Bundle Trust Board Meeting in Public Session 4 May 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 6th April 2021 *Chair* Item 5.1 Public Board Minutes April 2021v1.docx
5.2	Matters arising from the previous meeting/action log *Chair* Item 5.2 Public Action log April 2021.docx
6	Chief Executive Horizon Scan Including STP *Chief Executive* Item 6 Chief Executive's Report, 040521.docx
7	Patient/Staff Story *Director of Nursing* *Please be aware that sometimes our patient and staff stories can deal with very difficult subjects, which may affect you personally. If you are concerned about this the Trust Secretary can advise you of the subject to be discussed at the start of the meeting.*
7.1	BREAK
8	Strategic Objective 1 To Deliver high quality, safe and responsive patient services, shaped by best practice and our communities
8.1	Assurance and Risk Report from the Quality Governance Committee *Chair of QGC* Item 8.1 QGC Upward report April 2021.doc
9	Strategic Objective 2 To enable our people to lead, work differently and to feel valued, motivated and proud to work at ULHT
9.1	Assurance and Risk Report from the People and Organisational Development Committee *Chair of POD* Item 9.1 POD - Upward Report - April 2021.docx
10	Strategic Objective 3 To ensure that services are sustainable, supported by technology and delivered from an improved estate
10.1	Assurance and Risk Report from the Finance, Performance and Estates Committee *Chair of FPEC* Item 10.1 FPEC Upward Report April 2021.docx
11	Strategic Objective 4 To implement integrated models of care with our partners to improve Lincolnshire's health and wellbeing
11.1	Virtual Ward *Medical Director* Item 11.1 Covid Virtual Ward Trust Board report 22 April 2021.docx
12	Integrated Performance Report *Director of Finance & Digital* Item 12 Integrated Performance Report - Trust Board.docx
13	Risk and Assurance
13.1	Risk Management Report

Director of Nursing

Item 13.1 Strategic Risk Report - 4 May 2021 v2.pdf

13.2 Board Assurance Framework

Trust Secretary

Item 13.2 BAF 2020-21 Front Cover May 2021.docx

Item 13.2 BAF 2020-2021 v27.04.2021.xlsx

13.3 Audit Committee Upward Report

Chair of Audit Committee

Item 13.3 Audit Committee Upward Report.docx

13.4 Corporate Governance Manual (Standing Orders and SFIs)

Trust Secretary

Item 13.4 Corporate Governance Manual (Standing Orders and SFIs).docx

Item 13.4 Updated Extract Corporate Governance Manual April 2021.doc

14 Any Other Notified Items of Urgent Business

15 The next meeting will be held on Tuesday 1st June 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 6 April 2021

Via MS Teams Live Stream

Present

Voting Members:
Mrs Elaine Baylis, Chair
Dr Chris Gibson, Non-Executive Director
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
Mr Geoff Hayward, Non-Executive Director

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

In attendance:
Mrs Jayne Warner, Trust Secretary
Mrs Karen Willey, Deputy Trust Secretary (Minutes)
Ms Cathy Geddes, Improvement Director, NHSE/I
Dr Maria Prior, Healthwatch Representative
Mrs Angie Davies, Deputy Director of Nursing
Mrs Kathryn Helley, Deputy Director Clinical Governance

Apologies
Mrs Sarah Dunnett, Non-Executive Director
Dr Karen Dunderdale, Director of Nursing

454/21	**Item 1 Introduction** The Chair welcomed Board members and members of the public who had joined the live stream to the meeting. In line with guidance on Covid-19 the Board continue to hold meetings open to the public through the use of MS Teams live. In line with policy, papers had been published on the Trust website a week ahead of the meeting and the public able to submit questions in the usual manner.
455/21	The Chair moved to questions from members of the public. **Item 2 Public Questions** **Q1 Vi King** **Staff Survey** **Poor morale and bullying have been on-going concerns, for many years, so I feel nothing has changed.**

	Before my retirement from the Trust four years ago, I did a lot of work, with directors and managers, in my staff side role re: staff morale. **Please can I ask the Trust board, what they are going to do, about the poor staff survey. What lessons are going to be learnt from it.** **With the pandemic, I would have hoped things we in place to help staff morale. Therefore, the pandemic should not be used as an excuse.** The Director of People and Organisational Development responded: The staff survey results were due to be discussed during the meeting and the results were clearly disappointing for the Trust considering there had been a slight improvement the previous year. The results should be of concern not only to the Board but also to everyone across the organisation. The pandemic had had a significant impact on staff but it was noted that this had impacted all Trusts and other Trusts had achieved better results that United Lincolnshire Hospitals NHS Trust (ULHT). The pandemic could not and would not be used to excuse the results of the survey. It was noted however that this might have exacerbated some of the issues that impact staff morale, such as staff shortages and the extent that staff were redeployed to cover staffing gaps. Steps were being taken to address this and progress was being made in areas such as recruitment. The Trust had a significant number of Health Care Support Workers (HCSW) taking up posts in the coming month and there was also a strong pipeline of international nurse recruits. It was anticipated that by the autumn the number of vacancies within the Trust would reduce by more than half. The Trust were undertaking work to create better working environments for staff and there was a lot of activity to support the recovery of staff through the course of the next year. It was recognised after a difficult year that there needed to be a recovery period for staff as well as services. The Trust had a strong programme of support for staff through which it was hoped would address any issues of wellbeing that staff may face. It was recognised that some of the issues identified had been around for some time and the Board recognised the need to take stock and do something different to address the issues that exist. Discussions would take place later on the agenda regarding the culture and leadership programme which it was hoped would provide a framework to move forward and address issues. The Director of People and Organisational Development noted that this was not about what the Trust Board could do but that the whole organisation needed to work together to improve and make the Trust a better place to work. The Chair acknowledged that this was a whole Trust response and responsibility to improve morale within the organisation. **Q2 from Jody Clark** **In the chief executive horizon, it mentions being designated as an ICS (Integrated Care System) this April.** **Can you please explain what this means for patients and if it changes any accountability from the providers involved?**

	The Director of Improvement and Integration responded: The Integrated Care System (ICS) was a large topic and it was important to note that ICSs were being approved to cover all of England. Lincolnshire had been approved in March for a date to go live from 1st April 2021. There were 4 key priorities for the ICS, these being to improve population health and healthcare, tackle unequal outcomes and access, enhancing productivity and value for money and helping the NHS to support broader social and economic development. This meant that there was a wish to work differently to bring about different pathways and ways for people to access services, the principle way to do this was collaboration. It was important to note that Lincolnshire had been working more closely together over recent years and had a good track record. This approach would continue to be built upon in order to improve healthcare for people across the county. From the patient perspective the benefits would be threefold with a joining up of health and social care to enable health care and social care providers to provider services in a more integrated manner. This would offer a more streamlined approach to care. There is an aim to create better health outcomes and track these in a way that has not been done previously. Most importantly there is a wish to provide less fragmented experiences as there had been difficulties with communications between services. There are a number of people involved in healthcare and this was of working intends to breakdown traditional divisions. A white paper called 'Integration and Innovation: working together to improve health and social care for all' was released in February 2021. This outlined the expectations of ICSs potentially becoming statutory bodies from April 2022. The paper outlined the responsibilities that ICSs would pick up and the impact on patients and the population. This would result in Clinical Commissioning Groups being discontinued. However, this currently remained a white paper and further work would be required. From a provider and accountability perspective, the only expectation was to work together which would put commissioner and providers together. There was no expected impact on each provider in the standing of a statutory board but each would be under a duty to collaborate and work more closely with others.
456/21	**Item 3 Apologies for Absence** Apologies for absence were received from Dr Karen Dunderdale, Director of Nursing and Mrs Sarah Dunnett, Non-Executive Director. The Chair welcomed the Deputy Director of Nursing and Deputy Director Clinical Governance to the meeting in the absence of the Director of Nursing.
457/21	**Item 4 Declarations of Interest** There were no declarations of interest which had not previously been declared.
458/21	**Item 5.1 Minutes of the meeting held on 2 March 2021 for accuracy** The minutes of the meeting held on 2 March 2021 were agreed as a true and accurate record.

459/21	**Item 5.2 Minutes of the meeting held on 16 March 2021 for accuracy** The minutes of the meeting held on 16 March 2021 were agreed as a true and accurate record.
460/21	**Item 5.3 Matters arising from the previous meeting/action log** 1576/19 – Smoke Free ULHT – agenda item 259/21 – Staff Covid-19 Story – The Board noted that work was underway to develop a regular plan of activity and the position would be reported back to the Board in May. This would be tied in to the work focusing on staff wellbeing during the course of the year. The Trust would build on the national 6 steps to recovery and would include initiative to celebrate success and opportunities to connect staff to each other. The Chair was pleased to note that work was progressing noting that there were a number of Non-Executive Directors who were keen to be able to get back out in the organisation to meet with staff.
461/21	**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.
462/21	The Chief Executive reminded the Board that the pre-election period, known as purdah had commenced on 25th March and would run through until the local elections on 6th May. The NHS had issued guidance to NHS bodies regarding this period, which was designed to avoid actions of public bodies having any influence on the election or conduct of election campaigns.
463/21	This affected media issues where the Trust should avoid proactive media or attendance at events whereby contentious issues may be raised or policy matters discussed. Social media, including individual accounts, should also be limited to factual information only. Public Board discussions on future strategy should be deferred. This would also apply to the Board meeting scheduled for 4th May.
464/21	The NHS had now issued the priorities guidance for 2021/22, the current financial year and this contained 6 priorities for the NHS, these being health and wellbeing of staff; COVID-19 including the vaccination programme; learning from the pandemic to transform services, restore elective and cancer care and manage the increasing demand on mental health services; expanding primary care capacity; transforming community and urgent and emergency care to prevent inappropriate attendances in ED, improve timely admission to hospital for ED patients and reduce length of stay; working collaboratively across systems to deliver these priorities.
465/21	Contained within the report was some guidance in relation to finance and contracting rules as this applied to the first half of the year now known as H1.
466/21	A consultation had been issued regarding the NHS System Oversight Framework, which had been discussed at previous meetings of the Board, and included the recovery support programme and aimed to replace the special measures regime.

467/21	Lincolnshire had already indicated a desire to be part of the recovery support programme, given the Trusts double special measures, which would encompass all organisations in Lincolnshire, including the Clinical Commissioning Group (CCG). Further information would be available in due course as the consultation progressed and the Trusts involvement became clear.
468/21	The Chief Executive advised that the NHS incident level for the pandemic had now reduced to level 3 resulting in regional coordination rather than national command and control. The Trust were now seeing a dramatic reduction in the number of inpatients and information shared with staff was that there were 15 Covid-19 positive inpatients in the Trust.
469/21	The Sustainability and Transformation Partnership (STP) was now moving to become an Integrated Care System (ICS) as discussed in response to the public question. This would be developed throughout the year and as the current White Paper potentially became legislation this would influence what the ICS would look like.
470/21	The Acute Services Review pre-consultation business case had been received by regional colleagues and would now be presented at national level. It was anticipated that this would receive national approval and would then allow the CCG to conduct a public consultation.
471/21	The Chief Executive advised that at the time of writing the report the timescales relating to the outline business case from Pilgrim A&E had been different, noting that this had not yet been through regional colleagues. It was now expected that this would be to regional colleagues in the next two weeks and then on for national approval. It was anticipated that this would go through both processes successfully.
472/21	The Board were advised that the Trust were now dealing with Covid-19 as an endemic part of society rather than pandemic and progress was being made with regard to restoration and recovery of services, risk stratification of patients and the Grantham restoration work. This activity had been named Project Salus.
473/21	It was noted that National Volunteer week would be held at the beginning of June and the Chief Executive was keen to celebrate the volunteers at the Trust. As reported through the media the Trust had held a recognition week for staff to acknowledge the first year anniversary of the Trust admitting Covid-19 patients. Executive Directors had spent time out and about with staff commemorating what had been a difficult year, but a year in which staff had performed admirably and this had offered an opportunity to give thanks.
474/21	The Chief Executive noted the elements within the report which provided an update on staff absence and how the Trust were keeping staff safe and the focus on the wellbeing of staff. A key part of the national priorities was the focus on workforce and wellbeing of staff to support their recovery before services were back up and running. The Trust would do all it could to support staff to recover.
475/21	Referring back to the response from the Director of People and Organisational Development to the public question, the Chief Executive noted that it was understood that workforce numbers were an element influencing morale in the Trust. The Trust had however made good progress in relation to international nurse recruitment and healthcare support worker recruitment.
476/21	The Director of Finance and Digital presented the finance element of the report to the Board noting that the Trust had delivered a small deficit of £26k during February. It was worthy of note however this had been due to the delivery of £26k surplus in January.

477/21	The collective system position was the delivery of a breakeven position at the end of the year and at month 11 the Trust had achieved breakeven.
478/21	The Trust had received £58.9m of planned support with £0.5m of this not being required in January. The £0.5m support was required again in February. The income position was reported as £2m favourable to plan due to a number of additional income streams outside of the half 2 block.
479/21	The Director of Finance and Digital noted that the Trust would no longer incur the penalty for the elective incentive scheme that ran from October to November 2020 before being suspended.
480/21	The Board noted that expenditure was £3.5m more than planned mainly due to Covid-19 costs as at the time of planning Covid-19 was receding before wave 2 hit.
481/21	The Trust had incurred £400k of expenditure in respect of the Trusts element of the Covid-19 vaccination programme, this was funded on its own stream.
482/21	Overall the system had planned to deliver a £4m deficit which had now been revised to breakeven, this was anticipated to be achieved at the end of March when the accounts were completed.
483/21	Dr Prior asked how the Trust compared to others in relation to staff sickness related to stress and anxiety as the report indicated 1 in 8 were off for this reason.
484/21	The Chief Executive advised that this was slightly higher than other Trusts however the Trusts sickness and absence level had often been higher than others. There was a need to take in to account that not all stress was work related, this in no way minimised the effort the Trust needed to make as an employer but this was offered so that the figures were not misinterpreted.
485/21	Stress could not be considered in isolation and needed to be seen in the context of everything that was happening. Other Trusts had seen an increase in stress and absence figures however the Trust needed to tackle the position, recognising that overall sickness could at times be higher than other Trusts.
486/21	Dr Prior noted that all staff had access to lateral flow testing and asked what the uptake and compliance figures were.
487/21	The Chief Executive noted that at a recent staff session staff were reminded of the need to conduct lateral flow tests. It was anticipated that staff were conducting these but not always remembering to report them. All staff had access to tests and were encouraged to undertake these on the days allocated and report the results on to the Trusts system. This remained a key element of how the Trust were keeping staff well.
488/21	The Board noted that recently the use of lateral flow testing had been expanded well beyond healthcare staff to the whole adult population.
489/21	Mrs Libiszewski sought clarification on the restoration of services and how the Trust were enabling visitors to see family members in hospital.
490/21	The Chief Executive advised that this had been kept under constant review during wave 2 with visiting restricted. There had however been some exceptions and discussions, led by the Chief Operating Officer, were now taking place with clinical colleagues to understand how the Trust could allow visiting.

491/21	The Chief Operating Officer advised that the Trust were moving from controlled visiting to Covid-19 secure visiting in line with national guidance. This would align visiting to the types of areas that patients were in and tied in with the aforementioned Project Salus.
492/21	Inpatients would be designated as high, medium and low risk areas and in accordance with this visiting would be adapted for these areas. This continued to be worked through and would be introduced at each hospital site with the aim for this to be in place by the end of April.
493/21	This did not however impact on paediatrics, maternity or end of life patients where other systems were in place, and had been largely in place throughout Covid-19 with a risk based approach regardless of where patients were being cared for at end of life. For maternity services this has been about ensuring that, not only women could attend appointment but that their partners were able to as well.
494/21	Dr Gibson noted that positive news that 90% of staff had undergone the first Covid-19 vaccination but questioned what action was being taken in relation to the small number of staff who could not or would not have the vaccine. Dr Gibson asked if those staff would be reallocated duties to take this in to account.
495/21	The Director of People and Organisational Development advised that follow ups with these staff were being undertaken to understand the reason for not having the vaccination. There conversations were taking place through Occupational Health and there were a significant proportion of staff who had not had the vaccine due to pregnancy or a lack of full understanding of the vaccination. This had resulted in more people booking for a first vaccination.
496/21	The Board were advised that groups of staff would remain where personal choice meant they would not have the vaccine, despite the efforts to encourage this. There were currently no plans in place to make adjustments to working practices however it was expected that further guidance would emerge in the coming months about potential risks. This would determine the approach taken by the Trust.
497/21	The Director of People and Organisational Development noted that this was a contentious area where employment law could come in to play and further guidance was awaited on the steps the Trust would be required to take in respect of those staff.
498/21	Dr Gibson noted that people had become used to the green and blue classifications within the hospital setting and asked what communications would be offered to patients with regard to high, medium and low.
499/21	The Chief Operating Officer advised that this conformed to the national agenda and information and guidance had been issues some time ago. Green and blue pathways were well established and as numbers had reduced it provided an opportunity to put in place the levels and embed as a new and permanent way moving forward. This had come about as a result of Covid-19 however also applied to the management of infection control and illnesses such as norovirus and influenza and other infectious diseases. This would be tied in to visiting and associated public communications.
500/21	The Chair noted that there needed to be some sequencing to the work underway to ensure that there was time to enable staff to recover whilst considering how services were configured for the future. The Trust Board:

	• **Noted the update and significant assurance provided**
501/21	**Item 7 Patient/Staff Story** The Deputy Director of Nursing introduced the patient story to the Board advising that the story focused on a 12-year-old boy admitted to hospital in 2020 during lockdown. The patient had an existing diagnosis of Autism Spectrum Disorder (ASD) and lived at home with his parent, one of whom suffered with mental health illness.
502/21	The patient attended main stream school and friends meaning that through the regularity of life and routine his ASD could be managed at home. The patient want not known to mental health services and had no previous hospital admissions. The impact of lockdown had affected his routine and the social isolation resulted in physical symptoms and issues of not eating properly, this led to a hospital admission.
503/21	The parent had also experienced an adverse effect on their mental health during lockdown and this was considered a contributing factor for the patient.
504/21	The patient presented with a number of issues due to physical and mental health illness.
505/21	Rebecca Thurlow, Matron Paediatrics presented the story to the Board via a pre-recorded video noting that there had great partnership working between the Trust and Lincolnshire Partnership NHS Foundation Trust (LPFT). There had been partnership working between Boston and Lincoln Children and Young Peoples teams that placed the patient at the centre to ensure the needs of the child were met.
506/21	The Trust were developing a service with LPFT in order to improve communication and relationships however this had been delayed due to the impact of Covid-19. Due to the eating disorder the child had been admitted to the hospital and the diagnosis meant there was a need for greater partnership working. There were already systems in place however this enhanced the work.
507/21	When a patient presents with both physical illness, requiring acute care, but caused due to a mental health illness it had been identified that there was a need to address both elements of the illness together, rather than managing the physical illness before the patient could access mental health support.
508/21	The teams working with LPFT were now taking up the offer of shadowing the LPFT team in order to gain a better understanding on mental health, this would be reciprocated with LPFT shadowing within the Trust. As part of the partnership working consideration was now being given to the possibility of employing a mental health nurse on the Rainforest Ward.
509/21	Further work had been undertaken to, since the patient had been cared for, to develop multi-disciplinary teams that not only involved acute, community and mental health care but also the families to ensure the right care and pathways were in place for the child.
510/21	The Teams were developing a standard operating procedure that would detail clear escalation processes should they be required and weekly dial ins were taking place to discuss current and potential patients. LPFT team members were also attending the wards on a Monday in order to support the Trust and the families of patients on the ward where required. Supervision was also being offered from LPFT to staff to address any issues that may be experienced.

511/21	The Trust were now part of the regional network for eating disorders which would ensure that staff remained up to date with knowledge and there was also access to specialist training in order to ensure staff were supported.
512/21	Paperwork was being developed by LPFT and would be jointly ratified in order to enable information to be available within the patient records and shared across the services ensuring that the same information was shared with the patient and family.
513/21	There would also be a full review of nursing documentation for children due to the possibility of some children needing to be cared for in tier 4 beds in specialist areas, this would enable documentation to be completed in line with tier 4 beds ensuring clear handover of information.
514/21	The Team were now also involving the Children and Adolescent Mental Health Services (CAMHS) in meetings of children with ASD to engage sooner in any care offered, this was also being expanded to other mental health services to ensure full support was in place for the child.
515/21	The Deputy Director of Nursing summarised the story noting this provided a great example of partnership working with the patient at the centre, this would also support future development of other pathways in the Trust.
516/21	There had been a positive outcome for the patient who had suffered as a result of the national lockdown and this provided a reminder that it was something that everyone was living with and a number of patients continue to experience issues as a result.
517/21	Mrs Libiszewski offered thanks for the demonstration the impact of relationships between organisation could have on families and asked if there was more that could be learnt from the partnership supervision and if this model could be considered across other professions.
518/21	The Deputy Director of Nursing advised that conversations had started to take place in the organisation about learning lessons and sharing from patient experience, consideration was being given to how this could be shared.
519/21	The Board noted that this was a good example of provider collaboration as the system moved in to an Integrated Care System.
520/21	Dr Gibson noted that the use of video multi-disciplinary team meetings was another benefit of Covid-19 that should be maintained.
521/21	The Chair acknowledged the initiative the staff had used to find different ways of working with the patient and putting a team in place around them to ensure better outcomes. It was clear there had been learning throughout the process but that this continued to progress.
522/21	The story had demonstrated to the Board how the Trust wanted staff to work as part of day-to-day business. The Trust Board: • **Received the staff story**
	Item 8 Objective 1 To Deliver high quality, safe and responsive patient services, shaped by best practice and our communities
523/21	**Item 8.1 Assurance and Risk Report Quality Governance Committee**

	The Chair of the Quality Governance Committee, Mrs Libiszewski provided the assurances received by the Committee at the 23rd March 2021.
524/21	The Committee received the internal process of incident management and review, this related to those incidents where learning could be taken but a serious incident national framework was not triggered. There were a backlog of investigations and actions and support was in place from the central governance team with particular focus being offered to the medicine division.
525/21	The Board were advised that medicines management had been a concern for some time, the group had now been stood back up and were reporting to the Committee. There were a number of actions required to take place and a roadmap was being developed to incorporate all of these from internal audit reports, Care Quality Commission (CQC) reports and any other reviews that had taken place. The Committee looked forward to receiving the roadmap.
526/21	An update was received in respect of the harm review process and significant work had already taken place with positive work by some teams , particularly ophthalmology regarding the partial booking waiting list. It was expected that this would be replicated, based on a risk profile, across a number of specialties. The Board were advised that this was not an issue specifically to the Trust but a national issue that the Trust wanted to understand in order to know the impact on patients at United Lincolnshire Hospitals NHS Trust (ULHT).
527/21	The Committee had received a full update on all areas of infection prevention and control (IPC) and highlighted the Clostridium Difficile position with achievement of 63 cases against a trajectory of 110. Given the pandemic, it was a testament to the work of the teams that such a significant reduction had been achieved. The Committee noted the significant work happening across the whole IPC agenda.
528/21	Mrs Libiszewski noted that the Committee had been concerned in relation to the reporting groups of the Committee however there was now improvement being seen, not least with the Patient Safety Group. The group had taken forward a number of initiative associated with information being reviewed ahead of the Committee and seeking information to identify issues and putting actions in place to report to the Committee.
529/21	The Committee agreed the approach to the mortality review process agreeing that reviews should take place from August 2020 and not historically in order that learning from these would be relatively contemporary.
530/21	The Committee received an update from the Safeguarding Group and flagged to the Board concerns that had been raised in relation to the way in which mandatory training updates were being received in data, this had not included all staff groups, therefore some staff groups were not historically reporting data. This had been referred to the People and Organisational Development Committee but it was felt that the Board needed to understand what this meant in respect of the dashboard information being received. This had been flagged through safeguarding but there was concern noted that this may apply to other areas of mandatory training.
531/21	The Board were aware that the Patient Experience Group had not delivered in the way wanted, either reactively or to proactively engage in order to deliver care effectively however the Committee noted that there were now green shots coming through from the group.
532/21	The Clinical Effectiveness Group had highlighted that there would be difficulty in complying with the accessible standards NICE guidance until the Trust moved forward with IT systems and the Committee agreed for this to be referred to the Digital Strategy Group in order to understand what could be done ahead of implementing new patient systems.

533/21	The Committee had received an update on the application of 15 steps and embedding this in to the quality accreditation programme. This would be a positive way in which to engage with frontline teams and would enable Non-Executive Directors to meet with patients and staff in a way that was structured in to the accreditation programme.
534/21	The Committee received a full report from the Maternity and Neonatal Oversight Group following the first meeting. There had been a significant agenda and the group reviewed all key elements to report.
535/21	NHS England had allocated a maternity safety advisor to the Trust who had provided positive comment about the steps forward the Trust was taking. The Committee were advised that the report following the Ockenden submission had not yet been received. A verbal update was offered to the Committee from the Maternity Safety Non-Executive Director Champion who had attended the oversight group, offering feedback and triangulation of actions being taken.
536/21	The Committee continued to receive updates in relation to Quality Impact Assessments in order to monitor on a monthly basis and there was evidence of improvement.
537/21	The Committee received the CQC action plan and the information contained within this, it was noted that some schemes were not moving at pace but for obvious reasons. There was now a review of evidence, systems and processes in place to ensure robust review of the situation against the action plan.
538/21	The Committee reviewed the Board Assurance Framework (BAF) and the Risk Register noting that there were no changes to be made to the BAF by the Committee.
539/21	The Chair thanked Mrs Libiszewski for the comprehensive report noting the effort to manage the agendas and time of the meeting in order to take all business. Overall, there were some positive things coming through the Committee, particularly from the groups and there were now some areas of good practice.
540/21	The Chair noted the issues regarding medicines management noting that incidents had been flagged by the Committee. This was referenced by the CQC and there were outstanding items from internal audit. The Chair enquired as to the level of confidence that there was a robust plan in place to address the concerns.
541/21	The Medical Director advised that this was work in progress and having put in place the Medicines Quality Group, this would bring together the issue of internal pharmacy and the handling of medicines. This was about the interaction between pharmacy and the handling of medicines on the wards.
542/21	A roadmap had been developed in order to encompass each of the audit reports and to address the concerns raised by the CQC and Trust concerns. There had been a gap in respect of capacity within the pharmacy team due to the absence of a Deputy Chief Pharmacist. Approval had been received to create an additional post to recruit in order to improve capacity. Assurance was increasing that there was a clear rout to resolve the issue however the Board were advised that there was a considerable amount to work through due to the complexity of the problem. The mechanisms, process and monitoring were in place and the Trust were on a journey to improve.
543/21	The Chair noted that the Maternity and Neonatal Oversight Group would need to be kept under review due to this being a new group and due to the need to ensure that the correct governance was in place and reports were being received in the way intended.

	The Trust Board: • **Received the assurance report**
	Item 9 Objective 2 To enable our people to lead, work differently and to feel valued, motivated and proud to work at ULHT
544/21	**Item 9.1 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 from the 17th March 2021 meeting.
545/21	Mr Hayward noted that the report had been covered through a number of other reports discussed during the meeting however noted a key are to report to the Board in relation to the outstanding issue of the Medical School and the concern regarding the timeliness of delivery.
546/21	It was noted however that this would be discussed during the Private Board meeting which would offer an opportunity to explore the current position.
547/21	The Chair reflected that discussions had been held by the Board during the course of the meeting covered the upward reporting from the Committee and requested that the referred issue from the Quality Governance Committee was received at the next meeting.
548/21	Mrs Libiszewski sought clarity on the case law to understand if this was a case specific to the Trust.
549/21	The Director of People and Organisational Development advised that this was a well-publicised case brought to the attention of all NHS Trusts previously to ensure learning was taken from the case and support in place to individuals who had been suspended. The Trust Board: • **Received the assurance report**
550/21	**Item 9.2 Staff Survey inc. Culture and Leadership Programme** The Director of People and Organisational Development presented the report to the Board noting the details on the results from NHS Staff Survey 2020 had been received by the People and Organisational Development Committee and were now presented to the Board following the lift of the embargo in mid-March.
551/21	As alluded to in response to the public question the results were disappointing after some improvement had been seen in the 2019 survey results. The Director of People and Organisational Development advised that Board that some positive outcomes had been the continued improvement in response rates which had risen to 51% in 2020. This placed the Trust above average and was positive in the sense that this demonstrated staff saw the value in offering feedback about working in the Trust.
552/21	Overall, the Trust had slipped back in comparison to other acute Trusts in most of the results although one area for improvement had been the action taken in respect of errors, near misses and incidents.
553/21	There were some positive results from the survey and the work done to ensure the Trust were seen to respond to issues staff had identified was positive. In relation to staff who were positive about working for the Trust and recommending it was a place to work was only 46%

	compared to an average of 67% and only half of staff would recommend the Trust to friends and relatives for treatment. This compared to 75% for other Trusts.
554/21	The report summarised the position of the Trust in respect of the staff survey and the negativity of ULHT as an employer. Only 20% of staff believed that the Trust took positive action on health and wellbeing despite the huge effort put in to health and wellbeing activity during Covid-19, and subsequent support from mental health services.
555/21	This reflected the issue that staff did not feel more broadly that the organisation cared about them. There was something fundamental about the relationship between employees and the organisation.
556/21	In terms of the responses there had been a difference in scores seen between the divisions and directorates and these were being worked through locally for necessary action to be taken. Where there had been improvements in division the Trust were trying to ensure that learning was shared.
557/21	The primary response to the survey results would be for the Trust to embark upon the Culture and Leadership Programme which would provide a framework used across a number of Trust to address the issue of culture and consistency of leadership. These were known issues in the Trust and the impact of how people feel about working in the Trust and how they were cared for.
558/21	The Director of People and Organisational Development noted the need to draw a line under the results and move forward to the point where everyone understood their responsibility for making the Trust a better place to work and receive treatment. This was not something that could be done by the Board or managers. Everyone would need to come together to bring about the improvements that everyone wanted to see.
559/21	There had been the introduction of regular surveys linked to core learning completion to provide in year data so as to not rely on the national staff survey. There was a potential for this to become more frequent however the Trust had an ongoing pulse survey.
560/21	Interestingly the results, whilst limited to date, staff appeared to be more positive in answering the pulse questions. It would be interesting to see if the positive responses were sustained in year as more results were received.
561/21	The Chief Executive noted that this struck a chord as, after joining the Trust in 2019, there was a desire to focus on the people side of the organisation as set out in the 'Improving ULHT' paper. This focused on the style and behaviour needs however the Covid-19 pandemic had impacted this.
562/21	The themes coming from the results were culture, leadership, behaviours and communication. Some teams had been de-established during the pandemic and there remained issues with staffing numbers and there were some concerns about health and wellbeing. This was not always about the offer that Trust had in place but the ability of staff to take these up at the right time and to enable access.
563/21	The Chief Executive reinforce the point that this needed to be addressed as a collective and move forward. Throughout the Integrated Improvement Plan staff sessions there had been strong focus on people, identifying that through collective choice it could be different.
564/21	The survey results demonstrated that this was not just about senior leader behaviours but about civility of all and how staff treated each other when working in the Trust. When stating

	that the Trust needed to do something to improve there needed to be recognition from people that this was about the engagement of everyone.
565/21	There was a desire from people to move on from this and to not accept that ULHT had to be like this, the culture and leadership programme would play a key part. A Leading Together Forum would be established from a cross section of a number of leaders in order to change collective behaviours and approach.
566/21	The Chief Executive noted that whilst there had been some improvement in scores this was about the relative position that demonstrated how far the Trust needed to move forward. It was clear what needed to happen and collectively as a workforce and a Board this could be addressed. There was an expectation that regular updates would be provided to the Board to demonstrate progress. The Trust employed great people to do great things for others and there needed to be a well led and well engaged workforce to deliver this.
567/21	The Chair was pleased to hear the commitment to take forward staff morale through the culture and leadership programmed and thanked the Chief Executive for stepping up to lead the programme, this underlined the significance of the work.
568/21	Mrs Ponder noted that research across organisations had shown that the biggest single influence on engagement and satisfaction at work came from immediate line managers and asked if the programme would target that group of people. There was a need to increase the understanding of responsibility to lead, listen and build trusting relationships with staff.
569/21	The Chief Executive advised that this would be done in conjunction with the Leading Together Forum. This would consist of 250-300 leaders and would be people who influenced others and their behaviours and would not be about grade.
570/21	Behaviours would be a key focus and would be about the behaviour of all but particularly that of leaders and people understanding what was expected of them. Focus would be provided on feedback, clear standards, leadership, culture and behaviour. The Chief Executive was keen that the programme was integrated in to the Trusts Integrated Improvement Plan and there was a strategic initiative aligned to this.
571/21	Mrs Libiszewski noted that there were a number of programmes running in relation to quality change, inclusion and safety culture and stated that it would be important for the new programmes to have the same core underlying themes. There was a need to ensure staff developed the same skills and that programmes were embedded.
572/21	Mrs Libiszewski also noted that the roadshows had resonated across the organisation asking if there was an intention to relaunch these to show that the IIP would continue and there was an intention to deliver.
573/21	Linked to the actions of the Board, Mrs Libiszewski sought assurance on the confidence in the operating model being fit for purpose with staff equipped with the right tools and skills to deliver, asking when the outcome from the Trust Operating Model review would be seen.
574/21	The Director of Improvement and Integration offered assurance that the programmes described were interacting with a consistent and core theme running through them. As part of the IIP, 4 strategic initiatives had been identified which were multi-year must do, cannot fail pieces of work. These were safety culture, leadership and behaviours, rolling out of the improvement approach and methodology, outstanding care together programme and approach to the ICS.

575/21	As part of the programmes work was underway with NHSE/I, who own the culture and leadership programme, along with internal staff to ensure consistent language and approaches to be complementary rather than individual pieces of work.
576/21	Reinforcing that the IIP has not stopped had become a lower priority due to the Trusts response to Covid-19 however where there had been opportunities to reinforce the approach this had been done as part of the restoration and recovery work. It remained the intention to embed further ways of working within the restoration phase.
577/21	To embed this within the organisation, as part of improving the estate consideration was being given to how the new brand was built in and the approach and vision across the sites to 'see it, live it, breath it.' This would again reinforce the commitment to the IIP and what the Board had committed to achieve over the coming years.
578/21	Dr Gibson noted that the measures in place for quality of care provided by the Trust were often at or better than benchmarked figures for the same type of Trust. Noting that half of staff would not recommend treatment there appeared to be a discrepancy from the survey results. Dr Gibson asked for further investigation to identify if the quality measures were not correct or if the perception of staff was disparate.
579/21	The Chair noted the point made by Dr Gibson acknowledging that this was about the triangulation of what the data demonstrated against the narrative put to it. Consideration should be given to how the information was presented in the rounded way as described. **Action – Director of People and Organisational Development, 1 June 2021**
580/21	The Director of Improvement and Integration noted that this appeared to be about the relationship between high confidence in peoples own services but less so overall as an organisation.
581/21	The Chair summarised noting the disappointment in the results noting the least improved areas detailed within the report. The approach to be taken in order to address the results would need to be significantly different to that taken previously with a key element on the culture and leadership programme. The Trust Board: • **Received the report noting the limited assurance**
582/21	**Item 9.3 Smoke Free Policy** The Director of People and Organisational Development presented the report to the Board noting the since the introduction of the smoke free site policy and the no smoking policy for staff, patients and visitors, it had not been possible to judge if this was having the expected impact, largely due to Covid-19.
583/21	A review had been undertaken to assess if the steps being taken to enforce the policy were the right ones against recognised best practice. It was noted that what the Trust had sought to put in place were the right things to do in terms of the issues of information giving and support, alongside seeking to enforce the policy.
584/21	Due to Covid-19 the Trust were yet to see if there had been an impact and any impact currently was not consistent. This reflected the experience of other Trust who had sought to make sites smoke free.

585/21	The ability of the Trust to provide support to stop smoking had had a limited impact to date, as there had been limited opportunities to do this due to the need to work with partner organisations.
586/21	There had been evidence that staff were moving away from close proximity to smoke however there remained examples of staff continuing to do so. Staff were moving to the far reaches of the sites however this had caused some issue with residents at Lincoln. This demonstrated some success in respect of the messages given to staff who still wished to smoke and the expectations of the Trust.
587/21	There remained instances of patients and visitors smoking in close vicinity to building however this was linked to reduced footfall on sites.
588/21	The feedback from staff regarding challenging individuals was that on most occasions staff did not feel comfortable to challenge. Whilst there were security staff who did this they were few in number and this made the policing of the policy difficult.
589/21	As there was a move to a different phase of Covid-19 it was suggested that the policy by relaunched in May 2021. The Trust would have an opportunity to work in partnership with Public Health England and the One You Lincolnshire team to offer comprehensive services around health and wellbeing. This included support to stop smoking. In due course, this offer would be on site in order to support the message being communicated.
590/21	The Trust would use opportunities to interact more closely with patients and would continue to do so with the move toward the health inequalities agenda and wold look to use the Make Every Contact Count opportunity. The Trust were keen to focus on no smoking in terms of pre-operative patients and other attendances of people accessing services. Messages would continue to be passed to staff to support stopping smoking and staff would be dealt with in an increasing robust manner should they not comply with policy.
591/21	The Director of People and Organisational Development noted that other options to enforce the policy had been explore including the increase in the level of security on site, giving a more formal role to security staff in monitoring and managing smoking. There was also consideration of speaking signs, these had been used by other Trusts however, it was noted effectiveness of these had been limited.
592/21	The Director of People and Organisational Development advised that whilst these options had been considered, further investment and pursuit of these at this time was not recommended. The recommendation to the Board would be to relaunch the policy with a greater focus to work with One You on education and information. It was proposed that this be reviewed towards the end of the calendar year to determine if, with the change in circumstances with greater numbers on site, there was an impact on keeping the Trusts sites smoke free.
593/21	The Board noted that the experience of other Trusts was that achieving smoke free sites was difficult unless there was significant investment to police the policy.
594/21	The Chief Executive noted that the paper offered a helpful introduction and supported the view that this was the right thing to do as a health body and major provider of cancer care. There was more work to do on the education and enforcement with a need to follow through on the policy.
595/21	The Chair endorsed the view that this needed to be progressed, acknowledging that the Board were aware this would be difficult. There had been a positive start to implementing the policy however the focus could not been maintained due to Covid-19.

596/21	The Trust needed to enforce the policy for both staff and visitors with more work to be done to progress. The Board requested a review of the implementation of the policy to be presented to the Board in November 2021. **Action – Director of People and Organisational Development, 2nd November 2021** The Trust Board: • **Received the report noting the moderate assurance** • **Accepted the recommendations to:** ○ **Re-launch the Smoke Free Policy and the status as a Smoke Free Trust** ○ **Create a Smoke Free Policy Task and Finish Group** ○ **Re-engage with Lincolnshire Public Health Services and One You Lincolnshire** ○ **Ask security staff to take a more proactive role in approaching smokers and asking them to smoke off site**
	Item 10 Objective 3 To ensure that service are sustainable, supported by technology and delivered from an improved estate
597/21	**Item 10.1 Assurance and Risk Report from the Finance, Performance and Estates Committee** The Chair of the Finance, Performance and Estates Committee, Mrs Ponder provided the assurances received by the Committee from the 25th March 2021.
598/21	The Committee had noted concern through the Estates and Statutory Compliance report in respect of the shortage of appointed authorised engineers and persons'. The Committee were advised that progress was being made to fill these roles but there was further work to do.
599/21	A full review of critical infrastructure assets was being completed and this would further inform the capital investment programme providing reassurance to the Committee.
600/21	The Committee noted a level of concern regarding water safety at Grantham following targeted sampling however were assured of the immediate actions taken and the plans in place to resolve.
601/21	Assurance was sought the value for money in the investment of housekeeping had been achieved prior to further investment being made. The Committee were advised that a baseline would be established against other Trusts in respect of investment moving forward.
602/21	The finance report, as presented to the Board had provided assurance to the Committee and it was noted that the Trust had delivered the largest capital programme in 2020/21. It was noted that there would be some slippage of £1.5m due to the late receipt of funding in the year.
603/21	The Committee noted the move to the collective management of contracting across the system, working with system partners. The Committee were pleased to note the increasing credibility with regional colleagues and the system the Trust had achieve due to financial management across the Trust and system.
604/21	The Committee received the upward report from the Information Governance Group that provided assurance to the Committee.

605/21	Concerns were noted through the performance dashboard regarding cancer services and 52-week waiters which were not improving due to the impact of Covid-19. There had also been an adverse effect on the length of stay for patients. The intensive support programme had commenced that would impact the length of stay.
606/21	It was noted that there had been increased demand on breast services and the Committee noted that work was underway to increase capacity and reduce waiting times. Work had also commenced to set new trajectories for 62-day and 104-day waiters.
607/21	The Committee were advised that the Trust was now operating in the restore phase in response to Covid-19 and treatment in this phase would focus on clinical urgency rather than time based targets. It was unlikely that the Trust would see a considerable improvement in performance targets in traditional measures in the near future. Therefore the Committee requested a report more appropriate to the treating of patients according to clinical urgency in order to gain assurance.
608/21	Mrs Ponder noted that the Committee had received the draft annual report, this would be ratified at the April meeting.
609/21	The Committee received the Integrated Performance Report and sought confirmation of the timescale to step down the increased capacity in the Intensive Treatment Unit (ITU) put in place from national directives. The Committee noted that capacity at Pilgrim had returned to normal levels however Lincoln continued to hold additional capacity. The Committee was concerned of the ongoing impact of the recovery of other services due to the increased capacity diverting resource.
610/21	The Trust had failed to achieve 31-day radiotherapy treatment for the first time due to Covid-19 however there had been a successful bid for additional radiology equipment that would support the pull back of the target. Mobile units were in place but were unable to be utilised fully to support recovery due to social distancing measures. Additional capacity was being secured through the restoration of services.
611/21	The Committee received the urgent care report noting the improved performance in 12-hour trolley waits and delayed ambulance handovers and noted further support in place from NHS England to reduce bed pressures and improve urgent care pathways.
612/21	The Committee received the report on lessons learnt from the radiator serious incident and reviewed the risk register outside of the meeting. The Board Assurance Framework was considered and reflected key risks.
613/21	The Chair reflected on the largest capital programme in the history of the Trust and the effectiveness of the roll out of the programme. The net impact of this would be seen in the future. The Trust Board: • **Received the assurance report**
	Item 11 Objective 4 To implement integrated models of care with our partners to improve Lincolnshire's health and wellbeing
	No items
614/21	**Item 12 Integrated Performance Report**

	The Chair noted that the Committees had conducted due diligence on the relative objectives within the overall Integrated Performance reporting noting the current performance and actions required to improve.
615/21	The Director of Finance and Digital advised that the upward reports from the Committees had highlighted specific areas that had required further investigation and discussion.
616/21	The Chair sought clarity on the position of the 12-hour trolley breaches and the related serious incidents that had been reported.
617/21	The Deputy Director Clinical Governance noted that the process of undertaking a serious incident (SI) investigation was to understand if harm had come to the patient as a result of the incident. Since the report had been published, the Trust had requested to the CCG a downgrade for 9 of the 12 SIs due to the investigations concluding that no harm had occurred.
618/21	The Board were advised that the request had been approved by the CCG as the investigations had been concluded and it was possible to demonstrate that no harm had occurred. The Trust Board: • **Received the report and limited assurance noting current performance**
	Item 13 Risk and Assurance
619/21	**Item 13.1 Risk Management Report** The Deputy Director Clinical Governance presented the report to the Board advising that there was recognised evidence of a continued reduction in the risk relating to the Covid-19 pandemic as discussed throughout the meeting and the impact this was having on the organisation.
620/21	The Board were advised that the workforce capacity risk was also reducing due to the additional staff that the Trust had been able to attract. However, there was evidence of the increasing risk to staff morale, discussions during the meeting had conveyed the actions being put in place to address this.
621/21	Mr Hayward, through the Chair, sought confirmation that the Board were content in relation to the very high-risk category for the Covid-19 position. The Trust were seeing a reduction of patients in hospital and the vaccination programme was being successfully rolled out.
622/21	The Deputy Director Clinical Governance stated that as the Committees were able to reflect on the information being provided and the risks were being addressed that future reporting could show a reduction in the level of risk.
623/21	The Chief Operating Officer advised that caution needed to be exercised in regard to thinking that due to low numbers the Trust were safe or could return to business as usual. The Boards attention was drawn to the way in which the Trust needed to be configured in order to deliver care and treatment to patients. This was reducing the ability to do what was needed and there remained a high risk on the impact of care.
624/21	The Trust continued to have a very significant waiting list which was being managed and patients prioritised. It was hoped that the current risk level would reduce by the end of the year however needed to be retained for the coming months until substantial elements of the risk could be mitigated.

625/21	The Chair noted that this would remain under review against the emerging risk profile that was seen in the Committees and presented to the Board.
626/21	The Chair sought the views of the Board to endorse the closure of the risk relating to the UK exit from the EU and confirm satisfaction that all key risk indicators together with mitigating actions were relevant and appropriate. The Trust Board: • **Accepted the top risks within the risk register** • **Endorsed the closure of the risk relating to the UK exit from the EU** • **Received the report and noted the moderate assurance**
627/21	**Item 13.2 Board Assurance Framework** The Trust Secretary presented the Board Assurance Framework to the Board advising that this had been considered by each of the assurance Committees in the month and updates by the Executive Directors.
628/21	The Trust Secretary advised that the Audit Committee were responsible for the oversight of objective 2c and that this would be considered and reviewed at the next meeting due to take place on 12th April.
629/21	The Board were advised that there had been no movement of the RAG ratings and work was underway to transition the BAF with the planning work in to 2021/22, to reflect the objectives moving forward in to the new year.
630/21	The Chair noted that the Committees had given attention to the BAF noting that the achievement of some green and amber rated objectives demonstrated the commitment in the organisation to move some work forward during Covid-19. There remained a number of objectives that were red rated but for obvious reason. The Trust Board: • **Received the report and noted the limited assurance**
631/21	**Item 14 Any Other Notified Items of Urgent Business** There were no other notified items of urgent business
632/21	The next scheduled meeting will be held on Tuesday 4 May 2021, arrangements to be confirmed taking account of national guidance

Voting Members	**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**	**2 Feb 2021**	**2 Mar 2021**	**16 Mar 2021**	**6 Apr 2021**
Elaine Baylis	X	X	X	X	X	X	X	X	X	X	X	X	X
Chris Gibson	X	X	X	X	X	A	X	X	X	X	A	X	X
Geoff Hayward	A	A	A	A	A	A	A	A	X	X	X	X	X

Gill Ponder	X	X	X	X	X	X	X	X	X	X	X	X	X
Neill Hepburn	X	X	X	A	X	X	X	X	X	X	X	X	X
Sarah Dunnett	X	X	X	X	X	X	X	X	X	X	X	X	A
Elizabeth Libiszewski	X	X	X	X	X	X	X	X	X	X	X	X	X
Paul Matthew	X	X	X	X	A	X	X	X	X	X	X	X	X
Andrew Morgan	X	X	X	X	X	X	X	X	X	X	X	X	X
Mark Brassington	X	X	X	X	X	X	X	X	X	X	X	X	X
Karen Dunderdale	X	X	X	X	X	X	X	X	X	X	X	X	A

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~~ 06/04/2021	Agenda Item
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~~ 03/08/2021	Further work commissioned. Report now expected Summer 2021
2 March 2021	259/21	Staff Covid-19 Story	To develop a regular plan of activities, such as back to the ward, through staff engagement and organisational development activity	Rayson, Martin	04/05/2021	Annual engagement plan being developed by the OD Team including plans for regular opportunities for staff in support teams to visit and support clinical areas. To be considered by Trust Leadership Team in May
6 April 2021	579/21	Staff survey	Consideration to be given to triangulation of data between staff survey results and quality measures	Rayson, Martin	01/06/2021	Work being undertaken with Information Services to determine how information can be triangulated
6 April 2021	596/21	Smoke Free Policy	Post implementation review following relaunch to be presented to the Board	Rayson, Martin	02/11/2021	

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Public Trust Board*
Date of Meeting	*4 May 2021*
Item Number	*Item 6*
Chief Executive's Report	
Accountable Director	*Andrew Morgan, Chief Executive*
Presented by	*Andrew Morgan, Chief Executive*
Author(s)	*Andrew Morgan, Chief Executive*
Report previously considered at	*N/A*

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

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

Recommendations/ Decision Required	• *To note*

Executive Summary

System Overview

a) The COVID vaccination programme in Lincolnshire continues to progress well, with 440,000 people now having received their first dose and of these, 132,000 have also had their second dose.
b) Further work is continuing in relation to the establishment and development of the Lincolnshire ICS which was approved on 1st April 2021. This includes work on the development plan and on governance and assurance. Further national guidance is due over the coming weeks on the operating model, senior appointments and the Memorandum of Understanding that will be needed with NHSE/I. This is all subject to Parliamentary approval of the proposals in the White Paper which is due for a second reading in Parliament in June.
c) Guidance is also due to be published on the establishment of Provider Collaboratives, which involves providers working together to achieve the benefits of scale. It is likely that providers will be in a number of different Collaboratives involving both vertical collaboration within a geographical patch and horizontal collaboration across different patches.
d) The national consultation on the NHS System Oversight Framework (SOF) 2021/22 closes on 14th May. It has already been agreed that the Lincolnshire NHS system will participate in the Recovery Support Programme, which it is proposed will replace the Special Measures regime. Work is continuing around the appointment of the System Improvement Director, clarifying the anticipated SOF status of the NHS System and the constituent parts of the system, the relative roles and input of the national and regional Intensive Support Teams, and clarifying the metrics and exit criteria for the Recovery Support Programme.
e) Preliminary information indicates that the Lincolnshire NHS system has met its financial plan for 2020/21, by delivering a better outturn than the planned £4m year-end deficit.
f) The system is on course to produce and submit the draft 2021/22 system plan by the due date of 6th May. Final plans are due on 3rd June.
g) The pre-election 'purdah' period is still in force prior to the local elections on 6th May.

Trust Overview

a) The Trust's vaccination hubs have now completed their work relating to the provision of COVID second doses and both the hubs at Pilgrim Hospital Boston and Lincoln County Hospital have now closed.
b) The number of COVID positive inpatients continues to be low, with the reported figures now regularly in single figures across the Trust. This is enabling the Trust to continue to progress its work around Project Salus and the restoration of services at Grantham and District Hospital. The Trust and the Lincolnshire ICS are also exploring the potential for joining the national Elective Recovery Accelerator Programme. Systems who are accepted on to this programme are expected to restore elective activity to 120% of 2019/20 activity by the end of July.

c) The Trust has a Well-Led domain review with the CQC on 6th May as part of the CQC's Transitional Monitoring Arrangements.
d) A successful Wellbeing week for staff was held in the week commencing 19th April. The focus of the week was on celebrating and promoting all things wellbeing, whilst also providing staff with an opportunity to take time, pause and reflect. There were different themes on different days of the weeks, including Be Active, Take Notice, Give, Keep Learning, Stay Connected. There will be a further Wellbeing week in May. Alongside these targeted interventions, it will be really important that the Trust maintains a continued focus on staff wellbeing.
e) The Trust met its financial plan for 2020/21, returning a small surplus of £2.4m on income of £643m. It must be remembered that 2020/21 was not a typical year in finance terms due to the pandemic and the suspension of a number of elements of the usual NHS financial regime. The underlying position of the Trust remains a significant financial deficit which will need continued focus and attention.

Report to:	Trust Board
Title of report:	Quality Governance Committee Assurance Report to Board
Date of meeting:	20th April 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. 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 **Patient Safety Group Upward Report** The Committee noted the clear report from the group requesting that an update be provided on NatSSIPs and LocSSIPs at an appropriate time. The Committee noted the frequent reference to coding work seeking assurance on the resource in place. The Committee were advised that work was being undertaken to address the issue raised. The Committee raised concern regarding training within the organisation asking what strategy was in place for delivering the skills, knowledge and mandatory training. The Committee would make a referral to the People and Organisational Development Committee to understand what was in place for staff and to consider how training could be tailored to roles and not bands. The Committee were pleased to note the introduction of smart fridge's that would modernise the environment and support staff to undertake their roles. **Serious Incident Summary Report** The Committee noted the revised Serious Incident report which provided an update on the current position with new, open and closed incidents. The Committee noted the innovative approach taken within the emergency departments follow a series of patient falls resulting in the development of a risk assessment process. Following the implementation

	of the process there had been no further falls and this had had a positive impact on assessment areas. The Committee were pleased to receive the new reporting style and would expect that this would develop over time in order to continue to offer assurance. **Clinical Harm Review** The paper offered a stock check of the Trusts position noting that reasonable progress was being made however there remained a high number of outstanding harm reviews to be undertaken. The Committee were advised of the action being taken to progress the reviews noting that funding had been approved in order for the Trust to seek project management support. **High Profile Cases** The Committee acknowledged the new cases reported and were advised that action was being taken to review open actions to evidence completion and to embed this part of the process as business as usual. The Committee noted concern regarding the use of chemical restraint and sedation processes noting that future reporting would be expected through the Patient Safety Group. **IPC Group Upward Report** The Committee received the comprehensive report and noted that the Trust had ended 2020/21 with 4 MRSA Bacteraemia and 66 cases of clostridium difficile, against a target of 110. Following a successful deep clean programme during the response to Covid-19 the Committee noted the intention to continue with a structured deep clean programme in to 2021/22. The Trust had seen a significant increase in the cleanliness of clinical areas as a result. The Committee noted that the Trust were compliant with 7 areas of the hygiene code and partially compliant with 3 noting that the environment was an issue in achievement of some aspect of the code. **Medicines Quality Group Upward Report** The Committee received the upward report and the associated roadmap that detailed the actions to be taken to improve. The Committee noted that timescales were ambitious and that achievement would be dependent of posts being appointed to. It was acknowledged that a large element of the achievement would be based on cultural change within the Trust with the initial focus being on process change. The upward report highlighted the ongoing work of the group to increase divisional ownership and engagement.

	Lack of Assurance in respect of SO 1b Issue: Improve Patient Experience **Patient Experience Group Upward report and PLACE Lite Report** The Committee noted that the group were highlighting the perennial issues of communication noting that work was underway to address the concerns. The Committee received the PLACE Lite report appended to the upward report noting the increased cleanliness scores that had been achieved. The Committee noted that the Maternity Voices Partnership were now linked to the group. **Patient Story** The Committee received the first of the scheduled patient stories built in to the business cycle. The story related to maternity services and offered a positive experience of a new mother during her antenatal, labour and post birth journey. The Committee noted that there had been a number of changes within maternity services due to the impact of Covid-19 that had resulted in negative feedback through social media, complaints and the Patient Advice and Liaison Service. The Committee noted that despite the challenges negotiated due to Covid-19 the service had offered a positive birth experience for the family in question. **Children and Young People Oversight Group** The Committee noted that the group had been established to address cross divisional issues in relation to the hidden child. The Committee noted the progress that had been made within the paediatric services noting that this had for some time been a fragile service. A task and finish group had been established to address the hidden child concerns and there was now a move away from this being a fragile service. The Committee were pleased to note that the group had sought evidence to support the findings being presented in order that assurances were evidenced. The Committee noted the temporary service change that had been put in place to support the fragile service noting that whilst this was not part of the Acute Services Review discussion would need to be held through the Integrated Care System regarding progression. **Maternity and Neonatal Oversight Group** The Committee noted that the group had approved the terms of reference, receiving them for ratification.

	The Committee were advised that the formal feedback session regarding the Ockenden submission had taken place however written feedback was awaited. The group had identified the need to conduct deep dives each month to address areas that appeared to be a concern to understand if there were issues that needed to be addressed. The group would look to move away from RAG rating performance to SPC charts in order to move the dashboard to a trend analysis format. Support was being offered by the Trusts appointed Maternity Advisor from NHSE/I. The Committee noted that the CNST Maternity dataset was now being provided however concerns remained regarding the ability of the IT system. These continued to be raised at a national level. The Committee were advised that whilst Saving Babies Lives was rated as green there were concerns due to the Trusts performance on reducing smoking rates. This was however a wider system issue that needed to be addressed across the county. The Committee noted that there would be a focus on training for staff to ensure the correct training was undertaken and the Trust were in the process of completing an expression of interest to access monies associated with maternity workforce training. The Committee were advised that the Trust home birth rate was reported at 4.5% and was double the national average. The Committee received a verbal update from the Non-Executive Maternity Safety Champion noting that this offered triangulation of the information presented and the intention to formalise reporting going forward. **Nursing, Midwifery and AHP Advisory Forum** The Committee received the report noting the concerns regarding e-learning which had been raised previously in the meeting and would be referred to the People and Organisational Development Committee.
	Lack of Assurance in respect of SO 1c Issue: Improve Clinical Outcomes **Clinical Effectiveness Group Upward report** The Committee noted that the group had not met
	Assurance in respect of other areas: **Quality Accreditation Programme and Non-Executive Director Visits** The Committee received the update noting that the accreditation would

	commence in April across ward and nursing areas in the first instance before being rolled out to all Trust areas. The report provided clarity on assurances that would be gained on the quality of care either directly or indirectly and was in line with the Trusts quality improvement journey. The Committee were pleased to note that there would be a multi-disciplinary approach. The Committee welcomed the Non-Executive Director Visits papers noting that this continued to be developed to ensure involvement for all. An outline template was offered to the Committee to identify focus areas when conducting visits. It was noted that visits would include Clinical Commissioning Group colleagues offering external stakeholder views. The Committee noted that reporting of the outcome of visits would need to be aligned to an appropriate group and consideration as to how awards were presented to staff were taking place. The Committee would be keen for the Board to be involved in the awarding of accreditations as had been done previously and would be keen to understand the view of Board members as to how this could be achieved. **Update on lessons learned from LST Incident** The Committee received the report noting that the programme of low surface temperature works was nearing completion. The final task and finish group would be held in April. The Committee noted that contents of the report and the evidence of completion of the action plan so far noting the intention for a report to be presented on a monthly basis to provide updates on outstanding actions. The Committee were advised that the internal audit in to the serious incident process was being concluded and policy changes, where required, would be made following the outcome. Assurance was sought of the quality of serious incident reports to ensure that these were sufficient to be closed in a timely manner. The Committee were advised that monitoring of KPIs would demonstrate the quality and confirmation was received from the CCG that an increased level of quality was being seen. **Committee Annual Report** The Committee received the report for ratification requesting additions to provide assurance on the referral process between Committees and to reflect the delegation of authority from the Audit Committee in relation to clinical audit.

	The Committee, subject to the requested additions, ratified the report. **Committee Performance Dashboard** Assurance was sought in respect of the mortality rates for the Trust that these were within expected rates regardless of the time of day. The Committee noted that the Trust rated as 4th out of 10 within the peer group being advised that the Trust was not alerting for high levels of mortality. **Performance Review Meeting Upward Report** The Committee received the upward report from the divisional performance review meetings noting that the appointment of a decontamination lead was underway, jointly between the Director of Nursing and Chief Operating Officer. Central support was being offered to the divisions to support the progress on clearing backlogs of open serious incident actions and divisional investigations. The report provided triangulation of the issues being discussed by the Committee and offering context to the papers received. Concern was noted on the style of the report which would be addressed to ensure this offered assurance and exception reporting. **Quality Impact Assessments** The Committee received the report noting the update and requested that the detailed appendix be provided to future meetings. The Committee would continue to receive the report on a monthly basis. **Quality Account Priorities** The Committee received the Trusts long-term ambitions and quality priority areas. Work was underway to determine the measures for the coming year that would offer the detail behind the quality account. These would then be incorporated under the three pillars of quality. The Committee raised the need to consult and sought assurance that this would take place. The Committee noted that whilst there was no requirement to complete a quality account for the current year the standards of pervious years should be followed. The Committee noted that a decision would need to be taken on which of the priorities would link to the quality account with the remained of the priorities being delivered through the Integrated Improvement Plan. The Committee proposed that those featuring within the quality account should be those that focused across a wide range of patients.

	CQC Must Do and Should Do Actions and Regulatory Notices The Committee received the update noting that, following recent submissions and reviews by the CQC, the Trust were believed to be meeting the recommendations with the Section 29a notice. The Committee noted that the Section 29a could not be lifted until a subsequent inspection was conducted however noted the positive outcome of the recent review in to Children and Young Peoples Services. The Committee were also advised that work continued on evidence reviews with consideration being given to submit evidence to the CQC that demonstrated the Trust were meeting a significant number of the conditions of the Section 31 notice. The Committee offered thanks to the teams involved for the progress being made and the support in place for inspections. Whilst is was recognised that formal outcomes had not yet been received this was a positive step forward for the Trust.
Issues where assurance remains outstanding for escalation to the Board	
Items referred to other Committees for Assurance	The Committee referred to the People and Organisational Development Committee in order to understand the strategy in place to ensure that training could be tailored to roles and not bands to enable staff to receive the right skills, knowledge and mandatory training.
Committee Review of corporate risk register	The Committee reviewed the risk register accepting the risks and noting that the revised format of the risk register was currently being tested through the Director of Nursing's directorate.
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	M	J	J	A	S	O	N	D	J	F	M	A
Elizabeth Libiszewski Non-Executive Director	X	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
Sarah Dunnett Non-Executive Director										X	X	X
Neill Hepburn Medical Director	X	X	X	X	X	X	C	X	X	X	X	X
Karen Dunderdale Director of Nursing	X	X	X	X	X	D	X	A	X	X	X	X
Simon Evans Chief Operating Officer		X	X	A	X	D	C	C	C	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:	People and OD Committee Assurance Report to Board
Date of meeting:	22nd April 2021
Chairperson:	Elaine Baylis, Trust Chair
Author:	Karen Willey, Deputy Trust Secretary

Purpose	This report summarises the assurances received and key decisions made by the People and OD Assurance Committee. The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board. This assurance committee 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 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** **Safer Staffing** The Committee received the report noting the recommencement of the nursing workforce transformation programme. The Committee were advised that during March there had continued to be changes in ward case mix, staff moves and ward moves, this had impacted the report and raised concerns of variation. The Committee were assured that there was not a correlation between staff levels and patient harm. The Committee noted the move to Care Hours Per Day as the primary measure for staffing, moving away from the traditional fill rates. This would provide the proxy measure of variation in the context of ward changes. The Committee were advised that a review of establishments would be undertaken in May, acknowledging that this was later than planned due to the impact of Covid-19.

	Agency staff continued to be used however there had been a move to meet fill rates through use of the bank nursing workforce. It was noted that agency use was impacted at times for the need of higher skill sets being required. The safer staffing national assurance framework was presented to the Committee which captured the key aspects considered as part of the workforce modelling and deployment, providing March data which demonstrated compliance. The Committee noted that the final report from Birth Rate Plus was anticipated to be received by the Committee in May. **Stress/Anxiety Absence Deep Dive** The Committee received the deep dive noting that actions were taking place in order to support staff with stress/anxiety to return to work however noted that there needed to be a focus on prevention. The Committee were advised that the Organisational Development Team were offering wellbeing support to staff and were now taking a visible role on wards to offer opportunities for staff to seek support. The Committee noted that staff were reporting stress being linked to culture and leadership issues and the extent to which staff felt care for. Work being undertaken would be linked in to the culture and leadership programme being instigated alongside the work to support staff to recover following Covid-19. The Committee noted the transformational approach being taken in how the organisation was addressing the issue in an open and proactive manner. The Committee noted that the effectiveness of the activity being undertaken would be measured through staff sickness rates and the current wellbeing week would also be evaluated for effectiveness.
	Assurance in respect of SO 2b **Issue: Making ULHT the best place to work** **Freedom to Speak Up Guardian** The Committee received the report noting that this offered data from quarters 1-3 with quarter 4 data not yet due for submission.

The Committee noted that in year plans to develop the FTSU champions had been impacted due to Covid-19 however with the easing of lockdown restrictions work would be progressed.

The Committee noted the positive impact of the FTSU month and the proactive promotion of the guardian. This had identified the need to appoint a fulltime guardian and work was progressing well with the job out to advert.

The FTSU Guardian advised that relationships were being developed with the Organisational Development Team in order that concerns could be address and actions taken in an effective manner to support staff.

GMC Junior Doctor Survey – Quarterly update

The Committee received a verbal update on the progress that had been made to date following the latest junior doctor survey noting that a new checklist and programme was proposed for the August rotation of Junior Doctors.

The Committee noted that the next survey had been released sooner than expected meaning that current actions being taken to address previous issues may not have had the desired impact due to timing.

The Committee recognised that Covid-19 had offered challenge to the Trust and it was felt that this had compromised the educational training for the year with needs not being met.

The Committee noted that whilst there had been an impact on the actions being taken due to Covid-19 engagement continued with Junior Doctors in order to tackle identified issues.

The Committee would receive quarterly updates however noted that should there be a need, emerging risks should be alerted sooner.

Assurance in respect of other areas:

Committee Annual Report

The Committee received the report for approval noting some minor additions to be made to ensure consistency of reporting across the Board Committees. The report would be approved virtually following the amendments.

It was noted that the Committee had achieved a number of good things and supported assurance being received by the Board.

Performance Review Meeting upward report

The Committee received the upward report noting the discussions held during the divisional meetings. The Committee were advised of the concerns raised during the Finance, Performance and Estates Committee in relation to the delays in job planning.

The Committee were assured that concerns had been escalated through the divisions and actions were in place to resolve. This was a multifaceted issue relating to access to training and Staffside and management availability.

Committee Assurance Report

The Committee received the report noting the Trusts sickness absence position and the stabilisation of this in February.

The Committee were advised of the Covid-19 vaccination rate noting that 90% of staff had received their first vaccination. The Trust had received positive comment from the Chair of the NHS Confederation for the high achievement of vaccination uptake by Black, Asian and Minority Ethnic Staff.

The Committee noted the continued high spend on agency workforce noting however that this was moving in the right direction supported by the recent recruitment initiatives for both international nurses and Health Care Support Workers.

The Committee noted the assurances offered within the report recognising the control mechanisms that were in place and starting to take effect.

National People Programme

	The Committee received a verbal update on the National People Programme noting that the national report was due to be published at the end of April/May. **Board Assurance Framework** The Committee considered the assurances provided within the BAF and to the Committee during the meeting, agreeing the recommendation to change the RAF rating of objective 2a from red to amber.
Issues where assurance remains outstanding for escalation to the Board	No issues identified
Items referred to other Committees for Assurance	No items referred
Committee Review of corporate risk register	The committee received and reviewed the risk register noting that there were no changes to be made as a result of discussions during the meeting
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	**M**	**J**	**J**	**A**	**S**	**O**	**N**	**D**	**J**	**F**	**M**	**A**
Geoff Hayward (Chair)	No meetings held due to Covid-19		X	X	X	X	X	X	X	A	X	A
Sarah Dunnett			X	X	X	X	X	X	A	X	X	X
Non-Voting Members												
Martin Rayson			X	X	X	X	X	X	X	X	X	X
Simon Evans			X	D	D	D	C	C	C	C	C	C
Karen Dunderdale			X	X	X	X	C	C	C	C	C	X

X in attendance

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

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Report to:	Trust Board
Title of report:	Finance, Performance and Estates Committee Assurance Report to Board
Date of meeting:	22 April 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: Health and Safety and Fire Safety Update** The Committee noted that core updates had been received covering the previous month. The Committee noted that the Trust were entering phase 2 of the British Safety Council visit, constructive feedback had been received in relation to phase 1 which had focused on the management of staff safety during Covid-19. **Issue: Fire Safety Update** The Committee received the report and noted the updates presented following the core update provided the previous month.
	Assurance in respect of SO 3b Efficient Use of Resources **Issue: Finance Report inc CRIG Upward Report** The Committee noted that the Trust had achieved a draft year-end surplus of £2.4m which was ahead of the breakeven forecast. This was due to the late notification and receipt of funding to cover lost commercial income. The Committee were advised that there was not yet a year-end position for the system as other organisations needed to complete their year-end processes before a consolidated position would be available. Assurance

	was however provided that the system would report the forecast breakeven position as a minimum against the original H2 plan of a £4m deficit. The Committee noted that pay remained adverse to plan however the increase in pension and annual leave costs in M12 were offset by income allocations. The annual leave accrual position had allowed the Trust to announce at the commencement of wellbeing week the allocation of an additional day's annual leave for all substantive staff (pro-rata for part time staff). This would not hit the bottom line but was part of an allowable amount. The Committee noted the delivery of a £42m capital programme with £21m accounted for in the final month of the financial year through the investment in equipment and completion of planned works during March. A number of works would span in to 21/22 offering clear sight on the programme moving in to 21/22. The capital plan for the coming year was due to be presented to the Board and Committee. The Committee expressed thanks to the Finance Team for their ability to conduct the year end processes and produce the financial report to the Committee. The Committee noted the need to be cognisant that whilst a year-end surplus had been achieved the Trust continued to carry a significant underlying deficit (£95m at 31/3/2020). Finances would need to be managed carefully and diligently through the first half of the year to ensure the shift in reduction of money for H2 was managed. The Committee were keen that the underlying deficit position was considered exclusive of the Covid-19 impact in order to offer a true understanding of the position and to determine if the position had deteriorated. The Committee were advised that work continued to confirm the income figure for 21/22 with system partners. The Committee noted the ongoing issues with missing outcomes and requested that a paper be presented to the Committee identifying what action was being taken to address the issues in order that costs could be controlled and income maximised. The Covid-19 vaccination programme had received £663k of funding with £140k deferred at the year-end. The Committee were concerned that funding had not been recognised in the correct year. It was noted however that the accounting treatment was correct and that the cost relating to 20/21 was fully included in that financial year. The Committee noted the delivery of c£11m of CIP savings for the year which was greater than the requirement in the year of c£3m and requested a further update on how much of the savings were recurrent.

	The Committee received and noted the CRIG upward report.
	Assurance in respect of SO 3c Enhanced data and digital capability **Issue: Digital Hospital Group Upward Report** The Committee received the report noting the content.
	Assurance in respect of other areas: **Objective 4a Assurance Report** The Committee received the report noting that this offered assurance against 7 key areas that the Committee had not discussed in detail due to the governance light approach during Covid-19. The Committee received an update in relation to outpatient services and noted that Covid-19 had accelerated the objective to reduce outpatient activity. The Trust were above the target to reduce face-to-face appointments by 30%. The Committee were advised that Lincolnshire had been designated as an Integrated Care System, significant assurance was provided against the objective and the Trust were involved in future plans. The Committee were advised that the Integrated Community Care Programme had been discontinued by the CCG, key elements of the work were being addressed through other programmes within the system with no impact to the Trust. The Acute Services Review timeline continued to extend. The pre-consultation business case had been submitted and national feedback was awaited. The Paediatric service model had been accepted as an interim model for assessment during Covid-19. This would be presented to the Board as part of the fragile services review with a recommendation that this was no longer a fragile service. Work had continued on the Outstanding Care Together programme however it was not as advanced and mature as hoped due to the impact of Covid-19. The Committee were advised that discussions were being held to determine how investment could be prioritised to areas in order to progress.

	The Committee were pleased to receive the report noting that this had given confidence that the assurance rating presented in the Board Assurance Framework was accurate and underpinned by evidence. **Committee Annual Report** The Committee received the report for ratification requesting additions to provide assurance on internal audits, the referral process between Committees and minor amendments to the presentation of the report. The Committee, subject to the requested additions, agreed to formally ratify the final version of the report by email. **Integrated Improvement Plan** The Committee received and noted the contents of the report. There would be a process completed in order to close down the year 1 priorities. **Committee Performance Dashboard** The Committee received the report noting the improvement in 12-hour trolley waits however acknowledged the reduction in performance against ambulance conveyances. The Committee noted this had been due to peaks in activity being seen which were akin to winter levels. 90% of breaches were experienced during a window of 6 hours between late evening and early morning. The Committee raised concerns in relation to a number of reductions in performance being advised that these were related to the restoration of services and the way in which reconfigurations were being implemented along with categorisation of patients and urgency rather than waiting times. The Committee requested further information relating to outpatients seen within 15 minutes of appointment due to the reduction in performance. **Integrated Performance Report** The Committee noted that there were a number of indicators where performance continued to deteriorate including the recovery of 62-day and 104-day waits. Sizeable improvements had been made however, wave 2 of Covid-19 had had a detrimental impact. The Committee noted further recovery actions were in place with a plan being developed for submission to describe increased capacity in theatres and ICU. Breast services were the most significant concern within cancer services with the Committee being advised that interventions were in place to increase capacity.

	The Committee noted the deteriorated position of ambulance handovers however noted that the expansion of the Lincoln UTC was expected to have a positive impact with a reduction in time to see and assess patients and reduce overcrowding. The Committee were advised that the intensive support programme by ECIST and NHSE/I had commenced and would look to improve the rate of simple discharge. Sizeable improvements were expected from the end of April. The Committee noted the challenges being faced in cardiology due to the level of demand however noted that a review had been undertaken and a capital programme for developments would support capacity. **PRM Upward report and Roadmap** The Committee received the upward report noting the discussions held during the divisional meetings. The roadmap was received and articulated the move forward to the new performance management routine, which would be linked to the outstanding care together programme. **Cancer Performance** The Committee received the report noting the Trusts position as an outlier against benchmarking data. Actions were being taken to address the position. The Committee were advised of the need for the Trust to be able to address the increase in referrals that was predicted as a result of people not accessing care during the pandemic. There would be a need to be able to respond to offer treatment sooner than would usually be required. The Committee were advised that as part of the prioritisation of treatment of patients there would be a focus on ethnicity and deprivation. **Urgent Care** The Committee received the report noting the discussions held during the Integrated Performance Report item. **Internal Audit Reports** The Committee received the Data Security and Protection Toolkit Review, Core Financial Controls – Host and Core Financial Controls – Trust internal audit reports noting the significant assurance received for all. The auditors had raised the continued high levels of staff overpayments as a high risk, but the Committee were advised that this was already being reviewed by the Workforce and OD Committee.
Issues where assurance remains outstanding for	No additional items to raise.

escalation to the Board	
Items referred to other Committees for Assurance	The Committee wished to refer the delays in Job Matching to the Workforce and OD Committee for further review.
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 had provided comments for follow-up outside 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	**M**	**J**	**J**	**A**	**S**	**O**	**N**	**D**	**J**	**F**	**M**	**A**
Gill Ponder, Non-Exec Director	No meetings held due to Covid-19		X	X	X	X	X	X	X	X	X	X
Geoff Hayward, Non-Exec Director			X	X	X	X	X	A	X	X	X	A
Chris Gibson, Non-Exec Director			X	X	X	X	X	X	X	X	X	X
Director of Finance & Digital			X	X	X	X	X	X	X	X	X	X
Chief Operating Officer			A	D	X	X	C	C	X	X	D	X
Director of Improvement & Integration					A	X	C	C	C	C	X	X

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

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Public Trust Board*
Date of Meeting	*4 May 2021*
Item Number	*Item number allocated by admin*
Covid Virtual Ward	
Accountable Director	*Dr Neill Hepburn, Medical Director*
Presented by	*Dr Neill Hepburn, Medical Director*
Author(s)	*Alison Stringfellow, Dr Jim Campbell*
Report previously considered at	

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	*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	

Risk Assessment	
Financial Impact Assessment	*Neutral*
Quality Impact Assessment	*Positive*
Equality Impact Assessment	*Positive*
Assurance Level Assessment	• *Moderate*

Recommendations/ Decision Required	• *Continue working towards a Respiratory Virtual Ward in partnership with LCHS within the UECB forum*

Executive Summary

On 13th January 2021, as a response to current acute pressures, NHSE/I produced a national mandate for the establishment of a Covid-19 Acute Virtual Ward (CVW). The purpose was to provide early, supported discharge for adults in hospital with confirmed or suspected COVID-19 who are still receiving treatment but had an improving clinical trajectory(symptoms, function, oxygen saturation) and no fever for 48h consecutively (without medication to reduce fever).

A collaborative approach was adopted by ULHT and LCHS to deliver the mandate. A project group supported by clinical and corporate colleagues from across both organisations with input from the East Midlands Academic Health Science Network was established.

A model of care was developed jointly during January and February 2021 and adapted to deliver within existing resources, financial and staff. The 'Lincolnshire model' was implemented on the 1st March 2021 on a pilot basis following a positive 'mock' virtual ward round undertaken on the 18th February 2021. There was a ceiling of 5 patients on the virtual ward to test the concept using the PDSA (plan, do, study, act) methodology and to learn from both staff and patient experience.

It is important to recognise that this was a pilot scheme and managed a very small number of patients. However, he 4-week pilot demonstrates a proof of concept and has supported patients during the latter stage of wave 2 of Covid-19.

The project group recommend three potential future models are considered which could be used as a base to work up detailed proposals and for which funding would be required:

1. **Standard COVID model** - use for any future COVID waves, could base on current model with CAS clinician and SDEC/acute Med consultants. This could also be enhanced to include ED referrals.

2. **Respiratory based model (Derby model)** - expand case-mix to include oxygen dependent patients and non COVID respiratory illnesses with respiratory nurse specialist/advanced practitioners and consultant respiratory physician support 7 days a week.

3. **Acute medicine model** – expand case-mix to other acute medical conditions – with acute medicine advanced nurse practitioners and SDEC/acute Medicine consultants.

Supporting the development of the respiratory service is a key priority for the CCG, LCHS and ULHT.

Patients with respiratory illness are predominantly those who are deprived and have many comorbidities and, therefore and enhanced respiratory service will help address some of the Lincolnshire population's health inequalities. This is, therefore, an important factor as reducing health inequalities is a key driver for the ICS during 2021/2 and onwards.

1. Overview:

On 13th January 2021, as a response to current acute pressures, NHSE/I produced a national mandate for the establishment of a Covid-19 Acute Virtual Ward (CVW). The purpose was to provide early, supported discharge for adults in hospital with confirmed or suspected COVID-19 who are still receiving treatment but had an improving clinical trajectory(symptoms, function, oxygen saturation) and no fever for 48h consecutively (without medication to reduce fever).

Direction advocated that people with coronavirus that fell into high-risk groups would be given Oximeters to monitor their blood oxygen levels from home, with clinicians able to monitor the readings daily and intervene if required. Some patients are at significantly higher risk of deterioration following infection with Covid and this enhanced monitoring and treatment gives confidence to discharging clinicians and patients that they will be safely 'cared for' virtually following discharge from the acute setting.

A collaborative approach was adopted by ULHT and LCHS to deliver the mandate led by Dr Y Owen (LCHS Medical Director), Dr N Hepburn (ULHT Medical Director) and Dr J Campbell, Respiratory Consultant (retired) and a project group was established supported by clinical and corporate colleagues from across the two organisations with input from the East Midlands Academic Health Science Network.

2. The Model:

The model was developed jointly during January and February 2021 and adapted to deliver within existing resources, financial and staff.

Development of the model also benefitted from learning from other Covid Virtual Ward sites through discussion and research led by Dr Campbell (see learning notes below) and from input from Samson Ifere, Senior Improvement Lead, Patient Safety Collaborative, East Midlands Academic Health Science Network.

Learning from other units 1.docx

The Lincolnshire model was implemented on the 1st March 2021 on a pilot basis following a positive 'mock' virtual ward round undertaken on the 18th February 2021. There was a ceiling of 5 patients on the virtual ward to test the concept using the PDSA (plan, do, study, act) methodology and to learn from both staff and patient experience.

The pilot model and SOP are detailed below:

Mapping V0.4 8.3.21.docx

CVW SOP final version 4 8.3.21 .doc

3. Learning and Reflections at Week 4:

At this early stage, it is important to recognise that this is a pilot scheme and has managed a very small number of patients.

3.1 Data reporting shows:

- 6 admissions onto the ward during a 3 week period
- Average length of stay is 6 days
- No readmissions to acute care
- No patients called CAS for a clinical intervention outside of the daily virtual ward round/remote monitoring
- No new patients referred onto the ward from 18.3.21 due to:
    - Patients not meeting the criteria
    - Patients too ill to be referred onto the ward
    - A fall in the number of Covid-19 patients within acute care

3.2 Medical interventions whilst on the ward:

The table below lists the positive medical interventions undertaken on the 6 patients whilst on the virtual ward. This is over and above the general advice and support given to all the patients.

Intervention	Number
Diagnosis of new pulmonary emboli and avoidance of readmission	1
Treatment of steroid induced diabetes	1
Treatment of ongoing pneumonitis	2
Continuation of VTE prophylaxis within the community	3
Significant change in discharge medication (reduction in potential harm from discharge medication)	1
Advice on use of usual asthma therapy	1
Recommendation for review of usual medication by primary care (to avoid potential harm)	1
Identification of abnormal blood results and organisation of follow up bloods	1

3.3 Patient feedback:

Two completed patient feedback forms have been received so far indicating that patients found the service excellent and that they felt well supported during the initial period of discharge from hospital to their homes.

3.4 What went well?

- Really good collaborative work between LCHS & ULHT, both non-clinical and clinical staff, enabling the rapid development of a workable model.

- Without additional resources the CAS clinicians and Grantham SDEC consultants should be commended for taking on the clinical workload.

- Daily CAS clinician patient phone calls and board round with consultant medical staff provided a safe model of care.

- Using SystmOne and the virtual ward model within it as the clinical record worked well, enabling immediate sharing of clinical information with the relevant clinicians. Training for staff, who had not previously used the system, was simple and effective and there was timely response to clinician queries. Only outstanding issue is e-prescribing/electronic transfer of prescription.

- Early work on a digital platform is encouraging

3.5 Areas for consideration/further work:

- **Impact on workforce**. The pilot worked because of effective collaboration of the staff involved and the small caseload. Feedback from CAS clinicians noted that the morning patient phone calls took longer than expected – 30 mins for initial call and any complicated case (much quicker, of course, when the patient was stable and established on the ward). The system of daily board rounds and medical staff picking up subsequent patient contacts, including discharge discussions is heavily dependent on availability of consultant medical staff. This was manageable with the low caseload and reduced activity at Grantham SDEC but for a virtual ward of 20-25 patients would require designated staff (a rough estimate here for the medical staff input would be 4.5 PAs of consultant time per week - 4 PAs direct clinical care, 0.5 PA development/organisation). Note the NHSE suggestion in their COVID virtual ward briefing V1.0 of 1 PA per week is a gross underestimate of the workload. Furthermore, the suggestion by NHSE that this is a cost neutral exercise is very hard to understand.

  It is also important to recognize that, using the national criteria, this is not a scheme that will significantly reduce bed days within the Lincolnshire hospitals. It is best seen as a scheme to improve the care of patients in the early weeks post discharge. If expanded to ED, this again would be unlikely to reduce direct admissions but rather identify those patients who deteriorate in the community earlier and facilitate early readmission for treatment (dexamethasone/tocilizumab at present). To achieve a significant impact on bed days would require taking on a different cohort of patients (e.g. stable but oxygen dependent, non COVID cases).

- **Clinical staff skill base** - if the case mix of patients was to expand to include more complex respiratory patients (e.g. patients still oxygen dependent or non COVID respiratory admissions) the service would require much greater involvement by specialist respiratory nurses/advanced practitioners, both within the hospital and community.

- **In-reach** - relying on the in-patient ward staff to identify, train and on-board patients was a significant weakness of the pilot. Future models should aim to fund in-reach onto the in-patient ward by the virtual ward team.

- **Face to face medical review** - further work needs to be done to improve the pathway for patients requiring an urgent face to face medical review and investigations (the system of all patients going back to ED for assessment, although safe is inefficient and time consuming).

- **Prescribing within the virtual ward** - timely prescribing of urgent new medication - the medical staff need access to the e-prescribing and electronic transfer of prescription function within SystmOne.

- **Implementation of digital remote monitoring to support caseload management** - this work has been initiated and funding secured for the licenses and support with implementation from Spirit Digital.

3.6 Key successes from other sites:

- University Hospitals of Derby & Burton (South Derbyshire) ImpACT+ Covid19 Virtual Ward supporting patients with a continuing oxygen requirement safely at home, launched in 2018:
  - Managing the first 50 patients has led to well over 350 bed days saved (average 7 days per patient)
  - Very positive patient service user feedback

  (Source: Dr Deepak Subramanian, Respiratory Consultant, Derbyshire)

- Leicestershire Partnership NHS Trust and University Hospitals of Leicester NHS Trust (Glenfield Hospital) – Covid-19 Virtual Ward supporting patients without a continuing oxygen need:
  - Managing the first 65 patients on the virtual ward reduced the LOS from 5.5 to 3.3, equating to a cost saving of £69,000 (net saving based on cost of hospital beds minus cost of service)

  (Source: Dr Noel O'Kelly, Spirit Digital, working in partnership with Leicestershire on digital remote monitoring)

4. Conclusions & Recommendations

The 4-week pilot demonstrates a proof of concept and has supported patients during the latter stage of wave 2 of Covid-19.

If there is an appetite to continue with the virtual ward concept, the project group would recommend three potential future models which could be used as a base to work up detailed proposals and for which funding would be required:

4.1 **Standard COVID model** - use for any future COVID waves, could base on current model with CAS clinician and SDEC/acute Med consultants. To help manage the caseload, changing daily calls to every other or 3rd day depending on clinical assessment (some units are already doing this). This could also be enhanced to include ED referrals.

4.2 **Respiratory based model (Derby model)** - expand case-mix to include oxygen dependent patients and non COVID respiratory illnesses with respiratory nurse specialist/advanced practitioners and consultant respiratory physician support 7 days a week.

4.3 **Acute medicine model** – expand case-mix to other acute medical conditions – with acute medicine advanced nurse practitioners and SDEC/acute Med consultants.

5. Next Steps

Supporting the development of the respiratory service is a key priority for the CCG, LCHS and ULHT and will help address some of the Lincolnshire population's health inequalities as, by and large, respiratory patients are those who are deprived and have many comorbidities. This is important as reducing health inequalities is a key driver for the ICS during 2021/2 and onwards.

The project group proposes:

- using the proof of concept to work up a case of need for additional resources based on a respiratory model (+/_ other acute conditions) and use this as a 'stepping stone' to develop further integrated acute/community services in other patient groups including heart failure, frailty and diabetes.
- Maintain the Covid Virtual Ward in a state of readiness in the event of a 3rd wave of Covid
- continuation of the core project group to work up the respiratory model and case of need.
- continuation of work started on digital remote monitoring with Spirit Digital
- Continuation of work to enable electronic transfer of prescriptions by Acute Consultants to support ongoing pharmacological need of patients

Recommendations

Continue working towards a Respiratory Virtual Ward in partnership with ULHT within the UECB forum.

Appendices

Nil

Glossary

Nil

Meeting	Trust Board
Date of Meeting	4th May 2021
Item Number	Item 12
Integrated Performance Report for March 2021	
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

Falls

There have been three falls reported that have resulted in moderate harm for the month of March. These incidents are being reviewed in line with Trust policy and work is underway as described in the exception report to ensure that the Trust is able to engage and involve teams to promote early learning, sharing and changes in practice. The overall number of reported falls has decreased for the second consecutive month during March.

Pressure Ulcers Category 2

There has been 33 hospital acquired Category 2 pressure ulcers reported for the month of March against a trajectory of 28.3 and 1 Category 3. A review of all incidents is underway and any learning or themes will be brought through the Skin Integrity Steering Group. April will see the launch of the Tissue Viability e-learning package and a Focus on Fundamentals for Tissue Viability.

Incidents Investigation and Closure

Number of Serious Incidents

22 Serious Incidents were declared for March, a review has identified that 6 relate to the declaration of a number of ED 12 hour breaches that occurred in February and 3 related to Falls. The remaining 13 incidents are split between a range of specialties predominantly in the Medicine Division at both Lincoln and Pilgrim hospitals and no themes are emerging at this present time.

Medication Incidents reported as causing harm

March has seen a further decrease in medication incidents with harm to 15.5% against a trajectory of 10.7%. The number of incidents causing some level of harm (low /moderate /severe / death) has remained consistent with the last 12 months, however is higher than the national median. All pharmacists aligned to each Divisional CBU are currently working with the wards and departments to identify issues contributing to this higher level of reporting.

Mortality

HSMR

HSMR for the rolling 12 months is showing at 109.11 for the Trust which is an increase from the previous month and is now showing in the 'High' banding. Peer group analysis, identifies that ULHT has the fourth lowest HSMR of our ten peers (range 100.99 to 114.06). Due to the Covid-19 pandemic the rises in the HSMR were expected. A number of case note reviews are underway for alerting conditions and will be presented through the MoRals group.

SHMI

ULHT are in Band 2 within expected limits with a score of 109.90 a slight increase from the last reporting period. SHMI includes both deaths in-hospital and within 30-days of discharge and is reflective up to October 2020.

Clinical Audit and Effectiveness

National Clinical Audit Participation Rate

The % participation National Clinical Audit rate has remained at 95% again for the month of March. Actions to recover are in place and will be monitored through the Clinical Effectiveness Group.

eDD

The Trust achieved 92.3% compliance with sending eDDs within 24 hours for March 2021. 97.2% were sent anytime during the month of March 2021.

Sepsis based on February 2021 Data

1. **Sepsis screening compliance inpatient (Adult)**

Screening compliance for adult inpatients has shown a slight decrease at 86.2% against a trajectory of 90%. Analysis of the data has shown that the areas struggling to meet the standard are mainly medical wards with a similar pattern shown across both Pilgrim and Lincoln sites.

2. **Sepsis screening compliance inpatient (Paediatric)**

Sepsis screening compliance for inpatient (child) has decreased to 83% for January against a trajectory of 90%. Harm reviews have revealed no harm that has occurred and the Paediatric sepsis practitioner has highlighted that the relatively low overall numbers will cause the percentages to be fairly labile.

3. **Intravenous antibiotics within an hour (Paediatric ED)**

Compliance for Children's antibiotics within an hour in ED has decreased this month to 57% against a trajectory of 90%. The main driver for this poor compliance appears to be the direction of a paediatrician who request that the patients are transferred to the inpatient ward so precluding completion of the bundle prior to transfer. Actions to recover have been taken and can be seen below in the exception report.

4. **Intravenous antibiotics within an hour (Paediatric inpatient)**

Compliance for paediatric antibiotics within an hour as an inpatient has increased to 75% against a trajectory of 90%. This however represents only one patient and demonstrates that the overall low numbers have a disproportionate effect on the percentages.

1. **Intravenous antibiotics within an hour (Adult inpatient)**

Compliance for adult inpatient antibiotic administration has reduced to 86.6% for March. Harm reviews have been undertaken for all of the delayed treatments and whilst no severe harms have been detected there are 2 cases which will be discussed at the respective clinical governance meetings to share lessons learnt.

2. **Sepsis screening compliance ED (Paediatric)**

Compliance has fallen to 83% for this month with 11 patients having missed or delayed screens. Harm reviews have identified that all cases were for an alternate cause and not infection. There remains some wariness amongst staff with less paediatric experience to complete the screen.

Duty of Candour – February 2021 Compliance

The Trust achieved 88% compliance with the Duty of Candour, both in person notification (verbal) and written follow-up for January. This equated to 3 non-compliant incidents out of the 25 that were notifiable. Early daily notification to the Divisional Triumvirate is now in place and will be monitored to help improve compliance.

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 from August 2020 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 largely remained in operation.

Whilst this report covers February and March Performance it should be noted that as the demands of Wave 2 have diminished, the Trust is now moving into a period of restoration of services and is now guided by national requirements as set out in NHS England's 2021/22 Priorities and Operational Planning Guidance. This guidance which moves away from a focus on statutory access standards will have direct impact on performance, specifically RTT.

A & E and Ambulance Performance

4-hour performance for March was 71.98% a 0.86% deterioration from February (72.84%) against a trajectory of 83.12%. This is the fifth time in eight months the Trust's performance has been below the agreed trajectory, however, this performance was against a backdrop of a significant increase in attendances (against February numbers) of 21.16%. Performance against the 15min triage target deteriorated in March by 4.06% to 85.96%, below the trajectory of 88.50%. The recording of triage very slightly deteriorated in March by 0.08% compared with February.

Daily reporting to the System and NHSE/I continues via the Dep COO – Urgent Care whenever performance falls below 80%.

Ambulance conveyances for March were, 4588, 753 higher than in February an increase of 19.6%. 328 >59minute handover delays were recorded in March an increase of 110 from February. Delays experienced at PHB are attributed to the ongoing inability to flex the segregated pathways more responsively to the presenting demand. All handover delays are now reported to the CCG by EMAS but done so in the context of the overall site position.

Work continues with the System to reduce overall ambulance conveyances to ULHT. Dedicated UEC Project Management resource has been supported by the Innovation and Integration Team, to support the UEC Trusts Teams to effect sustainable change with a particular focus on SDEC to aid improved bed flow.

Project Salus is aiding the development of a responsive bed base with a speciality focus but is still requiring close operational oversight to ensure correct flow.

Length of Stay

LoS for non-elective admissions improved marginally in March February delivering 4.61 against a February performance of 4.77, but remains above the Trust 4.50 day target. Non elective admissions increased in March (associated with the significant increase in attendances) from 1522 to 1764 a 13.72% increase. Non-elective discharges increased only marginally by 2, however the number of LLOS reduced in March to 70 from 85 in February. The internal Discharge Cell continues to meet, led by the Dep COO – Urgent Care. The System wide Discharge Cell remains in operation 7days per week with twice daily calls.

Extensive work was undertaken system partners to acquire and agree funding and access to designated beds for the Trust's positive Covid-19 patients on pathways 1, 2 and 3. The Covid 2nd wave impact continues to reduce both in terms of inpatient and ITU demand, however, LCHS continue to modify their bed capacity in response to changing positive Covid-19 inpatient demand arrangements for which remain in place until the end of April 21.

Wave 3rd modelling has been announced with a suggested timescale of this next wave being July 2021.

Referral to Treatment

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

RTT performance continues and will continue to below trajectory and standard. February demonstrated a reduction in performance by 2.43% from January, with the Trust reporting 53.04% and reflects the ongoing focus on cancer and clinical urgency across a limited theatre and OPD base owing to the ongoing support of the required 150-200% capacity for ITU for this period. The Trust reported 1662 incomplete 52 week breaches for February end of month. In preparation for restoration the weekly PTL meeting were recommenced. However, in line with the national requirement for a focus on the reinstatement of time critical surgery, it is not expected to see significant RTT improvement before quarter 3, 2021/22.

With the ongoing pausing of the green pathways at both Lincoln and Pilgrim hospitals throughout February, the daily Cancer/Elective Cancellation Cell continued 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 continued to work with system provider partners and EMCA across the East Midlands to identify the most appropriate capacity for the most clinically urgent patients, with limited success.

The Trust continues to develop its processes for Clinical Harm reviews including over 52 week waits with a specific group established, led by the chief Operating Officer and Medical Director to review refine and develop robust governance processes and assurance.

Waiting Lists

Overall waiting list size has reduced from January decreasing by 1657 to 39,368 in February. The number of incomplete pathways is now approx. 336 more than in March 2018, however there remains a large cohort of patients remaining on the Trust's ASI list that are not accounted

for in this figure. Work continues between OPD and the CBUs regarding the returning to a standard 'polling' approach as part of our post wave 2 restoration plans.
Whilst the number of over 52week wait patients increased in February, the decrease in the number of continued with a further reduction in month of 1261.

The numbers of patients waiting over 26 weeks again reduced, decreasing by a further 733 from January 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.

The Trust reported 19 patients waiting over 80 weeks at the end of February. There is clear oversight and tracking of these patients; they are discussed internally with individual CBUs and also with CCG partners and NHSE/I colleagues at weekly meetings.

Cancelled Operations

'On the Day' Cancelled Operations saw a slight deterioration in February by 0.08%, but remains below the mean. This reflects the planned cessation of a significant proportion of the green lists across LCH and PHB, and the ongoing impact and increased risk of cancellations on the day owing to reduced assurance regarding the availability of post-operative HDU capacity to support the focus of time critical surgery being prioritised in line with national expectation.

These factors also contributed to the deterioration in performance of the 28 day treatment target from 9 patients breaching in January to 12 breaches in February.

The Cancer/Elective Activity cell continues to meet daily reviewing the prioritisation of elective surgery and supporting the planning and co-ordination of lists and activity in line with anticipated HDU capacity. Work with regional provider colleagues, EMCA and the Regional Hub to promote the surgery of the most critically urgent patients.

Plans are now being developed to increase the number of theatre sessions available, as the demand on additional critical care capacity begins to reduce.

Diagnostics

Diagnostics access performance continues to improve with February's performance standing at 68.94%. Endoscopy, continues to book cancer patients within 7-10 days and is now also booking routines, with improvements in Gastroscopy reporting 85 breaches compared to 298 in January, Cystoscopy improving from 194 in January down to 114 in February and Flexi Sigmoidoscopy significantly improved with a reduction from 75 breaches in January to 10 in February .

CT is much improved with 146 breaches for February compared to 306 in January

Ultrasound only had 3 breaches in February.

Neurophysiology reported 96 breaches for February compared to 456 for January

Audiology - Audiology Assessments had 0 breaches for January

Cardiology conitues to be challenged with echocardiography having 2051
breaches compared to 1961 in January, although echocardiography Stress /TOES had 58 breaches compared to 105 in January

Cardiology remians the main concern for the DM01 standing at 35.3% and is adversely affecting the overall position. (DM01 Performance with cardiac excluded is 84.30%)

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

The Cancer Data and Summary within this paper reflect the data and time period of the Cancer Standards Performance – Monthly Update Paper and therefore should note the content and context will be the same.

Patients waiting more than 62 and 104 days remains an absolute priority. Performance for February for the 62 Day Classic Cancer Target decreased by 7.1% compared to January, achieving 55.1% placing us below the national average (69.8%). Early indications are that our performance for March will be circa 64%.

As of 15th April there are 207 patients in the 62 day backlog down from a peak of 441); 54 patients over 104 days down from 163 in mid-July. Colorectal, Head and Neck, Gynaecology and Urology remain the most challenged specialties, although it should be noted as part of restoration increasing access to theatre lists along with a more assured availability of Level 2 post-operative HDU beds will support driving this back log down.

There are increasing numbers of inappropriate referrals owing to GPs utilising the 2ww pathway without having had a face to face consultation with patients. This has been raised with the CCG via the Planned Care Board. Patient compliance remains a challenge in a number of areas. A large proportion of these patients approx. 1/4 to 1/3 have mental health and/or social care needs that have the potential to provide significant challenges to achieving the pathway targets.

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.

The 31 day 1st treatment performance although improved continues to be affected by Covid-19 and reductions in theatre and ITU capacity combined with an ongoing reluctance of a high number of patients who were unfit or unwilling to engage with the NHS at this time for February.

In addition to the speciality clinical capacity post Covid, challenges include an ongoing 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.

Whilst, additional Vanguard theatres are now in place at Grantham going live in January 2021, the need to delivery 200% capacity for ITU over the reporting period has significantly reduced the numbers of lists able to be run at Grantham and as such has to date had limited impact in helping to reduce cancer backlog.

Workforce

Vacancy Rate

The Trust's overall vacancy rate has gradually declined since the summer of 2019, with a more rapid decline in the last couple of months. The Trust has recently completed, with support from NHSE/I a rapid recruitment exercise to fill all Health Care Support Worker vacancies. There has also been support for international registered nurse recruitment, with 120 new nurses joining the Trust in the last three months. There is a strong pipeline of not only nurse recruits, but also new medical staff through the first six months of the 21/22 financial year and, taking turnover into account, the Trust should be in a significantly better positon on turnover during this financial year.

This has yet to translate into a reduction in agency spend and, indeed, spend has increased in the last two months, This will be a focus for our Financial Recovery meetings in 21/22

Staff Suspensions

We are required to report to Board on the number of staff who are suspended from work pending the outcome of disciplinary investigations. The Trust has worked hard to minimise the number and length of suspensions. Suspension is not necessarily in the best interests of the individual, nor the organisation, if that person, who we continue to pay, can be used safely and effectively outside their normal role.

We therefore have just two staff suspended (employed under Agenda for Change terms) and they have been suspended for 90 and 57 days respectively.

Paul Matthew
Director of Finance & Digital
April 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	Jan-21	Feb-21	Mar-21	YTD	YTD Trajectory	Latest Month Pass/Fail	Trend Variation	Kitemark
Deliver Harm Free Care	Clostridioides difficile position	Safe	Patients	Director of Nursing	9	5	6	3	65		P		
	MRSA bacteraemia	Safe	Patients	Director of Nursing	0	1	2	0	4		P		
	MSSA bacteraemia cases counts and 12-month rolling rates of hospital-onset, using trust per 1000 bed days formula	Safe	Patients	Director of Nursing	TBC	0.08	0.04	0.08	0.05				
	E. coli bacteraemia cases counts and 12-month rolling rates, per 1000 bed days formula	Safe	Patients	Director of Nursing	TBC	0.11	0.12	0.08	0.07				
	Never Events	Safe	Patients	Director of Nursing	0	1	0	0	2		P		Timeliness, Completeness, Validation, Process (Reviewed: 12.06.19 Data available at: Specialty level)
	New Harm Free Care	Safe	Patients	Director of Nursing	99%	Data suspended							
	Pressure Ulcers category 3	Safe	Patients	Director of Nursing	4.3	0	2	1	16		P		
	Pressure Ulcers category 4	Safe	Patients	Director of Nursing	1.3	0	1	0	2		P		Timeliness, Completeness, Validation, Process (Reviewed: 12.06.19 Data available at: Specialty level)
	Pressure Ulcers - unstageable	Safe	Patients	Director of Nursing	19/20 will be used as a benchmark	5	5	8	60				
	Summary Hospital Mortality Indicator (SHMI) (rolling year data 6 month time lag)	Effective	Patients	Medical Director	100	110.35	109.45	109.9	109.46		F		
	Hospital Standardised Mortality Ratio - HSMR (rolling year data 3 month time lag)	Effective	Patients	Medical Director	100	102.53	105.20	109.11	100.41		F	A	
	Sepsis screening (bundle) compliance for inpatients (adult)	Safe	Patients	Director of Nursing	90%	87.90%	86.20%		86.55%		F		
	Sepsis screening (bundle) compliance for inpatients (child)	Safe	Patients	Director of Nursing	90%	88.00%	83.00%		86.60%		F		
	IVAB within 1 hour for sepsis for inpatients (adult)	Safe	Patients	Director of Nursing	90%	91.90%	86.60%		90.55%		F		
	IVAB within 1 hour for sepsis for inpatients (child)	Safe	Patients	Director of Nursing	90%	71.00%	75.00%		86.95%		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	Jan-21	Feb-21	Mar-21	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%	91.10%	91.00%		92.53%		P	A	
	Sepsis screening (bundle) compliance in A&E (child)	Safe	Patients	Director of Nursing	90%	90.30%	83.00%		89.81%		F	A	
	IVAB within 1 hour for sepsis in A&E (adult)	Safe	Patients	Director of Nursing	90%	94.80%	94.70%		95.56%		P		
	IVAB within 1 hour for sepsis in A&E (child)	Safe	Patients	Director of Nursing	90%	67.00%	57.00%		82.07%		F		
	Rate of stillbirth per 1000 births	Safe	Patients	Director of Nursing	4.20	2.64	2.44	2.86	2.34		P	B	
	Number of Serious Incidents (including never events) reported on StEIS	Safe	Patients	Director of Nursing	14	23	24	22	164		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	0.19	0.20	0.11	0.12		P		Timeliness, Completeness, Validation, Process
	Reported medication incidents per 1000 occupied bed days	Safe	Patients	Medical Director	4.3	4.42	6.40	5.56	5.12		P		
	Medication incidents reported as causing harm (low /moderate /severe / death)	Safe	Patients	Medical Director	10.7%	18.80%	17.20%	15.50%	14.63%		F		
	Potential under reporting of patient safety incidents / Reported incidents (all harms) per 1,000 bed days	Safe	Patients	Medical Director	30	33.58	34.38		35.01		P		
	Patient Safety Alert compliance (number open beyond deadline)	Safe	Patients	Medical Director	0	0	0		2		P		
	National Clinical audit participation rate	Effective	Patients	Medical Director	98%	95.00%	95.00%	95.00%	93.83%		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%	97.00%	97.70%	97.53%	97.17%		P		
	eDD issued within 24 hours	Effective	Patients	Medical Director	95%	93.50%	92.30%	92.30%	93.39%		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	Jan-21	Feb-21	Mar-21	YTD	YTD Trajectory	Latest Month Pass/Fail	Trend Variation	Kitemark
A Modern and Progressive Workforce	Overall percentage of completed mandatory training	Safe	People	Director of HR & OD	95%	87.85%	86.72%	86.49%	88.71%		F	B	
	Number of Vacancies	Well-Led	People	Director of HR & OD	12%	12.25%	11.54%	9.88%	12.13%		P	B	
	Sickness Absence	Well-Led	People	Director of HR & OD	4.5%	5.07%	5.14%	5.13%	5.01%		F		
	Staff Turnover	Well-Led	People	Director of HR & OD	12%	11.76%	12.09%	12.07%	11.21%		F	H	
	Staff Appraisals	Well-Led	People	Director of HR & OD	90%	74.80%	73.65%	76.43%	73.58%		F	A	
					£'000	£'000	£'000	£'000	£'000				
	Agency Spend	Well-Led	People	Director of HR & OD	TBC	-£4,058	-£3,651	-£4,546	-£42,052			H	

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	Jan-21	Feb-21	Mar-21	YTD		Latest Month Pass/Fail	Trend Variation	Kitemark
Improve Patient Experience	Mixed Sex Accommodation breaches	Caring	Patients	Director of Nursing	0	1	0	0	4		P		Timeliness, Completeness, Validation, Process
	% Triage Data Not Recorded	Effective	Patients	Chief Operating Officer	0%	0.20%	0.22%	0.30%	0.30%		F		
	Duty of Candour compliance - Verbal	Safe	Patients	Medical Director	100%	96.00%	88.00%		91.82%		F		
	Duty of Candour compliance - Written	Responsive	Patients	Medical Director	100%	96.00%	88.00%		88.18%		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	Jan-21	Feb-21	Mar-21	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	83.12%	71.41%	72.84%	71.98%	78.01%	74.05%	F	B	
	12+ Trolley waits	Responsive	Services	Chief Operating Officer	0	36	8	0	95	0	P	?	
	%Triage Achieved under 15 mins	Responsive	Services	Chief Operating Officer	88.5%	90.42%	90.02%	85.96%	90.68%	88.50%	F		
	52 Week Waiters	Responsive	Services	Chief Operating Officer	0	1053	1662		5143	0	F	H	
	18 week incompletes	Responsive	Services	Chief Operating Officer	84.1%	55.46%	53.04%		56.91%	84.10%	F	B	
	Waiting List Size	Responsive	Services	Chief Operating Officer	37,762	41,025	39,368		n/a	n/a	F	A	
	62 day classic	Responsive	Services	Chief Operating Officer	85.4%	62.16%	55.48%		65.12%	85.39%	F		
	2 week wait suspect	Responsive	Services	Chief Operating Officer	93.0%	78.18%	80.08%		85.13%	93.00%	F		
	2 week wait breast symptomatic	Responsive	Services	Chief Operating Officer	93.0%	4.24%	2.84%		38.55%	93.00%	F	B	
	31 day first treatment	Responsive	Services	Chief Operating Officer	96.0%	91.22%	93.68%		94.25%	96.00%	F		
	31 day subsequent drug treatments	Responsive	Services	Chief Operating Officer	98.0%	98.00%	97.73%		98.58%	98.00%	F		
	31 day subsequent surgery treatments	Responsive	Services	Chief Operating Officer	94.0%	78.95%	90.63%		88.65%	94.00%	F		
	31 day subsequent radiotherapy treatments	Responsive	Services	Chief Operating Officer	94.0%	88.89%	93.18%		92.53%	94.00%	F		
	62 day screening	Responsive	Services	Chief Operating Officer	90.0%	66.67%	72.73%		45.39%	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	Jan-21	Feb-21	Mar-21	YTD	YTD Trajectory	Latest Month Pass/Fail	Trend Variation	Kitemark
Improve Clinical Outcomes	62 day consultant upgrade	Responsive	Services	Chief Operating Officer	85.0%	76.55%	74.77%		79.96%	85.00%	F		
	Diagnostics achieved	Responsive	Services	Chief Operating Officer	99.0%	62.67%	68.94%		55.85%	99.00%	F	A	
	Cancelled Operations on the day (non clinical)	Responsive	Services	Chief Operating Officer	0.8%	1.06%	1.14%		1.51%	0.80%	F		
	Not treated within 28 days. (Breach)	Responsive	Services	Chief Operating Officer	0	9	12		118	0	F		
	#NOF 48 hrs	Responsive	Services	Chief Operating Officer	90%	81.97%	100.00%	100.00%	90.58%	90%	P		
	#NOF 36 hrs	Responsive	Services	Chief Operating Officer	TBC	68.85%	93.75%	100.00%	80.21%				
	EMAS Conveyances to ULHT	Responsive	Services	Chief Operating Officer	4,657	4,279	3,835	4,588	4,364	4,657	P		
	EMAS Conveyances Delayed >59 mins	Responsive	Services	Chief Operating Officer	0	263	218	328	207	0	F	A	
	104+ Day Waiters	Responsive	Services	Chief Operating Officer	5	66	68	61	780	60	F		
	Average LoS - Elective (not including Daycase)	Effective	Services	Chief Operating Officer	2.80	2.31	3.54	2.57	2.89	2.80	P		
	Average LoS - Non Elective	Effective	Services	Chief Operating Officer	4.50	4.76	4.77	4.61	4.37	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	19,883	17,800	18,220	19,646	4,524	F		
	Outpatients seen within 15 minutes of appointment	Effective	Services	Chief Operating Officer	70.0%	56.9%	54.3%	48.8%	45.68%	70.00%	F		
	% discharged within 24hrs of PDD	Effective	Services	Chief Operating Officer	45.0%	32.7%	32.4%	42.3%	35.33%	45.00%	F		

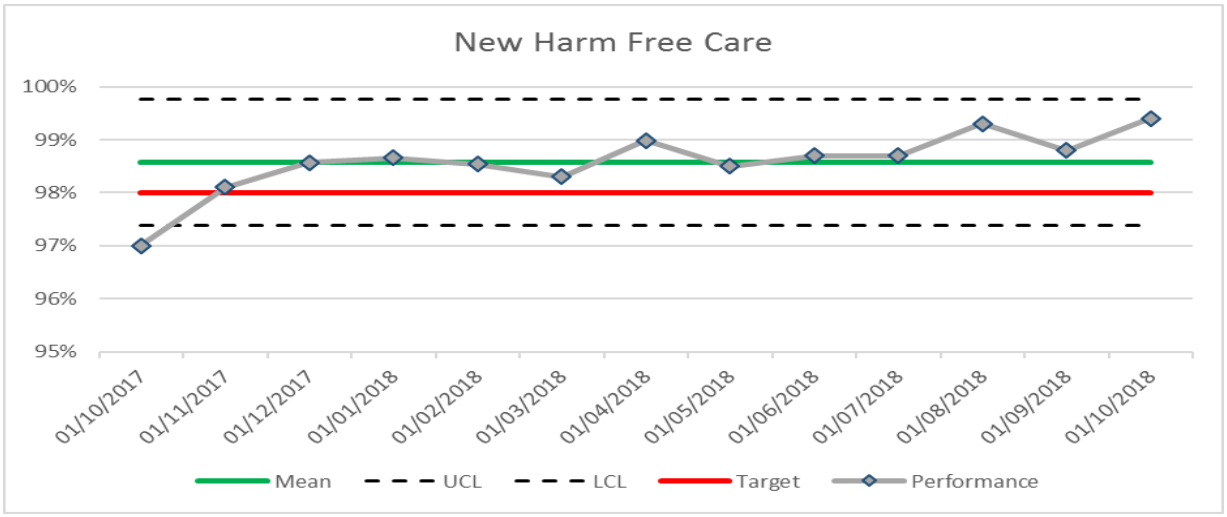
STATISTICAL PROCESS CONTROL CHARTS

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:



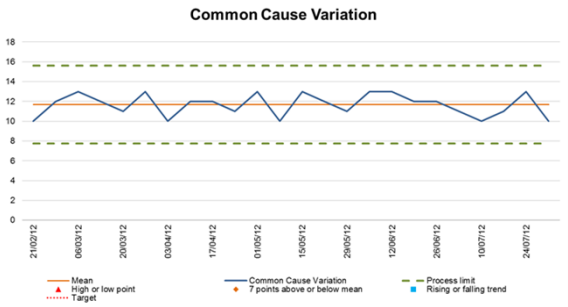
Normal variations in performance across time can occur randomly- without a direct cause, and should not be treated as a concern, or a sign of improvement, and is unlikely to require investigation unless one of the patterns defined below applies.

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

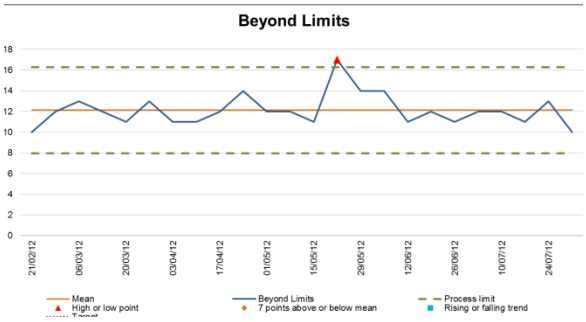
- Normal variation – (common cause) fluctuations in data points that sit between the upper and lower control limits
- Extreme values – (special cause) any value on the line graph that falls outside of the control limits. These are very unlikely to occur and where they do, it is likely a reason or handful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

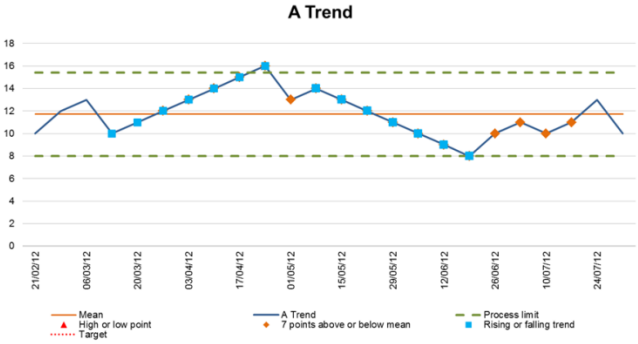


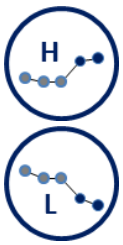
Extreme Values



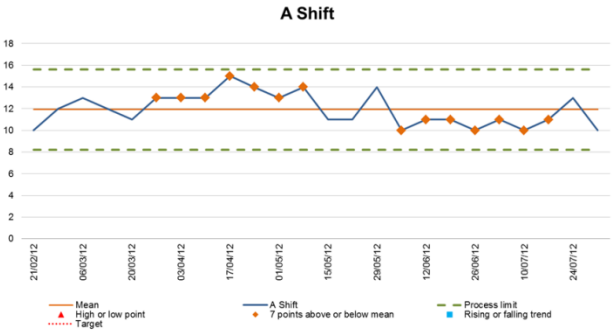
There is no Icon for this scenario.

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

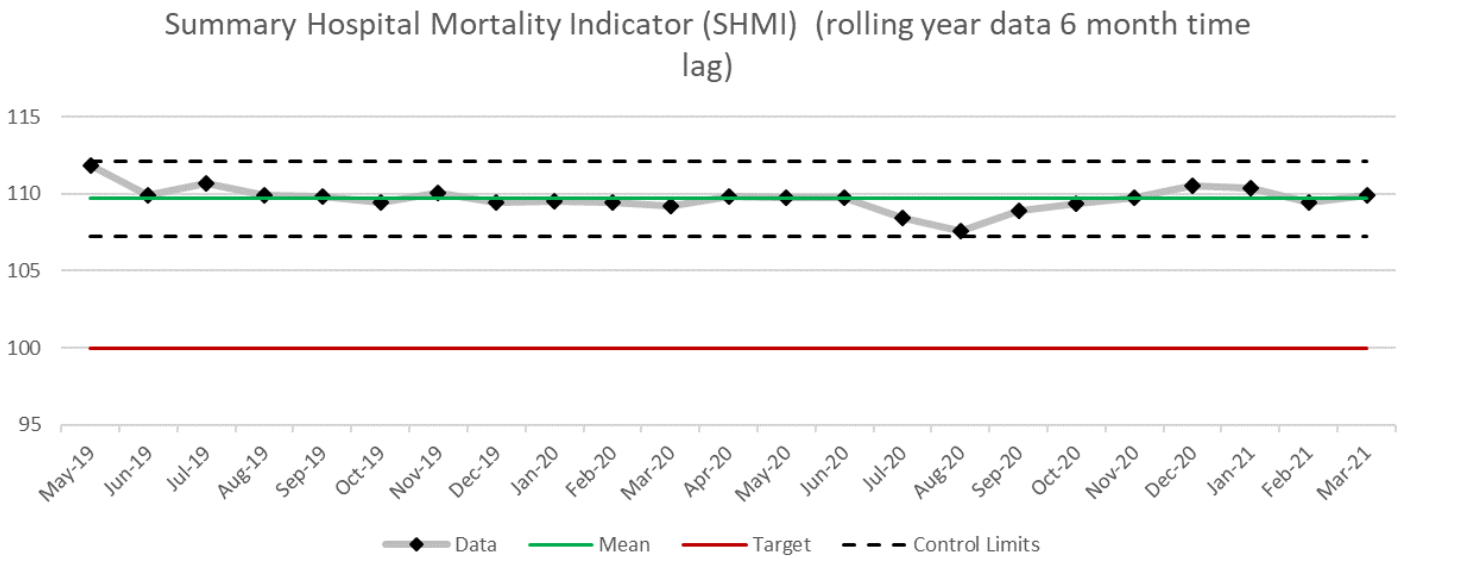
Where the target has been missed for at least 3 of the most recent data points in a row, or in a string of 7 of the most recent data points, at least 5 out of the 7 data points have missed.

DELIVER HARM FREE CARE – MORTALITY SHMI

Executive Lead: Medical Director

CQC Domain: Effective

Strategic Objective: Patients



Challenges / Successes:

ULHT SHMI is in Band 2 within expected limits with a score of 109.90 a slight increase from the last reporting period. SHMI includes both deaths in-hospital and within 30 days of discharge. The data is reflective up to October 2020.
Current in-hospital SHMI is 101.27.

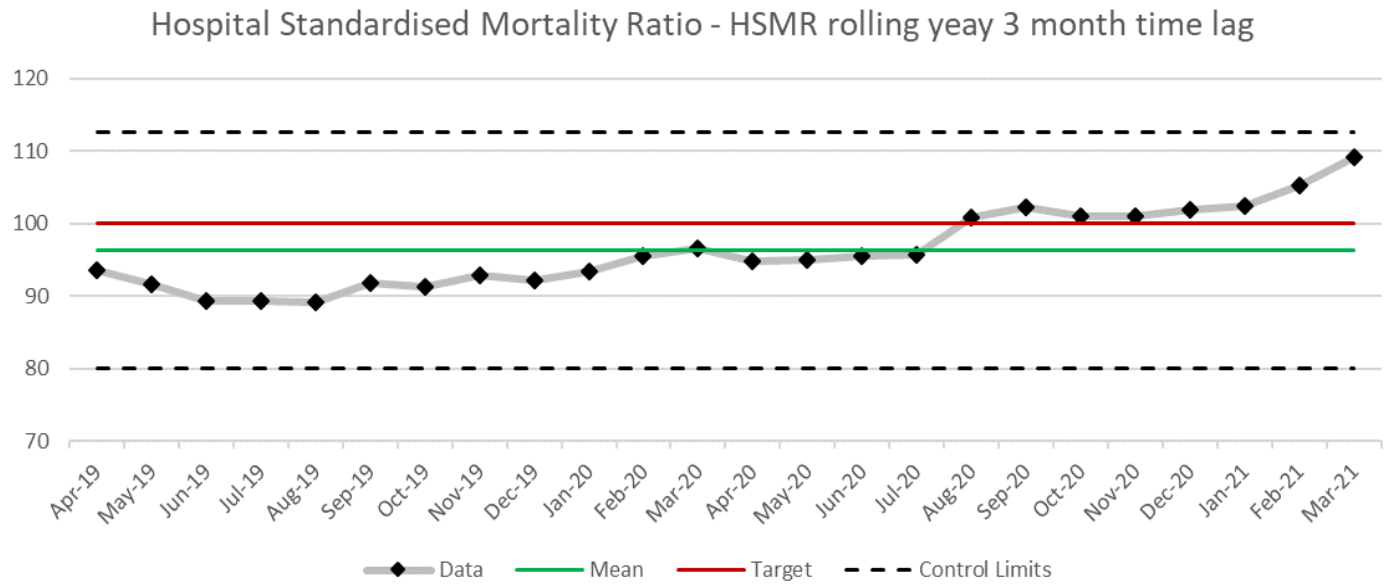
NHS Digital are excluding all data in regard to COVID-19.
An extract from NHS Digital shows that 1.0% of spells (750 spells), have been excluded due COVID-19 coding. The national average is 1.8%.

DELIVER HARM FREE CARE – MORTALITY HSMR

Executive Lead: Medical Director

CQC Domain: Effective

Strategic Objective: Patients



Challenges/Successes

ULHT's HSMR for the rolling 12-months is at 109.11 which is within the 'High' banding.
Peer group analysis, identifies that ULHT has the fourth lowest HSMR of our ten peers (range 100.99 to 114.06).

HSMR for the financial year and month is showing 'High' for the Trust, Lincoln and Pilgrim sites.
Due to the COVID-19 pandemic the rises in the HSMR were be expected.
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:

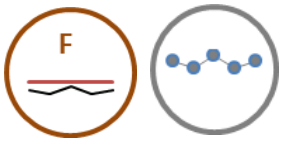
Acute Bronchitis – first month at Lincoln
Cardiac Dysrhythmias – first month at Lincoln
Coronary Atherosclerosis & Other Heart Disease – second month at Trust
Other Liver Disease – sixth month at Trust (case note review being presented at MorALS in April 2021)
Pleurisy pneumothorax/pulmonary collapse - second month at Trust (Review has been completed which identified failings in documentation/coding, potentially increasing HSMR)
Septicaemia – fifth month at Trust (case note review completed)
Skin & Subcutaneous Tissue Infections – first month at Grantham (diagnostic review completed)

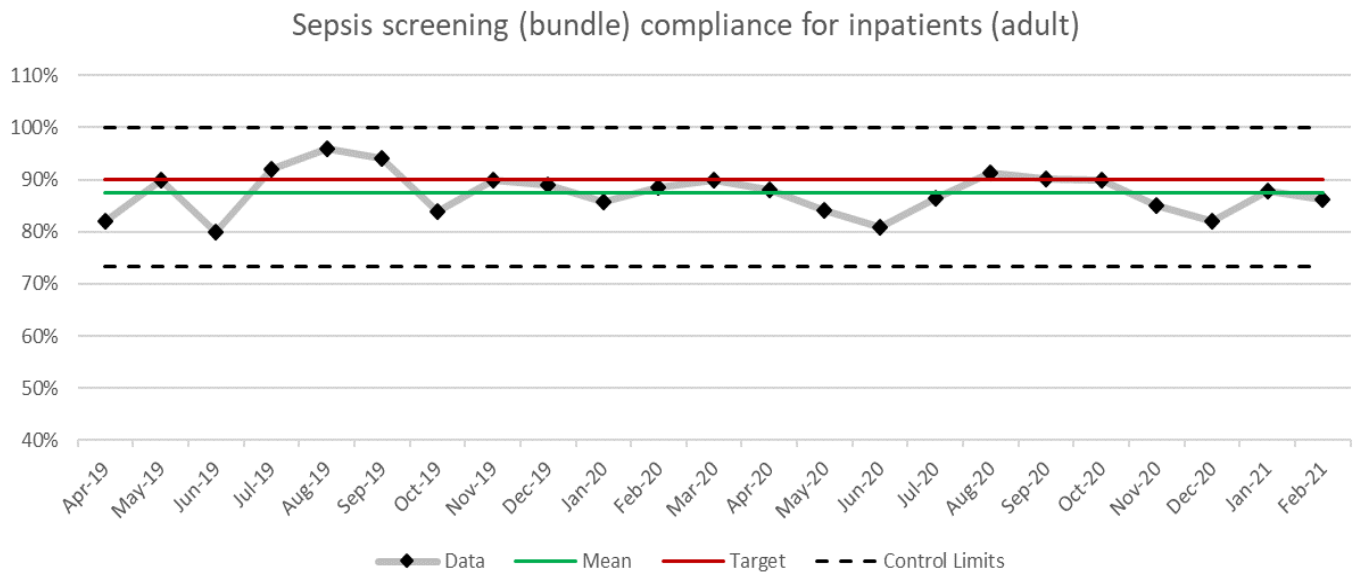
DELIVER HARM FREE CARE – SEPSIS SCREENING (BUNDLE) COMPLIANCE

Executive Lead: Director of Nursing

CQC Domain: Safe

Strategic Objective: Patients





Challenges/Successes

The compliance for February has declined to 86.2% with the omissions predominantly seen within the medical wards and reflects the additional challenges posed by Covid. The medical wards have seen many changes in personnel and purpose and this has impacted on the stability of the ward team. There has also been a challenge in ensuring that Sepsis is considered within a context of Covid pneumonia and whilst this is diminishing it is still ongoing.

Actions in place to recover

The restoration of services and the end of redeployment by the end of March will allow the Sepsis Practitioners to provide bedside training and with teaching being able to resume in the next month the message to screen all patients with a NEWS of 5 will be emphasised to all staff groups. The roll out of the Train the Trainer programme has been on hold for the last year but the core + panel has reconvened and a date is awaited for presentation with the supporting paperwork now submitted.

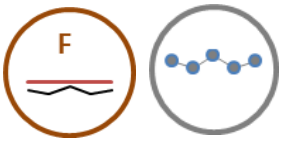
The principle of ward/department Trainers is expected to boost engagement and provide local support for areas.

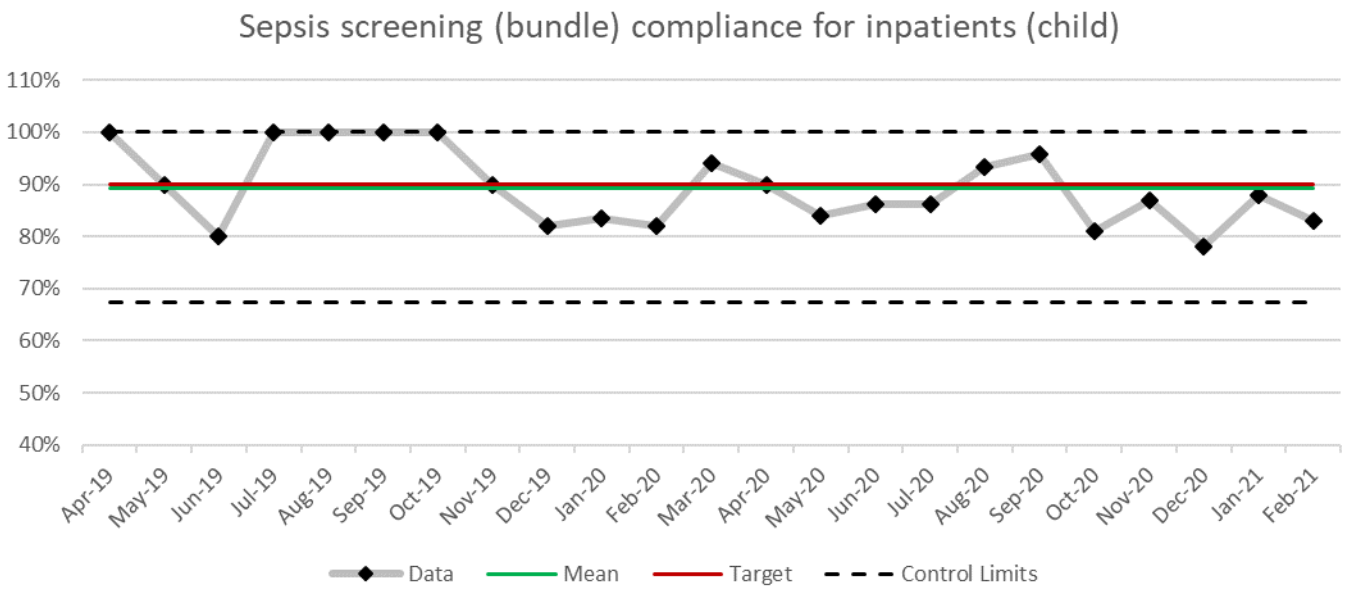
DELIVER HARM FREE CARE – SEPSIS SCREENING (BUNDLE) COMPLIANCE

Executive Lead: Director of Nursing

CQC Domain: Safe

Strategic Objective: Patients





Challenges/successes

The figures for February have slipped slightly to 83% from 88% Harm reviews have been performed on all the missed screens and no harm has been detected. The overall numbers are low and it is therefore difficult to draw conclusions through a thematic analysis but there does appear to be less confidence in using the sepsis tool amongst new registrants, Children's ward at Pilgrim has seen a marked decline from a consistently strong position.

Actions in place to recover.

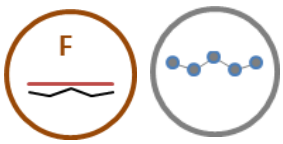
The Paediatric sepsis practitioner has worked closely with the ward leads of Safari and Rainforest to target training where it has been identified there is less confidence with the screening tool and bundle. This appears to have had a positive impact and the plan is to roll this out to Pilgrim site.

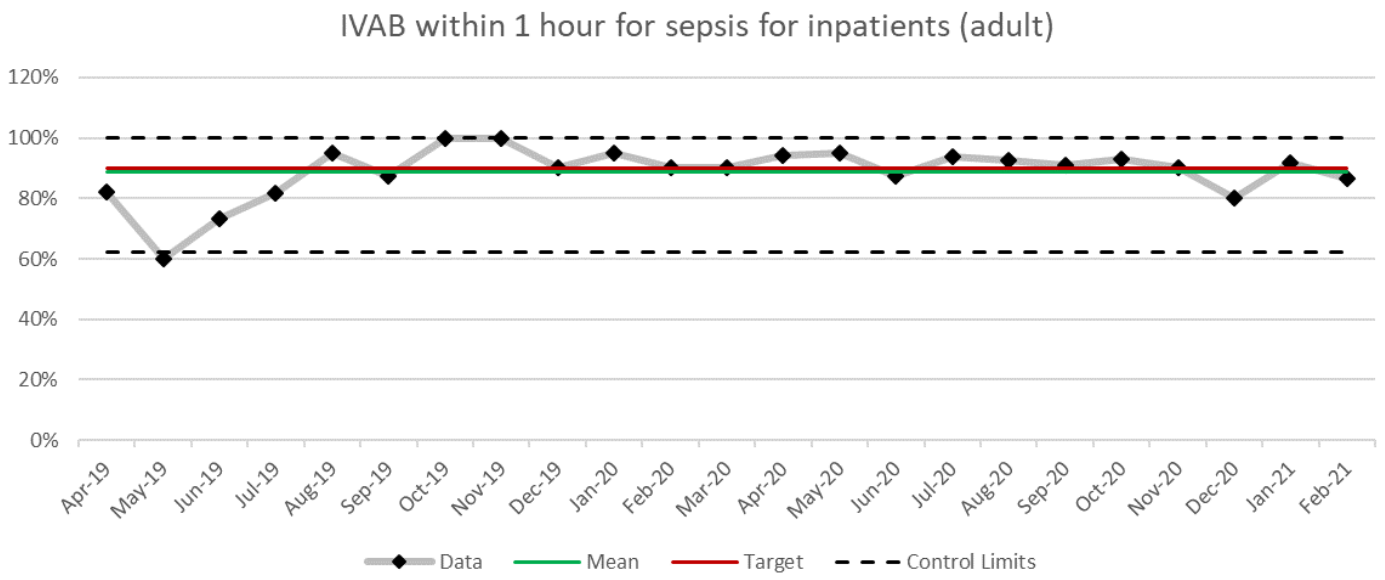
DELIVER HARM FREE CARE – IVAB WITHIN 1 HOUR FOR INPATIENTS

Executive Lead: Director of Nursing

CQC Domain: Safe

Strategic Objective: Patients





Challenges/successes

The performance for inpatients across both sites has dipped to 86% which is below the 90% standard. Harm reviews have been undertaken for all of the delayed treatments and whilst no severe harms have been detected there are 2 cases which will be discussed at the respective clinical governance meetings to share lessons learnt.

Actions in place to recover

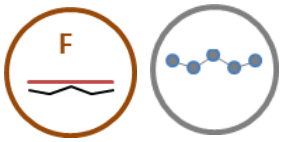
The previously discussed roll out of the “Train the Trainer” programme will greatly assist in supporting local improvement and it is hoped that the sepsis practitioners will be able to present this programme for approval in April. In the short term support has been offered to the respective ward leads. This is still hampered by the additional focus that is required for ED and the work that is ongoing around the section 31 notice. Clinical leadership for Sepsis has greatly improved with the commencement of the deteriorating patient group and this has provided more impetus for the improvement plans.

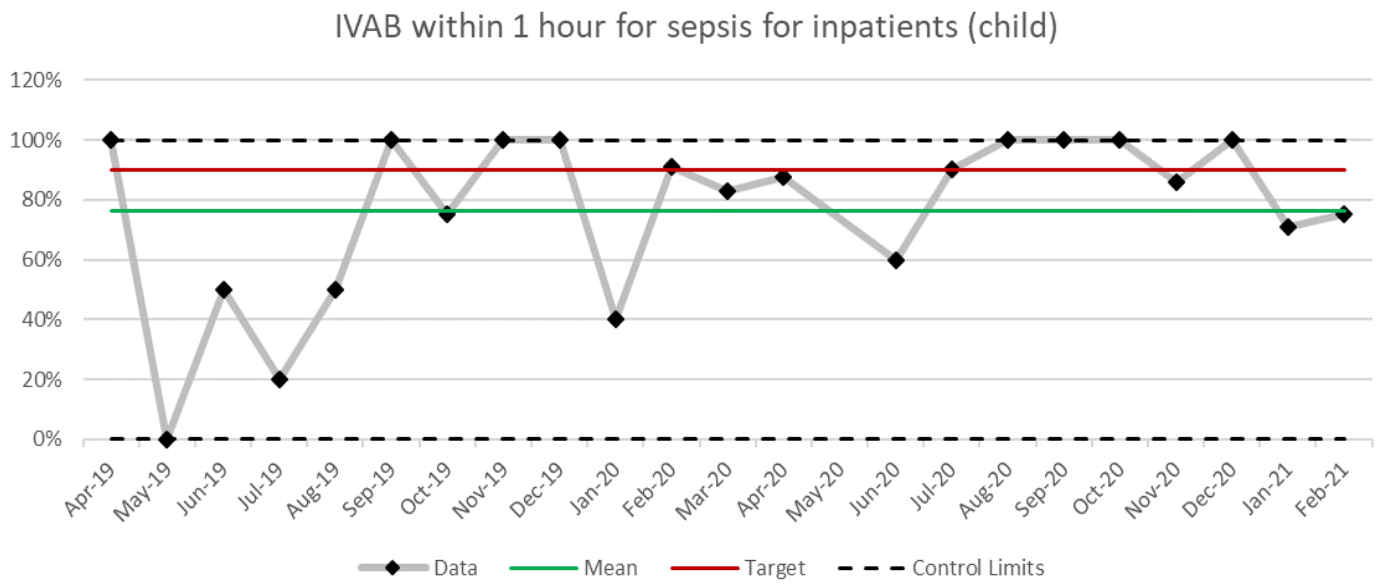
DELIVER HARM FREE CARE – IVAB WITHIN 1 HOUR FOR INPATIENTS

Executive Lead: Director of Nursing

CQC Domain: Safe

Strategic Objective: Patients





Challenges/successes

Compliance for bundle completion for inpatient (child) has continued to be below the 90% standard 75%. This however represents only one patient and demonstrates that the overall low numbers have a disproportionate effect on the percentages.

Actions in place to recover

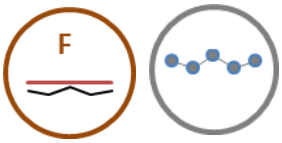
The main issue continues to centre around the correct selection of options within the bundle. In both cases it would have been appropriate to have selected the unsure option which would have allowed more time for the clinician to decide upon treatment options without proceeding directly to invasive interventions. This is being addressed as part of a training plan with the respective ward leads.

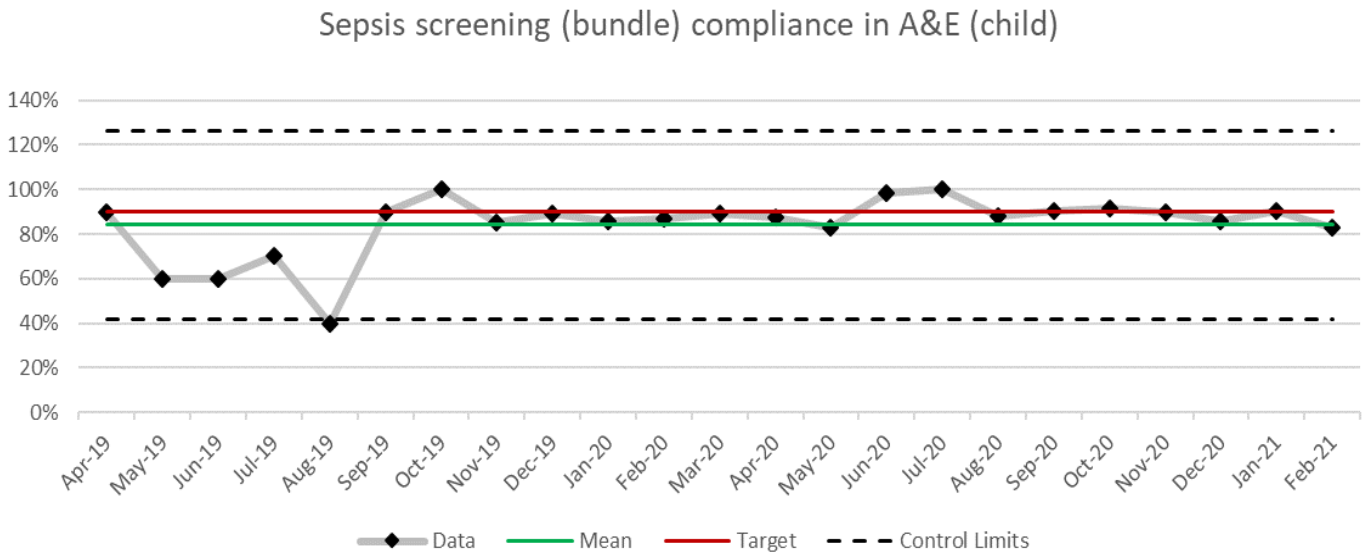
DELIVER HARM FREE CARE – SEPSIS SCREENING (BUNDLE) COMPLIANCE

Executive Lead: Director of Nursing

CQC Domain: Safe

Strategic Objective: Patients





Challenges/successes

Compliance has fallen to 83% for this month with 11 patients having missed or delayed screens. Harm reviews have identified that all cases were for an alternate cause and not infection. There remains some wariness amongst staff with less paediatric experience to complete the screen.

Actions in place to recover

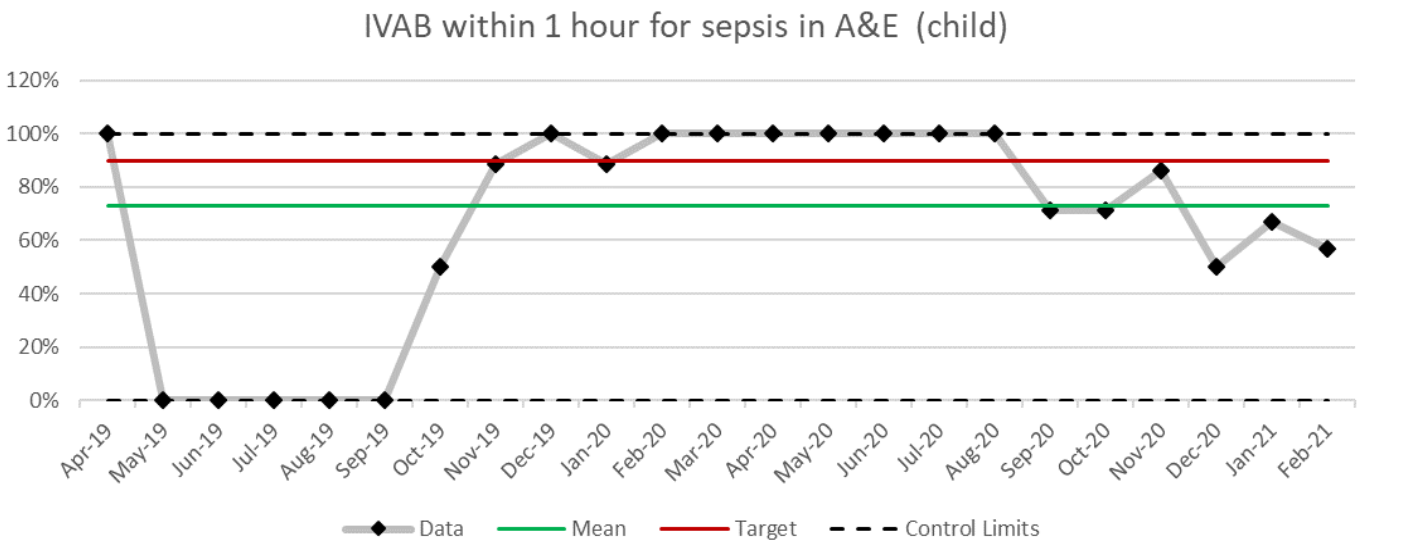
Previously paediatric training tended to focus upon those staff with existing paediatric competencies but this is being rolled out to all registered staff and 2 paediatric study days have been planned in April for both sites. A weekly focus group has commenced for the Emergency departments and has senior nursing and clinician support with clearly defined actions.

DELIVER HARM FREE CARE – IVAB WITHIN 1 HOUR IN A & E

Executive Lead: Director of Nursing

CQC Domain: Safe

Strategic Objective: Patients



Challenges/Successes

The compliance for IV antibiotics in ED (child) has fallen to 57% which is well below the 90% standard. The main driver for this poor compliance appears to be the direction of the paediatrician who request that the patients are transferred to the inpatient ward so precluding completion of the bundle prior to transfer.

Actions in place to recover

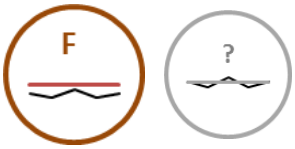
The cause for this delay was found to be as a result of the Paediatric doctor requesting that the child be transferred to the ward prior to the completion of the sepsis bundle rather than attending the patient in the department. This has been addressed at consultant level via the governance process and it has now been mandated that patient move should not happen prior to completion of the sepsis bundle. A working group has now been established by the Paediatric practitioner to improve the processes between the ED department and paediatrics and dedicated teaching is to commence in April to improve knowledge and skills.

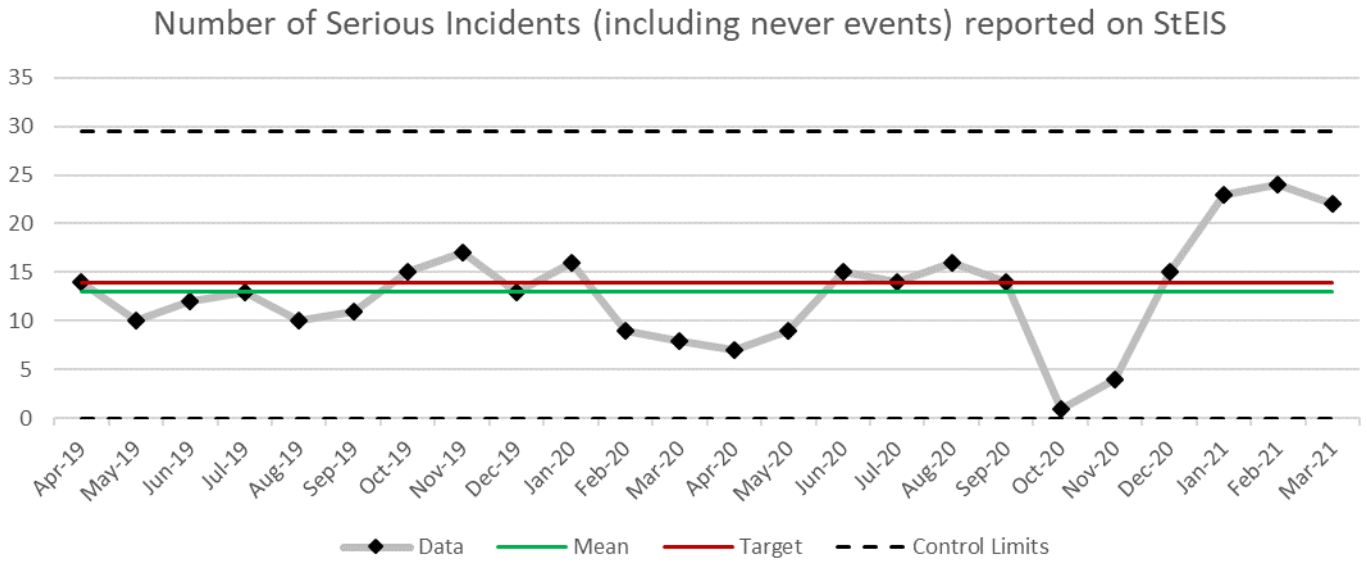
DELIVER HARM FREE CARE – SERIOUS INCIDENTS ON StEIS

Executive Lead: Director of Nursing

CQC Domain: Safe

Strategic Objective: Patients





Challenges/ Successes

- The Trust declared 22 Serious Incidents in March 2021, following on from 24 declared in February and 23 in January.
- None of those incidents actually occurred in March; 14 occurred in February, 4 in January; 1 in December, 1 in November, 1 in 2019 and 1 in 2018 (the last 2 reported via a complaint and a Coroner's Inquest).
- 6 of the 22 are waits in A&E of more than 12 hours, which are currently subject to clinical harm review.

Actions to Recover

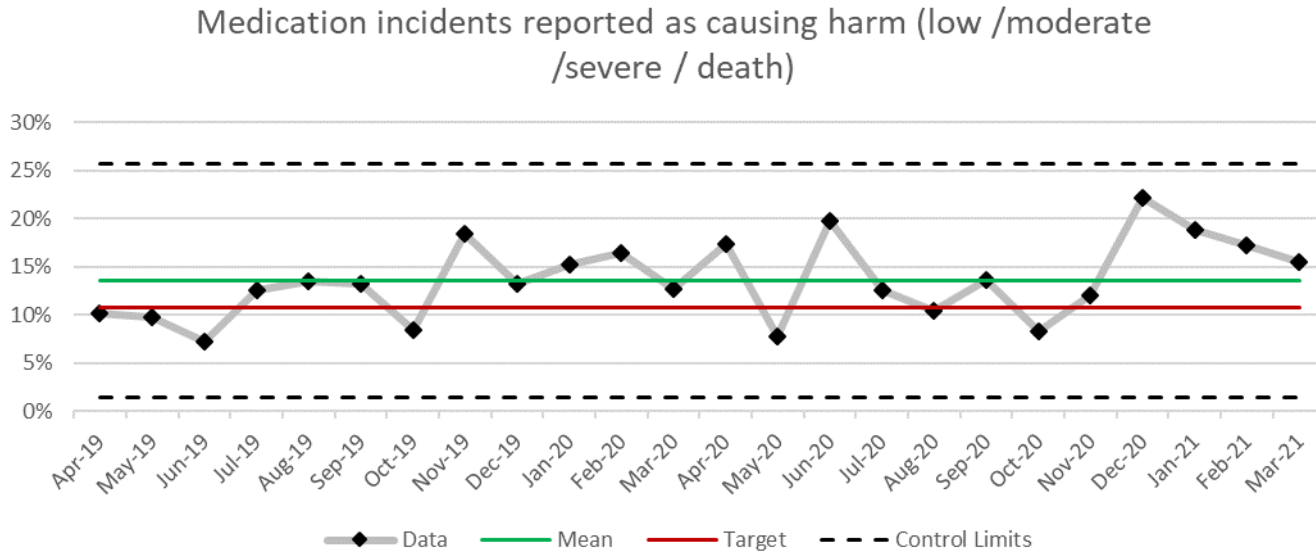
- The Trust's decision-making processes with regard to Serious Incidents have been strengthened in recent months, to deliver improved compliance with the national framework; as a consequence, Serious Incidents are now declared more promptly and the decision reviewed once more information has been gathered.
- This may result in more Serious Incidents being declared and subsequently down-graded.

DELIVER HARM FREE CARE – MEDICATION INCIDENTS CAUSING HARM

Executive Lead: Medical Director

CQC Domain: Safe

Strategic Objective: Patients



Challenges/ Successes

In the month of March the number of incidents reported was 148. The number of incidents causing some level of harm (low /moderate /severe / death) has remained consistent with the last 12 months, however is higher than the national median.

We know that staffing has been a significant issue with staff being redeployed.

Actions to Recover

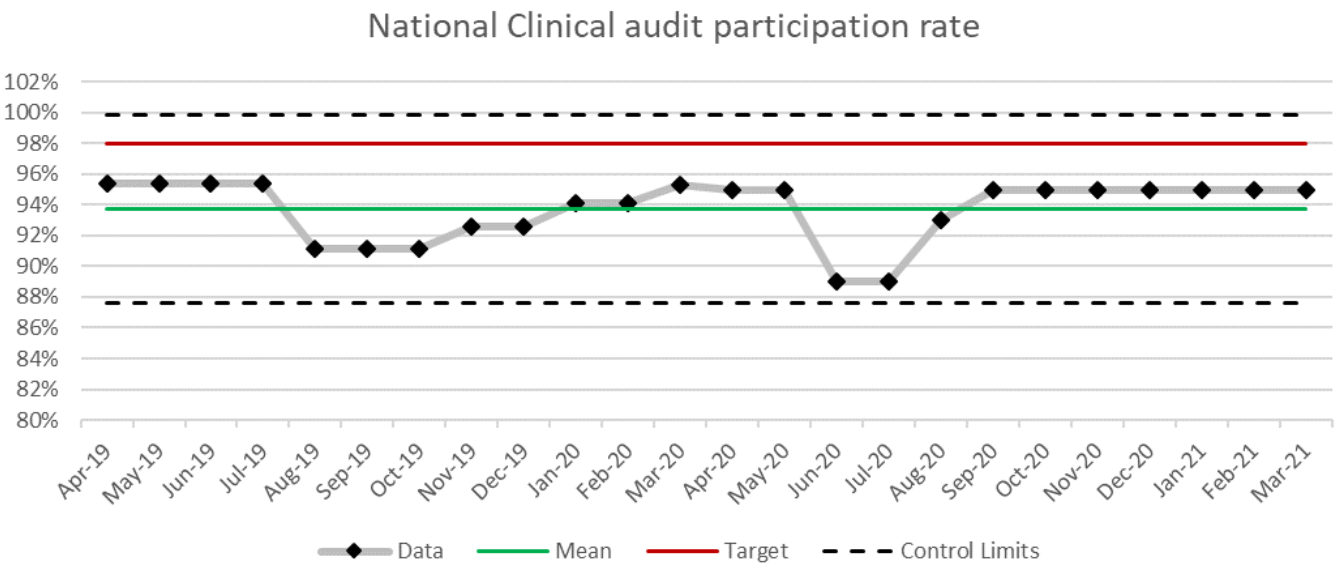
Each CBU pharmacist has been sent the medication incident reports and will work with wards to make

DELIVER HARM FREE CARE – NATIONAL CLINICAL AUDIT RATE

Executive Lead: Medical Director

CQC Domain: Effective

Strategic Objective: Patients



The % participation National Clinical Audit rate has remained at 95% for the month of March 2021 compared to a target of >98% the following is not compliant with data submissions;

- None Participation in the National IBD audit to be clarified with the Gastroenterologists as the latest National report lists all other eligible Trusts are participating, there is a participation fee to be paid by each Trust it's not clear if this is the reason for none participation – Escalated to the Division lead to review participation with the clinical team.

Elective procedures cancelled in line with NHS England Guidance

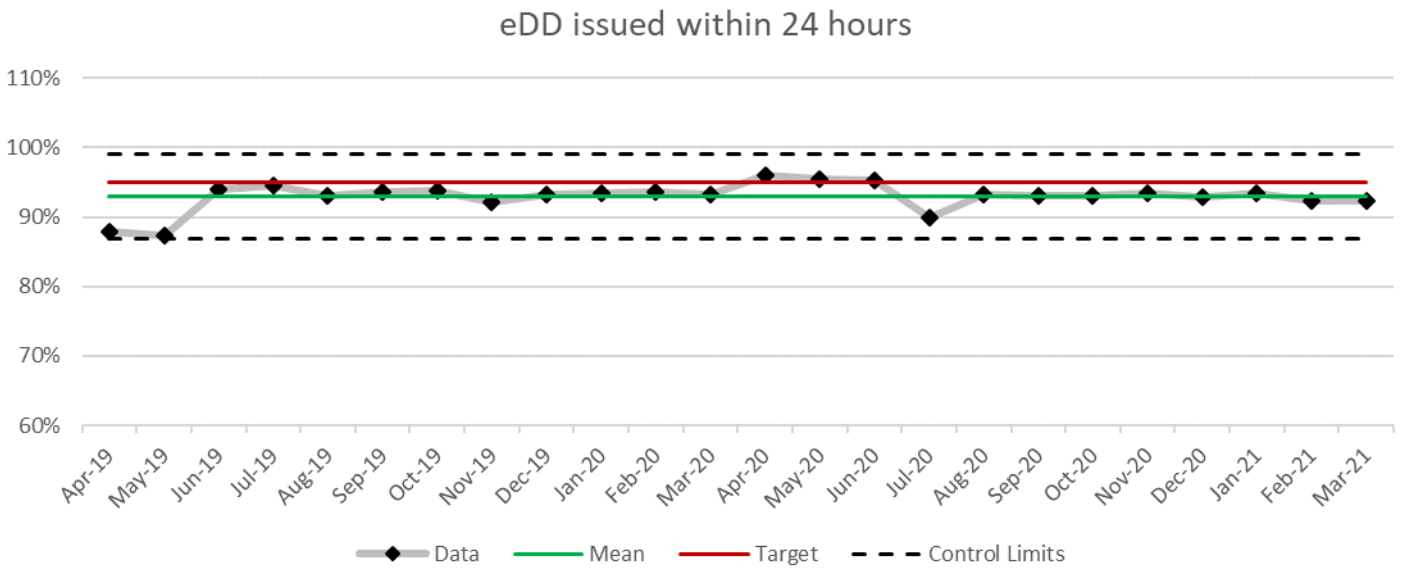
- Procedures that are now taking place this should improve participation submissions with the Green site restoration phase and as the Trust returns to normal working.
- PROMs submissions for hip and knee replacements continue to be lower than expected.
- Bowel cancer data submissions are lower than expected for Lincoln and Grantham escalated to clinical leads and the cancer team manager to improve data submission.
- Oesophageal gastric cancer data submission lower than expected new MDT Consultant lead has picked this up with the cancer team to submit the data.

DELIVER HARM FREE CARE – eDD ISSUED WITHIN 24 HOURS

Executive Lead: Medical Director

CQC Domain: Effective

Strategic Objective: Patients



Challenges/Successes

The Trust achieved 92.2% compliance with sending eDDs within 24 hours for March 2021. 97.2% were sent anytime during the month of March 2021.

Actions in place to recover:

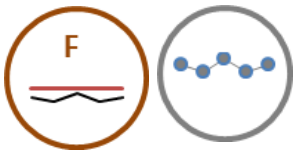
Paediatric eDD template being streamlined
eDD policy developed and sent for publishing

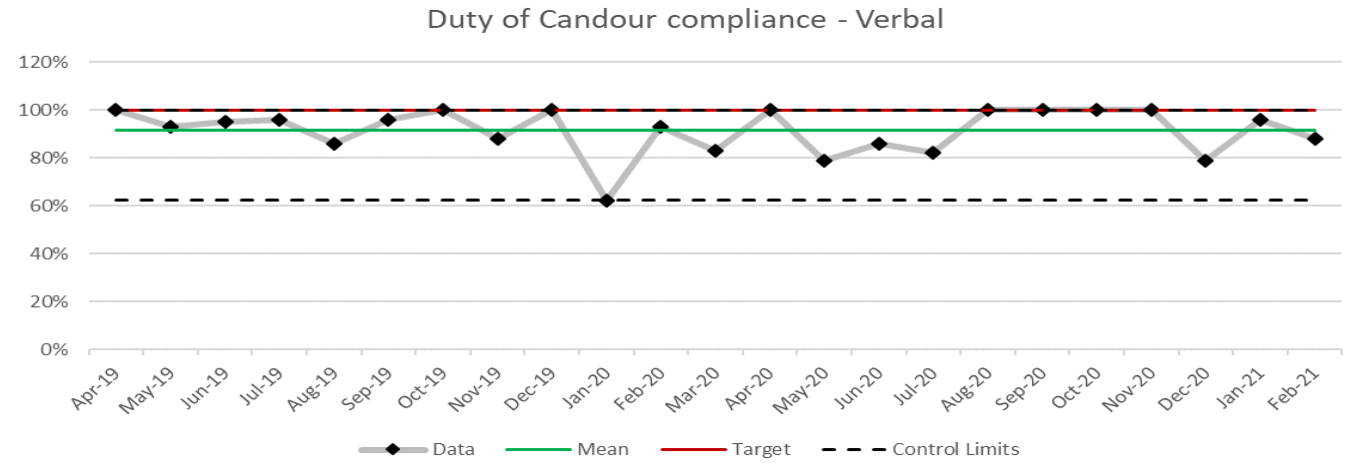
IMPROVE PATIENT EXPERIENCE – DUTY OF CANDOUR

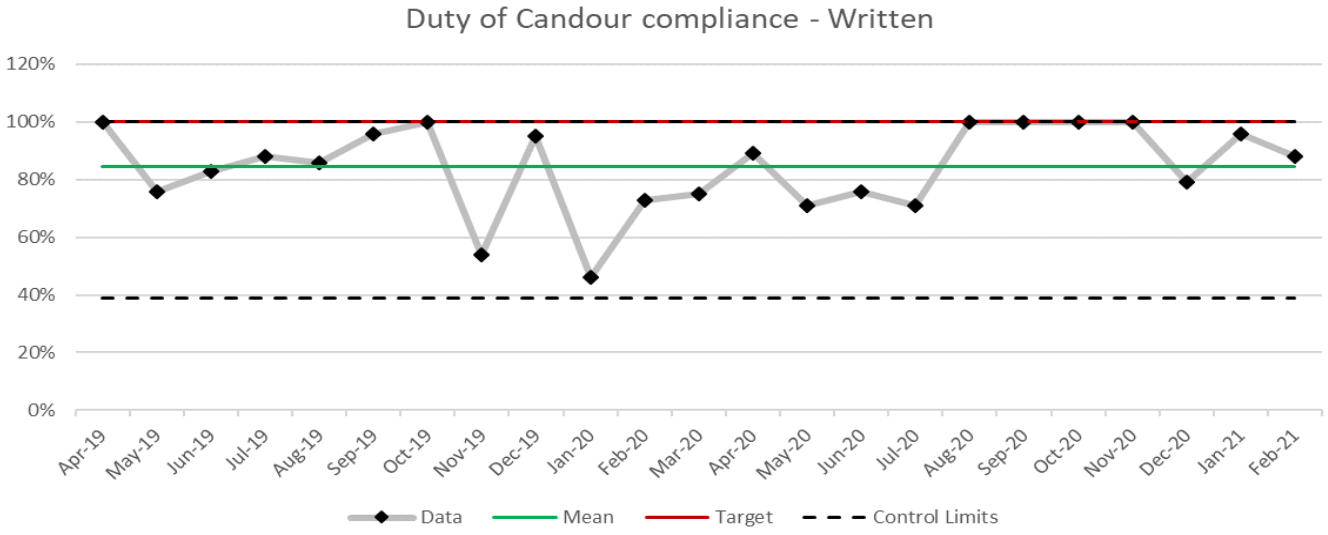
Executive Lead: Director of Nursing

CQC Domain: Caring

Strategic Objective: Patients







Challenges/Successes

- The Trust achieved 89% compliance with the Duty of Candour in February 2021, for both in person notification (verbal) and written follow-up.
- There were 3 non-compliant incidents, from 25 that were notifiable.
- 2 of the non-compliant incidents occurred within Surgery Division; 1 incident occurred in Medicine Division; all 3 have been declared as Serious Incidents and the patient or their representative will be contacted by the investigation team.

Actions in place to recover:

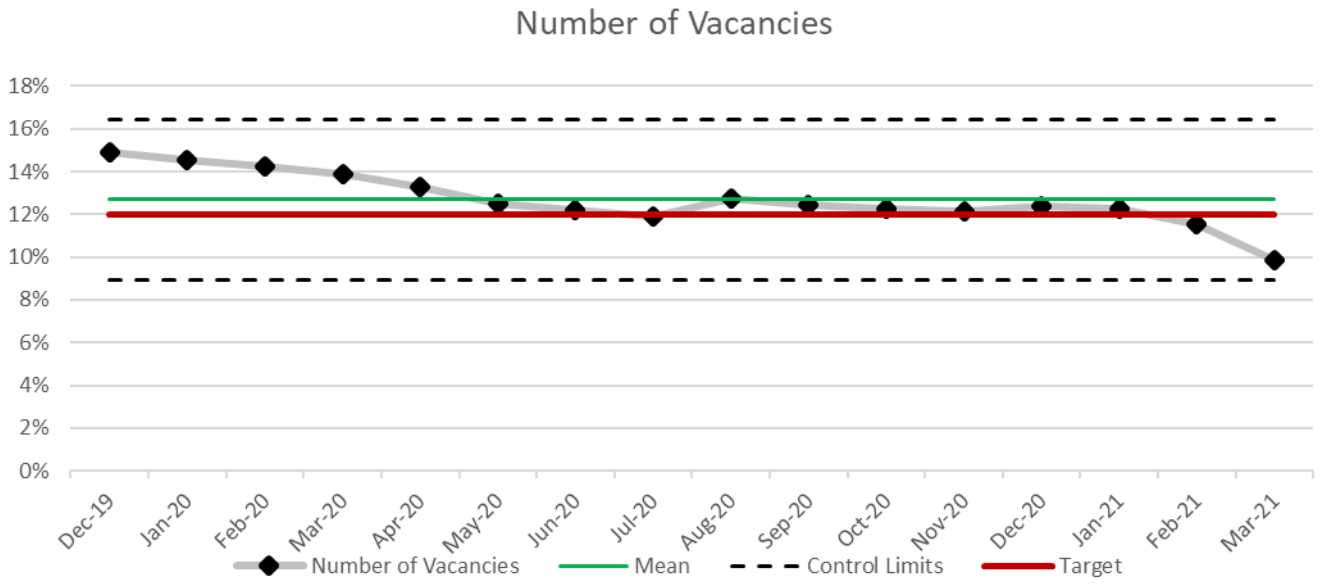
- The Risk & Incident now notify the divisional triumvirate on the next working day of all incidents where Duty of Candour applies, highlighting those that require completion.
- Amendments have also been made to Datix to provide additional guidance and prompts for Duty of Candour when reviewing the incident record.

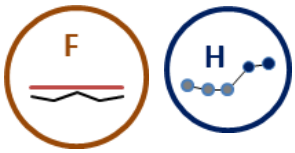
A MODERN AND PROGRESSIVE WORKFORCE – TURNOVER & VACANCIES

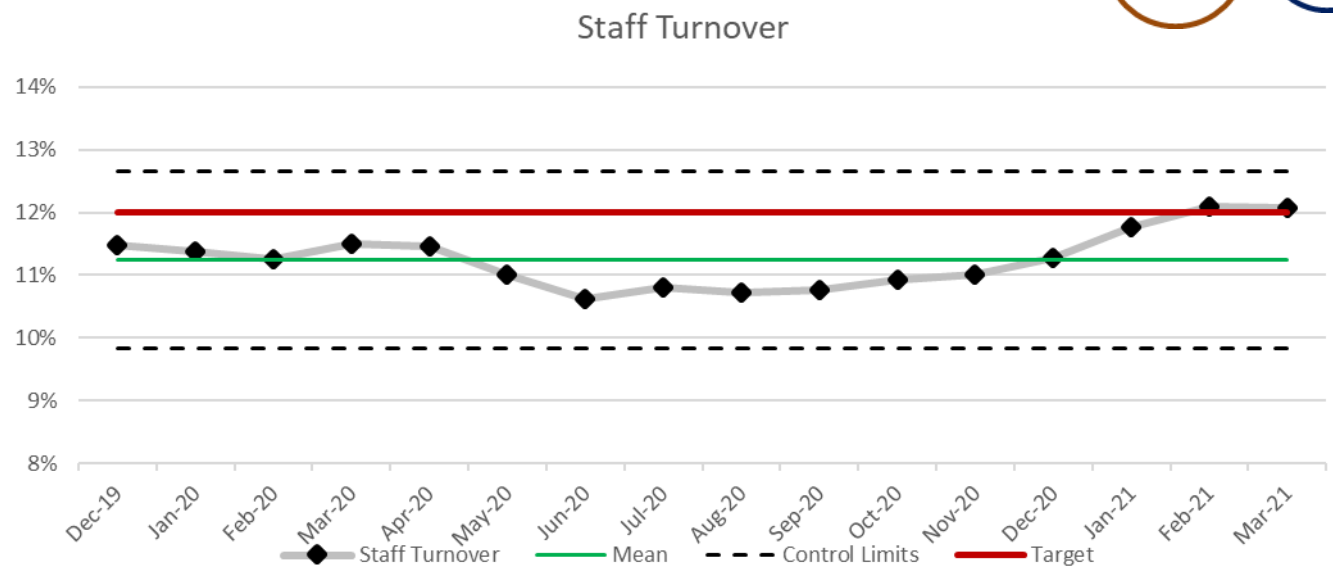
Executive Lead: Director of HR & OD

CQC Domain: Well-Led

Strategic Objective: People



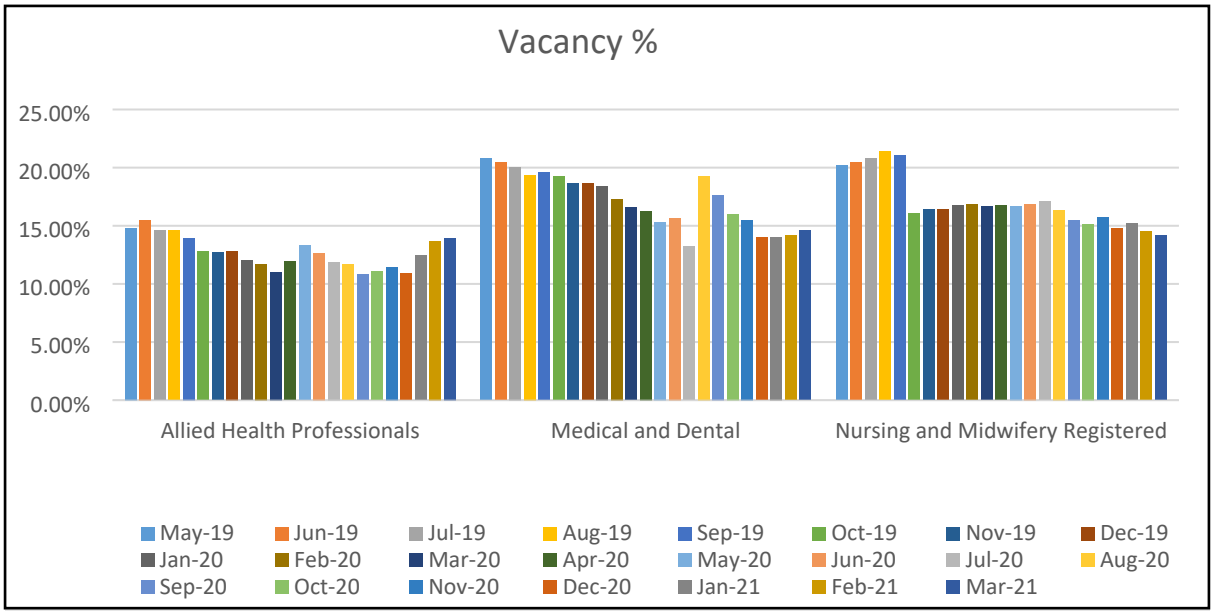




Overview

The chart below illustrates the Trust's overall vacancy has gradually declined since the summer of 2019, with a more rapid decline in the last couple of months.

The chart below shows the vacancy rate for the key clinical groups:



What this shows is that the overall reduction in vacancies is focused on nursing (registered and unregistered and other staff groups. With the support of NHSE/I we will have recruited around 120 international nurses to the Trust by the end of April. These will start in cohorts with the Trust through to the end of September upon successful completion of their training and exams. With domestic recruitment and NQNs we expect over 200 new starts by the Autumn, against the 320 vacancies. There is an expectation of further international nurse recruitment through to the end of the 2021/22 financial year and this, coupled with other recruitment activity planned, should enable us to minimise nursing vacancies by the spring of 2022.

There are over 200 new HCSWs due to start with the organisation before the end of May. This should leave a net nil vacancy position once they all start with the Trust,

We are seeking to become more sophisticated in terms of our pipeline reporting, taking into account recruitment in our TRAC recruitment system, other recruitment activity underway (largely medical and nursing) but yet to enter the recruitment system and overlay this with turnover data. The table below remains work in progress, but illustrates the data now available.

Staff Group	Vacancy Position 31 Mar 20	Current Vacancy Position 22 Mar 21	Progress between last year and this year	Trac Pipeline	Predicted Turnover for 6 month (up to end Sept)	Predicted Vacancy Position	Difference Between Future Vacancy Position & Current Position	Additional Actvity (inc Pipeline Adjustment)	Paused Recruitment	Adjusted Predicted Vacancy Position	Difference Between Future Vacancy Position & Current Position inc Additional & Paused
Add Prof Scientific and Technic	-33.20	-28.01	-5.19	0.00	-14.35	-42.36	14.35			-42.36	14.35
Additional Clinical Services *(see below)*	-135.23	-65.62	-69.61	86.00	-88.52	-68.15	2.52			-68.15	2.52
Administrative and Clerical *(see below)*	-243.08	-165.43	-77.65	12.90	-96.16	-248.69	83.26			-248.69	83.26
Allied Health Professionals	-47.22	-59.46	12.24	14.01	-27.35	-72.80	13.34	41.00		-31.80	-27.66
Estates and Ancillary *(see below)*	-80.88	-48.62	-32.27	1.40	-27.48	-74.69	26.08			-74.69	26.08
Healthcare Scientists	-12.54	-17.78	5.24	0.00	-5.17	-22.95	5.17			-22.95	5.17
Medical and Dental	-109.97	-120.19	10.22	52.60	-36.09	-103.68	-16.51	57.67	15.00	-31.01	-89.18
Nursing and Midwifery Registered*	-379.44	-315.60	-63.84	182.73	-108.61	-241.48	-74.12	104.59	44.00	-92.89	-222.71
Students	3.00	6.25	-3.25	0.00	-15.84	-9.59	15.84			-9.59	15.84
Grand Total	**-1038.56**	**-814.47**	**-224.09**	**349.64**	**-419.57**	**-884.40**	**69.93**	**203.26**	**59.00**	**-622.14**	**-192.33**

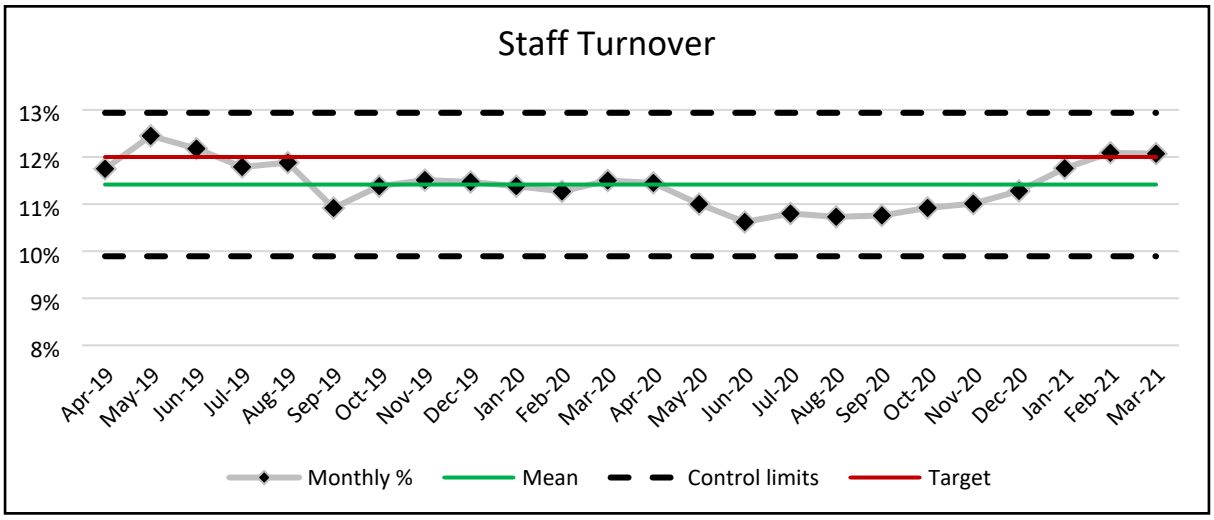
**26 International Nurses currently at B3 within staff group Additional Clinical Services will move to B5 to reduce nursing vacancies*

It illustrates the challenge in the last 12 months in terms of making progress in covering medical gaps when turnover is taken into account.

In terms of recruiting to our vacancies, there are strong pipelines in place for the recruitment of medical staff and active recruitment to 93 of the 119 fte medical vacancies. The remaining posts are on hold.

We will build on the success of the HCSW cohort recruitment programme to run similar exercises for HCSWs through the year and also for other clinical groups, to address the vacancy position among Allied Health professionals.

Turnover is shown in the graph below:



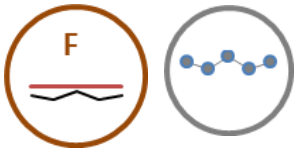
Turnover was increasing through the Autumn and Winter, but does now appear to have stabilised. We will be particularly focused on retaining our new recruits, both to HCSW roles and the international nurses, with a range of specific actions planned (around cultural awareness for example).

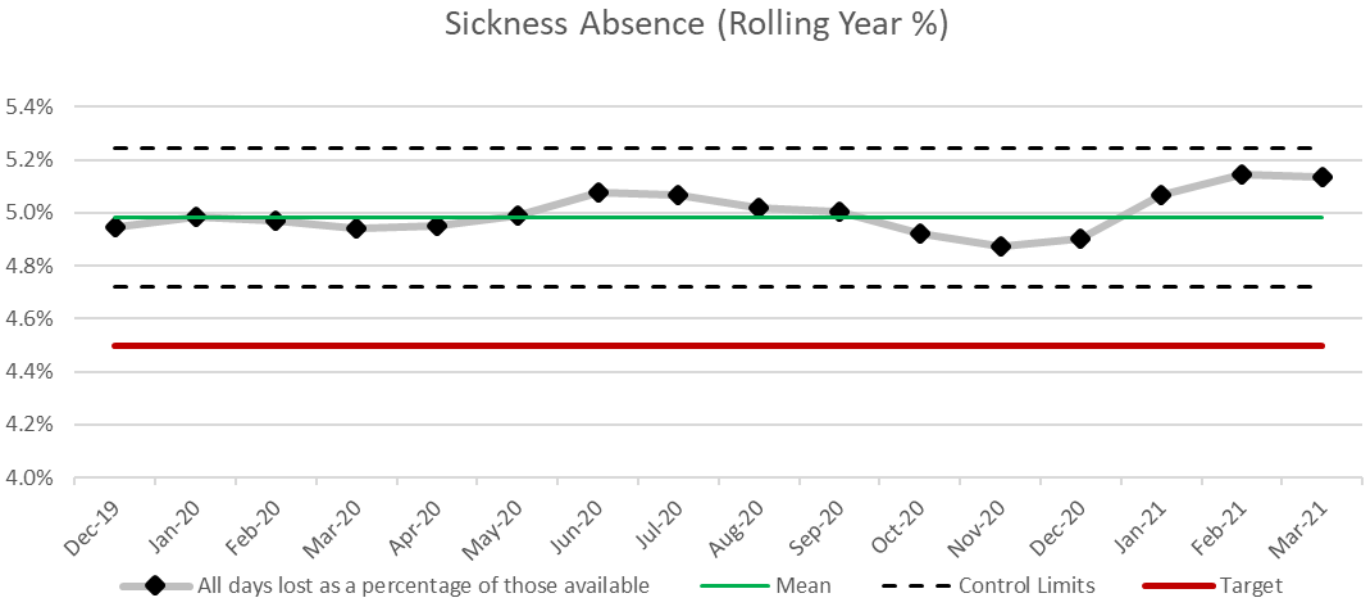
A MODERN AND PROGRESSIVE WORKFORCE – SICKNESS

Executive Lead: Director of HR & OD

CQC Domain: Well-Led

Strategic Objective: People





Overview

The monthly rate however has decreased from 6.33% in January '21 to 5.04% in February '21. This is evidence of the reduced impact of COVID. The reduction can be seen across all Divisions and Directorates, which is positive and reflects not only the lower incidence of COVID, but the on-going work between HR Business Partners, the ER team and managers.

DIVISION	JAN	FEB
MEDICINE	7.54%	5.70%
SURGERY	7.03%	6.05%
CSS	5.82%	4.34%
FACILITIES & ESTATES	8.20%	7.02%
CORPORATE	3.04%	2.68%
FAMILY HEALTH	4.68%	3.97%

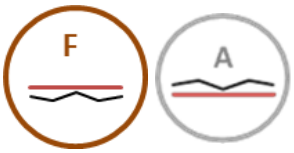
The April People and OD Committee undertook a deep dive into stress and anxiety absence, which has risen significantly, not only in ULHT, but across the NHS in the last 12 months. Our approach will be to focus on prevention (effective leadership and comprehensive wellbeing offer) and using our Attendance Management System to ensure early intervention and thereby supporting a speedy return to work.

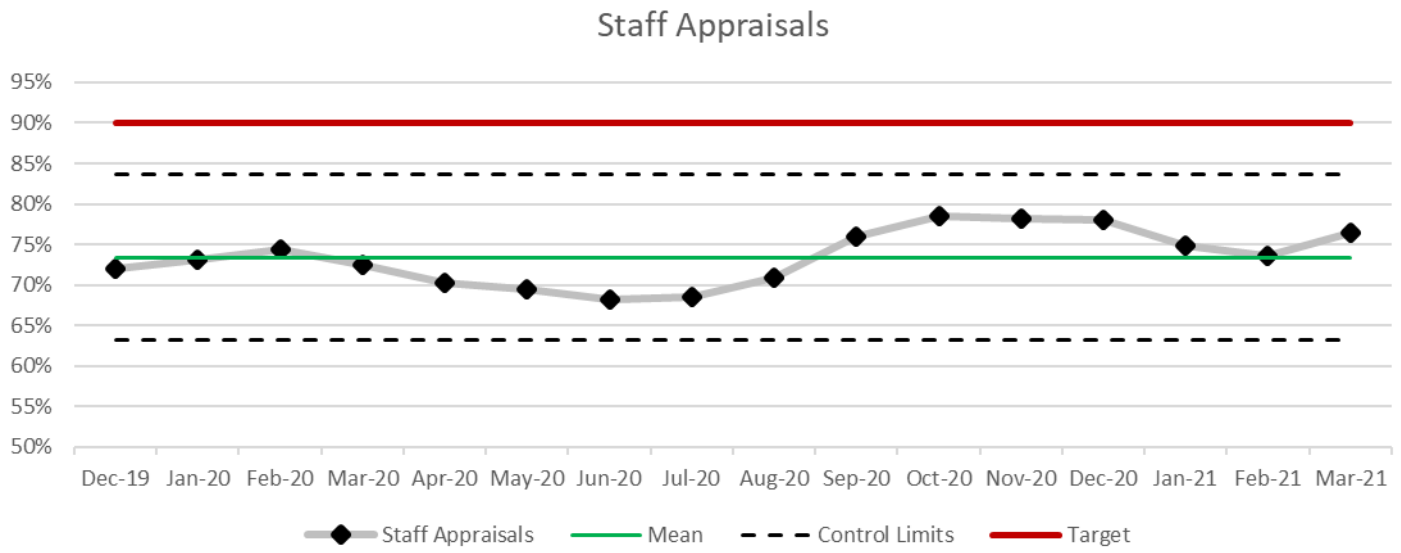
A MODERN AND PROGRESSIVE WORKFORCE – APPRAISALS

Executive Lead: Director of HR & OD

CQC Domain: Well-Led

Strategic Objective: People





Overview

The completion rate for AfC appraisals did recover during March. Over the last year, completion rates appear to be related to the impact of COVID on the Trust. During Wave 1 and Wave 2, appraisal completion rates declined, but rose in the period between (i.e. July to October).

We are seeking to refocus on appraisal as part of recovery. It is an opportunity to re-focus staff and discus their wellbeing. We have initiated a training programme for managers on having wellbeing conversations. The improvement in March was not as great as we would have hoped.

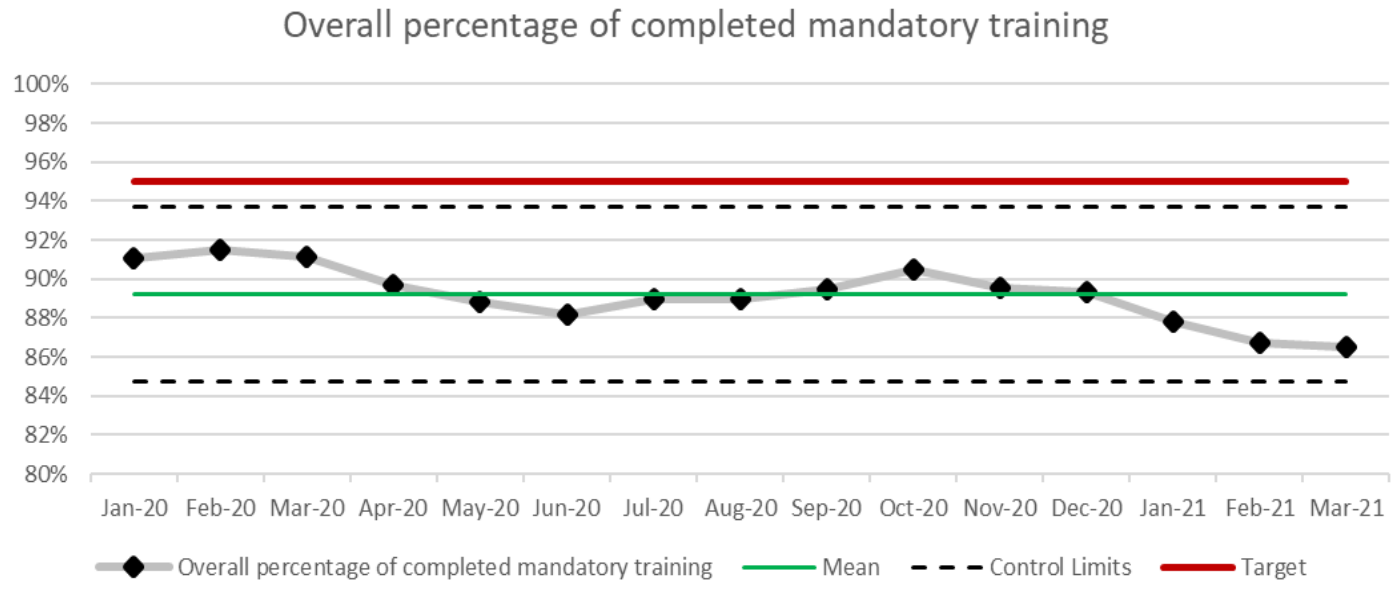
We are launching the new WorkPal system in May which will underpin individual performance management (i.e. on-going one-to-ones and supervision alongside formal appraisal). This will be an opportunity to refocus on appraisal. However we need a step change in attitudes towards the importance of this process, which may come through the Culture and Leadership Programme.

A MODERN AND PROGRESSIVE WORKFORCE – CORE LEARNING

Executive Lead: Director of HR & OD

CQC Domain: Well-Led

Strategic Objective: People



Overview

The decline in core learning compliance since October has not yet been reversed and is a concern.

We have identified some particular issues around compliance:

- Junior doctors have not been recording their completion of core learning on ESR
- Completion rates among nurse bank staff is particularly low

In addition we have identified that core learning plus is not profiled against individual roles, but against staff groups. We are over-stating the range of training that many people need to undertake to effectively and safely fufill their roles. Staff are not completing modules which they do not see as relevant to their roles, thereby impacting on compliance rates.

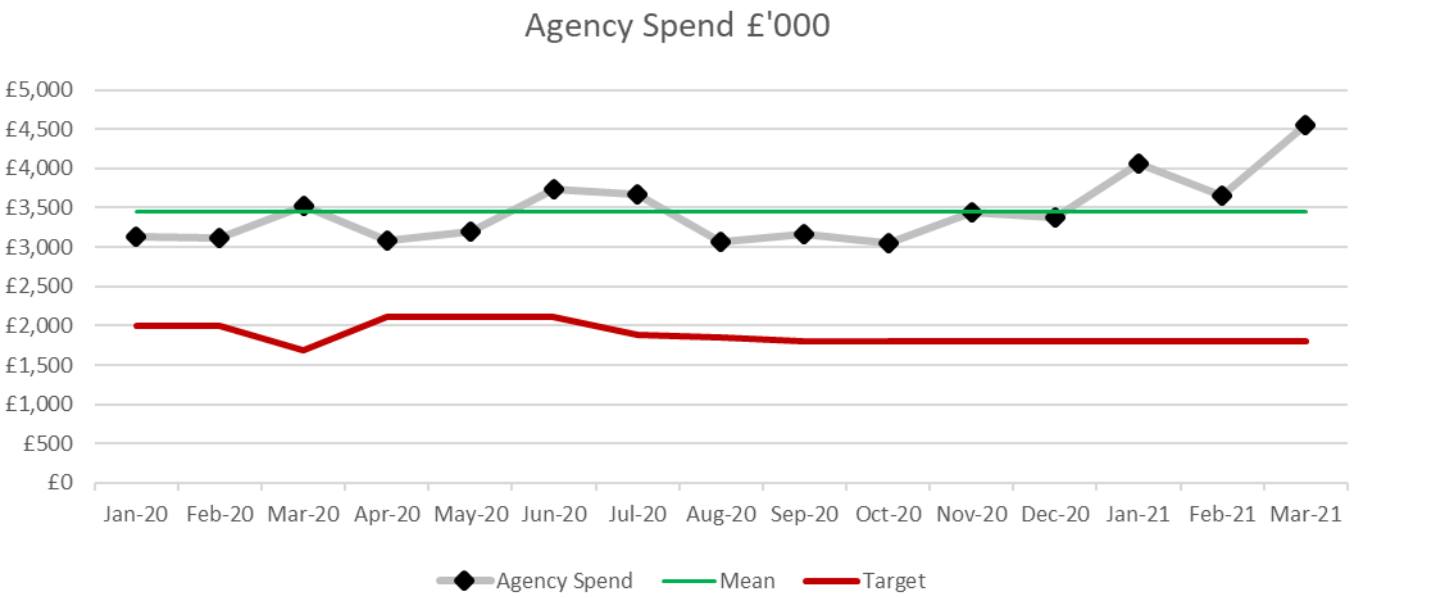
We had already initiated an overhaul of our approach to core learning and the above issues will be addressed as part of that role. We are currently scoping what could be a significant issue in respect of re-profiling core learning plus across all roles.

EFFICIENT USE OF OUR RESOURCES – AGENCY SPEND

Executive Lead: Director of HR & OD

CQC Domain: Well-Led

Strategic Objective: People



Overview

The overall level of agency spend has been increasing since October 2020 and there was a significant and concerning increase in March. Month on month agency spend has been lower than equivalent levels in the last two financial years, but spend is still above target.

It does show that agency spend during the second half of the year in particular was below the levels month on month in the last two financial years. This reduction is largely the result of the reduced reliance on medical agency spend. However levels of overall spend remain significantly higher than the NHSE/I target set.

Medical agency spend, which had been reducing, did increase in March. There was an increase in demand, primarily at consultant level, which resulted in an additional 1421 hours being booked. This represents the highest number of consultant hours booked since November 2020. These hours were primarily in the following specialties, Oncology, Gastroenterology, Stroke and Respiratory, where agency rates are the highest.

Nursing agency spend also continues to rise.

A reduction in agency spend is a key objective in the Integrated Improvement Plan for 21/22 and will be driven through the Financial Recovery meetings.

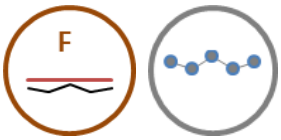
The Nursing Workforce Transformation Group is now meeting on a regular basis and reviewing nursing agency spend. The significant recruitment of registered nurses, which is referenced above, will also impact on levels of nursing agency spend. There is also a strong pipeline of medical recruits to consultant and other roles. We need to ensure that their appointment coincides with a step down in agency spend.

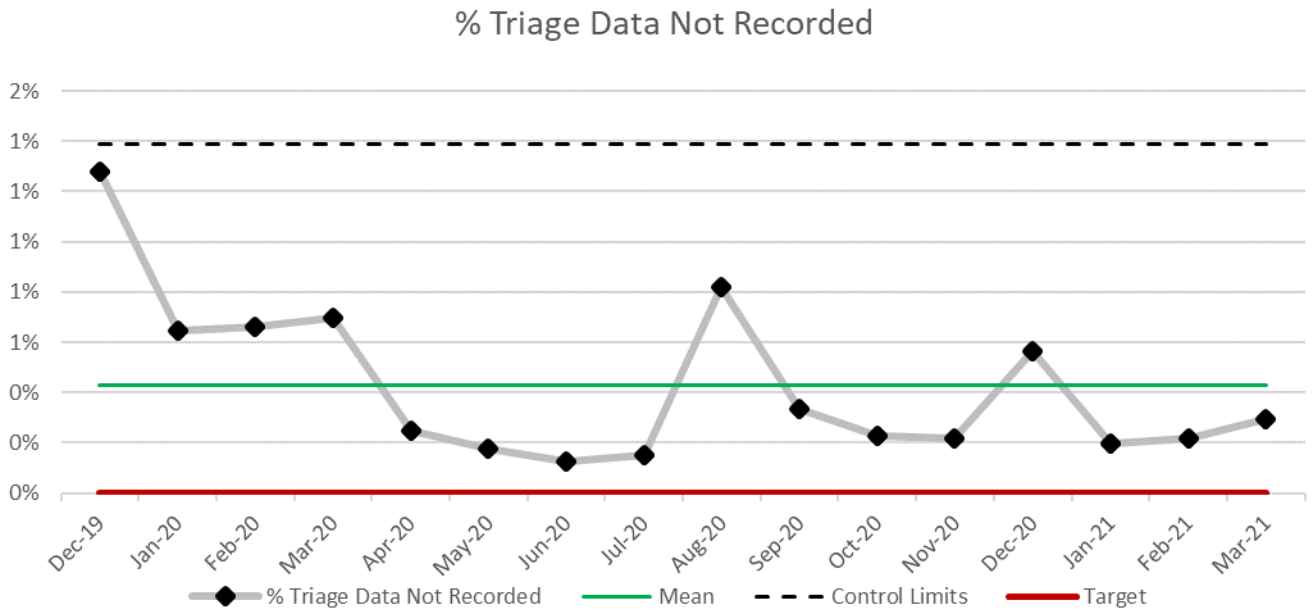
IMPROVE PATIENT EXPERIENCE – % TRIAGE DATA NOT RECORDED

Executive Lead: Chief Operating Officer

CQC Domain: Effective

Strategic Objective: Patients





Challenges/Successes

- March demonstrated a 0.08% negative variation in performance compared with February.
- Deterioration has been seen on both sites. This may coincide with an increase in attendances across all sites.
- The ability to provide two triage streams deteriorated in March due to staff absence through sickness and skill mix issues. Higher tier agency requests increased in March to attempt to mitigate the gaps. Both LCH and PHB struggled to cover two triage streams consistently over the 24-hour period.
- 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 but unlike previous months, this has been in and out of hours.

Actions in place to recover:

- Emergency Department staffing levels are reviewed by the staffing Hub x 3 daily and an emphasis on securing templated staffing is in place but is not assured.
- Training continues to be in place.
- The actions against this metric to ensure compliance and assure safety are overseen by the Clinical Lead, General Manager and Deputy Divisional Nurse responsible for Urgent and Emergency Care, in conjunction with the Emergency Department Lead Nurses, Matrons and Non-Clinical Support Teams.

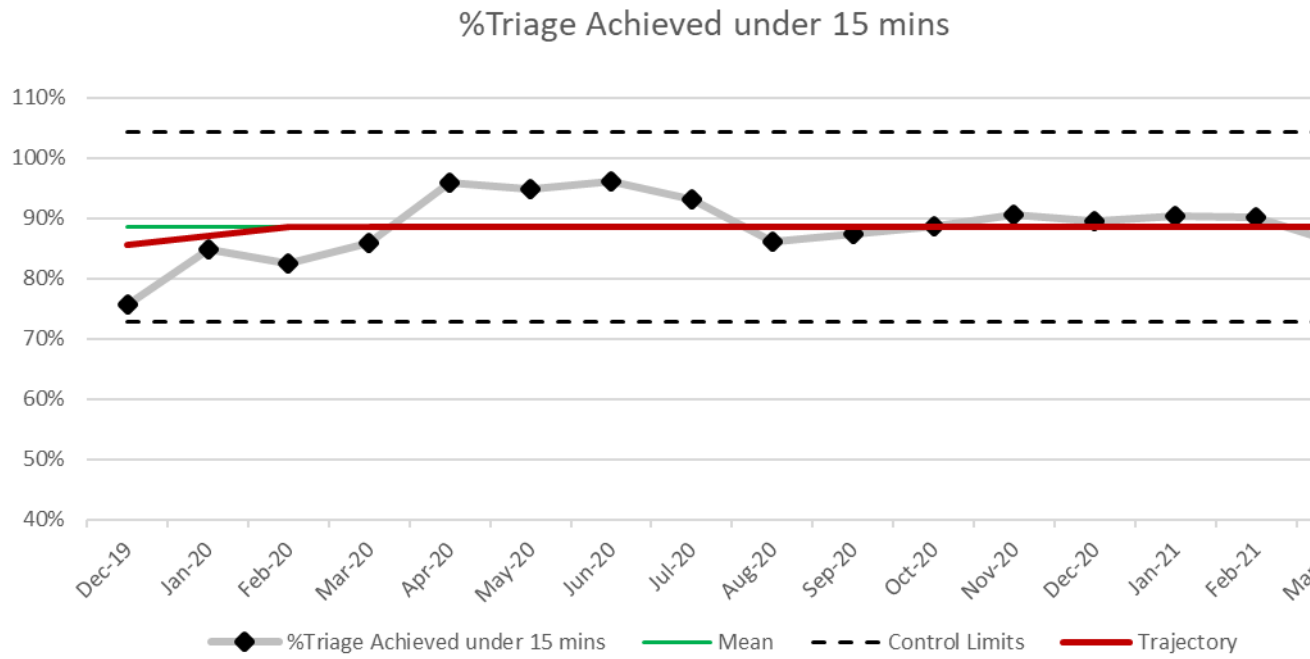
Triage time is a key patient safety performance indicator and forms an essential part of the department huddles. Performance against this safety indicator is scrutinised at the 4 x daily Capacity and Performance meetings where assurance must be given and demonstrated.

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 March by 4.06%. 85.96% in March versus 90.02% in February. This represents a negative variance 2.54% against the agreed trajectory of 88.50%
- LCH demonstrated a deterioration in performance of 6.9%. 82.10% for March compared to 90.10% for February. PHB improved from 90.50 % in February to 91.40%, an improvement of 2.40%.
- The balance between managing the blue pathway and green pathway in both our Emergency Departments and our Assessment Units continues to be problematic.
- The ability to provide two effective triage streams has proved problematic at both LCH and PHB.
- 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 recently appointed 8a Senior Nurse Leads and overseen by the Deputy Divisional Nurse/Lead Nurse for Urgent an Emergency Care and General Manager for Urgent and Emergency Care.

Actions in place to recover:

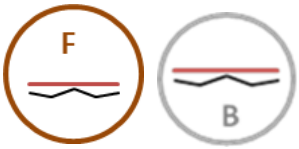
- The focus must remain on achievement of this safety metric.
- All recently appointed key operational Leaders within Urgent and Emergency Care have 'settled' into post and the expectations of action, remedy and output has been made explicit.
- Performance against this safety metric and that of others, are scrutinised and challenged 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 daily and every attempt is made to resolve this.

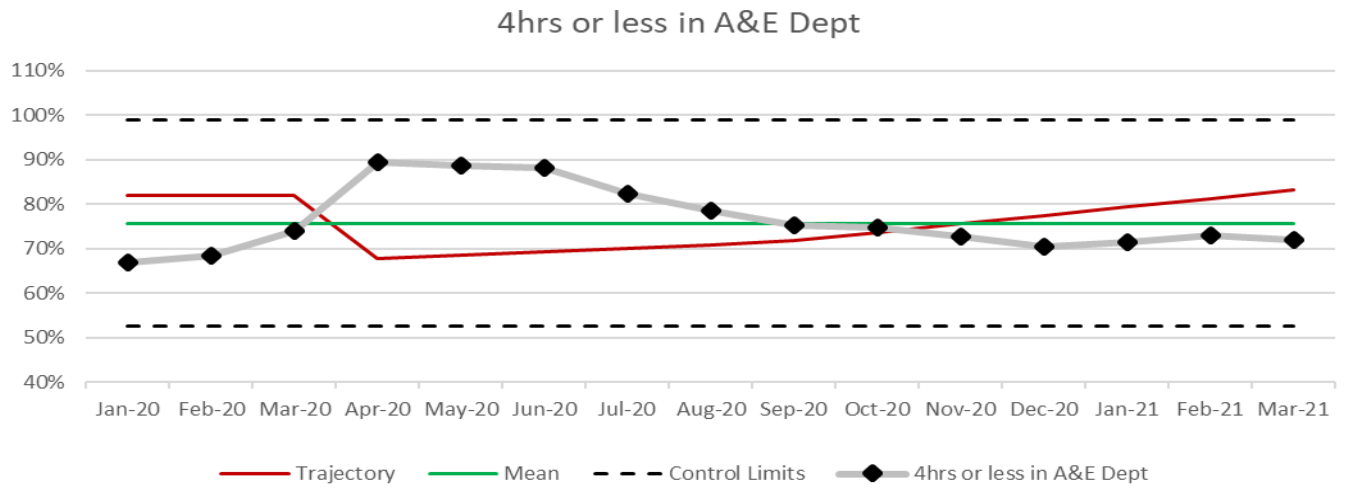
IMPROVE CLINICAL OUTCOMES – A&E 4 HOUR WAIT

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services





Challenges/Successes

The data and performance applied to this report is at day 2 of the national reporting cycle. A completed validation of the 4hr standard is by day 7 of the reporting cycle.

- March ED type 1 and streaming saw 15,749 attendances verses 12,418 in February (+3331 attendances). This represents a 21.16% increase. By site LCH experienced a 20.78% increase in attendances, PHB saw an increase of 20.43%. Grantham also experienced an increase in UTC attendances of 24.83%.
- March overall outturn for A&E type 1 and primary care streaming delivered 71.98% against an agreed trajectory of 83.12%.
- This demonstrates a deterioration in performance of 0.86% compared with February outturn.
- Performance continues below the agreed trajectory by 11.14%.
- By site, for March, LCH delivered 66.12%, a 3.58% deterioration on February's performance, PHB delivered 72.16%, a deterioration of 2.71%. GDH achieved 97.86% which was a deterioration of 0.98% compared to February. This includes type 1 and type 3 activity.
- The highest days of delivery by the Emergency Departments only was on 2nd March when PHB achieved 76.07% and on 21st March when LCH achieved 71.81%. The performance uplift from the UTCs was 8.63% at PHB (84.70%) and 6.26% at LCH (78.07%). Conversely, the lowest days of delivery by the Emergency Departments only was 19th March when PHB only achieved 36.84% and 24th March, when LCH only achieved 37.72%. The performance uplift from the UTCs activity was 15.66% (52.50%) and 21.54% (59.26%) respectively.
- Streaming at GDH, LCH and PHB experienced 408 >4hr transit time breaches in March compared with 150 in January an increase of 258 and an increase of 63.24%. The highest number proportionate to attendances was LCH. Steaming experienced an increase of 1726 attendances in March. 7290 compared with 5564 in February. This represents a 23.68%
- Daily reporting to the System and NHSe/i continues via the Deputy Chief Operating Officer, Urgent Care whenever daily Trust performance is below 80%

Actions in place to recover:

- The Recovery phase of COVID management will concentrate on the process improvements, not affected by volume. A revised Urgent and Emergency Care Delivery Programme led by General Manager, supported by dedicated Improvement Lead is in place. The focus is on improved access to ambulatory pathways to reduce the attendances to the Emergency Department, as well as effective use of 111 and EMAS alternative pathways. These services will serve to lessen the overall burden placed upon the Emergency Departments.

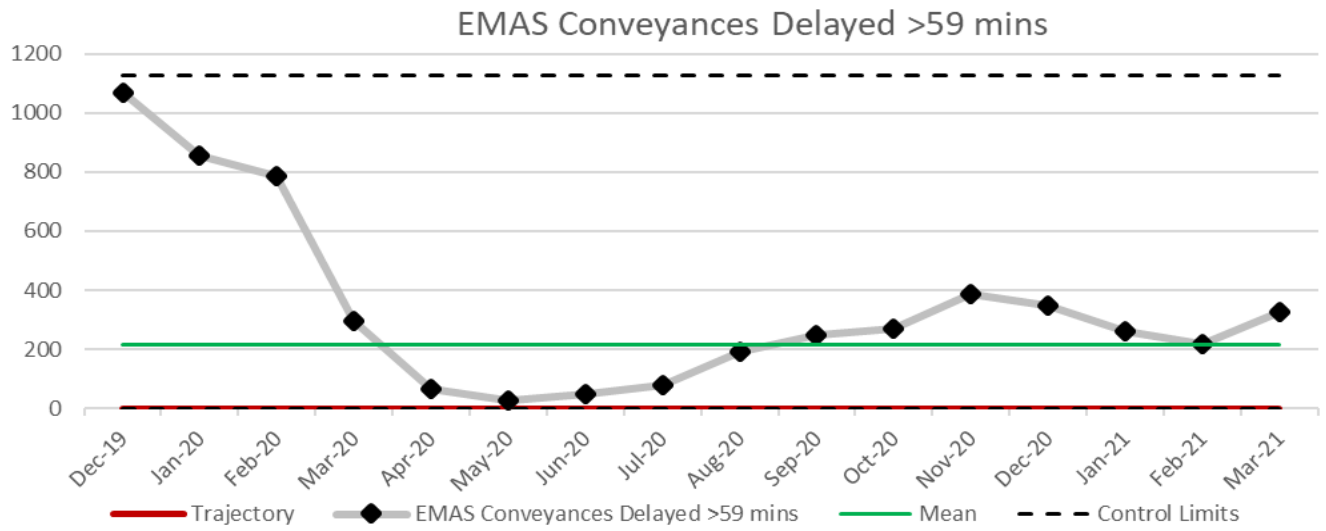
- These main drivers for change will lead to optimised SDEC pathways which in turn will release bed capacity and improve flow through the hospital. This will result in improved ambulance handover delays. A new national set of metrics will be introduced, and the trust will be benchmarked against these.
- 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.
- The Trust is currently being supported by NHSe/i and ECIST in an 8-week intensive support programme to ensure timely discharges, thus improving flow and reducing the number of patients in the Emergency Departments waiting for beds.

IMPROVE CLINICAL OUTCOMES – AMBULANCE HANDOVER >59

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services



Challenges/Successes

The narrative below needs to be read in the context of an increase of 753 conveyances compared to February. 4588 in March compared to 3835 in February. This represents a 16.42% increase.

- March reported 93.21% of handovers at LCH were <59 minutes and 92.22% at PHB. This is a slight deterioration against the February performance.
- March reported 328 >59-minute hand over delays. This is an increase of 110 on the February figure of 218. This represents a 33.54% increase in >59-minute ambulance handover delays. LCH had 178 >59-minute ambulance conveyances in March compared with 134 in February. This represents a 24.72% increase compared with February. PHB had 150 > 59-minute ambulance handover delays in March compared to 84 in February. This represents a 44% increase.
- March demonstrated a slight increase in >120mins handover delays overall by 5.10%. >120 mins at LCH in March was 23 compared to 36 in February, a reduction of 36.12% PHB >120 mins increased from 20 in February to 36 in March, an increase of 44.45%
- Delays experienced at PHB remain attributed to a continued inability to 'flex' the segregated pathways more responsively against the presenting demand particularly in the evening when conveyances demand is increased. However, the pattern is well known and consistent.
- 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 conveyances, conveyance avoidance and handover delays are discussed.
- All handover delays >59 mins are now reported to the CCG by EMAS but are done so in context of the overall site position.

Actions in place to recover

- As part of recovery and following confirmation of additional monies to enhance our urgent care facilities, work is progressing well to bring these plans to fruition. This includes a larger footprint for RAT. This measure seeks to ensure a significant reduction >59mins handover delays for both LCH and PHB.
- Dedicated UEC Project Management resource has been supported by the Innovation and Integration Team. This support will enable the UEC Trust Teams to effect a sustainable change with a particular focus on SDEC to reduce unnecessary admissions and generate improved bed flow. This also includes the missed opportunities exercise undertaken by Chris Morrow-Frost (NHSe/i UEC Lead). This work is shaping the improvement plans

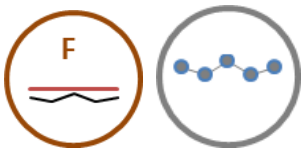
- Work continues within the System to reduce the overall ambulance conveyances to ULHT through implementing robust alternative pathways via Think 111 and CAS. This is reviewed daily via the 10.30am System Call and twice monthly Gold Patient Cell Calls.
  All ambulances at 30 minutes post arrival are 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.

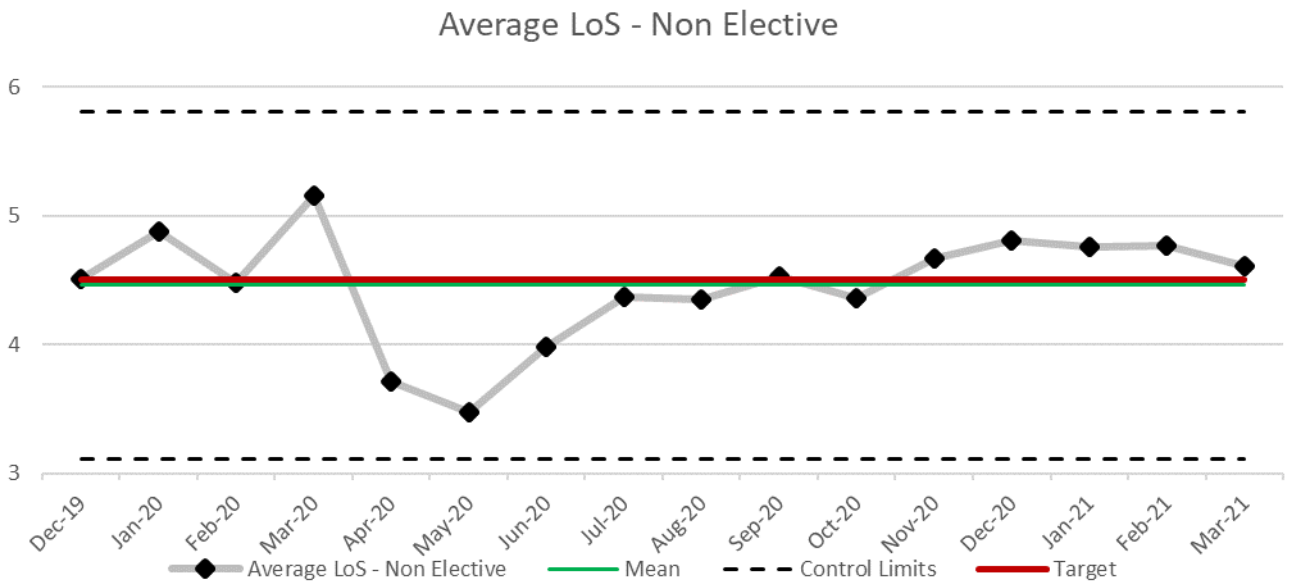
IMPROVE CLINICAL OUTCOMES – AVERAGE LOS NON-ELECTIVE

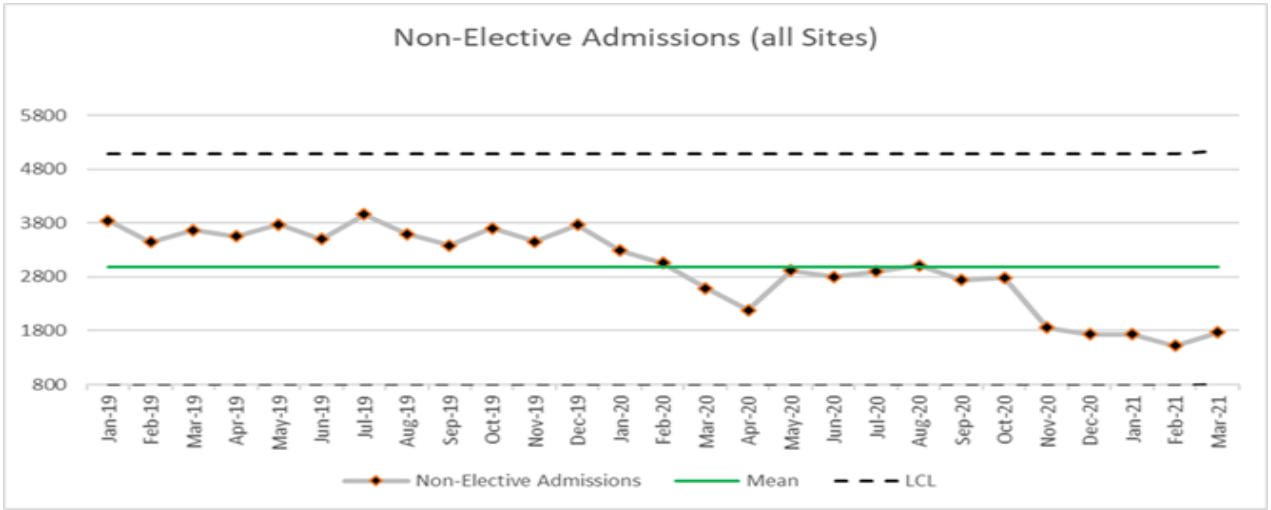
Executive Lead: Chief Operating Officer

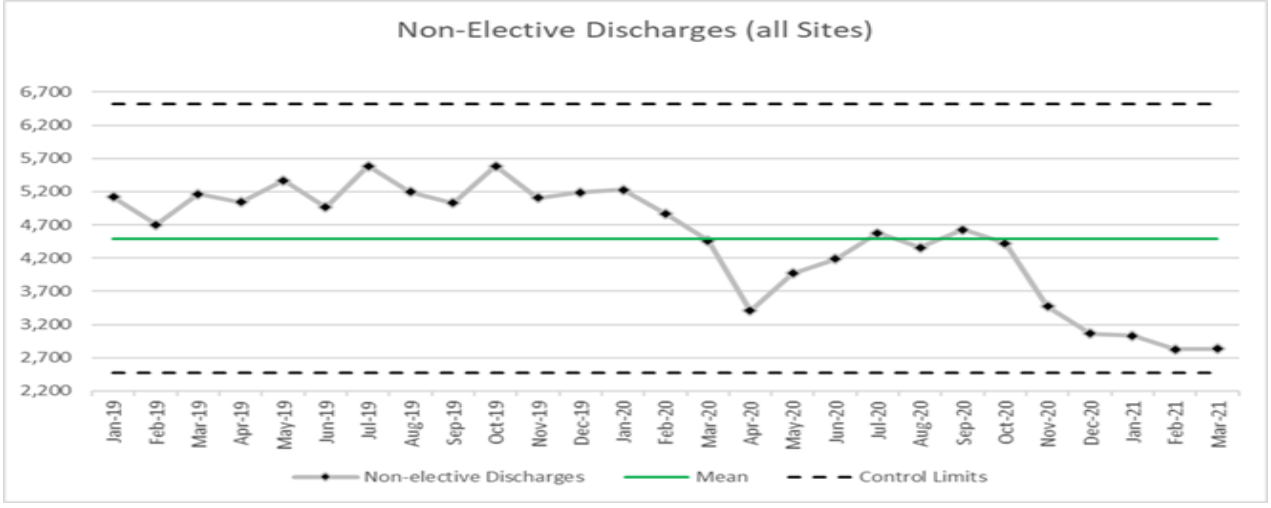
CQC Domain: Effective

Strategic Objective: Services









Challenges/Successes

- Average LOS for non-elective admissions (NELA) saw a slight improvement during March, delivering 4.61 ALOS compared to 4.77 ALOS in March. This represents a positive variation of 0.16 days but remains above the trust target of 4.50 days.
- LCH ALOS decreased from 5.16% days in February to 4.97 days in March. PHB deceased from 4.51 days in February to 4.30 in March.
- Non elective admissions increased in March to 1764 verses 1522 February. A 13.72% increase. A March 2020 admission profile (2589)) comparison to March 2021 (1764) shows a 31.87% decrease in non-elective admissions.
- Non elective discharges increased slightly from 2830 in February to 2,832 in March, an increase of 2. This represents a 0.08% increase
- The Strategic Internal Discharge Cell (SIDC) meetings led by the Deputy Chief Operating Officer, Urgent Care and the Deputy Medical Director, Patient Safety remains in place but are now monthly.
- Tactical Internal Discharge Cell (TIDC) remain weekly.
- An 8 weeks intensive discharge support programme is now in place led by ECIST/NHSe/i.
- Project Salus is aiding a responsive bed base with a speciality focus but this is still requiring close operational oversight to ensure the correct flow. This is now being led by the Deputy Chief Operating Officer for Urgent Care.
- The ward refurbishment and cleaning programmes have continued during March but with some disruption and delays.
- The C-19 second/third wave impact continues to reduce both from an inpatient and ITU demand and support point of view. Third/Fourth wave impact and modelling has been announced and the ICC is monitoring and will advise the Trust. The next wave prediction is July 2021.
- During March the numbers of patients with a LLOS decreased. 70 in March compared to 85 in February. A decrease of 15 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 was undertaken with system partners (LCHS and ASC) to acquire and agree funding and access to designated beds for our positive COVID19 patients on pathways 1, 2 & 3. The current arrangements are in place until the end of April.
- As the number of positive patients continues to reduce, the process and allocation of designated beds described above is under review.
- Funding has been agreed to maintain the 'Home First Partnership' programme.
- ULHT, LCHS and ASC are united in their commitment to ensure right patient, right place, right time.

Actions in place to recover

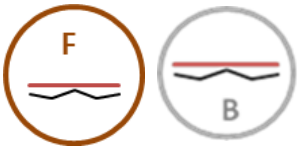
- Multi-agency discharge meetings continue take twice place daily, seven days a week. A Line by line reviews take place against each patient on pathway 1, 2 and 3. This process is robust and an increase the discharge of medically optimised patients across the entire week (7days) has being realised.
- Long length of stay meetings for each hospital site remain in place to support more complex patients through their discharge pathway.
- Work continues in respect of the discharge pathways, in particular pathway zero and especially at LCH. The internal discharge cell chaired by the Deputy Chief Operating Officer and Deputy Medical Director aligned to Patient Safety continues to support the delivery of this and in addition, the Trust as actively involved in an 8 week intensive discharge support programme led by ECIST/NHSe/i..
- As the COVID +ve demand reduces, the System is now reviewing access to the previous arrangement of secured and commissioned care homes who will support patients with positive swabs, especially pathway 1 and 2. We saw the benefit of this intervention/action during March.

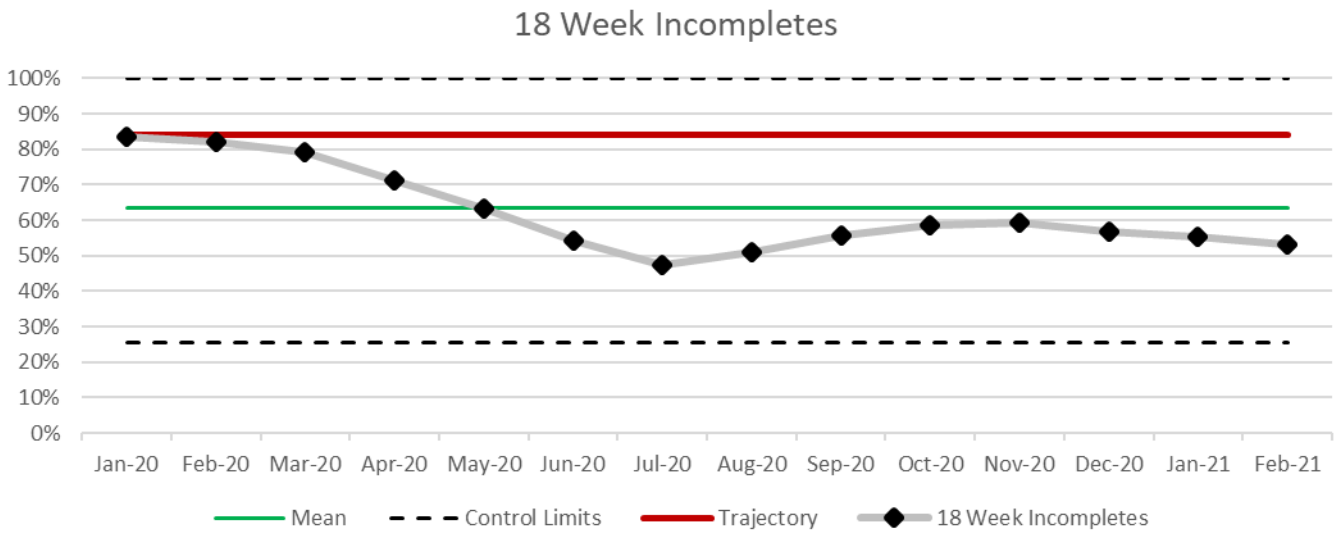
IMPROVE CLINICAL OUTCOMES - RTT 18 WEEKS INCOMPLETES

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services





Challenges/Successes

RTT performance is currently below trajectory and standard.

February saw RTT performance of 53.04% which is -2.43% down from January.

General Medicine was the lowest performing specialty, with performance decreasing from 40.70% last month to 33.33% (-7.37%). Neurology is performing slightly worse this month with a 1.25% decrease from 57.97% last month to 56.72% in February.

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

- Ophthalmology - 3212 (Increased by 372)
- Ent - 2407 (Increased by 177)
- Trauma & Orthopaedics - 1772 (Reduced by 228)
- Maxillo-Facial Surgery + Orthodontics + Oral Surgery - 1469 (Reduced by 40)
- Dermatology - 1380 (Reduced by 74)

Actions in place to recover:

Performance across most specialties is showing a slight decrease

As the figures above show, Ophthalmology performance has declined together with ENT. Maxillo-Facial surgery, Dermatology and Trauma & Orthopaedics.

The re-introduction of routine elective work for non- admitted activity continues to utilise video and telephone consultations, with more face to face appointments being set up where required.

Admitted routine elective work remains challenging, with available capacity being focussed on cancer.

Specialties achieving the 18 week standard for February were:

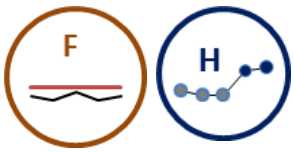
- Breast Surgery 92.98%
- Clinical Haematology 95.79%
- Clinical Physiology 100.00%
- Acute Internal Medicine 100.00% (one patient)
- Medical Oncology 100.00%
- Clinical Oncology 94.12%

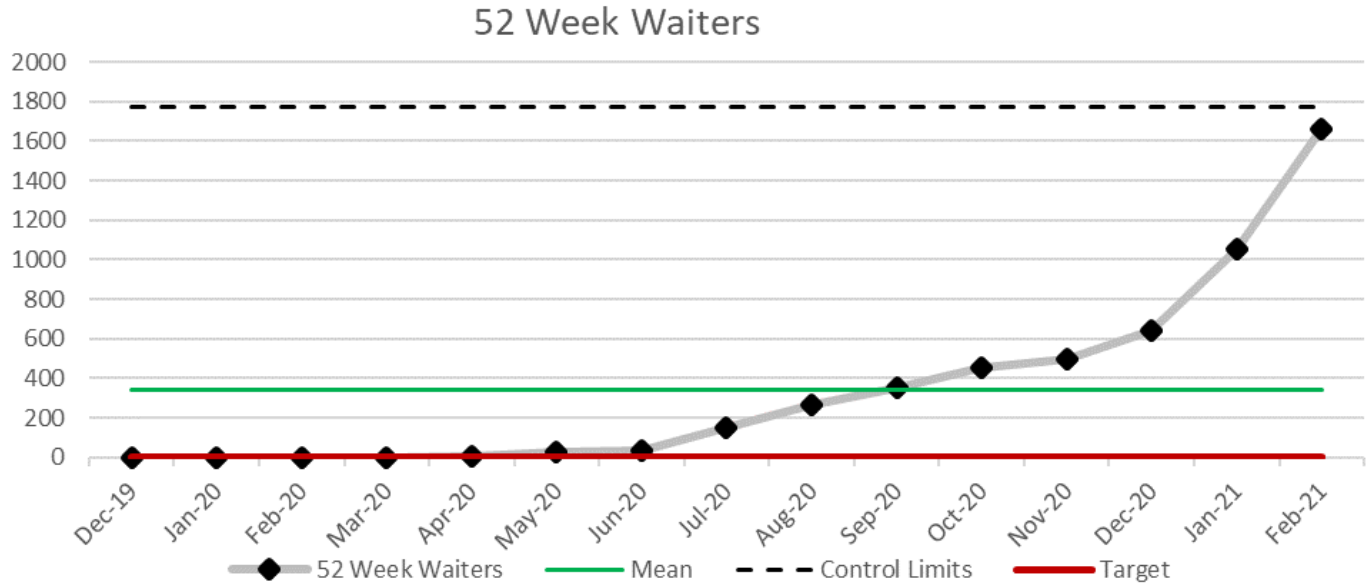
IMPROVE CLINICAL OUTCOMES – 52 WEEK WAITERS

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services





Challenges/Successes

The Trust reported 1,662 incomplete 52 week breaches for February end of month. An increase of 609 from January. However, focus is on these patients at the weekly PTL meeting to ensure that every patient is monitored and where appropriate virtual clinical assessment is made. Due to the high volume of long waiting patients, validation of these is very challenging.

A higher level, bi-weekly, RTT Recovery and Delivery meeting continues in order to monitor the situation.

Root cause analysis (RCA) and harm reviews will be completed by the relevant division for each patient. In January the Trust set up a Clinical Harm Oversight group. The meeting is led by the Chief Operating Officer. This gives focus on the improvement in the recording and monitoring of the harm review process.

Discussions around the reasons for 52 week breaches are being had; particularly looking at the quality and accuracy of data entry. The 18 week/RTT team continue to work on a training programme to address these issues and assist the divisions.

Actions in place to recover

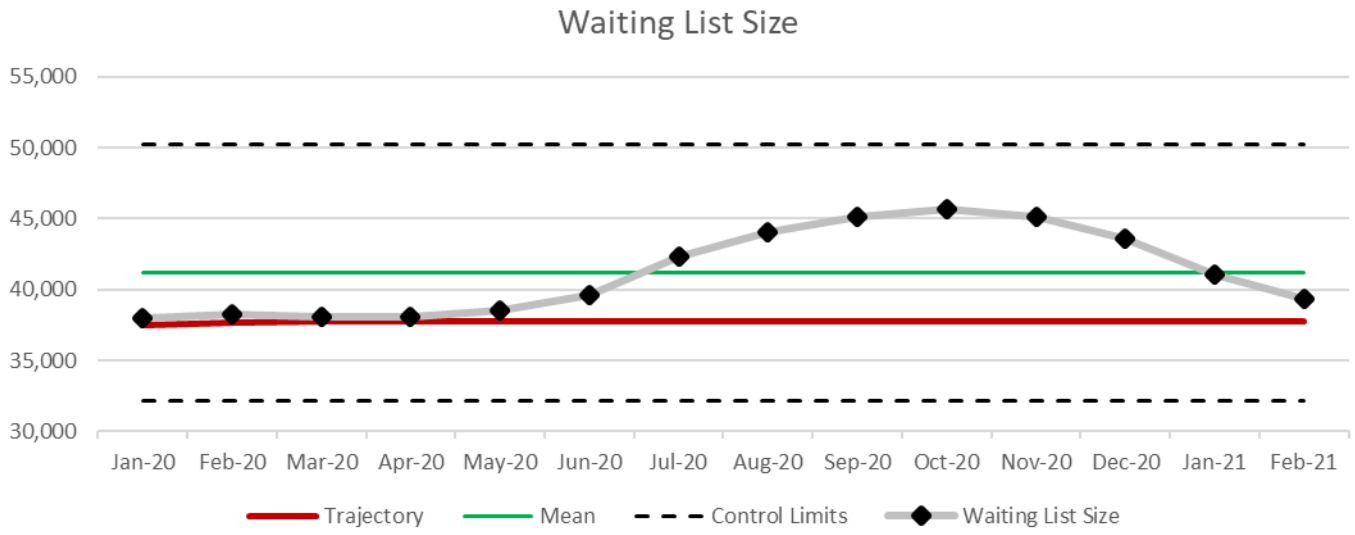
Recovery plans continue to be implemented; accounting for a changing environment.
Across the Trust outpatient services continue to use all available media to consult with patients.

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 January, with February total waiting list decreasing by 1,657 to 39,368. The incompletes position for February is now approx. 336 more than the March 2018 (39,032) target. This does not however, account for the approximately 8000 patients who are currently on the ASI list, needing to be added to the open referrals waiting list.

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

- Maxillo-Facial Surgery + Orthodontics + Oral Surgery +143
- Vascular Surgery +41
- Nursing Episode +30
- Nephrology +27
- Clinical Physiology, & Rehabilitation Service (both +10)

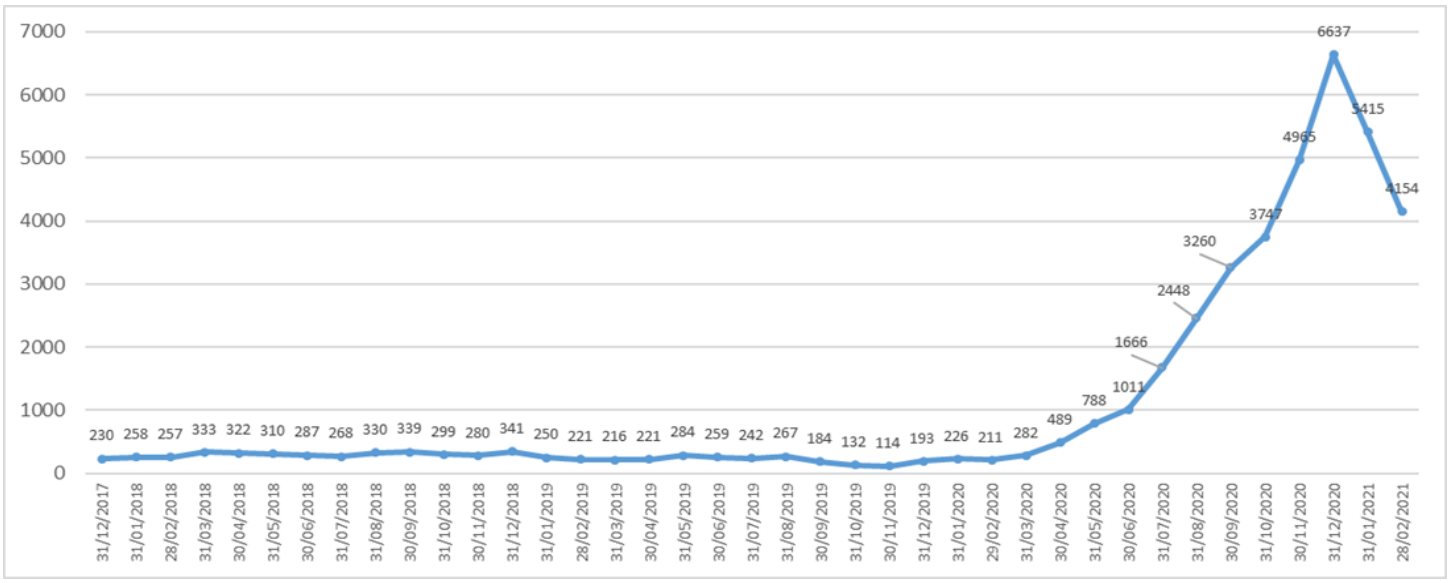
The five specialties showing the biggest decrease in total incomplete waiting list size from January are:

- Trauma & Orthopaedics - 447
- Dermatology -223
- ENT -189
- Neurology -117
- Ophthalmology -109

Actions in place to recover

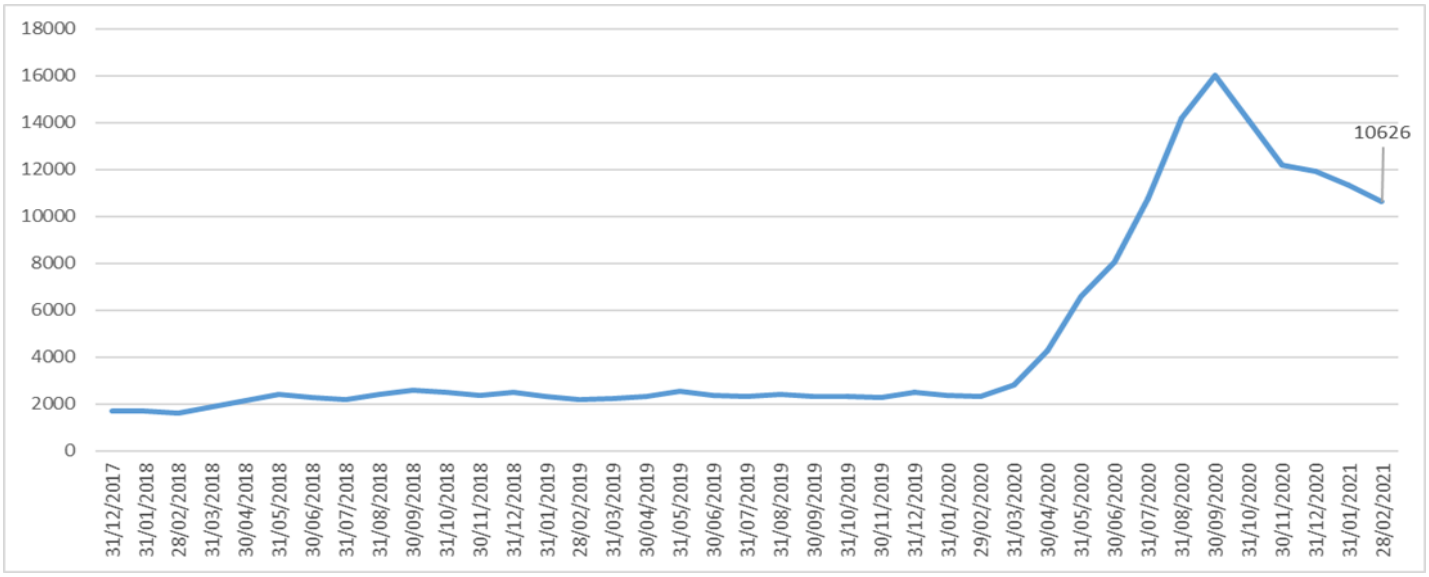
The longest waiting patients are tracked and discussed at the weekly PTL meeting. February showed 4,154 patients waiting 40 weeks and above as the chart below shows. January to February saw a decrease of patients waiting over 40 weeks, -1,261, with no specialties showing any increase above +1. Thirty-four specialties reduced their position compared to last month, with Trauma & Orthopaedics showing the best improvement of -229 patients.

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 28th February, shows a decrease of 733 patients from January. Twenty-nine specialties decreased their position with the largest decrease being seen in Trauma & Orthopaedics, - 281. The largest increase was seen in General Surgery, +23.

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



Total Number of Incomplete Patient Pathways at 80 Weeks and Above for ULHT

At the end of February, ULHT reported 29 pathways as waiting over 80 weeks for first definitive treatment.

- General Surgery 19
- Gynaecology 4
- Ent 2
- Ophthalmology 1
- Colorectal Surgery 1
- Trauma & Orthopaedics 1
- Maxillo-Facial Surgery 1

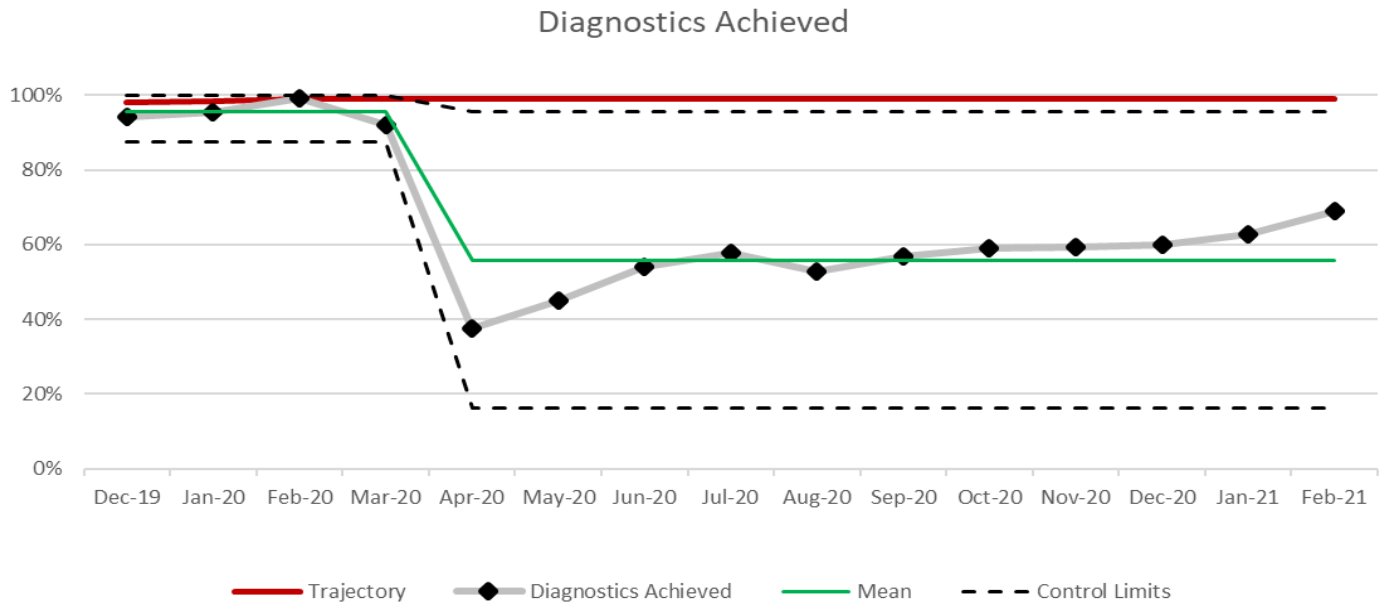
These patients are discussed at a weekly meeting with NHSE/I and CCG colleagues.

IMPROVE CLINICAL OUTCOMES – DIAGNOSTICS

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services



DM01 return for Feb 68.94%,

Challenges/Successes:

CT

- Much improved position of 146 breaches for December compared to 306 in January.
- Sourcing and retaining agency staff to man the additional CTs is difficult.
- Requesting an extension to the mobile CT scanner at Lincoln to maintain the positive progress.

Ultrasound

- Ultrasound only had 3 breaches in February which is a great performance during the Covid 19

Physiological Sciences

- Neurophysiology - peripheral neurophysiology LCH has improved reporting, 96 breaches for January compared to 456 for January.
- Audiology - Audiology Assessments had 0 breaches for January.
- Waiting lists are monitored weekly
- Additional capacity is being sort via outsourcing additional lists an over time.
- The new EEG machine has arrived at Boston and with the locum now in place the Pilgrim neuro physiology will start to improve its position as it had 177 breaches compared to 212 in January. We should see a great improvement to this position going forward.

Endoscopy

- Gastroscopy had a much to improve position of only 85 breaches compared to 298 in January.
- Cystoscopy carried out within endoscopy had 114 breaches compared to 194 in January.
- Flexi sigmoidoscopy had 10 breaches compared to 75 in January.

Endoscopy are live booking new referrals, the backlog is coming from the planned patients which endoscopy on now tackling and are reducing.

Cardiology

- Cardiology – echocardiography had 2051 breaches compared to 1961 in January
- Cardiology - echocardiography Stress /TOES had 58 breaches compared to 105 in January

The main concern for the DM01 for the trust is the cardiac position as this is pulling the overall performance down.

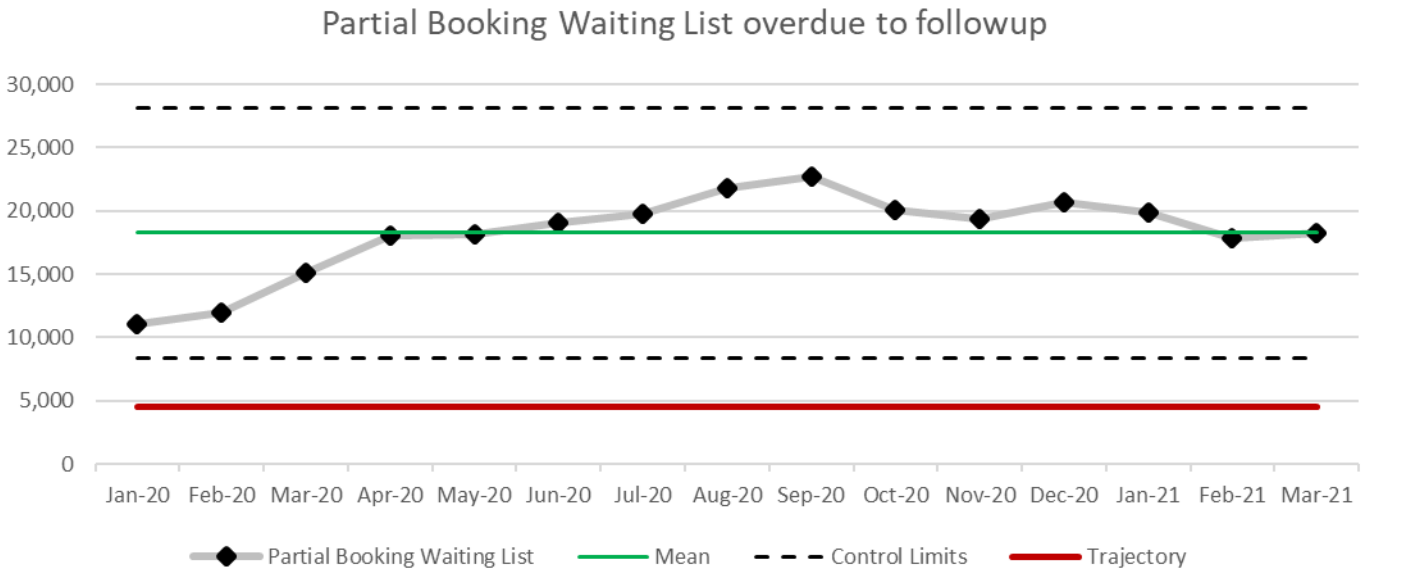
DM01 Performance with cardiac excluded is 84.30%
DM01 cardiac performance only 35.30%

IMPROVE CLINICAL OUTCOMES – PARTIAL BOOKING WAITING

Executive Lead: Chief Operating Officer

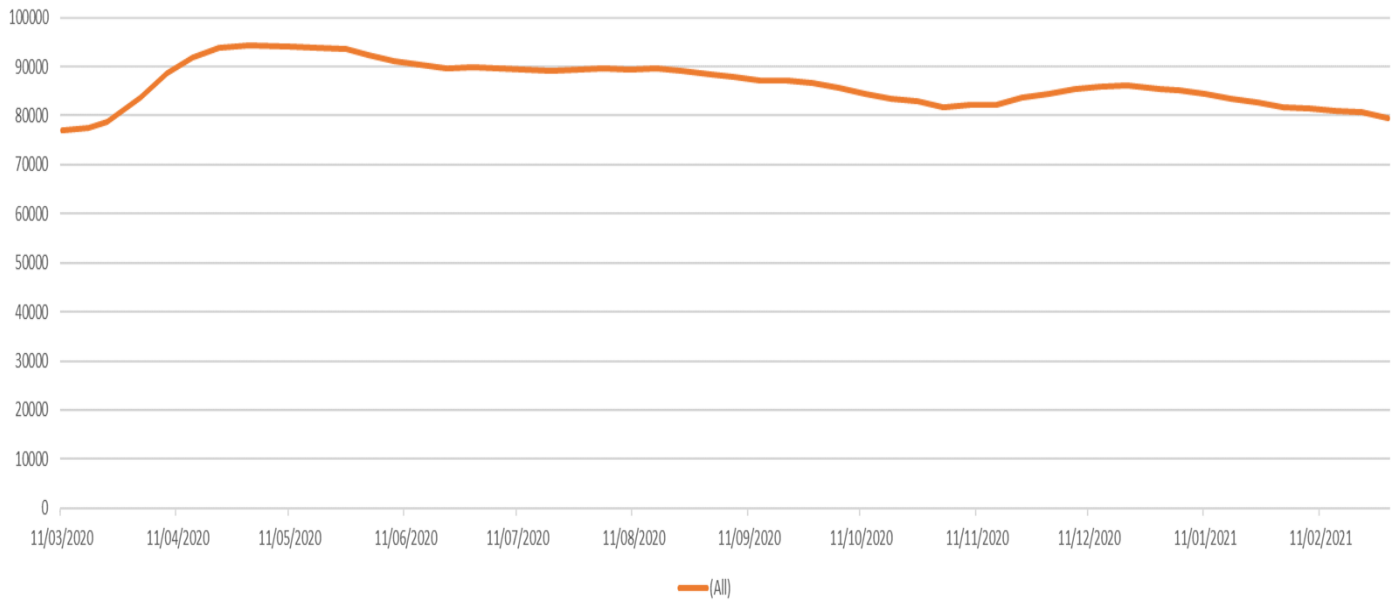
CQC Domain: Responsive

Strategic Objective: Services



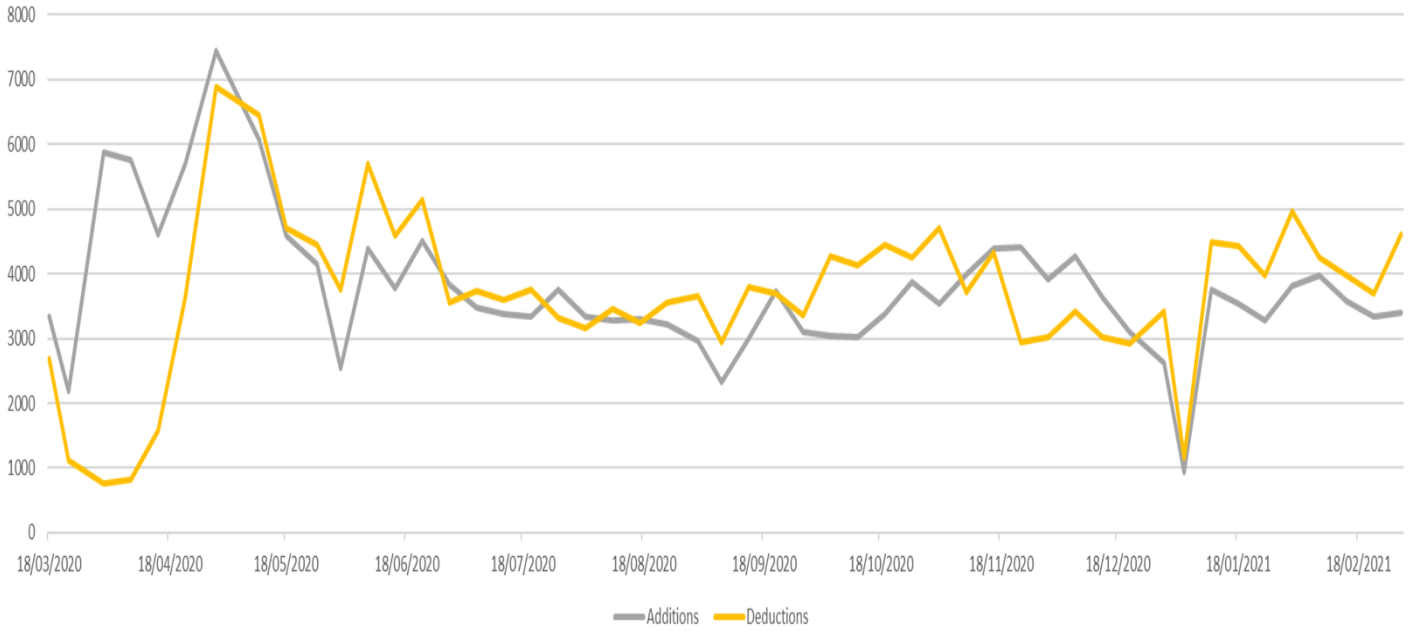
Challenges/Successes:

During the waves of Covid throughout the last year our waiting lists either grew or stagnated. Following these periods the organisation has been able to increase the activity to reduce the PBWL and continue the downward trend. The Trust is currently going through the process of completing speciality level restoration plans in line with the National guidance. The plans will be focused on clinical urgency and activity levels. Once completed they will agreed on as part of the restoration cell. The fortnightly meeting will continue and be monitoring the specialities against the plans submitted.



Actions in place to recover:

With the workforce pressures in place we have continued where possible with the administrative validation, clinical triage, and the scaling up of technology enabled care. The Trust restoration plans are currently being collated worked upon taking into account the risk stratification of our PBWL. The plans will be reviewed looking at the appropriate use of validation, PIFU (patient Initiated Follow Ups) and video consultations / telephone consultations. We are continuing with our PBWL meetings to offer support, challenge and an opportunity to review the plans.

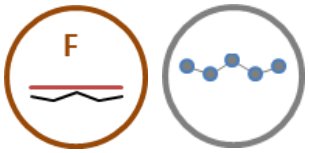


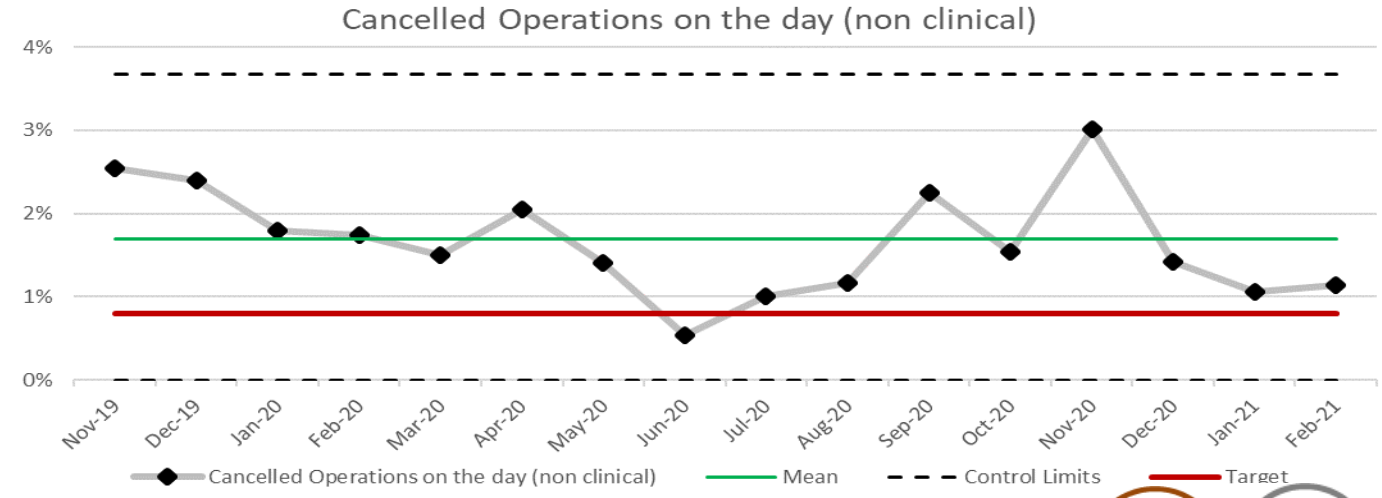
IMPROVE CLINICAL OUTCOMES – CANCELLED OPS

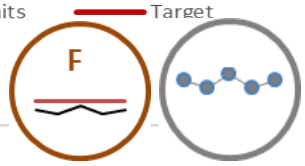
Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services







Challenges/Successes:

Primary reasons for on the day cancellations include; patients being medically unfit/ unwell, patients no longer requiring the surgery, lack of theatre time, and lack of HDU/ITU beds

Actions in place to recover:

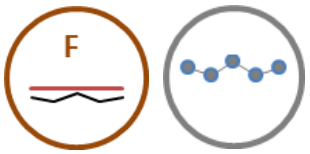
A daily review is in place to identify the root causes of all non-clinical cancellations and undertake remedial action to prevent re-occurrences

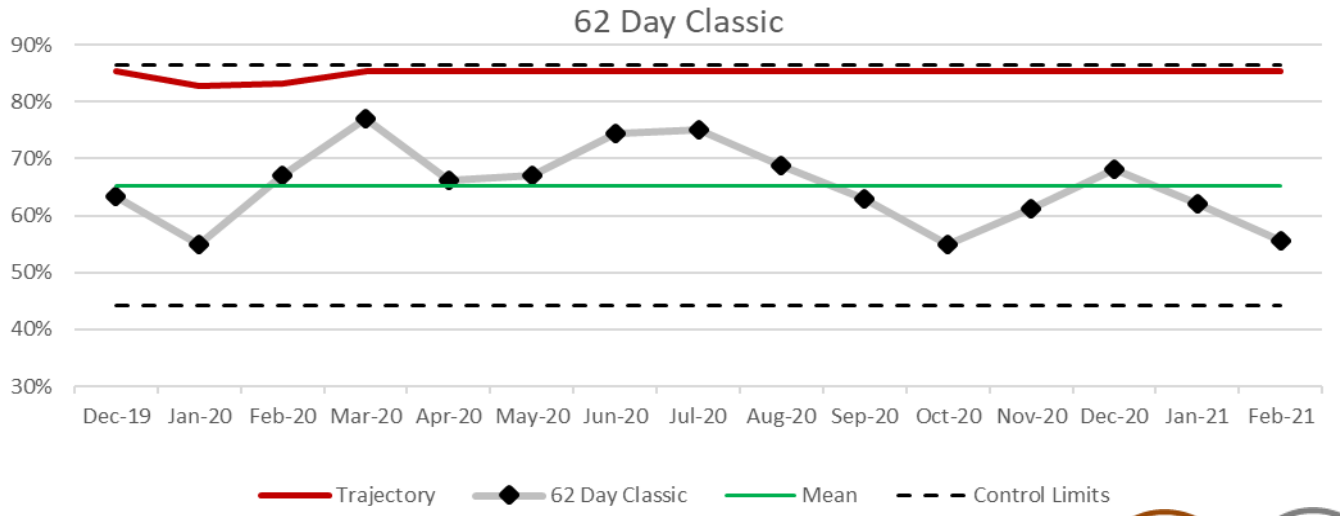
IMPROVE CLINICAL OUTCOMES – CANCER 62 DAY

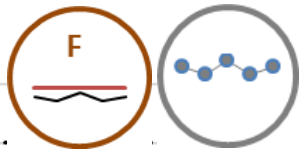
Executive Lead: Chief Operating Officer

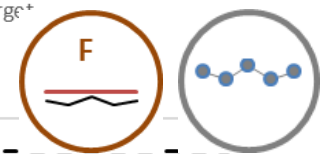
CQC Domain: Responsive

Strategic Objective: Services





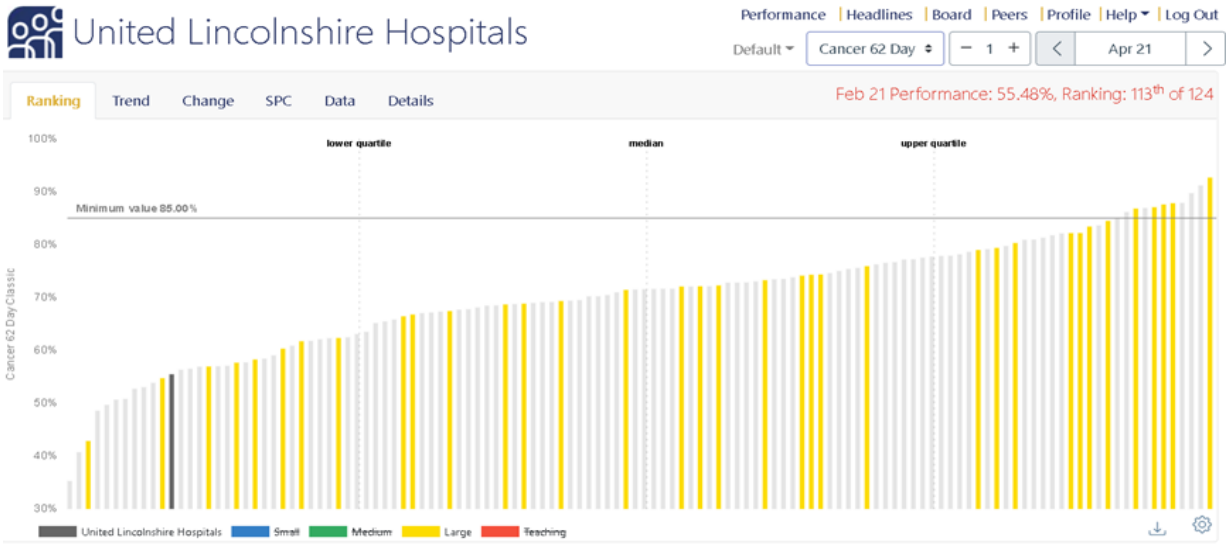




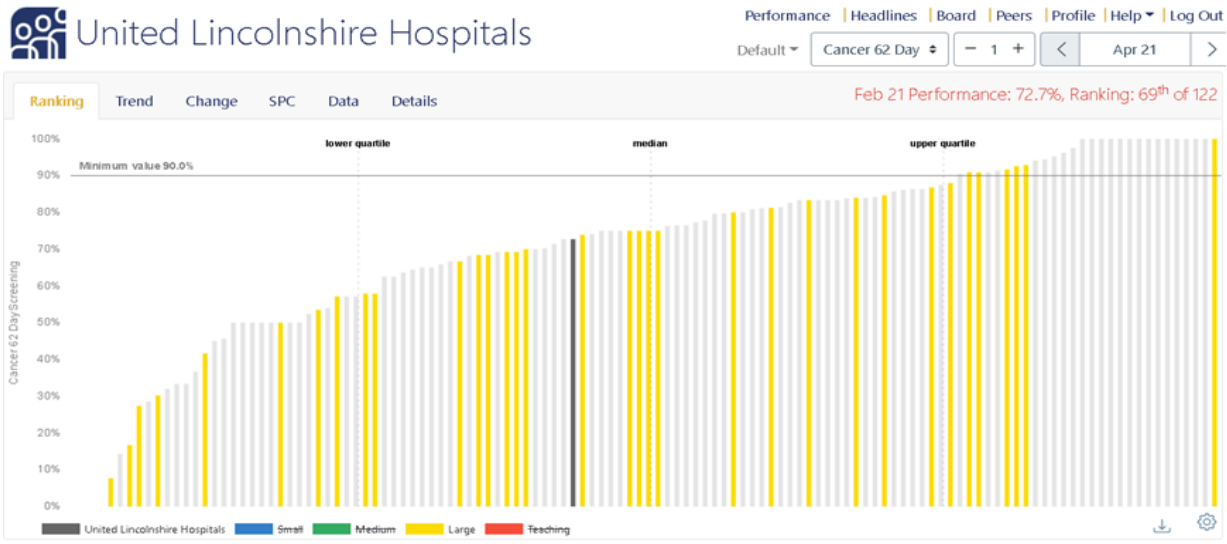
Challenges/Successes

In February our 62 Day Classic performance decreased by 7.1% compared to January, at 55.1% placing us both below the national average (69.8%) and in the lower quartile.

62 Classic



62 Screening



62 Upgrade

Early indications are that our March 62 Day Classic performance will be circa 64%.

Challenges to our performance include:

- Patient engagement in diagnostic process (reluctance to visit hospitals during COVID-19, including those waiting for first vaccine, second vaccine or 3 week 'effectiveness' period).
- 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.
- Reduced clinic throughput due to social distancing / IPC requirements, especially in waiting areas.
- Inappropriate referrals from GPs (eg not having face-to-face appointment prior to referral).
- Patients not willing to travel to where our service and / or capacity is.
- Patient acceptance & compliance with swabbing and self-isolating requirements.
- Reduced theatre capacity across the Trust, all Specialties vying for additional sessions -pre-covid level theatre capacity is not expected to be achieved until circa end June 2021.
- No access to Independent Sector capacity unlike other regional colleagues.
- Very limited success in identifying additional surgical capacity, in or out of region, through the East Midlands Cancer Alliance Surgical Hub.
- Increase in backlogs due to COVID-19 wave 2 impact on our services.
- 62 Day backlogs significantly in excess of pre-COVID levels for Colorectal, Head & Neck, Breast, Gynaecology 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 standard identified as Trust's single cancer performance work stream in the Integrated Improvement Program for 2021-22.
- Additional theatres installed at Grantham for Breast & Gynaecology.
- Review of Colorectal theatre list scheduling to better align with clinician availability and consideration of moving level 1 patients to Grantham.
- Successful bid for Radiology equipment: 5 low dose CT scanners (2 x PH, 2 x LC, 1 x GK), 2 digital X-ray rooms, 4 Ultrasounds (3 x general, 1 x Breast), 38 PACS reporting stations, replacement of Fluoro room, 3 DR Mammography rooms (1 each PH, LC and GK). Delivery is in stages between April and August.
- Endoscopy booking team recruited 3 fixed term WTE – now in post and training completed. A Case of Need is being written to request funding for these posts to become substantive because the additional workload will become business as usual.
- A Nurse endoscopist has been appointed on Bank who will support weekend lists – HR pre-employment checks have now been completed the booking of sessions can now commence.
- 2 fixed term WTE Endoscopist posts have gone through the interview and selection process twice with only 1 applicant, so a Case of Need is being written for permanent funding. This will support the Bowel Cancer Screening age reduction.
- Replacement of Pilgrim decontamination unit began in February and will be completed mid-May (this includes 4 weeks wait post installation of each set of new washers for mycobacteria test results).
- Dedicated admin resource within Colorectal CBU to support clinical engagement.

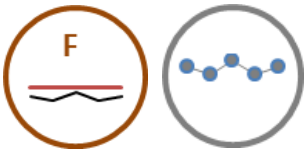
- Awaiting funding confirmation from EMCA for full-time Cancer Navigator posts to support Surgery, Medicine and Family Health.
- 2 H&N consultant posts have been recruited to, one due to start in April 2021, and another in July 2021.
- 2 Medical Oncologists were due to start in April. One has unfortunately withdrawn, and the other is now due to start in July 2021(covering Breast and GI).

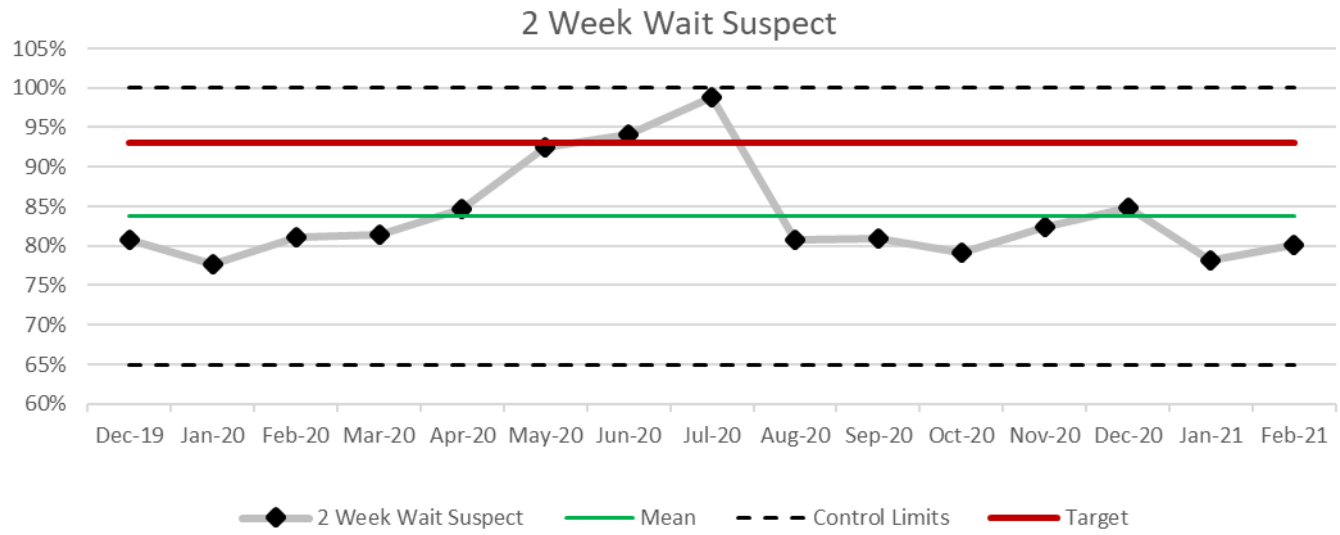
IMPROVE CLINICAL OUTCOMES – CANCER 2 WEEK WAIT

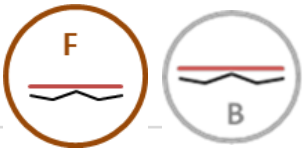
Executive Lead: Chief Operating Officer

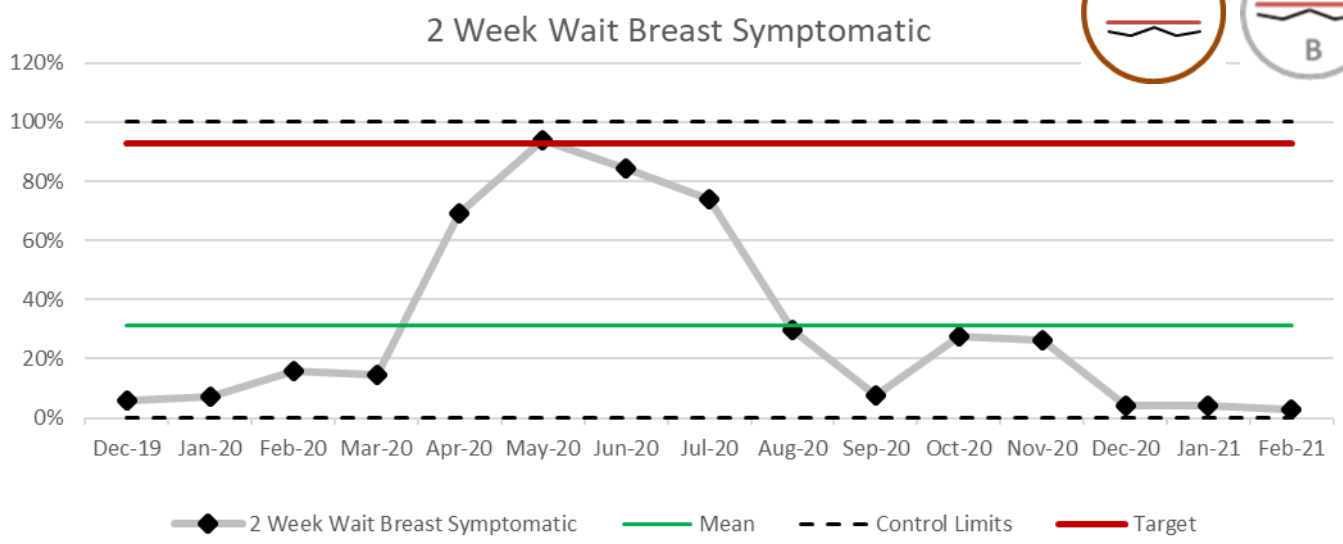
CQC Domain: Responsive

Strategic Objective: Services





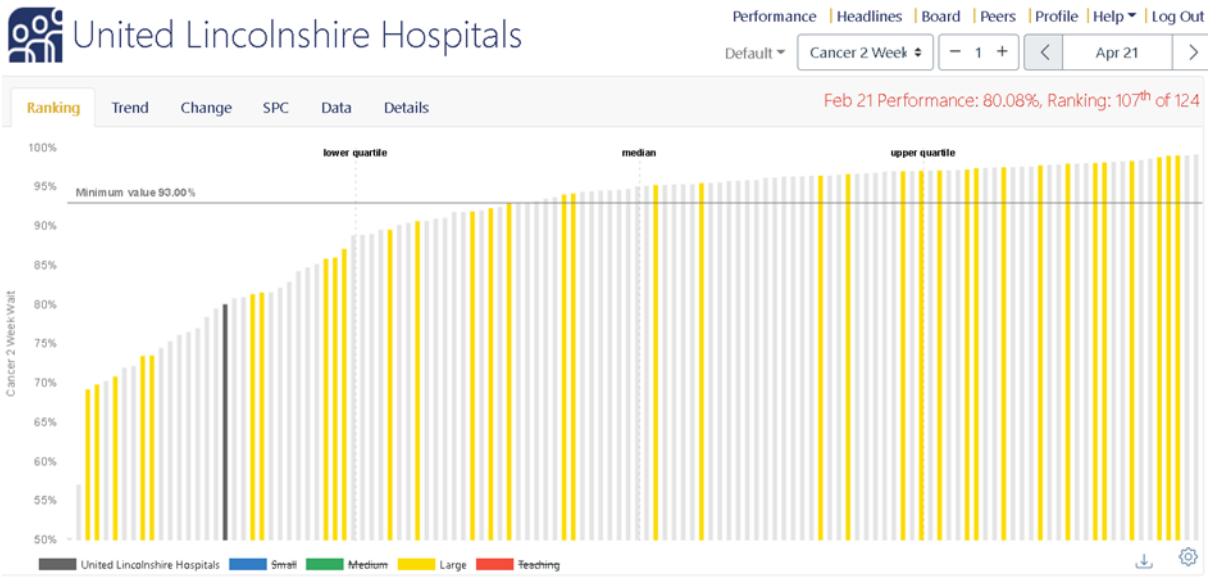




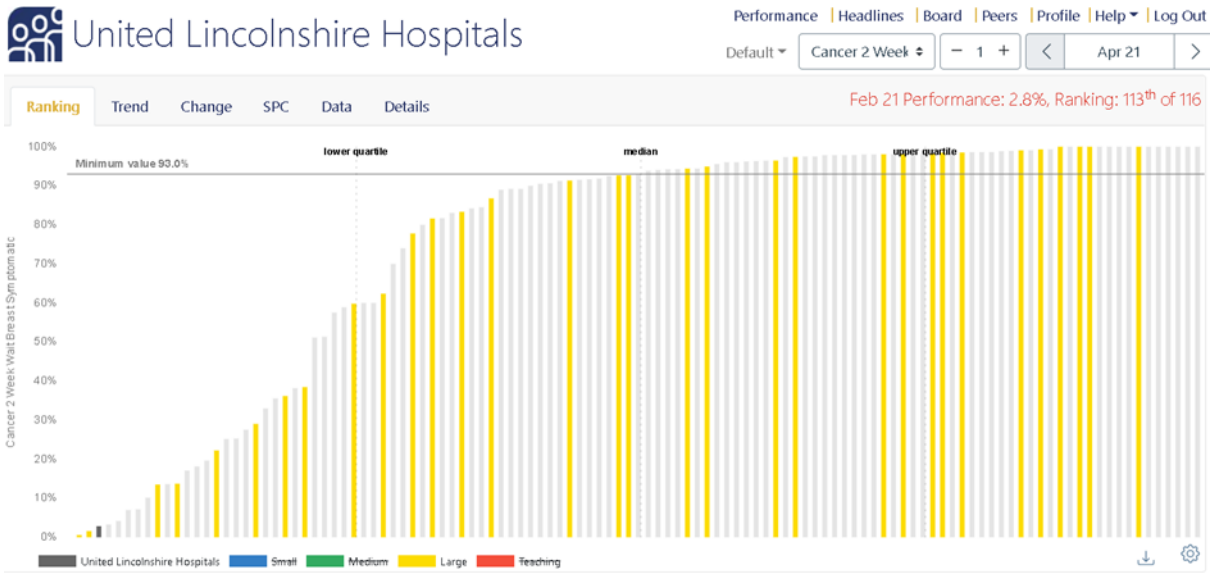
Challenges/Successes

The Trust's 14 Day performance continues to be significantly impacted by the current Breast Service One-Stop appointment alignment issues - 73% of the Trust's 14 Day breaches were within that tumour site. The 14 Day Breast Symptomatic has been affected by the same impact of the Breast Service One-Stop appointment alignment issues.

14 Day Suspect Cancer



14 Day Breast Symptomatic



Actions in place to recover:

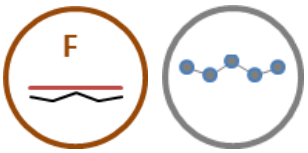
- Work continues to align all the 2ww Referral forms to NG12.
- Breast Services review (following final report from NHSI support).
- Gynaecology Direct Access ultrasound pathway due to commence.
- Lung Direct Access pathway now Trust wide.
- Pilot to appoint Lung patients within 48 hours trialled.
- 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 – no start date identified.
- Urology continued review of cystoscopy provision (was put on hold during COVID wave 2).
- Bladder and testicular pathway – scoping to revert to direct access pathway and Haematuria to one stop clinics

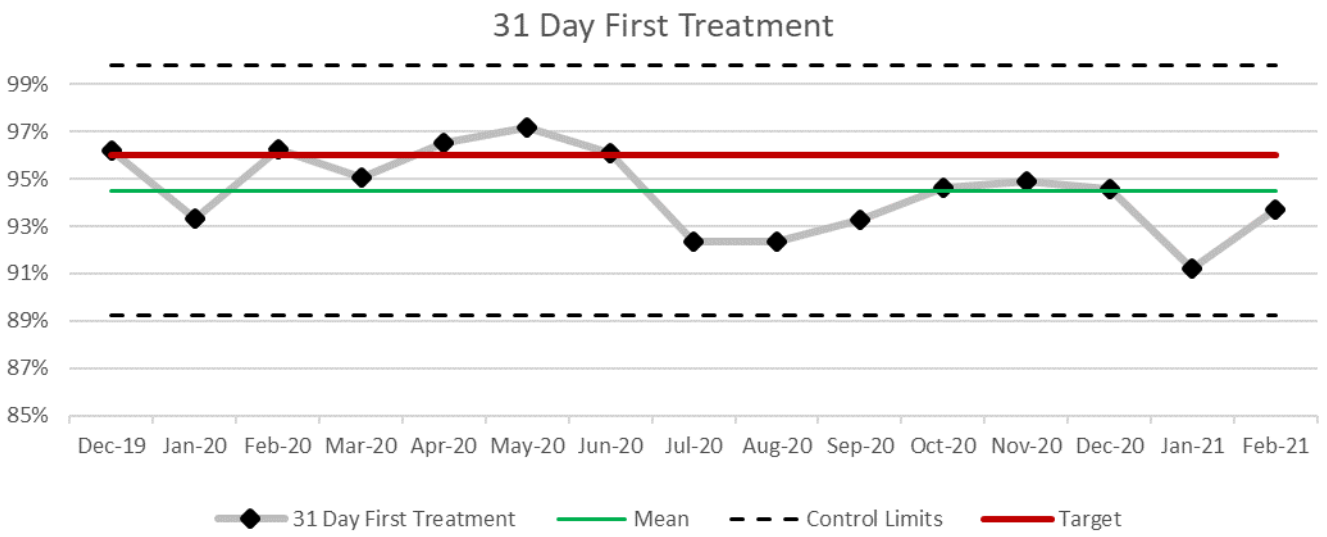
IMPROVE CLINICAL OUTCOMES – CANCER 31 DAY

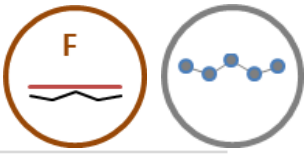
Executive Lead: Chief Operating Officer

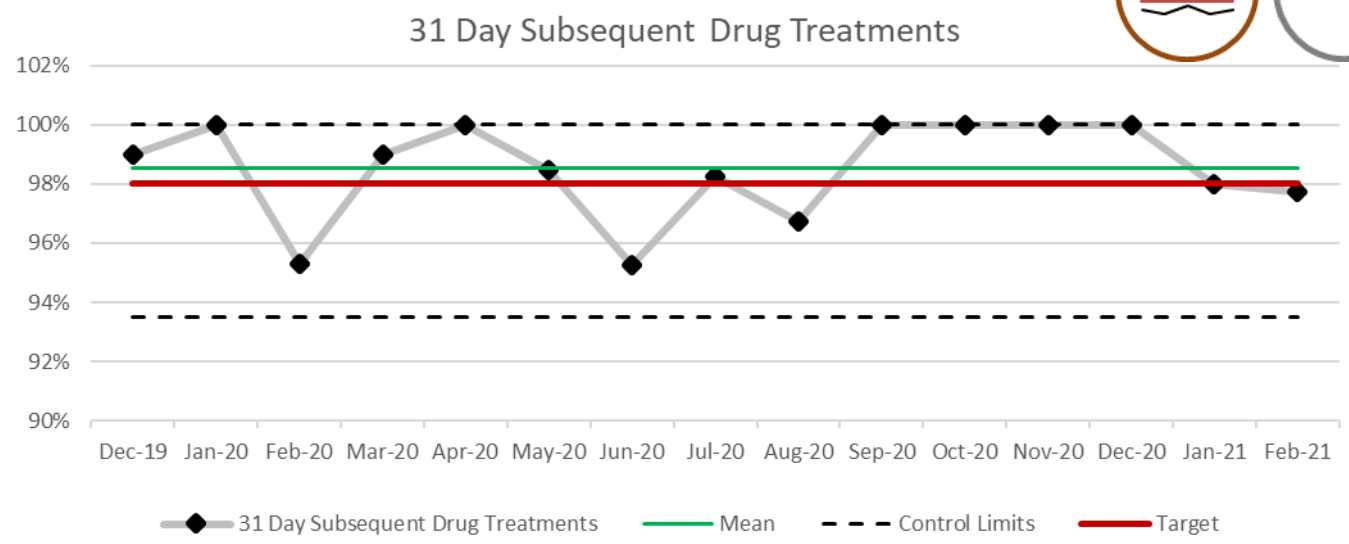
CQC Domain: Responsive

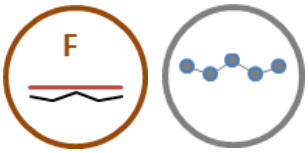
Strategic Objective: Services

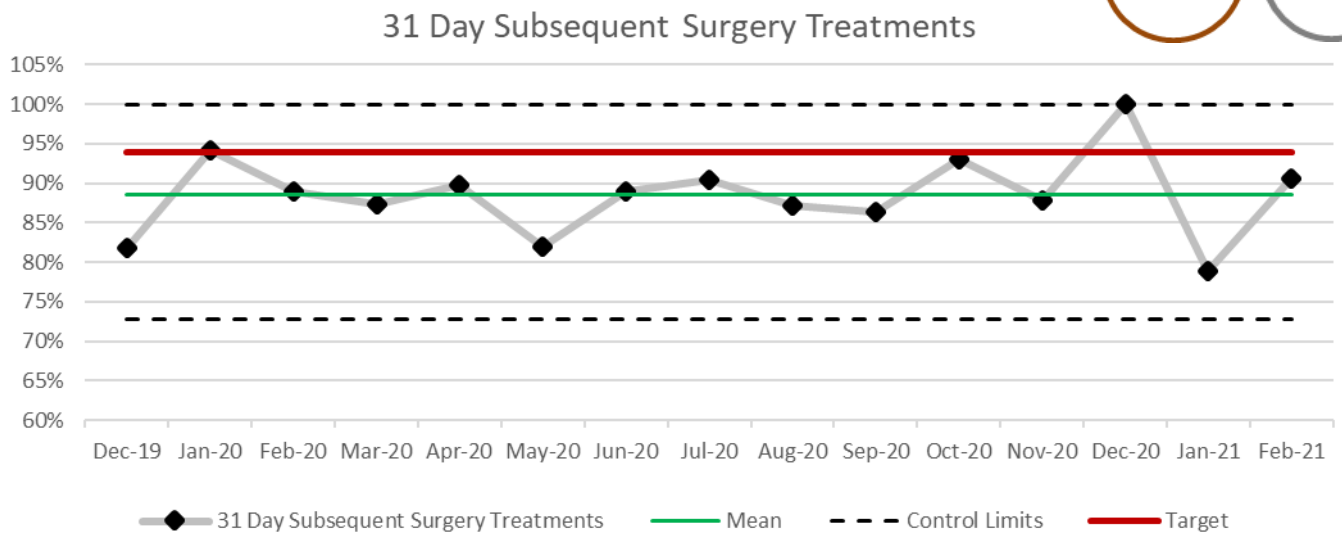


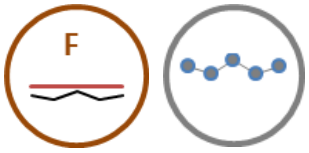


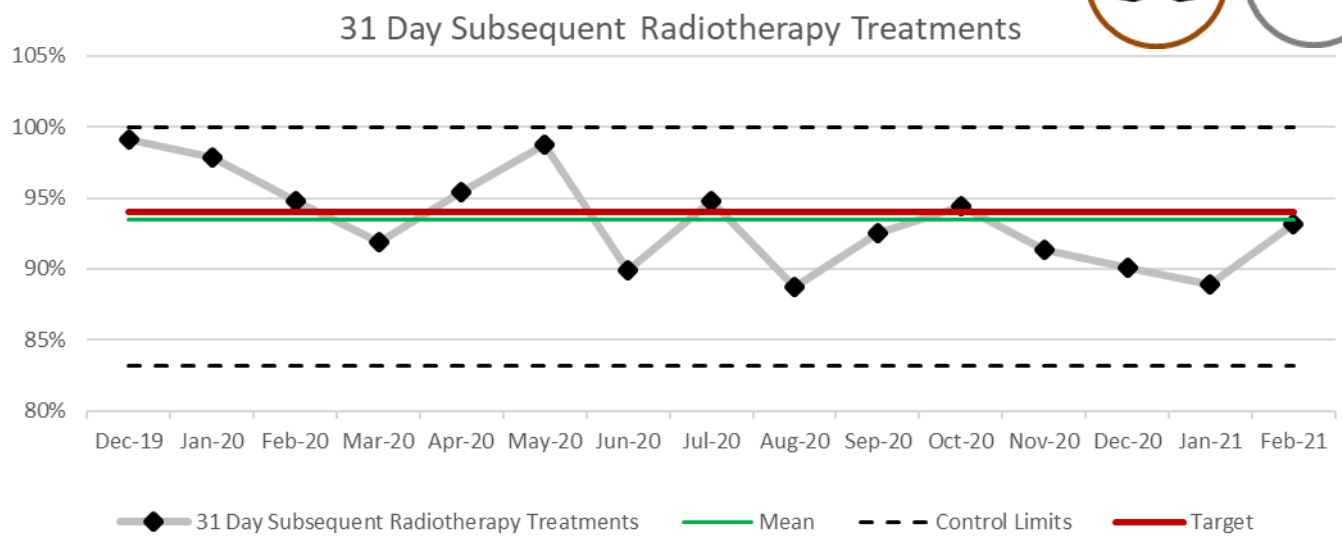








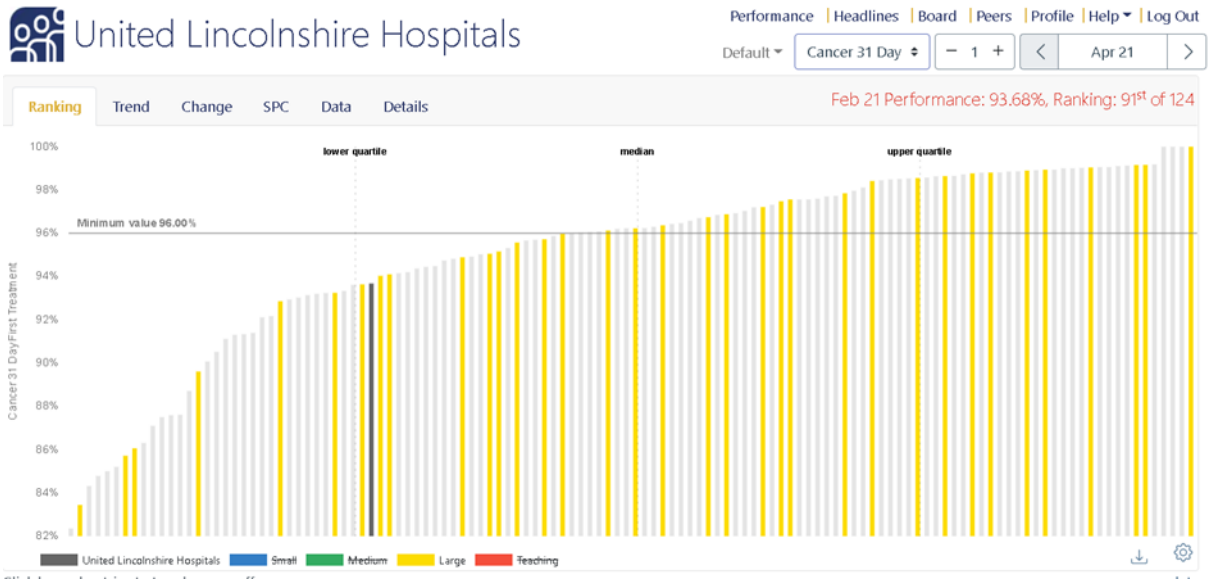




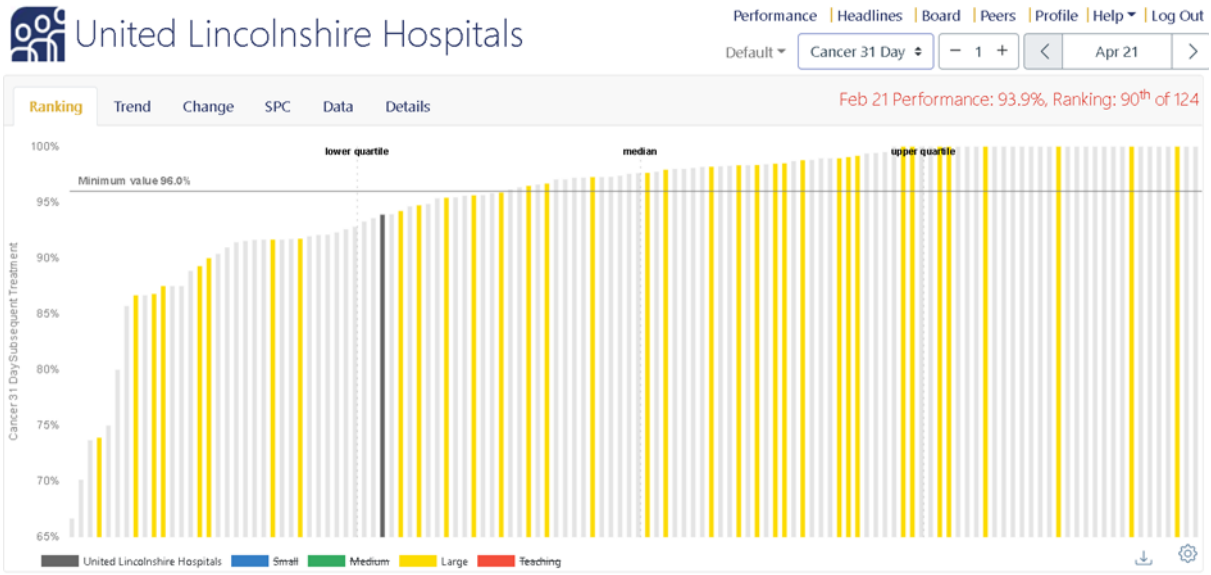
Challenges/Successes

The failure of the 31 Day standards was primarily due to the impact of COVID (the reduction in theatre capacity).

31 First



31 Subsequent



Actions in place to recover:

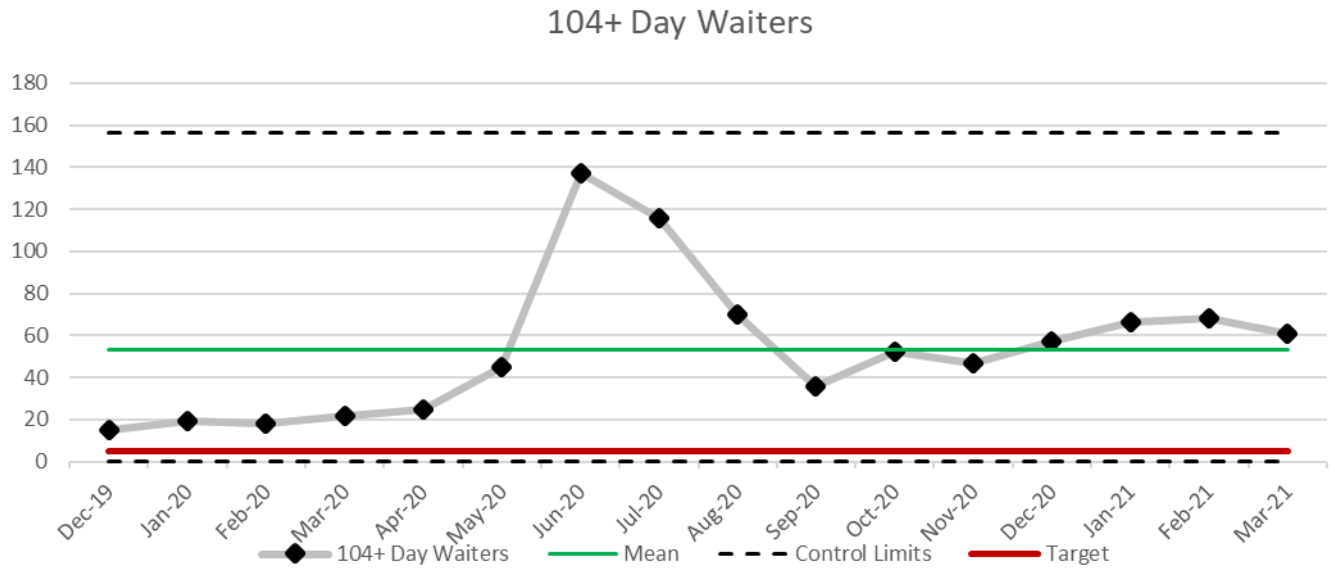
- Additional theatres installed at Grantham for Breast & Gynaecology.
- Review of Colorectal theatre list scheduling to better align with clinician availability and consideration of moving level 1 patients to Grantham.
- Colorectal Surgical patients discussed directly with NUH and SFHT for potential treatment within their Trusts.
- 2 H&N consultant posts have been recruited to, 1 due to start in April 2021, and another in July 2021.
- 2 Medical Oncologists were due to start in April. 1 has unfortunately withdrawn, and the other is now due to start in July 2021(covering Breast and GI).

IMPROVE CLINICAL OUTCOMES – CANCER 104+ DAY WAITERS

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

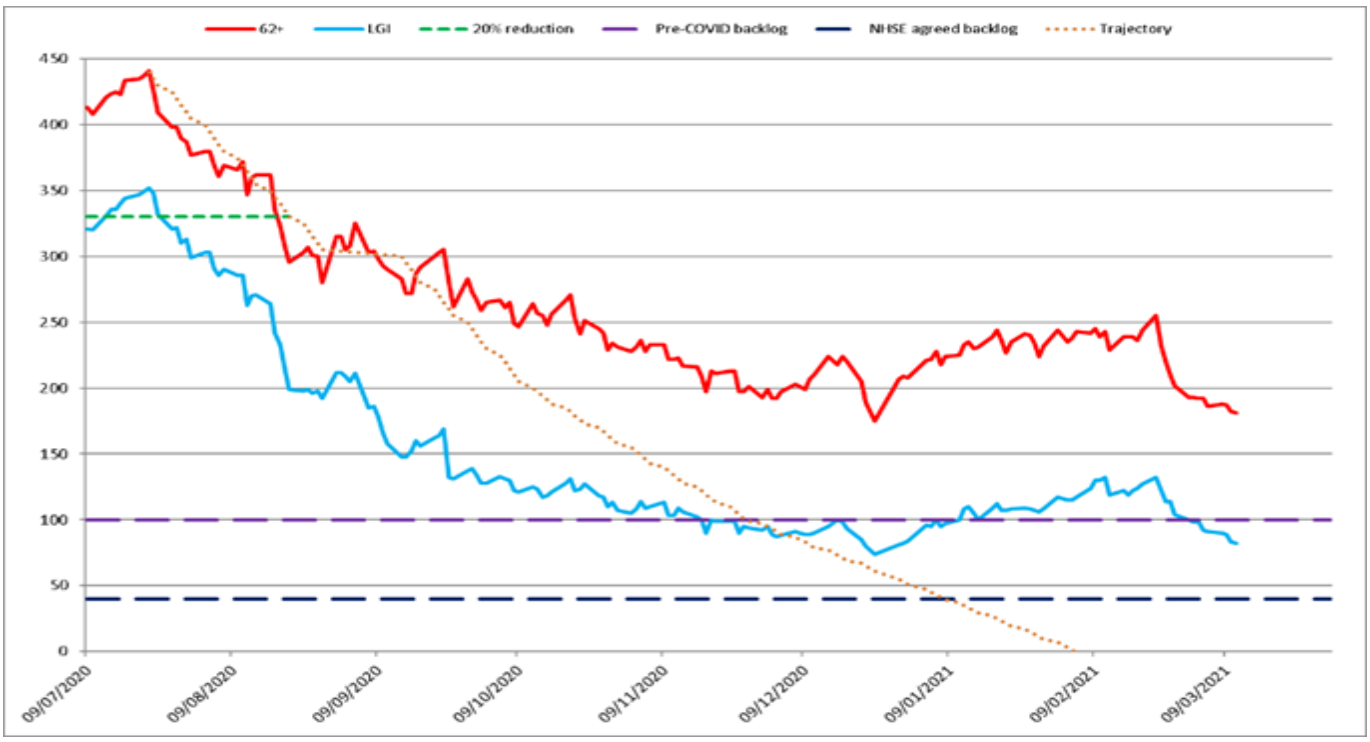
Strategic Objective: Services



Challenges/Successes

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

- As of 9th of April the 62 Day backlog is at 211 patients (from 441, target – below 40) **52% Reduction.**
- In August Colorectal patients accounted for c.70% of backlog and is now c.40%.
- Of the other tumour sites, Head & Neck, Breast, Gynae, and Urology remain outliers compared to pre-COVID levels.



104 Day Waiters as of 7th of April is at 66 (from 163, target – below 10) **58% Reduction.**

- 34 Colorectal
- 10 Urology
- 7 Head and Neck
- 6 Lung
- 3 Upper GI
- 2 each Breast and Gynae
- 1 each Skin and Sarcoma

Over 25% of the 104 Day Waiters have complex social or 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, including those waiting for first vaccine, second vaccine or 3 week 'effectiveness' period).
- 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.
- Reduced clinic throughput due to social distancing / IPC requirements, especially in waiting areas.
- Inappropriate referrals from GPs (eg not having face-to-face appointment prior to referral).
- Patients not willing to travel to where our service and / or capacity is.
- Patient acceptance & compliance with swabbing and self-isolating requirements.
- Reduced theatre capacity across the Trust, all Specialties vying for additional sessions -pre-covid level theatre capacity is not expected to be achieved until circa end June 2021.
- No access to Independent Sector capacity unlike other regional colleagues.
- Very limited success in identifying additional surgical capacity, in or out of region, through the East Midlands Cancer Alliance Surgical Hub.
- Increase in backlogs due to COVID-19 wave 2 impact on our services.
- 62 Day backlogs significantly in excess of pre-COVID levels for Colorectal, Head & Neck, Breast, Gynaecology 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

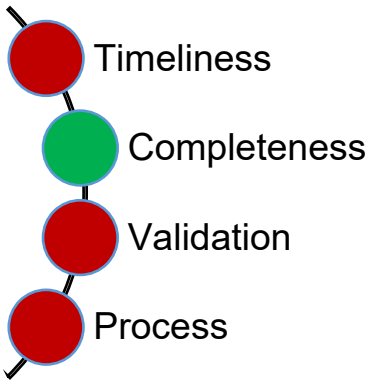
<u>Actions in place to recover:</u>

- 28 Day standard identified as Trust's single cancer performance work stream in the Integrated Improvement Program for 2021-22.
- Additional theatres installed at Grantham for Breast & Gynaecology.
- Review of Colorectal theatre list scheduling to better align with clinician availability and consideration of moving level 1 patients to Grantham.
-

- Successful bid for Radiology equipment: 5 low dose CT scanners (2 x PH, 2 x LC, 1 x GK), 2 digital X-ray rooms, 4 Ultrasounds (3 x general, 1 x Breast), 38 PACS reporting stations, replacement of Fluoro room, 3 DR Mammography rooms (1 each PH, LC and GK). Delivery is in stages between April and August.
- Endoscopy booking team recruited 3 fixed term WTE – now in post and training completed. A Case of Need is being written to request funding for these posts to become substantive because the additional workload will become business as usual.
- A Nurse endoscopist has been appointed on Bank who will support weekend lists – HR pre-employment checks have now been completed the booking of sessions can now commence.
- 2 fixed term WTE Endoscopist posts have gone through the interview and selection process twice with only 1 applicant so a Case of Need is being written for permanent funding. This will support the Bowel Cancer Screening age reduction.
- Replacement of Pilgrim decontamination unit began in February and will be completed mid-May (this includes 4 weeks wait post installation of each set of new washers for mycobacteria test results).
- Dedicated admin resource within Colorectal CBU to support clinical engagement.
- Awaiting funding confirmation from EMCA for full-time Cancer Navigator posts to support Surgery, Medicine and Family Health.
- 2 H&N consultant posts have been recruited to, one due to start in April 2021, and another in July 2021.
- 2 Medical Oncologists were due to start in April. One has unfortunately withdrawn, and the other is now due to start in July 2021(covering Breast and GI).

APPENDIX A – KITEMARK

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



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

Meeting	*Trust Board*
Date of Meeting	*4th May 2021*
Item Number	*Item number allocated by admin*
Strategic Risk Report	
Accountable Director	*Dr Karen Dunderdale, Director of Nursing*
Presented by	*Dr Karen Dunderdale, Director of Nursing*
Author(s)	*Matthew Hulley, Risk & Incident Manager*
Report previously considered at	*N/A*

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

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

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

Executive Summary

- This Strategic Risk Report focuses on the highest priority risks currently being managed within the Trust 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.
- As per last month there is continued reduction in the risk of the Covid-19 pandemic impacting on Trust services as can be seen by the Trust's inpatient numbers; however, there are also indications that the pandemic response has increased risk in some elective pathways as evidenced through the incident management systems and processes.
- The strategic risk for Workforce capacity & capability (recruitment, retention & skills) has reduced from a risk score of 20 to 12 following a review of the strategic objective 2a on the BAF at the People & OD Committee. The committee agreed to reduce the BAF from red to amber on the basis that effective controls are thought to be in place but assurances are uncertain and/or possibly insufficient at this stage to reduce this further.
- There are now 3 strategic risks that are rated very high:
  - Local impact of the global coronavirus (Covid-19) pandemic (25)
  - Capacity to manage emergency demand (20)
  - Workforce engagement, morale & productivity (20)

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.

1.3 All entries on strategic or operational risk registers should be formally reviewed and updated on a quarterly basis as a minimum requirement, although they can be updated in the interim if there is evidence that the level of risk has changed. The next round of quarterly reviews are due for completion by the end of June 2021.

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):

- Total number of confirmed Covid-19 inpatient cases - as of 26 April 2021 there had been 3,038 Covid-19 inpatient admissions within ULHT.
- Number of current in-patient admissions due to Covid-19 - 0 at Lincoln and 2 at Pilgrim on 26 April 2021 (compared with 17 and 12 respectively on 29 March).
- Patient deaths due to Covid-19 – total of 831 as of 26 April 2021; compared with 824 as of 29 March.

Gaps in control & mitigating actions:

- The England COVID alert level has reduced to Level 3 (epidemic is in general circulation).
- The NHS incident level remains at Level 3 resulting in the ability to progress restoration plans for the organisation.
- 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 in 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 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, with 76% of ULH staff now fully vaccinated

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 71.98% for March 2021 a deterioration of 0.86% from February.
- 12hour+ A&E waits – there was 2 reported in April demonstrating an improvement in process.
- March reported 328 >59-minute hand over delays. This is an increase of 110 on the February figure of 218. This represents a 33.54% increase in >59-minute ambulance handover delays.

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 and business case for investment on Pilgrim site (with government funding).
- The Urgent & Emergency Care 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 supports a more proactive response and delivery to system need.

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

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

Key Risk Indicators (KRIs):

- Staff appraisal rates - appraisal rates (excluding medical staff) across the Trust sat at 76% in March 2021 showing an increase against previous months against a target of 90%; Medical staff appraisal rates remain high at 94%.

- 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 will be implemented across the Trust from May 2021.
- 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.

3.2 There remains considerable uncertainty as to the future course of the pandemic and the risk posed to the Trust, however there are continued signs of improvement nationally and locally as a result of lockdown measures and the roll-out of the vaccination programme.

3.4 The risk of Workforce Capacity and Capability has been reduced from 20 to 12 following a review of the strategic objective 2a on the BAF at the People & OD Committee. The committee agreed to reduce the BAF from red to amber on the basis that effective controls are thought to be in place but assurances are uncertain and/or possibly insufficient at this stage to reduce this further.

3.5 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)	Review date
4083	Workforce engagement, morale & productivity	Reputation / compliance	20	Very high risk	31/03/2021
4175	Capacity to manage emergency demand	Service disruption	20	Very high risk	31/12/2020
4558	Local impact of the global coronavirus (Covid-19) pandemic	Harm (physical or psychological)	25	Very high risk	31/03/2021
4362	Workforce Capacity and Capability	Service disruption	12	High risk	30/06/2021
4437	Critical failure of the water supply	Service disruption	12	High risk	31/03/2021
4405	Critical infrastructure failure disrupting aseptic pharmacy services	Service disruption	12	High risk	30/06/2021
4406	Critical failure of the medicines supply chain	Service disruption	12	High risk	30/06/2021
4423	Working in partnership with the wider healthcare system	Service disruption	12	High risk	31/12/2020
4401	Safety of the hospital environment	Harm (physical or psychological)	12	High risk	31/03/2021
4402	Compliance with regulations and standards for mechanical infrastructure	Reputation / compliance	12	High risk	31/03/2021
3520	Compliance with fire safety regulations & standards	Reputation / compliance	12	High risk	31/03/2021
4081	Quality of patient experience	Reputation / compliance	12	High risk	31/12/2020
4082	Workforce planning process	Service disruption	12	High risk	31/03/2021
3689	Compliance with asbestos management regulations & standards	Reputation / compliance	12	High risk	31/03/2021
4043	Compliance with patient safety regulations & standards	Reputation / compliance	12	High risk	31/03/2021
4145	Compliance with safeguarding regulations & standards	Reputation / compliance	12	High risk	31/03/2021
4146	Effectiveness of safeguarding practice	Harm (physical or psychological)	12	High risk	31/03/2021
4157	Compliance with medicines management regulations & standards	Reputation / compliance	12	High risk	30/06/2021
4181	Significant breach of confidentiality	Reputation / compliance	12	High risk	31/12/2020
4179	Major cyber security attack	Service disruption	12	High risk	31/12/2020

4176	Management of demand for planned care	Service disruption	12	High risk	31/12/2020
4481	Availability & integrity of patient information	Service disruption	12	High risk	31/12/2020
4556	Safe management of demand for outpatient appointments	Harm (physical or psychological)	12	High risk	30/06/2021
4581	Heating (Trust Wide)	Harm (physical or psychological)	12	High risk	31/03/2021
4300	Availability of medical devices & equipment	Service disruption	16	High risk	31/12/2020
4156	Safe management of medicines	Harm (physical or psychological)	16	High risk	30/06/2021
4142	Safe delivery of patient care	Harm (physical or psychological)	16	High risk	31/03/2021
4144	Uncontrolled outbreak of serious infectious disease	Service disruption	16	High risk	31/12/2020
4044	Compliance with information governance regulations & standards	Reputation / compliance	16	High risk	30/06/2021
3690	Compliance with water safety regulations & standards	Reputation / compliance	16	High risk	31/03/2021
3720	Critical failure of the electrical infrastructure	Service disruption	16	High risk	31/03/2021
3688	Quality of the hospital environment	Reputation / compliance	16	High risk	31/03/2021
4003	Major security incident	Harm (physical or psychological)	16	High risk	31/03/2021
4403	Compliance with electrical safety regulations & standards	Reputation / compliance	16	High risk	31/03/2021
4404	Major fire safety incident	Harm (physical or psychological)	16	High risk	31/03/2021
4383	Substantial unplanned expenditure or financial penalties	Finance	16	High risk	30/06/2021
4480	Safe management of emergency demand	Harm (physical or psychological)	16	High risk	31/12/2020
4061	Financial loss due to fraud	Finance	4	Low risk	31/12/2020
4277	Adverse media or social media coverage	Reputation / compliance	4	Low risk	31/12/2020
4385	Compliance with financial regulations, standards & contractual obligations	Reputation / compliance	4	Low risk	31/03/2021
4386	Critical failure of a contracted service	Service disruption	4	Low risk	31/12/2020
4387	Critical supply chain failure	Service disruption	4	Low risk	31/12/2020

4388	Compliance with procurement regulations & standards	Reputation / compliance	4	Low risk	31/12/2020
4438	Severe weather or climatic event	Service disruption	4	Low risk	31/12/2020
4439	Industrial action	Service disruption	4	Low risk	31/12/2020
4440	Compliance with emergency planning regulations & standards	Reputation / compliance	4	Low risk	31/12/2020
4441	Compliance with radiation protection regulations & standards	Reputation / compliance	4	Low risk	01/06/2021
4467	Impact of a 'no deal' EU exit scenario	Service disruption	4	Low risk	30/06/2021
4469	Compliance with blood safety & quality regulations & standards	Reputation / compliance	4	Low risk	31/12/2020
4482	Safe use of blood and blood products	Harm (physical or psychological)	4	Low risk	31/12/2020
4483	Safe use of radiation (Trust-wide)	Harm (physical or psychological)	4	Low risk	31/03/2022
4514	Hospital @ Night management	Service disruption	4	Low risk	31/12/2020
4526	Internal corporate communications	Reputation / compliance	8	Moderate risk	31/12/2020
4528	Minor fire safety incident	Harm (physical or psychological)	8	Moderate risk	31/03/2021
4553	Failure to appropriately manage land and property	Finance	8	Moderate risk	31/03/2021
4384	Substantial unplanned income reduction or missed opportunities	Finance	8	Moderate risk	31/03/2021
4502	Compliance with regulations & standards for medical device management	Reputation / compliance	8	Moderate risk	31/12/2020
4579	Delivery of the new Medical Education Centre	Reputation / compliance	8	Moderate risk	31/12/2020
4486	Clinical outcomes for patients	Harm (physical or psychological)	8	Moderate risk	31/12/2020
4424	Delivery of planned improvements to quality & safety of patient care	Reputation / compliance	8	Moderate risk	31/12/2020
4476	Compliance with clinical effectiveness regulations & standards	Reputation / compliance	8	Moderate risk	31/12/2020
4389	Compliance with corporate governance regulations & standards	Reputation / compliance	8	Moderate risk	31/12/2020
4397	Exposure to asbestos	Harm (physical or psychological)	8	Moderate risk	31/03/2021

4398	Compliance with environmental and energy management regulations & standards	Reputation / compliance	8	Moderate risk	31/03/2021
4399	Compliance with health & safety regulations & standards	Reputation / compliance	8	Moderate risk	31/03/2021
4400	Safety of working practices	Harm (physical or psychological)	8	Moderate risk	31/03/2021
4351	Compliance with equalities and human rights regulations, standards & contractual requirements	Reputation / compliance	8	Moderate risk	31/03/2021
4352	Public consultation & engagement	Reputation / compliance	8	Moderate risk	31/12/2020
4353	Safe use of medical devices & equipment	Harm (physical or psychological)	8	Moderate risk	31/12/2020
4363	Compliance with HR regulations & standards	Reputation / compliance	8	Moderate risk	31/03/2021
4368	Efficient and effective management of demand for outpatient appointments	Reputation / compliance	8	Moderate risk	30/06/2021
4382	Delivery of the Financial Recovery Programme	Finance	8	Moderate risk	31/03/2021
4182	Compliance with ICT regulations & standards	Reputation / compliance	8	Moderate risk	31/12/2020
4177	Critical ICT infrastructure failure	Service disruption	8	Moderate risk	31/12/2020
4180	Reduction in data quality	Reputation / compliance	8	Moderate risk	31/12/2020
4138	Patient mortality rates	Reputation / compliance	8	Moderate risk	31/03/2021
4141	Compliance with infection prevention & control regulations & standards	Reputation / compliance	8	Moderate risk	31/12/2020
3503	Sustainable paediatric services at Pilgrim Hospital, Boston	Service disruption	8	Moderate risk	01/09/2021
3687	Implementation of an Estates Strategy aligned to clinical services	Service disruption	8	Moderate risk	31/03/2021
3721	Critical failure of the mechanical infrastructure	Service disruption	8	Moderate risk	31/03/2021
3722	Energy performance and sustainability	Finance	8	Moderate risk	31/03/2021

3951	Compliance with regulations & standards for aseptic pharmacy services	Reputation / compliance	8	Moderate risk	30/06/2021
4567	Working Safely during the COVID - 19 pandemic (HM Government Guidance)	Reputation / compliance	9	Moderate risk	30/06/2021
4497	Contamination of aseptic products	Harm (physical or psychological)	10	Moderate risk	30/06/2021

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*4 May 2021*
Item Number	*Item 13.2*
Board Assurance Framework (BAF) 2020/21	
Accountable Director	*Andrew Morgan Chief Executive*
Presented by	*Jayne Warner, Trust Secretary*
Author(s)	*Karen Willey, Deputy Trust Secretary*
Report previously considered at	*N/A*

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

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

Recommendations/ Decision Required	• *Board to consider assurances provided in respect of Trust objectives noting that framework has been reviewed through committee structure*
	• *Board to accept the change to the rating for objective 2a from red to amber*

Executive Summary

The relevant objectives of the 2020/21 BAF were presented to all Committees during April and the Board are asked to note the updates provided within the BAF.

Assurance ratings have been provided for all objectives and have been confirmed by the Committees. The rating for objective 2a has improved from red to amber following a proposal made to the People and Organisational Development Committee. The evidence presented to the Committee and discussions held allowed the Committee to confirm an amber rating for the objective.

The following assurance ratings have been identified:

Objective		Rating at start of 2020/21	Previous month (March)	Assurance Rating (April)
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	A
2b	Making ULHT the best place to work	R	R	R
2c	Well led services	A	A	A
3a	A modern, clean and fit for purpose environment	R	R	R
3b	Efficient use of resources	G	G	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	A	A
4c	To become a University Hospitals Teaching Trust	A	R	R

Board Assurance Framework (BAF) 2020/21 - April 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**												
						Group, lead & plan in place to support the delivery of an improved patient safety culture	Patient Safety Walk Rounds and Human Factors training delayed due to second wave of Covid-19	Human factors training is now rescheduled for June 2021	Trust Wide Accreditation Programme Reports Safeguarding, DoLS and MCA training and monitored monthly with appropriate escalation Safety Culture Surveys Sepsis Six compliance data HSMR and SHMI data Flu vaccination rates Audit of response to triage, NEWS, MEWS and PEWS IPC Assurance Framework FLOW audits CQC Ratings and progress on delivery of Must Do and Should Do actions and regulatory notices Monitoring nosocomial infection rates National Clinical Audits Dr Foster alerts Patient safety indicators in the IPR Quality and Safety Risk Report		Assurance gaps to be identified through Trust Board streamlined governance process and Quality Governance Committee. IPC identified gaps are being managed and monitired by reporting and gap analysis to the IPCG .		
						Robust Quality Governance Committee, which is a sub-group of the Trust Board, in operation with appropriate reporting from sub-groups.		Review of Quality Governance Committee and Sub-group structures					
						Patient Safety Group which is a sub group of the Quality Governance Committee in place meeting monthly.	Disruption to existing governance arrangements during the pandemic	Patient Safety Group & sub-group meetings have continued to take place throughout the pandemic					
						Infection Prevention and Control Committee in place and meeting monthly	The agenda reports on and monitors infection prevention and control requirements of the Health and Social Care Act "Hygiene Code". Reporting includes Divisional Leads, IPC Team, Antimicrobial Pharmacist.	Agenda reviewed on a month by month basis to ensure that urgent issues are picked up as well as continuous monitoring.					
						Relevant IPC policies and procedures in place and in date	Planned programme is in place to ensure a prioritised review and development of IPC policies and related procedures.	Planned programme with very good progress being made. Assurance and monitoring via the monthly IPCG. Policy at a glance documentation.					
						Process in place to monitor delivery of the Hygiene Code	Gap analysis with development plan is produced.	Divisional progress and exception reporting to the IPCG for assurance and monitoring purposes.					
						Infection Prevention and Control BAF in place and reviewed monthly	Gap analysis with development plan is produced.	National guidance followed on PPE / infection prevention & control; Pandemic Flu Plan initiated; separate care pathways for urgent & planned care, integration of IPC requirements into Grantham Restoration and Project Salus.					
						Separate care pathways in place for urgent and planned care to aim to eliminate risk of nosocomial infection	Initiation and implementation of restoration activity under the remit of Project Salus with a framework that is dictated by national IPC requirements	Via Project Salus steering group meetings. IPC support and guidance is provided					

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1a	Deliver Harm Free Care	Director of Nursing/Medical Director	Failure to manage demand safely Failure to provide safe care Failure to provide timely care Failure to use medical devices and equipment safely Failure to use medicines safely Failure to control the spread of infections Failure to safeguard vulnerable adults and children Failure to manage blood and blood products safely Failure to manage radiation safely Failure to deliver planned improvements to quality and safety of care Failure to provide a safe hospital environment Failure to maintain the integrity and availability of patient information Failure to prevent Nosocomial spread of Covid-19	4558 4480 4142 4353 4146 4556 4481	CQC Safe	Elective care patients assessed by test and symptoms to be Covid-19 risk minimised	Initiation and implementation of restoration activity under the remit of Grantham Restoration and Project Salus with a framework that is dictated by national IPC requirements (low, medium and high)	Via implementation of national COVID IPC guidance that describes categorisation of risk, low, medium and high. Elective patients who are tested as negative are in the low risk pathway	Incident Management Report Mortality Report Upward Reports of the: Safeguarding Group Medicines Quality Group Patient Safety Group (incorporating sub-groups) and the Clinical Effectiveness Group			Quality Governance Committee	R
						Establishment of Grantham 'Green Site' and temporary repurposing of A&E to an Urgent Treatment Centre under LCHS management.	Initiation and implementation of restoration activity under the remit of Grantham Restoration and Salus projects with a framework (low medium and high) that is dictated by national IPC requirements.	Via implementation of national COVID IPC guidance that describes categorisation of risk, low, medium and high.					
						Mortality group in place which meets monthly	Disruption to existing governance arrangements during the pandemic	Mortality Group meetings have continued throughout the pandemic; MorALS Group is now in place & reporting to Patient Safety Group					
						Monthly mortality report in place to track achievement of SHMI/Mortality targets	Gaps in the number of structured judgement reviews undertaken Impact of Covid-19 on coding triangles	Funding available to train an additional 40 members of staff to undertake structured judgement reviews by the end of March 2021					
						Robust policies and procedures for incident investigations, harm reviews and assurance of learning	Clinical harm review processes not all documented & aligned with incident reporting	Task and finish group in place to agree required changes to harm review processes and documentation					
						Theatre Safety Group developed	Disruption to existing governance arrangements during the pandemic	Theatre Safety Group has not met during the pandemic; group is being re-started, reporting to PSG. Pascal survey results are feeding into theatre safety work					
						Process in place to ensure safe use of surgical procedures (NatSIPs/LocSIPs)	Lack of assurance regarding progress of implementing NatSIPs/LocSIPs within the Trust	Review of progress being undertaken with a view to relaunching the programme; Group set up, divisional representation; quarterly reporting to PSG					
						Medication safety Group in operation	Lack of e-prescribing leading to increase in patient safety incidents	Replacement of manual prescribing processes with an electronic prescribing system; improvements to medication storage facilities; strengthening of Pharmacy involvement in discharge processes					
						Medical devices safety group in place which received relevant reports							

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						Appropriate policies and procedures in place to ensure medical device safety	Lack of assurance regarding staff training on the medical devices	Implementation of a central database of medical device user training records					
						Appropriate policies and procedures in place to recognise and treat the deteriorating patient,	Number of incidents occurring regarding lack of recognition of the deteriorating patient	Deteriorating Patient Group set up as a sub group of the Patient Safety Group to identify actions taken to improve; has its own sub-groups covering NIV; AKI; sepsis; VTE					
						Ensuring a robust safeguarding framework is in place to protect vulnerable patients and staff	?? Sedation group New funding needed to continue restraint training delivery. Business case needs to be developed or future restraint training requirement.	Updated policy & training in use of chemical restraint / sedation; strengthening of pathways & training to support patients with mental health issues					
						Dementia steering group relaunched April 2021 to provide oversight and direction in relation to Dementia and Delirium pathway.	Dementia pathway not in place. Dementia training Level 2 needs to be developed.	Dementia Level 1 training available and achieving 90%+. Joint work ongoing between ULHT and partners.					
						Safeguarding and Vulnerability Oversight Group (SVOG) established and meet Bi-monthly (reporting to QGC) with divisional Safeguarding.	Safeguarding training remains below expected level.	Training plans developed and in place for Safeguarding Children and Safeguarding Adults. Training redeveloped to mitigate for Covid and data monitored by Deputy Director Safeguarding and SVOG with appropriate escalation taken to divisional leads.					
						Appropriate policies and procedures in place to reduce the prevalence of pressure ulcers, including a Skin Integrity Group							
						Formal governance processes in place within divisions, including regular meetings and reporting, supported by a central governance team							
						Robust process in place to monitor delivery against the CQC Must Do and Should Do actions and regulatory notices	Second round of CQC Confirm and Challenge sessions cancelled due to second wave of Covid-19						
						Appropriate medical records management systems and processes in place	Current issues identified in relation to management of paper medical records	Implementation of an Electronic Patient Record (EPR) system; Group involving Dep DoN has met to begin to work on management of paper medical records					
						Patient Experience Group, which is a sub-group of the Quality Governance Committee, in place meeting monthly Robust Complaints and PALS process in place	Significant delay in co-design of services due to impact of Covid Complaints policy out of date	Amalgamation of the Complaints and PALS policy underway and due for completion end of 2021 - Completion end of March 2021	Quarterly Complaints reports identifying themes and trends presented at the Patient Experience Group Patient Experience Group upward report	Complaints & PALs Policy under review and will come to April meeting	Assurance gaps to be identified through Trust Board streamlined governance process and Quality Governance Committee		

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1b	Improve patient experience	Director of Nursing	Failure to provide a caring, compassionate service to patients and their families Failure to provide a suitable quality of hospital environment	3688 4081	CQC Caring	Patient Panel meeting monthly and reporting into the Patient Experience Group.	Staff training in relation to communication and engagement	IIP projects specifically: co-design; Schwartz Rounds; engaging with patients and families; real time surveying, involving in decisions about care.	Real time patient and carer feedback User involvement numbers National patient surveys Number of locally implemented changes as a result of patient feedback	IIP projects update to April meeting		Quality Governance Committee	R
						Care of the dying patient guidelines and procedures	QSIR virtual cohort paused due to Covid - plans to reset for March	Supporting visiting arrangements for EOL patients including virtual options as required	SUPERB Patient Experience Dashboard Patient Experience indicators in the IPR Care Opinion	Visiting arrangements reviewed through Gold Command. EoL arrangements updated.			
						Inclusion Strategy in place and in date	Delivery of Year 3 objectives of the Inclusion Strategy due to impact of Covid Patient Experience Strategy now out of date	Review of all relevant policies relating to Patient Experience underway		Patient Experience Plan 2020 – 2023 in date. Intranet updated. Plan to be added to April agenda and upwardly reported to QGC. Multi-agency working group scheduled 09.03.21 for review of Carers Policy.			
						Robust process in place for annual PLACE inspection accompanied by PLACE LITE	Inability to undertake Quality ward/department review visits due to Covid	Monthly review meetings of the Matrons Quality Metrics with the DoN and DDoN Review of process for ward / department visits underway with plans to recommence April 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.	Matron Quality Metrics PLACE Inspection reports Estates attendance and updates at the fortnightly CQC meetings	PLACE Lite report to April meeting.			
						Getting it Right First Time Reviews are undertaken	Due to Covid there is a delay in implementing GIRFT recommendations	Quarterly reports to Clinical Effectiveness Group GIRFT project Manager in post	Upward reports to QGC and its sub-groups KPIs in the integrated governance report Relevant internal audit reports Reports from the National Audit Programmes Reports from Divisions on compliance with NICE / TAs / local and national audit		Assurance gaps to be identified through Trust Board streamlined governance process and Quality Governance Committee		
						Clinical Effectiveness Group in place and meets monthly	The function of Clinical Effectiveness Group is evolving	Agenda reviewed on a meeting by meeting basis to ensure that all priority items are covered 2020/21 work plan developed with Terms of Reference					
						Clinical Audit Group in place and meets monthly	There are outstanding actions from local audits	Audit Leads present compliance with their local audit plan and actions					
						National and Local Audit programme in place and agreed	Audit findings do not always demonstrate the necessary improvements	Increased focus on reporting outcomes from audit Revision of Clinical Audit Policy to strengthen Introduction of the Clinical Audit Group attended by Clinical Audit Leads					

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1c	Improve clinical outcomes	Medical Director	Failure to provide effective and timely diagnosis and treatment that deliver positive patient outcomes	4558	CQC Responsive CQC Effective	Process for monitoring the implementation of NICE guidance and national publications in place	There are a number of pieces of guidance for which the baseline assessments are still required	Clearance of backlog of NICE guidelines and technical appraisal assessments				Quality Governance Committee	R

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						Document control process in place for clinical guidelines and SOPs	Issues identified with the current document control process	Task and finish group set up to identify action required to address					
						Process in place for taking part in the Patient Related Outcome Measures (PROMs) project	Due to Covid elective surgery was cancelled, number of submissions lower than expected (expected number based on previous years hips & Knee replacement)	The Trust has implemented project Salus and the restoration of services will be increase number of elective surgery cases which in turn will increase number of PROMS.					
						Divisional governance meetings in place	Triumvirate not fully appraised of their compliance with audit and NICE	Within the Integrated Governance Report compliance with NICE and audit is included					
						Enhanced governance support in place from the central team							
						Clinical Service Review Programme in place	The process does not include system partners leading to potential fragmentation in clinical pathways						
						Quarterly Learning Lessons Newsletter in place at both Division and Trust wide level							
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	COVID did have a significant impact on our ability to deliver the IIP projects, set out in the "controls" column, during 2020/21. The projects are currently being rescoped and resources are in place to deliver at pace in the 2021/22 financial year.	4362	CQC Safe CQC Responsive CQC Effective	Embed Robust workforce planning and development of new roles Fully engage with System People Plan, particularly work programme around "More People, Working Differently" Targeted recruitment campaigns to include overseas recruitment - NHSE/I supported project has enabled rapid recruitment of 120 new international nurses by the end of April 2021, with further cohorts expected through to the end of the 21/22 financial year. Rapid recruitment of HCSWs means that we now have a net nil vacancy position for that group Delivery of annual appraisals and mandatory training Creating a framework for	Recruitment progress set out in previous column. Pipeline report, which takes account of turnover, indicates significant reduction in vacancy rate in the next 6 to 9 months Implementation of Workpal paused due to Covid-19 wave 2 - now due in May 21 Talent management programme now resourced and progressing Roll-out of continuous improvement methodology will proceed at pace in 21/22 Workforce planning progressing in line with NHSE/I targets. Medical and nursing workforce	Covid Command and decision making structure alongside Board agreed lean governance arrangements have been in place during the COVID incident. As we move from managing COVID as an endemic, rather than a pandemic, normal management arrangements will be re-established. 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 Modern Employer targets Staff survey feedback Sickness/absence data Reported progress on the implementation of the NHS People Plan	Projects previously paused are now progressing at pace, including full participation in the System People Plan projects around "More People, Working Differently" Vacancy rate reducing since summer 2019 National Staff Survey results received - disappointing. Will inform the agreed Culture & Leadership Programme - in-year Pulse Survey results much more positive	Assurance gaps to be identified through Trust Board streamlined governance process and People and Organisational Development Committee	People and Organisational Development Committee	A

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						people to achieve their full potential Embed continuous improvement methodology across the Trust Reducing absence management Deliver Personal and Professional development	transformation groups meeting regularly. Vacancy rate reducing since summer 2019. Review of mandatory training underway and resource leading on all aspects of education and learning		and the Lincolnshire System Workforce Plan NB New indicators being developed for the 21/22 financial year	Sickness absence and turnover rates on par with other NHS Trusts in Lincolnshire			

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2b	Making ULHT the best place to work	Director of People and Organisational Development	COVID has had a significant impact on our ability to deliver the IIP projects, set out in the "controls" column. We do now have access to additional resources to increase capacity to support programmes around recruitment and sickness management. This will have limited impact in this financial year, but will enable programmes to move forward at pace in 2021/22. COVID has had a significant impact on the well-being of our staff. We recognise the need for a period of "staff recovery", which we will seek to plan to manage alongside the restoration of services. This will encompass increased access to mental health support.	4083	CQC Well Led	Embedding our values and behaviours - Culture & Leadership programme 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. The particular focus of this project has been on staff well-being through COVID. Our well-being programme is extensive and will be further enhanced to address the expected emotional and metal health fall-out from the COVID period. Participating fully in the development and implementation of the System People Plan, notably the "compassionate and inclusive culture" element Implementing Schwartz Rounds Embed Freedom to Speak Up and Guardian of safe Working Celebrate year of the Nurse/Midwife	Many Integrated Improvement Plan activity slowed down or paused due to Covid-19 in 20/21 financial year. However these are now being re-scoped and taken forward at pace in 21/22 We have significantly enhanced our communication and engagement during COVID. Initiatives such as "ELT live" have been well-received. Our work on the "core offer" has focused on the health and well-being of our staff during COVID. The wellbeing offer has been amended and extended to reflect experience and circumstances. We are now focused on the recovery of our staff alongside the recovery of services. Schwartz rounds deferred due to Covid-19. Leadership development work has largely been on hold and will be progressed as part of the Culture & Leadership programme.	Covid Command and decision making structure alongside Board agreed lean governance arrangements have been in place during the COVID incident. As we move from managing COVID as a pandemic to an endemic, we will look to re-establish more normal working arrangements. 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 NB New measures being developed for 21/22 year	National Staff Survey results received. Response will be considered as part of the Culture & Leadership programme. The new in-year pulse survey has significantly more positive responses than the equivalent metrics in the NSS Leadership development activity paused/slowed due to Covid-19 Schwartz rounds paused due to Covid-19 Trust adopting the six "building blocks for recovery": 1). Appreciation and Recognition – appreciation weeks 2). Rest and Recovery – additional carry forward of leave 3). Safe and Secure at Work – high take up of vaccines 4). Staff Experience – Culture & Leadership programme 5). Creating Capacity – rapid recruitment of HCSWs and international nurses 6). Healing – memorial planned Current Trust Wellbeing offer to staff: • Wellbeing calls to managers • Support on wards / depts. – OD team drop-in sessions on-site for wellbeing support (where requested by the service) • Additional counselling support provided • Steps to Change access	Staff survey results very disappointing - Trust response is Culture and Leadership programme led by the CX Leadership development activity to recommence post Covid-19 Recommencement of Schwartz rounds to be considered in June 2021, where appropriate Fully engaged with progressing work programmes of the System People Plan - well received at regional level	People and Organisational Development Committee	R

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										• OH counselling service • Chaplaincy support offer • What'sApp wellbeing line			
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 -paused for 20/21	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 Clinical and Corporate Policies and Guidelines now managed through single process by Trust Secretary Report to Audit Committee quarterly Report to ELT fortnightly	Audit Committee	A

Ref	Objective	Exec Lead	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	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
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. PLACE assessments have been suspended and delayed for a period during COVID Value for Money schemes have been delayed during COVID	Interim case for £9.6M of CIR has been reviewed and approved by NHSE with the majority of schemes due to deliver in 2020/21 Water/Fire safety meetings are in place and review of controls are part of external validation from authorised engineers. Capital Delivery Group has oversight of the delivery of key capital schemes. Estates Evolution forum and improvement team monitor progress through and has restarted now Wave 2 Covid has passed.	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	Infrastructure case has tackled £9.6M of the overall £100m+ backlog. 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.	Estates Evolution and Estates Group review compliance and key statutory areas. Development of 2021/22 Capital Programme will continue to ensure progress against remaining backlog of critical infrastructure. Capital Delivery Group will monitor the delivery of key capital programmes and ensure robust programme governance. IPC Cell/Group and upward reporting of cleanliness is reported through to QGC. Water Safety and Fire Safety Groups will report through alongside Health and Safety Groups to relevant sub-committees and provide a more comprehensive view offering assurance were it is possible and describing improvement where it is not. The appointment of Authorised engineers in key statutory areas will give responsible person/Executive arms length oversight of assurance gaps to fill.	Finance, Performance and Estates Committee	R
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

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
						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**												
	[illegible]	Director of	Failure of specialty teams to design and adopt new pathways of care		CQC Caring	Supporting the implementation of new models of care across a range of specialties Improvement programmes for cancer, outpatients and urgent care in progress, programme for theatres was on hold, and has been included in 21/22 plans Development and Implementation of new pathways for paediatric services - in progress, included in 21/22 plans.	Disruption to existing programme during pandemic	Outpatient Improvement Group continues to meet during 2020/21 Cancer Improvement Board continues to meet during 2020/21 with altered work programme Urgent care improvement dictated as part of COVID response CYP Group re-established	Reports -ELT / TLT			[illegible]	

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
4a	Establish new evidence based models of care	Director of Improvement and Integration	Failure to support system working Failure to design and implement improvement methodology		CQC Responsive CQC Well Led	Support Creation of ICS - Lincolnshire designation 1st April 2021 Support the development of an Integrated Community Care programme - Ceased by CCG Support the consultation for Acute Service Review (ASR) Phase 1 - PCBC with national team Implementing the Outstanding Care Together Programme to support the Organisation to focus on high priority improvements - in progress	Disruption to existing programme during pandemic	OCTP Exec led pillar meetings continue ELT/TLT oversight Board / system reporting	-Committees -Board -System -Region			Finance, Performance and Estates Committee	**A**
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 Adoption of HEE Midlands Charter Expansion of joint posts with UoL Medical School for Education and Research Development of job planned time for research with UoL Scope cross organisation clinical working		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 Feedback surveys of medical staff in training	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 Surveys from medical staff in training QA visits by University of Lincoln Medical School and HEE Midlands Review of training deficit following Covid-19 and individual recovery plans		Progress against HEE Midlands charter for medical education Internal and external QA of education and training GoSW monitoring	People and Organisational Development Committee	**A**

Ref	Objective	Exec Lead	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	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
4c	To become a University Hospitals Teaching Trust	Director of Improvement and Integration	Failure to develop research and innovation programme Failure to develop relationship with university of Lincoln and University of Nottingham Failure to become member of university hospital association			Developing a business case to support the case for change Gap analysis and Tracker - to commence Increasing the number of Clinical Academic posts Refresh of our Research, Development and Innovation Strategy - Complete Improve the training environment for medical students and Doctors	Deferred until 21/22 - agreed at FPEC Development of Gap Analysis, Tracker and Framework To develop a 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	Assurance to People and OD Committee	Reporting progress against Business Case in 21/22 to People & OD Committee Progress with application for University Hospital Trust status to recommence following pause for covid-19 wave 2. This work when commencing will give a gap analysis and tracker. Work to the number of clinical academic posts and training environment will commence once milestones sign-off by Medical Director.	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

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*4 May 2021*
Item Number	*Item*
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 12th April 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 Strategy Memorandum 2020/21

The Committee received the External Audit Strategy 2020/21 which summarised the External Audit approach, highlighted the significant risks and areas of key judgements and members of the audit team. The fee for the audit was agree din line with contract.

The Committee approved the final audit strategy memorandum. Noted the timeline for the audit to meet the deadline for completion of the audit ahead of the national accounts deadline for final approval and submission. The Committee noted that there was no requirement for an audit of the Quality Account.

The Committee recognised the risks within the audit of this being the first year of a new external audit contract and in the context of the pandemic. A particular area of focus would be covid expenditure and provisions.
The Committee noted the four key areas of significant risk, management override of controls, risk of fraud in revenue recognition, risk of fraud in expenditure recognition and valuation of land, buildings and dwelling assets.

The Director of Finance & Digital gave an overview to the Committee on the recent issues which had been highlighted at a Trust in Leicester. In particular the culture and behaviours and how the finance teams had operated.

The Internal Audit Lead was able to assure the Committee that they had taken the learning from the Leicester issues and explored these in the internal audit of core financial controls. The Director of Finance & Digital confirmed that the learning had been shared and discussed with the Finance Team

The Committee recognised that it was essential following on from this that the Non-Executive Directors ensure that they were speaking to teams below executive level.

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 a further six reports had been issued.

- Data Security and Protection Toolkit
- Core Financial Controls – Host ledger
- Core Financial Controls – Trust Controls
- Core Financial Controls – Host payroll
- Incident reporting and investigation (for management comment)
- Complaints (for management comment)

All reports would be considered by relevant assurance committees of the Board with a focus on implementation of recommendations.

A further three reviews were needed to complete to contribute to the year end opinion.

- Risk Management
- Estates Management
- Integrated Improvement Plan

The Committee noted that a number of reviews had been rolled in to the 2021/22 programme in response to the pandemic and the committee asked for a bridge document to give clarity on all in year changes.

The Committee noted that it was anticipated that the Trust would receive partial assurance for the Head of Internal Audit Opinion for the year. All parties provided assurance that work would be completed to allow the opinion to be produced.

The Committee were asked to approve the updated version of the Internal Audit Plan for 2021/22. This had been reviewed in light of the last 12 months and discussed and agreed with individual members of the board. The committee approved the Internal Audit Plan for 2020/21.

The Committee noted that there had been a reduction to 27 outstanding audit actions, four high risk, 17 medium risks and 6 low risks. The Committee noted that this was an improved position but that it was essential that momentum was maintained. The two areas where there had been limited progress reported were Recruitment and Research and Development and these had been referred to the People and OD Committee to follow up.

Counter Fraud

The Committee reviewed and approved the Local Counter Fraud Specialist Progress Report and Counter Fraud Operational Plan 2021/22. The Local Counterfraud Specialist highlighted to the Committee the increased public sector risk of fraud. The Committee noted that the Trust Secretary had taken on the role of Fraud Champion for the Trust. The Committee would consider moving forward how the Fraud Champion would report to the Committee.

The Committee agreed the Counter fraud work plan for 2021/22 which had been developed using a risk based approach and through self assessment against all new criteria. The Committee noted that the Trust must now have arrangements which met the Government Function Standard 013 Counter Fraud which came into effect on 1st April 2021. The Committee were advised that it was likely that the Trust may see a fall in some area ratings as a result of the changes to the national assessment process.

Compliance Report

The Committee received the regular report on compliance noting that this covered the period from January 2021 to March 2021. The Committee noted the level of waivers of standing orders remained high and agreed to review this area outside of the meeting. The Committee noted that the response to Covid-19 had impacted on this area.

The report was in a reduced format due to year end and did not include the financial reporting on losses and compensation payments, off payroll payments as these would feature as part of the year end accounts.

The capital spend during covid was detailed, highlighting how all expenditure had been through the required governance route at pace.

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 verbal update and noted the continued limited assurance provided. The Committee noted the actions in place to improve processes and ensure policies were adequately maintained and used. The Committee noted that some priority policies were still in need of review and the Chief Executive had reiterated with Executive the urgency of addressing those policies in their areas. It was noted that the need for additional support for the project to cleanse the document system had been recognised and this was now being considered. An interim support post had commenced in the meantime.

Corporate Governance Manual

An update to the Corporate Governance Manual to bring this in line with the change from EU to UK regulations following the EU Exit was presented to the Committee. These were the only updates to the manual and were approved for recommendation to Trust Board.

Risk management and revision of risk register

The Committee had noted the increasing number of overdue risks and the risk of the failure to complete reviews and update these. The Committee had previously requested assurance on the actions being taken to strengthen controls. The

Committee received a report on the proposed changes to the risk register to support improvement. The Committee noted the work and asked that the proposals were shared with Trust Board as owners of the risks. Risk Strategy and Policies would be updated accordingly.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Public Trust Board*
Date of Meeting	*4th May 2021*
Item Number	*Item 13.4*
Corporate Governance Manual update specifically relating to EU Exit within Standing Financial Instructions	
Accountable Director	*Paul Matthew, Director of Finance and Digital*
Presented by	*Jayne Warner, Trust Secretary*
Author(s)	*Jayne Warner, Trust Secretary*
Report previously considered at	*Audit Committee* *12 April 2021* *Approved*

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	*Insert risk register reference*
Financial Impact Assessment	*Insert detail*
Quality Impact Assessment	*Insert detail*
Equality Impact Assessment	*Insert detail*
Assurance Level Assessment	*Insert assurance level* • *Significant*

Recommendations/ Decision Required	• *The Trust Board are asked to give final approval to the amendment to the Corporate Governance Manual for publication.*

Executive Summary

The Corporate Governance Manual along with the Standards of Business Conduct Policy provide a comprehensive regulatory and business framework for the Trust.

An amendment to the manual in relation to the change in regulations as a result of the EU Exit was considered and agreed by the Audit Committee at its meeting in April 2021.

An updated version of the relevant sections of the manual is presented to the Trust Board for approval for publication. There have been no other changes to the Standing Orders or Standing Financial Instructions.

United Lincolnshire Hospitals NHS Trust

CORPORATE GOVERNANCE MANUAL

Document Information

Trust Policy Number	:	ULH-CORPORATE-SO01
Version	:	April 2021
Status	:	For approval by Board
Issued by	:	Trust Secretary
Issued date	:	
Approved by	:	Trust Board
Date of approval	:	
Date of review	:	

Change Control

Previous Versions	:	
Changes:Additions	:	Reflection of updated corporate governance /Committee structure and revised Trust Operating Model
Modifications	:	
Deletions	:	
Date of Issue	:	
Review Date	:	
Referenced Documents	:	
Relevant Legislation		NHS Corporate Governance Framework / NHS Manual for Accounts
Relevant Standards	:	

8. CUSTODY OF SEAL, SEALING OF DOCUMENTS AND SIGNATURE OF DOCUMENTS

8.1 Custody of Seal

The common seal of the Trust shall be kept by the Chief Executive or a nominated Officer by him/her in a secure place.

8.2 Sealing of Documents

Where it is necessary that a document shall be sealed, the seal shall be affixed in the presence of by the Chief Executive, and Chairman (addition of) or named deputy, and shall be attested by them.

8.3 Register of Sealing

The Chief Executive shall keep a register in which he/she, or another manager of the Authority authorised by him/her, shall enter a record of the sealing of every document. The register shall be reported to the Audit Committee.

8.4 Use of Seal – General guide

The Seal shall be affixed in the following general circumstances;

- All contracts for the purchase/lease of land and/or building
- All contracts for capital works exceeding £250,000
- ~~All lease agreements where the annual lease charge exceeds £30,000 per annum and the period of the lease exceeds beyond five years~~
- ~~Any other lease agreement where the total payable under the lease exceed £250,000~~
- ~~Any contract or agreement with organisations other than NHS or other government bodies including local authorities where the annual costs exceed or are expected to exceed £250,000~~ (The above deleted bullets will now be dealt with in line with authorisation limits for contract award reports as at para 17.6 SFIs)

This list is not exhaustive and further advice regarding the affixation of the Seal should be gained from the Trust Secretary or Director of Finance.

8.5 Signature of documents

Where any document will be a necessary step in legal proceedings on behalf of the Trust, it shall, unless any enactment otherwise requires or authorises, be signed by the Chief Executive or any Executive Director.

In land transactions, the signing of certain supporting documents will be delegated to Managers and set out clearly in the Scheme of Delegation but will not include the main or principal documents effecting the transfer (e.g. sale/purchase agreement, lease, contracts for construction works and main warranty agreements or any document which is required to be executed as a deed).

In the case of contracts for goods, works and services relating to non-pay expenditure officers should refer to Standing Financial Instructions.

STANDING FINANCIAL INSTRUCTIONS

17. PROCUREMENT AND CONTRACTING PROCEDURE

17.1 Duty to comply with Standing Orders and Standing Financial Instructions

The procedure for making all contracts by or on behalf of the Trust shall comply with these Standing Orders and Standing Financial Instructions (except where Standing Order No. 3.12 Suspension of Standing Orders is applied).

17.2 ~~EU Directives~~ UK Regulations Governing Public Procurement

~~European Union Directives~~ The Public Contracts Regulations including the current financial thresholds ~~on public sector purchasing promulgated by the UK Government https://www.gov.uk/guidance/transposing-eu-procurement-directives prescribing~~ prescribe procedures for advertising and awarding all forms of contracts shall have effect as if incorporated in these SFIs. ~~(EU thresholds are not per year but based on whole life costs of a contract).~~(update for UK not EU)

17.3 Policy and Procedure

The Director of Finance is responsible for ensuring policies and procedures are in place for the control of all procurement activity carried out within the Trust.

17.4 ~~Formal Competitive Procurement~~ Competitive Tendering

Competitive Tendering is the process by which price and/or quality is evaluated on a competitive basis between Tenderers in the market to determine the award of a contract. (addition)

17.4.1 General Applicability

(i) ~~The Procurement and Contract Procedure is governed by~~ Procurement is categorized into 4 ranges of expenditure, explained below. Unless specifically exempted below the Board shall ensure that competitive offers are invited for:

- the supply of goods, materials and manufactured articles;
- for the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the Department of Health and Social Care);
- for the design, construction and maintenance of building and engineering works, including construction and maintenance of grounds and gardens;
- disposals.

(ii) Through the ~~online Procurement~~ Trust's Finance System purchase orders are automatically generated for catalogue items where pricing has been competitively contracted or benchmarked against approved suppliers to ensure best value.

(iii) For all goods and services Trust Standing Orders and ~~EU~~ UK legislation dictates the different purchasing thresholds and the process route of purchasing.

(iv) For spend below ~~£5,000~~ £10,000 (excluding VAT) no formal procurement exercise is required, but value for money must still be demonstrated.

(v) For non NHS Supply Chain spend between ~~£5,000~~ £10,000~~-~~ £25,000 (excluding VAT) Procurement should be ~~engaged~~ undertaken through one of the routes outlined below ~~possible routes~~ :

~~a. Formal Procurement e.g. Tender or further competition under a compliant framework agreement – if there is a competitive market and /or the potential for future growth in spend~~

~~b. Three quotes – for a one-off purchase but in a competitive market. (In exceptional circumstances with the agreement of the Head of Procurement two quotes may be accepted) - see SFI 17.7.~~

~~c. Direct award – for a unique requirement but value for money must still be demonstrated.~~

(routes a-c above replaced with a-f below)

a. Proportionate Procurement, for example, a best value Request for Quote process comparing price and quality,
b. Further competition under a compliant framework agreement – if there is a competitive market and /or the potential for future growth in spend.
c. Three quotes – for a one-off purchase but in a competitive market a price only quote process can be undertaken
d. Less than three quotes – where a competitive market is not established, or demand in the market limits procurement options, one to three quotes will be accepted on the basis there is evidence of attempts to seek quotes and this is document on a procurement record.
e. Direct award – where only one provider can deliver the requirement, or for a unique requirement (value for money must still be demonstrated). A short Contract Award Report is required to demonstrate justifiable direct award.
f. Contract variation under an existing contract – providing the contract variation is no more than 10% of the original contract value or for technical or economic reasons, the variation is no more than 50% of the original contract value. Contract variations higher than these thresholds will require a new procurement process.

See SFI 17.9 for further details.

~~(vi)~~ For spend above £25,000 (excluding VAT) but below the current ~~OJEU limit~~ tender thresholds within PCR2015, or £100,000 for services described in Schedule 3 of PCR 2015, or £500,000 for works as described in PCR2015,

, Procurement must be engaged to undertake one of the following processes ~~in a formal procurement i.e. competitive local tender or further competition / direct award under a compliant framework agreement~~

(a-e below are additions)

a. Proportionate Procurement Exercise in the open market – where a price and quality evaluation is required, then a proportionate tendering approach to test the market should be undertaken by the Procurement Team.
b. Mini-competition through a compliant framework agreement.
c. Direct award under a compliant framework agreement
d. Contract variation under an existing contract – providing the contract variation is no more than 10% of the original contract value or for technical or economic reasons, the variation is no more than 50% of the original contract value. Contract variations higher than these thresholds are not permitted and will require a new procurement. Contract variations which result in a total value contract above procurement thresholds are not permitted, and will require a compliant procurement under the Public Contract Regulations 2015
e. In exceptional circumstances, a single tender waiver may be required

(vii) For spend above the current ~~OJEU~~ UK tender threshold limit, Procurement must be engaged ~~in a formal procurement i.e. competitive EU Tender or further competition / direct award under a compliant framework agreement.~~ To undertake one of the following
(a-d below are additions)

a. Procurement Process in line with procedures detailed within the Public Contracts Regulations 2015 i.e. competitive Tender
b. Further competition / direct award under a compliant framework agreement.
c. Contract variation under an existing contract – providing the contract variation is no more than 10% of the original contract value or for technical or economic reasons, the variation is no more than 50% of the original contract value. Contract variations higher than these thresholds are not permitted and will require a new procurement. Contract variations which result in a total value contract above procurement thresholds are not permitted, and will require a compliant procurement under PCR2015
d. In exceptional circumstances, a compliant direct award under the rules determined in Regulation 32 of PCR2015

For works contracts subject to a VFM assessment the Trust shall procure all building and estates capital schemes with an estimated value over £500,000 using the NHS Procure 22 Framework, or alternative public sector works Framework Agreement, unless there are valid and significant reasons for not doing so, as approved by the Director of Finance. The Trust will follow Department of Health and Social Care and Treasury guidelines for the procurement of all estates capital schemes. Procurement contracts and frameworks used to commission contractors shall be appropriate to the type and nature of capital scheme being procured and will be required to demonstrate value for money.

An appropriate record should be kept in the contract file where it has not been possible to invite a building or estates tender above ~~OJEU~~ UK Procurement limits through a framework.

(viii) All procurements must be undertaken in accordance with Procurement Standard Operating Procedures.

17.4.2 **Healthcare Services**

Where the Trust elects to invite tenders for the supply of healthcare services these Standing Orders and Standing Financial Instructions shall apply as far as they are applicable to the procurement and contracting procedure and need to be read in conjunction with SFI 17.11 and SFI No. 18.

(para below are additional)
Where procurement of healthcare services on the open market is undertaken, these will be in line with the Light Touch Regime for common procurement vocabulary codes described within Schedule 3 of the Public Contracts Regulations 2015.

Where the procurement of a sub-contractor for CCG commissioned service is required, the NHS England Standard Contract: Sub-contracts should be utilised in all cases.

17.4.3 **Exceptions and instances where formal tendering need not be applied**

Formal tendering procedures (i.e. local or UK) **need not be applied**:

(a) where the estimated expenditure or income does not, or is not reasonably expected to, exceed **£25,000**;

(b) where the supply is proposed under special arrangements negotiated by the Department of Health and Social Care in which event the said special arrangements must be complied with;

(c) regarding disposals as set out in SFI No. 26;

(d) where works or services connected to proposed works are to be commissioned from an approved Procure 22 Principal Supply Chain Partner (PSCP), as appointed formally to the Department of Health and Social Care framework agreement or its successor schemes; or

(e) where the supply is proposed under any external compliant contract / framework agreement to which the Trust has access. In such circumstances value for money and compliance to the agreement should be demonstrated.

17.4.4 Formal procurement procedures (i.e. local or above threshold tender / quotes or direct award) **may be waived** in the following circumstances:

(a) in very exceptional circumstances where formal procurement procedures would not be practicable and the circumstances are detailed in an appropriate Trust record.

(b) where the timescale genuinely precludes competitive procurement but failure to plan the work properly would not be regarded as a justification for a single tender;

(c) where specialist expertise is required and is available from only one source;

(d) when the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate;

(e) there is a clear benefit to be gained from maintaining continuity with an earlier project or compatibility with existing equipment / service. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive procurement;

(f) for building and engineering construction works and maintenance where there is either a direct legal enforcement of safety the consequence of which would result in the closure of the Trusts services and/or prosecution of the Trust and it's officials or a specified National or Local Health economy imperative where failure to deliver could place patients safety at risk.

The waiving of procurement procedures should not be used to avoid competition or for administrative convenience or to award further work to a supplier originally appointed through a competitive procedure

unless specifically covered within the original ~~agreement~~ procurement notice or contract.

Where it is decided that competitive procurement is not applicable and should be waived, the fact of the waiver and the reasons should be documented reviewed by procurement, authorised by the Director of Finance and / or Chief Executive and recorded in an appropriate Trust record and reported to the Audit Committee at each meeting.

17.4.5 **Fair and Adequate Competition**

Other than where the exceptions set out in SFI Nos. 17.1 and 17.4.1 and 17.4.3 apply, the Trust shall ensure that requests for procurement are sent to ~~a sufficient number of~~ no less than three firms/individuals to provide fair and adequate competition as appropriate, and in no case less than two firms/individuals, having regard to their capacity to supply the goods or materials or to undertake the services or works required. The deadline for returns must be considered reasonable.

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17.5 Tendering Procedure for Goods, Materials, Services and Disposals including non NHS provided health care.

17.5.1 **Invitation to tender**

(i) All invitations to tender shall be issued via the appropriate e procurement/sourcing portal in use within the Trust.

(ii) All invitations to tender shall state that no tender will be accepted unless it has been submitted via the appropriate e procurement/sourcing portal adhering to all the required terms of the invitation to tender but specifically the requested time and date of return.

(iii) Every tender for goods, materials, services or disposals shall embody such of the NHS Standard Terms and Conditions of Contract as are applicable. Any contract that is projected not to be under such terms must be referred to the ~~Head~~ Deputy Director of Procurement prior to any contractual agreement.

(iv) Every tender for building or engineering works not procured under the procure 22 framework with an approved Principal Supply Chain Partner (except for maintenance work, when Estmancode guidance shall be followed) shall embody or be in the terms of the current edition of one of the Joint Contracts Tribunal Standard Forms of Building Contract) Standard forms of contract or, when the content of the work is primarily engineering, the General Conditions of Contract recommended by the Institution of Mechanical and Electrical Engineers and the Association of Consulting Engineers (Form A), or (in the case of civil engineering work) the General Conditions of Contract recommended by the Institute of Civil Engineers, the Association of Consulting Engineers and the Federation of Civil Engineering Contractors. These documents shall be modified and/or amplified to accord with Department of Health guidance and, in minor respects, to cover special features of individual projects.

17.5.2 **Receipt and safe custody of tenders**

The Chief Executive or his/her nominated representative will be responsible for the electronic receipt, and safe custody of tenders received within the e-procurement system until the time appointed time for the electronic seal to be opened.

17.5.3 **Opening tenders and Register of tenders**

(i) As soon as practicable after the date and time stated as being the latest time for the receipt of tenders, the electronic vault will be opened by ~~senior nominated member of the procurement team.~~the procurement project lead

(ii) Every tender received shall be marked with the date of opening automatically by the e-procurement software and will maintain a full auditable record of the opening process.

~~(iii)~~ Incomplete tenders, i.e. those from which information necessary for the adjudication of the tender is missing, ~~and amended tenders should be dealt with in the same way as late tenders. (Standing Order No. 17.5.4 below).~~shall be addressed in accordance with PCR 2015 Regulation 56(4)

(iv) Appropriately detailed electronic notes shall be kept in the contract file to detail any matters such as action taken in respect of late tenders, non-compliant bids or any other matters relevant to tender receipt and opening.

17.5.4 **Admissibility**

(i) Tenders submitted but not received until after the due time and date (at which point the electronic vault is locked), may be considered only if confirmation of submission is received from the e-sourcing portal. The Chief Executive or his/her nominated officer will decide whether there are exceptional circumstances e.g. System failure on the part of the Portal having been uploaded in good time but delayed through no fault of the tenderer.

(ii) Only in the most exceptional circumstances will a tender be considered which is received after the opening of the other tenders and only then if the tenders that have been duly opened have not left the custody of the Chief Executive or his nominated officer or if the process of evaluation and adjudication has not started.

(iii) While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential, recorded, and held in safe custody by the Chief Executive or his nominated officer.

(iv) Where only one tender is sought and / or received, it must be demonstrated that the price to be paid is fair and reasonable and will ensure value for money for the Trust. This will be recorded in the appropriate documentation namely the contract award report.

17.5.5 **Acceptance of formal tenders (See overlap with SFI No. 17.6)**

(i) Any discussions with a tenderer which are deemed necessary to clarify technical aspects of his tender before the award of a contract will not disqualify the tender. All such questions must be raised and responded to via the e procurement system to maintain audit trails and transparency.

(i) Evaluation criteria will be based on either:

- the lowest price; or
- the most economically advantageous cost over the whole life of the Contract based on a combined evaluation of price and quality

It is accepted that the lowest price does not always represent the best value for money. Other factors affecting the success of a project may include (without limitation):

(a) Qualitative elements of the bidders proposal;

(b) understanding of client's needs;

(c) feasibility and credibility of proposed approach;

(d) ability to complete the project on time.

Where other factors are taken into account in selecting a tenderer, these must be documented in the contract ~~file~~award report, and the reason(s) for not accepting the lowest priced tender clearly stated.

Criteria taken into account in selecting a successful tenderer must be clearly recorded and documented in the invitation to tender/quote.

(iii) No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these instructions except with the authorisation of the Chief Executive or nominated officer

(iv) The use of these procedures must demonstrate that the award of the contract was:

(a) not in excess of the going market rate / price current at the time the contract was awarded; or

(b) that best value for money was achieved.

(v) All tenders should, subject to compliance with the provisions of the Freedom of Information Act 2000 as amended, be treated as confidential and should be retained for:

(a) 6 years after contract completion - successful tenders
(b) 6 years after contract start - unsuccessful tenders.

(vi) All tenders should be assessed for embedded derivatives and embedded leases utilising a standard checklist. Any proposed tender award which indicates the existence of either should be notified to the Assistant Director of Finance – Financial Services, prior to award.

17.6 Authorisation of Procurement Awards (Internal Trust Process)

Providing all the conditions and circumstances set out in these Standing Financial Instructions have been fully complied with, formal authorisation for the awarding of a contract (internal Trust process) must be authorised by the following staff to the value of the contract as follows:

	Threshold Value (total requirement)	Operational Purchasing Manager	Head of Category Procurement Governance Manager	Deputy Director of Procurement	Director of Finance	Chief Executive	Trust Board
Aggregated Total Contract Value	< £5000	✔					
	< £25,000	✔	✔				
	< £100,000		✔	✔			

	< £250,000		✔	✔	✔		
	< £250,000 - £1m		✔	✔	✔	✔	
	£1m+		✔	✔	✔	✔	✔

For all contract awards requiring Trust Board approval, these must be submitted to FPEC for assurance.

These levels of authorisation may be varied or changed only with the express agreement of the Trust Board.

Formal authorisation to initiate any procurement process must be put in writing in the form of a Procurement Sponsorship Form for all procurement processes where the award value is expected to exceed £25,000..

17.7 Signing of Commercial Procurement Contracts (External Document)

17.7.1 The signing of the commercial procurement contracts must only be undertaken by the following Trust Staff and within the identified value limits

< £50,000 – Deputy Director of Procurement
£50,000 – £250,000 Director of Finance
>£250,000 – Director of Finance and Chief Executive

17.8 Private Finance and leasing for capital procurement (see overlap with SFI No. 24)

17.8.1 When the Board proposes, or is required, to use finance provided by the private sector (PFI) the following should apply:

(a) The Director of Finance shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.

(b) Where the sum exceeds delegated limits, a business case must be referred to the appropriate department or agency for approval or treated as per current guidelines.

(c) The proposal must be specifically agreed by the Board of the Trust.

(d) The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

17.8.2 Where it is proposed that leasing be considered in preference to capital procurement then the following should apply:

(a) The selection of a contract / finance company shall be on the basis of a competitive process;

(b) All proposals to enter into a leasing agreement shall be referred to the Director of Finance before acceptance of any offer;

(c) The Director of Finance shall ensure that the proposal demonstrates best value for money; and

(d) The proposal shall be agreed in writing by the Director of Finance prior to acceptance of any offer to the lease.

In the case of property leases the relevant NHS guidance shall be followed and procurement rules do not apply.

17.9 Compliance requirements for all contracts

The Board may only enter into contracts on behalf of the Trust within the statutory powers delegated to it by the Secretary of State and shall comply with:

(a) The Trust's Standing Orders and Standing Financial Instructions;

(b) ~~EU Directives~~ UK Procurement Regulations and other statutory provisions;

(c) any relevant directions issued by Treasury, the Department of Health or other Statutory Body.

(d) such of the NHS Standard Contract Conditions as are applicable.

(e) contracts with Foundation Trusts must be in a form compliant with appropriate NHS guidance.

(f) Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis of the Procurement.

(g)

17.10 Personnel and Agency or Temporary Staff Contracts (see overlap with SFI Nos. 20.6, 20.9, 21.2.3)

The Chief Executive shall nominate officers with delegated authority to design and operate a process for engaging with and enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.

17.11 Healthcare Services Agreements (see overlap with SFI No. 18)

Service agreements with NHS providers for the supply of healthcare services shall be drawn up in accordance with the National Health Service Act 2006 as amended and administered by the Trust. Service agreements are not contracts in law and therefore not enforceable by the courts. However, a contract with a Foundation Trust, being a PBC, is a legal document and is enforceable in law.

The Chief Executive shall nominate officers to commission service agreements with providers of healthcare in line with a commissioning plan approved by the Board. Where Health Services require an external contractor or non-NHS provider, SFI 17.4.2 must be considered.