would only be done once to be received by all respective Boards. In the absence of detailed reports the high level summary provided progress against the priorities and was presented for information.
1845/20	The Chair noted that this had also been received to the System Leaders Board and conversations had taken place around what sits behind the report to provide the right level of assurance, whilst also forming part of the phase 3 response to report to the regulators. The Trust Board • **Received the report**
1846/20	**Item 11 Integrated Performance Report** The Chair invited the Board to receive the report containing October performance data. The executive summary was self-explanatory and the Committees had referenced the relevant metrics within the upward reports. The Trust Board: • **Received the report and limited assurance noting current performance**
	Item 12 Risk and Assurance
1847/20	**Item 12.1 Risk Management Report** The Director of Nursing presented the report to the Board advising that this provided a short and strategic risk report which focused on the highest priority risks being managed in the Trust.
1848/20	The highest risks continued to relate to Covid-19 and the potential impact on patients, staff and the continued provision of a full range of clinical services. The report also offered a summary of the current strategic risks included within the report.

1849/20	Dr Gibson noted that there was reference to a system wide resilience review and system resilience group in the context of the Trusts strategic risk around emergency demand. Dr Gibson was unclear that the Board had received any detail relating to the review.
1850/20	The Chief Operating Officer advised that this tied back to the update from the Chief Executive in relation to the work completed by the System to prepare for Phase 3 and the winter period. The letter that summarised the output of the review was awaited and would be shared with Board members once received.
1851/20	The Chair noted the report outlined the top risks, particularly in relation to quality and safety and the impact of Covid-19. There were a number of risks relating to capacity to manage emergency demand, finance and workforce. Board members were invited to confirm that the risk register presented captured the top risks for the organisation and the actions and mitigations were appropriate.
1852/20	Mrs Libiszewski asked if there was an increased risk relating to EU Exit.
1853/20	The Director of Improvement and Integration advised that additional risks had not currently been identified. A checklist had been received by the Trust for completion ahead of return by the end of the week. Discussions would be held with subject matter experts across the organisation to complete this. The position remained as a watching brief. The Trust Board: • **Accepted the top risks within the risk register** • **Received the report and noted the moderate assurance**
1854/20	**Item 12.2 Board Assurance Framework** The Chair noted that the Board Assurance Framework (BAF) had been reviewed by each of the Committees and noted that a request had been made to revert the BAF to the pre-Covid-19 format.
1855/20	The Board would not see the BAF until February 2021 and the Chair noted that it would be important to receive this as complete as possible ahead of the end of the financial year.
1856/20	The Chair noted that assurance had been received that this would not cause additional work for Executive colleagues and that most of the work would be conducted through the Committees and Trust Secretariat.
1857/20	The Trust Secretary noted that the Committees were having difficulty in lining up the narrative in the BAF, in the current format, due to assurances being received in some areas. The work to revert the BAF would be completed within the Team, populating with assurances in place and ensuring that this was reflective of what was being seen by the Committees.
1858/20	It was recognised however that some areas would continue to be significantly affected by Covid-19 and as such a balance would need to be found to reflect this.
1859/20	The Chair noted that importance to capture assurance on all work that was being done and not just that directly related to Covid-19.
1860/20	Mrs Libiszewski supported the amendment but sought assurance that there would be no structural change.

1861/20	The Chair confirmed that there would be no changes to the structure but that this would utilise the format in place and ensuring that reporting and activity was captured to offer assurance against all strategic objectives. The Trust Board: • **Received the report and noted the limited assurance** • **Accepted recommendations as outlined in the report**
1862/20	**Item 13 Any Other Notified Items of Urgent Business** There were no other notified items of urgent business
1863/20	The Chair noted that it was clear that the Trust was facing challenging times and offered personal thanks to the Chief Executive and Executive Directors for leading the response for all service demands including Covid-19.
1864/20	Support was offered by the Chair to Executive Directors should they feel that the Trust Board could provide additional support.
1865/20	The Chair thanked all members of the organisation for responding magnificently and noted that there would continue to be a need for people to step up their response for some time.
1866/20	The next meeting will be held on Tuesday 2 February 2020, arrangements to be confirmed taking account of national guidance

Voting Members	**4 Feb 2020**	**3 Mar 2020**	**7 Apr 2020**	**5 May 2020**	**2 June 2020**	**11 June 2020**	**7 July 2020**	**4 Aug 2020**	**1 Sept 2020**	**6 Oct 2020**	**3 Nov 2020**	**1 Dec 2020**
Elaine Baylis	X	X	X	X	X	X	X	X	X	X	X	X
Chris Gibson	X	X	X	X	X	X	X	X	A	X	X	X
Geoff Hayward	X	X	X	A	A	A	A	A	A	A	A	X
Gill Ponder	X	X	X	X	X	X	X	X	X	X	X	X
Neill Hepburn	X	X	X	X	X	X	A	X	X	X	X	X
Sarah Dunnett	X	X	X	X	X	X	X	X	X	X	X	X
Elizabeth Libiszewski	X	A	X	X	X	X	X	X	X	X	X	X
Paul Matthew	X	X	X	X	X	X	X	A	X	X	X	X
Andrew Morgan	X	X	X	X	X	X	X	X	X	X	X	X
Victoria Bagshaw	X											
Mark Brassington	X	X	X	X	X	X	X	X	X	X	X	X
Karen Dunderdale		X	X	X	X	X	X	X	X	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
1 October 2019	1576/19	Smoke Free ULHT	Post implementation review to be presented to the Board	Rayson, Martin	~~07/04/2020~~ ~~03/11/2020~~ 01/12/2020	Agenda Item for Private Board December. Deferred due to covid pressures
4 February 2020	077/20	Assurance and Risk Report Quality Governance Committee	Review of TOM and governance to be presented to the Board	Evans, Simon	~~07/04/2020~~ ~~07/07/2020~~ 03/11/2020	Further work commissioned. Report now expected March 2021
1 December 2020	1831/20	BAME Network update	Chair and Chief Executive to meet with Chair and Vice Chair of the BAME Network	Baylis, Elaine/Morgan, Andrew	02/02/2021	Meeting arranged. Complete
1 December 2020	1840/20	Assurance and Risk Report from the Finance, Performance and Estates Committee	Mrs Ponder and Mrs Libiszewski to discuss the approach to the harm review process	Ponder, Gill/Libiszewski, Liz	02/02/2021	Discussion has taken place. Updates included within upward reports from Committees. Complete

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Public Trust Board*
Date of Meeting	*2 February 2021*
Item Number	*Item 6*
Chief Executive's Report	
Accountable Director	*Chief Executive*
Presented by	*Andrew Morgan, Chief Executive*
Author(s)	*Mark Brassington, Deputy 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	*Insert assurance level* • *Significant*

Recommendations/ Decision Required	• *To note*

Executive Summary

1. **Introduction**

   As well as the usual CEO updates this report also has updates from Directors on key issues. This is in recognition of the need to reduce the burden on Directors of writing reports during the current Wave 2 of COVID, whilst still providing appropriate assurance to the Board.

2. **CEO System Overview**

   - Following the approval of the Pfizer and Astra Zeneca vaccines we have been successfully running hospital vaccination hubs at Lincoln and Pilgrim as part of the wider Lincolnshire plan that includes local vaccination services and also vaccination centres. Significant progress has been made in Lincolnshire with vaccinating cohorts 1-4 as outlined by the Joint Committee for Vaccinations and Immunisations. We continue to operate under national instruction. We are also able to report that we have been working hard to improve the uptake of the flu vaccination amongst NHS staff. The latest report indicates ULHT have successfully vaccinated 90% of colleagues.
   - Much of the focus within the system remains on managing Wave 2 of COVID and winter demand.
   - We have now received feedback following the positive Acute Services Review (ASR) Panel review meeting with Midlands NHSE/I on 12th November. Work is underway to respond to the queries raised by the middle of February after which we expect it to proceed to the National Panel for review and hopefully approval.
   - Our Designation pack for becoming an Integrated Care System has been reviewed by NHSE/I colleagues with further feedback provided to us. An updated designation pack will be shared with regional colleagues by 8th February.
   - As a system we continue to monitor the impact of leaving the EU. At the time of writing there have been no concerns or escalations raised.

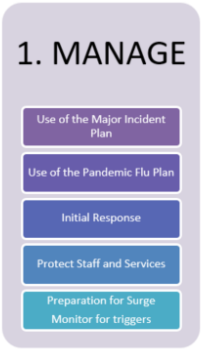
3. **CEO Trust Overview**

   - The Trust has allocated over 7,300 lateral flow test kits to enable colleagues to test themselves for COVID twice weekly. Over 58,500 lateral flow tests have been completed with a positive rate of less than 1%. This is a really important adjunct for us to keep our colleagues and patients safe. We have also been able to implement rapid COVID testing for all admissions via our Emergency Departments This is enabling us to determine COVID status for all admissions prior to moving patients into hospitals beds. This again is another action we are taking to help to keep our colleagues and patients safe.
   - In January we were able to reopen Dixon ward following a seven month and £1 million upgrade to our gastroenterology ward. This sets our new standard for Infection Prevention and Control for our ward environments
   - Finally I am pleased to share that we have won two healthcare awards. Firstly an Estates and Facilities Innovation award at this year's Health

Business Awards – for actions we have taken to reduce our carbon footprint which included replacing our lighting and combined heat and power units. Secondly, Vel Saktivel won Working with finance – clinician of the year award at the Healthcare Financial Management Association due to his extensive work in orthopaedics.

4. Covid – Incident and Operational Update

The NHS continues to operate in a level 4 incident and as such we continue to be governed by national direction of the response to the pandemic and increasing number of cases of Covid-19 in hospitals across the country.
In response to this the Trust put in place immediately a full Incident Command Centre approach echoing the model used in the initial stages of the pandemic in March. Plans developed in March this year did consider the need to return to this status and therefore the Trust re-activated its MANAGE phase plan to respond to the current challenges.



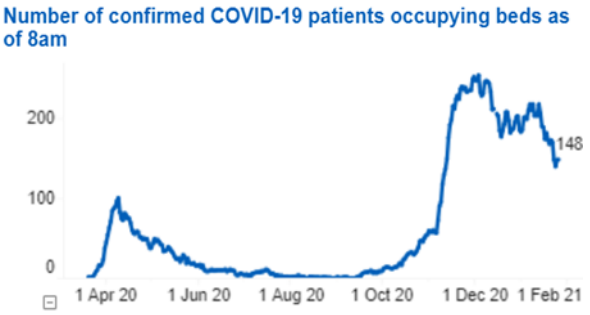
Objective
- Put in place the necessary resources and management operations
- Immediately necessary changes; constraints based and preparation for surge

Policies
- Pandemic Influenza Plan, and
- Major Incident Plan

Plans developed
- Surge Plan v8 – Triggers in Critical Care and Ward Based Demand
- Oxygen & Bed Allocation Plan
- Workforce Plan

Unlike Wave 1 the most recent increase in Covid-19 demand on services and staff is in the context of much busier hospitals conducting emergency and elective care at levels similar to pre-Covid-19 pandemic. A number of factors are driving this:

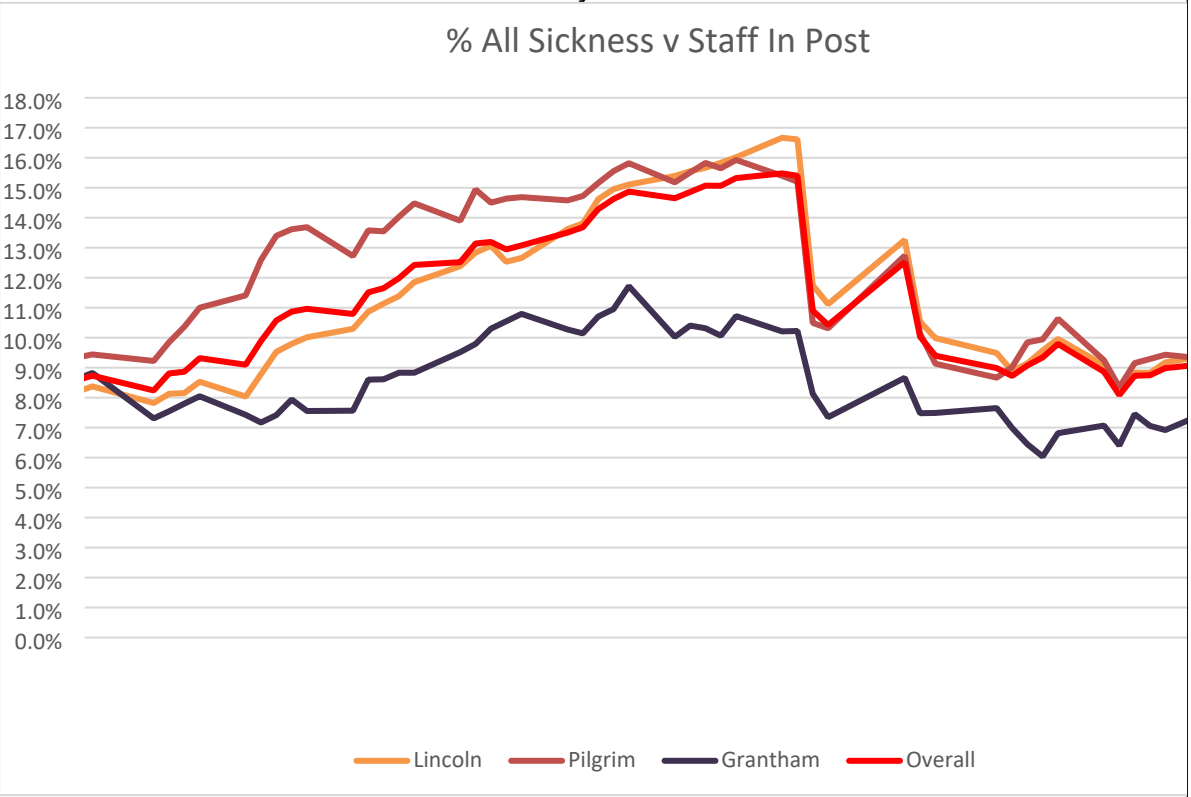
- Wave 2 Urgent Care demand has returned to pre-covid levels thus increasing the burden placed upon the trust in supporting the number of patients requiring inpatient care and demand on Emergency Departments
- There are increased numbers of patients that are Covid-19 positive that require care that cannot be supported by homes/services in the community in wave 2 increasing delays to discharge although the system has responded through commissioning designated beds to care for patients with a COVID-19 positive status.
- The prevalence of Covid-19 in Lincolnshire in recent weeks is significantly higher than in Wave 1, resulting in more than double the number of patients in our hospitals. At the peak of Wave 2, the Trust was caring for 253 confirmed cases (4th Dec)



- The intention in Wave 2 was a continuation of Cancer and clinically urgent care appointments/treatments. Due to the unprecedented increase in COVID-19 admissions to our hospitals, some service suspension has been experienced on the Green pathways based at Pilgrim and Lincoln. The Trust is working closely with the regional cancer Hub to ensure treatment pathways continue through prioritisation. In addition, increased activity has been planned at Grantham Green Site.
- The level of staff absence and reduced agency staff fill rates increased to a critical level in December but is now showing improvement.

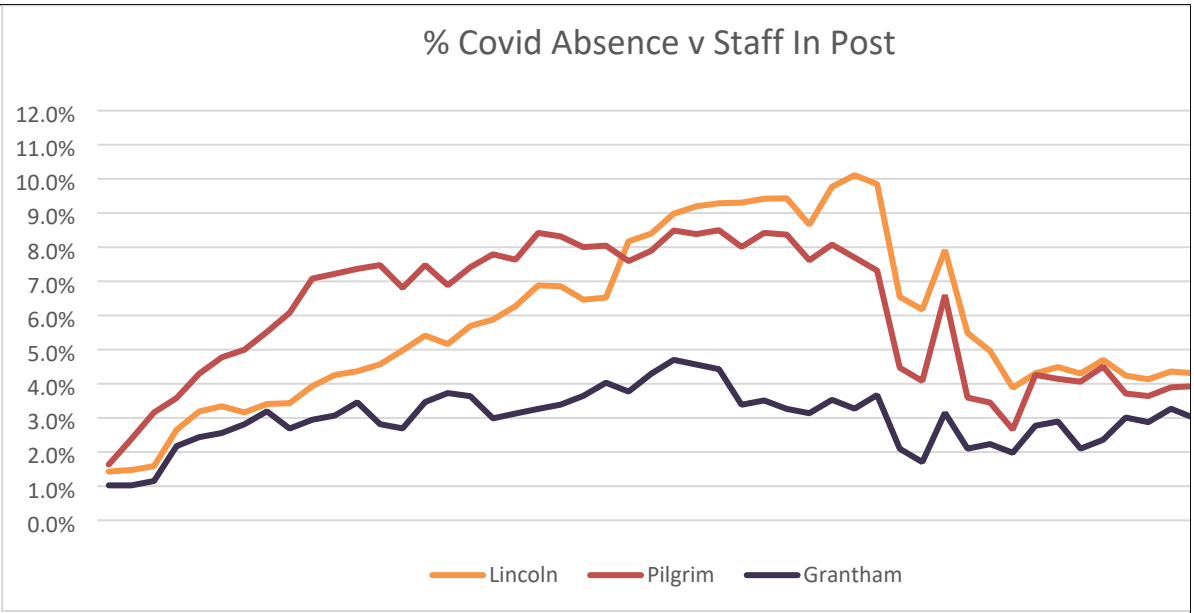
5. Staff Absence

As of 25th January, the overall percentage absence rate was 9.44%. The chart below shows the sickness rate since early-November.



At the end of December an exercise was undertake to review all recorded absence in our systems and ensure absence records had been closed by managers when staff had returned to work. That re-set significantly reduced overall absence rates. The introduction of the Attendance Management System for all staff from February, will enable the more accurate recording and management of sickness.

The chart below shows the COVID sickness rate for the same period by site. The chart shows the same re-set at the end of the year, but also the lower sickness rates at Grantham and the fact that since the beginning of 2021, COVID sickness rates have reduced.



There are a significant number of staff who are absent for reasons other than COVID. There has been a growth compared to the same period in 2019/20 in the number of people absent owing to stress. We have brought in additional resources in both the Employee Relations Team and Occupational Health to assist in managing core absence. There is a particular focus on managing the well-being of our staff in order to prevent absence and support the return to work and this is detailed below.

6. Keeping our staff safe

We have a framework in place to ensure our staff are safe at work. There is regular communication about the appropriate use of PPE. Where we have been concerned about inappropriate use of PPE, we have introduced a process where staff are taken through a rapid training programme on PPE and are strongly reminded of our expectations of them as employees. We are about to embark on a further communications campaign to promote safe working and the use of PPE.

96% of all our staff and 100% of our BAME staff have had a COVID risk assessment. Adaptations to working arrangements have been made where necessary, including advising that staff work on green pathways. We update our risk assessments based on PHE guidance.

All staff have now been issued with a personal thermometer to enable them to monitor their own temperature and they are advised do so twice a day. In addition well-being points are in place at the Grantham Green Site and at the entrance to clinical areas and those attending those sites are asked to take their temperature on arrival.

At two hospital hubs we have vaccinated 7,500 ULHT staff and over 4,000 other health staff in line with the guidance on vaccination priorities set by the Government. We are now also focusing on vaccinating social care staff, again in line with Government guidance. We are following up with the staff who have not as

yet received the vaccine to determine whether they have made a positive choice and to explore whether they can be persuaded to do so (in line with our duty of care to staff and patients.

7. Well-Being

An extensive well-being offer remains in place through the COVID pandemic. We are focusing in particular on the well-being of staff in ICU, given the increased demands placed upon them. However, our offer is available to all staff and we are starting to plan for the longer-term, recognising there will be a long recovery process, once the initial incident is over.

The particular actions taken in the last two months are as follows:

- All staff received a Christmas card thanking staff for their hard work, signed by Exec Team members
- All staff (including bank staff) were entered into a prize draw. This has been extremely well received by staff on social media
- Two physical wellbeing hubs are established at LCH and PBH, open five days a week, 10am -4pm. In the first few weeks of opening, 65 staff attended. This was for a variety of reasons and some staff were escalated to immediate help from Occupational Health. Attendance will be kept under review.
- A Whats'app support line has been set up for staff who aren't able to leave their work area to visit the hubs.
- All ward managers are receiving wellbeing calls to (a) check on their own wellbeing and (b) to ask if they need support in managing staff sickness.
- Additional counselling support has been procured to provide "in-situ" support on or most challenged wards
- A bid for additional funds for Health and Well Being is being submitted to the Charitable Funds Committee
- Execs and OD team members did ward walk rounds before and during Christmas period with Christmas cards reminding staff of the key wellbeing offers
- Managers have been trained in the process and skills necessary for de-briefs.

ULHT is working in partnership with system health and care colleagues as part of the Lincolnshire People Plan to explore system wide Heath and Well Bing offers, linking in particular with the expertise available in LPFT.

The SBAR (Situation, Background, Assessment, Recommendations) provides a regular communication to staff on the Trust response to COVID. ELT Live ensures the Executive Leadership Team have visibility and the Team continue to visit different sites.

8. Increasing Supply

We have continued to take action to increase supply, most recently and specifically to create a pool of ICU buddies to enable capacity in our Units to be increased by 100%. This was an example of very effective partnership working with our staffside colleagues to rapidly put in place a solution.

Alongside this, we have continued to offer incentive rates to nursing bank staff and others where we need to stimulate supply. Corporate staff remain redeployed, notably to support the efficient running of our vaccination hubs. We have benefited from the redeployment of both armed force staff and staff from across the system to supplement our on staff, in order to sustain safe staffing levels.

COVID absence amongst our staff has highlighted the impact of vacancy levels in ULHT. With both financial and project management support from NHSE/I, we have initiated rapid recruitment projects to fill vacant HCSW posts and to access around 200 international nursing recruits in the national recruitment pipeline. Recruits from these pipelines will join the Trust from February onwards and we are bolstering on-boarding capacity to ensure they land well.

9. National Finance Regime

- The national NHS M1-M6 financial regime which provided sufficient central resource to enable each organisation to break-even has now ended and has been replaced for M7-M12 with an STP based income envelope.
- The Lincolnshire income envelope is inclusive of proposed block arrangements for each of the three Providers and the CCG and £87m 'top up, growth and COVID related' income that the STP has agreed an apportionment of planned support across the four organisations.

10. ULHT Month 9 Financial Headlines

- The Trust has delivered a deficit of £0.3m for the month of December after planned support from the Lincolnshire system of £12.3m; the Trust has delivered a breakeven position YTD after planned support from the Lincolnshire system of £36.1m.
- The income position is £1.9m favourable to plan driven by passthrough income and other non-recurrent benefits including education income, both that have offsets in expenditure.
- The Pay position in December is £1.4m adverse to plan; the year to date pay position is £2.1m adverse to plan. Actual Pay expenditure of £34.8m in December is c£0.6m higher than £34.2m in November.
- The increase includes; the impact of enhanced bank rates and one off incentive payments in December in order to ensure safer staffing levels, Bank Holiday enhancements payable under Agenda for Change for Christmas Day and Boxing Day, and expenditure in relation to the Vaccination Programme
- Excluding Depreciation, the Non Pay position is £0.3m favourable to plan in December and year to date is break even.
- The reported position includes £0.5m higher than planned expenditure year to date in relation to the additional costs of Covid.
- The reported position also includes £0.1m of expenditure in relation to the Covid Vaccine Programme for which the Trust will be funded on a retrospective basis through a validation process
- Capital expenditure YTD stands at c£13.4m which remains c£6.8m behind revised plan.

- The forecast CRL expenditure remains on track, with the newly formed Capital Delivery Group providing oversight.
- The month end cash balance is £68.1m which is an increase of £54.4m against cash at 31 March 2020.

11. System Month 9 Financial Position

- Against the STP income envelope the Lincolnshire system submitted a planned year-end deficit of £4m.
- 100% of this deficit position sits within the CCG with the three Provider trusts planning a zero break-even position.
- The overall system position reported at Month 9 is of £1.1m. This represents a favourable variance against plan of £4m, this is primarily driven by a favourable position in the CCG.
- The system-wide year-end forecast position is a £4m favourable forecast to plan.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Public Trust Board*
Date of Meeting	*2nd February 2021*
Item Number	*Item number allocated by admin*
2nd Quarterly Review following temporary conversion of Grantham Hospital to a Covid-19 Green Site Model	
Accountable Director	*Simon Evans – Chief Operating Officer*
Presented by	*Simon Evans – Chief Operating Officer*
Author(s)	*Phil Browne – Deputy Chief Operating Officer-Planned Care*
Report previously considered at	*N/A*

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

Risk Assessment	*4558 – Local Impact of the Global Coronavirus (Covid-19) Pandemic* *The paper is in direct response to mitigating this risk*
Financial Impact Assessment	*The temporary establishment of a Covid-19 Green site at Grantham Hospital was as a direct response to a Level 4 National Incident, not requiring a detailed FIA to be considered; however clear processes to authorise financial expenditure in line with the agreed business case have been established to support a detailed evaluation to take place.*
Quality Impact Assessment	*Completed June 20*
Equality Impact Assessment	*Completed June 20*
Assurance Level Assessment	*Significant*

Recommendations/ Decision Required	• *The Trust Board is invited to review the report enclosed and note the Trusts response to Covid-19 in regards to the Grantham Green site model.*

	• *Considering the latest challenges the Trust faces with Covid-19 and the response described within this report the Trust Board is asked to approve the recommendation to continue with the Green site model at Grantham as planned through to 31st March 2021.*

Contents

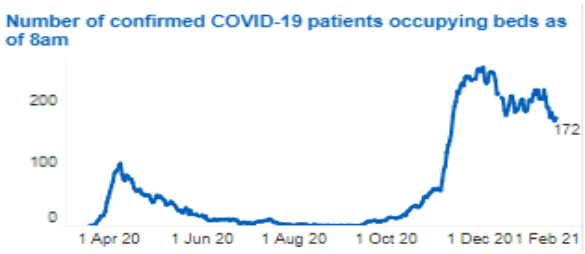
1. Executive Summary

The development of a Green Site at Grantham was one important element of the Trust's Covid-19 Strategy and Recovery Plan, the proposal for which was considered by the board on 11th June 2020, with go live 29th June 2020.

The overarching objective was to support requirements for Urgent Care in response to Covid-19, whilst simultaneously addressing the need to re-establish and maintain access to elective care, providing a structure upon which the Trust's Phase 3 planning for elective recovery could be based.

The objectives and key outputs, including the activity modelling as presented in the initial proposals, was quite reasonably based upon the circumstances, assumptions and understanding of the nature of the pandemic at that time.

On the 21st September 2020 it was announced that the UK alert level was being raised from Level 3 to Level 4, with the risk of transmission 'High or rising exponentially'. England remained at a Level 4 for the duration of the second quarter to which this report pertains, with Level 5 escalation announced on 4th January 2021. As such the achievements of the Trust that this report highlights and discusses are all the more remarkable when placed in the context of Wave 1 of the pandemic and a developing Wave 2 throughout the 2nd quarter of the Green Site model. On 9th November, following a steady increase from mid-October, case numbers in Wave 2 of the pandemic surpassed Wave 1 peak demands and went on to be 250% of the previous Covid-19 hospitalised cases. This ultimately necessitated the repeated temporary cessation of both the Lincoln County Hospital and Boston Pilgrim Hospital Green pathways and all surgical procedures therein.



In enacting the proposals put forward on June 11th 2020 the Trust had 3 initial aims: -

Aim	RAG	Evidence
Infection Prevention and Control (IPC) Excellence		No Covid 19 peri-operative infections have occurred since implementation.
Capacity to deliver at scale		Continued service provision. Increased utilisation. Increased Procedures/List. Development of planned additional x2 Vanguard modular theatres
Future service resilience		Out with day to day operational challenges, all services have remained open despite ongoing escalating Covid 19 prevalence across the Trust

The establishment of a Green Site at Grantham, being one important element of the Trust's overall Covid-19 Strategy and Recovery plan, was formally evaluated in September 2020. This paper serves to build on that initial Qtr1 evaluation, addressing the recommendations contained therein.

The detail within this review provides significant evidence of the ongoing achievement of the Trust's 3 strategic aims required as RAG rated above.

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

Priorities	RAG
To enable planned surgery to resume to a level which maintained the current waiting list level, ensuring no further deterioration.	
To bring the Trust's overall cancer surgery activity back to pre Covid-19 levels and indeed aim to exceed this level so that within 3 weeks there will be no waiting list for cancer surgery	
To continue to treat the 80 patients historically receiving chemotherapy at Grantham, whilst transferring the treatment of 1932 patients from Lincoln and Pilgrim.	
To contribute to and increase in the Trust's overall capacity to undertake urgent endoscopy work.	
To increase the number of patients receiving outpatient care by an indicative 9000 patients per annum.	
To provide UTC services 24/7 to the majority of patients who attended A&E – 20,014 attendances	

The initial quarterly report highlighted that the full effect of these changes upon other sites and services provided by the Trust remained to be fully quantified and understood. Acknowledging that the interdependencies were indeed complex, it suggested a strengthening of the approach to evaluation going forward that would inform both organisational and system-wide decision making as the NHS continues to respond to the Covid-19 pandemic. Owing to the impact of Wave 2, it has been challenging, due to the need for ongoing tactical decisions affecting operational delivery, to provide consistent evaluation against what has proved to be an ever-changing background of need and demand to support the Trust's operations across 4 sites.

The Trust's original criteria to determine the return of Grantham hospital to the pre Covid-19 model (and further developed as part of the initial quarterly review) are represented below:

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

The 6 criteria were designed to consider all known scenarios that would lead, at first, to a consideration of amendment of the model, which in turn could lead to reverting back to the original pre-Covid-19 model. They are sufficiently broad to consider the full range of risks to stakeholders internally (patients) and externally (other organisations both in and out of NHS Midlands). The measures or indicators used as evidence to trigger are not greatly sophisticated in nature, but are considered to be highly visible and easy to communicate so as to easily alert the Trust to a need to consider its response differently. An assessment of these triggers and measures is detailed within this report, which confirms that no criteria have been met that would suggest the need to substantially change the temporary model put in place or revert back to pre-Covid-19 configurations.

The purpose and context of the development and decision making supporting the establishment of the Grantham Green Site model is well stated in the first Quarterly Report. It has not altered and, as such, will not be repeated or revisited here.

Contained within the 1st quarterly review were 10 recommendations relating to operational and strategic aspects of the Green Site model, which are summarised below: -

Primary Recommendation regarding the Grantham Green site model:

1. Continuation to last for the duration of Covid-19 to at least 31 March 2021. This timescale to be subject to a system-wide review of the full next quarter activity available in early January 21 for the Trust Board's consideration in February 21.

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

Site Specific

2. Consider strengthening the **Operational Management Capacity** to provide oversight to the delivery of the Green site model at Grantham, to last for the duration of Covid-19.
3. Consider establishing a **Grantham Green site working group**.
4. Invite the endoscopy working group to remodel **endoscopy activity.**
5. Invite the chemotherapy management team to remodel **chemotherapy activity** based upon the transfer of all patients onto the Grantham site.
6. Consider the identification of a single individual taking responsibility for standardising, coordinating and reporting on **surgical performance** of the Trust as a whole, this to include overall surgical performance at Grantham.
7. Formally establish with LCHS a collaborative framework for comprehensively evaluating the **impact to patients** and staff following the closure of Grantham A&E.

Corporate

8. Consider ways of establishing a **dialogue with all staff** currently working at Grantham, those visiting Grantham and those transferred from the Grantham site, to ensure all experiences and suggestions inform learning and ongoing strengthening of the temporary model.
9. Ensure any future need to redeploy staff is based upon clear corporate criteria relating to skills and need, to promote **fairness and equality**.
10. Consider inviting STP colleagues to support the trust develop an explicit framework for establishing and sustaining **effective engagement with staff** to strengthen communication across the trust.

Whilst a number of these actions has been executed, the 2nd Covid wave has created sufficient constant flux as to necessitate the ongoing assessment and reassessment of delivery of operational services across ULHT sites and has, as such, precluded the completion of others. Progress against these recommendations will, however, be discussed within the main body of this paper.

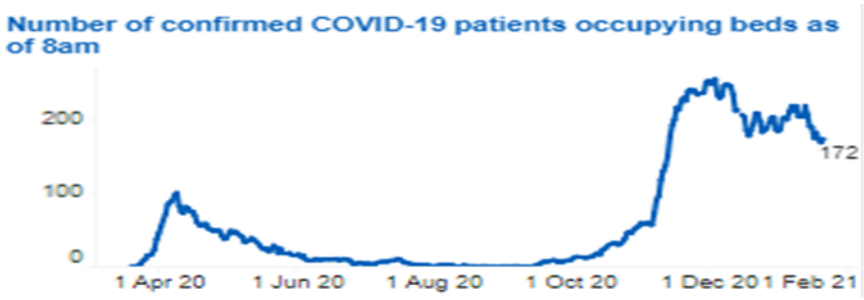
However, it is clear the Grantham Green site model continues to provide a significant contribution to the Trust's delivery of urgent, elective and diagnostic care, in the face of an ongoing Wave 2 and increasing numbers of Covid +ve patients, whilst also preparing for a predicted Wave 3. The ability to maintain green pathways at both Lincoln County and Pilgrim Hospitals has already been compromised and they are likely to continue to be affected for the foreseeable future.

This paper therefore seeks Trust Board approval for the continuation of the temporary service changes enacted in June 2020 as a consequence of establishing the Grantham Green site model. The timescale for this continuation being to 31 March 2021.

2. Purpose

This paper seeks to present progress and provide assurance of the ongoing delivery against the initial aims of the Green Site model, initiated at Grantham Hospital from 29th June 2020, and against the findings of the 1st quarterly review, including progress against 10 key recommendations.

The findings must be seen in the context of an ever-changing and challenging environment brought about by both Wave 2 and an increasingly-developing Wave 3 of the Covid 19 pandemic, which has seen peak activity at 250% of that experienced during Wave 1.



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

Specifically, the aim of the 1st Quarterly Review paper was to:

- Evaluate the extent to which the aims and intentions of the approved green site model at Grantham were achieved
- Identify learning and subsequent opportunities for further improvement in any aspect of site specific and or trust wide performance
- Review the ongoing need and potential timescales for a Green Site model
- Recommend intentions and options for ongoing evaluation and the next quarterly review scheduled for January and assessment at February 21 Board.
- To state criteria for closing the Green Site and reverting to pre Covid-19 service configuration

This 2nd quarterly review will continue to review the current model in a similar way to the 1st review. Specifically it will:

- Evaluate the extent to which the aims and intentions of the approved Green Site model at Grantham were achieved
- Identify learning and subsequent opportunities for further improvement in any aspect of site specific and or trust wide performance
- Review the ongoing need and potential timescales for a Green Site model
- Review whether there has been any need or trigger of criteria for closing the Green Site and reverting to pre Covid-19 service configuration

A separate and subsequent paper to this review will seek to:

- Review the ongoing need and potential timescales for a Green Site model beyond 31st March 2021.

3. Assessment of Service Delivery

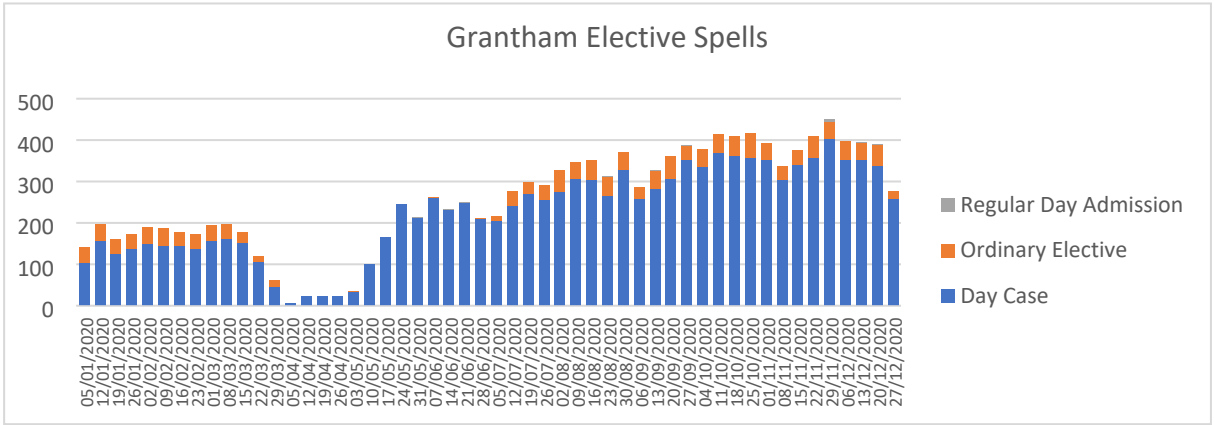
The development of the proposal for the Trust Board on 11th June and going live with a Green Site model from 29th June was recognised as a significant achievement for the Trust. The pace with which the complex proposal was required to be taken forward was only achieved through the significant efforts and commitment of many colleagues across corporate and operational divisions, and in the face of an ever-changing local and national situation.

Throughout the second quarter of implementation, the three elements upon which the Grantham Green Site model was predicated have been maintained, namely:

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

The fact that no elective surgical patient has contracted Covid-19 whilst in Grantham hospital represents a kite mark for the IPC standards in place across the Trust. Whilst the site has not been entirely absent of Covid-19, investigations have supported that no patient contracted Covid-19 as an inpatient through failure of IPC excellence.

Despite the ongoing challenges of Wave 2, including the significantly larger impact experienced across the Trust sites and the inconsistency with which the Green pathways at both Lincoln and Pilgrim have been able to be deployed and maintained, Grantham activity throughout the 2nd Quarter has remained strong. The graph below provides a site-wide indication of the extent to which all inpatient spells (which include all activity relating to elective surgery, endoscopy and chemotherapy) have increased at Grantham. The comparison and increase from pre Covid-19 activity levels are clearly presented.



It is important to recognise that the activity modelling presented in the original proposals in June were predicated upon the circumstances and assumptions known at that time. Throughout the Covid-19 pandemic both emergency and planned demand for services have continued to change, which inevitably has affected the accuracy and relevance of the forecast and quantified targets set. The continued Wave 2 and developing Wave 3 have resulted in significant challenges across the sites in continuing to deliver elective activity.

There have been multiple complexities in seeking to evaluate the delivery of these indicative patient flows and activity levels within an environment that has continued and will continue to change because of Covid-19. Operational staff have certainly reflected upon the benefits of setting up explicit trust wide performance management systems from implementation of the Grantham model to record,

track and report upon the many specific aspects of Grantham activity, with the aim of understanding the impact this has made to the level of performance for the Trust overall.

The assessment of any intervention or action to extend or improve the delivery of services will continue to present considerable challenges in accurately reflecting performance within a fast-changing national context.

There is no doubt that establishment of a Green Site has resulted in several new specialties now operating from Grantham, with indications that there is potential for this surgical activity to increase further (e.g. via the introduction of modular theatres from January 2021). The strengthening of the multi-professional approach to developing these opportunities has significantly improved the Trust's internal capabilities to address ongoing Covid-19 challenges as they continue to present themselves.

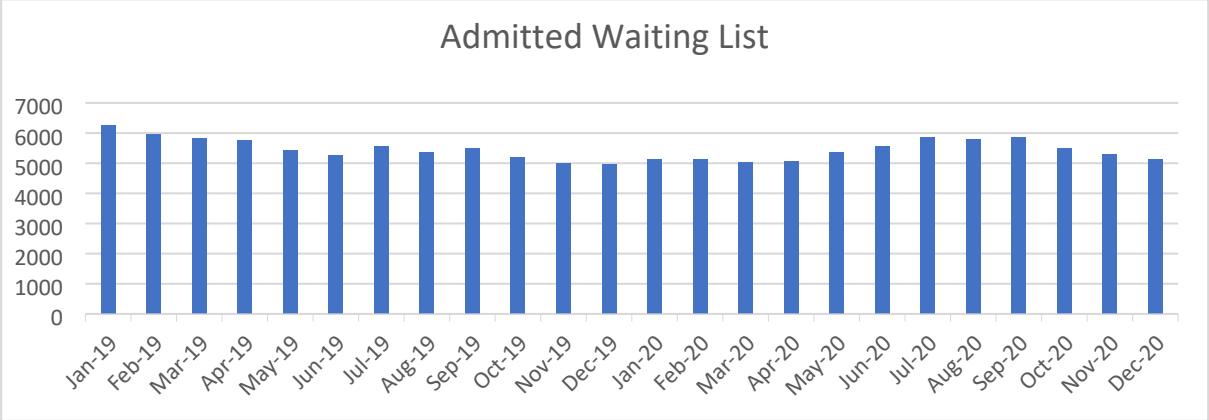
3.1. Operational Delivery

3.1.1. Planned Surgical activity:

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

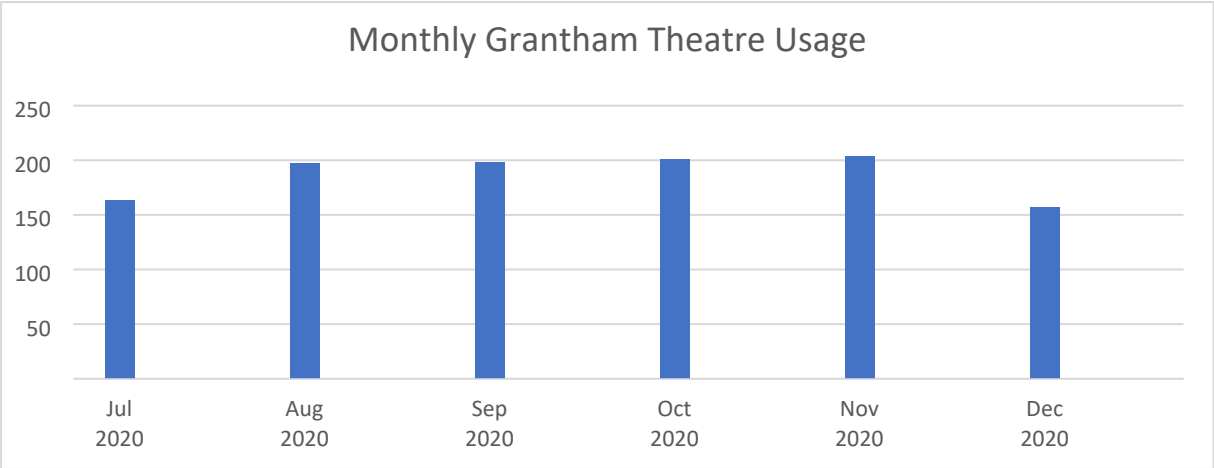
The two surgical wards at Grantham supported by the fully functioning theatres have enabled further progress in managing a range of new specialties at Grantham, with the trend of incremental increases being achieved most weeks until the advent of Wave 2.

The chart below provides a profile of the Trust's admitted waiting list from January 2019 to December 2020. *(NB December figures are subject to final validation)*



There is a steady increase in the size of the admitted waiting list from March 20 and the start of the pandemic. The introduction of the Grantham Green Site model correlates with a reduction in the waiting list through to the end of Dec 20. This has been achieved through the provision of increased numbers of sessions since July 2020.

Again, it is important to place this achievement in the context of Wave 2 and the inability to consistently apply Green pathways at both the Lincoln and Pilgrim sites. The reduction, in the face of these pressures at Lincoln and Boston, demonstrates the contribution Grantham has and continues to play in managing the Trust's admitted waiting list.

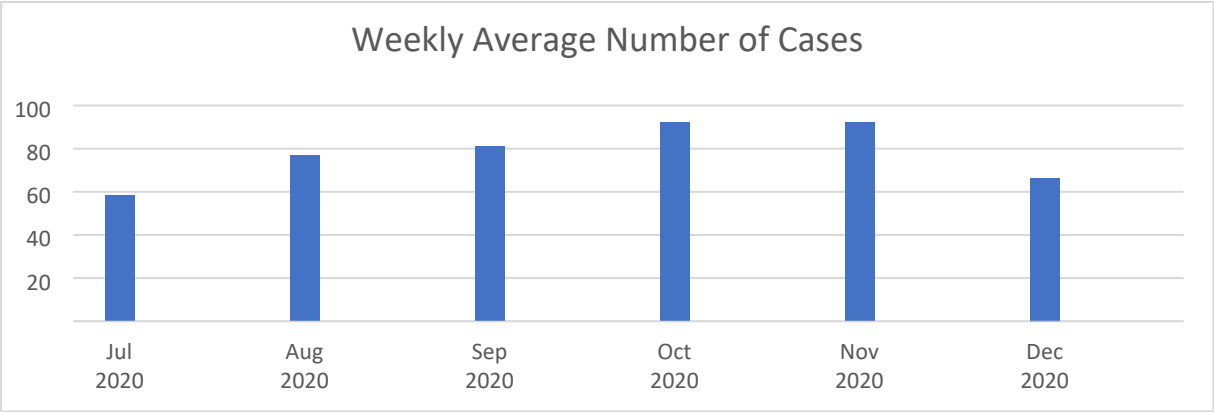


Monthly session utilisation has increased since the establishment of the Grantham Green Site and has, despite the challenges of Covid-19 Wave 2, remained consistent up until December 20, whilst noting an expected reduction in utilisation during planned closures during the Christmas period.

Considering the potential for theatre utilisation to be a constraint that could impact upon activity levels, the chart below evidences a trending increase in theatre utilisation since establishment of the Green Site model to date. The stepped increase in cases from the end of July marked the initial move to utilise weekend capacity for orthopaedic elective lists. An original indicative level of 25 cases per day was identified, on the premise that ophthalmology would be undertaken on site. Whilst the average number of cases, also highlighted in the first quarterly review, falls below that indicated as part of the initial proposal, it must be viewed within the context of the consistently-changing environment and need for operational flexibility in responding to Covid-19. Of particular influence upon the total numbers per week was the decision, in line with Phase 4 Recovery Planning, to open Louth for the provision of ophthalmic surgery rather than using Grantham operating capacity.

The re-opening of Louth to provide ophthalmic surgery has fundamentally altered the case mix and speciality profile. The substitution at Grantham with orthopaedics, which has a significantly lower case number per list in comparison to ophthalmology, has resulted in the ongoing apparent under-performance against initial targets at Grantham. The current average of circa 8-10 cases per day being undertaken, but with a trend of increasing activity for most weeks, needs to be viewed in this context.

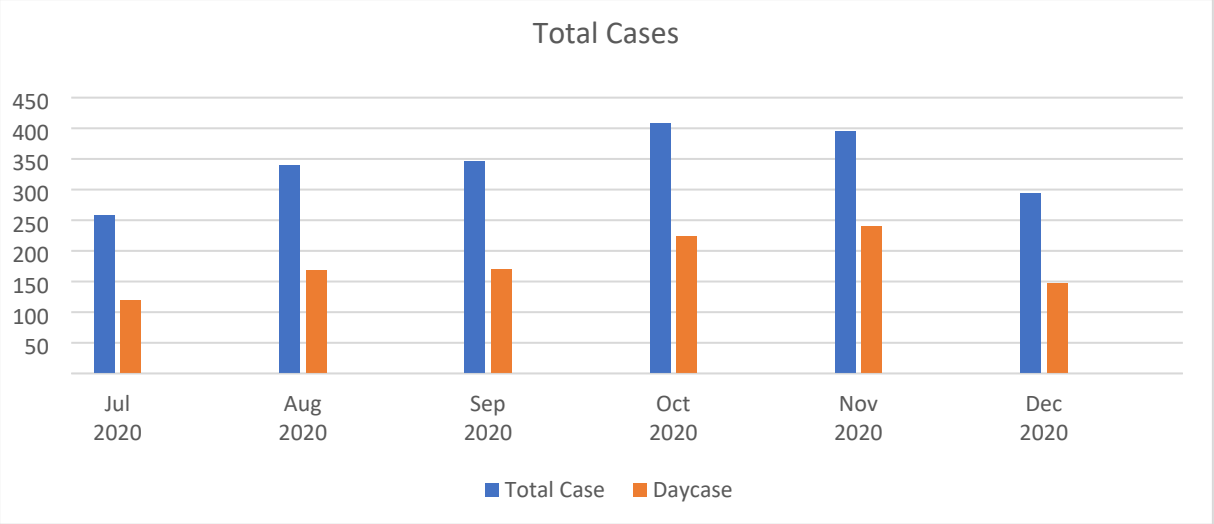
Average number of admissions per week is contained in the chart below.



The average number of cases per list was in July 20 1.6 but has steadily increased to circa 2 cases per list from October 2020.

	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020
Average cases per list	1.6	1.7	1.8	2	1.9	1.9

The increase in throughput is also, in part, driven by the gradual increase in the proportion of day case activity as a percentage of overall activity as shown below.



However, considering the changes to case mix, utilisation and activity, as detailed in the charts above, numbers have consistently improved month on month from 58.4 per week to a peak of 92.3 in November.

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

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

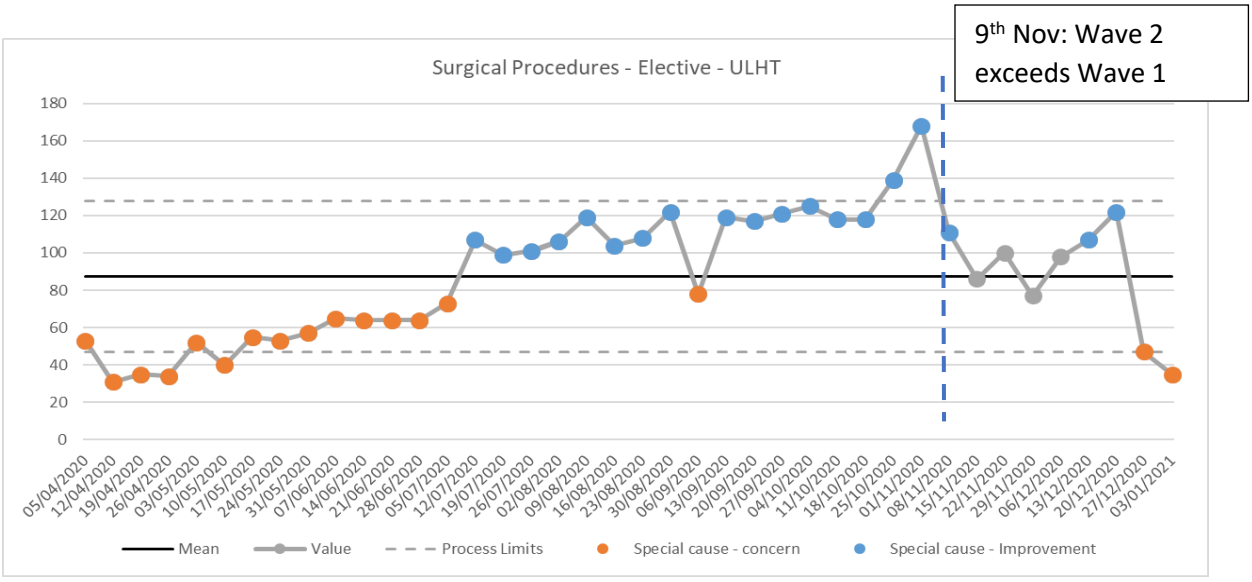
Specialty	Pre-Covid Cases (w/e 12th Jan - w/e 15th Mar)	Qtr 1 Cases (w/e 12th Jul - w/e 13th Sept)	% Change	Recent Case (w/e 20th Sept – w/e 27th Dec	% Change (from Qtr 1 review)
100 - General Surgery	396	192	-52%	310	61.5
101 - Urology	121	259	114%	365	40.9
103 - Breast Surgery	31	125	303%	145	16.0
104 - Colorectal Surgery	8	0	-100%	0	0
110 - Orthopaedic	764	150	-80%	313	108.7
120 - Ear Nose & Throat	7	27	286%	71	162.9
130 - Ophthalmology	318	0	-100%	1	
144 - Max Facial Surgery	40	195	388%	205	5.1
145 - OMF Surgery	0	1		3	300.0
192 - Critical Care Med *	50	13	-74%	11	-18.1
300 - General Medicine	24	45	88%	9	-80.0
301 - Gastroenterology	135	2	-99%	63	3050

302 - Endocrinology	1	0	-100%	5	
303 - Haematology (Clin)	297	582	96%	988	69.8
320 - Cardiology	0	2		44	2100
330 - Dermatology	3	0	-100%	0	
340 - Chest	6	0	-100%	1	
370 - Medical Oncology	20	272	1260%	366	34.6
410 - Rheumatology	0	7		6	-14.3
430 - Care of the Elderly	6	0	-100%	0	
502 - Gynaecology	35	99	183%	105	6.1
800 - Clinical Oncology	50	1190	2280%	1953	64.1
811 – Int. Radiology	33	0	-100%	1	
999 - Unknown	0	3		0	

*reflects Level 1 critical care – coding validation required

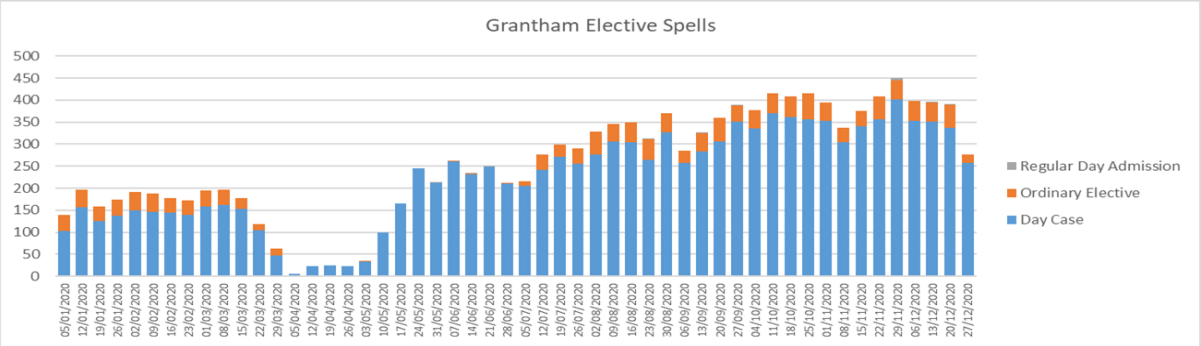
The activity levels highlighted in the first quarterly review, and shown in the table above, reflect the expected increases in specialties moved to the Green Site with three notable exceptions; orthopaedics which has reduced by 80%, general surgery by 52% and colorectal surgery by 100%. However, since the 1st Quarterly review was published it can be seen that these specialties have all experienced a significant increase in those early volumes with increases of 108.7% and 52% for orthopaedics and general surgery respectively. In addition, the specialties of urology, breast and ENT have all seen significant increases in numbers of patients being treated with increases of 40.9%, 16% and 162.9% respectively. *(It should be noted that whilst orthopaedics has not achieved pre-Green Site model numbers the case mix of patients has changed significantly to longer and more substantial procedures).*

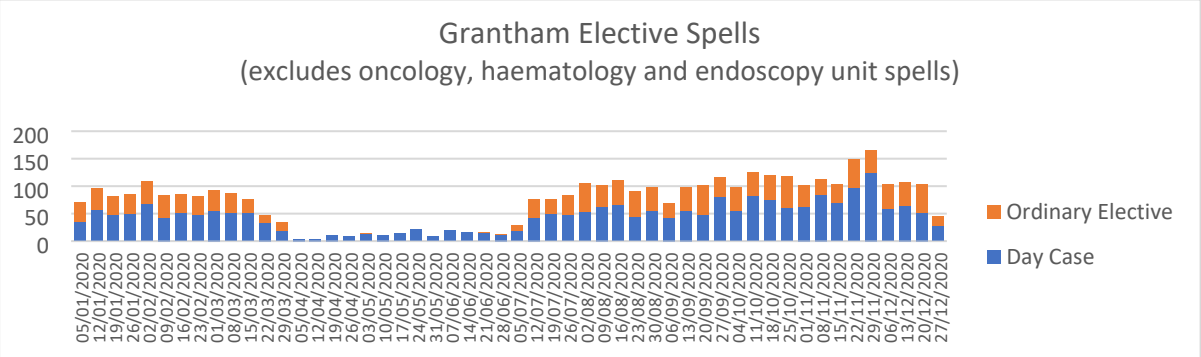
More recently in Wave 2 of the pandemic, the Trust's overall elective output has significantly reduced through November and into the festive period, as demonstrated below. It should be noted that initial modelling of the impact of a second wave of COVID 19 upon the Green pathways at Lincoln and Boston led the Trust to expect a 15%+ reduction in elective activity. Wave 2 Covid-9 activity has peaked at 250% of Wave 1, and the graph below provides an illustration of the impact this has had on the Trust overall elective output.



In contrast, Grantham elective spells have remained in a strong position, providing further evidence of the effectiveness of the Green Site model in supporting the delivery of key surgical interventions to the people of Lincolnshire.

Total Grantham Elective Spells pre- and post-implementation of the Green Site model are shown below, including and excluding oncology/haematology and endoscopy.





In response to the first quarterly review, work to continue to improve the capacity of the Green Site model has been undertaken. The commissioning of two Vanguard modular theatres was proposed and agreed, with 'go-live' dates for provision of additional capacity to support both breast and gynaecology cancer operating set for January 2021.

Aside from the challenges of further increasing the levels of surgery undertaken at Grantham, the Trust's overall number of elective surgical procedures undertaken has clearly increased since the end of June following implementation of the Green Site model and Green pathways across other sites. This provides assurance to the Board that the Trust's approved plan for Recovery is delivering the overall targets set operationally. However, whilst significant progress was being made, since mid-November the increasing pressures relating to Wave 2 have resulted in multiple temporary cessations of the Green pathways at both Pilgrim and Lincoln, with the resulting impact upon overall elective care numbers.

It should, however, be noted that the Grantham Green Site model has continued to operate and maintain a level of elective activity throughout, supporting ongoing elective operating in the face of the challenges faced across the wider Trust.

3.1.2. Cancer Surgical activity:

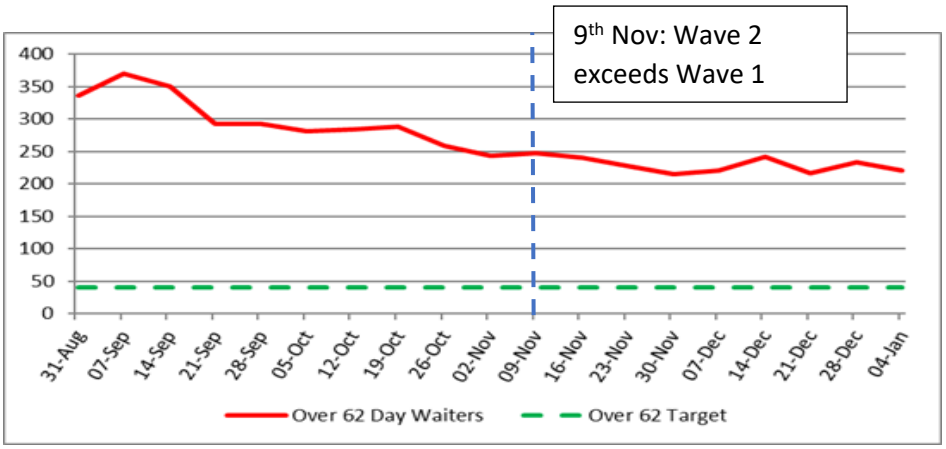
The aim of the Grantham Green Site model was to undertake in excess of 13 cancer surgeries per week, to bring the Trust's overall cancer surgery activity back to pre Covid-19 levels and indeed aim to exceed this level so that within 3 weeks there will be no waiting list for cancer surgery.	RAG

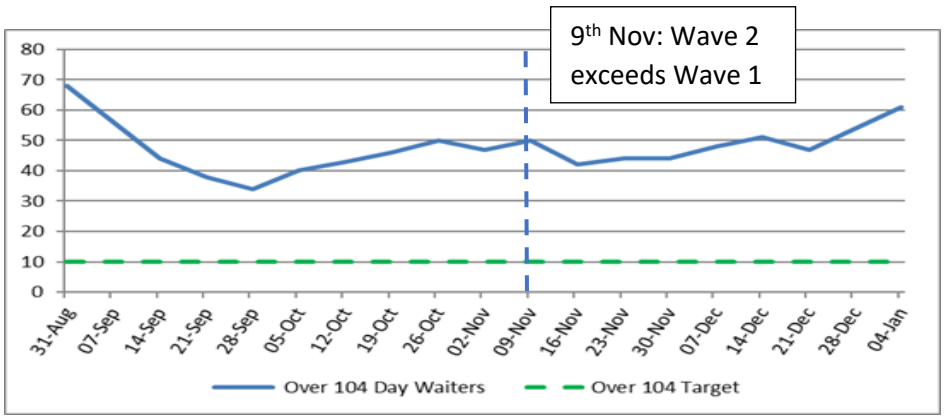
This aim has been partially achieved but has been significantly impacted by Wave 2 and the developing Wave 3 of the Covid 19 pandemic.

Positively, as highlighted in the initial quarterly review, referrals to the Trust have continued to increase and had broadly returned to pre Covid-19 levels, as represented in the graph below. There has since been a significant drop in referrals from mid-December, although this now appears to be recovering to 90% of baseline referrals. This will require ongoing review.

The Wave 2 and Wave 3 and the resulting pressures on access to both critical care and theatres has impacted on the recovery of the Trust's cancer performance and continues to do so.

Whilst Grantham Green Site provides the opportunity to undertake some cancer work, not all cancer activity can be undertaken on site, particularly those requiring HDU post-operative care.





From the outset of Wave 2 the daily prioritisation and review of cancer and elective activity has been instigated via senior clinical review. Access to theatre is managed on a daily basis as well as a weekly confirm and challenge session with the specialities. Where possible, less urgent treatment is substituted with cancer operating which has been displaced from the Lincoln and Pilgrim pathways.

As such, Grantham continues to play a vital role in supporting the Trust's ongoing delivery of cancer operating. The introduction of the Vanguard modular theatres in January 2021 will further enhance cancer operating, supporting increased lists for both breast and gynaecology cancer procedures.

3.1.3. Chemotherapy activity:

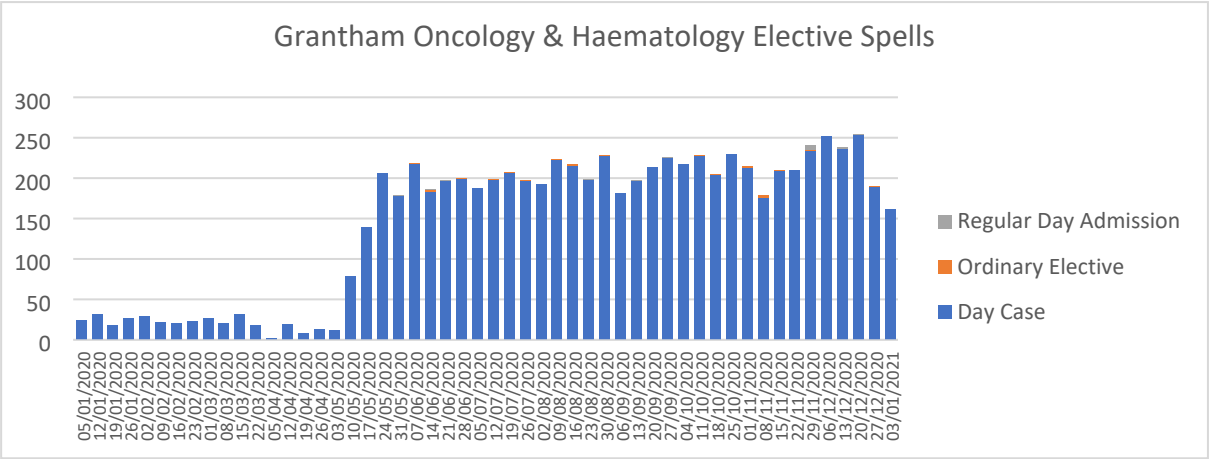
The aim of the Grantham Green Site model was to continue to treat the 80 patients historically receiving chemotherapy at Grantham, whilst transferring the treatment of 1932 patients from Lincoln and Pilgrim.	RAG

The aim of the Grantham Green Site model was to provide chemotherapy in much larger volumes, accommodating the circa 80 patients in Grantham and transferring other chemotherapy patients from across Lincolnshire to the low-risk site. Initially 1932 patients were estimated to be able to be treated from the larger Grantham chemotherapy unit, which was to be operated from a ward area within the hospital that offered significantly increased distancing and a much higher level of protection from transmission of Covid-19 for these most vulnerable patients.

This aim has been achieved in terms of the effective transfer of all patients previously receiving outpatient chemotherapy at Lincoln and Pilgrim to Grantham. The exception to this is where patients require specialist acute inpatient care with oncology teams that are part of an emergency spell, or where patients require multiple treatment regimens such as radiotherapy and the use of the Trust's Linear Accelerators.

Specialty	Pre Covid Volumes (Grantham)	Qtr 1	Qtr 2	% increase Qtr 1 to Qtr 2
Medial Oncology	20	272	366	34.6%
Clinical Oncology	50	1190	1953	64.1%
Clinical Haematology	297	582	988	69.8%

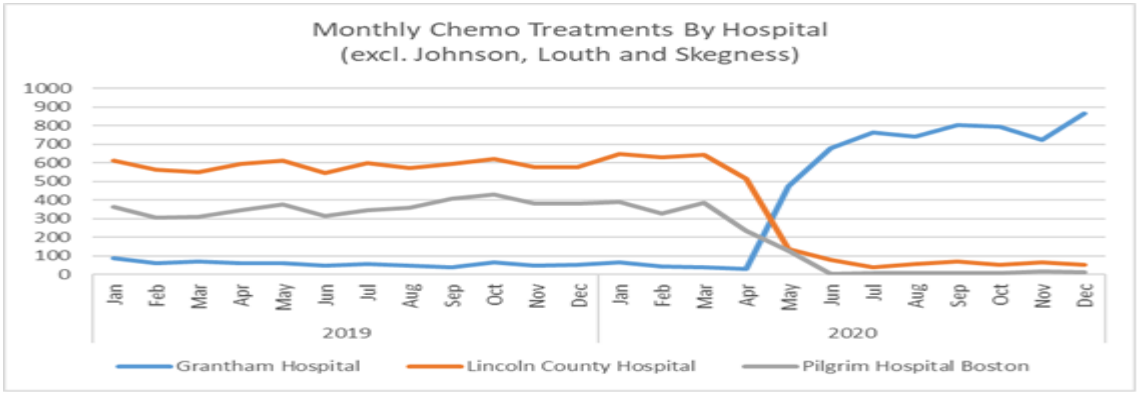
The graph below evidences the significant increase in chemotherapy activity undertaken at Grantham since mid-May (in episodes of care). The timing of this increase in activity reflects the Trust Board's endorsement of the Recovery plan for the Trust and the immediate opportunities taken within oncology to implement this plan.



Inpatient Admissions For Chemotherapy - By Hospital

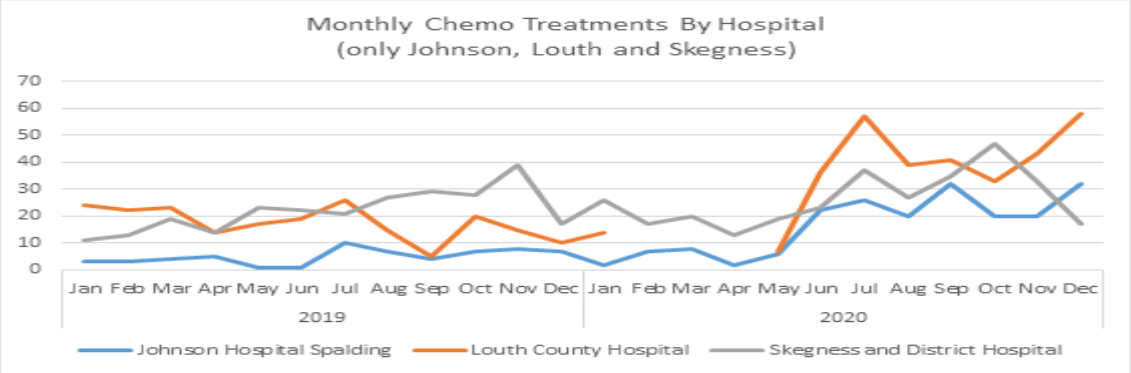
Chemo Admissions	Mont																							
	2019												2020											
Year	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Grantham Hospital	85	62	67	61	60	46	57	47	37	63	46	50	65	41	38	28	475	678	765	743	803	793	724	867
Johnson Hospital Spalc	3	3	4	5	1	1	10	7	4	7	8	7	2	7	8	2	6	22	26	20	32	20	20	32
Lincoln County Hospita	613	562	549	595	613	547	598	571	592	620	576	576	649	629	644	516	137	76	39	55	70	51	65	51
Louth County Hospital	24	22	23	14	17	19	26	15	5	20	15	10	14				7	36	57	39	41	33	43	58
Pilgrim Hospital Bostor	363	306	308	343	374	315	345	358	407	430	382	379	391	329	385	233	127	3	6	6	7	8	17	12
Skegness and District H	11	13	19	14	23	22	21	27	29	28	39	17	26	17	20	13	19	23	37	27	35	47	33	17

The graph below illustrates the profile of site delivery and provides significant assurance around the achievement and maintenance of the initial aim to transfer the delivery of care to the Grantham site.



Whilst some patients have found travel to Grantham difficult, the service has responded by increasing the provision of the mobile chemotherapy unit from 3 days per week to 5 days per week, (2 days at Skegness, 2 days at Spalding and 1 day at Louth). This was determined to be key, not only in responding to patients' needs and supporting those suitable patients to receive their care closer to home, but also importantly in providing an increased confidence for patients to attend clinical sites and settings to receive key ongoing treatment regimens.

The graph below demonstrates the increased mobile chemotherapy delivered from the mobile unit, providing assurance of the responsiveness to patient need provided by the service delivery teams.



The above tables and graphs demonstrate the shift of service delivery in line with the stated aim. Very positive feedback has been received from both patients and staff regarding this change, and should provide the Board with significant assurance that this aim has been successfully achieved.

3.1.4. Outpatient performance:

The aim of the Grantham Green Site was to increase the number of patients receiving outpatient care by an indicative number of 9000 patients per annum.	RAG

Validated data shows that in the 4 weeks between 17th August and 14th September, a total of 2500 outpatient appointments were attended at Grantham, 726 of which were new 1st outpatient appointments. As this averages 625 appointments per week, this would suggest we could expect 9438 outpatient appointments being undertaken at Grantham per annum.

In addition to outpatient activity being run at Grantham hospital itself, the introduction of the Grantham Health Centre and Gonerby Road health clinics have increased the number of services being offered locally in Grantham. This represents additional services compared to the original model approved in June 2020. The introduction of these new sites has increased the number of outpatient services available, with 9280 appointments being provided during the 2nd Quarter (Oct - Dec). ULHT now provides a much greater spectrum of services across Grantham including:

- General surgery,
- Vascular surgery,
- Trauma and orthopaedics,
- Ophthalmology,
- Dermatology and paediatric dermatology (some of which are provided from GP surgeries locally)
- Gastroenterology,
- Clinical physiology tests,
- Cardiology,
- Neurology,
- Antenatal outpatient services

This range of services and modality of delivery has been increased in Quarter 2 in response to patient need and the call for increased face to face provision.

The following tables demonstrate those services delivered across Quarters 1 and 2, demonstrating the increase in services available to patients specifically face to face at the Gonerby Road development. This is whilst maintaining telephone and video clinics delivered from Turnpike Close.

Major services such as diabetes/endocrine, general surgery, respiratory and gynaecology are all now available via telephone/video clinics or face to face either at Grantham Hospital or Gonerby Road.

Telephone/video clinics (Turnpike)

	July 20	August	September	October	November	December 20
Dermatology	Service Commenced					
Diabetes	Service Commenced					
Endocrine	Service Commenced					
Gastroenterology	Service Commenced					
Neurology	Service Commenced					
Orthopaedics	Service Commenced					
Respiratory	Service Commenced					
Rheumatology	Service Commenced					
General Surgery	Service Commenced					
Vascular	Service Commenced					

Face to face Green pathway (Grantham Hospital Site)

	July 20	August	September	October	November	December 20
General Surgery	Service Commenced					
OMF	Service Commenced					
Physiotherapy	Service Commenced					
Haematology	Service Commenced					
Gynaecology				Service Commenced		

Face to face Blue pathway (Vine Street)

	July 20	August	September	October	November	December 20
Ante Natal	Service Commenced					
Cardiac Phys	Service Commenced					
Cardiology	Service Commenced					
Dermatology	Service Commenced					
Plastic Surgery	Service Commenced					

Face to face Blue pathway (Gonerby Road)

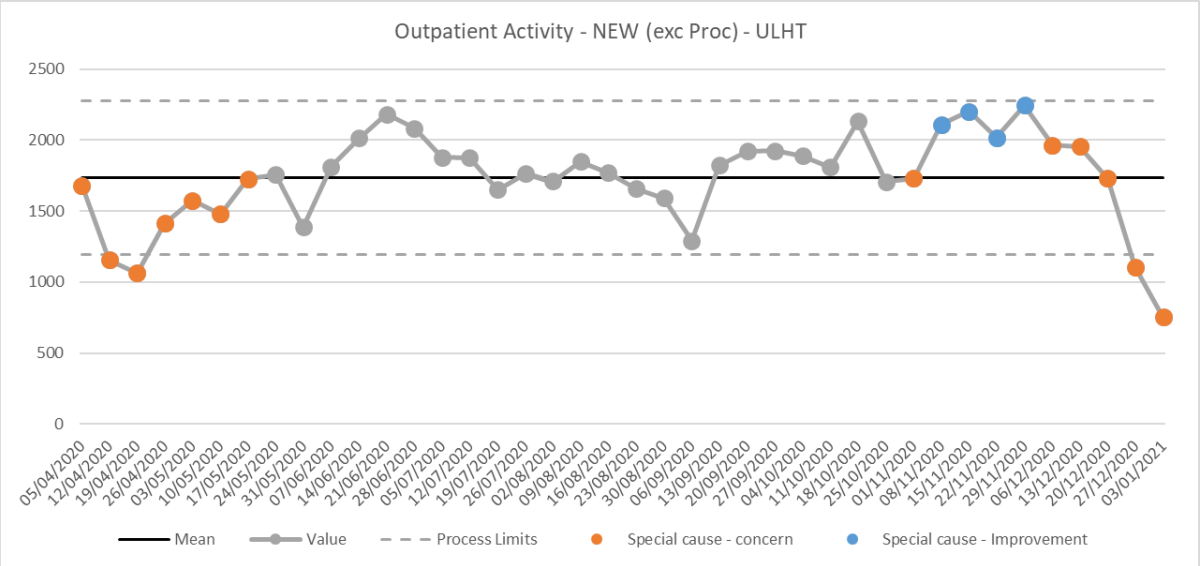
	July 20	August	September	October	November	December 20
Cardiac Phys			Service Commenced			
Cardiology			Service Commenced			
Diabetes				Service Commenced		
Endocrine				Service Commenced		
Orthoptist	Service Commenced					
Gastro	Service Commenced					
Haematology			Service Commenced			
Nephrology	Service Commenced					
Neurology	Service Commenced					
Ortho	Service Commenced					
Fracture Clinic						Service Commenced
Physio				Service Commenced		
Respiratory				Service Commenced		
Rheumatology				Service Commenced		
General Surgery				Service Commenced		
Vascular				Service Commenced		
X-Ray				Service Commenced		

The table below provides figures for the various services delivered from Gonerby Road, from the dermatology services at Vine Street, from Grantham Health Centre, as well as activity delivered non-face to face from Turnpike Close.

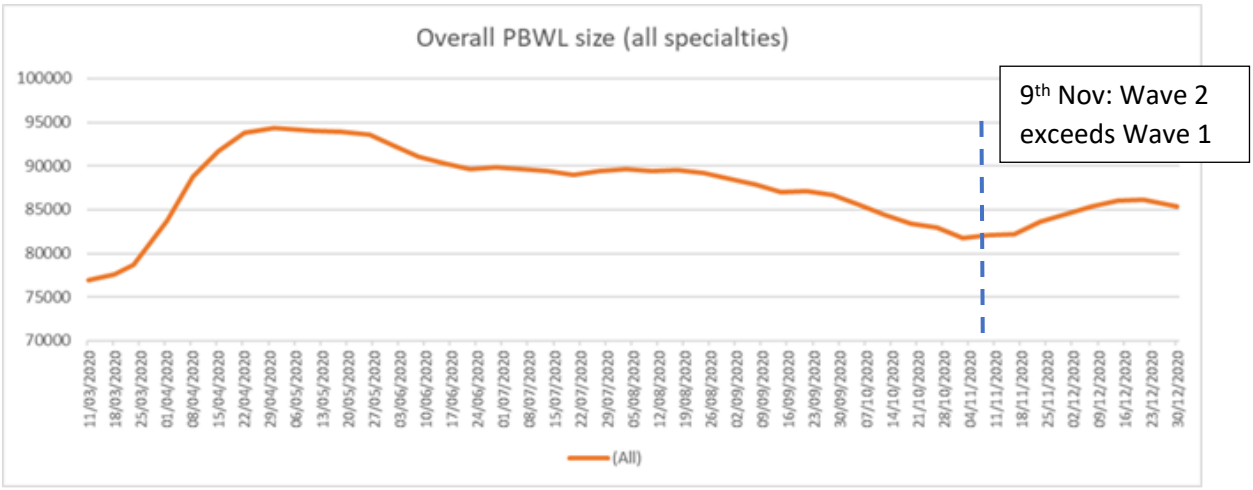
Service	Site	Sept	Oct	Nov	Dec	Total	Comments
Outpatients	Gonerby Road	499	536	781	794	**2610**	Face to face activity
Outpatients	Turnpike Close	438	451	534	450	**1873**	VC and telephone clinics
Outpatients - Dermatology	Vine Street Surgery	228	187	206	159	**780**	
Diabetic eye screening	Gonerby Road		80	240	225	**545**	

Audiology	Gonerby Road		4	10	0	**14**	Activity moved to Spalding due to noise
AAA screening	Gonerby Road		10	50	46	**106**	
Cardiac Phys - Echos	Gonerby Road	166	202	213	162	**743**	
Cardiac phys - other	Gonerby Road	209	288	244	241	**982**	
Xrays	Gonerby Road	0	333	235	285	**853**	
OT	Gonerby Road	0	26	36	33	**95**	
Physio	Gonerby Road	0	365	465	582	**1412**	
Gynae/Antenatal	Health Centre/Green	289	269	273	265	**1096**	
Totals		**1540**	**2751**	**3287**	**3242**	**11109**	

The graph below demonstrates that the Trust's over level of outpatient 1st appointments undertaken increased steadily from September, increasing to a peak in mid-October before falling back in the face of Wave 2 requirements to take down some outpatient activity to support increased staff ward coverage. Whilst activity recovered to a new peak by the end of November, the Trust has since seen a reduction, in part owing to the festive period but also in response to the developing Wave 3, and the tactical need to provide ongoing enhanced staff support to the wards in providing frontline inpatient care and supporting flow and discharge.



The graph below represents the Trust's overall PBWL *(Partial Booking Waiting List - the waiting list for patients that require outpatient follow-up appointments),* which clearly evidences the start of an improving position following approval of the Trust's Recovery plan. In addition, it highlights the effect of Covid-19 Wave 2 and the recent increase in the waiting list size. This reinforces the importance of the continuation of the Green Site arrangements and Green pathways in operation across the Trust.



Assurance can be derived from the above graphs and tables that the additional activity delivered across Grantham has, and continues to, provide essential support to the Trust's ongoing outpatient activity. In spite of the impact of the Covid 2nd Wave, the Grantham Green Site has specifically helped to offset the lost outpatient activity that has been stood down to support the increasing complexity of flow and varying ward configurations across both Lincoln and Pilgrim hospitals.

3.1.5. Urgent Diagnostic Endoscopy performance:

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

The ULHT endoscopy service is a multi-site service comprising of 9 procedure rooms across 4 units at Lincoln County Hospital, Pilgrim Hospital, Boston, Grantham and District Hospital and Louth County Hospital. The service was heavily impacted by COVID, with the two main sites (Lincoln and Pilgrim) closed on 23rd March to all except emergency inpatients in readiness to become escalation areas for additional COVID inpatient beds, and staff redeployed to support the wards. Grantham re-opened for 2ww suspected cancer patients in April 2020 to ensure cancer diagnostics were not compromised. (Louth endoscopy was closed due to the much-needed refurbishment of their decontamination unit).

The Endoscopy Task Force Cell was set up on 1st July following the regional and national directives on recovering the endoscopy service. The task force cell was made up of workstreams including endoscopy, capacity and demand, surgery division, medicine division, primary care, estates ad facilities, procurement and IPC and HR/workforce. The cell moved at pace, reporting to the Gold Command every Tuesday evening.

The national guidance from BSG (British Society of Gastroenterologists), JAG and PHE was rapidly changing, the service was on a continual plan, do, act and review cycle. Demand and capacity modelling was reviewed weekly due to the many changes in guidance. With each guidance change came the opportunity to create more capacity until the service reached the point where it had returned to pre-COVID capacity across the procedure rooms. Patient flow was adapted through the department to maximise throughput whilst adhering the social distancing requirements.

During the first 8 weeks a clear recovery plan was implemented. This was achieved by working with all workstreams. The upper and lower GI pathways were clinically reviewed, updated and agreed. We worked closely with Primary Care to look at options for demand management and implementing FIT (faecal immunochemical testing) in the community, colon capsule endoscopy and trans-nasal endoscopy. Estates and facilities have assisted with perspex screens to maximise recovery bay space to pre-COVID numbers.

The Lincoln and Pilgrim units re-opened on 1st July as staff were returning from redeployment.

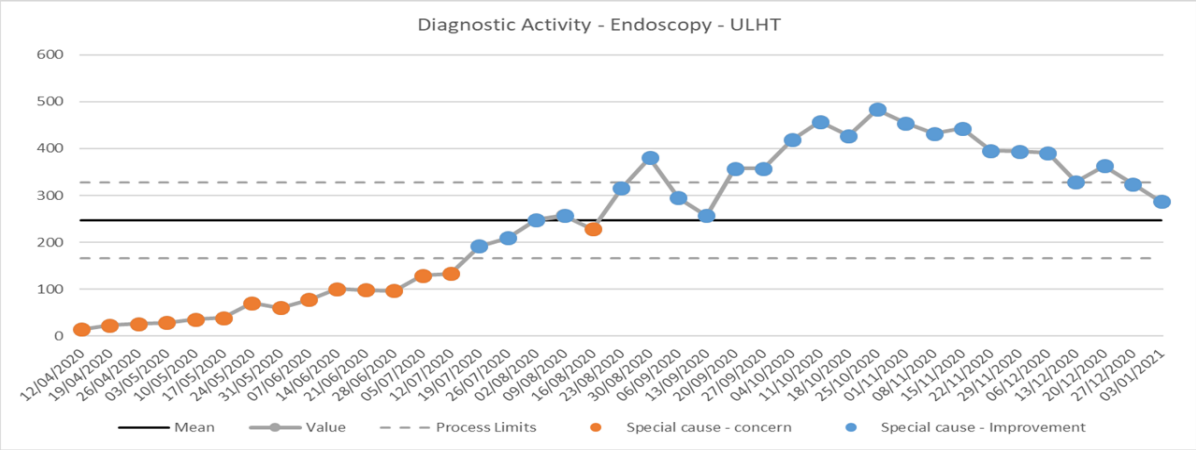
The Louth decontamination unit replacement was completed in September (£230k of investment).

The regional ask was for the diagnostics services to clear their 104+ day cancer backlog by 21st August and reduce the over-62 day by 20%. ULHT endoscopy service cleared all 104+ days and 62-104 day waiters by 17th August 2020. This would not have been possible without the Grantham green site being a designated site for 2 week wait suspected cancer patients, working from April 2020.

The service moved to full 7 day working and had a clear trajectory to be back to pre-COVID performance for both DM01 and Cancer by November 2020 in readiness for the winter (originally predicated on no COVID second wave). The booking of routine patients commenced in September 2020 and the service met its projected trajectory for cancer and urgent referrals.

Prior to Wave 2, the trust wide performance of all diagnostic activity shows significant increases in excess of 100% being delivered against previous years. This represented the largest recovery of any trust in the Midlands and is demonstrated in the graph below.

The graph below evidences the increase in endoscopy activity across the Trust as prioritised within the Trust's Recovery plan, of which Grantham increased activity is a key component.



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

Despite this, the outcome being sought regarding the Trust's ability to achieve urgent 2 week waits for diagnosis when cancer is suspected is being achieved and maintained, demonstrating the Trust's approach to increasing access to endoscopy has undoubtedly been effective, and indeed has been held to be an exemplar in response and recovery to the challenges of Covid-19.

A critical factor influencing performance has been that since fully reopening the Grantham endoscopy suite the number of cases possible per list has been appropriately reduced to comply with national guidance on COVID infection prevention & control standards, with these reduced activity levels at Grantham factored into the ULHT Recovery Plans. Additional activity has been activated at other sites (e.g. Medinet) to ensure the backlog of endoscopy work is cleared in coming months, in line with the Trust's operational objectives.

The service was successful with a bid to NHSE for funding of £1.26m which will fund the Pilgrim decontamination unit and also £750k of replacement stacks and scopes with a planned installation start January 2021.

This is a significant achievement by the whole team, not only within endoscopy but collaborative working with all workstreams involved has enabled the recovery project to progress at significant pace, all for the main objective of providing a high quality, safe and JAG accredited endoscopy service for the people of Lincolnshire.

Whilst Wave 2 continues to present significant challenges, the Board should take significant assurance regarding the actions taken, and progress currently being demonstrated.

3.1.6. UTC performance:

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

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

Similarly, the original model anticipated that the admission rate from Grantham UTC would be 6.9%, with the actual rate being recorded as 5.6%.

Activity Levels

Since the 1st quarterly review the number of attendances at Grantham Urgent Treatment Centre (UTC) remains consistent. Since opening, Grantham UTC has seen 14,305 patients (up until 09/01/21), including those attending for Out of Hours appointments, **providing assurance that the aim to cater for 20,014 pa will be achieved and indeed surpassed.**

Of these, 98% of people have been seen, treated and discharged within four hours of their arrival time and 93% are seen within 15 minutes of arrival. The percentage of patients referred to A&E is below average for urgent treatment centres in Lincolnshire and stands at 5.12%.

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

The Impact to Patients

An analysis has been undertaken on the impact to patients who may now be required to attend either Lincoln or Boston Emergency Departments.

The table and graph below shows those patients with a Grantham postcode who have historically attended Lincoln ED, against current attendance. Whilst attendance in early 2020 was generally below that experienced in 2019 there was a sharp increase in the month immediately following the temporary closure of the Grantham ED and reclassification to a UTC.

The growth since June is consistent across our EDs with Wave 2 demand, with the initial prediction of growth of 1185p.a. (circa 100 per month) based upon initial experiences of Wave 1.

GDH Postcodes seen in LCH/PHB EDs	Predicted increase	Actual increase
Monthly average 2nd Quarter	c.100	138

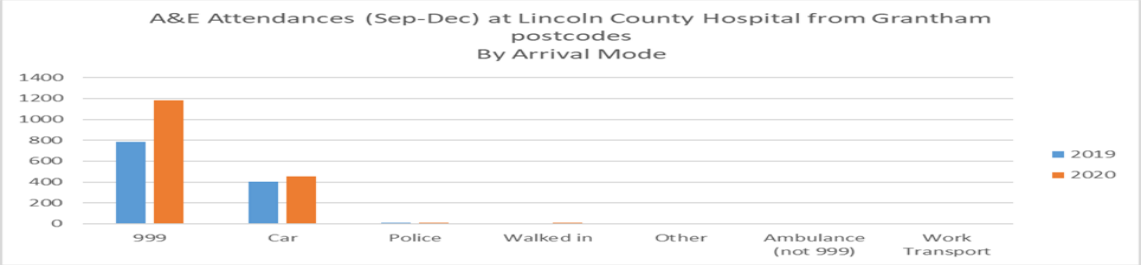
GDH Postcodes admitted in LCH/PHB EDs	Predicted increase	Actual increase
Monthly average 2nd Quarter	c.106	87

The monthly average for Oct – Dec 2020 of patients with a GDH postcode attending at LCH and PHB Emergency Departments whilst higher than that predicted, represents approx. 1.25 patients per day increase over the predicted numbers and should be viewed in the context of the likely greater patient attendance during the Wave 2 of the Covid pandemic.

The monthly average for the same period of patients with a GDH postcode admitted via LCH and PHB Emergency Departments was however, less than those predicted as detailed above equating to 0.62 less admission per day for that quarter.

Total GDH Postcodes "Seen" in Lincoln ED

	2019	2020	Difference
January	278	259	**-19**
February	307	253	**-54**
March	291	298	**+7**
April	268	192	**-76**
May	303	251	**-52**
June	271	288	**+17**
July	292	451	**+159**
August	295	368	**+73**
September	302	415	**+113**
October	315	428	**+113**
November	291	428	**+137**
December	302	391	**+89**



Similarly, the table and graph below shows those patients with a Grantham postcode who have historically been admitted via Lincoln ED against current admissions. Again, whilst admissions were generally below that experienced in 2019 there was a sharp increase in the month immediately following temporary closure of the Grantham ED and reclassification to a UTC. However, although initial predictions of increased admissions of 1277p.a. (circa 106 per month) were profiled, despite the increased pressures of Wave 2, actual admissions averaged over the quarter have been only 87 per month.

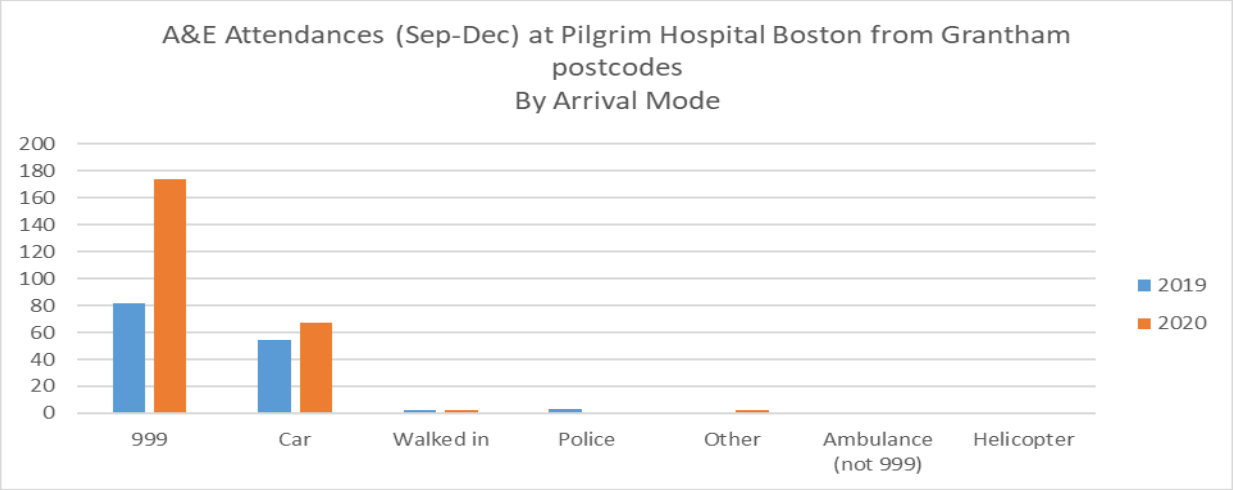
Total GDH Postcodes "Admitted" in Lincoln

	2019	2020	Difference
January	128	105	**-23**
February	117	104	**-13**
March	128	137	**+9**
April	111	98	**-13**
May	129	121	**-8**
June	118	136	**+18**
July	113	208	**+95**
August	140	186	**+46**
September	105	188	**+83**
October	135	196	**+61**
November	116	210	**+94**
December	132	188	**+56**
Monthly Average since service change	**124**	**196**	**+73**

A similar analysis of the impact of these changes for all patients who may now be required to attend Pilgrim ED is presented below. The table and graph below quantify those patients with a Grantham postcode who have historically attended Pilgrim ED against current attendance. Again, whilst attendance in early 2020 was generally below that experienced in 2019, there has been increasing attendance since June with a sharp increase in August.

Total GDH Postcodes "Seen" in Pilgrim ED

	2019	2020	Difference
January	38	25	**-13**
February	39	24	**-15**
March	33	30	**-3**
April	39	19	**-20**
May	35	16	**-19**
June	36	17	**-19**
July	55	39	**-16**
August	43	87	**+43**
September	25	52	**+27**
October	37	55	**+18**
November	41	61	**+20**
December	39	78	**+39**



The table and graph below show those patients with a Grantham postcode who have historically been admitted via Pilgrim ED against current admissions. Again, whilst admissions have been generally below that experienced in 2019 there has been a trend of increasing admissions since August.

Total GDH Postcodes "Admitted" in Pilgrim ED

	2019	2020	Difference
January	15	15	**0**
February	19	16	**-3**
March	20	20	**0**
April	20	10	**-10**
May	19	9	**-10**
June	19	12	**-7**
July	27	20	**-7**
August	29	37	**+8**
September	10	23	**+13**
October	21	24	**+3**
November	10	31	**+21**
December	17	43	**+26**
Monthly Average since service change	**19**	**30**	**+11**

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

3.2. Quality & Safety

The maintenance of a safe environment for all patients at Grantham is predicated upon robust IPC arrangements to maintain the site Covid-19 free. A commitment was given within the proposals for a Green Site for all aspects of the IPC Board Assessment Framework (BAF) to be met. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users. In the absence of any reported concerns regarding the safety of patients at Grantham, assurance will now be sought to evidence the consistency of systems and processes in place

across Grantham to escalate and report any concerns, incidents or near misses. Currently the Trust has assessed the following aspects in detail relating to all services at Grantham:

1. The provision and maintenance of a clean and appropriate environment in managed premises that facilitates the prevention and control of infections
2. Appropriate antimicrobial in use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance
3. Provision of suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion
4. Prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people
5. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection
6. Provision of secure adequate isolation facilities
7. Adequate access to secure laboratory support as appropriate
8. Implementation of policies designed for the individual's care and provider organisations that will help to prevent and control infections
9. Systems in place to manage the occupational health needs and obligations of staff in relation to infection

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

A review of the IPC Board Assurance Framework tool was undertaken in November 2020, and again in January 2021. This report is developed for scrutiny at the Trust's IPC group and reported through to the Trust's Quality Governance Committee.

3.3. Patient & Staff Experience

Patient Survey:

To understand the impact of the temporary service change on patients, an initial patient survey was undertaken with 110 responses received, representing a very small sample of the patients treated at Grantham since June. The details of this report were presented in the first Quarterly review.

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

Many individual members of staff were individually recognised and praised for the positive impact they made to patients' experiences at Grantham. Some specific practical suggestions were offered regarding how facilities for relatives accompanying patients could easily be improved upon, which the operational teams addressed.

The limitations of such a small sample were recognised, and in response as a Lincolnshire system an ongoing engagement exercise was initiated to further understand patient experience around the

Grantham Hospital Green Site model. This in turn has helped, and will continue to help, improve services offered to Lincolnshire patients.

Therefore, a more comprehensive and collaborative approach to patient engagement has been developed, (including other providers of care in Lincolnshire most notably LCHS), covering the following: -

- Online survey – Public
- Online survey – Inpatient users
- Face to face service user questionnaires – clinic and hospital settings
- Personal patient interviews
- Friends and Family Test and patient experience data gathering

With this much broader approach, we have been able to gather both patient and winder public views on the temporary changes made at Grantham and District Hospital.

From these activities, we have so far received feedback from patients and public across 24 different postcodes of Lincolnshire and some surrounding border areas.

Data gathering for this patient experience and public opinion exercise will continue on an ongoing basis, however this second quarterly review includes all available data up to 7th January 2021.

Although these last 7 days of questionnaires were captured outside the 3-month window being examined in this report, it was deemed necessary in order to accommodate patients who would feedback about service experience that took place over the holiday/Christmas period.

In this second quarter timeframe, 507 surveys were completed. 462 surveys were completed online by the public and 46 were completed in hospital. Full results of this survey to date can be found on the 'sharing your views' page of the Trust website.

In excess of 5000 Outpatient Department Friends and Family questionnaires have been sent to patients along with more than 1000 chemotherapy day ward and over 750 inpatient and endoscopy department users. These have elicited over 3000 ratings and 2474 comments.

Results

The full analysis and results generated more than 400 pages of intelligence, and a summary of the main findings are detailed below. As previously described, the catchment of public spanned across all of Lincolnshire but where results provide experiences of specific locations they are described below.

<u>Attendance at Grantham Hospital</u>

By far the majority of respondents to this survey (87%) would choose to visit Grantham and District Hospital if needed, rather than Lincoln, Boston or other hospitals in the surrounding areas. Three quarters had attended a hospital or community venue in the last 12 months on between 1 and 3 occasions, mainly Grantham Hospital but also some at Gonerby Road Health Clinic and fewer at Grantham Health Centre. Over half had attended the A&E / Urgent care services with fewer attending for outpatients and diagnostics appointments.

When asked why they chose to attend Grantham Hospital, by far the main reasons were because it was either the nearest location to where they live (92.8%) or they asked to get their care and treatment there (92.9%).

Satisfaction

The levels of satisfaction of the care and treatment received were high with over 94% satisfied or very satisfied at Grantham Hospital, 70.7% at Gonerby Road Health Clinic and 38.3% at Grantham Health Centre. Levels of dissatisfaction were extremely low, but for the latter two locations there were high levels of 'don't know' responses to this question.

Good experiences

282 respondents to the survey provided 529 comments about what was good about their experiences, which focussed on the following:
Workforce: Staff were considered excellent, caring, supportive, kind, respectful, reassuring or listened as well as being professional and knowledgeable.
Efficiency and waiting times: Treatment was efficient, patients usually seen quickly and on time.
Travel, location and parking: Good location, accessible and local.
COVID-19 measures/cleanliness: Patients felt safe at Grantham Hospital due to social distancing and the Green status and were happy with the cleanliness and provision of masks to patients.
Treatment: Care or treatment received was excellent, good, that they felt well looked after or that they were grateful.
Organisation, processes and communication: Organisation or communication was good throughout treatment and some were happy with the referral process, the booking in system or the transfer process.
Fully functioning Grantham Hospital: A small number of respondents mentioned the importance of having a fully functioning Grantham Hospital.

Improvements

264 respondents to the survey provided 290 comments about what could have been improved about their experiences which focussed on the following:
Nothing / happy with service: Many couldn't think of anything that needed improving.
Service offering: Some addressed the closures, indicating that either an A&E is needed or that services such as X-ray and fracture clinics need to be reintroduced at Grantham Hospital.
Workforce: Behaviour was raised by some, indicating that the staff were either rude, unfriendly or lacked empathy.
Environment and décor: Thought to need improving including signposting, cleanliness and temperature of buildings and investment in facilities.
Travel and parking: Requires improvement at Grantham Hospital, free parking requested, too far to travel to other hospitals.
Appointments: Improve waiting times, information to patients about delays, make it easier to be able to change appointments.
Treatment: More adequate equipment and facilities needed to improve treatments available rather than having to go elsewhere. More accurate diagnosis and treatment needed.
Security: Some respondents felt uncomfortable by their questioning, with others finding them rude and obstructive or unhelpful.
Visitors and family support: Allow visitors to attend with patients.

Communication: Improve communications such as more information before tests and appointments and better liaison with GPs. Also, clarity is required from 111 about the booking process at the UTC and whether it is required.

Impact of receiving care and treatment at Grantham

201 respondents to the survey provided 289 comments about the impact of receiving care and treatment at Grantham Hospital rather than another hospital.

By far the majority of comments focussed on travel, with respondents stating that Grantham was local to them, not too far to travel to, easy to find and easy to get to. This was particularly important for those who did not have means of transport to get to other hospitals, as travelling to Lincoln or Boston Hospitals was considered more difficult for them. However, some also mentioned that for others, travelling to Grantham was in fact further and more difficult. One respondent stated that the extra distance to travel to Grantham was not a problem and that safety was a priority.

Other respondents felt that overall, attending Grantham resulted in a less stressful visit and gave them peace of mind.

Some commented that despite Grantham Hospital being closest to where they live, they still have to travel to other hospitals for treatments that aren't available locally or for follow up appointments and care. However, some also mentioned that whilst Grantham wasn't their local hospital, they travelled there for cancer treatment during the pandemic which wasn't available elsewhere. Despite other hospitals being more convenient for them, they understood why their treatment had been moved to Grantham.

Attendance at other hospitals

When asked, 39.4% had attended Lincoln County Hospital, 36.8% hadn't attended any others and 18.2% attended others (such as QMC Nottingham) and 16.5% had attended Pilgrim, Boston. Nearly half of these respondents (45.9%) indicated that they couldn't have attended Grantham Hospital on those occasions as the service isn't available or they were not given Grantham as an option (33.3%).

Impact of receiving care and treatment at another hospital

173 respondents to the survey provided 276 comments about the impact of receiving care and treatment at Grantham Hospital rather than another hospital.

Again, the majority of comments focussed on travel, indicating that they had to travel further for their care and treatment, resulting in a long journey, taking more time out of their work or school days and often with additional costs such as fuel and childcare. This meant reliance on family or friends and some felt it had a negative impact on their mental health due to anxiety of travelling. However, for some respondents who lived closer to another hospital, this was more convenient than receiving their treatment at Grantham.

Some felt that their treatment could have taken place at Grantham and others indicated that they felt safer at Grantham due to a feeling that it was more Covid-19 safe than other hospitals.

Temporary changes to Grantham Hospital due to Covid-19

As a result of the temporary changes at Grantham Hospital due to COVID-19, 26.2% of respondents didn't know if the care or treatment that they would normally receive had changed. However, 38.1% indicated that it had changed to some extent while 35.8% said it hadn't changed.

When asked why they thought it had changed, nearly half (47.1%) said the service they needed had been moved to another location. 29.4% indicated that they did not need treatment or care during this time and 3.3% decided not to access care or treatment during the COVID-19 pandemic. Other examples of change were that they received a remote appointment rather than face to face, it had been suspended or cancelled or they had to wait longer.

Impact of the temporary changes to Grantham Hospital due to Covid-19

206 respondents to the survey provided 271 comments about the impact of the temporary changes to Grantham Hospital due to Covid-19.

Again, the majority of comments focussed on travel and transport, indicating they had to travel further which took longer, especially with a lack of public transport and concerns were raised about this in an emergency and the impacts on things like mental health, childcare and associated costs.

Comments were also provided from those who had experienced cancellations due to the service no longer being available while others had to wait longer for appointments or to be seen. While some were able to retain their appointments remotely, others felt dissatisfied with the treatment received in this way.

Some respondents didn't feel safe and so didn't attend their appointments, particularly at hospitals other than Grantham.

Any other comments

194 respondents to the survey provided 323 comments about any other experiences of attending Grantham Hospital for care or treatment.

Many of the respondents felt that the hospital was either excellent, they preferred this hospital, or that they were either happy/felt comfortable/felt safe at this hospital or with the treatment they received and thanked the staff. Some were disappointed that the treatments they required were not available at Grantham Hospital and felt the hospital needed more investment. Specific comments were made suggesting services should be reinstated once the pandemic is over, and in particular the A&E.

This was mostly due to the impacts of longer travel to other hospitals, especially in an emergency, and when public transport is not available and people don't drive this can become extremely costly.

Some respondents also mentioned feeling reassured by having a local hospital in Grantham and that making it a Green Site was a positive decision.

Some respondents provided great feedback about their specific experiences, all of which are available to read in the full report.

Friends and Family Test

Area	Surveys Sent	Ratings Received	Comments Received	Would Recommend %	Positive Comments Example	Negative Comments Example
Ward 2	789	386	318	93%	Amazing staff, helpful and caring	Poor communication about surgery and post-op advice
Endoscopy	886	389	358	97%	Staff made me feel safe regarding Covid	Poor experience during procedure, felt neglected
Day Ward *(Chemo Therapy)*	1,134	398	335	94%	Could not have been looked after better. Staffed made me feel confident	Medication sent to wrong hospital, considerably increasing the time my appointment took
Outpatient Department Attendees	5,743	1851	1463	89%	Everyone at Moy park went out of their way to be helpful.	Degree of chaos trying to deliver services on a building site

Staff Survey:

An initial survey of staff working on the Grantham site has also been undertaken, with 157 responses received. This would represent an approximate 75% response rate from the staff identified within the model retained on site.

It is recognised that understanding the views and differing perceptions of all staff involved in delivering services at Grantham is helpful in both evaluating the impact of service changes and informing the options going forward. Similarly, the Trust has sought to understand the experience and perspectives of those staff relocated from the Grantham site to ensure a balanced picture is developed regarding the experiences of staff to complement patient feedback and assist in informing ongoing development and provision of services.

The development of a more effective and sustainable approach to engaging with staff that have moved from or remain working on the Grantham site has been established, with the development of a HR-led action plan, a live document which will be maintained for the duration of the changes to service at Grantham.

Initial analysis of responses presented mixed levels of confidence in the steps taken to manage risks of Covid-19 at Grantham Hospital. Specific concerns related to the consistent application of IPC standards potentially impacting upon the safety of the environment for patients have been consistently addressed, and the application of the stringent IPC processes has been maintained. The Grantham Green site remains a limited-access site, with prior approval required for staff accessing the 'Green' environment. As expected, at the time, most staff reported being directly affected by the changes; with workload, levels of support available, communication and effect upon mental /emotional health being identified as most significantly impacted.

Positive staff feedback recognised the extent to which immediate managers both valued and were interested in individuals' health and wellbeing. However, a clear area for improvement was identified, with an ask for senior managers to strengthen existing levels of engagement and communication with staff, specifically in terms of actions taken in response to feedback received.

In addition to the usual local departmental engagement through the line manager structure, the Executive Leadership Team have maintained direct engagement through weekly meetings with Staffside representatives for all unions.

Recognising that there are groups of staff who work in services that span organisational boundaries, regular meetings take place between LCHS and ULHT teams to ensure the views of UTC staff are sought and fed into the process of wider consideration. Whilst it is anticipated that many of the specific issues raised by staff will be able to be clarified or addressed swiftly, some of the issues pertaining to the clinical model in place will necessitate wider engagement and discussion to understand fully the nature of concerns and identify the most appropriate actions to be taken. The establishment of the Grantham Green Site Working Group provides a forum to receive operational updates from across the ivisions including HR and Staffside attendance.

Engagement with Trade Unions

Following engagement and consultation with TUs in advance of the formal presentation of the Green Site proposals in June, executive representatives have continued to meet weekly with Staffside representatives to ensure their ongoing involvement in evaluating the implementation of the model. TUs have continued throughout to raise the views of their member so that these may be considered alongside the views available from patients and other stakeholders. This level of engagement will continue for the duration of changes implemented at Grantham, to ensure the full impact on staff of any changes are fully understood and to inform ongoing evaluation.

3.4. Recognition and Response to Public Concerns

Specific Concerns raised by the public:

All individual concerns raised to the Trust Board at its extraordinary meeting in June 2020 have been responded to directly and in full either in the meeting or in writing by the CEO. These have subsequently been shared with the wider leadership team, with consideration being given to enable learning from these to influence future actions. These activities supplement the other engagement activities described earlier in section 3.3

A number of concerns raised have led to additional measures being put in place to mitigate risks or concerns in addition to the initial Green Site model published in June 2020. These additions have continued into the second quarter of operating. Some examples of this are;

- The implementation of dedicated transport services for patients to and from Grantham Hospital via a new Patient Transport Service contract with Ambicorp Ltd., a CQC-licensed independent patient transport provider.
- Maternity and paediatric services have been restored at the Grantham Family Health Centre and additional services have been put in place at the Grantham Green site itself for the most vulnerable patients.
- Additional outpatient services have been restored at the clinical assessment and treatment centre at Gonerby Road in Grantham, reducing the need for patients to travel to services at Pilgrim and Lincoln hospitals.
- Additional theatre capacity has been installed in the form of two Vanguard Modular Theatres, to be fully operational January 2021 to support cancer operating specifically (but not exclusively) breast and gynaecology.

- Children's services are restarting with Green pathways at Grantham Hospital and additional pathway services are in development at Gonerby Road.
- In addition to Grantham Green Site surgical services, the Independent Sector are supporting the Trust at the BMI facility in Lincoln, Ramsey in Boston and St Hughes in Grimsby.

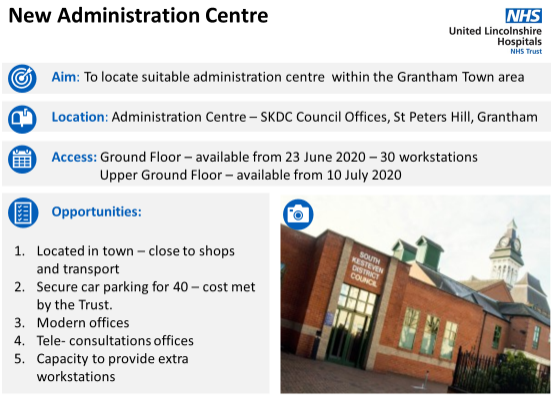
Specific Concerns raised by Elected Representatives

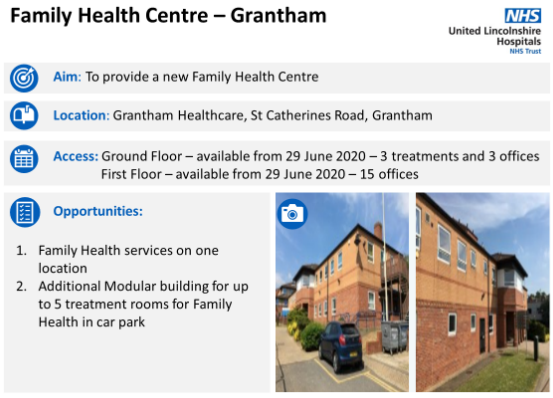
Concerns were expressed by local elected representatives that focused upon the impact to residents required to travel to services that were being moved from the Grantham site. The importance of these concerns has been recognised by the Trust, and as previously discussed in this paper a number of developments of several new sites away from the immediate Grantham Hospital site, but within the Grantham locality, have been completed and are in operation.

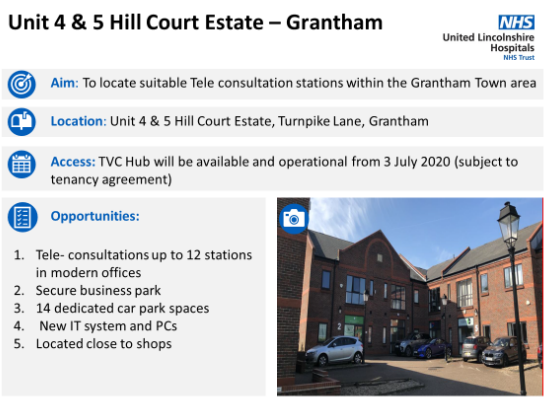
As previously highlighted in this paper, these developments provide an increasing choice for Lincolnshire patients which to access services in Grantham. In addition, these developments have enabled the Trust to increase local access to services in Grantham above what had been proposed in June 2020.

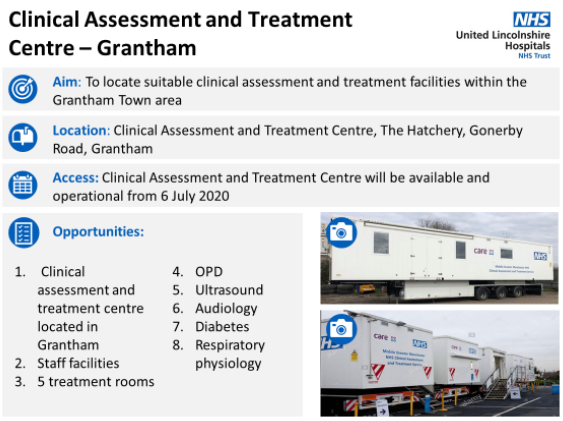
These developments serve to maintain the highest level of protection and IPC standards on the Green site, enable the Trust to continue to restore services suspended during the manage phase of the epidemic and reduce both patient and staff need to transfer to other hospital sites across Lincolnshire.

Details of the 4 new sites are described below:









3.5. Recommendations from 1st Quarterly Report

Primary Recommendation regarding the Grantham Green site model:

Approval was granted by Trust Board to continue Green Site Model in October 2021.

The Trust Board is invited to approve the continuation of the temporary service changes enacted in June as a consequence of establishing the Grantham Green site model. The timescale for this continuation to last for the duration of Covid-19 to at least 31 March 2021. This timescale to be subject to a system wide review of the full next quarter's activity available in early January 21 for the Trust Board's consideration in February 21.

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

Site Specific

In addition to the recommendation to continue the Green site model there were a number of recommendations made in the first quarterly review in October 2020. Each of these recommendations and their subsequent reciprocal action are described below.

1.	*Consider strengthening the **Operational Management Capacity** to provide oversight to the delivery of the Green site model at Grantham, to last for the duration of Covid-19. This capacity to ensure the establishment of a comprehensive performance management framework so that ongoing evaluation and routine reporting of the impact of these arrangements may be made. This to include* • *routine triangulation of Grantham **surgical activity** data pertaining to patient activity, theatre and bed utilisation to identify opportunities for further improvement of operational performance and update original modelled activity projections within the context of overall Trust activity.* • *revised **OP attendance** targets for Grantham* • *an audit of IPC standards on the Grantham site, against the IPC BAF*	

Operational management has been strengthened by the appointment of a dedicated Clinical Site Manager at Grantham hospital. This Matron-level post has day-to-day oversight of operational capacity and acts as a dedicated senior manager to Grantham Hospital. Whilst an early initial appointment was unsuccessful, the vacancy was appointed to in this second quarter and will support the development of the ongoing performance management of Grantham Hospital activity.

The regular presence on site of the Divisional Managing Director for Surgery and Deputy Chief Operating Officer, combined with regular Executive site visits, also provides very senior manager oversight.

Revised outpatient attendance targets were incorporated into this second quarterly review and exceeded.

IPC standards on all sites have been reviewed in the context of the IPC BAF and this will continue to be reviewed. Most notably to date is the efficacy of the measures in place at Grantham which have maintained the ultra-high level of Covid-19 protection for our most vulnerable patients.

2.	*Consider establishing a **Grantham Green site working group** with clear terms of reference to undertake a review the existing Clinical Model with a view to further optimising capacity at Grantham and formally refresh the activity modelling, activity targets and QIAs & EIAs previously undertaken. This to include modelling of intended rehabilitation services to be present on the Grantham site from 1st November identifies clear activity and performance targets, the monitoring of which may be included in the ongoing Grantham wide evaluation and next formal review and as part of the Trusts overall performance reporting.*	

The Grantham Green Site Working Group has been established. The group has representation at an Executive level as well as divisional operational representation (clinical and non-Clinical), Human Resources and Staff side representatives. Clear terms of reference have been established and whilst initially meeting fortnightly, it is now moving to a weekly meeting in preparation for changes to services from 1st April 2021 in line with current Green Site timescales.

3.	*Invite the endoscopy working group to remodel endoscopy activity trust wide in anticipation of easing of IPC requirements, translating this to explicit targets for Grantham going forward, including the potential for establishing 12hr sessions. This information to enable a routine monthly evaluation of performance to be reported on as part of the Trusts overall performance reporting.*	

Endoscopy service delivery was moderated in line with IPC, JAG and British Association of Gastroenterology guidance. The service made excellent progress in delivering recovery following Wave 1, as discussed in the main body of this paper; the services approach and success being recognised and held as an exemplar at a local, regional and national level.

4.	*Invite the chemotherapy management team to remodel chemotherapy activity based upon the transfer of all patients onto the Grantham site. This information to enable a routine monthly evaluation of performance to be accurately and consistently reported on as part of the Trusts overall performance reporting.*	

The aims and objectives of the service relating to the development of the Green Site at Grantham have been fully implemented as detailed in the main body of this paper. There has been a clear and obvious transfer of patient services as intended, surpassing initial intentions, whilst retaining services across the wider ULHT footprint to cater for urgent pathway cohort of patients.

5.	*Consider the identification of a single individual taking responsibility for standardising, coordinating and reporting on surgical performance of the Trust as a whole, this to include overall surgical performance at Grantham.*	

The responsibility for this sits under the auspices of the Divisional Managing Director for Surgery as delegated by the Divisional Director of Surgery. Performance is reported, monitored and managed through the Trust's operational management structure and reported via the Divisional Performance Review Meetings.

6.	*Formally establish with LCHS a collaborative framework for comprehensively evaluating the impact to patients and staff following the closure of Grantham ED, findings to shared monthly with all stakeholders and as part of the next formal quarterly review of the Grantham Green model.*	

A collaborative relationship has been established and further developed throughout the Grantham Green Site model operational delivery. The teams meet monthly as a minimum, but in this second

quarter of the model being operational has increased to fortnightly. The group reviews operational issues covering operational delivery, quality, patient experience including complaints and compliments, and staffing.

Corporate

7.	*Consider ways of establishing a dialogue with all staff currently working at Grantham, those visiting Grantham and those transferred from the Grantham site, to ensure all experiences and suggestions inform learning and ongoing strengthening of the temporary model.*	

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

The wishes and needs of staff are represented and monitored through the Grantham Green Site Working Group. There is both Staffside and HR representation, as well as operational divisional senior representatives ensuring that views of staff reach a broad and influential audience. An action plan has been developed and is led by the HR Business Partner - progress against which is monitored via this group.

Redeployment of staffing across all sites now operates through a single 'staffing hub', and as such a consistent approach is applied across all sites. This is overseen by a very senior 'nurse commander' to ensure that safety is maintained and that staff are treated fairly and responsibly when being transferred or moved across clinical areas.

9.	*Consider inviting STP colleagues to support the trust develop an explicit framework for establishing and sustaining effective engagement with staff to strengthen communication across the trust.*	

A collaborative approach has been established with LCHS colleagues through both UTC operational management and delivery teams. At a more senior level, a collaboration of Deputy Chief Operating Officer - Planned Care (ULHT), Associate Director of Communications and Engagement (ULHT), Strategic Engagement Lead (Optum Commissioning Support Services), and the Stakeholder Engagement Manager and Patient Experience Lead (LCHS) has been established to strengthen the relationships between provider stakeholders, and ensure sustained collaborative review of the impact of the change in services upon the ongoing patient experience.

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

At the June 11th Extraordinary Trust Board meeting it was agreed the proposed model of care should run temporarily until 31st March 2021. Within that same proposal was confirmation that there would be a quarterly review where the model would be evaluated against a set of criteria designed to indicate either a change to the model is required or a complete revert back to previous model should commence.

The below criteria were developed and agreed in the first quarterly review in October 2020. These criteria reflect when circumstances, either within the Trust's control or outside of its control, would require the model to change or revert back to pre-Covid-19 arrangements.

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

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

The fast-changing national position regarding prevalence of Covid-19 and the introduction of tighter restrictions to reduce transmission presents an extremely challenging and complex environment within which the Trust must seek to both continue to deliver against existing priorities to restore service delivery, whilst revisiting contingency plans in the event of national or local guidance changing.

Under these circumstances the criteria above remain wholly appropriate, with the importance being to continue to strengthen current methods and mechanisms for evaluating specific aspects of performance within the context of the Trust's overall performance, such that the most informed decisions may be taken by the Trust Board in due course.

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

Trigger	Rationale	Measure or Indicator
○ Where Regional or National Incident Directives state this model is either incompatible with a model of care or where through the NHSE/I Command structure a request is made to revert to the pre Covid-19 model	Whilst working within emergency measures either at national Emergency planning level 3 or 4 the Trust must respond to regional or national directives.	Directive from NHSE/I either via MIDSEAST or national Command Centres/Incident Directors.
○ Where Impact on other health organisations results in a request for mutual aid directly relating to the temporary model.	Where consequences of the model have unintentional impact on other organisations to a level requiring formal mutual aid for cessation or change of the current model.	Formal Aid Request via the Local Resilience Forum.
○ Where substantial previously unidentified risk is identified with a threat to life or limb within the existing models of care.	Where new risks are identified that indicate a substantial threat to loss of life or limb that had not been identified there is a need to urgently review and	Completed Risk Assessment that indicates an inability to mitigate risk through countermeasures.

	potentially change/cease the current model.	
○ Overall waiting lists for Cancer patients reaches levels to support 62 & 104 day treatment standards, and incomplete waiting lists reduced to pre Covid-19 standard.	Where the Trust has responded completely to the pandemic incident and restored services to levels of care within safe constitutional standards the current model should be reviewed and consideration be made to reverting back to pre-covid models.	62 day Backlog Patients <40 patients 104 day backlog <10 patients Incomplete waiting list < 37,762
○ Covid-19 alert level reduces to L2 or below	L2 Covid-19 Alert level reducing would indicate a substantial decrease in the risk of Covid-19 being acquired in the community and subsequently in hospital. This would reduce the need for such high IPC measures and would trigger a consideration of change of model or revert back to previous state.	Covid-19 Alert Level <=2
○ Activation of the Trusts Full Covid-19 Surge Plan	The impact of a subsequent wave of Covid-19 or other winter extreme demand events (including a Major Incident) could trigger the need to convert all Inpatient Capacity and re-task supporting services to Covid-19 or Urgent and Emergency Care facilities.	OPEL L4 Indicators for the whole system.

These 6 criteria were designed to consider all known scenarios that should lead, initially, to at least a consideration of amendment of the model. This in turn could trigger reverting back to the original pre-Covid-19 model.

They are sufficiently broad to consider the full range of risks to stakeholders internally (patients) and externally (other organisations in and out of NHS Midlands Region). The measures or indicators used as evidence to trigger are not greatly sophisticated in nature, but are considered to be highly visible and easy to communicate so as to easily alert the Trust to a need to consider its response differently.

The national expectation that local intentions to restore elective services would continue for as long as possible reflected a 'window of opportunity' for the Trust to continue providing services for the benefit of all patients across Lincolnshire. This was reinforced by a letter received in September from the National Strategic Incident Director advising trusts to continue to strengthen local efforts to re-establish elective services whilst reviewing local escalation plans in anticipation of increasing hospital admissions. Despite recent developments there has been to date no contrary advice formally issued to the Trust to stand down elective care.

4.1. Evaluation of Current Circumstances:

The following assessment has been revisited in the context of the Quarter 2 position in order to ascertain whether the triggers for change in model/revert back to pre Covid-19 model have been met.

The below table evaluates data available and provides statements of fact against each criteria.

Trigger	Current State	Has the Indicator been Triggered?
1. Where Regional or National Incident Directives state this model is either incompatible with a model of care– where through the NHSE/I Command structure a request is made to revert to the pre Covid-19 model	No directives have been received by the Trust to date suggesting incompatibility with the current temporary model. Subsequent guidance sent through MIDSEAST and from national teams support the use of Green Sites.	No
2. Where impact on other health organisations results in a request for mutual aid directly relating to the temporary model.	No requests for mutual aid have been received. Regular reviews of patients accessing other organisations urgent care services as a result of the temporary model indicate a lesser impact than that described in the June 11th proposal.	No
3. Where substantial previously unidentified risk is identified with a threat to life or limb within the existing models of care.	No new substantial risks have been identified.	No
4. Overall waiting lists for Cancer patients reaches levels to support 62 & 104 day treatment standards, with all other waiting lists reduced to pre Covid-19 levels.	Reductions in waiting lists for cancer have occurred and all initial surgical waits have been treated or seen in alternative services. At the end of December 2020 62 day Treatment Standard backlog was at 221 against a trigger of 40 or less 104 day Treatment Standard backlog was 61 against a trigger of 10 or less Overall waiting list levels remain above pre Covid threshold of 37,762. At the end of December the total waiting list was 43,413.	No
5. Covid-19 alert level reduces to L2	National Covid-19 alert L4	No
6. Activation of the Trusts Full Surge Plan	There have been no occasions where OPEL4 levels have been reached on a system wide basis.	No

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

5. Findings & Recommendations

The aims and intentions upon which the Green Site model was predicated remain sound. Wave 2 and a developing Wave 3 of the Covid 19 pandemic provides the opportunity to revisit the Green Site model arrangements, not least in the context of the current roll-out of the COVID-19 vaccine to staff and defined cohorts of patients.

Whilst there is no doubt that the services approved within the Green Site model have been implemented as intended, the full effect of these changes upon staff, Grantham residents, patients, other sites and services provided by the Trust remain to be fully quantified and understood. However, this should be viewed within the context of an ever-changing environment and operational demands, and as such a need for an ever-changing tactical approach.

It is clear that the Green Site model has made a significant contribution to supporting the ongoing delivery of care to a group of patients who may otherwise have been more significantly impacted by the Covid 19 pandemic.

There is, in such a changing environment, always opportunity for reflection on the findings from this review to inform future tactical decisions in responding to ongoing need. Not least, the decision required of the Board in relation to a sanctioning of a third quarter of the model through to 31st March 2021, and in light of the current ongoing prevalence of the pandemic which had not been predicted, the future of such Green Site model arrangements beyond March 31st.

Subject to the decision required below, a further quarterly review will be undertaken for the period January – March 2021 and will be compiled in April for the May 2021 Board meeting.

Decision Required:

Primary Recommendation: -

In the context with the achievements described in this report of the Grantham Green site model and the increased risk of national Covid-19 level 5, and actual challenges faced with the closure of surgical pathways at Lincoln and Pilgrim Hospitals the Trust Board is invited to approve the primary recommendation to continue with the Green site model at Grantham as planned through to 31st March 2021.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Public Trust Board*
Date of Meeting	*2nd February 2021*
Item Number	*TBC*
Recommendations on the temporary Grantham Green Site operating model, put in place in response to Covid-19, post 31st March 2021	
Accountable Director	*Simon Evans – Chief Operating Officer*
Presented by	*Simon Evans – Chief Operating Officer*
Author	*Simon Evans – Chief Operating Officer*
Report previously considered at	*N/A*

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

Risk Assessment	*4558 – Local Impact of the Global Coronavirus (Covid-19) Pandemic* *The paper is in direct response to mitigating this risk.*
Financial Impact Assessment	*The temporary establishment of a Covid-19 Green site at Grantham Hospital was a direct response to a Level 4 National Incident, not requiring a detailed FIA to be considered; however clear processes to authorise financial expenditure in line with the agreed business case have been established to support a detailed evaluation to take place.*
Quality Impact Assessment	*Original Completed June 20 as part of recommendations. A revised QIA will be developed for sign-off prior to any chance*
Equality Impact Assessment	*Original Completed June 20 as part of recommendations. A revised EIA will be developed for sign-off prior to any chance*
Assurance Level Assessment	*Significant*

Recommendations/ Decision Required	- The Board is asked to review this paper alongside the Grantham Green Site second quarterly review.

	The Board is asked to review and confirm the 5 recommendations described in this report, one of which will be the review of a subsequent paper for decision at March 2021 board.

1. Purpose

The purpose of this paper is to put forward recommendations to the ULHT Trust Board appertaining to the future operating model at Grantham and District Hospital and other associated services beyond 31st March 2021, following the temporary establishment of a Green site at Grantham in June 2020. This paper is not to replace the second quarterly review which will be presented at February 2021 ULHT Trust Board in line with previous commitments described in the initiation document approved in June 2020.

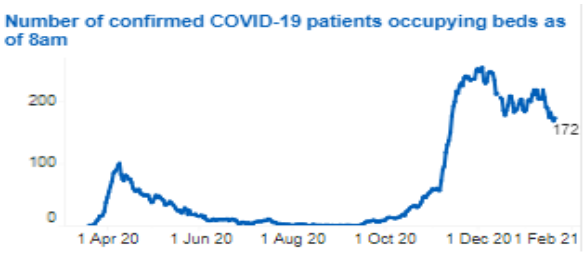
2. Introduction and Background

The development of a Green Site at Grantham was one important element of the Trust's Covid-19 Strategy and Recovery Plan, the proposal for which was considered by the Board on 11th June 2020, with go live 29th June 2020.

The overarching objectives were to support requirements for urgent care in response to Covid-19, whilst simultaneously addressing the need to re-establish and maintain access to elective care, providing a structure upon which the Trust's planning for elective recovery could be based.

Principles agreed in the development of the model in June 2020 included adherence to strict Infection Prevention and Control procedures (IPC Excellence), creating capacity to address backlogs of patients waiting for treatment from Wave 1 and the ability to sustain any new model in the face of future waves of Covid-19 outbreaks. Research available in June 2020 supported the development of 'Green sites', with two major research papers from China and Europe (Italy) demonstrating the positive impact of operating in a Covid-19 -free environment. Whilst a third paper described the impact on patient outcomes of perioperative Covid-19, in particular the substantial increase in fatalities.

On 9th November, following a steady increase from mid-October, ULHT case numbers in Wave 2 of the pandemic surpassed Wave 1 peak demands and went on to be 250% of the previous Covid-19 hospitalised cases. This ultimately necessitated the repeated temporary cessation of both the Lincoln County Hospital and Boston Pilgrim Hospital Green pathways and all surgical procedures therein. At the same time Grantham Green site surgery and treatments were able to continue.



Although more detail can be found in the second quarterly review of the Grantham Green Site model, it is important to note that whilst operating this configuration no patient has contracted Covid-19 in Grantham hospital after surgery, despite more than 2,500 patients having received their surgery and more than 5,500 treatments taking place.

3. Current position and ability to forecast impact of Covid-19

At the point of production of this report (25th January 2021) the national Covid-19 alert level is at level 5, indicating there is a material risk of healthcare services being overwhelmed. It has been at this level since 4th January 2021.

In addition to this, the NHS Emergency Preparedness and Response level is also at its maximum Level 4, requiring trusts to work within strict directives from NHSE/I. This response maintains a command-and-control function within the NHS and reduces some local decision making in order to consistently respond to the national Covid-19 pandemic.

A national Covid-19 vaccination programme is underway across all regions. In Lincolnshire this vaccination programme is running in line with national directives with cohorts of high-risk patients/staff being vaccinated first. On 30th December 2020 the national Joint Committee on Vaccination and Immunisation (JCVI) announced that as many people on the priority list as possible should be vaccinated with a first dose and that second doses should be 12 weeks and not 4 weeks after the initial dose. This change in approach, whilst increasing the number of people vaccinated with some protection, does reduce the number of people who have the full effect of the vaccination described by the manufacturers Pfizer/BioNTech and AstraZeneca(Oxford).

As of 24th January 2021 6315 patients have confirmed Covid-19 in hospitals across the midlands compared to a previous peak of 3,429 on 12th April 2020. This substantial increase in hospitalisation of patients with Covid-19 has been explained by a second variant of Covid-19 that is 30%-70% more transmissible than the original variant that presented in wave 1.

In ULHT hospitals on the 24thJanuary 2021 139 patients have Covid-19 compared to an initial peak of 100 positive Covid-19 patients on 9th April 2020. This has reduced from a new peak that was experienced on 4th December when 253 patients had positive Covid-19 status across Pilgrim and Lincoln hospitals.

This transition from Wave 1, through Wave 2 and now to a Wave 3 which is moving across England re-affirms that despite IPC measures and lockdowns at different levels regionally and nationally, Covid-19 still represents a substantial risk to the provision of healthcare services across the country and Lincolnshire specifically.

At the time of production of this report there are no forecasted infection models developed that have high confidence predictions of the future impact of vaccination and/or Covid-19 second variant on Lincolnshire. Models being used that have been developed locally, regionally and nationally have limited time intervals only, providing confident forecasts into February 2021.

There are currently no publications or research papers that describe the impact of vaccination programmes on perioperative mortality in either mixed or Covid-19-free hospitals, largely as a result of the vaccination programme being so recently started.

Recommendation 1 – Considering the relative lack of evidence about the impact of Covid-19 on services and patients post-April 2021, it is recommended that ULHT commission a review of all available research, preferably with significant contribution from Public Health England and the Director of Public Health. This commission will aim to ascertain the new risk factors of operating mixed Covid-19 free and Covid-19 positive pathways, factoring in all known research about the Covid-19 vaccination programme and new variants of Covid-19.

Recommendation 2 – ULHT Trust Board are invited to consider additional recommendations to revert to pre-Covid-19 models of care, or not, at Grantham hospital at the March 2021 board. This will provide time for recommendation 1 to be completed whilst still maintaining sufficient time to operationalise changes in service back to a pre-pandemic model if required.

As result of the impact of Wave 2, waiting lists for cancer, planned elective care and diagnostics have once again started to grow. It is likely that after 1st April the NHS national will move to a recovery phase. This phase will require the large-scale restoration of elective services in order to tackle the backlog of patients waiting for planned care appointments/operations. It will not be possible for this recovery of activity to take place during wave 3, and therefore there is already certainty that additional clinical/physical capacity will be required.

Recommendation 3 - All areas where additional physical clinical/physical capacity has been put in place as part of the temporary changes to the Grantham Green Site model should remain in place past 1st April for at least 3 months, subject to review. Specifically, but not exhaustively this includes:

- **The additional two theatres at Grantham Hospital**
- **Gonerby Road treatment and diagnostic facilities**
- **Grantham Health Centre facilities and additional clinical rooms**
- **Additional MRI/CT mobile scanners at Lincoln, Pilgrim and Gonerby Road in Grantham**

The use of Independent Sector capacity will be subject to national contracting developments; however the continued use of independent sector capacity is also recommended where available in this next phase.

4. Operationalisation of previous models of care

The development of the original temporary model approved in June 2020 was implemented over a 12 week period into September 2020. Although a number of important changes were put into place in July and August, this operationalisation did not complete until September owing to the complexity of some originally unforeseen consequences of the model. In particular, the transfer of non-clinical services off the Grantham Hospital site to alterative locations in Grantham and other ULHT hospitals.

Having undertaken these and other important changes to deliver the necessary services in response to the Covid-19 pandemic, it is unlikely that the same 12 week window will be required to revert services back to pre-Covid-19 models. However, workforce redeployment and changes of this magnitude would typically require a 6 week window in order to combine both new workforce locations and to ensure patients and the public are informed with sufficient notice.

Recommendation 4- Considering the necessary lead time to plan services reverting back to pre-Covid-19 models, it is recommended that active planning should start immediately to build rotas and put in place operational plans to restore pre-Covid-19 models of care at Grantham hospital from 1st April. By undertaking these planning tasks and engaging with key stakeholders over the next month the implementation time should be reduced down to 2 weeks. Should a decision to revert back be confirmed in March, this planning will ensure the implementation by 1st April 2021.

Recommendation 5- Staff, Public and patient engagement activities should continue as described in the latest quarterly reviews to ensure strong communication between staff, public and ULHT. This will support active patient involvement in developing and operating safe, effective services going forward. This should as a minimum continue with communication methods already in use, but also actively canvas staff and public opinion about changes made.

5. Summary

The temporary arrangements put in place as part of the Trust's response to Covid-19 and restoration of services that offer protection from Covid-19 were due to continue till 31st March 2021.

The decision to revert back or to continue the Green Site model cannot reasonably be made at the current time, considering factors such as the Covid-19 vaccination programme, Covid-19 alert level 5, hospital levels of Covid-19 positive patients at twice the level of wave 1 and new variants emerging.

As such, recommendations have been put forward to gain better understanding of these factors, at the same time as practically preparing to revert back to pre covid-19 model at Grantham hospital, keeping additional clinical capacity where possible for future recovery activities.

A final recommendation on service configuration from 1st April should be made after this work has been undertaken in March 2021.

Report to:	Trust Board
Title of report:	Quality Governance Committee Assurance Report to Board
Date of meeting:	15th December 2020
Chairperson:	Liz Libiszewski, Non-Executive Director
Author:	Karen Willey, Deputy Trust Secretary

Purpose	This report summarises the assurances received and key decisions made by the Quality Governance Assurance Committee (QGC). The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board's response. This assurance committee meets monthly and takes scheduled reports from all Trust operational committees according to an established work programme. The Committee worked to the 2020/21 objectives. The Trust are responding to the second 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.
	Lack of Assurance in respect of SO 1a Issue: Deliver harm free care **Incident Management Report** The Committee received the report **Infection Prevention and Control assurance report** The Committee received the report noting that there had been a number of outbreaks however significant actions were being put in place to address these issues. The Committee were advised that there were over 80% of staff who had received the annual flu vaccination. Following the visit to Pilgrim Hospital by NHS Improvement an action plan had been put in place to address concerns raised. The Committee requested that the action plan be presented to the next meeting. The Committee received and reviewed the IPC BAF noting the areas of further work however updates would be required to ensure that mitigation actions were taking place and assurance could be provided. **High Profile Cases** The Committee received the report noting that regular updates were also received by the Board. The Committee were keen that the Trust reviewed actions identified for previous cases to ensure these had been completed ahead of coroner's inquests.

	Harm Review The Committee received the report noting that the actions requested earlier in the year had not progressed at pace. The Committee were unable to provide assurance to the Board on the process or of this being embedded. The Committee noted that there were areas where the process worked reasonably well, however these needed to be brought together in order to ensure oversight. Evidence of those processes that were working had not been received by the Committee. **Mortality** The Committee noted the NHSE/I required desktop review of mortality review processes that had been undertaken and requested that timescales were included against actions. The previous work on the mortality reduction strategy work undertaken had resulted in a structured process for the Trust with some minor actions to be taken. The Committee noted that difficulties of interpreting mortality in relation to Covid-19 deaths due to the consideration that was required of co-morbidities and lack of benchmark data.
	Lack of Assurance in respect of SO 1c Issue: Improve Clinical Outcomes **Ethics Committee** The Committee were pleased to see the breadth of conversations taking place both internally and across the system to ensure standards were set to protect patients. It was noted that whilst there had been nervousness of embedding ReSPECT within the organisation is was clear to see that there had not been an inappropriate approach to the use of this or Do Not Attempt Resuscitation orders.
	Assurance in respect of other areas: **QIA Process and QIA's processed during Covid-19** The Committee received the report noting that the business as usual process had been stood down as CIPs were not being delivered however the Committee raised concerns regarding work that was being carried out where a QIA could not be evidenced. The process had been introduced in a modified manner as part of the Covid Gold Command Structure to capture service and pathway changes however it was recognised that there had been a gap in QIAs for the first few weeks of the Covid-19 response. The Committee recognised the huge scale of change that had taken place however requested clarification on the QIAs presented to identify those

	that were routine and others that were Covid-19 related and the risk scoring associated with the changes. The Committee asked that the Trust aligned the process across the system and requested monthly reporting to ensure assurance was received. **Proposed arrangements for QGC and Reporting Groups** The Committee received the report noting that revised terms of reference and work programmes for the reporting groups would be received in January. The Committee agreed to direct reporting from the Maternity, Mortality and Children and Young People Groups in order that assurance could be directly received. The Committee noted that divisional reporting would not be received directly in to the Committee and sought clarity from the Board on the reporting route. **Integrated Improvement Plan** The Committee welcomed the report noting that there needed to be a clear indication of the link of information between the IIP and CQC action plans. **Committee Performance Dashboard** The Committee received the dashboard noting that due to timing of the meeting this was incomplete. The Committee raised concerns regarding the low level of Serious Incident figures reported and noted that there needed to be clarity over how these were reported when grouped by theme. The Committee sought clarity re the reporting of outbreaks as serious incidents Concerns were raised due to the number of re-opened complaints however the Committee were reassured that this was due to the work being undertaken to clear the backlog. Due to the significant number being closed this would lead to an increase in the number being re-opened. The Committee noted that there had been a significant reduction in overdue complaints and there was a continuing improvement in both pressure ulcers and falls, contributing to a lower number of Serious Incidents. Despite the pressures being faced by the Trust improvements were being maintained. **Maternity Dashboard** The Committee received the dashboard noting the position and actions being taken. Concern remained in relation to post-partum haemorrhage and the number of caesarean sections being performed but the divisional action being taken was noted.

	CNST The Committee received the report requesting that future reports contained an update on the actions being taken and timescales for achievement, within the maternity report. Concerns were raised in relation to uptake of PROMPT training, as it was felt that this was not being achieved. This would have an impact on the actions outlined in one of the HSIB investigations. The Committee also sought clarity on the progress to achieving against the national benchmarking data as the Trust were not in the position that the Committee had understood the Trust to be in. The Committee wished to understand the barriers in place to achieve the actions and further assurance was requested. The Committee noted that there was some impact from the IT system being used however this was would not resolve and improve the actions required alone. The Committee received a gap analysis against the recent CQC report from Nottingham University Hospitals conducted by the Head of Midwifery. The report was not RAG rated so it was unclear if this satisfied the actions or if there was further work to do. The Committee requested that this be linked to the actions required in the recently received requirement to conduct a gap analysis against the interim findings in the Ockenden report. **CQC Update** The Committee received the update noting how this linked to the Integrated Improvement Plan. The Committee noted that there continued to be areas that required further work in order to progress the action plan. The Committee noted that positive actions and significant work that had been undertaken in Urgent Care with progress being seen.
Issues where assurance remains outstanding for escalation to the Board	Harm Review – the Committee were unable to receive assurance on the process of harm reviews or if this had been embedded within the Trust. Oversight of the disparate process would be required to understand if harm had occurs and if so what mitigation was in place. The Committee were unable to provide assurance on the Quality Impact Assessment process.
Items referred to other Committees for Assurance	None
Committee Review of corporate risk register	The Committee reviewed the risk register noting the EU Exit risk alters due to the possible impact on obtaining supplies and food. The Finance, Performance and Estates Committee have oversight of this.
Matters identified	None

which Committee recommend are escalated to SRR/BAF	
Committee position on assurance of strategic risk areas that align to committee	The Committee considered the reports which it had received which provided assurances against the strategic risks to strategic objectives.
Areas identified to visit in dept walk rounds	Department walk around currently suspended.

Attendance Summary for rolling 12 month period

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

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

Report to:	Trust Board
Title of report:	Quality Governance Committee Assurance Report to Board
Date of meeting:	19th January 2021
Chairperson:	Liz Libiszewski, Non-Executive Director
Author:	Karen Willey, Deputy Trust Secretary

Purpose	This report summarises the assurances received and key decisions made by the Quality Governance Assurance Committee (QGC). The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board's response. This assurance committee meets monthly and takes scheduled reports from all Trust operational groups according to an established work programme. The Committee worked to the 2020/21 objectives. The Trust are responding to the second 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.
	Lack of Assurance in respect of SO 1a Issue: Deliver harm free care **Incident Management Report** The Committee received and noted the content of the report being advised of a serious incident that had recently been reported via legal services, that occurred in 2016 and had not been reported on the Datix system. The Committee were advised that systems were in place to ensure this delay in reporting did not reoccur. **CNST Maternity** The Committee received the monthly update noting that NHS Resolution had confirmed a delay of the submission date to July 2021. The Committee noted the continued challenge to achieve the maternity services dataset and training. Training had been impacted by the inability to conduct face to face training with staff however the Committee were assured that actions in place were on track to achieve by July 2021. The Committee were advised of 7 reports to the Healthcare Safety Investigation Branch (HSIB), 4 reported in 2019, 2 in 2020 and one reported from another provider where the Trust were involved in antenatal care. The Committee noted that the homebirth service, that had been suspended at the beginning of Covid-19, had been running as normal

	since July 2020. There had been an impact on the ability to deliver Continuity of Carer however Covid-19 had not impacted on the number of women seen. The Committee were advised that Birth Rate Plus was due to conclude and the outcome would be reported to the People and Organisational Development Committee and Trust Board. **Ockenden Report** The Committee received the report noting the content presented and were advised that the high level gap analysis was due for submission at the end of February. The Committee were advised that a board assurance template and reporting template had been developed in order to support reporting, this would be presented to the Committee in February. Proposed reporting arrangements were offered to the Committee whereby the assurance report and dashboard would be presented to the Committee for discussion and issues of escalation upwardly reported to the Board. The assurance report and dashboard would be appended to the Committee upward report to the Board. The Committee are seeking the agreement of the Board for the proposed reporting arrangements that will offer scrutinised data. **Harm Reviews** The Committee noted that the Task and Finish Group were making good progress. However noted some concerns regarding the level of harm, it was felt that this could be better articulated within the report. Further detail was being considered through the task and finish group that would require validation ahead of being reported in order to understand the level of harm. The Committee noted that the opening of the green site at Grantham Hospital and ophthalmology services at Louth Hospital had been in response to mitigate harm to patients. The Committee would continue to receive a monthly report. **IPC Visit NHSE/I Action plan** The Committee received the action plan following the visit from NHS England/Improvement on 5th November 2020 and noted that further detail and clarity had been requested following feedback from the visit. A number of actions had been taken immediately following the visit with 9 amber rated actions being reported. The Committee were advised that this was due to further evidence being gathered to support completion of the actions. The Committee noted the 10 Key NHS Actions and the Trusts compliance level, the detail of which would be presented to the February meeting.

	Trust Mortality Report The Committee received the reporting noting that the relative position of the Trust, compared to others, remained largely unchanged. This however only provided reassurance to the Committee due to national benchmarking not yet being available that took account of Covid-19 **Mortality – Covid Deaths** The Committee reviewed the content of the report and noted that the guidance received had been in draft and was not yet officially in use. The Committee noted that the decision had been taken to continue to use the guidance as this offered a clear process to aid the management and reporting of hospital onset Covid-19 cases. Validation of the figures presented would be required. **Patient Safety Group Upward Report** The Committee were pleased to receive the well-written action focused report from the group and noted that the sub-groups would be reinvigorated and supported to restart following Covid-19 activity. This would result in additional reporting and intelligence moving forwards. **High Profile Cases** The Committee received the report noting the cases reported. The Committee discussed the focus of the report identifying that this could be further improved. Future reporting would provide themes of the cases that were being reported.
	Assurance in respect of other areas: **Reporting Groups – Work programme/Terms of Reference** The Committee received the second report of the review of the Committee and three of the reporting groups. The Committee noted the need for direct reporting of maternity and neonatal services for which reporting would be developed, following receipt of the Ockenden report and development of an action plan. A Maternity and Neonatal Executive Group would be established chaired by the Director of Nursing. The Committee raised concerns regarding the proposed work programme for the Committee and quantity of monthly requesting that frequency of reporting be considered. The Committee noted the significant work that had taken place during a difficult time period in order to improve the Committee and reporting group function. The Committee recognised the need for upward reporting to be structured and for there to be consistency across the reporting groups. The Committee asked that all reporting groups receive a similar treatment and the recent internal audit report be taken into account in the report to the Committee in February.

	Committee Self-Assessment The Committee received the results of the self-assessment noting those aspects that would be developed into an action plan which would be presented at the February meeting. The Committee discussed how participation with the self-assessment could be broadened to provide a wider perspective of how the Committee functioned. **Committee Performance Dashboard** The Committee received the dashboard noting the content. Discussion took place in relation to sepsis data and the concerning deterioration in performance. The Committee were advised that data was being submitted fortnightly to the Care Quality Commission through the section 31, how this could be reported through to the Committee was being considered to ensure more timely data. The Committee noted that the Sepsis Practitioners had been redeployed in to frontline care to support services. **Quality Impact Assessments** The Committee received the report noting that some assurance had been received that Quality Impact Assessments (QIA) were completed and discussed for the period of the pandemic through Gold Command. There was a need for any changes made to be reviewed as part of an ongoing process. The Committee were advised that a QIA Panel was in place and a draft policy had been developed. There was a need to identify themes and outcomes along with how many QIAs had been agreed or rejected. The Committee were seeking assurance of an embedded and robustly applied process. In order to ensure assurances were received the Committee would receive monthly updates. **Internal Audit Reports** The Committee received the internal audit reports relating to the Governance review of Committees supporting the Trust Board and Medicines Management. The Committee noted that actions within the governance audit would be addressed through the review currently being undertaken of the Committee and supporting groups. The Committee raised concerns regarding the medicines management report and the capacity within the service to address the actions raised. The Committee noted that staff from the Pharmacy team had been redeployed to support the vaccination programme. Additional support was being sourced to support the team and it was noted that actions would need to be supported through key interaction with ward staff.

Issues where assurance remains outstanding for escalation to the Board	None
Items referred to other Committees for Assurance	None
Committee Review of corporate risk register	The Committee reviewed the risk register noting that a number of actions were past the due date. The Committee were advised that support was being offered from the central governance team to Divisions in order to support the updating of the register. This support would be extended to corporate areas.
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	Department walk around currently suspended.

Attendance Summary for rolling 12 month period

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

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 February 2021*
Item Number	*Item 7.2*
Ockenden Response and Proposed QGC and Board Reporting Arrangements	
Accountable Director	*Karen Dunderdale, Director of Nursing*
Presented by	*Karen Dunderdale, Director of Nursing*
Author(s)	*Libby Grooby, Head of Midwifery* *Kathryn Helley, Deputy Director of Clinical Governance*
Report previously considered at	*Quality Governance Committee*

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	
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	*To Be Confirmed*
Financial Impact Assessment	*Not Applicable*
Quality Impact Assessment	*Not Applicable*
Equality Impact Assessment	*Not Applicable*
Assurance Level Assessment	*Moderate*

Recommendations/ Decision Required	*The Trust Board is asked to:-* - *note the content of the report and identify any further actions required at this stage* - *approve the QGC and Board Reporting recommendations*

Executive Summary

On 10 December 2020, the Ockenden report was published outlining the 'Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust'. The following paper provides an update in respect of:-

- the Trust's submission of the required gap analysis
- proposal regarding regular reporting to the Quality Governance Committee and Trust Board.

Ockenden Submissions

Following the publication of the report, the Trust was required to submit an initial, high level, gap analysis against the immediate and essential actions. This was reviewed by a sub-group of the Trust board, the Trust's Local Maternity and Neo-natal System (LMNS) and NHSI Maternity Improvement Advisor and submitted by the required date of 21 December 2020 and is attached as **Appendix 1**.

Subsequently, there has been a request to complete an assurance and assessment tool which is to be submitted by the Senior Responsible Officer (SRO) of the LMNS. The original submission date was set at 15 January 2021 but due to the significant pressure in the system as a result of the Covid-19 pandemic, this date has been extended to 15 February 2021. However, at the time of receiving notification of the extension, the Trust had already completed the template and undertaken an internal challenge meeting with a sub-group of the Trust Board and the SRO. A date had been set to hold an extra-ordinary meeting of the LMNS on 13 January 2021 in order to review prior to submission. A decision was made to continue with this meeting and agreement made that the maternity team would continue to work on any outstanding actions and if the paper required further update, that a virtual sign off process would be used prior to final submission. **Appendix 2** provides the Board with a summary of the actions identified within the response which will be included with the Maternity Assurance Action Plan along with any other actions which emerge as the Ockenden report is reviewed. Also attached as **Appendix 3** is the paper considered by the LMNS. Overall, the paper and assurances provided was received very favourably with only minor suggestions for addition made.

Quality Governance and Board Reporting

The Ockenden report makes recommendations regarding information Boards should receive to ensure that they have sufficient oversight and assurance regarding maternity services. In addition to this, there are criteria within the CNST safety standards that require oversight by the Board. To ensure that the Board receives the appropriate level of data and information to discharge its responsibilities, whilst also ensuring that the correct level of challenge takes place at the Quality Governance Committee, a review has been undertaken and recommendations made regarding the information to be received by both parties. This will take the form of a Maternity Dashboard and supplementary Maternity Assurance Report outlining those aspects

not able to be included in a dashboard and other issues for escalation and by exception.

To ensure that the Trust has sufficient support to and assurance of Midwifery Services, it has been agreed to set up a Maternity and Neo-natal Oversight Group which will be Chaired by the Director of Nursing and be a sub-group of the Quality Governance Committee.

Following discussions with maternity networks, the Head of Midwifery has been able to ascertain that the majority of Trusts are taking the full suite of information to the Trust Board due to the significant high profile nature of maternity services. It is recommended that the Maternity Assurance Report and Dashboard be submitted for discussion at the Quality Governance Committee from the newly formed Maternity and Neo-natal Oversight Group. The Quality Governance Committee, in turn, will raise any issues of escalation in their upward report to the Trust Board. The Maternity Assurance Report and Dashboard would be appended to the Upward Report for information and context. This will ensure that the relevant discussions take place at the appropriate level of the organisation, whilst still meeting the requirement of reporting to the Trust Board. The Quality Governance Committee approved this approach at their meeting on 19 January 2021 and are making this recommendation to the Trust Board.

Conclusion/Recommendations

The Trust Board is asked to:-

- note the content of the report;
- note the work which is underway to strengthen assurance reporting in respect of maternity; approve the proposed reporting arrangements to Quality Governance Committee and Trust Board
- identify any further actions required at this stage.

Actions Arising from Ockenden Maternity Services Assessment and Assurance Tool (January 2021)

Action 1: Enhanced Safety	
1	Enhance Board reporting to include safety incidents
2	Work with the LMNS to ensure Regional oversight of incidents
3	Secure external expert clinical opinion on cases of fetal death, maternal death, neonatal brain injury and neonatal death
4	Alternative digital solution to be sourced (linked to issues with Medway)
5	Revise safety improvement plan to ensure it reflects all elements of the perinatal model (March 2021)
Action 2: Listening to Women and Families	
6	Implement the role of independent senior advocate once clarity has been received from NHSE
7	Develop the Trust's maternity services NED role further in accordance with national guidance
8	Develop agreed pathway to formalise feedback mechanisms with the MVP chair and the LMNS (March 2021)
Action 3: Staff Training and Working Together	
9	Enhance Board reporting regarding training compliance
10	Action plan to be developed to increase compliance with training due to issues during COVID 19 pandemic (February 2021)
11	Consideration of Sunday telephone ward round being in person (March 2021)
12	Alignment of funding to the agreed safety priorities to determine the best use of the resource within Maternity Services
13	Discussion with Trust to ensure funding for midwifery training is clearly identified and allocated appropriately.
Action 4: Managing Complex Pregnancy	
14	Fully implement the NICE Intrapartum guidance for complex women
15	Ongoing work to develop further specialist clinics
16	Development of audit required to measure compliance. Auditing is challenging due to issues with Medway.
17	Multiple pregnancy and joint epilepsy clinics to be developed
18	Review and potential further development of maternal medicine referral pathways once Maternal Medicine Centres have been confirmed. This will need support from the clinical network
Action 5: Risk Assessment Throughout Pregnancy	
19	Development of audit to measure compliance with risk assessments at every contact
20	Education of midwifery and obstetric staff to ensure risk assessments undertaken correctly
21	Further development of PCSP and tools to enable meaningful conversations about plans of care and place of birth (March 2021)
22	Further development of the birth choice clinic to facilitate further attendances
Action 6: Monitoring Fetal Wellbeing	
23	The Labour Obstetric Leads have been identified as the Obstetric Fetal Monitoring Lead. Job descriptions and job plans will need to be amended to reflect this allocation.

Action 7: Informed Consent	
24	Qualitative feedback from women to understand if their needs for information and personalised care were met, working with the MVP (March 2021)
25	Development of discussion tools to aid meaningful conversations (March 2021)
26	Review resources on maternal request caesarean section options (January 2021)
Maternity Workforce Planning	
27	Review workforce when Birth-rate plus report available (March 2021)
Midwifery Leadership	
28	Consideration to be given to implement the recommendations and have a Director of midwifery in post with a Head of Midwifery in every unit within the organisation, with the exception of smaller units.
29	Consideration to be given to increasing the existing WTE of consultant midwives
30	Trust to consider the inclusion of RCM representative/network Midwifery Lead/LMEs on selection panel for senior midwifery posts
NICE Guidance Relating to Maternity	
31	Streamline the process to ensure timely review and implementation of relevant new and updated NICE guidance (March 2021)

Family Health Division

OCKENDEN REVIEW OF MATERNITY SERVICES – URGENT ACTION

Action Required	Lead	Progress/Evidence
Enhanced Safety		
A plan to implement the Perinatal Clinical Quality Surveillance Model, further guidance will be published shortly	DHOM/Governance Leads/ Trust Board/ LMNS	The Trust can confirm that it has received the draft Perinatal Clinical Quality Surveillance Model and has a plan to implement the actions as per below:- • Draft Perinatal Clinical Quality Surveillance Model reviewed • Actions against 5 principles considered • Await further guidance as described • Once received, plan to be formulated to implement model • Ongoing work to develop further principles 1 and 2 to ensure:- - Strengthened Board Oversight - Strengthened LMNS oversight This will improve existing board and LMNS reports and strengthen reporting on Maternity safety with immediate effect. **The Trust confirms that it is awaiting further guidance prior to confirming full implementation of this action.**
All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB	DHOM/Governance Leads/Matrons/Consultant Midwife	The Trust can confirm that the Trust Board receives a monthly report on SIs but this is not specific to maternity. With immediate effect this will be amended to separate out maternity and HSIB cases. The next Trust Board is 2 February 2021. The following reporting is already in place:-

		• SI reports are signed off at SI meeting which includes Trust Board members. • Si reports are shared with board. • SI discussed at Divisional Performance Review Meetings and slide included in reporting pack. • The LMNS safety update to include update on maternity SI's with immediate effect. • Reporting process in place to report any SI to HSIB that meets criteria for referral as per national guidance. • HSIB and SI reports shared with staff at clinical governance meeting and Newsflash at handovers to learn from experience. • Safety lead in post to help coordinate HSIB and SI recommendations. **The Trust confirms that this action is implemented.**
Listening to Women and Families		
Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services.	DHOM/LMNS/MVP	The Trust can confirm that there are a number of mechanisms in place for gathering service user feedback as follows:- • MVP has been established since 2017 • Involvement of MVP chair and members in all Maternity Transformation work streams • Neonatal Voice Partnership established 2018 which was the first in the country • Military Voice Partnership established 2020 • Active Social Media Accounts across the MVP, LMNS and ULHT which shares consistent information for women • Better Births Lincolnshire website accessible to all women and staff

		• 2/52 Joint MVP and Maternity live Facebook Q&A sessions commenced 28 July 2020 • Good evidence of partnership working through pandemic • Support from MVP with guidance for women during Covid 19. **The Trust confirms that this action is implemented.**
In addition to the identification of an Executive Director with specific responsibility for maternity services confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard. Further guidance will be shared shortly.	Safety Champions/ HOM/Exec team	The Trust can confirm that there is a named Executive Director and Non-Executive Director with specific responsibility for maternity services as indicated below:- • Karen Dunderdale, Director of Nursing • Sarah Dunnett, Non-executive Director Board level Safety Champion in place • The Director of Nursing has a direct link to the Head of Midwifery with regular 1:1s in place to discuss the Maternity Safety agenda and escalate to board if required. In addition to the above, there is a full time Head of Midwifery in post who works within the Divisional Triumvirate along with the Clinical Director and the Divisional Managing Director. **The Trust confirms that it is awaiting the further guidance described prior to confirming full implementation of this action.**
Staff Training and working together		
Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.	Clinical Lead Maternity Services/Inpatient matron	The Trust can confirm that it complies with this requirement as follows:- • Weekdays: Twice daily ward rounds and one telephone ward round. • Weekends: Ward round in the morning and Tel ward round at night as minimum but more if needed.

		• 56 hours of on floor weekly cover for Boston and 63 hours in Lincoln (in line with current RCOG standards). **The Trust confirms that this action is implemented.**
Joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented, In the meantime we are seeking assurance that a MDT training schedule is in place	PDM/Consultant Midwife/ Clinical Lead Maternity Services	The Trust can confirm that there is an MDT training schedule in place which includes the following and will put a plan in place to implement any further guidance as necessary once published:- • Joint MDT training in place for PROMPT, Skills and Drills and CTG. Training continued during pandemic over teams • MDT Skills Walk through on both labour suites as activity allows • Training schedule in place • Compliance with all disciplines of staff monitored and reported through Governance and Quality Governance Committee. In additional to training, there are a number of MDT meetings which take place to support the maternity governance arrangements as follows:- Obstetrics MDT Induction of Labour Pathway Perinatal mortality meetings PPH meetings ATTAIN **The Trust confirms that this action is fully implemented.**
Confirmation that funding allocated for maternity staff training is ring-fenced and any CNST Maternity Incentive	Divisional Triumvirate/Finance Lead	The Trust can confirm that funding is allocated for maternity staff training. The Trust can provide assurance that maternity staff

Scheme (MIS) refund is used exclusively for improving maternity safety		training has been funded throughout the year and there has been ongoing work around improving maternity safety. In the current financial year, CNST monies have not been identified as a separate budget line and have been included within baseline budgets. However, from 2021/22, there will be a distinct finance investment budget line for CNST providing transparency in this area. In order to ensure that the CNST money is utilised for improving maternity safety. Alignment to the agreed safety priorities will determine the best use of the resource within Maternity Services. **The Trust confirms that this action is fully implemented.**
Managing complex pregnancy		
All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place	Clinical Lead Maternity Service/ Audit Leads	The Trust can confirm that all women with complex pregnancy have a named consultant lead. In terms of audit, an audit will be in place by January 2021 **The Trust confirms that this action is fully implemented.**
Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres	Clinical Lead Maternity Services/Matrons	The Trust has a number of specialist clinics in place as described below and plan to develop these further. Clinics in Place:- • Obstetrics High risk clinics offered are Diabetic clinic, Haematology clinic, Preterm birth prevention clinic, Clinics to be Developed:- • Multiple pregnancy clinic and Joint epilepsy clinic are being developed.

		In relation to maternity medicine specialist centres, we work closely with Nottingham University Hospitals, our tertiary centre to ensure that necessary services are in place. **The Trust confirms that this action is fully implemented.**
Risk Assessment throughout pregnancy		
A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance	Clinical Lead Maternity Services /Deputy Head of Midwifery/ Audit Lead/ Audit midwife	The Trust can confirm that risk assessment processes are in place as follows:- • Risk assessment completed at Booking on Medway and reviewed at further appointments • Process in place for risk assessments to be reviewed at every antenatal contact • There are a number of audits in pace to assure the Trust of compliance and further audits are in development to provide greater assurance. Regular audits of these will be in place by January 2021. **The Trust confirms that whilst the risk assessments are in place further work needs to be undertaken to audit compliance before assurance can be given that the action is implemented.**

Monitoring Fetal Wellbeing		
Implement the saving babies' lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.	Clinical Educators/ Antenatal Lead Obstetrician/ Matron Antenatal services	The Trust can confirm that the Saving Babies Lives bundle is fully implemented:- • The Lead Midwife role for element 4 is included in the Clinical educator job description. Obstetric Lead identified as Labour Ward Lead. • Addition to job description to clarify the role and expectation is needed. • Antenatal Clinic Matron and Lead Obstetrician for Antenatal services oversee implementation of SBLv2. • Weekly MDT CTG meetings in place • Guideline reviews are in place • CTG training delivered in mandatory training • Yearly Assessment in place • Mandatory training records maintained and reviewed by senior team • Weekly CTG meetings via Teams • Compliance with Saving babies life being audited **The Trust confirms that this action is fully implemented.**
Informed Consent		
Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is	Clinical Lead Maternity Services/ DHOM	The Trust can confirm that information for women is available in written format.

available on the Chelsea and Westminster website		Choices leaflet designed in line with Chelsea and Westminster which describes pathways of care and is available on all social media websites as described above. Mum and Baby app has been developed and implemented for Lincolnshire by the Better Births team. This has been based on the Chelsea and Westminster model, but adapted for local maternity systems and pathways. **The Trust confirms that this action is fully implemented.**

Maternity services assessment and assurance tool

Following release of the 7 Immediate and Essential Actions (IEAs) United Lincolnshire Hospital Trust has completed this tool and assessed our current position. Completion of the tool was undertaken by senior midwives and medical colleagues with critical oversight from the MVP chair, the MIA, Safety Champion and the wider maternity team. The assurance document was then shared and challenged by the Trust Board and the LMNS members prior to ratification and submission. Whilst no assurance has been asked of Neonatal services the same level of scrutiny exists following the peer review process.

Assurance can also be given that ULHT are continuing to work through the ten Maternity incentive scheme actions including all the underpinning requirements as set out in the technical guidance.

Section 1

Immediate and Essential Action 1: Enhanced Safety

Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight.

- Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months.

- External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death.

- All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months

Link to Maternity Safety actions:

Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?
Action 2: Are you submitting data to the Maternity Services Dataset to the required standard?
Action 10: Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification scheme?

Link to urgent clinical priorities:

(a) A plan to implement the Perinatal Clinical Quality Surveillance Model
(b) All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB

What do we have in place currently to meet all requirements of IEA 1?	Describe how we are using this measurement and reporting to drive improvement?	How do we know that our improvement actions are effective and that we are learning at system and trust level?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will mitigate risk in the short term?

Monthly maternity report and maternity dashboard presented to Quality Governance Committee. Dashboard includes SI/HSIB reported numbers. Monthly report and oversight of maternity dashboard at LMNS. Dashboard includes SI/HSIB reported numbers. Monthly report to divisional CG includes progress on actions where clinical change is required and any additional incident actions. Action plan review meetings in place to monitor outstanding actions.	Robust monitoring of actions to ensure learning embedded Action plans and task and finish groups for when a need for quality and safety improvements is identified from SI/HSIB reports, dashboard or other external reports. Red flags on dashboard are monitored and reviewed if consistently red for 3 months. Working groups convened to identify any actions needed to improve. Improvement actions monitored and reported through governance meetings.	Local monitoring of themes and trends to identify effectiveness of implemented change and identify any further areas that require improvement. Improved clinical outcomes and reduction in Sis. Maternity indicators/dashboard, clinical audit, Benchmarking Audit plan used to audit any improvement actions identified.	Actions from incidents where clinical change is required now included in Board and LMNS reports. First report due to Board February 2021. Requirement now to monitor compliance in reporting. Single Acute provider LMNS. LMNS to support development of a process to ensure regional oversight	HoM/Deputy HoM Safety Champion LMNS	Ongoing support from board and LMNS to table reporting. Development of a process to obtain regional oversight	Improvement in Board and LMNS reporting to ensure both have improved SI oversight.

External clinical opinion on cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death not currently in place. All cases that meet criteria are reported to HSIB	Review of some cases is taking place within Maternity and Neonatal network Process to ensure all appropriate cases reported.	HSIB action plans shared locally and action plans monitored for compliance	Requirement to secure external opinion on cases	LMNS support HoM/Deputy HoM	LMNS/ Clinical network support required to develop a robust process for appropriate external clinical review for cases outside HSIB referral criteria such as complex PMRT.	All SI reports have multi-disciplinary review, completion and sign off within the Trust. All cases meeting HSIB criteria are reported. All PMRT reports are completed by a multi-disciplinary team. Support will be sought from the Clinical Network for any complex cases requiring external review

SI reports are signed off at SI meeting which includes exec members of the Trust Board. SI discussed at PRM and slide included in reporting pack. Reporting process in place to report any SI to HSIB that meets criteria for referral. Trust currently reported 100% of qualifying cases to HSIB. HSIB and SI reports shared with staff at clinical governance meeting and Newsflash at handovers to learn from experience Safety leads in post to help coordinate HSIB and SI recommendations Quarterly Learning Lessons Newsletter in place	As above SI findings are used to generate quality improvement initiatives and monitored through action plan review meetings. Clinical audit plan supports the audit of any quality improvement identified.	Effectiveness of improvement actions monitored through audit plan	Monthly Board Report now includes a summary of all SI reports and a summary of the key issues identified.	HoM/Clinical Director		

Trust current clinical system is Maternity Medway. This system does not currently allow full submission to MSDS.	Medway challenges reported up to board through PRM. Ongoing work with NHS digital and Medway to address compliance with MSDS		Ongoing work with maternity Medway Alternative digital solution needs to be scoped	Digital midwife/ HoM	Financial support for digital solution	Continued work with Maternity Medway
Perinatal Clinical Quality Surveillance Model received	Included action plan in safety Improvement plan		Revise safety improvement plan to ensure it reflects all elements of the perinatal model.	Consultant MW/Safety Leads March 2021	Full review and implementation of the PCQS model may require additional resource	Safety Improvement plan already in place and reported to the board on a monthly basis.

Immediate and essential action 2: Listening to Women and Families
Maternity services must ensure that women and their families are listened to with their voices heard.

- Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards.
- The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome.
- Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions.

Link to Maternity Safety actions:
Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?
Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?
Action 9: Can you demonstrate that the Trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?

Link to urgent clinical priorities:

(a) Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services.
(b) In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard.
(c)

What do we have in place currently to meet all requirements of IEA 2?	How will we evidence that we are meeting the requirements?	How do we know that these roles are effective?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will we mitigate risk in the short term?

No senior advocate role currently.			Appointment of an independent senior advocate role which reports to both the Trust and the LMS Boards. Once clarity about this role has been received from NHSE the Trust will work to implement**.**		Agreement to support role and national direction. Will require support from Trust board to fund and develop Further guidance to understand the scope and requirements of the role.	Continue with current SI and complaints processes. Meetings with families to continue with senior midwifery and clinical attendance.

Non-exec director Board Level Safety Champion in place. Links with MVP/LMNS in place. DoN has direct link to HoM. Regular 1:1 in place to discuss Maternity Safety agenda and escalate to board if required.	Non-exec director is board level safety Champion. Attends Safety Collaborative meeting which has oversight of the Maternity Safety plan.	The Trust can confirm that there is a named Executive Director and Non-Executive Director with specific responsibility for maternity services as indicated below: - Director of Nursing and Non-executive Director Board Level Safety Champion in place The HoM has a direct link to the Director of Nursing with regular 1:1s in place to discuss the Maternity Safety agenda and escalate to board if required. Monthly update to QGC discussing Maternity safety agenda In addition to the above, there is a full time Head of Midwifery in post who works within the Divisional Triumvirate along with	NED safety champion role in place for several years. Develop the Trust's maternity services NED role further in accordance with national guidance	HOM/Clinical Director/ Clinical Leads	Further resources maybe needed to develop NED safety champion role further.	

		the Clinical Director and the Divisional Managing Director.				

MVP has been established since 2017 Involvement of MVP chair and members in all Maternity Transformation work streams Neonatal Voice Partnership established 2018 which was the first in the country Military Voice Partnership established 2020 Active Social Media Accounts across the MVP, LMNS and ULHT which shares consistent information for women Better Births Lincolnshire website accessible to all women and staff 2/52 Joint MVP and Maternity live Facebook Q&A sessions commenced 28 July 2020	Minutes from MVP meetings. Email contacts with MVP. Recordings of Facebook live sessions. Feedback from Chair via LMNS,	Continued engagement and feedback	Develop agreed pathway to formalise feedback mechanisms with the MVP chair and the LMNS.	HoM/ Consultant Midwife/LMNS March 2021	Further resources to support the development of MVP may be required as the role of the MVP develops.	Continue to respond to feedback from women following the channels already in place.

Good evidence of partnership working through pandemic Support from MVP with guidance for women during Covid 19						

Immediate and essential action 3: Staff Training and Working Together
Staff who work together must train together

- Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year.
- Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward.
- Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only.

Link to Maternity Safety actions:

Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?
Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?

Link to urgent clinical priorities:

(a) Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.
(b) The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place

What do we have in place currently to meet all requirements of IEA 3?	What are our monitoring mechanisms?	Where will compliance with these requirements be reported?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will we mitigate risk in the short term?

An overarching Maternity Services Education Strategy and Training Needs Analysis outlines the training requirements for all members of the maternity MDT. These documents describe the annual mandatory training programme content and its delivery.	The maternity training database is maintained as a RAG rated live document to evidence compliance and is circulated to SLT and Midwifery Managers on a monthly basis. A monthly reported is presented by the Maternity Education Team at Clinical Governance. The database enables monitoring of individual staff, staff groups by area of work, site and line manager. This facilitates a robust method of prioritising staff attendance at training.	Currently compliance is included on the Maternity Dashboard and presented at Clinical Governance. Maternity dashboard shared with LMNS and Trust Board. Going forward training compliance will be included as narrative in board reporting and shared with the LMNS.	Training compliance and any required escalation to be included in monthly board reporting. This report for board will be shared and presented at the LMNS to enable compliance with required recommendations. Action plan to increase compliance with training due to issues with this during COVID 19 pandemic	HOM/DHOM/ Consultant Midwife/Heads of Service/ Maternity Education Team February 2021	Sufficient workforce to enable staff to be released from clinical duty to attend. Review of WTE uplift for training requirement to enable compliance	To enable compliance with the CNST Safety Action 8 requirements additional training days have been planned to address the shortfall that has occurred due to cancellation of some study days due to Covid-19. Training is currently delivered digitally via MS TEAMS and this includes weekly CTG meetings. Walk-through drills are delivered in clinical areas. The training needs analysis has been thoroughly reviewed, amended and

						training developed aligned to the CNST Safety Action 8 requirements and the newly published Core Competency Document.
These documents are regularly reviewed (at least bi-annually) aligned to national standards and documents, evidenced-based care and identification of local cases and learning. Significant restructuring of training occurred from June 2020 to ensure that training continued to be provided despite the safety measures required to due Covid-19.	Education report monitored through Clinical Governance Meetings Agenda Item	Governance minutes Board and LMNS	Continuation of upward reporting to Board and LMNS	HoM/ Deputy		

Weekdays: Twice daily ward rounds and one telephone ward round. Weekends: Ward round in the morning and Tel ward round at night as minimum but more if needed. 56 hours of on floor weekly cover for Boston and 63 hours in Lincoln (in line with current RCOG standards). Consultant led and attended by multi-disciplinary team including midwives and anaesthetic staff.	Matron reviews during quality audits	Matron's Quality Report	Consideration of telephone ward being in person- this will require review of P.A.s and job descriptions. This will be reviewed as part of job planning process.	Clinical Director March 2021	Potential increase in resources to support addition of presence for 2nd round at weekend.	Continue with current ward round provision. Matron's and Band 7 Co-ordinator to escalate concerns.

In the current financial year, CNST monies have not been identified as a separate budget line and have been included within baseline budgets. Funding for training of maternity staff via the LMNS is monitored and reported on to ensure it is used for purpose intended. Training monies allocated to trust currently held centrally	Finance records for LMNS and Trust	Reported through LMNS	From 2021/22, there will be a distinct finance investment budget line for CNST providing transparency in this area. In order to ensure that the CNST money is utilised for improving maternity safety. Alignment to the agreed safety priorities will determine the best use of the resource within Maternity Services. Discussion with Trust to ensure funding for midwifery training is clearly identified and allocated appropriately.	Finance director/ HoM	Improved communication with finance and the IPLU to ensure that funds are utilised efficiently.	

Immediate and essential action 4: Managing Complex Pregnancy
There must be robust pathways in place for managing women with complex pregnancies

Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.

- Women with complex pregnancies must have a named consultant lead
- Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team

Link to Maternity Safety Actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?

Link to urgent clinical priorities:

a) All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.
b) Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres.

What do we have in place currently to meet all requirements of IEA 4?	What are our monitoring mechanisms?	Where is this reported?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?

Guidelines and pathways in place for managing women with complex pregnancies Currently Obstetrics High risk clinics offered are Diabetic clinic, Haematology clinic, Preterm birth prevention clinic,	Guideline group established and reviews all guidelines against best practice Audits in place for diabetic and pre-term clinics	Guideline compliance reported through CG Audits presented to audit meeting	Fully implement the NICE Intrapartum guidance for complex women. Ongoing work to develop further specialist clinics Development of audit required Multiple pregnancy and joint epilepsy clinic are being developed.	HoM/Clinical Leads/Clinical Network Clinical Director/Clinical Leads May 2021	Additional medical and midwifery resources may be needed to further develop specialist clinics	Continue to provide care in line with current guidelines identifying high risk pregnancies and referring as indicated.
Links established with tertiary centres and criteria for referral in place	Referrals monitored by screening co-ordinator	KPIs for Screening	Review and potential further development of maternal medicine referral pathways once Maternal medicine Centres have been confirmed. This will need support from the clinical network		As above	Continue with current referral pathways
Named consultant identified for all high risk women	Audit in place to monitor compliance with named Consultant			Audit midwife		

SBLv2 implemented within Trust	Audits in place as required with SBLv2.	SBLv2 reported through Safety Collaborative meeting and exception reported to CG, Divisional Cabinet, PRM and Board if required.	Auditing of data is challenging due to earlier issues raised around maternity Medway.		As above. Resources to review alternative digital solution	Ongoing manual audits to give compliance assurance.

Immediate and essential action 5: Risk Assessment Throughout Pregnancy
Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.

- All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional
- Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.

Link to Maternity Safety actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?

Link to urgent clinical priorities:

a) A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance.

What do we have in place currently to meet all requirements of IEA 5?	What are our monitoring mechanisms and where are they reported?	Where is this reported?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?

Risk assessment completed at Booking on Medway and process in place for review at further appointments. Theses risk assessments include allocation to low/high risk pregnancy and midwife/consultant as lead professional.	Audits in place but will include review of place of birth by January 2021 to	Audit meetings	Development of audit for ensuring risk assessments at every contact. Education of midwifery and obstetric staff to ensure risk assessments undertaken correctly. Further development of PCSP and tools to enable meaningful conversations about plans of care and place of birth.	Clinical Lead/Consultant Midwife/Quality and Audit Midwife/Digital Midwife/Professional Development Midwives/Antenatal Clinical Managers March 2021	Additional resources to support development of the Maternity Information system to enhance the risk assessments and capacity for documenting PCSP. Additional midwifery and obstetric workforce to ensure robust delivery and use of PCSP.	Work on going with maternity Medway and staff compliance with documentation
Birth choices clinic in place. Clear PCSP documented following consultation. Ongoing work with Maternity Medway to ensure that the system supports completion of the risk assessments		Birth choices clinic data held on Medway PAS	Further development of the birth choice clinic to facilitate further attendances Further review of the Maternity Medway system.	Consultant midwife		

Immediate and essential action 6: Monitoring Fetal Wellbeing

All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.

The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on: -

- Improving the practice of monitoring fetal wellbeing –
- Consolidating existing knowledge of monitoring fetal wellbeing –
- Keeping abreast of developments in the field –
- Raising the profile of fetal wellbeing monitoring –
- Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported –
- Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.
- The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training.
- They should also lead on the review of cases of adverse outcome involving poor FHR interpretation and practice. •
- The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 and subsequent national guidelines.

Link to Maternity Safety actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?
Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?

Link to urgent clinical priorities:

a) Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.

What do we have in place currently to meet all requirements of IEA 6?	How will we evidence that our leads are undertaking the role in full?	What outcomes will we use to demonstrate that our processes are effective?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?

The Fetal Monitoring Lead Midwife is included with the Professional Development Midwife role. They are able to demonstrate expertise and effectively lead on all noted above. They achieve this by: Attendance at the East Midlands Fetal Monitoring Group and will also attend the 2-day Baby Lifeline CTG Masterclass in January 2021 (delayed due to Covid-19). The FM lead midwives in collaboration with Obstetric Consultants/ Consultant Midwife review the EFM training on annual basis and develop and update the teaching and assessment tools. Weekly CTG review meetings are conducted via MS TEAMS, learning outcomes and attendance are recorded.	Completion of audits. Facilitation of CTG meetings and PROMPT training. Regularly attendance at external training and meetings recorded via attendance certificates and minutes of meetings. Attendance at incident meetings and serious investigation meetings recorded through minutes. A learning bulletin will be shared following CTG meetings.	Compliance with training monitored via the Maternity Training Database and CTG meetings attendance. Audit and generating actions plans on any findings and areas identified for improvements. Review of evaluation feedback from training days.	The Labour Obstetric Leads have been identified as the Obstetric Fetal Monitoring Lead. Job descriptions and job plans will need to be amended to reflect this allocation.	HOM and Clinical Director March 2021	Job planning and additional resource to facilitate implementation of the Obstetric Lead role to support FM Lead Midwives. Support for FM Leads to attend the East Midlands Fetal Monitoring Group and any other identified relevant external training e.g. CTG Masterclass	All elements are currently complied with the exception of the formalisation of the Obstetric Fetal Monitoring Lead, however CTG meetings are well-attended by the Obstetric Teams.

The FM Lead Midwives undertake audit to ensure compliance as per SBLCBv2 and attend incident review and serious investigation meetings. The FM Lead midwives offer bespoke support to staff who are identified through case review and/or assessment as requiring additional support and education.						

Immediate and essential action 7: Informed Consent
All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.

All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care

Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care

Women's choices following a shared and informed decision-making process must be respected

Link to Maternity Safety actions:

Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?

Link to urgent clinical priorities: a) Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website.						
What do we have in place currently to meet all requirements of IEA 7?	**Where and how often do we report this?**	**How do we know that our processes are effective?**	**What further action do we need to take?**	**Who and by when?**	**What resources or support do we need?**	**How will we mitigate risk in the short term?**

Information for women is available in written format. Choices leaflet designed in line with Chelsea and Westminster which describes pathways of care and is available on all social media websites as described above. Mum and Baby app has been developed and implemented for Lincolnshire by the Better Births team. This has been based on the Chelsea and Westminster model, but adapted for local maternity systems and pathways.	Annual CQC maternity survey ask questions around choice and information – Most recent survey showed Trust to be 'better that expected'.	Monitoring CQC survey scores Listening to women's feedback	Qualitative feedback from women to understand if their needs for information and personalised care were met (working with the MVP). Development of discussion tools to aid meaning conversations. Review resources on maternal request caesarean section options.	Consultant Midwife March 2021 Consultant Midwife March 2021 Consultant Midwife January 2021	Access to online survey resources/online focus groups	Information available on Trust website, LMNS website and the Lincolnshire version of the Mum and Baby app is now available.

Section 2						
MATERNITY WORKFORCE PLANNING						
Link to Maternity safety standards: Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard Acti**on 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?**						
We are asking providers to undertake a maternity work-force gap analysis, to have a plan in place to meet the Birthrate Plus (BR+) (or equivalent) standard by the 31st January 2020 and to confirm timescales for implementation.						
What process have we undertaken?	**How have we assured that our plans are robust and realistic?**	**How will ensure oversight of progress against our plans going forwards?**	**What further action do we need to take?**	**Who and by when?**	**What resources or support do we need?**	**How will we mitigate risk in the short term?**

Birth-rate plus undertaken in 2017 and 2018. Staffing was in line with recommendations. Table top exercise with NHSE in July 2019 based on data from March 18- April 19. Staffing at ULHT in line with findings. Currently being re commissioned. Completion date February 2021 Staffing reports Bi-annually. Completed in August 2020 Need to add medical workforce	Bi- annual report to board	Matron's Quality Report. Bi-annual staffing report. Red Flags from the acuity tool. Staffing is review on a weekly basis in the operate meeting.	Review workforce when Birth-rate plus report available.	HoM/Deputy HoM/Clinical Leads March 2021	Further resource may be required if gaps identified.	Continue with current mechanisms for oversight.

MIDWIFERY LEADERSHIP

Please confirm that your Director/Head of Midwifery is responsible and accountable to an executive director and describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care

The Head of midwifery has a direct link to the Director of Nursing with regular 1:1s in place to discuss the Maternity Safety agenda and escalate to board if required.
In addition to the above, Head of Midwifery works within the Divisional Triumvirate along with the Clinical Director and the Divisional Managing Director.

Seven steps to strengthen midwifery leadership as set out in the RCM Manifesto:

- **A Director of Midwifery in every trust and health board, and more Heads of Midwifery across the service.**

As above there is a full time Head of Midwifery who works across the Trust and provides the senior midwifery voice for the Family Health Division. The current post holder is in an Interim role. The role also provides the Lead Nurse cover for Gynaecology, Breast, Neonatal and Paediatric services. There are plans for the roles to be separated and substantive roles for HoM and separate Lead nurse to be advertised.

Consideration needs to be given to implement the recommendations and have a Director of midwifery in post with a Head of Midwifery in every unit within the organisation, with the exception of smaller units.

Not fully compliant

- **A lead midwife at a senior level in all parts of the NHS, both nationally and regionally**

For national delivery.

- **More consultant midwives**

Full time Consultant midwife in post. Recommendation is for at least one consultant midwife in every maternity unit. Consideration to be given to increasing the existing WTE.

Not fully compliant

- **Specialist midwives in every trust and health board**

ULHT has specialist midwife posts for;
Bereavement
Risk
Audit

NICE GUIDANCE RELATED TO MATERNITY						
We are asking providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Where non-evidenced based guidelines are utilised, the trust must undertake a robust assessment process before implementation and ensure that the decision is clinically justified.						
What process do we have in place currently?	**Where and how often do we report this?**	**What assurance do we have that all of our guidelines are clinically appropriate?**	**What further action do we need to take?**	**Who and by when?**	**What resources or support do we need?**	**How will we mitigate risk in the short term?**
NICE guidance is benchmarked when launched or as guidelines are updated. Compliance against NICE guidance is monitored through Divisional Clinical Governance.	Actions plans when required are held centrally by the trust and this process is overseen by the NICE and Best Practice Co-ordinator.	Any required changes to guidelines are taken through the Maternity Guidelines Group, a MDT sub-committee of the Clinical Effectiveness Group. All guidelines are signed off through the over-arching Clinical Effectiveness Group. Guidelines not directly informed by NICE are generally informed by national policy e.g. SBLCB.	Streamline the process to ensure timely review and implementation of relevant new and updated NICE guidance.	Quality and Audit Midwife/Clinical Leads/Consultant Midwife March 2021	Additional resources to develop guidelines and support audit of compliance	Continue with current processes which already ensure oversight of clinical guidelines through a robust process.

Report to:	Trust Board
Title of report:	People and OD Committee Assurance Report to Board
Date of meeting:	10th December 2020
Chairperson:	Geoff Hayward, Non-Executive Director
Author:	Karen Willey, Deputy Trust Secretary

Purpose	This report summarises the assurances received and key decisions made by the Workforce and OD Assurance Committee. The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board. This assurance committee meets monthly and takes scheduled reports according to an established work programme. The Committee worked to the 2020/21 objectives. The Trust are responding to the second 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	**Assurance is respect of SO 2a** **Issue: A modern and progressive workforce** **Committee Assurance Report** The Committee received the assurance reported and noted the impact on the delivery of the Integrated Improvement Plan due to the response to wave 2 of Covid-19. **Safer Staffing** The Committee received the report and noted the update that had been provided in relation to the impact of Covid-19 on the workforce. The Committee noted that there remained as yet no equivalent medical workforce paper and were keen that this be provided in the future.
	Assurance in respect of SO 2b **Issue: Making ULHT the best place to work** **Committee Assurance Report**

The Committee noted that 97% of staff had completed risk assessments related to Covid-19 with 100% of BAME staff having been completed. The Committee noted that there were concerns raised regarding compliance with social distancing and risk assessments, along with the taking of annual leave and agreement of carry forward. The position relating to leave required clarification. The Committee were advised that the Covid-19 vaccination programme had commenced, some concerns had been raised by staff but these had been addressed by the project team.
Lack of Assurance in respect of SO4c **Issues: To become a University Hospitals Teaching Trust** **No items**
Assurance in respect of other areas: **Covid-19 Workforce update** The Committee were provided with an update in relation to the workforce position noting that the average figure for sickness was 13% with sickness in some areas much higher. The Committee noted that the Trust had the 7th highest sickness rate in the Country which was significantly impacting on the ability to staff areas. There was concern over the staffing position for the Christmas period with work being undertaken to review rotas in light of the absence position. The Committee were advised that action was being taken against staff who were non-complaint with IPC and PPE rules and guidelines due to the continued outbreaks being seen. A review of the well-being offer and hubs was being undertaken, these had been well received to date. The Committee noted that the vaccination programme had commenced and whilst this had been difficult to establish at short notice there had been a great effort to get this up and running. Consideration as to how this would continue to be delivered over the coming months would be

	required. The Committee were advised that 78% of frontline staff had now received the flu vaccination and the vaccination programme would continue with the intention of achieving 90% by the end of February 2021. **Job planning** The Committee noted that a number of corporate staff had been redeployed to support clinical staff and the vaccination programme. As such the team continued to try and maintain job planning activity to ensure progress, an update would be provided in the New Year. **Risk Report** The Committee noted that there had been a reduction in fragile services with high risk factors, noting that this had reduced from 58% last March to 38%. The improvements being seen provided assurance to the Committee. The Committee also noted that the report demonstrated an impact on activity to improve the workforce position, whilst this was being impacted by Covid-19 the Committee were assured by the improvements.
Issues where assurance remains outstanding for escalation to the Board	None
Items referred to other Committees for Assurance	None
Committee Review of corporate risk register	The committee received and reviewed the risk register noting that activity to improve the workforce position was likely to be impacted by Covid-19. Where risks were affected by workforce issues the Committee requested that these were reviewed to ensure risks were accurately reflected.

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

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

Report to:	Trust Board
Title of report:	People and OD Committee Assurance Report to Board
Date of meeting:	14th January 2021
Chairperson:	Geoff Hayward, Non-Executive Director
Author:	Karen Willey, Deputy Trust Secretary

Purpose	This report summarises the assurances received and key decisions made by the Workforce and OD Assurance Committee. The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board. This assurance committee meets monthly and takes scheduled reports according to an established work programme. The Committee worked to the 2020/21 objectives. The Trust are responding to the second 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	**Assurance is respect of SO 2a** **Issue: A modern and progressive workforce** **Committee Assurance Report** The Committee received the assurance report noting that work was underway to ensure that talent management was progressing in order that this could be implemented at an appropriate time following the easing of the response to Covid-19. The Committee were advised that there was an expectation that all staff, who wished to receive the Covid-19 vaccination, would receive this by the end of January 2021. Work was underway across the system to deliver the vaccine to priority groups. An offer of support had been received from NHS England to enable the Trust to increase international recruitment. The Committee were advised that further funding would be released to ensure additional nurses were able to be appointed to the Trust, funding would be utilised to support education and pastoral care.

	The Committee noted the intention to recommence the staffing pipeline report in order that the Committee may receive assurance for both the nursing and medical workforce. The Committee noted the continued positive action to manage agency spend noting the grip and control in place. The Committee would be keen to see a roadmap that demonstrated how this work would move from transactional grip and control to transformation of recruitment, impacting on agency expenditure.
	Assurance in respect of SO 2b **Issue: Making ULHT the best place to work** **Initial feedback on 2020 National Staff Survey** The Committee received the initial staff survey results for 2020 noting that these were disappointing. Once the free text had been received this would further inform the results and actions to be taken. The Committee noted that there would need to be an overall cultural focus to address the results that could target responses to each area of the Trust. The health and well-being offer to staff had recently been refreshed with a particular focus on ICU staff. Support from Lincolnshire Partnership Foundation NHS Trust was also in place and a long term plan to manage the recovery of staff over the coming year was being developed. **GMC Junior Doctor Survey** The Committee received the latest results and proposed way forward following the GMC Junior Doctor survey noting that the results had been impacted due to Covid-19. The Committee were advised that a task and finish group would be established to address the concerns raised and implement actions involving both doctors in training and employed by the Trust. The Committee were advised that an education dashboard had been proposed in order to monitor the frequency and quality of the education provided by the Divisions.

	The Committee were supportive of the proposed way forward and were encouraged by the focus on leadership to hold supervisors to account. Quarterly updates were requested by the Committee to monitor the actions.
	Lack of Assurance in respect of SO4c **Issues: To become a University Hospitals Teaching Trust** **Medical School Update** The Committee received an update in relation to the medical school noting that there had been slow progress with professorial recruitment and consideration of the approach used to recruit would be taken. The Committee were advised of the new quality assurance methodology, noting that the Trust were currently at the pilot stage for this to be put in place.
	Assurance in respect of other areas: **Committee self-assessment** The Committee received the results of the annual self-assessment noting the aspects that would be developed in to an action plan to be presented to the February meeting. **Board Assurance Framework** The Committee received the Board Assurance Framework noting the revision to the pre-Covid-19 format. The Committee sought further assurance on the rating for Objective 4b - Advancing professional practice with partners.
Issues where assurance remains outstanding for escalation to the Board	None
Items referred to other Committees for Assurance	None

Committee Review of corporate risk register	The committee received and reviewed the risk register noting that the staff survey risk would require an update following receipt of the latest results.
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	**F**	**M**	**A**	**M**	**J**	**J**	**A**	**S**	**O**	**N**	**D**	**J**
Geoff Hayward (Chair)	A	A	No meetings held due to Covid-19			X	X	X	X	X	X	X
Sarah Dunnett	X	X				X	X	X	X	X	X	A
Non-Voting Members												
Martin Rayson	X	X				X	X	X	X	X	X	X
Simon Evans	A	D				X	D	D	D	C	C	C
Victoria Bagshaw	X											
Karen Dunderdale		A				X	X	X	X	C	C	C

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:	Finance, Performance and Estates Committee Assurance Report to Board
Date of meeting:	17 December 2020
Chairperson:	Gill Ponder, 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 2020/21 objectives. The Trust are responding to the second 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 **Issue: Assurance Report Health and Safety Group** The Committee noted concern over the content of the report as this did not provide assurance to the Committee. Support would be offered to the author of the report to ensure clear and well-articulated assurance or lack of were included within future reports. **Issue: Statutory Compliance – Health & Safety** The Committee received a report on the Covid Assurance Assessment undertaken by the British Safety Council. The report outlined the recommendations following the report that the Trust needed to undertake.
	Lack of Assurance in respect of SO 3b Efficient Use of Resources **Issue: Finance Report** The Committee noted that Month 8 had reported £0.2m favourable to plan however there had been a change to the cost base due to Covid-19. The Committee noted the significant growth in Bank staff costs of £0.8m with a £0.4m increase in agency also seen. The increase had been seen due to the significant staffing shortages that necessitated the Trust taking action to incentivise supply by increasing rates to the critical workforce groups.

	Overall the Trust were maintaining the forecast of breakeven for the year along with the System maintaining the overall forecast position of a £4m deficit, there was concern noted however regarding the pay pressures. Due to the difficulty being faced by the Trust in accessing Agency staff intensive support regionally and nationally was being offered to the Trust. The Committee noted that cost improvement plans were favourable in month and noted the positive impact that had been seen following the reintroduction of the breast screening service staffed substantively. The Committee were advised that there would be a change to financial arrangements for 2021/22, noting that this was expected to be a blended tariff approach with a system envelope and collaborative working. **Issue: Capital Delivery Group** Capital expenditure for the year to date was c£9.5m which remained c£10.6m behind plan. The Committee noted works were underway with regard to capital spend including the development of the Urgent Treatment Centre at Lincoln and the Modular Theatres at Grantham were expected to open on 4th January. The Committee noted its concern in relation to the risk of delivery of the Electrical Infrastructure and Electronic Prescribing Schemes. The Committee noted that any changes to the delivery of capital in year would need to be considered against the associated risks to ensure the correct works were prioritised.
	Assurance in respect of other areas: **Committee Self-Assessment** The Committee received the results of the self-assessment noting those aspects that would be developed into an action plan which would be presented at the January 2021 meeting. **Committee Performance Dashboard** The Committee received the dashboard noting that bed occupancy was declining due to staff shortages and infection control issues due to the second wave of Covid-19. The Committee noted the positive position of 104 day waits given the position of the organisation in responding to Covid-19. The number of ambulance handover delays had increased due to the challenges being faced in moving patients. The Committee were advised that recent changes had been made to pathways and it was hoped this would lead to improvements.

	Integrated Performance Report The Committee noted the improvement in the report which allowed for a focused remit for the Committee. The Committee noted the slight delay in the vanguard theatres being installed however noted that the modular units were imminently due onsite. Concerns were raised regarding 52 week waits which would be monitored and also harm to patients, it was recognised however that this was being considered by the Quality Governance Committee. The Committee were advised that a review of the 12 hour trolley wait reporting was being undertaken due to a breakdown in the process. There had been a number of challenges with reporting and validation however a detailed report would be received by the Committee in January 2021. **Integrated Improvement Plan Report** The Committee noted some slippage on the delivery of programmes of work due to the impact of Covid-19.
Issues where assurance remains outstanding for escalation to the Board	No additional items to raise.
Items referred to other Committees for Assurance	**QGC –** The Committee requested that CGC provide assurance that harm reviews focused on harm resulting from things the Trust did not do, as well as things that were done and caused harm.
Committee Review of corporate risk register	Due to the reduced agenda, the Committee did not review the risk register during the meeting.
Matters identified which Committee recommend are escalated to SRR/BAF	The Committee was assured that the BAF was reflective of the key risks in respect of the strategic objectives of the organisation.
Committee position on assurance of strategic risk areas that align to committee	As above
Areas identified to visit in dept walk rounds	Department walk around currently suspended

Attendance Summary for rolling 12-month period

Voting Members	J	F	M	A	M	J	J	A	S	O	N	D

Gill Ponder, Non-Exec Director	A	X	X	No meetings held due to Covid-19	X	X	X	X	X	X
Geoff Hayward, Non-Exec Director	X	X	X		X	X	X	X	X	A
Chris Gibson, Non-Exec Director	X	A	X		X	X	X	X	X	X
Director of Finance & Digital	X	X	X		X	X	X	X	X	X
Chief Operating Officer	X	D	A		A	D	X	X	C	C
Director of Estates & Facilities	D	X								
Director of Improvement & Integration							A	X	C	C

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

Report to:	Trust Board
Title of report:	Finance, Performance and Estates Committee Assurance Report to Board
Date of meeting:	22 January 2021
Chairperson:	Gill Ponder, 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 2020/21 objectives. The Trust are responding to the second 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 **Issue: Assurance Report Estates, Infrastructure and Environment Group** The Committee raised concern regarding the lack of assurance provided by the report however noted that there had been a radical change within the Estates team that would reset the approach of the service. The Committee were reassured that there would be a more robust assurance framework and reporting in place moving forwards. The Committee noted concern regarding confined spaces notices from the Health and Safety Executive and requested further assurance of the position of the notices be provided to the Committee.
	Assurance in respect of SO 3b Efficient Use of Resources **Issue: Finance Report** The Committee noted that a deficit had been delivered in month due to the agreement that any surplus would reside in the CCG to offset the £4.0m deficit held by them as part of the Lincolnshire STP plan. The Trust had achieved a small YTD surplus at Month 9 having taken into account a reduction of income of £0.5m in relation to the Elective Incentive Scheme. The levels of activity set in the recovery plan had not been achieved in September and October; from November onwards the

	scheme had been suspended where an organisation had greater than 15% of beds occupied by Covid-19 positive patients or an unusually high sickness rate. The Trust had met both the criteria for the suspension of the scheme in November and December. The Committee noted the adverse variance to pay however this had reflected the incentive payments in place to attract staff in nursing and housekeeping for additional shifts. The Committee sought confirmation of the position of the incentives going forward noting that this was being reviewed to determine the impact of volume and price to ensure the correct balance. The system had reforecast from the £4m deficit to a break-even position noting that other providers in the system had forecast surpluses. The Trust had over performed in Quarter 3 and this was expected to be continue in the final quarter. This position had demonstrated to the region a level of credibility and continued work to deliver the financial envelope. The Committee were advised that regionally there had been an over commitment on capital and the Trust were working with regional colleagues to consider how £3.5m could be deferred until 21/22. This would result in the Trust slipping or pausing some schemes which in turn would allow for further preparatory work to take place before the schemes are delivered in Q1. The Committee noted the success of the Trust to manage the Quarter 3 finances in the new model against the context of the impact on the Trust of the latest wave of the pandemic and recognised that whilst a breakeven position was being achieved, work would continue to maintain the position. The Committee also noted that a supportive recruitment intervention was taking place nationally, which would assist in reducing Agency spend.
	Assurance in respect of other areas: **Committee Self-Assessment Action Plan** The Committee received the self-assessment action plan agreeing the proposed actions and to receive quarterly updates to the Committee. **Board Assurance Framework** The Committee received the Board Assurance Framework noting the revised content and change to the rating of objective 3b – Efficient Use of Resources to Green. The Committee noted that the Trust had delivered the agreed plan in Q3 in line with the revised national financial framework and were on track to deliver the agreed position for Q4, resulting in the improved RAG rating.

	Committee Performance Dashboard The Committee received the dashboard noting a concern in the increase of elective length of stay. The Committee were advised that this was due to the focus on acute and clinically urgent cases which given their complexity resulted in longer stays. The result in the change of focus was having an incremental effect. The Committee noted the number of on the day cancellations and were reassured that the position was being managed through advance communication with patients to advise of the pressures and explain that cancellations could occur due to Covid-19 and in the interest of patient safety. Cancellations were actively being made at the last possible moment to ensure as many patients as possible could be seen. The Committee noted the fluidity of ICU demand and capacity and the continued support being offered to neighbouring trusts with non-clinical transfers. **Integrated Performance Report** The committee noted the report and the increase in patients waiting over 62 days for cancer treatment, there had also been an impact on improvement of the 104 day waits. Whilst this remained a priority focus for the Trust the Committee were advised of the regional and national focus on recovery of cancer services. The Committee were advised that the harm review process for the Trust was now being focused on those patients who were not receiving treatment to ensure that the Trust were aware of any harm and increased risk. The Committee considered the feasibility of increasing theatre capacity however were advised of the staffing impact within theatres due to the national requirement to increase ICU capacity. Staff from theatres were supporting ICU colleagues. **Urgent Care update to include A&E 12 Hour Wait Report** The Committee received the report noting the content. The Committee were advised that the data presented in relation to beds occupied against absent staff demonstrated the position the Trust had been in and were advised that this was greatly improved. The Committee were advised that the Trust were trying to move away from the use of occupancy as a metric and had worked with NHS England who recognised the position and had offered support to improve the position. The Committee noted the correction to the 12-hour trolley wait data and the action taken to prevent recurrence. The Committee were advised that the Trust had been offered support

	from NHS England for early adoption of the Emergency Care Clinical Standards. Full detail of the indicators would be presented to the March Committee. **Stroke and Cardiac Services update** The Committee received the update noting that there had been improved performance against the SSNAP (Sentinel Stroke National Audit Programme) indicators. Whilst Covid-19 had significantly detracted from the previously strong performance the Committee were assured that the model in place had been agreed and would be supported to continue. The Committee were advised that there was unlikely to be any contractual issues with the service. **Overseas Visitors Charging and Cancellation Policy** The Committee received the policy noting that this would need to be reviewed in 6 months to ensure that it was fit for purpose. Assurance would be reported within the finance report through trend analysis and a suite of KPIs.
Issues where assurance remains outstanding for escalation to the Board	No additional items to raise.
Items referred to other Committees for Assurance	None
Committee Review of corporate risk register	Due to the reduced agenda, the Committee did not review the risk register during the meeting, but Committee members had reviewed the risk report and risk register prior to the meeting and submitted relevant comments and questions
Matters identified which Committee recommend are escalated to SRR/BAF	The Committee was assured that the BAF was reflective of the key risks in respect of the strategic objectives of the organisation.
Committee position on assurance of strategic risk areas that align to committee	As above
Areas identified to visit in dept walk rounds	Department walk around currently suspended

Attendance Summary for rolling 12-month period

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

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

Meeting	Trust Board
Date of Meeting	2nd February 2021
Item Number	Item 11
Integrated Performance Report for December 2020	
Accountable Director	Paul Matthew, Director of Finance & Digital
Presented by	Paul Matthew, Director of Finance & Digital
Author(s)	Sharon Parker, Performance Manager
Report previously considered at	N/A

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

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

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

Executive Summary

Quality

Number of Serious Incidents Declared

25 Serious Incidents were declared for December 2020. A review of these has identified that 10 relate to the declaration of a number of ED 12 hour breaches. Clinical harm reviews are underway for all affected patients with support from the CCG to downgrade these incidents if no harm established. Clinical Governance team are currently working with the Medicine Division as part of the Clinical Harm review work.

Medication Incidents reported as causing harm

Over the last three months there has been an increase in medication incidents with harm showing December at 22.2% against a trajectory of 10.7%. All pharmacists aligned to each Divisional CBU are currently working with the wards and departments to identify issues contributing to this increase in reporting.

Mortality

HSMR

HSMR for the rolling year (October 19 – September 2020) is showing at 101.85 for the Trust which is in expected limits. Lincoln site is outside the expected limits at 110.70 for the rolling year; with 98 more deaths than predicted (1022 Observed: 924 Predicted). COVID-19 deaths are being attributed to a

diagnosis group (Viral infection), which is not included within the HSMR 56 Basket Diagnosis Groups. However, should a patient have COVID-19 included as a secondary diagnosis, these will pull thorough into the datasets.

Septicaemia (except in labour): alerting for the seventh month at Lincoln and now at Trust level – Case note review has been delayed due to the redeployment of the Sepsis Practitioners – additional resource currently being identified to support with this review.

Other liver diseases: Third month alerting at Trust Level, and a second month at Pilgrim. The clinical lead will be contacted for a case note review to commence.

SHMI

ULHT are in Band 2 within expected limits with a score of 110.53, which has continued to increase over the last three-month reporting period. SHMI includes both deaths in-hospital and within 30-days of discharge and is reflective up to July 2020. ULHT's current in-hospital SHMI is 99.38 and is below threshold limits.

Dr Foster is assisting the Trust review cases which fall into the higher diagnosis groups. NHS Digital are excluding all data in regard to COVID-19. An extract from NHS Digital shows that 0.8% of spells (620 spells), have been excluded due to COVID-19 coding. The national average is 1.5%.

Mixed Sex Accommodation Breach

The single sex breach occurred in December and has been validated. Further investigation of the incident is required to identify any actions to be taken to prevent reoccurrence.

Operational Performance

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

Operational performance for the periods of August-December where data is available reflects the Recovery Phase where services are being reinstated as part of this Phase 3 Recovery programme. From August 1st this recovery commenced with ambitions to returning to pre-Covid-19 levels of waiting lists, response times and constitutional standards, in line with expectations as set out in Sir Simon Stevens' letter of 31st July 2020.

However, the Covid-19 2nd wave has impacted significantly against the Trusts plans, posing challenges across both non-elective and elective pathways, including cancer, and resulting in the intermittent pausing of the green pathways at both Lincoln and Pilgrim hospitals. The Grantham Green Site has remained in operation.

A & E and Ambulance Performance

4-hour performance for December was 70.54% down 2.24% from the November performance of 72.78%, and has now fallen 6.88% below the planned trajectory of 77.42%, this is against a slight increase in activity of 0.42% from November. This is the second time in 6 months the Trust's performance has dropped below the trajectory, it is against a backdrop of 8 months of consecutive deterioration in performance. Both recording and achievement of the 15min triage targets deteriorated with % not recorded increased from 0.22% to 0.57% and a corresponding slight fall in achievement against from 90.65% to 89.48%. However, it continues to be above the mean performance, slightly above trajectory and well within control limits.

Ambulance conveyances for December were 4365 compared to 4304 in November, a slight rise of 1.4%. However, the Trust saw a slight drop in >59-minute ambulance handover delays, from 388 in November to 350 in December.

Following a comprehensive internal review for November, the previously reported figure of 4 has increased to 10. Disappointingly there was a significant deterioration 12+ hour trolley waits of 41 in December all at Lincoln County Hospital, reflecting the challenges in managing the ever changing blue and green pathway demand, compounded by a significant reduction in available workforce.

The daily capacity cell continues to meet have been reinstated with a multidisciplinary approach, including a daily system call to try to reduce the burden on the acute trust, supported by three times daily reviews via the Trust wide Capacity Flow meetings. NHSE/I are supporting improvement strategies including further engagement with the System via daily calls to reduce the overall burden on the Acute Trust.

Length of Stay

LoS for non elective admissions deteriorated in December from 4.67 in November to 4.81 and remains above the Trust target of 4.5 days. Non elective discharges also deteriorated in December from 3469 (November) to 3064 in December a drop of 405, (11.68%).

Length of Stay meetings on each hospital site remain in place to support complex patients through their discharge along with multi agency meetings in place daily (7 days per week). In addition the System has secured and commissioned care homes that will support patients with positive swabs particularly pathways 1 and 2.

Elective length of stay has seen a significant rise from 2.38 days in November to 3.90 days on December reflecting the changing case mix admitted owing to the limited number of green pathways across Pilgrim and Lincoln sites.

Referral to Treatment

RTT performance for November was 59.33% up from 58.46% in October an improvement of 0.87% reflecting the cessation of the green pathways available at Lincoln and Pilgrim throughout November. The Trust reported 498 incomplete 52 week breaches for November end of month. Whilst in response to the ongoing pressures relating to Covid-19 Wave 2, the weekly PTL meeting have been temporarily stood down to free up key operational staff to support operational flow, a weekly review is maintained by the Dep COO – Planned Care and the Operations Manager-18 Week/RTT Trust Lead. All long waiters are reviewed and escalation is made to the individual CBU as required to ensure clinical review and prioritisation occurs.

With the intermittent pausing of the green pathways at both Lincoln and Pilgrim hospitals the daily Cancer/Elective Cancellation Cell continues to meet daily in response to the Covid 2nd Wave with senior clinical review and prioritisation daily of all cancellations, and 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.

The cell continues to work with system provider partners and EMCA across the East Midlands to identify the most appropriate capacity for the most clinically urgent patients.

Waiting Lists

Overall waiting list size has decreased from October to November by 561, from 45,674 to 45,113. The number of incomplete pathways is now approx. 6081 more than in March 2018.

October to November saw an increase of patients waiting over 40 weeks of +1218 with Ophthalmology showing the greatest increase (+376). Month end position was 4965 patients reflecting the pressures on these pathways.

However, the numbers of patients waiting over 26 weeks again reduced, decreasing by 1901 from October reflecting the work undertaken to clinically prioritise and treat the most clinically urgent patients first. The longest waiting patients are tracked and discussed weekly with escalation as appropriate and reported bi-weekly to NHSE/I.

Cancelled Operations

Cancelled operations rose in November to 3.01% from 1.54% in October reflecting the increasing pressures of Covid 19 Wave 2, critical incidents and pressures upon Theatre staffing and Critical Care availability, as well as patients unwilling to proceed to surgery during Wave 2.

However, against those patients cancelled on the day, there was no reduction in performance in the 28 day target with breaches totalling 10 in November as in October.

Partial Booking Waiting List – Overdue Follow Ups

The overdue follow up numbers in December rose slightly following two months of an improving position. This was driven by a reduction in activity in a number of specialties in response to the need to manage increasing numbers of Covid patients across an increased bed base. A reduce

available workforce and increased sickness has also resulted in the cancellation of clinics further reducing capacity.

An administrative/technical validation exercise is due to commence in January. Clinical triage, introduction of PIFU and an ongoing use of non-face to face engagement continues where possible but have in some areas needed to be scaled back.

Diagnostics

(Diagnostics December Data Not Yet Available) Diagnostics access performance continues to improve albeit by 0.13%, with achievement in November of 59.24%. Endoscopy, continues to book cancer patients within 7-10 days and is now also booking routines. There are however growing pressures in Respiratory Physiology and Cardiac CT's.

Cardiac Physiology has over 2000 breaches in November reflecting the regional challenges with this service. The Division of Medicine continue to work with regional partners to identify potential solutions.

Patient compliance remains a challenge in light of the Covid-19 second wave. Other modalities and diagnostic services are continuing to recover, however the focus remains on Cancer, Urgent Care and clinically urgent patients.

Cancer

Performance for November for the 62 Day Classic Cancer Target increased by 6.1% compared to October, at 61% placing us both below the national average (75.55%) and above the lower quartile.

Backlog number of patients waiting more than 62 and 104 days remains an absolute priority and is part of Covid-19 Recovery phases. As of the beginning of January there remains 57 patients over 104 days down from 163 in mid-July (65% reduction). Colorectal cancer capacity remains a challenge and accounts for 32 of these 48. Over one quarter (24%) of these patients have significant complex/mental health needs. The temporary pausing of green pathways owing to Covid-9 related pressures has impacted upon activity and the 62 day recovery. However, there is ongoing work across the system to identify the most appropriate capacity for the most urgent and longest waiting cancer patients, with daily senior clinical review and prioritisation of any cancellations. ULHT patients are being reviewed at partner organisations MDTs as well as escalation to EMCA. Although there was an improvement in the 31 day 1st treatment, it was missed and was predominantly affected by Covid-19 and reductions in capacity owing to social distancing combined with an ongoing reluctance of a high number of patients who were unfit or unwilling to engage with the NHS at this time.

In addition to the speciality clinical capacity post Covid, challenges include an increasing resistance to travel; available capacity across the ULHT sites; patient engagement and compliance with swabbing and isolation guidance; and limited OPD capacity owing to social distancing and cleaning guidance.

However, additional Vanguard theatres are in place for Grantham going live in January 2021. The focus will be on increasing Cancer activity in Breast and Gynae. Additional administrative support for colorectal is in place and a programme of enhanced clinical engagement and allocation has commenced. The return of a consultant from sabbatical will support Head and Neck Cancer recovery. A further post, having been re advertised, is due to be shortlisted in the near future.

Paul Matthew
Director of Finance & Digital
January 2021

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

PERFORMANCE OVERVIEW

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	Oct-20	Nov-20	Dec-20	YTD	YTD Trajectory	Latest Month Pass/Fail	Trend Variation	Kitemark
Deliver Harm Free Care	Clostridioides difficile position	Safe	Patients	Director of Nursing	9	3	4	3	51		P		
	MRSA bacteraemia	Safe	Patients	Director of Nursing	0	0	0	0	1		P		
	MSSA bacteraemia cases counts and 12-month rolling rates of hospital-onset, using trust per 1000 bed days formula	Safe	Patients	Director of Nursing	TBC	0.04	0.00	0.01	0.04				
	E. coli bacteraemia cases counts and 12-month rolling rates, per 1000 bed days formula	Safe	Patients	Director of Nursing	TBC	0.04	0.01	0.01	0.05				
	Never Events	Safe	Patients	Director of Nursing	0	0	0	0	1		P		Timeliness, Completeness, Validation, Process
	New Harm Free Care	Safe	Patients	Director of Nursing	99%	Data suspended							Timeliness, Completeness, Validation, Process
	Pressure Ulcers category 3	Safe	Patients	Director of Nursing	4.3	2	1	1	13		P		
	Pressure Ulcers category 4	Safe	Patients	Director of Nursing	1.3	0	0	0	1		P		Timeliness, Completeness, Validation, Process
	Pressure Ulcers - unstageable	Safe	Patients	Director of Nursing	19/20 will be used as a benchmark	6	3	3	42				
	Summary Hospital Mortality Indicator (SHMI) (rolling year data 6 month time lag)	Effective	Patients	Medical Director	100	109.34	109.75	110.53	109.31		F		
	Hospital Standardised Mortality Ratio - HSMR (rolling year data 3 month time lag)	Effective	Patients	Medical Director	100	100.98	101.04	101.85	98.67		F	A	
	Sepsis screening (bundle) compliance for inpatients (adult)	Safe	Patients	Director of Nursing	90%	90.00%	85.00%		86.99%		F		
	Sepsis screening (bundle) compliance for inpatients (child)	Safe	Patients	Director of Nursing	90%	81.00%	87.00%		87.95%		F		
	IVAB within 1 hour for sepsis for inpatients (adult)	Safe	Patients	Director of Nursing	90%	93.00%	90.00%		92.19%		P		
	IVAB within 1 hour for sepsis for inpatients (child)	Safe	Patients	Director of Nursing	90%	100.00%	86.00%		89.07%		F		

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PERFORMANCE OVERVIEW

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	Oct-20	Nov-20	Dec-20	YTD		Latest Month Pass/Fail	Trend Variation	Kitemark
Deliver Harm Free Care	Sepsis screening (bundle) compliance in A&E (adult)	Safe	Patients	Director of Nursing	90%	93.60%	93.00%		93.09%		P	A	
	Sepsis screening (bundle) compliance in A&E (child)	Safe	Patients	Director of Nursing	90%	91.20%	90.00%		91.08%		P	A	
	IVAB within 1 hour for sepsis in A&E (adult)	Safe	Patients	Director of Nursing	90%	95.50%	96.00%		96.21%		P		
	IVAB within 1 hour for sepsis in A&E (child)	Safe	Patients	Director of Nursing	90%	71.40%	86.00%		91.10%		F		
	Rate of stillbirth per 1000 births	Safe	Patients	Director of Nursing	4.20	2.39	2.40	2.39	2.24		P	B	
	Number of Serious Incidents (including never events) reported on StEIS	Safe	Patients	Director of Nursing	14	1	4	25	107		F	?	Timeliness, Completeness, Validation, Process
	Catheter Associated Urinary Tract Infection	Safe	Patients	Director of Nursing	1				0				
	Falls per 1000 bed days resulting in moderate, severe harm & death	Safe	Patients	Director of Nursing	0.19	0.00	0.00	0.04	0.10		P		Timeliness, Completeness, Validation, Process
	Reported medication incidents per 1000 occupied bed days	Safe	Patients	Medical Director	4.3	5.21	4.91	4.18	5.01		F		
	Medication incidents reported as causing harm (low /moderate /severe / death)	Safe	Patients	Medical Director	10.7%	8.30%	12.00%	22.20%	13.78%		F		
	Potential under reporting of patient safety incidents / Reported incidents (all harms) per 1,000 bed days	Safe	Patients	Medical Director	30	33.69	33.24	31.02	35.23		P		
	Patient Safety Alert compliance (number open beyond deadline)	Safe	Patients	Medical Director	0	0	0	0	2		P		
	National Clinical audit participation rate	Effective	Patients	Medical Director	98%	95.00%	95.00%	95.00%	93.44%		F		
	7 day Services Clinical Standard 2 (all patients have a Consultant review within 14 hours of admission)	Effective	Patients	Medical Director	90%	Not Collected audit done twice a year							
	7 day Services Clinical Standard 8 (ongoing review)	Effective	Patients	Medical Director	90%	Not Collected audit done twice a year							
	Venous Thromboembolism (VTE) Risk Assessment	Safe	Patients	Medical Director	95%	97.46%	96.65%	96.95%	97.09%		P		
	eDD issued within 24 hours	Effective	Patients	Medical Director	95%	93.10%	93.36%	Pending validation	93.71%		F		

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NHS United Lincolnshire Hospitals NHS Trust

PERFORMANCE OVERVIEW

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	Oct-20	Nov-20	Dec-20	YTD	YTD Trajectory	Latest Month Pass/Fail	Trend Variation	Kitemark
A Modern and Progressive Workforce	Overall percentage of completed mandatory training	Safe	People	Director of HR & OD	95%	90.47%	89.56%	89.33%	89.27%		F		
	Number of Vacancies	Well-Led	People	Director of HR & OD	12%	12.29%	12.15%	12.36%	12.43%		F	B	
	Sickness Absence	Well-Led	People	Director of HR & OD	4.5%	4.92%	4.87%	4.90%	4.98%		F		
	Staff Turnover	Well-Led	People	Director of HR & OD	12%	10.92%	11.01%	11.28%	10.95%		P		
	Staff Appraisals	Well-Led	People	Director of HR & OD	90%	78.51%	78.20%	78.04%	73.12%		F		
					£'000	£'000	£'000	£'000	£'000				
	Agency Spend	Well-Led	People	Director of HR & OD	TBC	-£3,047	-£3,450	-£3,382	-£29,797				

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	Oct-20	Nov-20	Dec-20	YTD		Latest Month Pass/Fail	Trend Variation	Kitemark
Improve Patient Experience	Mixed Sex Accommodation breaches	Caring	Patients	Director of Nursing	0	1	1	1	3		F		Reviewed: 12.06.19 Data available at: Specialty level — Timeliness, Completeness, Validation, Process
	% Triage Data Not Recorded	Effective	Patients	Chief Operating Officer	0%	0.23%	0.22%	0.57%	0.33%		F		
	Duty of Candour compliance - Verbal	Safe	Patients	Medical Director	100%	100.00%	100.00%		93.38%		P		
	Duty of Candour compliance - Written	Responsive	Patients	Medical Director	100%	100.00%	100.00%		88.38%		P		

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NHS United Lincolnshire Hospitals NHS Trust

PERFORMANCE OVERVIEW

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	Oct-20	Nov-20	Dec-20	YTD	YTD Trajectory	Latest Month Pass/Fail	Trend Variation	Kitemark
Improve Clinical Outcomes	4hrs or less in A&E Dept	Responsive	Services	Chief Operating Officer	77.42%	74.76%	72.78%	70.54%	80.03%	71.65%	F	L	
	12+ Trolley waits	Responsive	Services	Chief Operating Officer	0	2	10	41	53	0	F		
	%Triage Achieved under 15 mins	Responsive	Services	Chief Operating Officer	88.5%	88.62%	90.65%	89.48%	91.31%	88.50%	P	A	
	52 Week Waiters	Responsive	Services	Chief Operating Officer	0	452	498		1786	0	F	H	
	18 week incompletes	Responsive	Services	Chief Operating Officer	84.1%	58.46%	59.33%		57.59%	84.10%	F	B	
	Waiting List Size	Responsive	Services	Chief Operating Officer	37,762	45,674	45,113		n/a	n/a	F	H	
	62 day classic	Responsive	Services	Chief Operating Officer	85.4%	54.86%	61.20%		66.31%	85.39%	F		
	2 week wait suspect	Responsive	Services	Chief Operating Officer	93.0%	79.21%	82.40%		86.67%	93.00%	F		
	2 week wait breast symptomatic	Responsive	Services	Chief Operating Officer	93.0%	27.75%	26.40%		51.62%	93.00%	F		
	31 day first treatment	Responsive	Services	Chief Operating Officer	96.0%	94.64%	94.90%		94.67%	96.00%	F		
	31 day subsequent drug treatments	Responsive	Services	Chief Operating Officer	98.0%	100.00%	100.00%		98.58%	98.00%	P		
	31 day subsequent surgery treatments	Responsive	Services	Chief Operating Officer	94.0%	93.02%	87.90%		88.20%	94.00%	F		
	31 day subsequent radiotherapy treatments	Responsive	Services	Chief Operating Officer	94.0%	94.39%	91.30%		93.21%	94.00%	F		
	62 day screening	Responsive	Services	Chief Operating Officer	90.0%	66.67%	88.90%		34.57%	90.00%	F	?	

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

PERFORMANCE OVERVIEW

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	Oct-20	Nov-20	Dec-20	YTD	YTD Trajectory	Latest Month Pass/Fail	Trend Variation	Kitemark
Improve Clinical Outcomes	62 day consultant upgrade	Responsive	Services	Chief Operating Officer	85.0%	87.43%	76.60%		81.56%	85.00%	F		
	Diagnostics achieved	Responsive	Services	Chief Operating Officer	99.0%	59.11%	59.24%		52.83%	99.00%	F		
	Cancelled Operations on the day (non clinical)	Responsive	Services	Chief Operating Officer	0.8%	1.54%	3.01%		1.62%	0.80%	F		
	Not treated within 28 days. (Breach)	Responsive	Services	Chief Operating Officer	0	10	10		87	0	F		
	#NOF 48 hrs	Responsive	Services	Chief Operating Officer	90%	93.55%			89.03%	90%			
	#NOF 36 hrs	Responsive	Services	Chief Operating Officer	TBC	91.94%			77.66%				
	EMAS Conveyances to ULHT	Responsive	Services	Chief Operating Officer	4,657	4,712	4,304	4,365	4,400	4,657	P	B	
	EMAS Conveyances Delayed >59 mins	Responsive	Services	Chief Operating Officer	0	270	388	350	186	0	F	H	
	104+ Day Waiters	Responsive	Services	Chief Operating Officer	5	52	47	57	585	45	F		
	Average LoS - Elective (not including Daycase)	Effective	Services	Chief Operating Officer	2.80	2.50	2.38	3.90	2.92	2.80	F		
	Average LoS - Non Elective	Effective	Services	Chief Operating Officer	4.50	4.36	4.67	4.81	4.25	4.5	F		
	Delayed Transfers of Care	Effective	Services	Chief Operating Officer	3.5%	Submission suspended			3.13%	3.5%			
	Partial Booking Waiting List	Effective	Services	Chief Operating Officer	4,524	20,055	19,385	20,675	19,983	4,524	F	A	
	Outpatients seen within 15 minutes of appointment	Effective	Services	Chief Operating Officer	70.0%	37.3%	46.8%	47.9%	40.76%	70.00%	F		
	% discharged within 24hrs of PDD	Effective	Services	Chief Operating Officer	45.0%	34.6%	31.7%	36.9%	35.66%	45.00%	F		

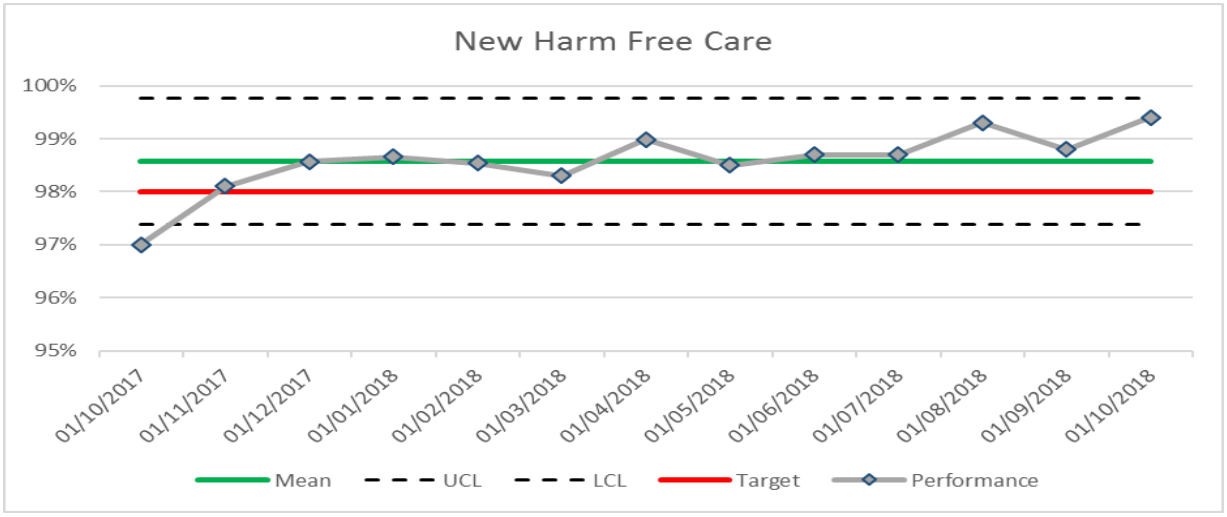
STATISTICAL PROCESS CONTROL CHARTS

Statistical Process Control (SPC) charts are an analytical tool that plot data over time. They help us understand variation which guides us to make appropriate decisions.

SPC charts look like a traditional run chart but consist of:

- A line graph showing the data across a time series. The data can be in months, weeks, or days- but it is always best to ensure there are at least 15 data points in order to ensure the accurate identification of patterns, trends, anomalies (causes for concern) and random variations.
- A horizontal line showing the Mean. This is the sum of the outcomes, divided by the amount of values. This is used in determining if there is a statistically significant trend or pattern.
- Two horizontal lines either side of the Mean- called the upper and lower control limits. Any data points on the line graph outside these limits, are 'extreme values' and is not within the expected 'normal variation'.
- A horizontal line showing the Target. In order for this target to be achievable, it should sit within the control limits. Any target set that is not within the control limits will not be reached without dramatic changes to the process involved in reaching the outcomes.

An example chart is below:



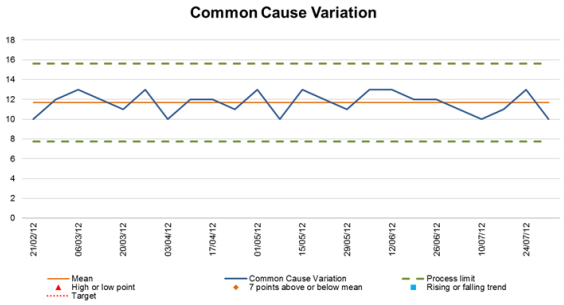
Normal variations in performance across time can occur randomly- without a direct cause, and should not be treated as a concern, or a sign of improvement, and is unlikely to require investigation unless one of the patterns defined below applies.

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

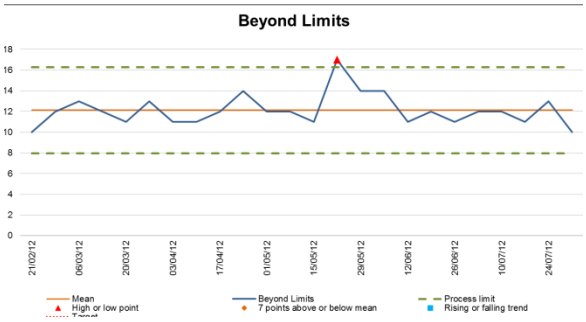
- Normal variation – (common cause) fluctuations in data points that sit between the upper and lower control limits
- Extreme values – (special cause) any value on the line graph that falls outside of the control limits. These are very unlikely to occur and where they do, it is likely a reason or handful of reasons outside the control of the process behind the extreme value
- A trend – may be identified where there are 7 consecutive points in either a patter that could be; a downward trend, an upward trend, or a string of data points that are all above, or all below the mean. A trend would indicate that there has been a change in process resulting in a change in outcome

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

Normal Variation

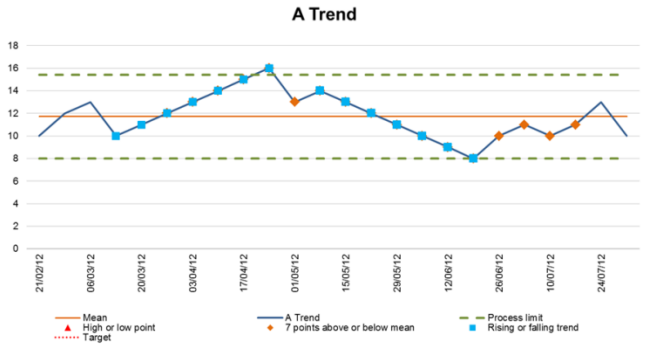


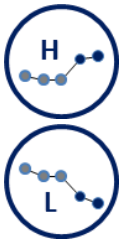
Extreme Values



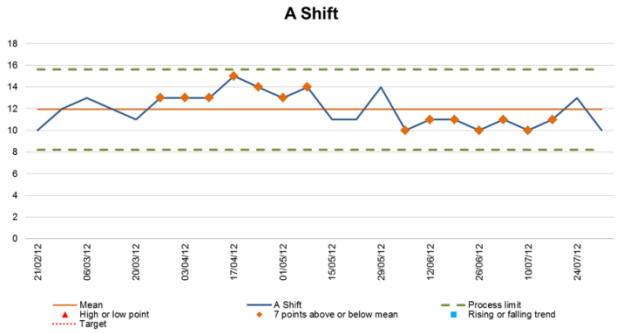
There is no Icon for this scenario.

A Trend (upward or downward)





A Trend (a run above or below the mean)



Where a target has been met consistently

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

Where a target has been missed consistently

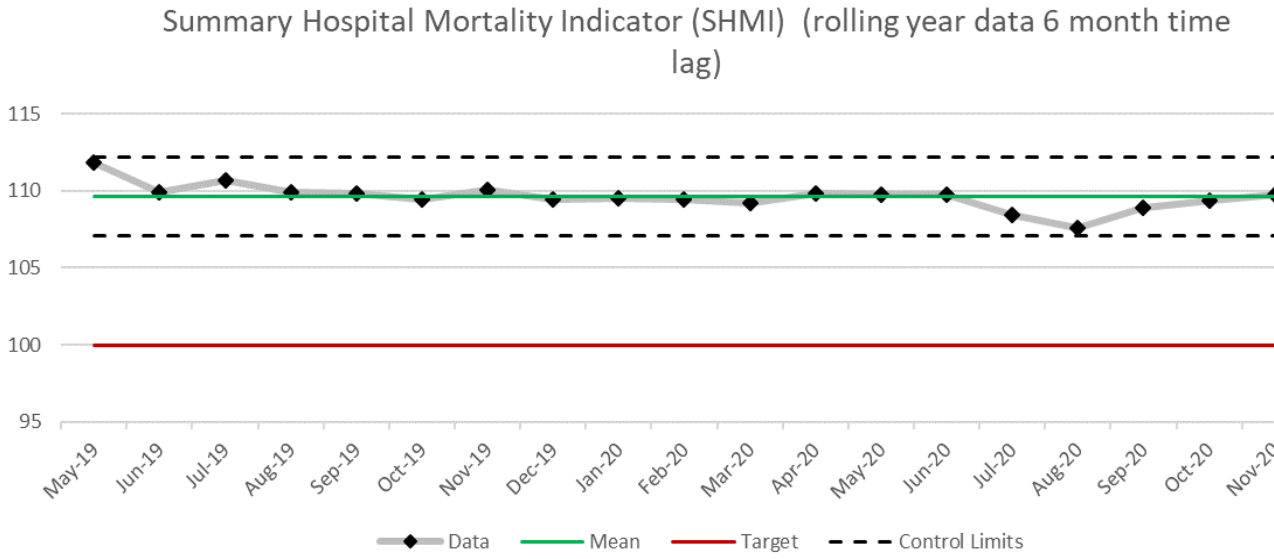
Where the target has been missed for at least 3 of the most recent data points in a row, or in a string of 7 of the most recent data points, at least 5 out of the 7 data points have missed.

DELIVER HARM FREE CARE – MORTALITY SHMI

Executive Lead: Medical Director

CQC Domain: Effective

Strategic Objective: Patients



Challenges / Successes:

ULHT are in Band 2 within expected limits with a SHMI of 110.53, an increase from the last reporting period.
SHMI includes both deaths in-hospital and within 30-days of discharge. The data is reflective up to July 2020.

ULHT's current in-hospital SHMI is 99.38 and is below threshold limits.
Clinical Governance are assessing if data can be requested from NHS Digital which may help the Trust analyse data.

Dr Foster is also assisting the Trust review cases which fall into the higher diagnosis groups.
NHS Digital are excluding all data in regard to COVID-19. An extract from NHS Digital shows that 0.8% of spells (620 spells), have been excluded due COVID-19 coding. The national average is 1.5%.

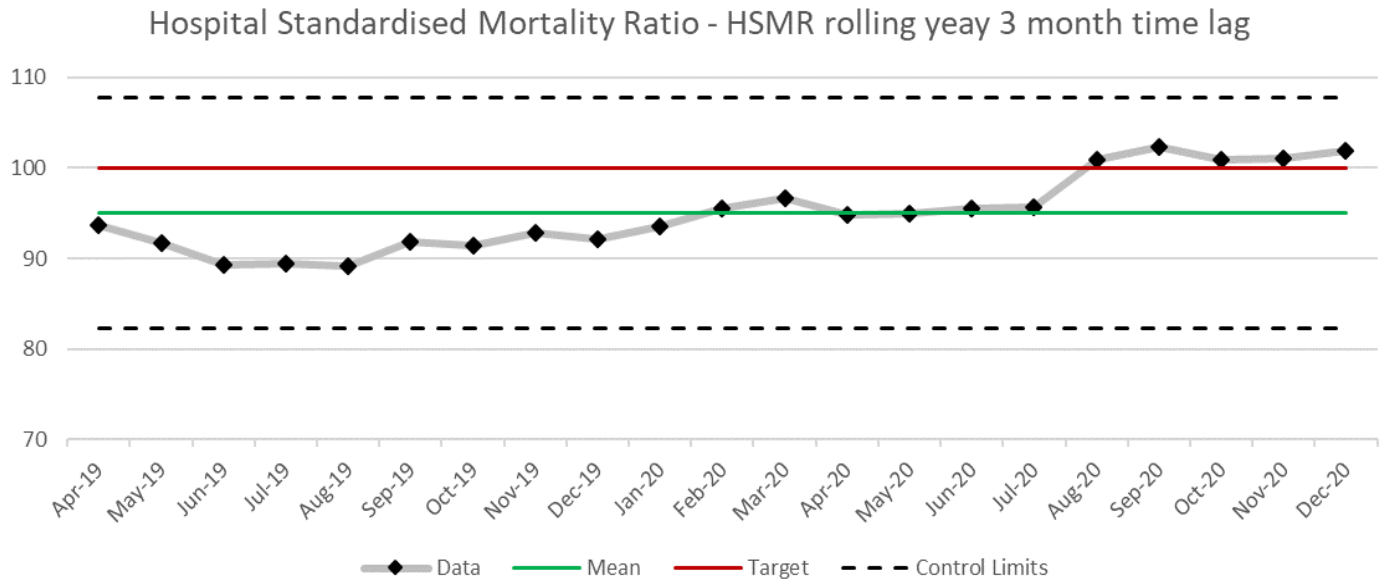
Alerts:
Pneumonia.

DELIVER HARM FREE CARE – MORTALITY HSMR

Executive Lead: Medical Director

CQC Domain: Effective

Strategic Objective: Patients



Challenges/Successes

ULHT's HSMR is at 101.85, which is within expected limits.
Lincoln site is outside the expected limits at 110.70 for the rolling year; with 98 more deaths than predicted (1022 Observed: 924 Predicted).
Pilgrim and Grantham are achieving better than the expected threshold limits for the rolling year.
HSMR for the financial year is showing above expected for the Trust and Lincoln sites. However, due to the COVID-19 pandemic this was to be expected. Pilgrim is above the threshold but not highlighted.
HSMR for the financial year is showing above expected for the Trust and Lincoln site, a continuing trend in the current COVID-19 pandemic.
HSMR by divisions - all divisions are within expected limits for the rolling year, financial year and current month.
COVID-19 deaths are being attributed to a diagnosis group (Viral infection), which is not included within the HSMR 56 Basket Diagnosis Groups. However, should a patient have COVID-19 included as a secondary diagnosis, these will pull thorough into the datasets.

Alerts

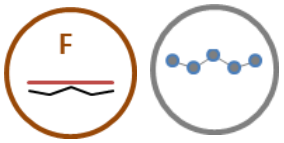
- Septicaemia (except in labour): alerting for the seventh month at Lincoln, at Trust level. Clinical Governance has held meetings with the Sepsis Practitioners to discuss and a case note review is being undertaken (cancelled in December due to redeployment of Sepsis Practitioners). Plan to be completed in January 2021.
- Other liver diseases: Third month alerting at Trust Level, and a second month at Pilgrim. The clinical lead will be contacted for a case note review to commence.
- Pleurisy pneumothorax pulmonary collapse: First month alerting at Trust and Pilgrim
- Liver disease alcohol-related: First month alerting at Trust level.
- Skin and subcutaneous tissue infections: First month alerting at Grantham.

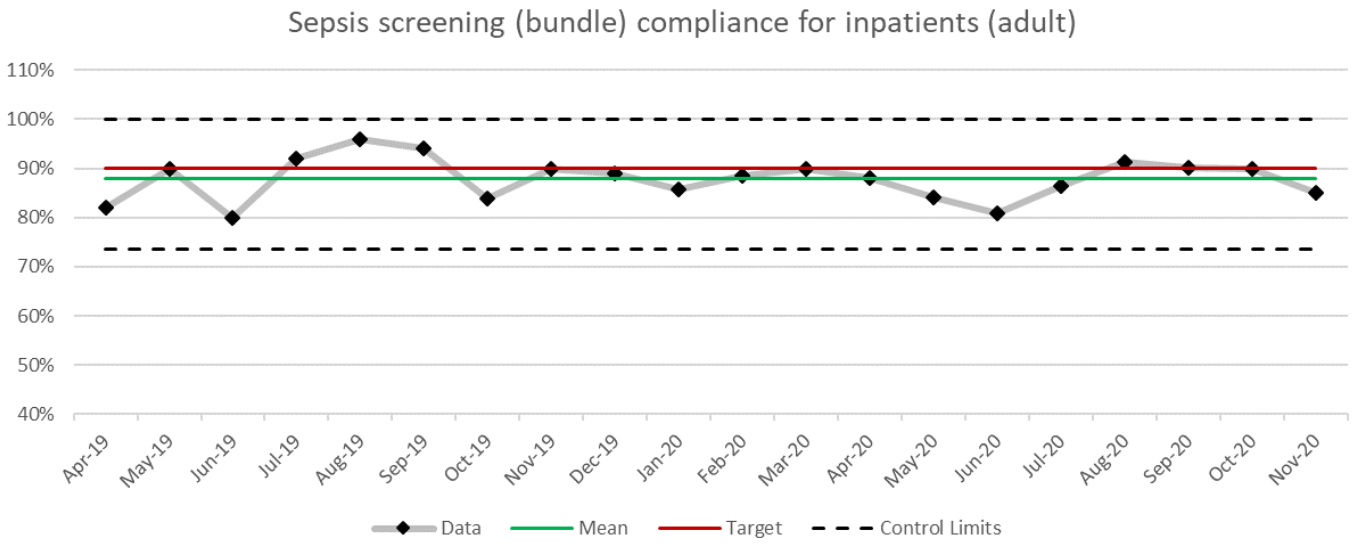
DELIVER HARM FREE CARE – SEPSIS SCREENING (BUNDLE) COMPLIANCE

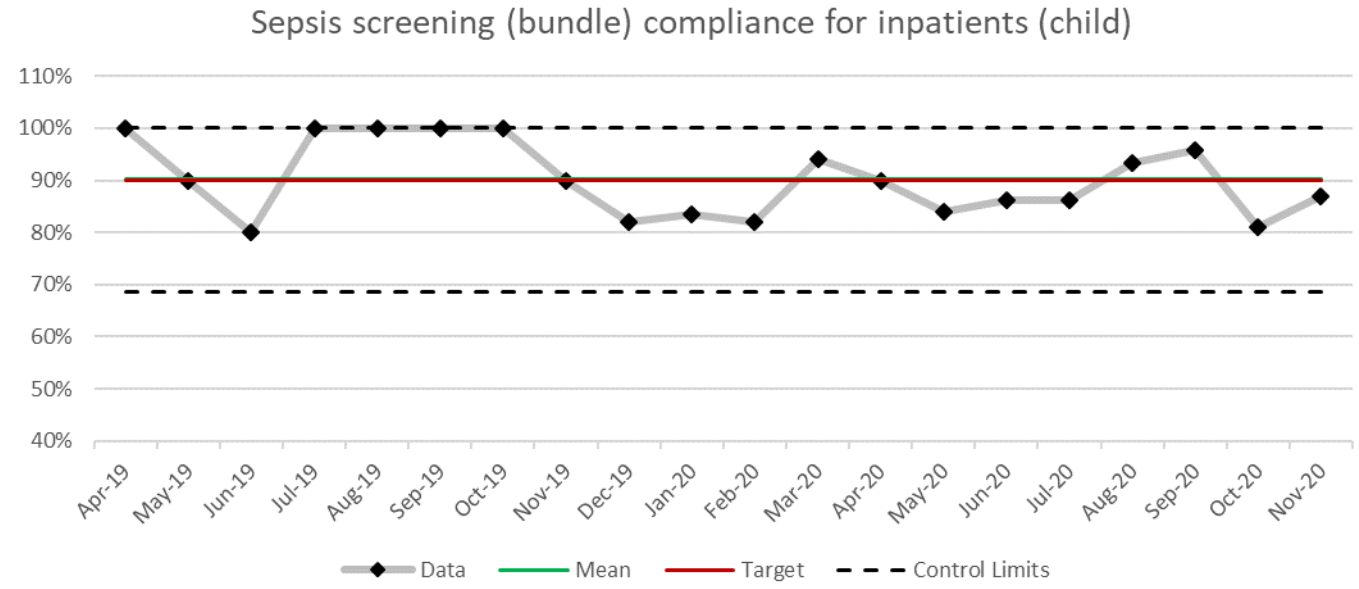
Executive Lead: Director of Nursing

CQC Domain: Safe

Strategic Objective: Patients





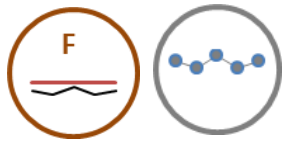


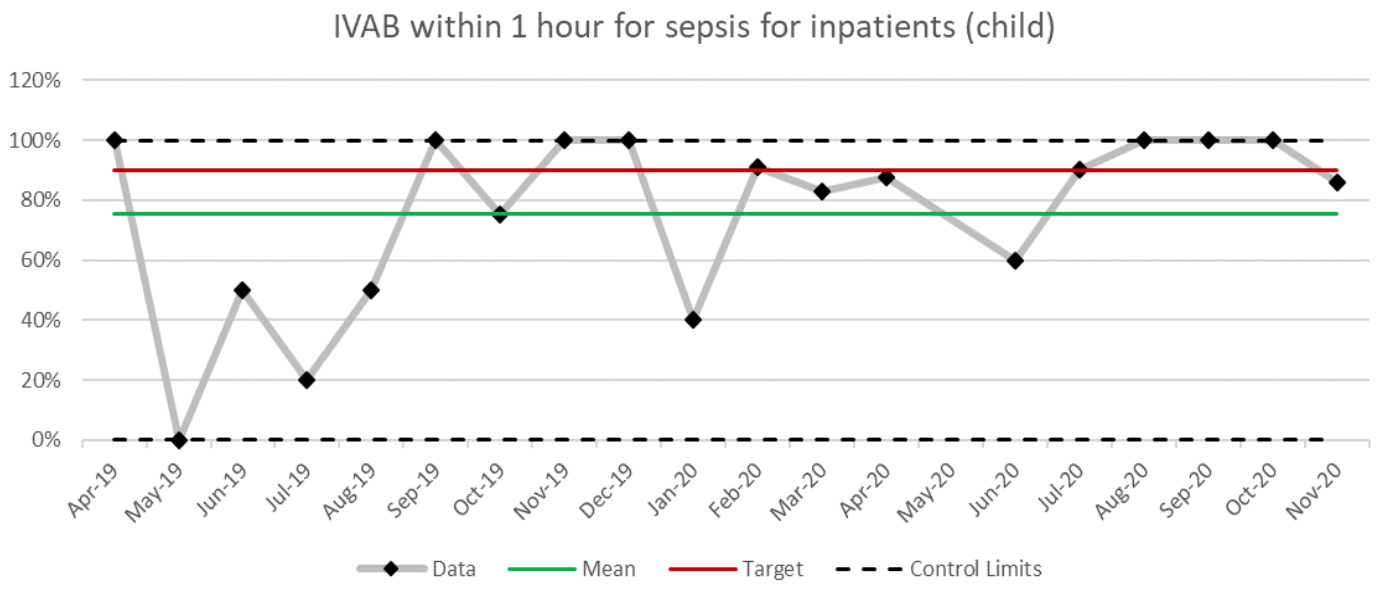
DELIVER HARM FREE CARE – IVAB WITHIN 1 HOUR FOR INPATIENTS

Executive Lead: Director of Nursing

CQC Domain: Safe

Strategic Objective: Patients





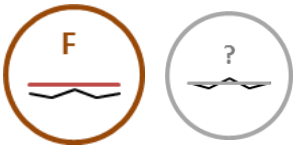
Sepsis leads have been re deployed to A & E causing delays in data.

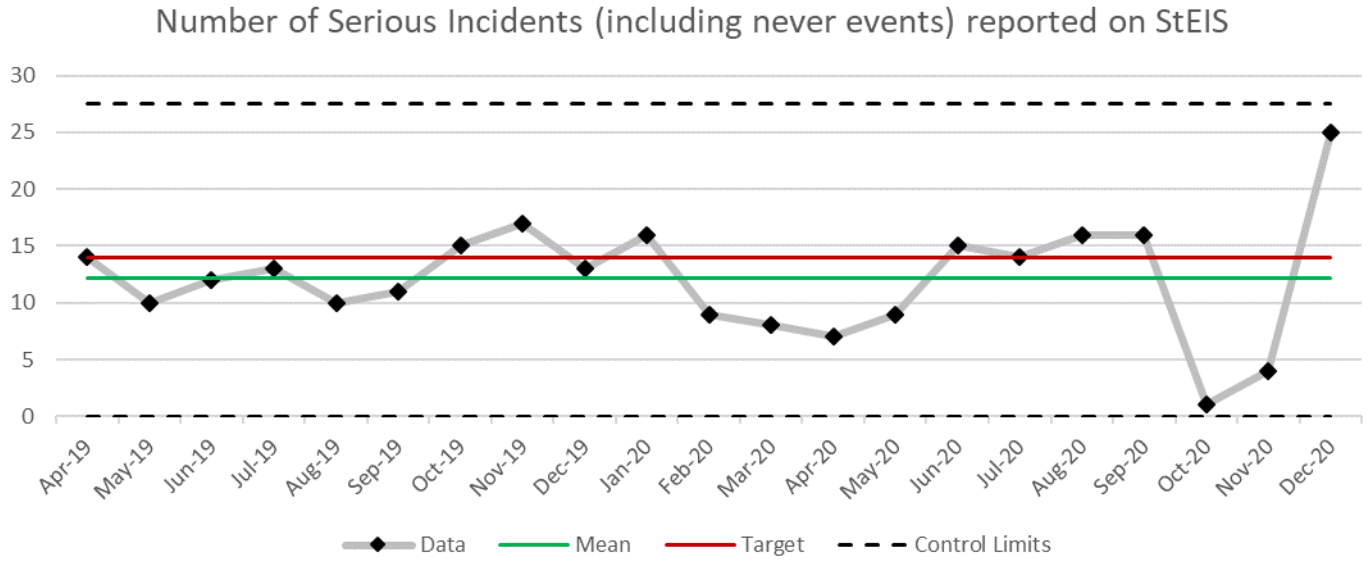
DELIVER HARM FREE CARE – SERIOUS INCIDENTS ON StEIS

Executive Lead: Director of Nursing

CQC Domain: Safe

Strategic Objective: Patients





Challenges / Successes:

- The Trust declared 25 Serious Incidents in December 2020, a significant increase on the last 2 months (4 were declared in November and 1 in October).
- Of those 25 incidents, there were 10 that actually occurred in December; 8 in November; 4 in October; and 1 in April 2016 that has only recently been reported.
- The average for 2020/21 to December is 10 Serious Incidents occurring per month

Actions in place to recover:

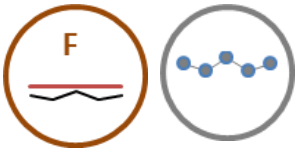
- 10 of the Serious Incidents declared in December concerned breaches in A&E of 12 hours from decision to admit (DTA), some of which involved multiple patients; Medicine Division are currently completing harm reviews for all affected patients to determine the impact of these incidents

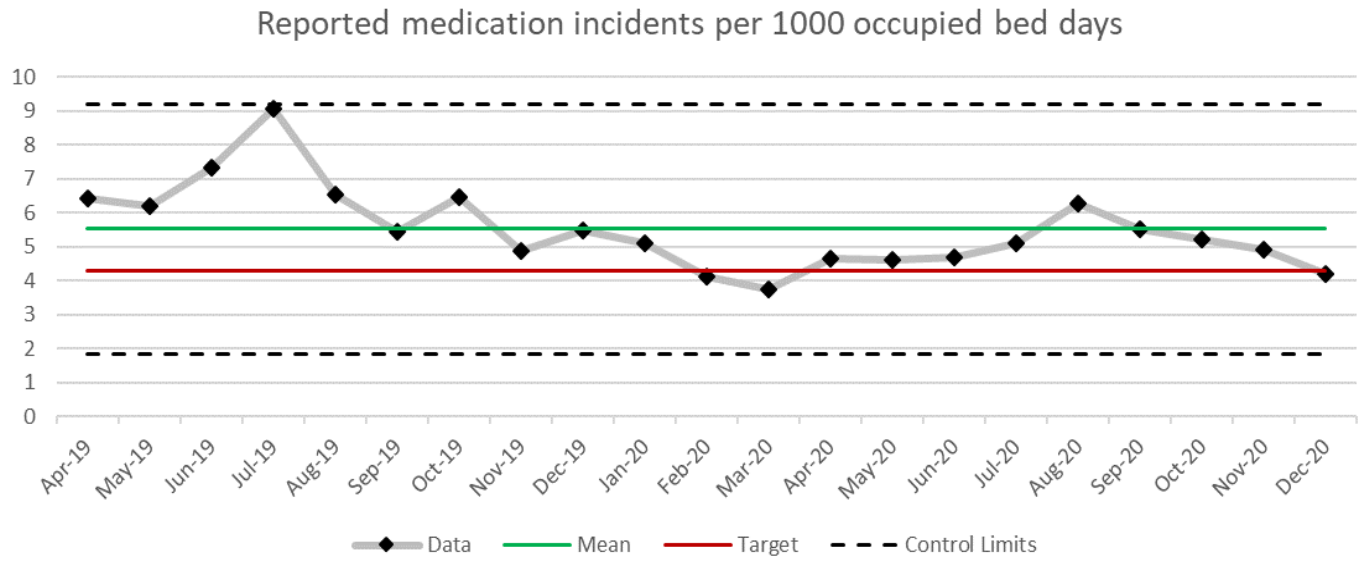
DELIVER HARM FREE CARE – MEDICATION INCIDENTS CAUSING HARM

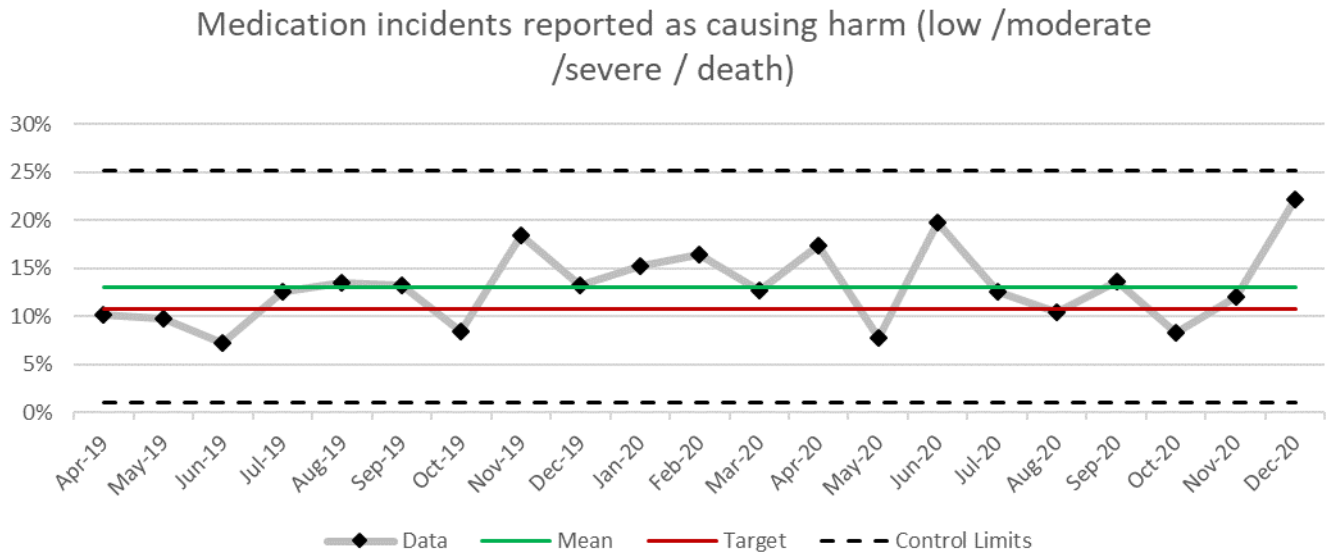
Executive Lead: Medical Director

CQC Domain: Safe

Strategic Objective: Patients







Challenges / Successes:

Staffing has been a significant issue. We have agency and inexperienced staff working on wards that are already under significant pressure with the ongoing pandemic.

Actions in place to recover:

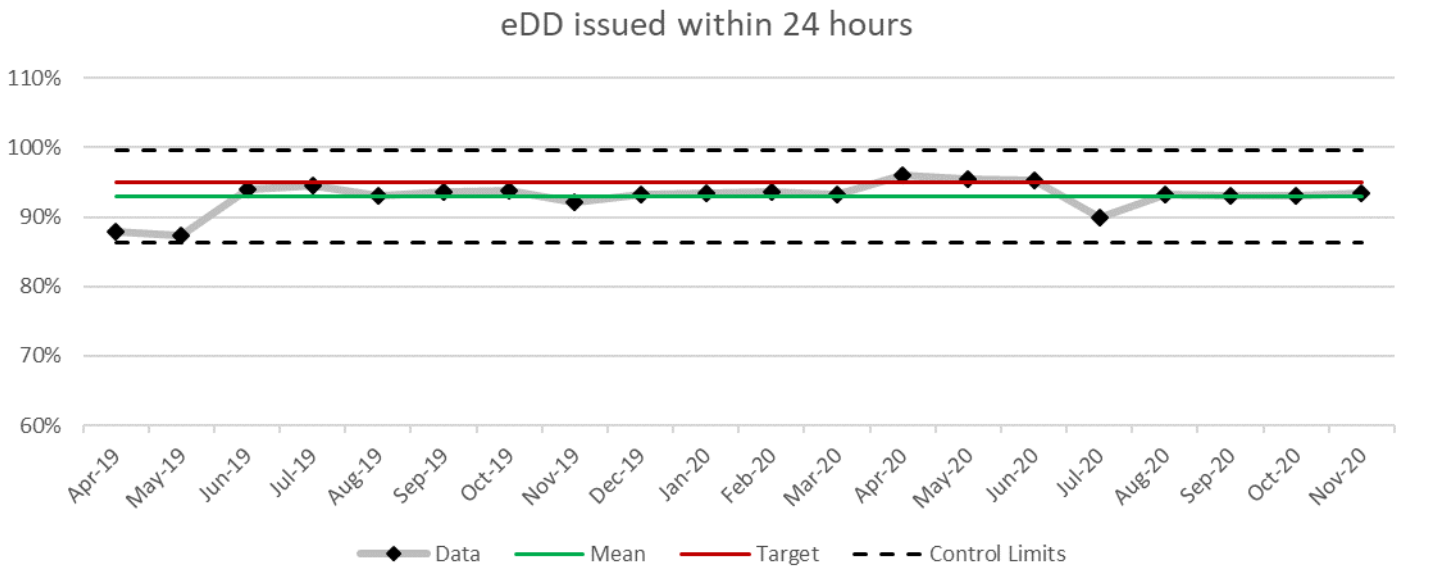
Each CBU pharmacist has been sent the medication incident reports and will work with wards to make improvements. As a Pharmacy department we are working closely with the Post Grad education department to put together some training for the Junior Doctors.

DELIVER HARM FREE CARE – eDD ISSUED WITHIN 24 HOURS

Executive Lead: Medical Director

CQC Domain: Effective

Strategic Objective: Patients



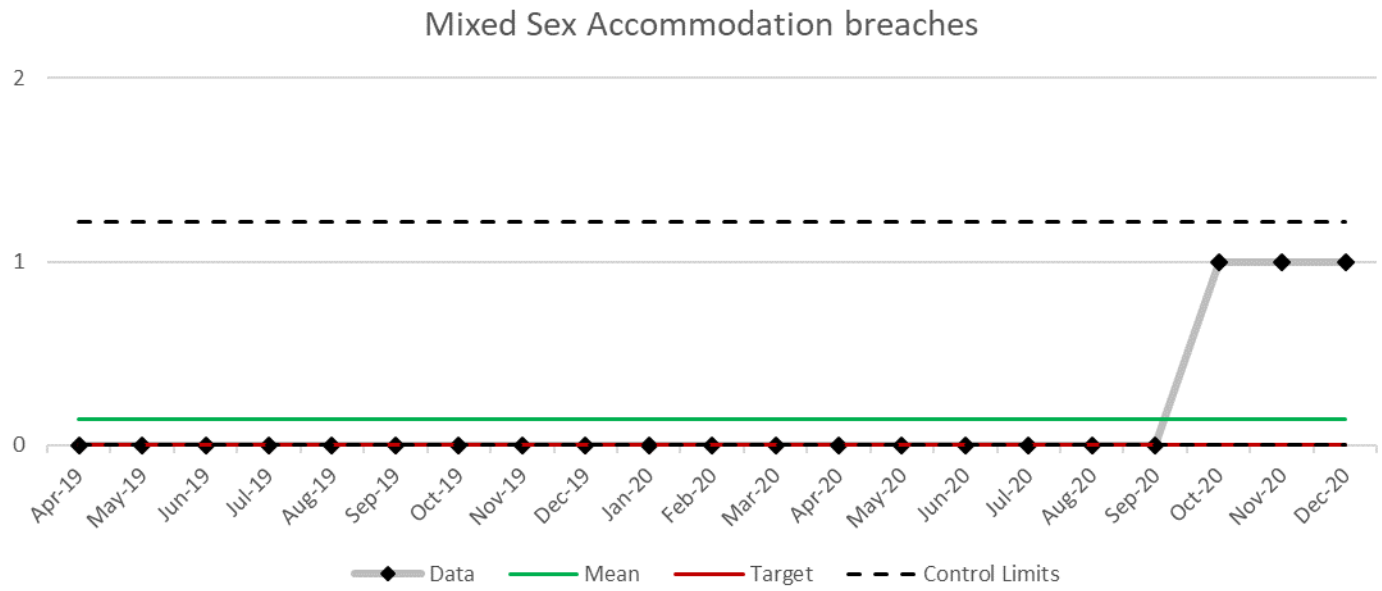
eDD data for December not available and needs validating.

IMPROVE PATIENT EXPERIENCE – MIXED SEX ACCOMMODATION

Executive Lead: Director of Nursing

CQC Domain: Caring

Strategic Objective: Patients



Actions in place to recover:

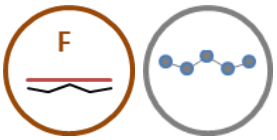
Further investigation of the incident is required to identify any actions to be taken to prevent reoccurrence.

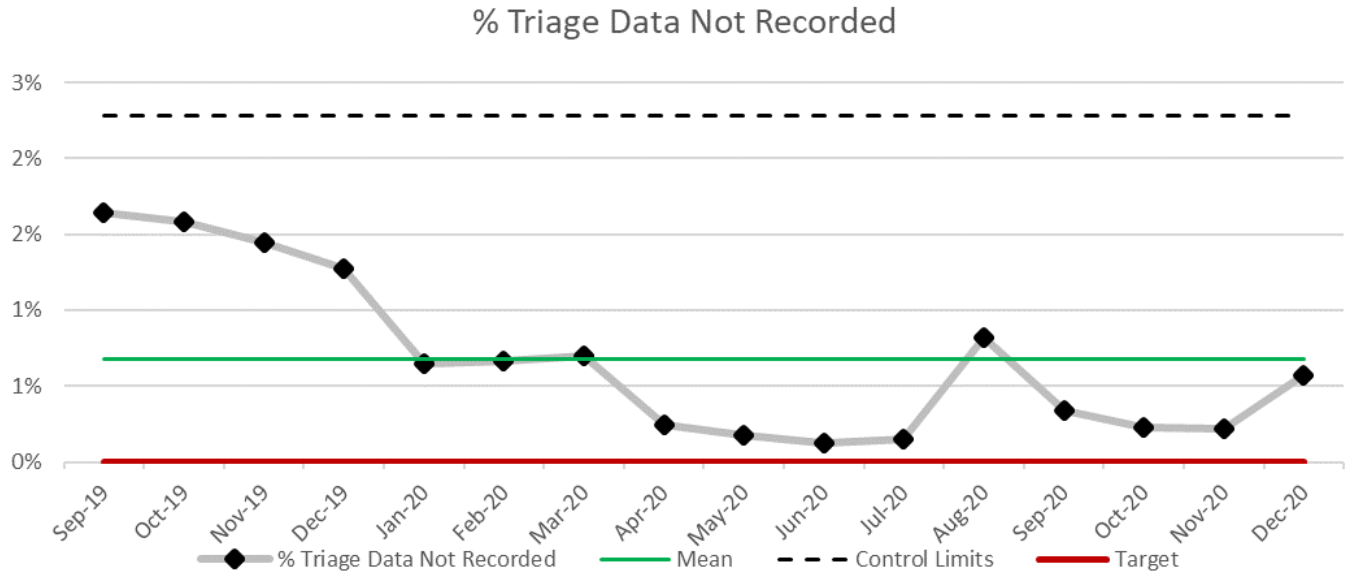
IMPROVE PATIENT EXPERIENCE – % TRIAGE DATA NOT RECORDED

Executive Lead: Chief Operating Officer

CQC Domain: Effective

Strategic Objective: Patients





Challenges/Successes

- December demonstrated a 0.35% negative variation in performance compared with November and whilst this is well within control limits the shift is of concern.
- Deterioration has been seen on both sites even though attendances have reduced.
- The ability to provide two triage streams has seen challenges in December to an increased staff absence through Covid-19 related sickness and reduced bank and agency fill.
- Achievement against this metric is co-dependent upon having a fully trained and compliant staffing rota as well as the individual compliance of staff.
- The UEC Operational Leads continue to be proactive in addressing recording compliance in real time in hours but the main contributory factor is out of hours.

Actions in place to recover:

- Emergency Department staffing levels are reviewed by the staffing Hub x 4 daily and an emphasis on securing templated staffing is in place but is not assured.
- Training is in place and will be rolled out wider to 'interim' staff following redeployment.
- The actions against this metric to ensure compliance and assure safety are overseen by the Deputy Divisional Nurse responsible for Urgent and Emergency Care.

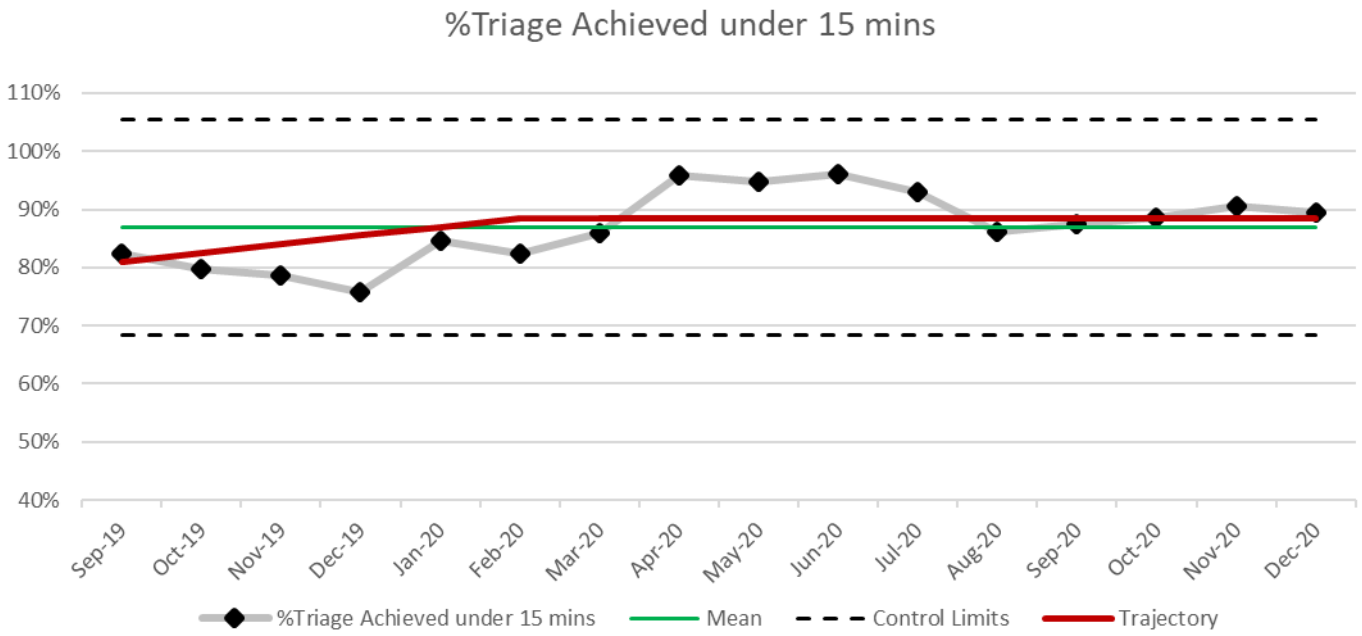
Triage time is a key patient safety performance indicator and forms an essential part of the department huddles. Performance against this safety indicator is scrutinised at the 4 x daily Capacity and Performance meetings.

IMPROVE CLINICAL OUTCOMES – %TRIAGE ACHIEVED UNDER 15

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services



Challenges/Successes

- Triage under 15 minutes deteriorated in December by 1.17%. 89.48% in December versus 90.65% in November. The balance between managing the blue pathway and green pathway in both our Emergency Departments and our Assessment Units continues to be problematic, even with reduced attendances.
- The ability to provide two triage streams has also deteriorated.
- Measures are in place to assure the delivery of this key metric improvement trajectory toward 100%.
- This metric continues to be captured as part of the daily and weekly CQC assurance reporting and performance is discussed daily by clinicians as part of the ED safety huddles led by the Deputy Divisional Nurse for Urgent an Emergency Care and now the newly appointed General Manager for Urgent and Emergency Care.

Actions in place to recover:

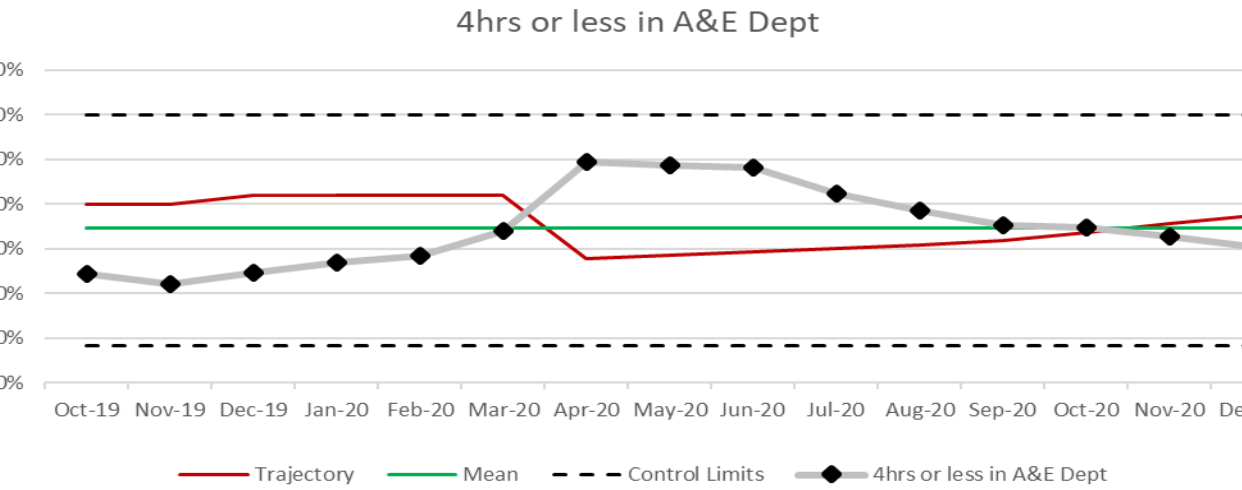
- The focus must remain on achievement of this safety metric.
- All key operational posts have now been appointed to within Urgent and Emergency Care and the expectation of action and remedy has been made explicit.
- Clear action and recovery plans are scrutinised at the four times daily Performance and Capacity meetings.
- Staffing deficits that may impact on the ability to maintain a second triage stream both in and out of hours are highlighted and every attempt is made to resolve this.

IMPROVE CLINICAL OUTCOMES – A&E 4 HOUR WAIT

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services



Challenges/Successes

- December ED type 1 and streaming was 13,624 attendances verses 13,568 in November. This represents a 0.42% increase. By site LCH experienced a 1.83% decrease in attendances, PHB saw an increase of 4.07%. Grantham also experienced a slight increase in UTC attendances of 1.47%. The PHB increase can be attributed to the number of temporary ambulance conveyance deflects from LCH to PHB applied during December.
- December overall outturn for A&E type 1 and primary care streaming delivered 70.54% against an agreed trajectory of 77.42%.
- This demonstrates a further deterioration in performance of 2.24% compared with November outturn. Performance has deteriorated for 8 consecutive months, and the slight increase in attendances of 0.42% does not explain this deterioration.
- Performance is now below the agreed trajectory by 6.88%. Concern in respect of this safety metric has been raised both regionally and nationally. Daily System calls are in place as well as the provision of daily updates to the regional UEC Team.
- By site, for December, LCH delivered 67.90%, a 6.21% improvement on November's performance, PHB delivered 63.03%, a deterioration of 8.74%. GDH achieved 98.14% which was a slight improvement of 0.07% compared to November. This includes type 1 and type 3 activity.
- The highest days of delivery by the Emergency Departments only was on 19th December when LCH achieved 67.76% and 24th December when PHB delivered 74.68%. The performance uplift from the UTCs was 11.48% at LCH (79.24%) and 6.97% at PHB (81.65%). Conversely, the lowest days of delivery by the Emergency Departments was 13th December when PHB only achieved 32.11% and 23rd December, when LCH only achieved 41.13%. The performance uplift from the UTCs activity was 23.84% (55.95%) and 18.09% (59.22%) respectively.
- Streaming at GDH, LCH and PHB experienced 90 >4hr transit time breaches in December compared with 117 in November a reduction of 27 and a decrease of 23.08%. The highest number proportionate to attendances was PHB.

Actions in place to recover:

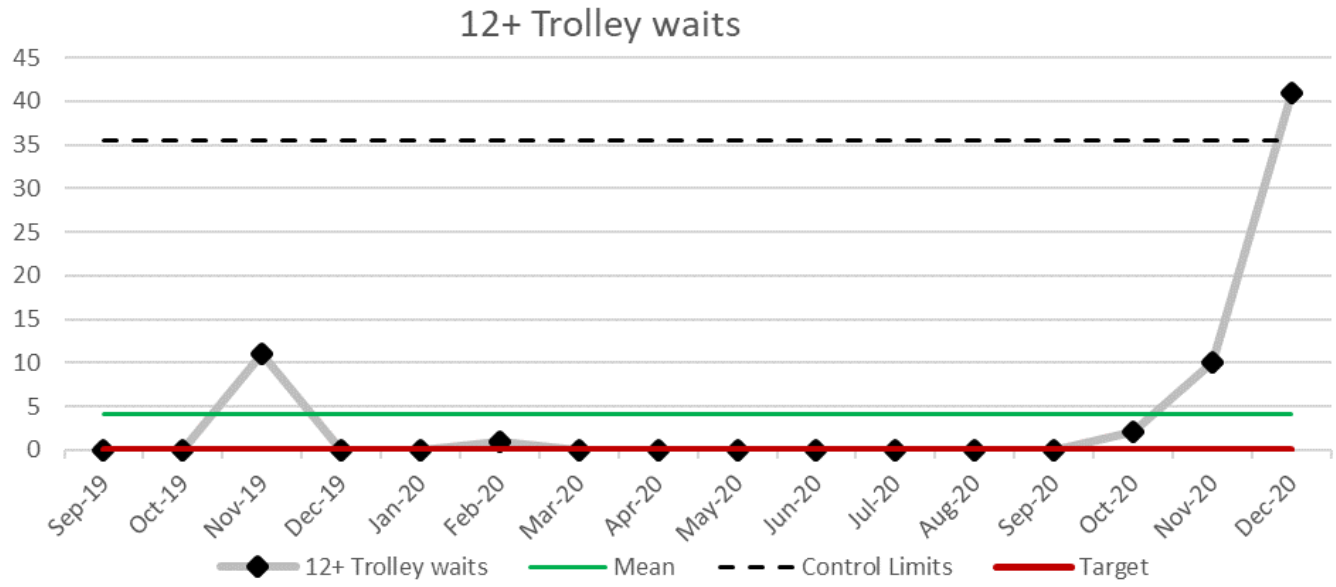
- The Recovery phase of COVID management reflects those process improvements, not affected by volume, in a revised Urgent and Emergency Care Improvement Programme led by a recently appointed dedicated Improvement Lead. This appointment, working in Partnership with the Clinical and Non-Clinical Urgent and Emergency Care Teams will drive sustainable change. This appointment is directly lined managed by the Clinical Lead for our Emergency Departments.
- The main drivers for change are optimised SDEC pathways to release the burden placed upon the Emergency Departments and is in line with Regional/National direction of travel. This will result in improved ambulance handover delays.
- The ability to continually respond dynamically in all urgent and emergency care access areas will support patients to be seen by the right person, in the right service, at the right time in and out of hours.

IMPROVE CLINICAL OUTCOMES – 12 HR + TROLLEY WAITS

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services



Challenges/Successes

- Following a comprehensive internal review for November the reported figure of 4 for November increased to 10.
- The Trust experienced and recorded 41 x 12+ hour trolleys waits in December 2020, all at Lincoln County Hospital.
- All previously reviewed +12hr trolleys waits have been revalidated. This has led to more reportable waits.
- The Trust is working closely with national regulators in reviewing and reporting these breaches.
- Poor flow and an inability to respond to blue and green pathway demand has generated a demand and capacity double jeopardy.
- The actual impact of Wave 2/3 in terms of surge and associated capacity required, has been compounded by a significant reduction in available workforce.
- December continued to experience both Ward and Staff outbreaks resulting in 'closed' G&A core beds and a suspension of the 'Green Pathways' at both Pilgrim and Lincoln.
- Since the 'intervention' in November at PHB, availability and access to the correct bed type has continued to prove successful but the similar interventions at Lincoln County did not yield the same benefit. LCH remains our most vulnerable site both from a flow and IPC perspective.
- Proactive situational response escalations are in place locally and with System Partners and Regulators.

Actions in place to recover:

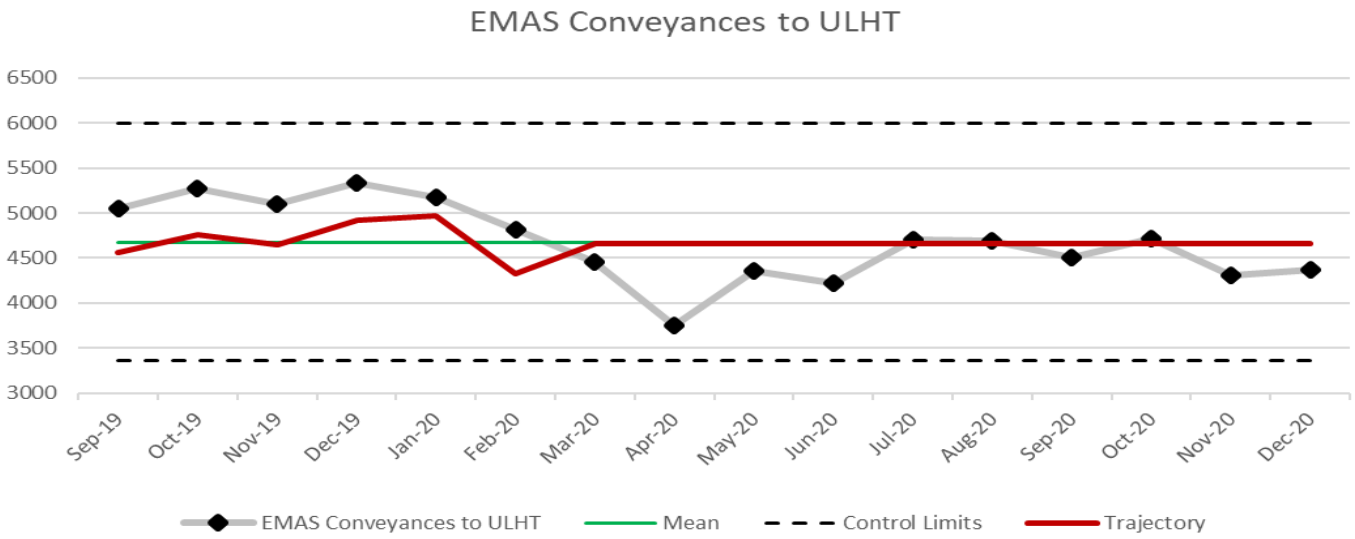
- Daily Capacity Planning Cell meetings are in place and include key stakeholders to assess, plan and agree the flow interventions required and escalate to Gold Command any obstacles for resolution.
- A multi-disciplinary approach to unblock discharge delays across all sites on pathways 0, 1, 2 & 3 is in place and feeds into the daily Capacity Planning Cell chaired by the Divisional Managing Director for Medicine and Emergency Care.
- Three times daily reviews via the Trust wide Capacity Flow meetings are in place to determine progress on discharge to ensure reduced burden on our Emergency Departments and elimination of +12 hr Trolley Waits.
- Daily System and Regulator Gold Calls are in place to secure plans to reduce the burden on the Acute Trust.

IMPROVE CLINICAL OUTCOMES – AMBULANCE CONVEYANCES

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services



Challenges/Successes

- Ambulance conveyances for December were 4365 compared to 4304 in November. This represents an 1.4% increase in conveyances across all sites.
- By site, LCH conveyances were 2543 in December compared with 2577 in November, a 1.32% decrease, PHB was 1777 in December compared with 1696 in November, an increase of 4.56%. Multiple conveyance deflects were put in place from LCH to PHB during December including bespoke deflects from GDH to PHB. GDH also experienced an increase in conveyance in December, 45 compared to 31 in November, an increase of 31.12%.
- Load share for conveyances from GDH to PHB and LCH is more balanced but requires constant monitoring by both the Trust Operational Teams and the UEC CBU.
- We continue to work with the System to reduce our overall attendances and conveyances by ensuring all admission avoidance pathways are robust and communicated clearly.
- The use of CAS for advice and admission avoidance options appears to have increased, but the expected benefit to ULHT has not been realised.
- The development of the Priority Admission Response Units (PARU), which are designed to be a safe and secure environment to provide an alternative 'waiting area' for those patients requiring inpatients beds to reduce the burden in the Emergency Department Departments has been delayed further. Estates completion and the ability to safely staff these may be rate limiting factors.

Actions in place to recover

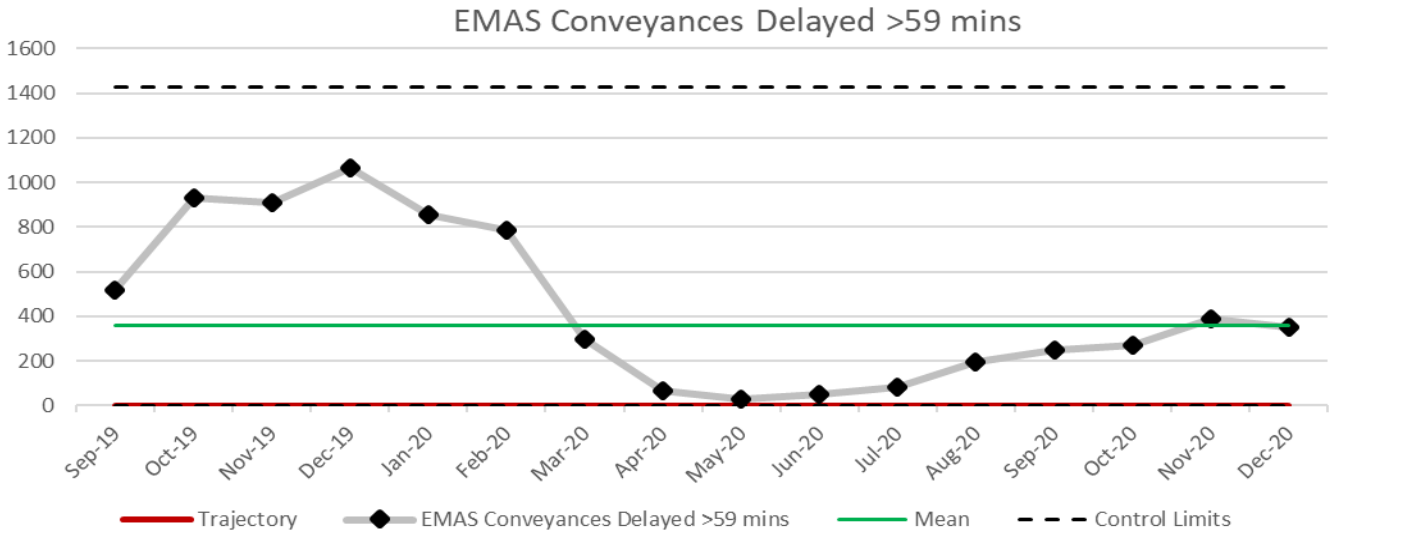
- Recovery plans are in place by the Trust for urgent and emergency care (UEC) which include patients being appropriately clinically managed through alternative streams to avoid large numbers of patients in the emergency department leading to possible delays in Ambulance handover. None of these have yet been realised.
- Increased resourcing of CAS by LCHS which includes an extended criterion.
- An increase to the overall footprint of our Emergency Departments is currently underway with secured funding.
- System Partners are committed to delivering a reduction on the overall burden on the Acute Trust. The Systems UEC Recovery plans give transparency and assurance of the Recovery plans developed and agreed to support this. Regional and National support continues to be made available.

IMPROVE CLINICAL OUTCOMES – AMBULANCE HANDOVER >59

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services



Challenges/Successes

- December reported 350>59-minute hand over delays. This is a decrease of 38 on the November figures of 388. This represents a 9.8% decrease in >59-minute ambulance handover delays. LCH had 204 >59-minute ambulance conveyances in December compared with 287 in November. This represents a 28.92% decrease in December compared with November. PHB had 146 > 59-minute ambulance handover delays in November compared to 101 in November. This represents a 30.83% increase at PHB.
- Delays experienced at LCH and PHB remain attributed to a continued inability to 'flex' the segregated pathways more responsively against the presenting demand.
- There continues to be a challenge regarding the pattern of conveyance and poor flow, especially at LCH.
- Robust relationships exist with the Lincolnshire EMAS Divisional Operations Manager, Clinical Site Manager, ULHT Operational Silver Commander and Operational CCG Silver to ensure any concerns are raised.
- Daily System Calls are in place at 10.30am where number of conveyance, conveyance avoidance and handover delays are discussed.

Actions in place to recover

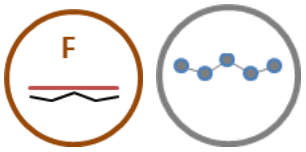
- As part of recovery and following confirmation of additional monies to enhance our urgent care facilities, work continues to bring these plans to fruition. This will include a larger footprint for RAT. This measure seeks to significantly reduce >59mins handover delays.
- Dedicated UEC Project Management resource has been secured to address handover delays. The Project Manager is working with the UEC Trust Teams to effect a sustainable change with a particular focus on SDEC to reduce unnecessary admissions and generate improved bed flow.
- Work continues within the System to reduce the overall ambulance conveyances to ULHT through implementing robust alternative pathways via Think 111 and CAS. This is reviewed daily via the 10.30am System Call and twice weekly Gold Patient Cell Calls
- All ambulances at 30 minutes post arrival are now escalated to the Clinical Site Manager (CSM) if there is no robust plan to 'off load'. The Clinical Site Manager (CSM) will work to resolve locally and will escalate to the Silver Commander if the handover delay protocol will be breached.

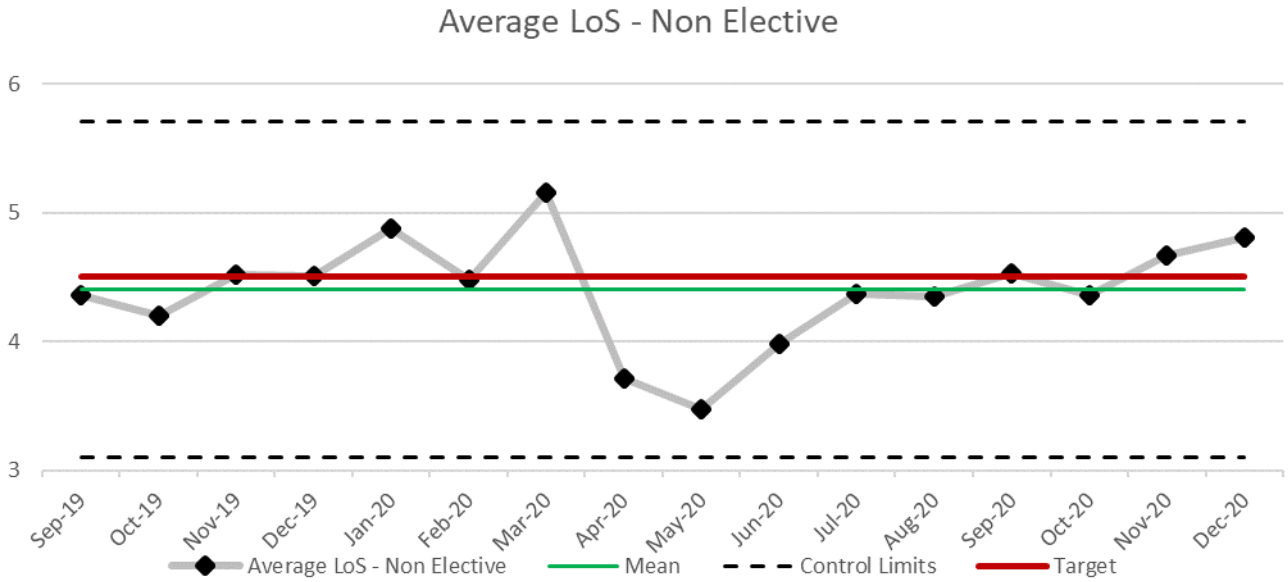
IMPROVE CLINICAL OUTCOMES – AVERAGE LOS NON-ELECTIVE

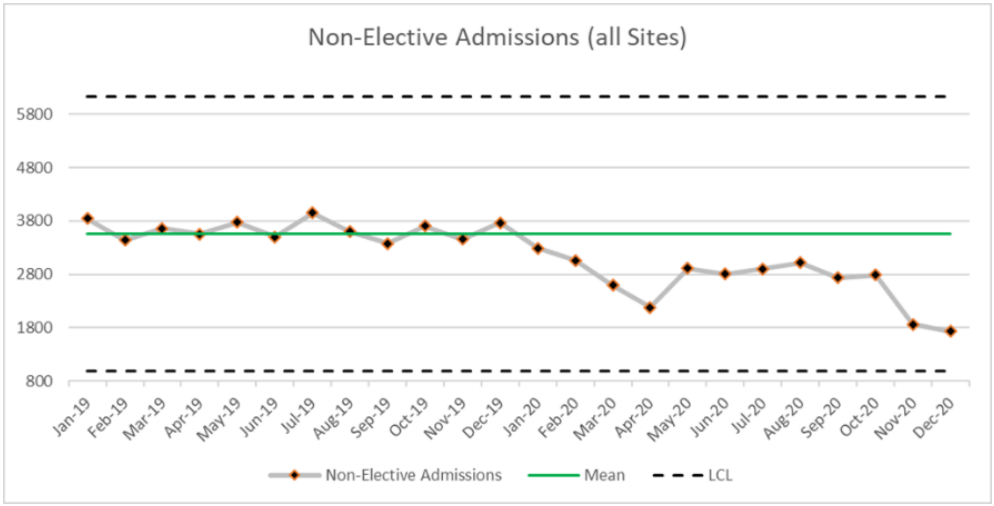
Executive Lead: Chief Operating Officer

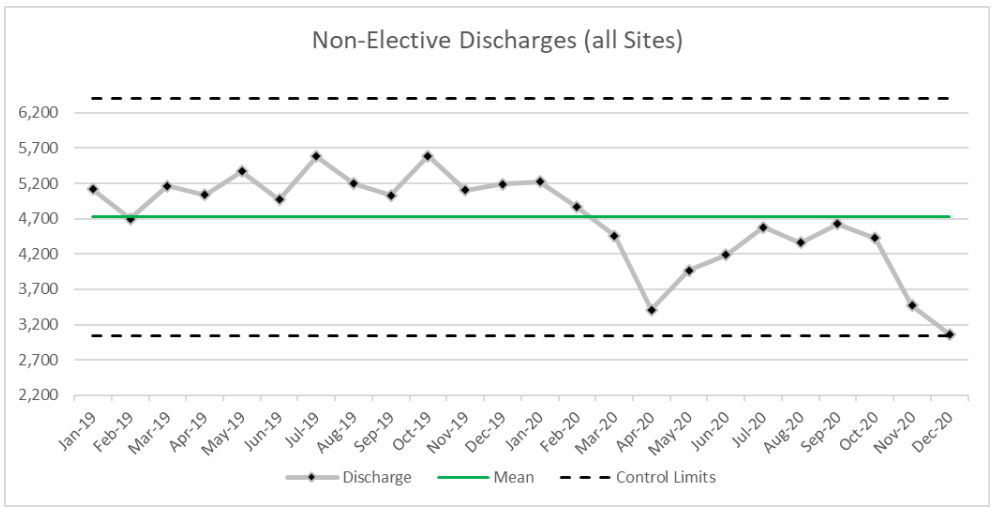
CQC Domain: Effective

Strategic Objective: Services









Challenges/Successes

- Average LOS for non-elective admissions (NELA) saw a deterioration during December, delivering 4.81 ALOS compared to 4.67 ALOS in November. This represents a negative variation of 0.41 days and is above the trust target of 4.50 days.
- Non elective admissions decreased in December to 1729 verses 1858 in November. This represents a 6.95% decrease. A December 2019 admission comparison to December 2020 shows a 54.05% decrease in non-elective admissions. 3762 NELA in December 2019 verses 1729 in December 2020.
- Non elective discharges decreased from 3,469 in November to 3,064 in December, a reduction of 405. This represents a 11.68% reduction.
- We did not experience the Christmas Eve increased discharge phenomenon of previous years.
- G&A core bed availability within ULHT has reached its tolerance at PHB and LCH. This continues to be compounded by Coronavirus outbreaks on several wards, patients and staff. This has rendered a significant number of beds unusable across our acute sites.
- The C-19 third wave modelling (prevalence and bed requirement) has proven accurate to +/- 5 days but increased pressure on our ICU beds is now apparent. Fourth wave impact and modelling has been announced
- During November the numbers of patients with a LLOS decreased slightly. 92 in December compared to 112 in November. A decrease of 20 patients.
- The work of the system wide discharge cell continues to address inequalities in access for both Community care and adult social care and remains in operation 7 days a week with twice daily calls.
- Extensive work has been undertaken with system partners to acquire and agree funding and access to designated beds for our positive Covid patients on pathways 1, 2 & 3.
- LCHS have redesigned their bed capacity to support positive Covid patients transfers from Acute Beds.

Actions in place to recover

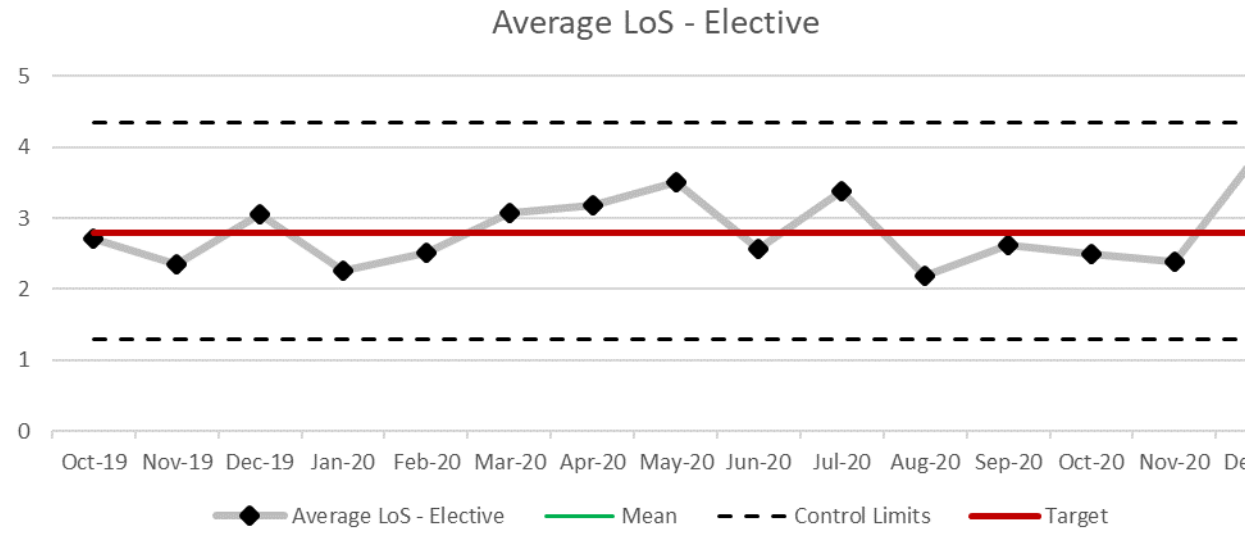
- Multi-agency discharge meetings continue to take place daily, seven days a week. Line by line reviews take place against each patient on pathway 1, 2 and 3. This process is now robust and an increase the discharge of medically optimised patients across the entire week (7days) is being realised.
- Long length of stay meetings for each hospital site remain in place to support more complex patients through their discharge pathway.
- More work is required in respect of the discharge pathways, in particular pathway zero and especially at LCH.
- The System has secured and commissioned care homes who will support patients with positive swabs, especially pathway 1 and 2 where the demand is the greatest. 4 Care Homes have been commissioned to provide these services. We are seeing the benefit of this intervention/action. ULHT, LCHS and LCC are managing these pathways with LCHS re-designing their current bed reconfiguration.

IMPROVE CLINICAL OUTCOMES – AVERAGE LOS ELECTIVE

Executive Lead: Chief Operating Officer

CQC Domain: Effective

Strategic Objective: Services

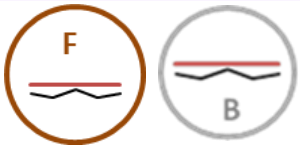


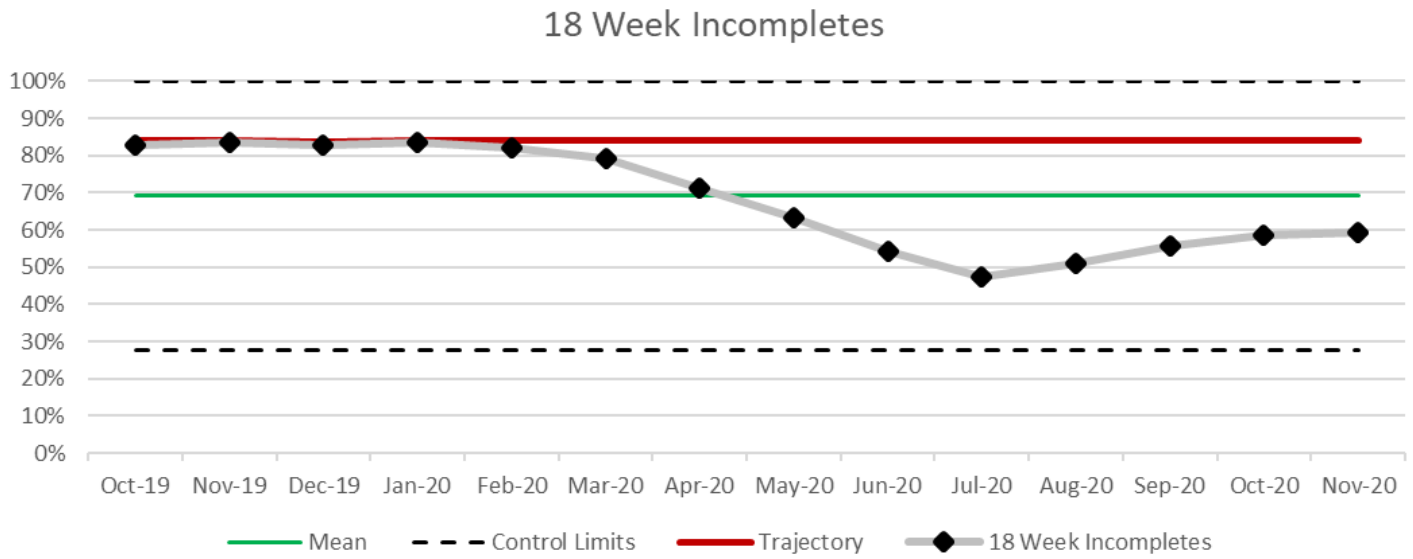
IMPROVE CLINICAL OUTCOMES - RTT 18 WEEKS INCOMPLETES

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services





Challenges/Successes

RTT performance is currently below trajectory and standard.

November saw RTT performance of 59.33% which is +0.87 % better than October.

General Medicine was the lowest performing specialty, with performance decreasing from 44.12% last month to 42.18% (-1.94%). Neurology has improved this month with a 4.76% increase from 49.73% last month to 54.49% in November.

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

- Ophthalmology - 3093 (Decreased by 220)
- Trauma & Orthopaedics - 2256 (Decreased by 107)
- ENT - 1818 (Increased by 31)
- Maxillo-Facial Surgery + Orthodontics + Oral Surgery - 1441 (Decreased by 158)
- Dermatology - 1369 (Increased by 88)

Specialties achieving the 18 week standard for November were:

- Paediatric Cystic Fibrosis 100% (one patient)
- Paediatric Diabetic Medicine 100% (one patient)
- Medical Oncology 100%
- Clinical Oncology 96.83%

Actions in place to recover:

Performance across most specialties continues to increase albeit slowly.

As the figures above show, despite having the highest number of 18w breaches, these specialties have shown an overall decrease in numbers. With Ophthalmology and Maxillo-Facial Surgery, Orthodontics and Oral Surgery seeing the largest increase in performance.

The re-introduction of routine elective work for both admitted and non- admitted was suspended over the last two weeks due to the Trust having to declare a Critical Incident. This has now been stepped down to a standby situation and recovery plans continue.

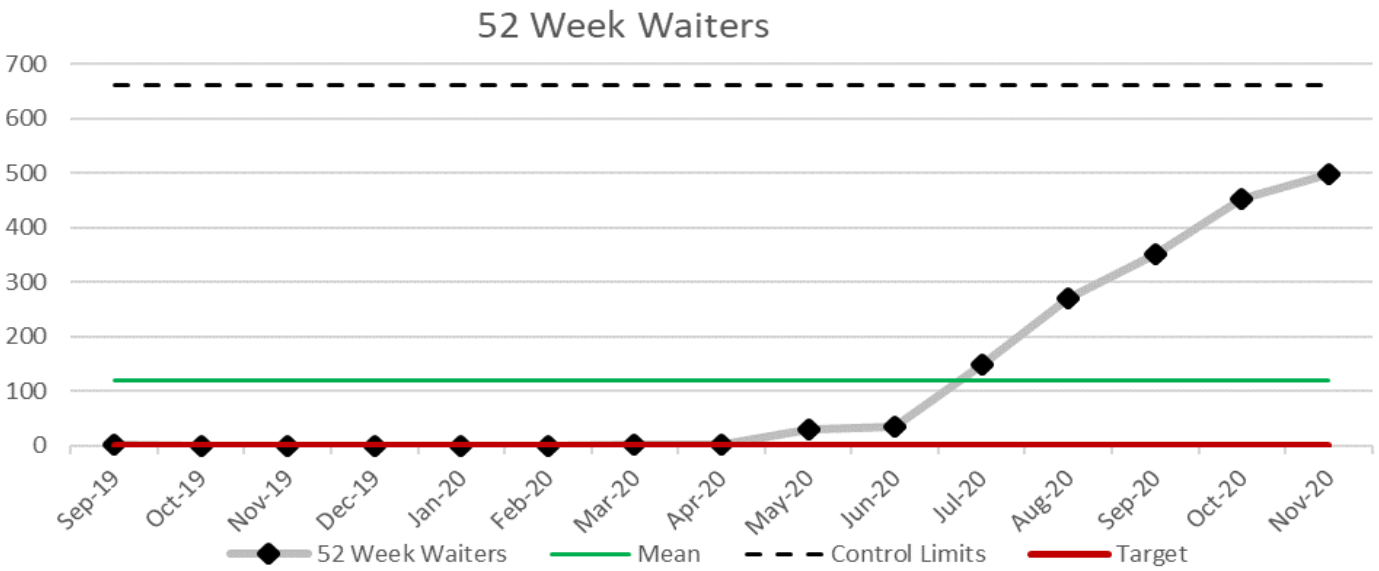
The Endoscopy service are working closely with the divisions identifying their longest waiting routine patients and prioritising these together with clinically urgent patients.

IMPROVE CLINICAL OUTCOMES – 52 WEEK WAITERS

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services



Challenges/Successes

The Trust reported four hundred and ninety-eight incomplete 52 week breaches for November end of month.

Root cause analysis (RCA) and harm reviews will be completed by the relevant division for each patient. Where required, discussions around the incorrect data entry will be had with relevant staff and necessary actions implemented.

As anticipated there are an increased number of breaches declared each month. However, full focus is on these patients at the weekly PTL meeting to ensure that there is a plan for every patient. Currently, due to the pressures associated with the second wave of the pandemic, this meeting has been temporarily stood down. However, a bi-weekly RTT Recovery and Delivery continues in order to monitor the situation.

Actions in place to recover

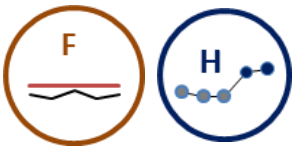
Recovery plans continue to be implemented; accounting for a changing environment.
Across the Trust outpatient services continue to use all available media to consult with patients.

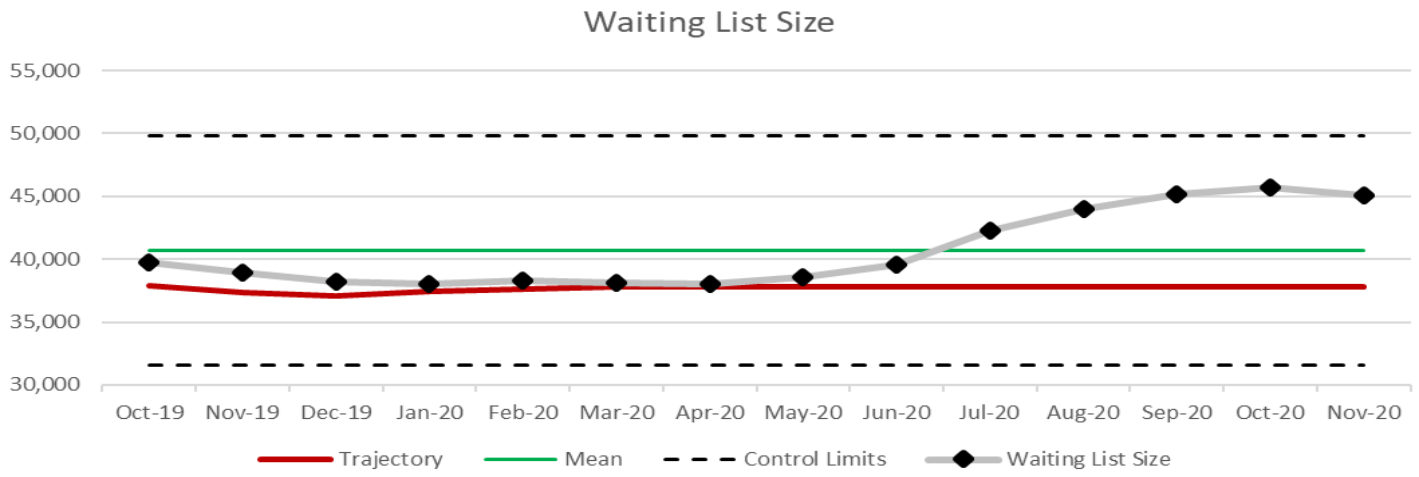
IMPROVE CLINICAL OUTCOMES – WAITING LIST SIZE

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services





Challenges/Successes

Overall waiting list size has decreased from October, with November total waiting list decreasing by 561 to 45,113. The incompletes position for November is now approx. 6081 more than the March 2018 (39,032) target.

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

- Ophthalmology + 220
- Gynaecology + 146
- Paediatrics + 37
- Colorectal Surgery + 36
- Nephrology + 29
-

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

- Cardiology - 149
- Neurology - 145
- Rheumatology - 129
- Trauma & Orthopaedics - 111
- Urology - 101

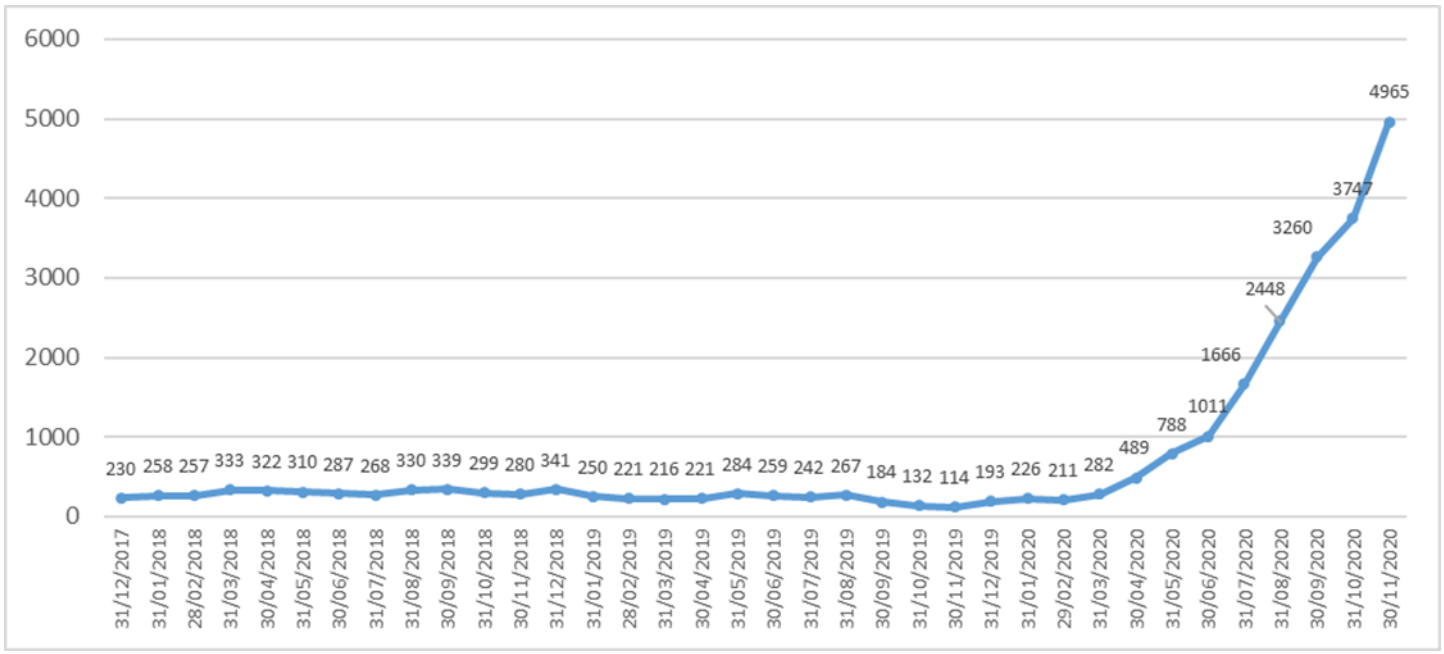
Actions in place to recover

The longest waiting patients are usually tracked and discussed at the weekly PTL meeting, however, due to the current situation, this is currently stood down and concerns are raised at the bi-weekly RTT Recovery and Delivery meeting.

November showed 4965 patients waiting 40 weeks and above as the chart below shows.

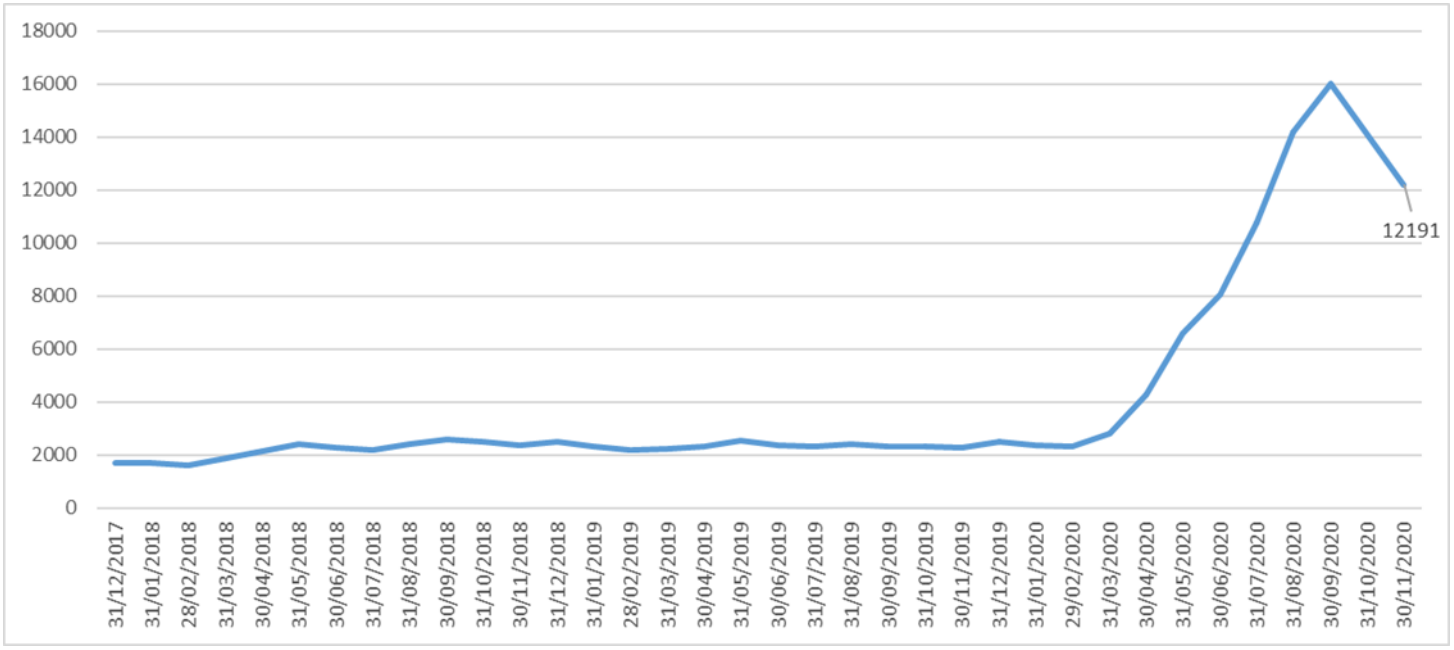
October to November saw an increase of patients waiting over 40 weeks, +1218, with Ophthalmology (+376) showing the largest increase. Seven specialties reduced their position compared to last month, with General Surgery showing the best improvement of -15 patients from last month.

Total Number of Incomplete Patient Pathways at 40 Weeks and Above for ULHT by Month



The chart below illustrates incomplete patient pathways waiting 26 weeks and above. Progress up to 30th November, shows a decrease of 1901 patients from October. Twenty-four specialties decreased their position with the largest decrease being seen in Ophthalmology, - 440. The largest increase was seen in Paediatrics, +31.

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

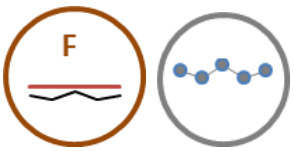


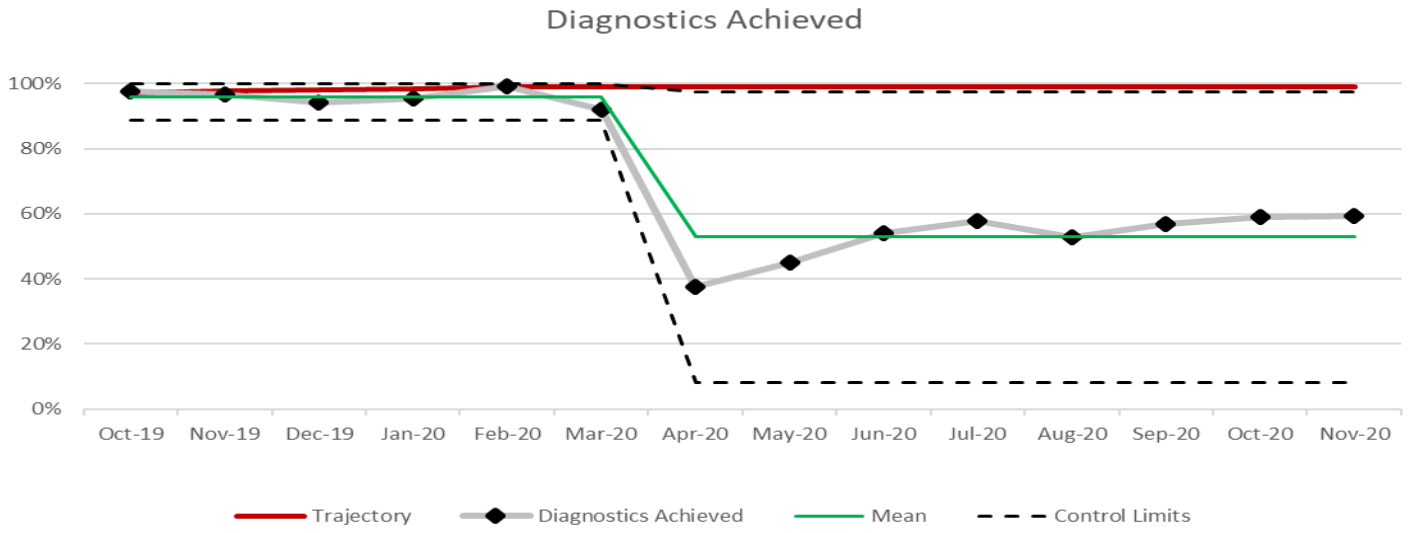
IMPROVE CLINICAL OUTCOMES – DIAGNOSTICS

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services





Challenges/Successes:

DM01 return for Nov was 59.24%, which is an improvement from October 59.11%.

CT - although the number of breaches has reduced from October as return

increasing inpatient demand is taking outpatient in GP capacity.

Growing backlog of cardiac CT's will need additional capacity from cardiology consultants.

Sourcing and retaining agency staff to operate the additional CT's is proving difficult.

Physiological Sciences

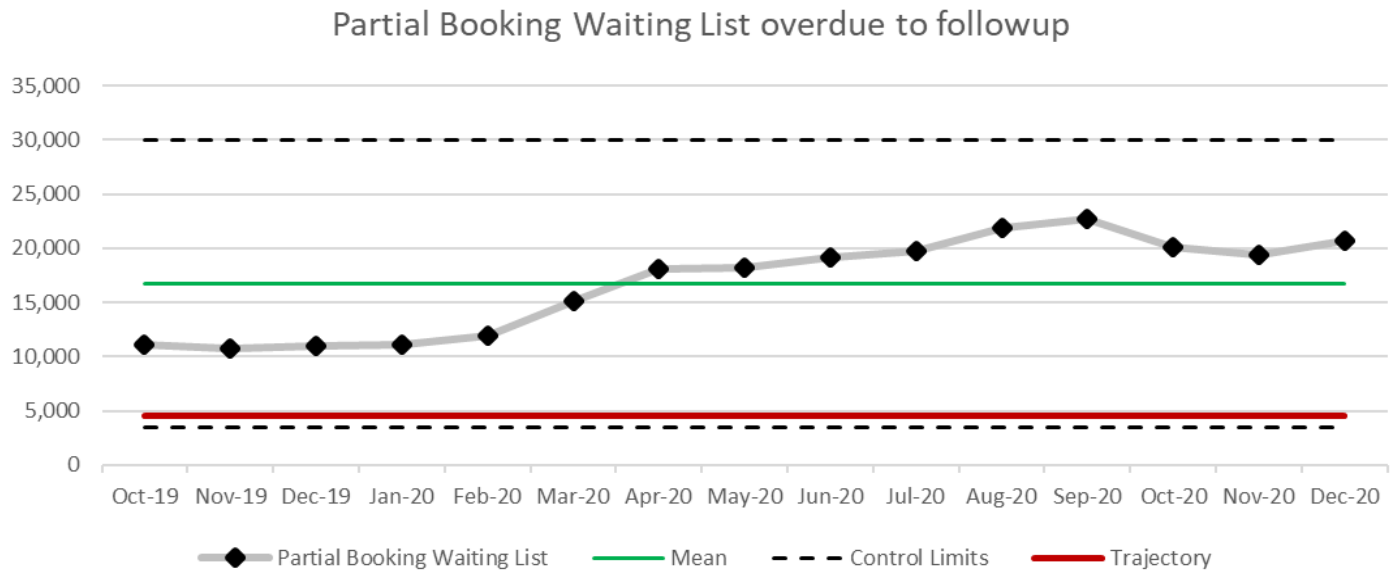
- There are growing backlogs for Respiratory Physiology.
- All Physiology Sciences that sit within the diagnostic clinical business unit have gone through a mini risk summit, where we have looked at the backlog and discussed possible plans to recover the position. We should have these in draft form by the end of this December.
- Waiting lists are monitored weekly.
- Additional capacity is being sourced via outsourcing, additional lists and overtime.
- Cardiac Physiology had over 2000 breaches in November this is a regional issue and Medicine are working with the region on solutions going forward.

IMPROVE CLINICAL OUTCOMES – PARTIAL BOOKING WAITING

Executive Lead: Chief Operating Officer

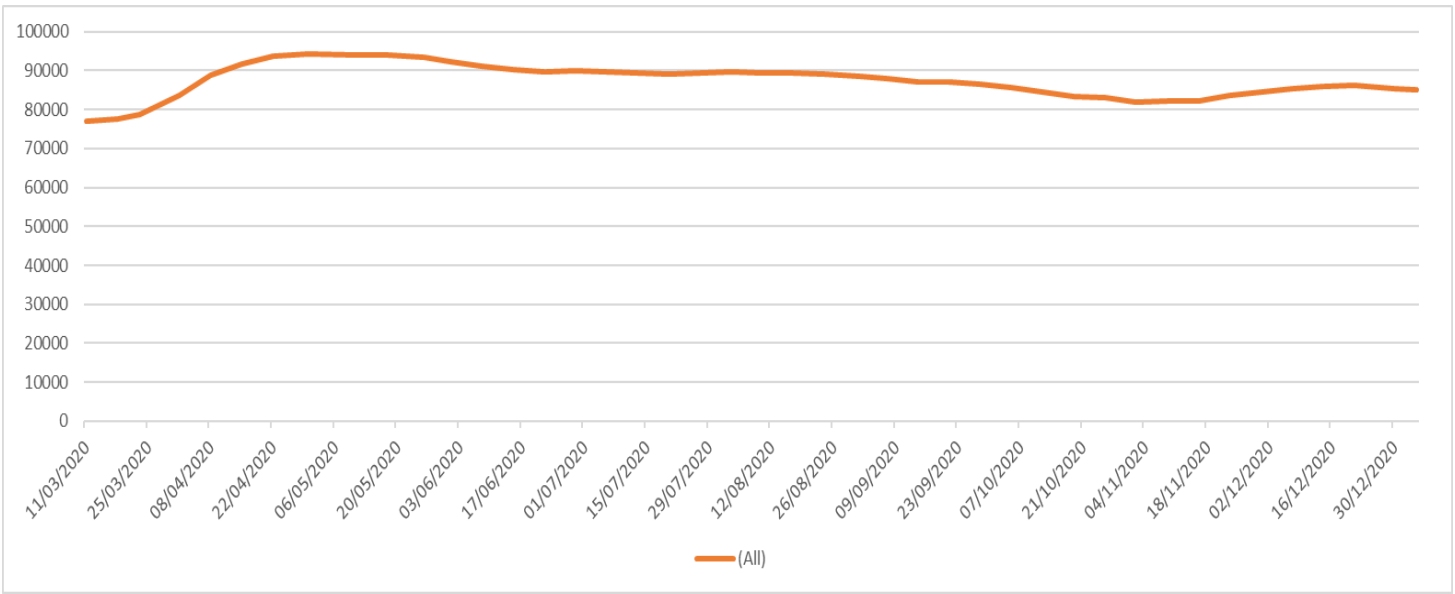
CQC Domain: Responsive

Strategic Objective: Services



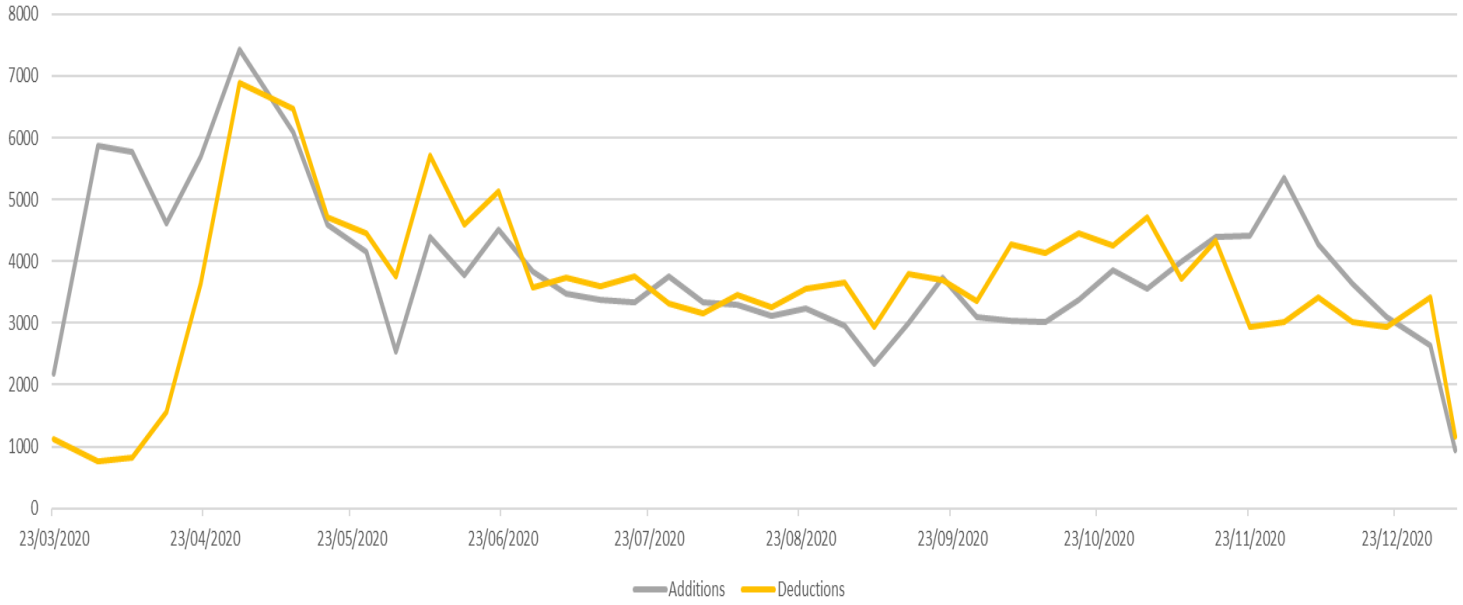
Challenges/Successes:

Following a period of growth through March to May due to a significant reduction in routine outpatient activity because of the Trust's response to COVID-19 first wave. The Trust started to reduce the PBWL in line with its recovery plan to reduce the PBWL to pre covid levels. The increase in covid patients within the Trust has impacted on the recovery plan and has meant reduced activity in certain specialities, as they have been required to cover wards. It has also impacted on the workforce availability which has meant some outpatient clinics have had to be cancelled. This has not impacted all specialities and some specialities eg ophthalmology and urology have continued to make improvements.



Actions in place to recover:

With the workforce pressures in place we have continued where possible with the administrative validation, clinical triage, introducing PIFU (patient Initiated Follow Ups) and the scaling up of technology enabled care. These actions have had to be scaled back and are dependent on the speciality involved. We are continuing with our PBWL meetings to offer support were possible but additions and deductions are currently going in the wrong direction.

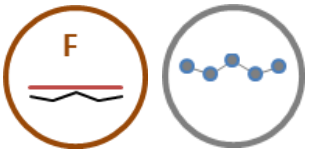


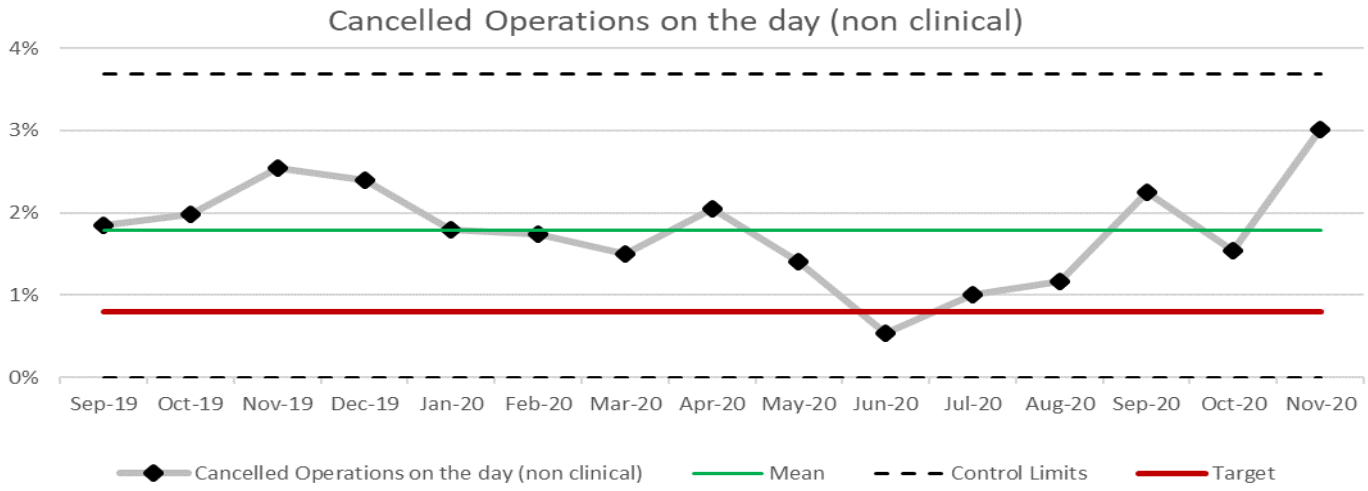
IMPROVE CLINICAL OUTCOMES – CANCELLED OPS

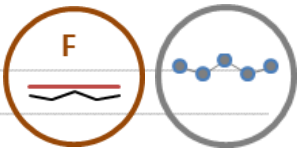
Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services







Challenges/Successes:

There has been an increase in the number of on the day cancellations. Reasons for cancellations include patients being medically unfit, patients no longer requiring the surgery, lack of theatre time, patients being unwell/ not wishing to proceed.

Actions in place to recover:

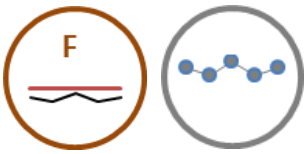
The list allocations are being reviewed to see if any changes can be made to reduce the volume of cancellations.
Analysis ongoing to ensure coding of cancellations is accurate

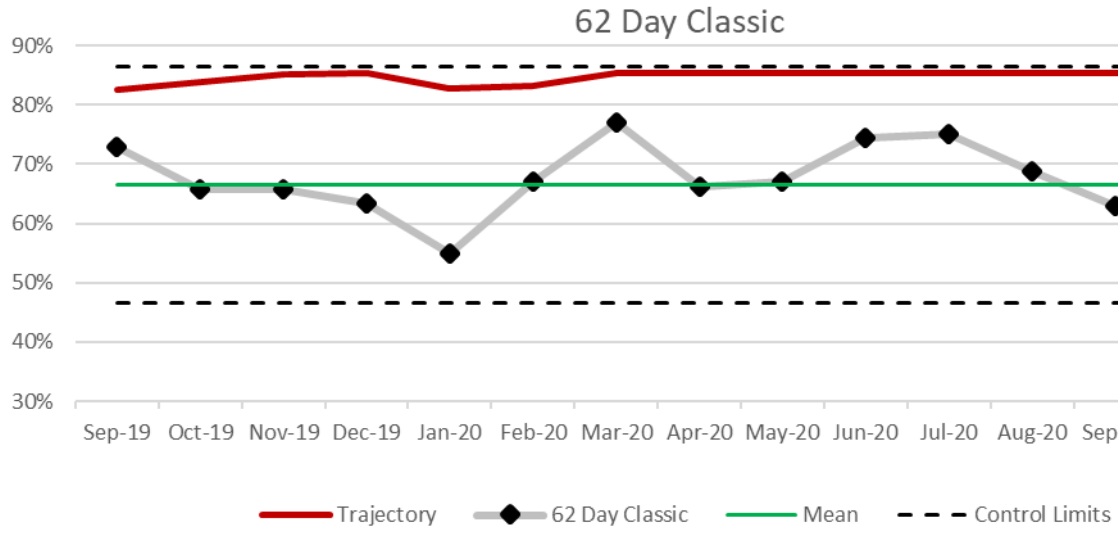
IMPROVE CLINICAL OUTCOMES – CANCER 62 DAY

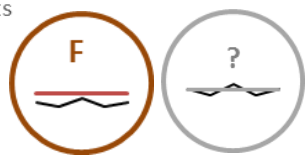
Executive Lead: Chief Operating Officer

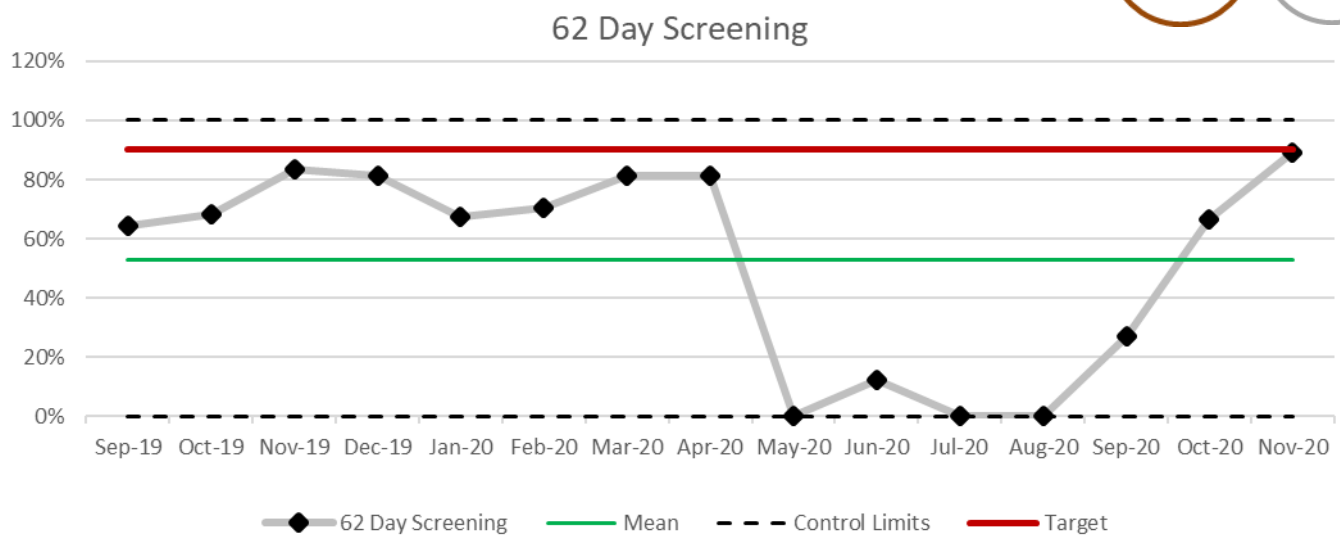
CQC Domain: Responsive

Strategic Objective: Services



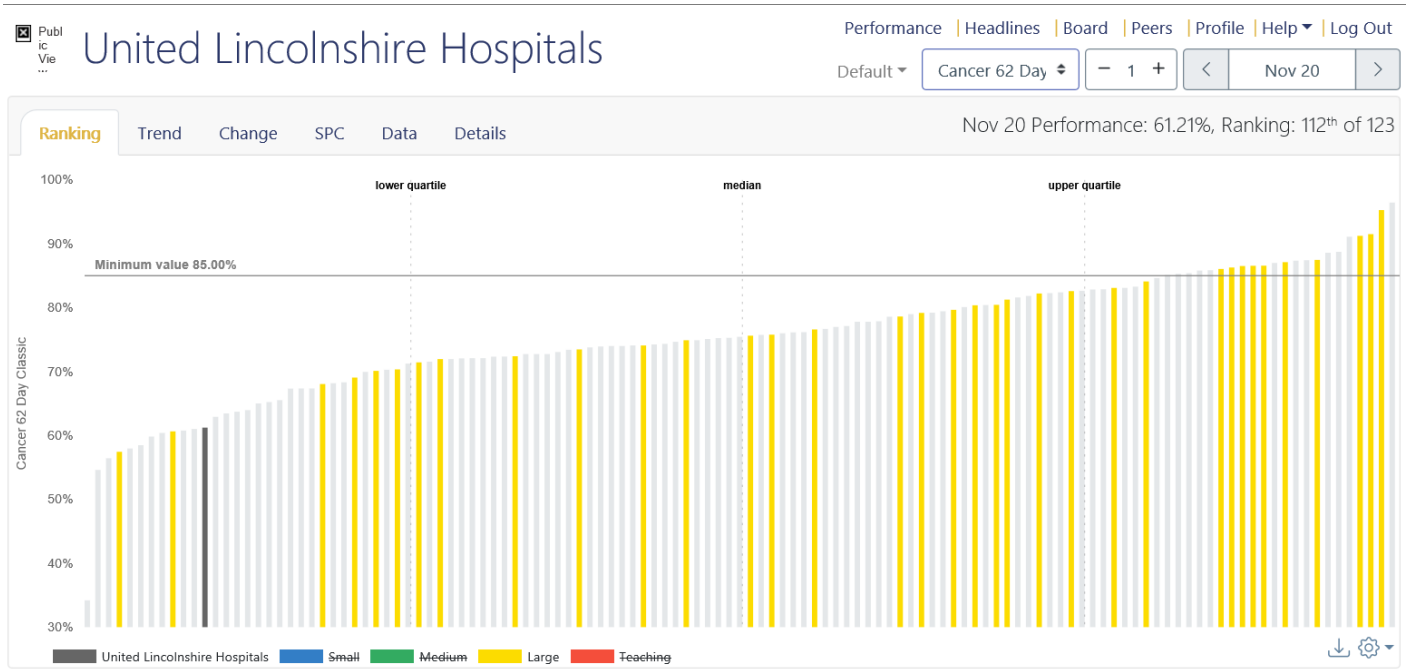


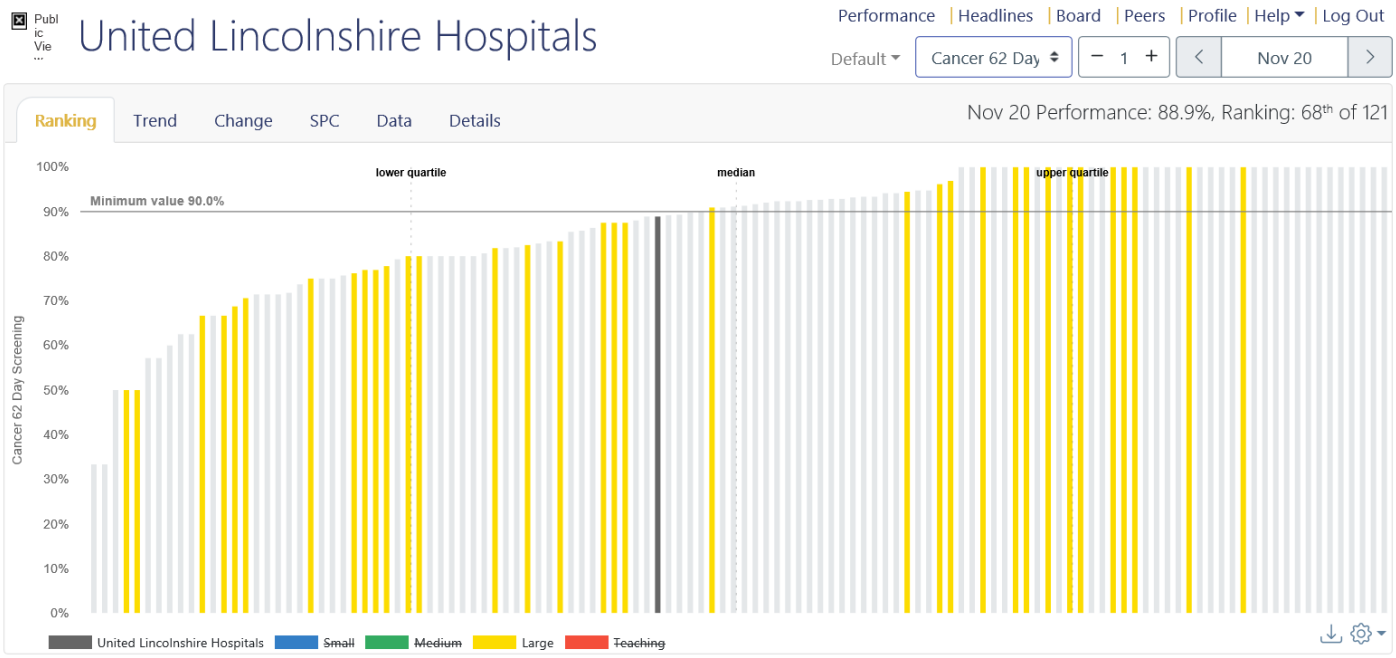


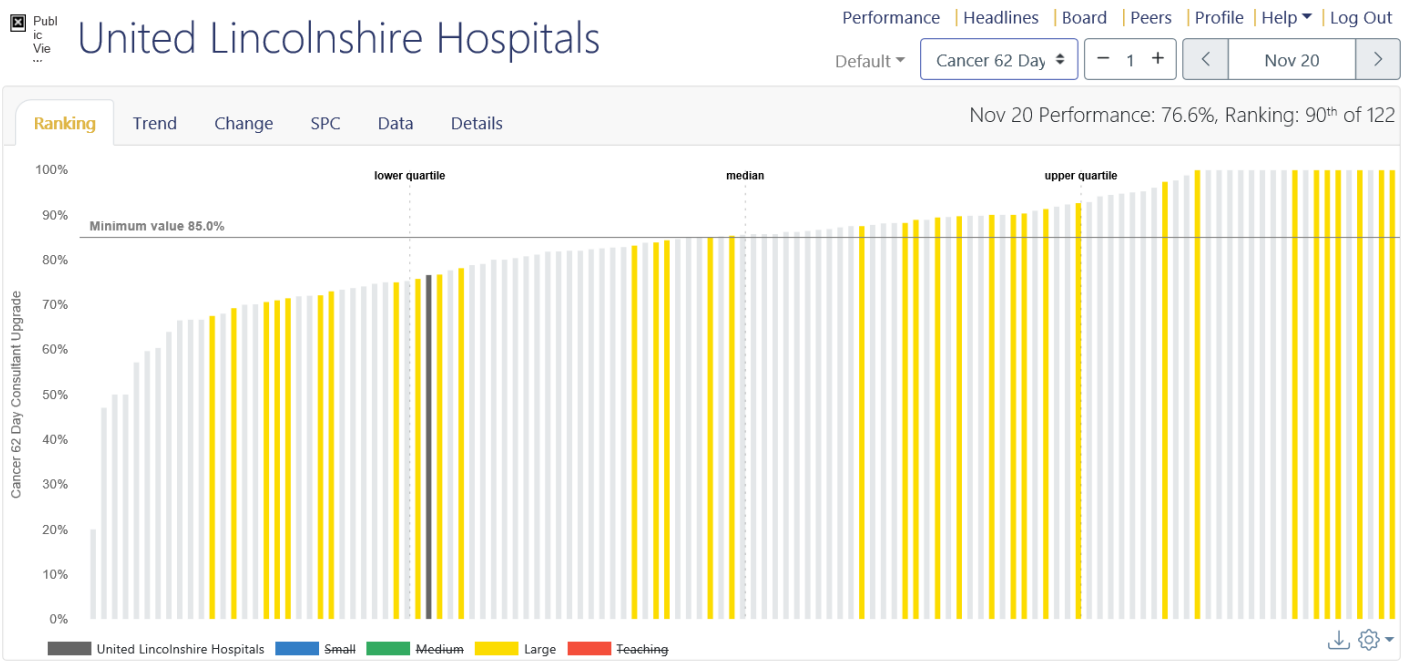


Challenges/Successes

In November our 62 Day Classic performance increased by 6.1% compared to October, at 61% placing us both below the national average (75.55%) and ahead of the lower quartile.







Early indications are that our December 62 Day Classic performance will be circa 60%

Challenges to our performance include:

- Inappropriate referrals from GPs (eg not having face-to-face appointment prior to referral)
- Patient engagement in diagnostic process (reluctance to visit hospitals during COVID-19 with the second surge threat, and now reality, amplifying this effect)
- Increased time to book diagnostics with patients due to COVID requirements (for Endoscopy it has increased from 6 mins to 16 mins per patient) can add to patient anxiety and reluctance to attend
- Capacity not always where patient is willing to travel.
- Patient acceptance & compliance with swabbing and self-isolating requirements
- Limited outpatient capacity due to social distancing requirements
- Reduced theatre capacity across the Trust, all Specialties vying for additional sessions
- Severely restricted access to Independent Sector capacity relative to regional colleagues
- Recognition that backlogs created during COIVD-19, due to stopped/reduced services, are still progressing through diagnostic and treatment pathways
- 62 Day backlogs significantly in excess of pre-COVID levels for Colorectal, Head & Neck, Upper GI and Urology
- 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

<u>Actions in place to recover:</u>

- 28 Day FDS identified as Trust's single cancer performance work stream in the Integrated Improvement Program for 2021-22.
- Additional theatres being installed at Grantham for Breast & Gynaecology, with first due 14th January 2021 (coming from Italy but delayed as factory closed due to COVID).
- Breast Services review (awaiting final report from NHSI support)

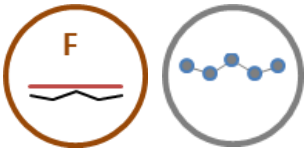
- Review of Colorectal theatre list scheduling to better align with clinician availability and consideration of moving level 1 patients to Grantham.
- Additional relocatable CT at Boston.
- Bid for 'blue' CT at Grantham.
- Endoscopy booking team recruited 3 WTE – currently undertaking training.
- 2 WTE Endoscopist posts going through the interview and selection process.
- £1.26m NHSE funding awarded for replacement of Pilgrim decontamination unit as well as new stacks and scopes. Decontamination unit at Boston now signed off with orders placed for stacks and scopes (scope guide for Grantham, stacks and scopes for Lincoln and Boston) – delivery time approx. 4 weeks.
- Dedicated admin resource within Colorectal CBU to support clinical engagement.
- Return of H&N consultant (from sabbatical) and third post to be re-advertised.
- Oncology Fragile Service under review with new locum consultant started 14th December (urology, breast and non-melanoma skin). Two Medical Oncologists are due to start in April 21 (Urology, Renal , Lung, Skin and Breast).

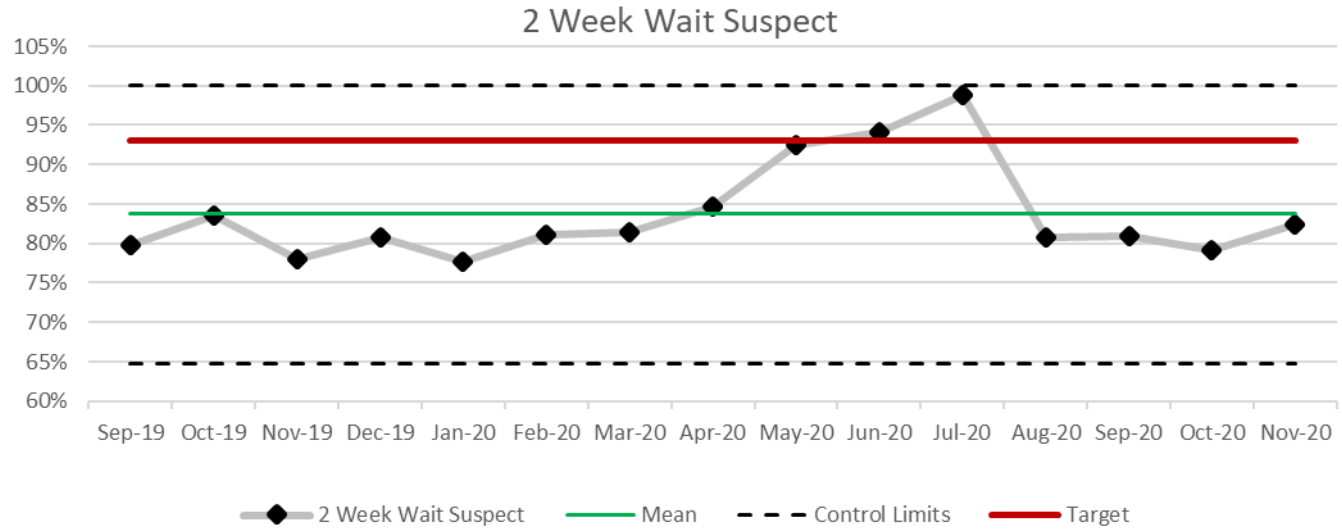
IMPROVE CLINICAL OUTCOMES – CANCER 2 WEEK WAIT

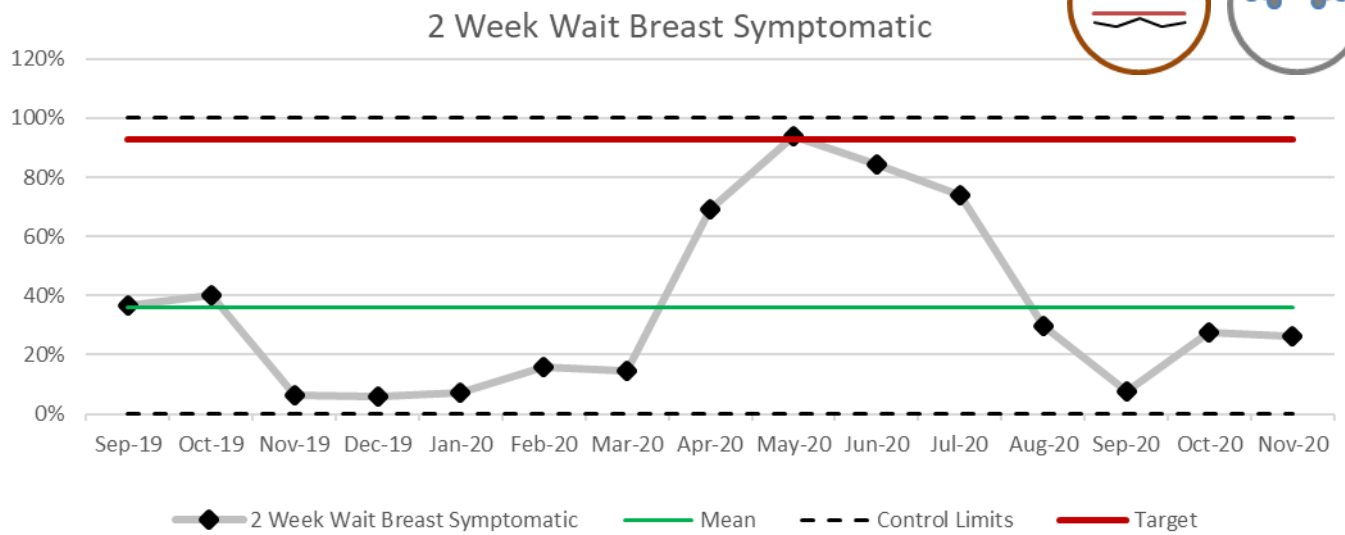
Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services

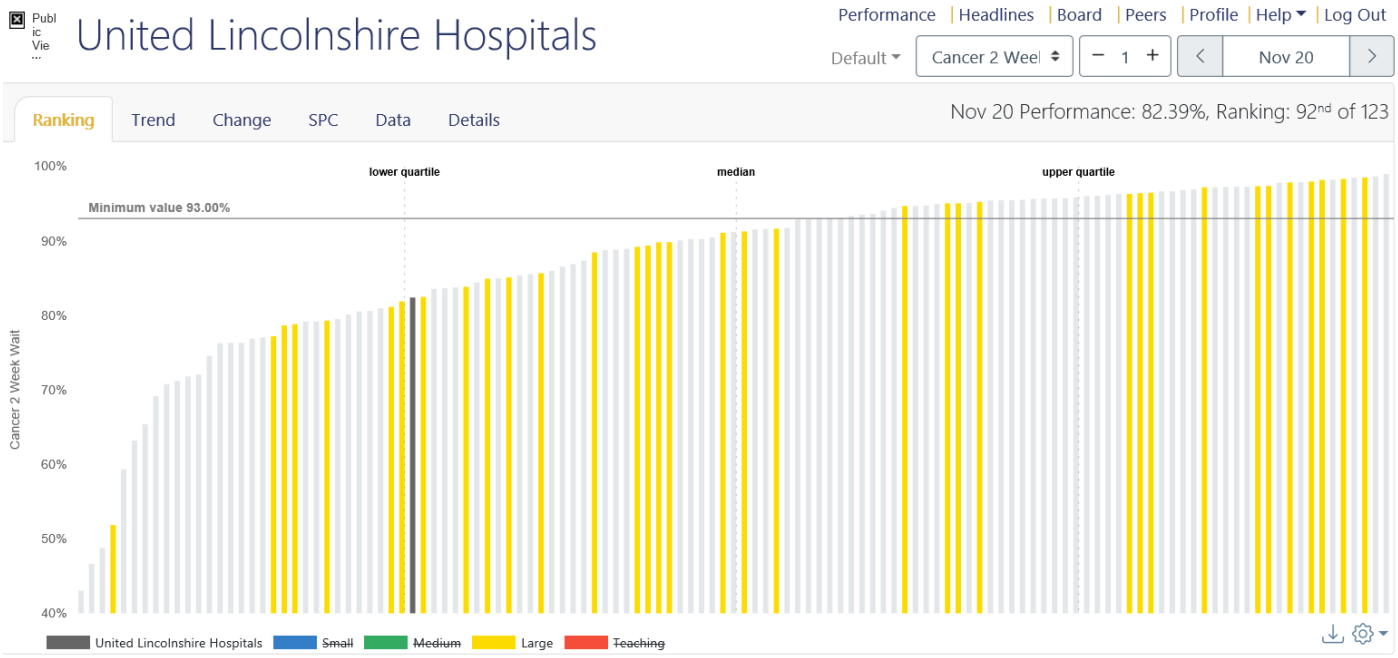


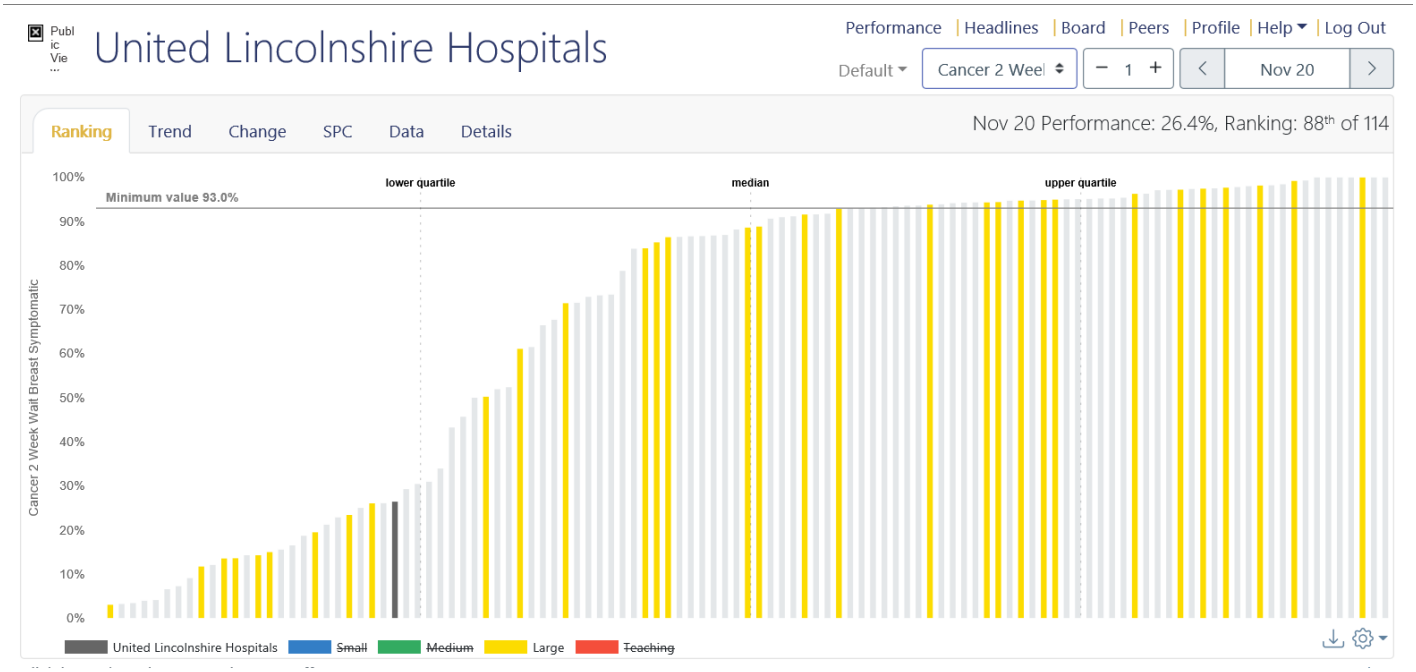




Challenges/Successes

The Trust's 14 Day performance continues to be significantly impacted by the current Breast Service One-Stop appointment alignment issues - 69% of the Trust's 14 Day breaches were within that tumour site. The other tumour site that considerably under-performed include Gynaecology (13%).





Actions in place to recover:

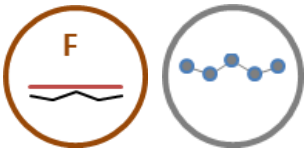
- Work continues to align all 2ww Referral forms to NG12.
- Breast Services review (awaiting final report from NHSI support).
- New Gynae ultrasound Direct Access pathway due to commence w/c 9th November but delayed due to COVID surge.
- H&N Neck Lump Direct Access pathway pilot commenced on 16th November.
- Lung Direct Access pathway to commence Trust wide.
- Pilot of triaging all Skin 2ww referrals – early stage of development at present, no start date identified.
- Project to establish Upper GI Direct Access pathway by Jan 21.
- Urology continued review of cystoscopy provision (on hold during COVID wave 2).

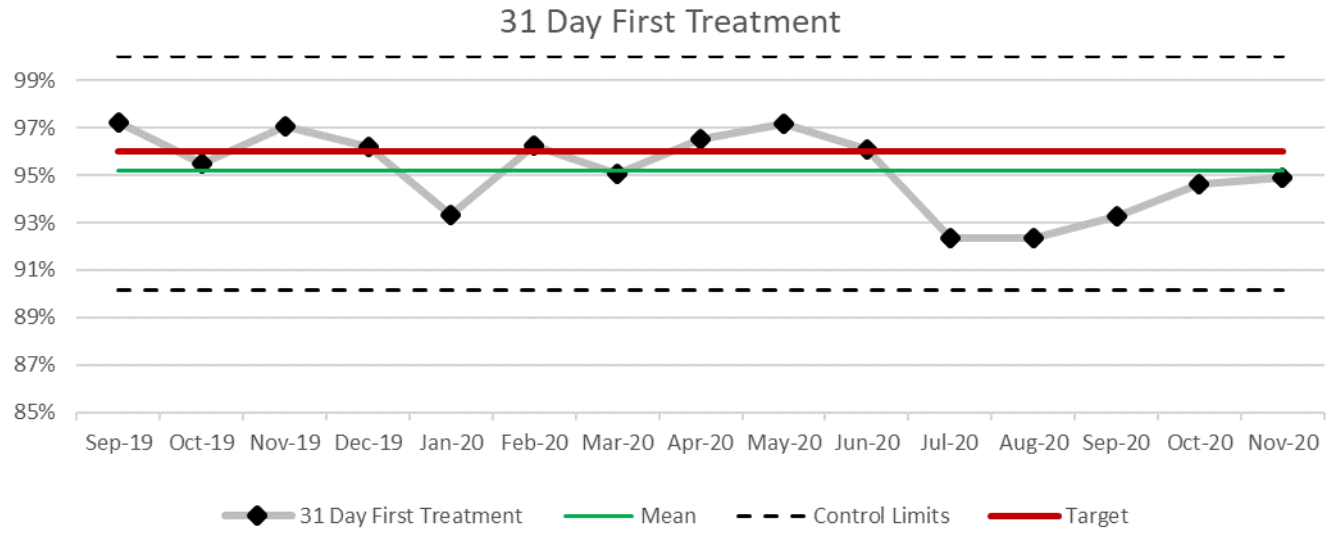
IMPROVE CLINICAL OUTCOMES – CANCER 31 DAY

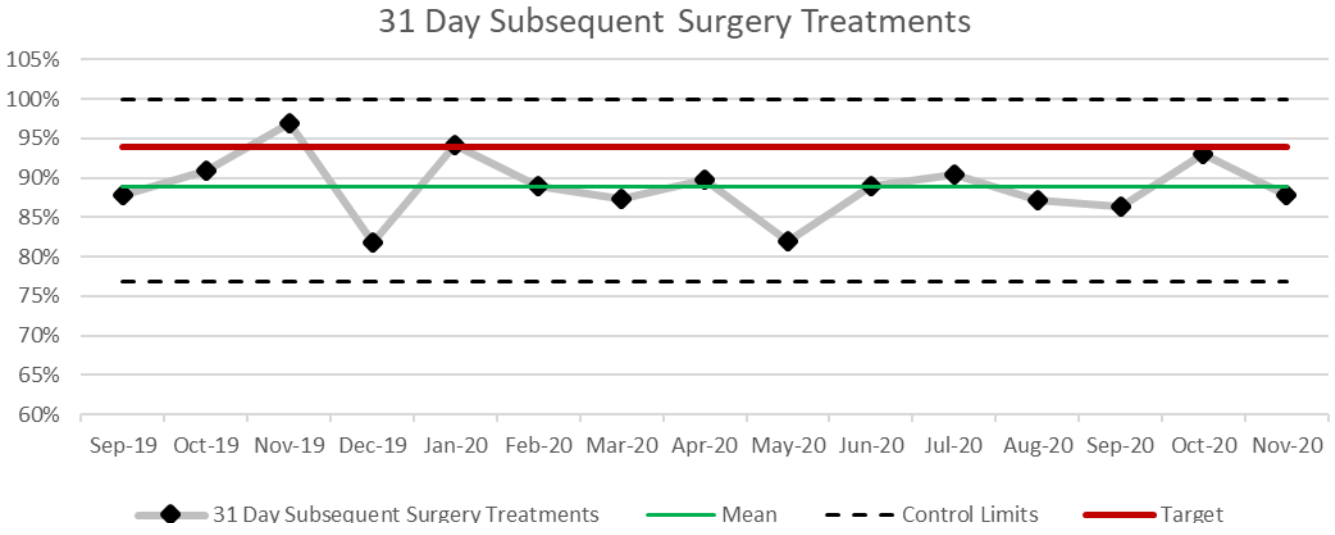
Executive Lead: Chief Operating Officer

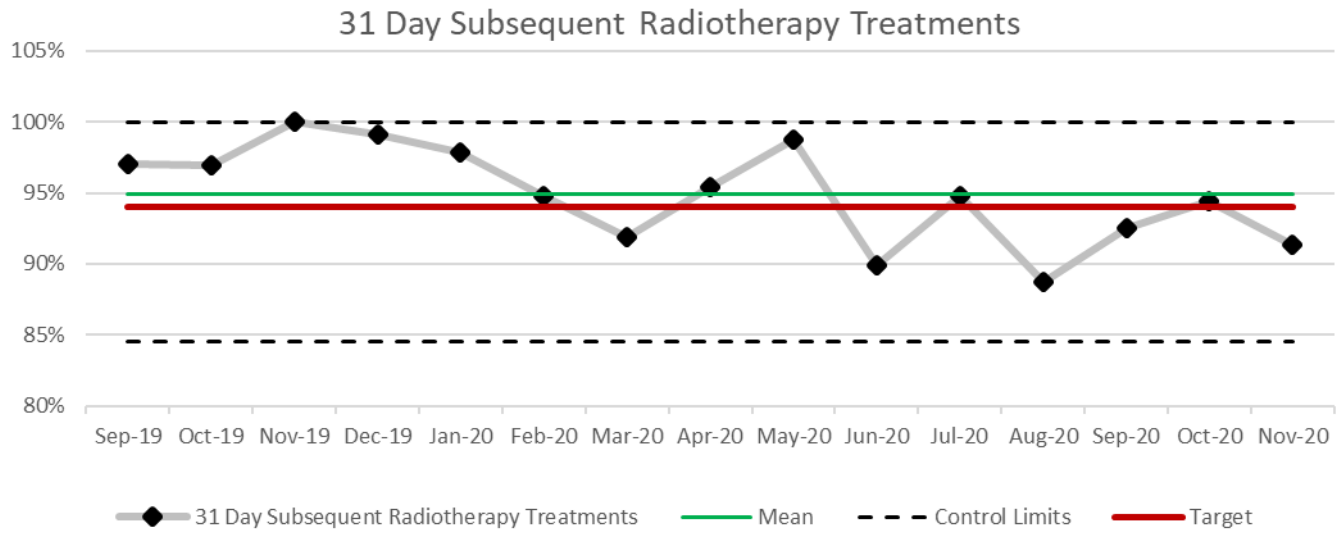
CQC Domain: Responsive

Strategic Objective: Services



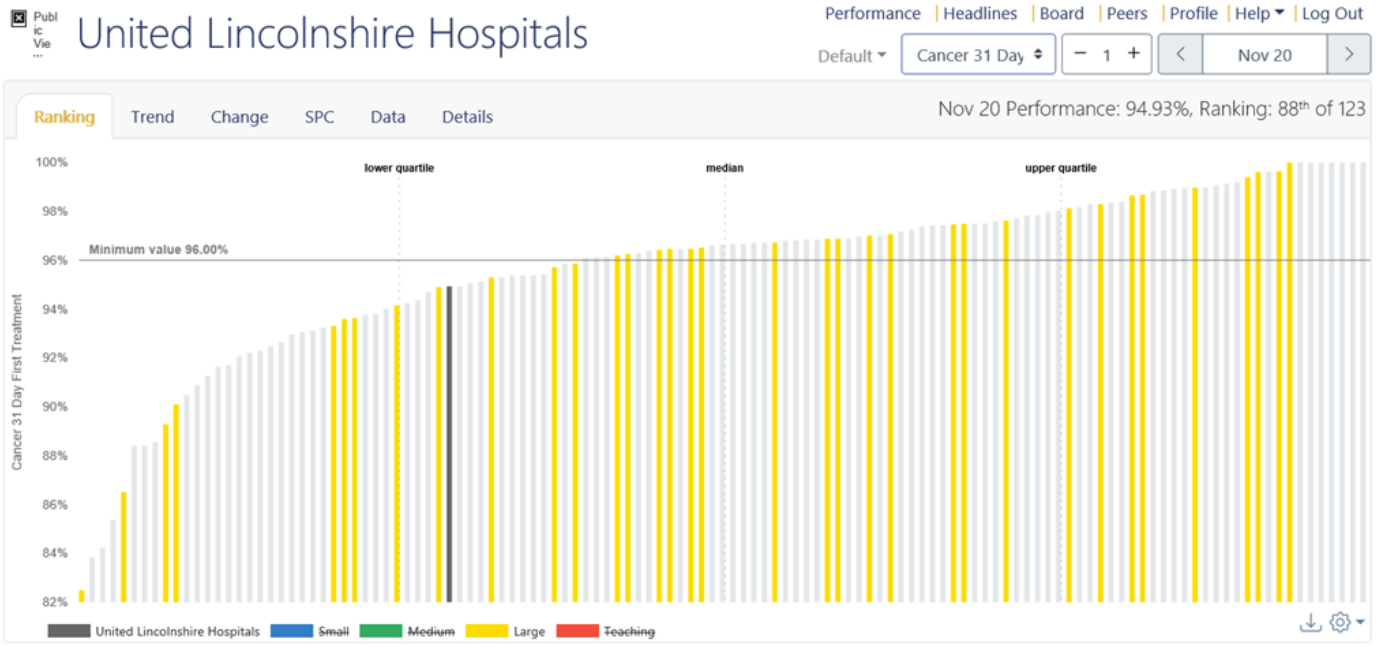


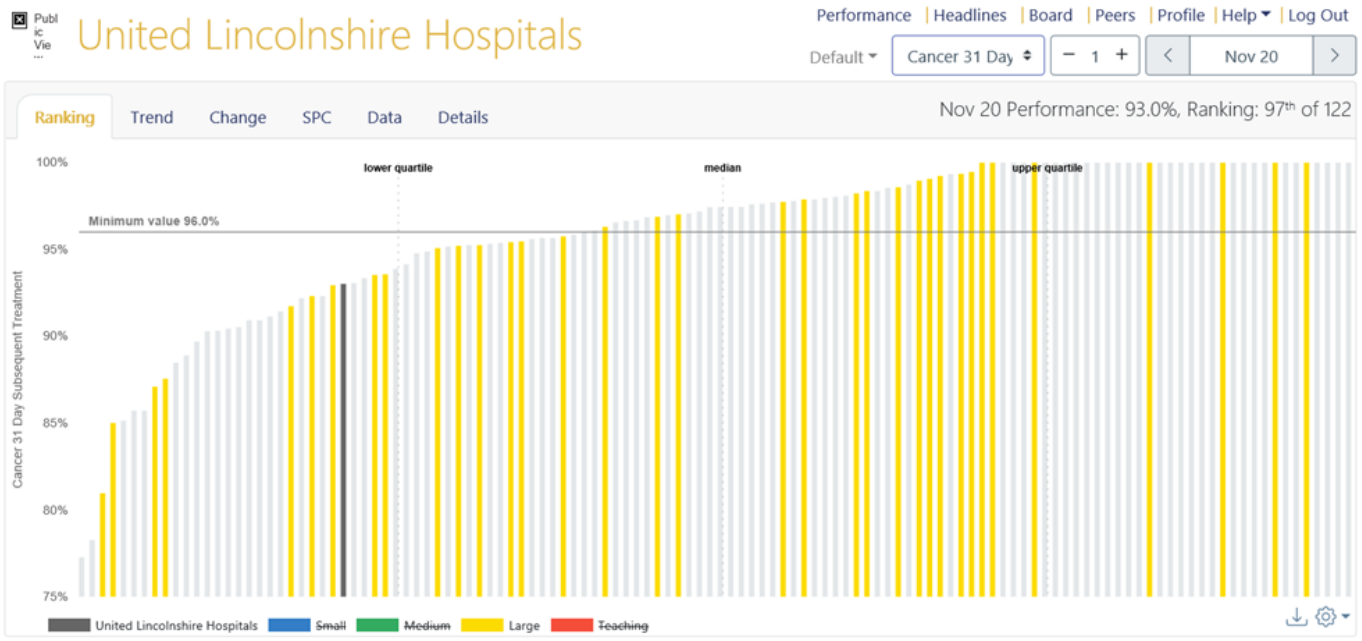




Challenges/Successes

The 31 Day standards were missed primarily due to the impact of COVID (the reduction in capacity due to social distancing).





Actions in place to recover:

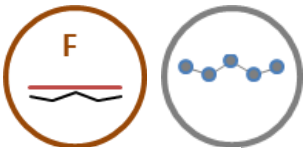
- Additional theatres being installed at Grantham for Breast & Gynaecology, with first due 14th January 2021 (coming from Italy but delayed as factory closed due to COVID).
- Review of Colorectal theatre list scheduling to better align with clinician availability and consideration of moving level 1 patients to Grantham.
- Return of H&N consultant. Unfortunately the 3rd post appointed to and due to start in December had to withdraw. This post has now been re advertised and is due to be shortlisted.
- Oncology Fragile Service under review with new locum consultant started 14th December (urology, breast and non-melanoma skin). Two Medical Oncologists are due to start in April 21 (Urology, Renal , Lung, Skin and Breast).

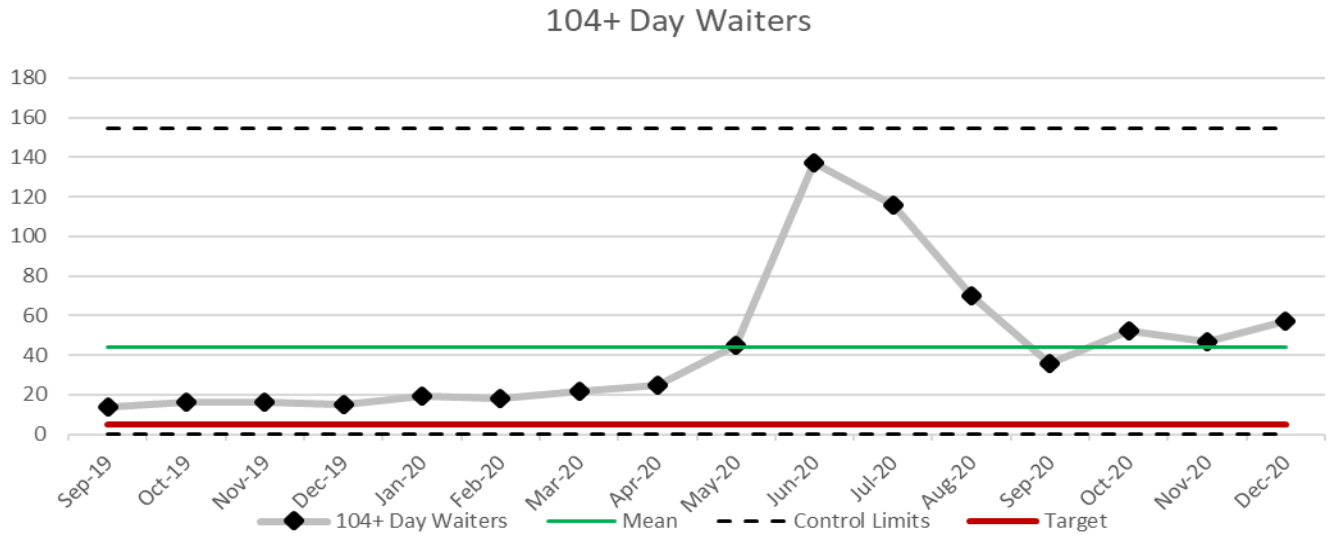
IMPROVE CLINICAL OUTCOMES – CANCER 104+ DAY WAITERS

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services

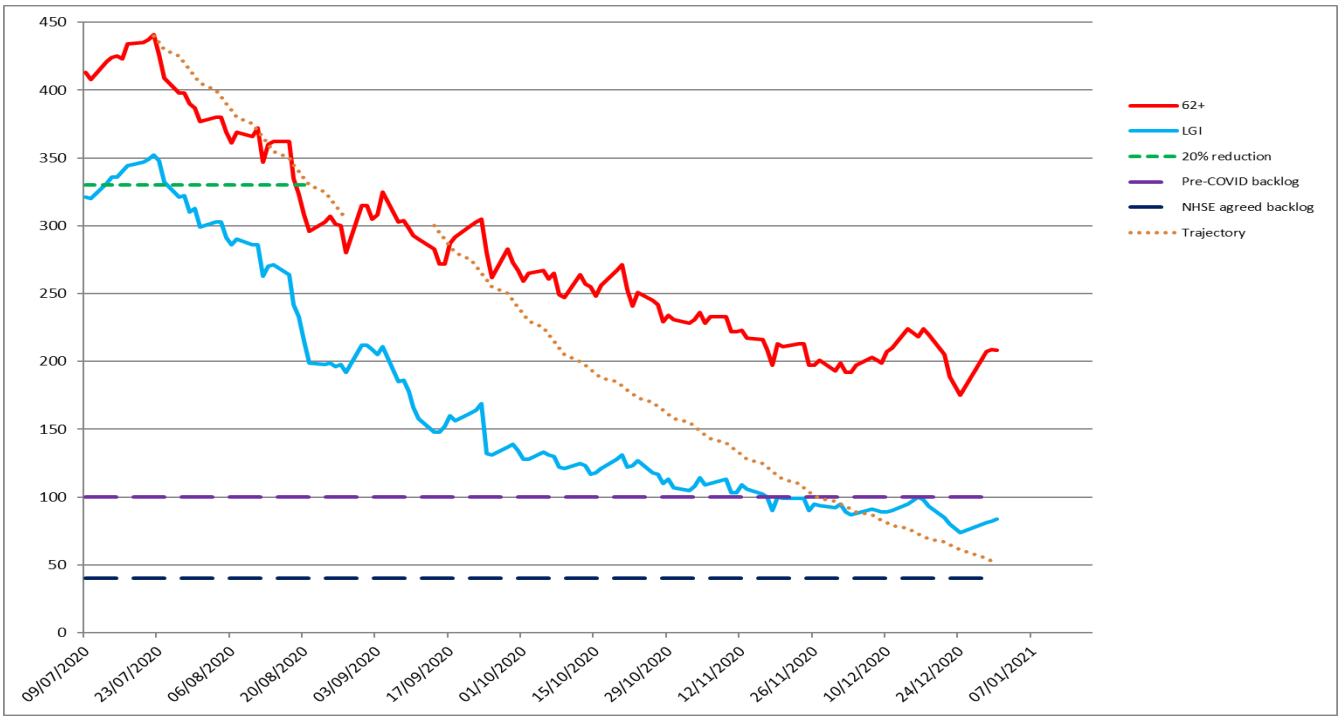




Challenges/Successes

Though the backlog has been reducing, it has not been at the speed required.

- As of 8th of January the 62 Day backlog is at 224 patients (from 441, target – below 40) 49% Reduction
- In August Colorectal patients accounted for c.70% of backlog and is now c.43%
- Of the other tumour sites, Head & Neck, Gynae, Urology and Upper GI remain outliers compared to pre-COVID levels



104 Day Waiters as of 7th of January is at 57 (from 163, target – below 10) **65% Reduction**

- 32Colorectal
- 7 Urology
- 6 Head and Neck
- 5 Lung
- 2 each Upper GI and Haematology
- 1 each Gynae, Breast and Sarcoma

Over 24% of the 104 Day Waiters have complex/mental health needs requiring significant specialist nurse involvement (Pre-Diagnosis CNS)

Challenges to reducing the backlogs:

- Patient engagement in diagnostic process (reluctance to visit hospitals during COVID-19 with second surge threat, and now reality, amplifying this effect)
- Increased time to book diagnostics with patients due to COVID requirements (for Endoscopy it has increased from 6 mins to 16 mins per patient) can add to patient anxiety and reluctance
- Capacity not always where patient is willing to travel
- Patient acceptance & compliance with swabbing and self-isolating requirements
- Limited outpatient capacity due to social distancing requirements
- Reduced theatre capacity across the Trust, all Specialties vying for additional sessions
- Severely restricted access to Independent Sector capacity relative to regional colleagues
- Recognition that backlogs will be created during COIVD-19 wave 2, due to stopped/reduced clinical services.
- Capacity within Divisions to give necessary attention to Cancer
- 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

<u>Actions in place to recover:</u>

As for the 62 Day Performance actions:

28 Day FDS identified as Trust's single cancer performance work stream in the Integrated Improvement Program for 2021-22.

Additional theatres being installed at Grantham for Breast & Gynaecology, with first due 14th January 2021 (coming from Italy but delayed as factory closed due to COVID).

Breast Services review (awaiting final report from NHSI support)

Review of Colorectal theatre list scheduling to better align with clinician availability and consideration of moving level 1 patients to Grantham.

Additional relocatable CT at Boston

Bid for 'blue' CT at Grantham

Endoscopy booking team recruited 3 WTE – currently undertaking training.

2 WTE Endoscopist posts going through the interview and selection process.

£1.26m NHSE funding awarded for replacement of Pilgrim decontamination unit as well as new stacks and scopes. Decontamination unit at Boston now signed off with orders placed for

stacks and scopes (scope guide for Grantham, stacks and scopes for Lincoln and Boston) – delivery time approx. 4 weeks.

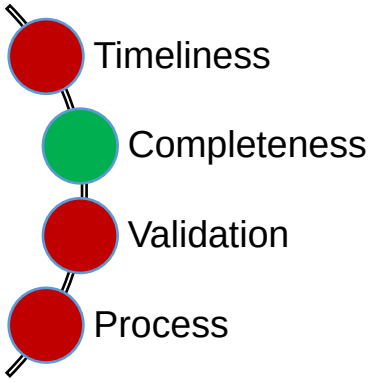
Dedicated admin resource within Colorectal CBU to support clinical engagement

Return of H&N consultant (from sabbatical) and third post to be re-advertised

Oncology Fragile Service under review with new locum consultant started 14th December (urology, breast and non-melanoma skin). Two Medical Oncologists are due to start in April 21 (Urology, Renal , Lung, Skin and Breast).

APPENDIX A – KITEMARK

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



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

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*2 February 2020*
Item Number	*Item 12.1*
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 15th January 2021, the meeting was held with a reduced agenda in line with the Trust approach during the covid response and considered the following items:

External Audit Progress Report

The Committee noted that Mazars the Trust's newly appointed extrenal auditors were progressing plans to conduct their interim audit work in early February, following which the final audit plan would be produced and shared with the Committee for review and approval. The Committee noted that final national guidance had not yet been issued by the regulator in relation to all of the elements of the year end work however it was expected that the Quality Account would not be subject to audit and the annual reporting requirements would be reduced as had been the case for the previous year end. Mazars advised that expenditure incurred as a result of the covid response would be a specific feature of the year end audit.

The Committee noted the publication of the Financial Reporting Council's Audit Quality Inspection and asked that Mazars addressed the areas raised in future papers presented to the Committee.

Internal Audit

The Committee were advised of progress against the Internal Audit Plan 2020/21 and specifically sought assurances in relation to the ability of Internal Audit to complete the necessary elements of the plan which would allow the production of a Head of Internal Audit Opinion for the Trust. The Trust Internal Audit providers were able to confirm that there were eight reviews which required completion to achieve this, two of these were already in progress. Assurance was sought from the Committee that the capacity was available to deliver the remainder of the planned work. This was confirmed by the Internal Audit Team and the Trust. A revised escalation process had been agreed with the Trust to ensure that all key contacts are clearly identified and agreed at the start of an audit, the scope is formally signed off and all final reports are completed on a timely basis.

The Committee received final reports on Medicines Management, Workforce Planning, Temporary Staffing, Governance Review (all Partial Assurance with improvement required). All reports would be considered by relevant assurance committees of the Board with a focus on implementation of recommendations.

The Committee sought assurance on the outstanding review of the Trust Operating Model. The Internal Audit provider advised that this report was now planned for quarter four.

The Committee noted that there were 35 outstanding audit actions, two high risk, 20 medium risks and 13 low risks. The Committee noted that this was an improved position but that it was essential that momentum was maintained and that audit recommendations completion dates should not be allowed to

unnecessarily extend. The Committee asked that the high risk outstanding actions were cross referenced to the Trust Risk Register and action taken to address implementation.

Internal Audit confirmed there would be a review of what was proposed in the audit plan for 2021/22 as it was acknowledged that the Trust risks may have changed. This will be undertaken in conjunction with Trust management. The final plan will be reviewed at the next meeting of the Committee.

Counter Fraud

The Committee reviewed and approved the Local Counter Fraud Specialist Progress Report. The Committee were assured that the Trust had taken steps to increase the counter fraud capacity. The Committee noted the heightened risk of fraud arising from the pandemic.

Compliance Report

The Committee received the regular report on compliance noting that this covered the period from October 2020 to December 2020. The Committee noted the level of waivers of standing orders remained high. The Committee noted that the response to Covid-19 had impacted on this area.

The Committee asked that the report was shared with at the Trust Executive Leadership Team meeting as it flagged a number of areas which were alerting related to cultures, behaviours and compliance.

Policies Management

The Committee received a report against progress with the actions to address outstanding policies. This supported the assurance rating for the well led objective within the Trust Board Assurance Framework.

Board Assurance Framework

The Committee confirmed that the Board Assurance Framework remained relevant and effective for the Trust and the focus was on the appropriate risks. The Committee noted that objective 2c – Well Led Services was the remit of the Audit Committee. The Committee noted that the work programme had been updated accordingly to reflect the assurances that the Committee would seek in respect of this. The Committee confirmed the Amber rating for objective 2c.

One element of objective 2c was the implementation of a robust policy management system. The Committee received a report and noted the limited assurance provided. The Committee noted the actions in place to improve processes and ensure policies were adequately maintained and used. The Committee asked for assurance that risks associated with out of date policies were being mitigated against.

Risk Management

The Committee noted the increasing number of overdue risks and the risk of the failure to complete reviews and update these. The Committee requested the attendance of the Deputy Director of Clinical Governance at the next meeting to seek assurance on the actions being taken to strengthen controls.

Meeting	*Trust Board*
Date of Meeting	*Tuesday, 2 February 2021*
Item Number	*Item 12.2*
Strategic Risk Report	
Accountable Director	*Dr Karen Dunderdale, Director of Nursing*
Presented by	*Dr Karen Dunderdale, Director of Nursing*
Author(s)	*Paul White, Risk & Incident Lead*
Report previously considered at	*N/A*

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

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

Recommendations/ Decision Required	*Trust Board is invited to review the report and identify any areas of strategic risk requiring further action*

Executive Summary

- This Strategic Risk Report focuses on the highest priority risks currently being managed within the Trust as the impact of the second wave of the Covid-19 pandemic continues to be felt across all divisions and corporate services.
- 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
- 2 strategic finance risks have been reviewed and reduced in rating from Very high risk (20) this quarter:
  - Substantial unplanned expenditure or financial penalty – reduced to High risk (16)
  - Delivery of the financial recovery programme – reduced to Moderate risk (8)

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.

2. Strategic Risk Profile

2.1 There is 1 strategic quality & safety risk with a current rating of Very high risk:

Risk title (ID)	Local impact of the global coronavirus (Covid-19) pandemic (4480)		
Current risk rating	Very high (25)	**Risk lead**	Lisa Carroll
Lead group	Infection Prevention & Control Group		

Key Risk Indicators (KRIs):

- Number of Covid-19 confirmed cases within Lincolnshire – as of 22nd January 2021 there had been 2,474 Covid-19 inpatient admissions within ULHT
- Number of Covid-19 in-patients – 120 at Lincoln and 49 at Pilgrim on 22nd January 2021; COVID-19 numbers have remained relatively static for the past 40 days with daily discharges of COVID-19 positive patients balancing with new COVID-19 positive patients
- Patient deaths due to Covid-19 – total of 648 on 22nd January 2021, compared with 568 on 11th January and 329 on 4th December 2020.
- 24 Covid outbreaks declared within the Trust to 6th January 2021

Gaps in control & mitigating actions:

- England Covid alert level is at Level 5 (transmission is high or rising exponentially and there is a material risk of healthcare services being overwhelmed); third national lockdown in place
- London have declared a major incident on the basis of requiring multi-agency support to respond to a surge in Covid cases; other regions including the Midlands have been asked to support this response
- Intensive care capacity to be increased to 200%
- 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 is use for site access; PPE use; social distancing; patient admissions & discharges; staff rapid testing; use of essential equipment & oxygen
- Essential information to all staff continues to be provided through daily SBAR briefings; the Trust also continues to brief relevant external stakeholders
- Work is currently taking place to identify hospital-onset Covid-19 cases that meet the incident reporting and potentially the Serious Incident criteria
- Staff vaccination programme in progress – aim to offer first vaccine to all staff by end of January

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 (20)	**Risk lead**	Simon Evans
Lead group	Divisional Performance Review Meetings (PRMs)		

Key Risk Indicators (KRIs):

- A&E waiting times against the constitutional standard – 4-hour performance was 74.76%, for October; 72.78% for November; 70.54% for December
- 12hour+ A&E waits – there were 2 in October; 10 in November; and 41 in December

- Ambulance handover times >59 minutes – in October there were 270 ambulance handover delays; in November there were 388; in December, 350

Gaps in control & mitigating actions:

- Specific concerns relate to ambulance handover delays, increased non-elective admissions, stranded and super-stranded patients
- Lincoln site reconfiguration plans & business case for investment on Pilgrim site (with government funding)
- The U&EC improvement programme has undertaken an internal review of process, key stakeholders and original milestones where off track clear rectification plans are now in place
- A system wide resilience review has also been commissioned and completed
- System Resilience Group (SRG) is the vehicle by which assurance will be given, for example the 13 government funded schemes for LCC
- Partnership working within the system and a more intuitive winter plan at ULHT will support a more proactive response and delivery to system need

2.3 There are 2 strategic finance, performance or estates risks that were previously rated as Very high (20) and have now been reduced on review:

- Substantial unplanned expenditure or financial penalties (Risk ID 4383) has reduced to High risk (16)
- Delivery of the Financial Recovery Programme (Risk ID 4382) has reduced to Moderate risk (8)

2.4 There are 2 strategic people & organisational development risks with a current rating of Very high risk:

Risk title (ID)	Workforce capacity & capability (recruitment, retention & skills) (4362)		
Current risk rating	Very high (20)	**Executive lead**	Martin Rayson
Lead group	Workforce Strategy Group		

Key Risk Indicators (KRIs):

- Staff vacancy rates – overall vacancy rate reduced to 12.4% in September, to 12.3% in October and 12.2% in November, against a target of 12%
- Staff turnover rate overall is around 10% (as of September 2020)
- Sickness absence rates – the 12 month rolling absence rate to September 2020 was 5%; to October and November it was 4.9%, against a target of 4.5%; rolling year average does mask a significant increase due to Wave 2 COVID, peaking at above 10% pre-Christmas
- Bank & agency usage (medical and nursing) - Total agency spend increased in November, largely as a consequence of an increase in medical agency spend / increase in COVID related shifts covered by agency; Nursing agency expenditure also increased again in November as a consequence of the impact of COVID.

- Core Learning compliance rates – increased to 89.5% in September and to 90.5% in October and were 89.6% in November; the Trust achieved the 95% compliance rate for IG training during September

Gaps in control and mitigating actions:

- The Attendance Management System has successfully gone live with our first 2 Cohorts - Corporate back office staff not in Healthroster and ICT
- Workforce supply is a work-stream in the Integrated Improvement Plan.
- Medical bank is now at 40%, a continuous upward trend which is reducing the agency bill
- Director of Nursing has introduced a refreshed forum for transforming the nursing workforce with an early focus on nursing agency use and cost.
- Introduction of a Medical Transformation Programme; risk now driven by shortages in key fragile services.
- Focus in Restoration and Recovery phases on ensuring agency spend does not increase.
- Temporary impact of Covid-19 on workforce capacity across all services – additional occupational health support in place & being continually strengthened.
- Review of core-learning - content and way it is managed – February (was December).

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

Key Risk Indicators (KRIs):

- Staff appraisal rates - appraisal rates (excluding medical staff) across the Trust increased in September 2020 to 75.9% and to 78.5% in October (having fallen to below 70% between May and July) and was 78.2% in November, against a target of 90%; Medical staff appraisal rates remain in the high 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 – % recommending place to work was 45.1% in 2019 and 46% in 2020; % agreeing positive action on health and wellbeing was 19.1% in 2019 and 21% in 2020

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.

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	Risk Type	Rating (current)	Risk level (current)
4558	Local impact of the global coronavirus (Covid-19) pandemic	Harm (physical or psychological)	25	Very high risk
4175	Capacity to manage emergency demand	Service disruption	20	Very high risk
4362	Workforce capacity & capability (recruitment, retention & skills)	Service disruption	20	Very high risk
4083	Workforce engagement, morale & productivity	Reputation / compliance	20	Very high risk
4144	Uncontrolled outbreak of serious infectious disease	Service disruption	16	High risk
3688	Quality of the hospital environment	Reputation / compliance	16	High risk
4044	Compliance with information governance regulations & standards	Reputation / compliance	16	High risk
4156	Safe management of medicines	Harm (physical or psychological)	16	High risk
3690	Compliance with water safety regulations & standards	Reputation / compliance	16	High risk
3720	Critical failure of the electrical infrastructure	Service disruption	16	High risk
4403	Compliance with electrical safety regulations & standards	Reputation / compliance	16	High risk
4383	Substantial unplanned expenditure or financial penalties	Finances	16	High risk
4300	Availability of medical devices & equipment	Service disruption	16	High risk
4480	Safe management of emergency demand	Harm (physical or psychological)	16	High risk
4481	Availability & integrity of patient information	Service disruption	12	High risk
4437	Critical failure of the water supply	Service disruption	12	High risk
4405	Critical infrastructure failure disrupting aseptic pharmacy services	Service disruption	12	High risk
4406	Critical failure of the medicines supply chain	Service disruption	12	High risk
4423	Working in partnership with the wider healthcare system	Service disruption	12	High risk
4401	Safety of the hospital environment	Harm (physical or psychological)	12	High risk

ID	Title	Risk Type	Rating (current)	Risk level (current)
4402	Compliance with regulations and standards for mechanical infrastructure	Reputation / compliance	12	High risk
4176	Management of demand for planned care	Service disruption	12	High risk
4181	Significant breach of confidentiality	Reputation / compliance	12	High risk
4179	Major cyber security attack	Service disruption	12	High risk
4157	Compliance with medicines management regulations & standards	Reputation / compliance	12	High risk
3689	Compliance with asbestos management regulations & standards	Reputation / compliance	12	High risk
4145	Compliance with safeguarding regulations & standards	Reputation / compliance	12	High risk
4146	Effectiveness of safeguarding practice	Harm (physical or psychological)	12	High risk
4043	Compliance with patient safety regulations & standards	Reputation / compliance	12	High risk
3503	Sustainable paediatric services at Pilgrim Hospital, Boston	Service disruption	12	High risk
3520	Compliance with fire safety regulations & standards	Reputation / compliance	12	High risk
4142	Safe delivery of patient care	Harm (physical or psychological)	12	High risk
4081	Quality of patient experience	Reputation / compliance	12	High risk
4082	Workforce planning process	Service disruption	12	High risk
4581	Heating (Trust Wide)	Harm (physical or psychological)	12	High risk
4556	Safe management of demand for outpatient appointments	Harm (physical or psychological)	12	High risk
4497	Contamination of aseptic products	Harm (physical or psychological)	10	Moderate risk
4567	Working Safely during the COVID -19 pandemic (HM Government Guidance)	Reputation / compliance	9	Moderate risk
4526	Internal corporate communications	Reputation / compliance	8	Moderate risk
4528	Minor fire safety incident	Harm (physical or psychological)	8	Moderate risk
4553	Failure to appropriately manage land and property	Finances	8	Moderate risk
4502	Compliance with regulations & standards for medical device management	Reputation / compliance	8	Moderate risk

ID	Title	Risk Type	Rating (current)	Risk level (current)
4579	Delivery of the new Medical Education Centre	Reputation / compliance	8	Moderate risk
4486	Clinical outcomes for patients	Harm (physical or psychological)	8	Moderate risk
4476	Compliance with clinical effectiveness regulations & standards	Reputation / compliance	8	Moderate risk
4384	Substantial unplanned income reduction or missed opportunities	Finances	8	Moderate risk
4467	Impact of a 'no deal' EU Exit scenario	Service disruption	8	Moderate risk
4424	Delivery of planned improvements to quality & safety of patient care	Reputation / compliance	8	Moderate risk
4389	Compliance with corporate governance regulations & standards	Reputation / compliance	8	Moderate risk
4397	Exposure to asbestos	Harm (physical or psychological)	8	Moderate risk
4398	Compliance with environmental and energy management regulations & standards	Reputation / compliance	8	Moderate risk
4399	Compliance with health & safety regulations & standards	Reputation / compliance	8	Moderate risk
4400	Safety of working practices	Harm (physical or psychological)	8	Moderate risk
4363	Compliance with HR regulations & standards	Reputation / compliance	8	Moderate risk
4368	Efficient and effective management of demand for outpatient appointments	Reputation / compliance	8	Moderate risk
4382	Delivery of the Financial Recovery Programme	Finances	8	Moderate risk
4404	Major fire safety incident	Harm (physical or psychological)	8	Moderate risk
4138	Patient mortality rates	Reputation / compliance	8	Moderate risk
4141	Compliance with infection prevention & control regulations & standards	Reputation / compliance	8	Moderate risk
3687	Implementation of an Estates Strategy aligned to clinical services	Service disruption	8	Moderate risk
3721	Critical failure of the mechanical infrastructure	Service disruption	8	Moderate risk
3722	Energy performance and sustainability	Finances	8	Moderate risk
3951	Compliance with regulations & standards for aseptic pharmacy services	Reputation / compliance	8	Moderate risk

ID	Title	Risk Type	Rating (current)	Risk level (current)
4003	Major security incident	Harm (physical or psychological)	8	Moderate risk
4177	Critical ICT infrastructure failure	Service disruption	8	Moderate risk
4180	Reduction in data quality	Reputation / compliance	8	Moderate risk
4182	Compliance with ICT regulations & standards	Reputation / compliance	8	Moderate risk
4351	Compliance with equalities and human rights regulations, standards & contractual requirements	Reputation / compliance	8	Moderate risk
4352	Public consultation & engagement	Reputation / compliance	8	Moderate risk
4353	Safe use of medical devices & equipment	Harm (physical or psychological)	8	Moderate risk
4061	Financial loss due to fraud	Finances	4	Low risk
4385	Compliance with financial regulations, standards & contractual obligations	Reputation / compliance	4	Low risk
4386	Critical failure of a contracted service	Service disruption	4	Low risk
4387	Critical supply chain failure	Service disruption	4	Low risk
4388	Compliance with procurement regulations & standards	Reputation / compliance	4	Low risk
4277	Adverse media or social media coverage	Reputation / compliance	4	Low risk
4438	Severe weather or climatic event	Service disruption	4	Low risk
4439	Industrial action	Service disruption	4	Low risk
4440	Compliance with emergency planning regulations & standards	Reputation / compliance	4	Low risk
4441	Compliance with radiation protection regulations & standards	Reputation / compliance	4	Low risk
4469	Compliance with blood safety & quality regulations & standards	Reputation / compliance	4	Low risk
4482	Safe use of blood and blood products	Harm (physical or psychological)	4	Low risk
4483	Safe use of radiation (Trust-wide)	Harm (physical or psychological)	4	Low risk
4514	Hospital @ Night management	Service disruption	4	Low risk

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*2 February 2020*
Item Number	*Item 12.3*
Board Assurance Framework (BAF) 2020/21	
Accountable Director	*Andrew Morgan Chief Executive*
Presented by	*Jayne Warner, Trust Secretary*
Author(s)	*Karen Willey, Deputy Trust Secretary*
Report previously considered at	*N/A*

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

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

Recommendations/ Decision Required	• *Board to consider assurances provided in respect of Trust objectives noting that framework has been reviewed through committee structure*

Executive Summary

The relevant objectives of the 2020/21 BAF were presented to all Committees during December 2020 and January 2021.

As agreed at the Trust Board in December 2020 the format of the Board Assurance Framework was reverted to the standard format as the Trust continued to operate business as usual alongside the response to Covid-19. As a result of the revision a significant number of updates have been made throughout.

Assurances ratings have been provided for all objectives and the Board are asked to note that the assurance ratings for objectives 3b and 4b have been updated and are detailed in the table below.

The following assurance ratings have been identified:

Objective		Rating at start of 2020/21	Previous month (December)	Assurance Rating (January)
1a	Deliver harm free care	R	R	R
1b	Improve patient experience	R	R	R
1c	Improve clinical outcomes	R	R	R
2a	A modern and progressive workforce	R	R	R
2b	Making ULHT the best place to work	R	R	R
2c	Well led services	A	A	A
3a	A modern, clean and fit for purpose environment	R	R	R
3b	Efficient use of resources	G	R	G
3c	Enhanced data and digital capability	A	A	A
4a	Establish new evidence based models of care	R	A	A
4b	Advancing professional practice with partners	G	G	A

4c	To become a University Hospitals Teaching Trust	A	R	R

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Board Assurance Framework (BAF) 2020/21 - January 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**												
			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			Developing a safety culture Theatre Safety Group Improving the safety of Medicines management through Medicines Quality Group Ensuring early detection and treatment of deteriorating patients Ensuring safe surgical procedures Ensuring a robust safeguarding framework is in place to protect vulnerable patients and staff Separate care pathway for urgent and planned care to aim to eliminate risk of nosocomial infection Maintaining our HSMR and improving our SHMI Delivering on all CQC Must Do	Patient Safety Walk Rounds and Human Factors training delayed due to second wave of Covid-19 Impact of Covid-19 on coding triangles Second round of CQC Confirm and Challenge sessions cancelled due to second wave of Covid-19	National guidance followed on PPE / infection prevention & control; Pandemic Flu Plan initiated; separate care pathways for urgent & planned care; Lincoln A&E reconfiguration project; Pilgrim A&E re-development project Replacement of manual prescribing processes with an electronic prescribing system; improvements to medication storage facilities; strengthening of Pharmacy involvement in discharge processes Review of Never Events & effectiveness of LocSSIPs / theatre safety programme; improved timeliness & delivery of NIV; revised policies, procedures & training to support deteriorating patients; implementation of Trust-wide electronic patient handover system; strengthening of	Trust Wide Accreditation Programme Reports National and Local Harm Free Care indicators Safeguarding, DoLS and MCA training Safety Culture Surveys Sepsis Six compliance data HSMR and SHMI data Flu vaccination rates Audit of response to triage, NEWS, MEWS and PEWS CQC Ratings and progress on delivery of Must Do and Should Do actions and regulatory notices		Assurance gaps to be identified through Trust Board streamlined governance process and Quality Governance Committee		

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1a	Deliver Harm Free Care	Director of Nursing/Medical Director	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 spread of Covid-19	4558 4480 4142 4353 4146 4556 4481	CQC Safe	Delivering on all CQC Must Do actions and regulatory notices Ensure continued delivery of the hygiene code Reduce the risk of nosocomial transmission when care cannot be delayed and testing status not known Medical records management systems & processes Ensuring continued incident investigations, harm reviews and assurance of learning Speciality governance programme Elective care patients assessed by test and symptoms to be Covid-19 risk minimised Patient Safety Group Urgent and emergency care in a defined zone Establishment of Grantham 'Green Site' & temporary repurposing of A&E to an Urgent Treatment Centre under LCHS management		system; strengthening of discharge processes; clinical service review of Respiratory Medicine Implementation of a central database of medical device user training records Updated policy & training in use of chemical restraint / sedation; strengthening of pathways & training to support patients with mental health issues Proposals to address staffing capacity gaps and estates availability issues to improve appointment slot utilisation; measures required to manage risks associated with use of virtual consultations as default option - assessment in progress Implementation of an Electronic Patient Records (EPR) system Review of Quality Governance Committee and Sub-group structures	regulatory notices Monitoring nosocomial infection rates National Clinical Audits Dr Foster alerts Patient safety indicators in the IPR Quality and Safety Risk Report Incident Management Report Mortality Report Upward Reports of the: Safeguarding Group Medicines Optimisation and Safety Group Patient Safety Group (incorporating sub-groups) and the Clinical Effectiveness Group			Quality Governance Committee	R
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	Greater involvement in the co-design of services working closely with Healthwatch and patient groups Greater involvement in decisions about care Deliver Year 3 objectives of our Inclusion Strategy Redesign our communication and engagement approaches to broaden and maximise involvement with patients and carers	Significant delay in securing divisional projects QSIR virtual cohort paused due to Covid-19 and all scheduled sessions cancelled until the New Year	Estates works planned across Lincoln, Pilgrim and Grantham hospitals to address identified through the PLACE survey (Patient-Led Assessment of the Clinical Environment) - including decoration of walls, windows & fascias; flooring; and bed space curtains / track systems. IIP projects specifically: co-design; Schwartz Rounds; engaging with patients and families; real time surveying, involving in decisions about care. Ensure Patient Panel optimised and continue current work to embed patient voice and experience within QSIR programmes. Review of Patient Experience Group	Getting real time patient and carer feedback Hold 6 listening events Thematic reviews of complaints and compliments, Quarterly/Annual Reports User involvement numbers National patient surveys Number of locally implemented changes as a result of patient feedback Patient experience indicators in the IPR Patient Experience Group Upward Report Quality and Safety Risk Report		Assurance gaps to be identified through Trust Board streamlined governance process and Quality Governance Committee	Quality Governance Committee	R

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1c	Improve clinical outcomes	Medical Director	Failure to provide effective diagnosis and treatment that deliver positive patient outcomes Failure too provide timely diagnosis and treatment that deliver positive patient outcomes	4558	CQC Responsive CQC Effective	Ensuring our Respiratory patients receive timely care from appropriately trained staff in the correct location Ensuring recommendations from Get it Right First Time (GIRFT) Reviews are implemented Ensuring compliance with local and national clinical audit reports Ensuring NICE guidance and national publications are implemented Ensuring guidelines and SOPs are current and reviewed within the agreed timescales Review of pharmacy model and service Clinical Effectiveness Group		Clearance of backlog of NICE guidelines and technical appraisal assessments Developing the use of national and local clinical audit data to evaluate clinical effectiveness Strengthening the management of clinical effectiveness at divisional level through improved information and reporting	Numbers of NIV patients receiving timely care Numbers of unplanned ITU admission numbers Monitoring the implementation of GIRFT recommendations Implementation of recommendations with local and national clinical audit reports Clinical effectiveness indicators in the IPR Clinical Effectiveness Group Upward Report		Assurance gaps to be identified through Trust Board streamlined governance process and Quality Governance Committee	Quality Governance Committee	R
SO2	**To enable out people to lead, work differently and to feel valued, motivated and proud to work at ULHT**												
2a	A modern and progressive workforce	Director of People and Organisational Development	The second wave of COVID and the potential for a third, is having a very significant impact on the ability to progress the programmes that will enable us to fundamentally improve the indicators against this objective. Wave 3 is likely to impact through January and February. We are exploring options through region and utilising national funding, to increase capacity to support programmes around recruitment and sickness management. However impact is likely to be limited in this financial year.	4362	CQC Safe CQC Responsive CQC Effective	Embed Robust workforce planning and development of new roles Targeted recruitment campaigns to include overseas recruitment Delivery of annual appraisals and mandatory training Creating a framework for people to achieve their full potential Embed continuous improvement methodology across the Trust Reducing absence management Deliver Personal and Professional development	Next steps following options paper to TLT to be picked up in the New Year Implementation of Workpal paused due to Covid-19 wave 2 Cancellation/pause of key programmes due to Covid-19 wave 2 Limited capacity within team to deliver, start delayed until OD Lead in place	Covid Command and decision making structure alongside Board agreed lean governance arrangements have been in place during the COVID incident. We have re-established the Workforce Strategy Group, who are overseeing delivery of the People workstreams of the IIP and have designed a report to give assurance to the People and OD Committee, highlighting actions to manage control gaps. The Operational Equality and Diversity Group will undertake a similar role for workforce equality and diversity issues.	Vacancy rates Turnover rates Rates of appraisal/mandatory training compliance Learning days per staff member Staff survey feedback Sickness/absence data Reported progress on the implementation of the NHS People Plan and the Lincolnshire System Workforce Plan		Assurance gaps to be identified through Trust Board streamlined governance process and People and Organisational Development Committee	People and Organisational Development Committee	R

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2b	Making ULHT the best place to work	Director of People and Organisational Development	Wave 2 and the potential Wave 3 of COVID patients has had a significant impact on our ability to deliver the Integrated Improvement Plan programmes that would impact on indicators against this objective. Resources have been redeployed to support the Trust's COVID response and this is likely to continue through January and February. Whilst additional staff have been appointed to take forward projects, we have been actively reassessing the progress we are likely to make by year end	4083	CQC Well Led	Embedding our values and behaviours Reviewing the way in which we communicate with staff and involve them in shaping our plans Adapting our responsibility framework and leadership programmes in line with the NHS Leadership Compact Revise our diversity action plan for 2021/22 to ensure concerns around equity of treatment and opportunity are tackled Agree and promote the core offer of ULHT, so our staff feel valued, supported and cared for Implementing Schwartz Rounds Embed Freedom to Speak Up and Guardian of safe Working Celebrate year of the Nurse/Midwife	Leadership training activity paused due to Covid-19 Schwartz rounds deferred due to Covid-19	Covid Command and decision making structure alongside Board agreed lean governance arrangements have been in place during the COVID incident. We have re-established the Workforce Strategy Group, who are overseeing delivery of the People workstreams of the IIP and have designed a report to give assurance to the People and OD Committee, highlighting actions to manage control gaps. The Operational Equality and Diversity Group will undertake a similar role for workforce equality and diversity issues.	WRES/ WDES Data Staff survey feedback - engagement score, recommend as place to work Number of staff attending leadership courses Number of Schwartz rounds completed (once implemented) Protect our staff from bullying, violence and harassment - measure through National Staff Survey Reports on progress in implementing the NHS People Plan and the Lincolnshire System Workforce Plan Use of NHSI Covid pulse survey			People and Organisational Development Committee	R

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2c	Well led services	Chief Executive	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 Led	Review of executive portfolios - Complete Simplify Trust strategic framework - Complete Embedding Divisional Governance structures to operate as one team Delivery of risk management training programmes Review and strengthening of the performance management & accountability framework - Complete Development and delivery of Board development programme - Complete Shared Decision making framework Implemented a robust policy management system Ensure system alignment with improvement activity Operate as an ethical organisation	None None Training delayed due to Covid-19 None Councils suspended due to Covid-19	Corporate support offer made to divisions Review of document management processes New document management system - SharePoint Single process for polices	Third party assessment of well led domains Internal Audit assessments Completeness of risk registers Annual Governance Statement Number of Shared decision making councils in place Numbers of in date policies	HOIA Opinion will be received in April 2021 8 councils established. Target for 2021 was 6 Movement on policies still not fast enough	Feedback tools to review progress/success Additional resource support from ICT/Libraries Report to Audit Committee quarterly Report to ELT fortnightly	Audit Committee	A

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SO3	**To ensure that services are sustainable, supported by technology and delivered from an improved estate**												
3a	A modern, clean and fit for purpose environment	Chief Operating Officer	Covid-19 impact on supplier services who are supporting the improvement, development, and maintenance of our environments. Availability of funding to support the necessary improvement of environments (capital and revenue)	3720 3520 3688 4403 3690	CQC Safe	Develop business case to demonstrate capital requirement Delivering environmental improvements in line with Estates Strategy Continual improvement towards meeting PLACE assessment outcomes Review and improve the quality and value for money of Facility services including catering and housekeeping Continued progress on improving infrastructure to meet statutory Health and Safety compliance	Business Case is not fully signed off and articulates a level of capital development that cannot be rectified in any single year.	Interim Critical Infrastructure Case has been shared with NHSE and allocation of funding available in 2020/21 has been targeted at high risk areas of Fire, Water safety, Electrical and Inpatient Environmental Areas Control gaps identified and reported through to Gold Command Structure where Covid related. Water/Fire safety meetings are in place and review of controls are part of external validation from authorised engineers. Now that additional capital funding has been secured for critical infrastructure a new Forum will be created to capture progress and feed back into governance systems how risks are mitigated and alleviated. Audits of changes are carried out internally and externally as part of NHSE change processes as well as contained within internal reviews.	PLACE assessments Capital Delivery Group Highlight Reports 6 Facet Surveys Reports from authorised engineers Staff and user surveys MiC4C cleaning inspections Response times to urgent estates requests Estates led condition inspections of the environment Response times for reactive estates repair requests Progress towards removal of enforcement notices	PLACE Assessments have been reduced to PLACE/light in lieu of access and staffing restrictions during Covid. 6 Facet Survey are not recent and require updating. Collation of Audits across all areas during Covid are partial due to availability of high viral load areas.	Assurance gaps identified are addressed through the command structure governance process, and mitigation steps taken. Additional reporting by exception is put in place to provide evidence and contribute to assurance process. Covid-19 related gaps identified are escalated through estates and facilities group as part of upward reporting and where urgent or significant impact to Exec Leadership Team, where immediate actions can be taken. IPC Cell/Group and upward reporting of cleanliness is reported through to QGC and has continued to cover key issues throughout Covid response	Finance, Performance and Estates Committee	**R**
3b	Efficient use of our resources	Director of Finance and Digital	Efficiency schemes do not cover extent of savings required. Continued reliance on agency 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 Phase 3 - Recovery and second COVID wave.	4382 4383 4384	CQC Well Led CQC Use of Resources	Delivering £27m CIP programme in 20/21. Paused due to COVID with a revised ambition to meet a 1% CIP in H2 Delivering financial plan; a monthly break-even position inclusive of Coivd-19 (including Restore and Recovery), aligned to the Trust and Lincolnshire STP financial plan / forecast for 2020/21 Covid-19 financial governance process Utilising Model Hospital, Service Line Reporting and Patient Level Costing data to drive focussed improvements. Paused due to COVID Implementing the CQC Use of Resources Report recommendations. Paused due to COVID Working with system partners to	Operational ownership and delivery of efficiency schemes Urgent and unplanned Restore and Covid related costs Reliance on temporary staff to maintain services, at increased cost	Divisional Financial Review Meetings - paused due to COVID Centralised agency & bank team Lincolnshire STP financial plan Lincolnshire STP collective management of financial risk Savings plan, monitoring and reporting. Internal Audit: Integrated Improvement Plan CIP - Paused Temporary Staffing - Complete Education Funding - TBC Estates Management - Q4 Workforce Planning - Complete	Delivery of revised CIP Achievement of both ULHT and STP financial Plan	Model Hospital Benchmarking/Reporting - paused due to COVID CQC Use of Resources - paused due to COVID	Gaps are being reviewed monthly with a view to reintroduce as soon as operational pressures allow. National guidance has been focused on recovery, cost control, projections and system working. Further guidance in respect of 21/22 is expected in due course.	Finance, Performance and Estates Committee	**G**

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						Working with system partners to deliver the Lincolnshire Plan. Detailed activity modelling aligned to resource requirements to support Trust and System response to Phase 3. Financial Reporting to Board							
3c	Enhanced data and digital capability	Director of Finance and Digital	Tender for Electronic Health Record is delayed or unsuccessful - Paused as a result of Covid response, restarted in Jan 21. Tactical response to Covid-19 may impact in-year delivery. Major Cyber Security Attack Critical Infrastructure failure	4177 4179 4180 4182 4481	CQC Responsive	Improve utilisation of the Care Portal with increased availability of information - Impacted by Covid-19 as paused. Commence implementation of the electronic health record - Paused as a result of Covid response, restarted in Jan 21. Undertake review of business intelligence platform to better support decision making Implement robotic process automation Improve end user utilisation of electronic systems Complete roll out of Data Quality kite mark	Cyber Security and enhancing core infrastructure to ensure network resilience. Roll-out IT equipment to enable agile user base. Redeployment of staff as a result of Trust response to Covid-19.	Digital Services Steering Group Digital Hospital Group Operational Excellence Programme Outpatient Redesign Group	Number of staff using care portal Delivery of 20/21 e HR plan Number of RPA agents implemented Ensuring every IPR metric has an associated Data Quality Kite Mark Delivering improved information and reports Implement a refreshed IPR	Schemes paused to enable tactical response to Covid-19. Limited progress being made where possible. Information improvements aligned to reporting needs of Covid-19. IPR paused in line with IIP work and expected to be in place for M1 reporting 21/22.	Management of control gaps being reintroduced in a phased way as impact of Wave 2 reduces. Steady implementation of PowerBI through specific bespoke dashboards and requests. Continue to review this as part of wider BI platform Workplan being drafted to ensure compliance before end of Financial year where possible, delayed by resource availability.	Finance, Performance and Estates Committee	A
SO4	**To implement integrated models of care with our partners to improve Lincolnshire's health and well-being**												
4a	Establish new evidence based models of care	Director of Improvement and Integration	Specific projects paused during the Covid 19 manage phase, specific projects are now progressing with delivery throughout the Covid Recovery Phase		CQC Caring CQC Responsive CQC Well Led	Supporting the implementation of new models of care across a range of specialties - in progress Support Creation of ICS - commencing Support the development of an Integrated Community Care programme - on hold Support the consultation for Acute Service Review (ASR) Phase 1. Assurance panel held with NHSE/I on 12/12/20to review the Pre-Consultation Business Case. Requests for further information from that session have been prepared and it is hoped the consultation process can begin during 2021. Improvement programmes for cancer, outpatients and urgent	Support required from the Trust to the System not yet identified	Control gaps identified and reported through to Gold Command Structure Delivery of service transformation aligned to the IIP overseen by the Trust Leadership Team.	Numbers of new models of care established Delivery of ASR Year 1 objectives Improvement in health and wellbeing metrics		Steady implementation of the Outstanding Care Together Programme to identify Strategic priorities for the remainder of 2020/21 and for 2021/22 aligned to the IIP. Roll out of Outstanding Care Improvement System has started with Wave 1 in Medicine Outpatient Transformation work has been escalated from the perspective of moving to virtual and telephone consultations which has also enabled outpatient activity to continue safely during the Covid Pandemic. The Lincolnshire system has agreed a new system	Finance, Performance and Estates Committee	A

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						care in progress, programme for theatres is on hold Development and Implementation of new pathways for paediatric services - in progress Implementing the Outstanding Care Together Programme to support the Organisation to focus on high priority improvements.	Data reporting				architecture to support the implementation of an Integrated Care System. In the new architecture, ULHT has been allocated the system lead role for cancer and access. Simon Evans is the SRO for access and Dr Neill Hepburn the SRO for cancer. The SRO's has been asked to scope out their programmes for 2021/22.		
4b	Advancing professional practice with partners	Director of Nursing	Specific projects paused during Covid 19 response		CQC Caring CQC Responsive CQC Well Led	Supporting the expansion of medical training posts Support widening access to Nursing and Midwifery and AHP Support expansion of Paediatric nursing programme Developing System wide rotational posts Scope framework to support staff to work to the full potential of their licence Ensure best use of extended clinical roles and our future requirement Development and appointment to further joint academic / Trust appointments at consultant and trainee grades for Education Development and appointment to joint academic/Trust appointments for research Development and reporting of detailed quality metrics for education for undergraduates Development of a modernised library and information service across organisations Implementation of the Research and Innovation strategy		Students who are on placement have been allowed to choose where they wish to work and have been supported in their request. There is a formal route of raising any concern via HEE, HEIs and locally. Any issues have been managed in a timely manner	Increase in training post numbers Numbers on Apprenticeship pathways Numbers of dual registrants Numbers of joint posts and non medical Consultant posts Numbers of pre-reg and RN child				**A**

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4c	To become a University Hospitals Teaching Trust	Medical Director	Specific projects paused during Covid 19 response			Developing a business case to support the case for change Gap analysis and Tracker Increasing the number of Clinical Academic posts Refresh of our Research, Development and Innovation Strategy Improve the training environment for medical students and Doctors Tracker vs Framework	Research activity directed to Covid-19 Development of memorandum of understanding with University of Lincoln Development of honorary contracts and joint working practices with University of Lincoln and University of Nottingham	Gap analysis and Tracker developed and updated quarterly against national criteria Development of internal Quality Assurance framework for Education	Progress with application for University Hospital Trust status Numbers of Clinical Academic posts RD&I Strategy and implementation plan agreed by Trust Board GMC training survey Stock check against checklist			People and Organisational Development Committee	R

The BAF management process

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

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

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

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

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

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

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

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