Bundle Trust Board Meeting in Public Session 1 June 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 4th May 2021 *Chair* Item 5.1 Public Board Minutes May 2021.docx
5.2	Matters arising from the previous meeting/action log *Chair* Item 5.2 Public Action log May 2021.docx
6	Chief Executive Horizon Scan Including STP *Chief Executive* Item 6 Chief Executive's Report, 010621.docx
6.1	BREAK
7	Strategic Objective 1 To Deliver high quality, safe and responsive patient services, shaped by best practice and our communities
7.1	Assurance and Risk Report from the Quality Governance Committee Item 7.1 QGC Upward report May 2021v1.doc
8	Strategic Objective 2 To enable our people to lead, work differently and to feel valued, motivated and proud to work at ULHT
8.1	Assurance and Risk Report from the People and Organisational Development Committee Item 8.1 POD - Upward Report - May 2021v1.docx
8.2	Nursing and Midwifery Framework *Director of Nursing* Item 8.2 Front Cover - Nursing Framework.docx Item 8.2 Nursing and midwifery framework 2021-2026.pdf
8.3	Birth Rate Plus *Director of Nursing* Item 8.3 BirthratePlus Report for - Trust Board - June 2021.docx
9	Strategic Objective 3 To ensure that services are sustainable, supported by technology and delivered from an improved estate
9.1	Assurance and Risk Report from the Finance, Performance and Estates Committee Item 9.1 FPEC Upward Report May 2021v1.docx
9.2	Annual Plan (Integrated Improvement Plan Year 2) Item 9.2 Year 2 of the IIP 250521.pdf
10	Strategic Objective 4 To implement integrated models of care with our partners to improve Lincolnshire's health and wellbeing
10.1	Grantham Restoration *Chief Operating Officer* Item 10.1 Grantham Restoration Board Paper 25052021 v5.pdf
10.2	University Teaching Hospitals Status *Deputy Chief Executive* Item 10.2 University Hospital Trust Board June 21.docx

Item 10.2 University Hospital Association.pdf

11 Integrated Performance Report

Item 11 Integrated Performance Report - Trust Board.pdf

12 Risk and Assurance

12.1 Risk Management Report

Item 12.1 Strategic Risk Report - May 2021.pdf

12.2 Board Assurance Framework

Item 12.2 BAF 2020-21 Front Cover June 2021.docx

Item 12.2 Item BAF 2020-2021 v27.04.2021.xlsx

Item 12.2 BAF 2021-2022 v26.05.2021.xlsx

13 Any Other Notified Items of Urgent Business

14 The next meeting will be held on Tuesday 6th July 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 4 May 2021

Via MS Teams Live Stream

Present

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

Apologies
Mrs Gill Ponder, Non-Executive Director
Mr Geoff Hayward, Non-Executive Director
Ms Cathy Geddes, Improvement Director, NHSE/I

633/21	**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.
634/21	The Chair moved to questions from members of the public. **Item 2 Public Questions** **Q1 – Jody Clark** **With the restoration of Grantham Hospital services, can you please confirm that all the services are returning? Particularly the Acute Care Unit. I see from the information that the Emergency Admissions Unit is returning in June and the Same Day Emergency Care is staying but we still need the ACU for local residents to be inpatients, when required.** The Chief Operating Officer responded:

	The Trust intended to restore services to Grantham Hospital, similar to what was in place in May 2020 and restoration of services was progressing well with a number of services already back in place. The paper presented to the Board regarding the restoration described that it would not be possible to put services back exactly as they had been prior to Covid-19 on the basis on enhanced infection, prevention and control (IPC) measures. There was a need to consider that Covid-19 was still with us and as such the Trust required to take the necessary precautions to protect patients from contracting Covid-19. This would mean some services would go in to different locations and in different configurations. There was an expectation to replicate the services in place, including the Acute Care Unit (ACU). It was currently unlikely that this would be a single unit with the functions of the ACU replicated across two areas so that patients could continue to access the service as they had done pre-Covid-19. **Q2 – Vi King** **This is a question in three parts, as you can see, they all amalgamate to the same.** **A.** **Can you confirm that you will have appropriate skilled staff in sufficient numbers to run A/E with full resus as prior to "temporary" closure.** **B.** **Can you confirm there will be no additional restrictions to the ones in place prior to change to UTC.** **C.** **How can an A/E run without any sort of ACU facility?** **D.** **Can you confirm patient safety is your top priority, if so then I refer to the above and ask for confirmation that a full CCOT service is on site, as required by CQC when looking into hight morality rates.** The Chief Operating Officer responded: When the Accident and Emergency service restarted this would be appropriately staffed in line with the operating model that was in place in May 2020. There would be no further restrictions as this would be restored to the May 2020 model and pathways. This would incorporate how the Trust managed potential Covid-19 patients and pathways would be in place to deal with patients potentially presented with symptoms or potentially having Covid-19. The Chief Operating Officer noted that the A&E could run without an ACU facility but an A&E would require access to teams to help stabilise patients, potentially provide enhanced for patients that were possibly awaiting transfer to an Intensive Care Unit or to another specialist centre. Those services had been in place previously and would be in place when resorted to support the A&E.

	The Chief Operating Officer confirmed that patient safety was a top priority for the Trust noting that the changes that had been made during Covid-19 and the response to the pandemic had been to ensure that patient safety was always put first and ensure they were protected and did not come to harm. The Critical Care Outreach Team (CCOT) had continued to operate at Grantham and would continue to do so. This would be supplemented with an enhanced be function that the Trust was looking to put in place. This would not only be for surgical patients but spilt out for medical patients who may also require enhanced care. The Chief Operating Officer noted however that this would not be a high dependency unit of intensive care unit these had not been in place at Grantham Hospital and would not be put in place.
635/21	**Item 3 Apologies for Absence** Apologies for absence were received from Mrs Gill Ponder, Non-Executive Director, Mr Geoff Hayward, Non-Executive Director and Ms Cathy Geddes, Improvement Director, NHSE/I
636/21	**Item 4 Declarations of Interest** The Chair and Mrs Libiszewski declared their interest in the Virtual Ward paper due to being members of the Board of Lincolnshire Community Health Services NHS Trust (LCHS). The Chief Executive also declared an interest due to being an employee of LCHS, seconded to United Lincolnshire Hospitals NHS Trust noting however that there was no involvement in management, decision making or discussions.
637/21	**Item 5.1 Minutes of the meeting held on 6 April 2021 for accuracy** The minutes of the meeting held on 6 April 2021 were agreed as a true and accurate record subject to the following amendments: 531/21 – Should read – shoots not shots
638/21	**Item 5.3 Matters arising from the previous meeting/action log** The Chair noted that there were no items requiring review.
639/21 640/21 641/21	**Item 6 Chief Executive Horizon Scan including STP** The Chief Executive presented the report to the Board noting that this had reverted to the usual format offering a System overview and Trust overview. This was due to recognise the partial return to as normal an approach as possible, bearing in mind the position of Covid-19 across the Trust. The Chief Executive advised Board members that the pre-election period continued with local authority elections due to taken place on 6th May. Whilst the purdah period remained in place this restricted the activity of the Board to ensure that discussions and comments did not refer to issues of policy on controversy. The Chief Executive noted the key points within the report offering an update on the vaccination programme that continued to progress well across the county. The hospital vaccination hubs had now closed and had delivered over 41k vaccinations across the hubs.

642/21	The Chief Executive extended thanks to the staff who had worked in both setting up the vaccination programme at the Trust and for the part played in the delivery at the hubs and the input in to the large vaccination centres. This had been a significant area of success.
643/21	It was noted that the Integrated Care Systems (ICS) remained subject to parliamentary approval with a second reading of the white paper due to take place in June. Guidance pieces were currently emerging including information about the terms of governance, memorandums of understanding that system would have with the NHS and also Provider Collaboratives. Work had commenced in Lincolnshire in relation to Provider Collaboratives and the Board were reminded that this was being led for the system by the Director of Improvement and Integration.
644/21	It was noted that there had been a focus in Lincolnshire on vertical integration and collaboration would take place with general practice, community and mental health providers. The national guidance being released would be about the horizontal collaboration and the engagement with other acute trusts in different health systems.
645/21	A national consultation regarding the system oversight framework was underway with a proposal regarding the ending of the special measures regime. The Chief Executive had previously reported that Lincolnshire would be part of the recovery support programme, work remained to be completed to determine the system level support, as opposed to organisational support levels.
646/21	Work would be required on the metrics that would sit alongside the recovery support programme. This would detail the requirements of entering and exiting the programme and what delivery would be required to achieve this. It was expected that this would be a short period, of around a year. The current regime had not always worked as anticipated with Trusts remaining in the regime for extended periods.
647/21	The Chief Executive reported financial position for the system and Trust at the end of the year, highlighting that the last financial year had been unusual with the normal regime suspended. There had been additional funds provided as part of the Covid-19 response.
648/21	Although a small surplus had been delivered at the end of 2020/21 the Trust continued to have a significant underlying deficit. The financial issues had not been resolved and there was work to do with system partners to rectify the position. It was anticipated that normal financial regimes would be in place for the second half of 2021/22.
649/21	The Chair noted the report and underlined the final point in relation to the underlying financial issues that would require focus over the course of the next year. The work in the system was also noted and thanks offered to both Executive Directors and Non-Executive Directors for the active involvement in the ICS activity that support the Trusts contribution to future arrangements. The Trust Board: • **Noted the update and significant assurance provided**
650/21	**Item 7 Patient/Staff Story** The Director of Nursing introduced the patient story to the Board advising that the story was about a family's experience of the Trust and the impact of Covid-19 restrictions, in particular visiting restrictions and their experiences.

651/21	The story also detailed the lessons learnt, in part due to the experiences shared and equally a number of actions had been put in place, not just for Covid-19 but longer term that were being worked through by the Patient Experience Group.
652/21	Via a pre-recorded video the patient's relative offered the experience of the family in trying to receive updates of the patients condition. The patient had been in the care of the Trust, on a number of wards, for more than 5 weeks. All of which had been whilst visiting had been restricted due to Covid-19.
653/21	The patient, who had been cared for by his partner for the past 2 years, suffered with dementia, Parkinson's Disease and general frailty. The patient had been admitted to the Trust with bowel obstruction.
654/21	The patient's relative had contracted the Trust due to the family's continued inability to get through to the ward for information about the patient causing distress, anxiety and frustration.
655/21	The Board noted that sadly, during the preparation of the story the patient had passed away. The family said that the end of life care delivered was excellent and they had been able to be with him during this time.
656/21	The patient's relative noted that there had been an attempt to ensure that calls were made at what was felt to be an appropriate time in order to seek an update however noted that this was not always achieved. The relative noted that when they were not successful at speaking to a member of staff they would always need to call back as calls were not returned.
657/21	The benefit of having a named nurse was recognised however this did not mean that the rest of the staff should not take an overall interest of responsibility. Concerns were raised by the family in respect of the handover process and it appeared that information was not being shared.
658/21	The family noted that if there had been a time identified to call, even if restricted, that would have been ok. The family recognised that the wards were busy and the idea of a virtual visiting time, a time when people could phone through and know someone was available, would have made a difference.
659/21	It was noted that when it was possible to speak to someone on the phone, 90% of the time the experience was positive however, there was increased frustration of needing to try to get through.
660/21	The family felt that the system had let them and the staff down. There had been some fantastic nursing staff who were clear and empathetic to the family who offered confidence in a difficult situation. In general when the family were able to speak to staff on the ward the general feeling was that they were doing a good job, professional and confident.
661/21	The inability to contact staff and being unable to visit had increased the anxiety of the family and due to the patient's illness there had been fluctuation of his condition. The family were unaware one day to the next whether the patient was experiencing a good or bad day. This amplified the anxiety being experienced.
662/21	Following a ward move the family were unable to speak to staff for an entire weekend and whilst there had been attempts to phone through the calls were not picked up. Unfortunately it was noted that the experience was not unusual and the Trust had received feedback through social media, Patient Advice and Liaison and Complaints that echoed the story presented.

663/21	In response to the experiences faced the Trust had established a Communications Working Group tasked with taking forward recommendations from an overarching communications review. The working group consisted of clinical leads and organisational development and the meetings to date had been well attended.
664/21	The first meeting of the group had focused on telephone calls and it was understood that there were a number of technical issues. A number of pilots were being taken forward with 3 wards across Lincoln and Pilgrim with dedicated mobile phones with a safeguarded number for relatives to call at a designated time.
665/21	The was a strong feeling from the group for the need for a standard operating procedure to be developed in order to be able to communicate with staff, families and relatives in order to explain how the ward worked and the best time to call. It was important that this also detailed the need for staff to be courteous, responsive and compassionate with a view to moving away from the phrase 'not my patient'. This would ensure that all staff understood the latest information about the patients and were able to report this to a relative should they take a call.
666/21	The Director of Nursing thanked the Board for allowing the story to be shared and was grateful for the time taken by the patients relative to offer the story and insight from the family's perspective.
667/21	Whilst it was positive that excellent nurses were identified it was clear that the 10% of what had not gone well had overshadowed this. There was a clear insight in to the issues and actions being taken with conversations being held with ward leaders about how wards were organised in a different way and to understand the move away from 'not my patient'.
668/21	The Director of Nursing advised the Board that on 12th May 2021 the nursing and midwifery framework would be launched and would be presented to the June Board meeting. This would set out the direction as nurses and midwives across the Trust for care closest to patients both in terms of patient safety, experiences and professionalism and leadership.
669/21	The Chair reflected the powerful nature of the patient stories at the Board and the impact these had upon members of the Board, particularly when this did not go as well as they should have done. The story reminded of the need to understand the needs of the patients and their families and to reflect on how they were supported. The ability to learn from the story was demonstrated in the response from the Head of Patient Experience who narrated the video and the Director of Nursing, improvements were already being made.
670/21	Mrs Libiszewski reflected that the story was positive but not unique to the Trust noting that there was a need to ensure language was supportive. There was a need to ensure staff were supported developmentally with the avoidance of punitive language as part of the Just Culture, Human Factors training and the Integrated Improvement Plan work. Mrs Libiszewski sought assurance that the term to outlaw not my patient was old style language that would not be used through the framework.
671/21	The Director of Nursing noted that there was no better way to work with and influence colleagues than to be supportive. There was a need for compassionate and authentic leadership to ensure all patients received the best care as well as support to families. The Trust would offer a supportive approach in order to develop all of the workforce.
672/21	Mrs Dunnett asked if the stories seen by the Board were shared with staff in order to support learning. Mrs Dunnett also noted the need to ensure that action was being taken to address wider communities in Lincolnshire, especially for those where English was a second language.

673/21	The Director of Nursing advised that information was shared further within the hospitals with staff. This was being built upon and over the past months a library of stories had been developed in order that these could be used for training sessions, particularly where there may be supportive development training sessions. There was a desire to see these used more frequently.
674/21	In respect of English as a second language, work was underway with a number of interpreters through the Patient Experience Group in order to offer information outside of the hospitals in other languages. Spiritual leaders and leaders of other communities were also being engaged to support this work. It was recognised that the Trust could do more.
675/21	Dr Gibson noted that since the rise of mobile telephony people had become used to being in touch via both audio and visual means, on a more frequent basis, which potentially exacerbated anxiety and concern when a patient was admitted to hospital. Dr Gibson strongly encouraged the Communications Working Group to think radically about how patients and relatives interacted using mobile technology.
676/21	The Director of Nursing highlighted that during the second wave of Covid-19, where there had been no visiting except for exceptional circumstances, the Trust had piloted the use of iPads and phones in order that patients could face time with relatives. This had worked well however consideration was now being given to different modalities to support communications. The use of volunteers to support those patients less familiar with technology was also being considered in a way not previously done.
677/21	The Chief Executive endorsed the actions being taken and supported the use of alternative modalities and asked when this may be in place to resolve the types of issues experienced. The Chief Executive also asked if there were known wards that were of repeat concern and if there would be benefit in taking a mystery shopper approach to test and audit those areas or if there were examples of good experience.
678/21	Whilst some members of the Board could not always comment on clinical standard of care comment could be offered on things such as friendliness, difficulties on the phone and car parking as examples.
679/21	The Director of Nursing noted that it was not possible to offer a timescale however the Patient Experience Group had oversight and this would be upwardly reported to the Quality Governance Committee. Work would take place with teams in the Patient Experience Group in order to pull together a trajectory plan which would be reported through the governance structures.
680/21	It was noted that there were repeated areas of excellence and concern and best practice would be shared across wards from the Communications Working Group and other mechanisms.
681/21	The Director of Nursing noted that the Quality Governance Committee had received a report in respect of ward review visits that had commenced in April. All wards would be visited and a number of other visits would be drawn together including PLACE and the reintroduction of Non-Executive and Executive Director visits.
682/21	A series of visits would be pulled together to allow clinical and support areas to be visited, all Board members would be included in order to add an element of mystery shopping. The culmination of the visits would be accreditation of the wards with the first ward to go through the process in November. The Board would be included in the awarding of the accreditation.

683/21	The Chair offered thanks for the presentation of the story noting it was important that the Board had a clear focus on patient experience. The Chair offered apologies to the family and others who had had similar experiences, this was not the quality of care and relationships with patients and families that the Board were content with.
684/21	It was the intention that those improvements described were made, as a learning organisation feedback was taken seriously and would be acted upon in the way described with assurance mechanisms in place.
685/21	The Chair offered thanks to the family and condolences from the Board for the loss of the patient who was clearly a much loved member of the family. 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
686/21	**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 20th April 2021 meeting.
687/21	The Committee received the update report from the Patient Safety Group noting the significant improvement in the operation of the group. A theme coming through a number of papers to the Committee was around the offer of training for staff and if this was fit for purpose. This had been referred to the People and Organisational Development Committee in order to consider the Trusts offer for statutory and mandatory training. It was hoped the Trust would move to a more responsive approach in order to support frontline staff to deliver care.
688/21	Mrs Libiszewski noted the learning within the serious incident report and the evidence that teams were picking up on issues and learning from these. The Committee had received an example of this through patient falls in the emergency department resulting in a change in practice and continuation of improvement was expected.
689/21	The Committee continued to monitor clinical harm reviews and the impact on waiting lists, this was being monitored on a monthly basis.
690/21	There had been a significant improvement within IPC not only in the approach to deep cleaning but also against the IPC Board Assurance Framework and reportable infections. The Trust had seen a significant reduction in clostridium difficile.
691/21	The Committee had received the upward report from the Medicines Quality Group along with the roadmap which the Board had been aware was expected. This pulled together a number of reports including the Care Quality Commission (CQC) action plan and internal audit reports. The Committee noted that the roadmap was ambitious with tight timescales.
692/21	The Executive Directors were improving support to pharmacy with many improvements around cultural changes needed in the organisation. It was noted that whilst timescales were included within the plan this would not be resolved quickly and would require continuous work. This did however link to the integrated improvement plan.

693/21	The Committee had received a patient story and heard about the significant work happening in the Patient Experience Group. There were issues of communications which were well understood and there was an intention of pulling together a plan to address this which would be received by the Committee.
694/21	The Committee were pleased to have received a patient story and to hear the evidence of learning from this.
695/21	The Committee had received the first report from the Children and Young People's Oversight Group noting the significant progress with the fragile service. The Board were well sighted on the changes and embedded review and significant work that had taken place.
696/21	There was further work being undertaken in relation to the hidden child, these being children admitted to adult service, and the support in place for children.
697/21	The Committee continued to receive significant reports in relation to the Maternity and Neonatal Oversight Group that was in place. The Committee were advised that verbal feedback had been received in relation to the Trusts Ockenden submission with formal feedback awaited from NHS England/Improvement.
698/21	The Committee noted that work was required across the system in relation to smoking rates noting that this was not only a maternity issue but a wider health issues for the population of Lincolnshire.
699/21	In addition to the reports received a verbal update was provided to the Committee by the Non-Executive Direction Maternity Safety Champion.
700/21	Further work was seen in relation to the 15 Steps programme with Non-Executive Directors keen for these to be re-established. The accreditation process had been refreshed which would support embedding across the organisation from the previous approach. The Committee were advised of the rigour which would be applied and welcomed the opportunity for individuals to be part of the mystery shopper approach.
701/21	Mrs Libiszewski noted that the Clinical Commissioning Group were assured by the quality of serious incident reports being offered with the Committee noting that it was helpful to understand that not only were these being delivered in a timely manner but the actions were smart and quality was improving.
702/21	The Board were advised that the Quality Account had been stood down in 2020/21 due to Covid-19 but that this was now reinstated and the Quality Account for the year would need to be published by the normal due date. Further work would be undertaken to develop the objectives for the current year and these would need to be aligned to the Integrated Improvement Plan (IIP). The first iteration had been seen by the Committee and as this developed would be upwardly reported to the Board.
703/21	The Committee were also on a monthly basis reviewing the CQC must and should do actions and regulatory notices, noting that there was significant work happening across the Trust to look at evidence folders and review processes.
704/21	The Committee referred to the People and Organisational Development Committee the strategy to support the tailoring needs of staff in mandatory and statutory training.
705/21	The Chair noted the positive progress being made despite the difficult environment and thanks the Executive Directors for driving work forward in the circumstances.

706/21	The Board were pleased to receive the assurances in relation to medicines management which had caused concern for some time.
707/21	Mrs Dunnett in the role of Non-Executive Director Maternity Safety Champion, offered an update to the Board noting that the role continued to develop and relationships were being built both internally and externally.
708/21	Positive progress was being made in terms of the maternity governance structure both internally and across the system noting that there was external representation at the oversight group from the Clinical Commissioning Group and Maternity Voices Partnership.
709/21	Most issues being raised were in relation to communications particularly in respect of induction of labour as such a deep dive would be reported to the oversight group.
710/21	A further concern was with regard to reaching out and engaging will all communities across Lincolnshire with a wider theme coming from national guidance around the health and wellbeing of families, particularly looking at the public health perspective.
711/21	The Chair was pleased to receive the substantial report from the Committee noting the referrals that had been made to the People and Organisational Development Committee.
712/21	The Chair noted the request for the Board to be involved in the awarding of accreditations noting that the Board would be delighted to support this. 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
713/21	**Item 9.1 Assurance and Risk Report People and Organisational Development Committee** The Chair for the People and Organisational Development Committee, Mrs Baylis provided the assurances received by the Committee from the 22nd April 2021 meeting.
714/21	Mrs Baylis noted that the Committee had received the safer staffing report which offered a detailed update on ward case mix, ward and staff moves and the management of staffing in the organisation. The Committee received assurance that there was no correlation between staffing levels and patient harm.
715/21	The Committee were advised that the establishment review would be undertaken during May and whilst this was later than expected, the position was understandable due to the circumstances.
716/21	The Committee continued to have focus on absence management and received a deep dive paper in relation to stress and anxiety. This had been a good analytical piece of work, which had provided insight in to the challenges of working in the organisation during Covid-19. The paper detailed the wellbeing offers in place and the support available to staff.
717/21	The overriding point from the paper was the shift in approach from being reactive to taking a proactive preventative approach, the Committee received detail about the arrangements in place.

718/21	Mrs Baylis noted the positive impact of the Freedom to Speak Up month that had generated a lot of interest and conversations had been followed through by the guardian champions in different parts of the organisation.
719/21	The Committee noted the verbal update in relation to the General Medical Council Junior Doctor Survey noting that a new checklist and programmes was proposed for the August rotation.
720/21	The Trust were taking leaning and putting new arrangements in place for the coming rotations of Junior Doctors. The Committee noted that the next survey had been released sooner than anticipated so there was caution that the results may not demonstrate the actions that were being put in place.
721/21	The Committee received the detailed assurance report and as a consequence of the report, together with the deep dive and safer staffing reports the Committee took the view that green shoots were being seen in key areas of the business of the Committee. As such, the decision was taken to move the assurance rating on the Board Assurance Framework for objective 2a from red to amber.
722/21	The Committee were seeing a marked difference in the level of analysis, insight and assurance being offered. The Trust Board: • **Received the assurance report** • **Noted the change to the RAG rating of objective 2a of the Board Assurance Framework from red to amber**
	Item 10 Objective 3 To ensure that service are sustainable, supported by technology and delivered from an improved estate
723/21	**Item 10.1 Assurance and Risk Report from the Finance, Performance and Estates Committee** The Deputy Chair of the Finance, Performance and Estates Committee, Dr Gibson provided the assurances received by the Committee from the 22nd April 2021 meeting in the absence of the Committee Chair.
724/21	Dr Gibson noted that the Committee continued to receive improved reports that had previously been seen in respect of objective 3a noting the quality, structure and depth of reporting. The Committee noted the planned inspection by the British Safety Council continued and useful feedback had been received by the Trust.
725/21	The Committee had received an update on the major fire safety programme noting that this was approaching conclusion.
726/21	The Committee noted, in respect of objective 3b that the Trust were reporting the achievement of a year-end surplus for 2021/22 but, as highlighted by the Chief Executive, arrangements for the year had been different. The Committee congratulated the finance team on how this had been delivered in additional to the Trusts largest capital programme of £42m.
727/21	The Committee were made aware that work continued to confirm the income figure for 2021/22 with system partners and the financial arrangements for the year, these would evolve as arrangements moved back to a more conventional system.

728/21	The Committee received an update in relation to objective 4a for the first time in some months due to Covid-19 noting the plan to reduce outpatient contacts was well above the target of reducing face-to-face contacts. This was mostly due to the success of remote consultations by phone and video call.
729/21	Progress was also noted in respect of working with partners in relation to the ICS and the Committee received significant assurance on this and the involvement of the Trust in the development of the plans.
730/21	The Committee were disappointed to be advised that the integrated community care programme had ceased but were assured that key elements of work had been absorbed in to the system with no impact to the Trust.
731/21	The Acute Services Review timeline continued to extend however, the Committee noted that although the pre-consultation business case had been submitted and national feedback was awaited. This was seen as crucial for the implementation of stable services in Lincolnshire.
732/21	The Committee noted the success of the paediatric model and it was anticipated that this would be presented to the Board as part of the fragile services review, with a view to this being reported as no longer fragile.
733/21	The Committee noted that the outstanding care together programme was not as mature as hoped due to Covid-19 but discussions were being held to determine how this would be prioritised moving forward.
734/21	The Committee considered the draft annual report and subject to some minor changes, this had been approved.
735/21	The Committee received the performance report noting the backlogs due to Covid-19 were being addressed but causing some challenges in the achievement of performance targets. This was noted particularly in relation to cancer services and the Committee noted concern in the ability to rapidly address the backlog. It was noted however that a number of changes and alterations had been made in order to improve performance.
736/21	The Committee were advised that in addressing the backlog prioritisation of patients would be on the basis of clinical need over timing which could result in deterioration of performance against targets ad these were based on timing.
737/21	The Committee had referred to the People and Organisational Development Committee concerns regarding job matching for further review.
738/21	The Chair took the opportunity to formally record the Boards thanks to Mrs Ponder who would be coming to the end of her term with the Trust as a Non-Executive Director the following week. It was unfortunate that Mrs Ponder was unable to attend the meeting however the Chair expressed appreciation for Mrs Ponders' time, commitment and professionalism noting that Mrs Ponder had exercised the Non-Executive Director responsibilities and been a great contributor to the Board and the Chair of the Finance, Performance and Estates Committee. The Chair wished Mrs Ponder well for 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
739/21	**Item 11.1 Virtual Ward** The Medical Director presented the paper to the Board noting that becoming part of the ICS, for the Trust to move forward was dependent on the Trust not only resolving internal processes, staffing and quality issues but formulating ways of working involving healthcare partners.
740/21	The virtual ward had offered the opportunity to do this via the NHS England/Improvement (NHSE/I) national directive during Covid-19 to establish a Covid-19 virtual ward. The Trust had not been set up to do this ad so linked with Lincolnshire Community Health Services NHS Trust (LCHS) who had similar arrangements in place.
741/21	A project team was established led by Dr Campbell, Consultant Chest Physician who was able to offer technical input, set up of the pilot based on the NHSE/I model and modify this to suit the needs of Lincolnshire. At an early stage of establishing the virtual ward a practice ward round was conducted which identified that there were no patients who met the criteria.
742/21	Throughout the process the model evolved in order that this was deliverable, safe and effective. The virtual ward offered supportive discharge services with the aim of identifying Covid-19 patients who would deteriorate.
743/21	The Medical Director noted that other Trusts offered a different service and were able to extract patients from the emergency departments in order that they could return home rather than being admitted. It was felt that during the pilot this was not something that could be offered.
744/21	The Board were advised that there were only a small number of patients admitted on to the virtual ward with a number of them requiring some intervention in order to support discharge. It was noted however that none of the patients admitted to the virtual ward required readmission to hospital. This offered reassurance that the selection and support given to patients was suitable.
745/21	The Medical Director noted that there was a significant workforce requirement to deliver the service and it became clear that in order to run the ward properly this would require a significant amount of time from medical staff and the ACP team within the hospital.
746/21	In order to roll this out at pace a significant investment would be required and this would need to be factored in as the Trust looked to develop the respiratory service.
747/21	The pilot had now concluded and there was considerable learning from this. The process was now in place and it would be possible, if needed, to re-establish the service. The greatest fain from the pilot was the demonstration of the ability to work with another provider across the healthcare system both quickly and effectively to produce an innovative model of care.
748/21	This was of particular important in respiratory medicine as the patient group had a significant number of admissions and were a significantly deprived patient population. Addressing health inequalities would be a key objective within the ICS and health service plans.
749/21	The Chair noted that this offered a good example of collaboration and supported the direction of the ICS and caring for patients in their own home where it was safe to do so. This offered proof of concept through the pilot.

750/21	Mrs Libiszewski reiterated the declaration of interest made noting this was a fantastic piece of work, which demonstrated the importance as a system to consider how innovative approaches took place, in order to support patients close to home.
751/21	The report detailed that there were a small number of patients however, 2 medication incidents had been captured. Mrs Libiszewski asked what steps were being taken in order to address the errors that had occurred.
752/21	The Medical Director indicated that the incidents had been notified through Datix and would go through the normal learning procedures. The Trust were aware that the discharge process was not as good as it should be and the virtual ward had confirmed this. There was a significant amount of work through the medicines quality work stream and through the development of electronic prescribing in order to improve safety.
753/21	The Medical Director noted that the interface was a high-risk area and this had confirmed the value of more innovative support to patients once discharged and to offer more gradual support to the discharge process.
754/21	Dr Gibson noted that the data from Derby and Leicestershire implied that savings could be made to offset the investments required in remote monitoring and asked if this would be presented to the Board as part of the next stages of development.
755/21	The Medical Director noted that Derby and Leicestershire were better established with a community respiratory team that was consultant led. For Lincolnshire the savings could come through once there was a better established platform to work from. The greater gains would not be seen through beds day but through quality improvement with safer discharges and a better respiratory services that would reduce admissions.
756/21	The Chair noted that it was exciting to see that things could be done differently noting that the Board were asked to endorse the direction of travel to establish a virtual respiratory ward. Oversight of this would be through the Emergency and Urgent Care Board however the Chair noted that it would be useful for this to be seen by the Quality Governance Committee and the Board to maintain oversight.
757/21	The Chair thanked colleagues who had worked up and developed the virtual ward. The Trust Board: • **Received the report** • **Endorsed the direction of travel**
758/21	**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.
759/21	The Director of Finance and Digital noted that the upward reports had covered the detail within the report. It was noted that the report did not contain a finance update but this would be included within the report from June 2021.
760/21	Dr Prior sought clarification and assurance for patients on the elective waiting list, asking what measures were in place to ensure up to date clinical information was held on all patients to enable accurate assessment of clinical priority and to capture deterioration of patient conditions.

761/21	The Chief Operating Officer advised that there was a lot of work being undertaken in respect of waiting lists and that the Trust had completed a large patient contact exercise whereby the Trust had been in touch with all patients waiting for procedures on the admitted waiting list.
762/21	Patients had been contacted using a national proforma as a way to help prioritisation. From this there had been a substantial amount of contact with patients to discuss their current position and if there was a need to escalate or deescalate them on the waiting list.
763/21	National guidance had been applied, the P System, which allocated a patients need to be treated from P1, requiring treatment in the next 72 hours, down to P5 and P6 where a patient did not have an acute issue that required treatment and could be addressed at a later date.
764/21	This was being expanded on a system basis to all patients on all waiting lists, including those who required follow ups but not necessarily treatment. If there was a need for more information in order to allocate a patient correctly contact was being made via telephone or virtual appointment.
765/21	A much broader communications systems was being worked on to ensure patients would easily be able to navigate what would be a different was of being treated due to the priorities on clinical urgency. This would also feature factors such as deprivation and other protected characteristics in order the patients could be identified who may be at higher risk as a result of waiting for care.
766/21	Mrs Dunnett noted the work being undertaken within the emergency departments and wider areas regarding flow however within the report an increase of 20-25% had been noted in the demand being seen through the front door. Mrs Dunnett was keen to understand if there was a known reason for these increases.
767/21	The Chief Operating Officer noted that typical prediction models and the understanding of activity within urgent care had not panned due to the disruption of Covid-19. This had disturbed the whole demand for urgent care and how patients and the public accessed emergency services. There had been a need to develop new models of understanding and how access might work in respect of national lockdown and the release of these.
768/21	A resurgence in confidence to access urgent care had been seen following a 66% reduction in demand during wave 1. This represented the lack of confidence that patients and the public had in coming in to hospital and being kept safe from infectious diseases. The increase in access had demonstrated a restoring of confidence.
769/21	It was recognised that the Trust may now be seeing patients who should have accessed care a number of months ago. Data was not available to support this however the clinical teams had noted that patients had had conditions for some time but were only now choosing to access emergency care services. As a result a patient who may have come in a planned was now accessing services in an unplanned manner.
770/21	Whilst the Trust were seeing peeks in activity it was noted that the overall levels of demand were below winter thresholds from previous years and below the summer peak typically seen as people moved to the east coast. The Trust were now preparing for a further increase as restrictions were lifted. The Trust Board: • **Received the report and limited assurance noting current performance**

	Item 13 Risk and Assurance
771/21	**Item 13.1 Risk Management Report** The Director of Nursing presented the report to the Board noting that this offered an update of the strategic risks and focused on the highest priority risks being managed by the Trust.
772/21	The Director of Nursing noted that there had been reductions in risks including the number of inpatients being cared for that were positive with Covid-19 and there had been an increased risk in the number of patients on the elective pathways.
773/21	The Board were advised, as detailed through the People and Organisational Development upward report that the risk relating to workforce and capability had been reduced.
774/21	There were 3 high risks remaining on the risk register these being the impact of Covid-19, which was monitored on a weekly if not daily basis, capacity to manage emergency demand and the strategic risk of workforce engagement, morale and productivity.
775/21	A summary of all risks recorded on the strategic risk register had been appended to the report.
776/21	The Chair noted the report inviting the Board to endorse the top risks and recognised the previously very high risk in relation to workforce had reduced as a consequence of papers received to the People and Organisational Development Committee. The Trust Board: • **Accepted the top risks within the risk register** • **Received the report and noted the moderate assurance**
777/21	**Item 13.2 Board Assurance Framework** The Trust Secretary presented the Board Assurance Framework to the Board advising that this had been reviewed through the Committees in month.
778/21	The People and Organisational Development Committee had moved objective 2a from red to amber in month due to the assurances received by the Committee.
779/21	Work was being completed to transition to the 2021/22 Board Assurance Framework (BAF) alongside planning colleagues to ensure this was aligned. The first draft would be presented to the Committees in May.
780/21	The Chair invited the Board to endorse the BAF as presented noting the changes in rating from the People and Organisational Development Committee. The Trust Board: • **Received the report and noted the limited assurance**
781/21	**Item 13.3 Audit Committee Upward Report** The Chair of the Audit Committee, Mrs Dunnett, provided an update to the Board from the meeting held on 12th April 2021 noting that the meeting was held under the governance light approach with a reduced agenda to reflect this.

782/21	Mrs Dunnett advised the Board that the Committee had agreed the External Audit Strategy for 2020/21. It was noted that this was the first year of the new external auditors and as such more in-depth work would be completed in order to familiarise them with the Trust.
783/21	The Committee had noted areas of risk in relation to Covid-19 and the impact on contracts, additional expenditure and levels of stock for instance personal protective equipment. This would be recognised in stock and increase the valuations of stock in the Trust.
784/21	Mrs Dunnett noted that property valuations were an area of risk and as such would have an increased focus.
785/21	Good progress had been reported from the team on the first external audit with the team on track to reach an opinion in June 2021 in accordance with the national timelines. To date there were no issues to report.
786/21	The Committee received a progress report from Internal Audit who had worked hard to complete the 2020/21 programme with a further 6 audit completed since the last report to the Board. 3 audits were in the process of being complete and Internal Audit would be able to provide a Head of Internal Audit Opinion for the Trust in time for the year-end accounts.
787/21	Mrs Dunnett noted that progress was being made to follow up on recommendations to strengthen areas of weakness with 2 areas requiring further work, in particular research and recruitment. This had been referred to the People and Organisational Development Committee in order to follow up on the status of recommendations.
788/21	A positive report had been received from Counter Fraud and actions were being taken proactively across the Trust. The Committee agreed the Fraud Plan for 2021/22 that was compliant with new national guidance.
789/21	The Committee received a reduced compliance report for the period January 2021 to March 2021 noting that the response Covid-19 had had an impact.
790/21	The Committee noted a particular issue in ensuring policies were up to date, resource was being invested in order to move to a more up to date position.
791/21	A lot of work was ongoing with regard to risk management and the Committee had been in receipt of updates in terms of the new approach to risk for 2021/22.
792/21	Mrs Dunnett noted that the Committee had received updated to the Corporate Governance Manual that reflected changes due to the EU Exit. These changes were endorsed by the Committee and recommended to the Board.
793/21	Dr Gibson noted the report received from a Trust in Leicester and the learning from this that noted that Non-Executive Directors should speak with teams below Executive level and sought clarity on this.
794/21	Mrs Dunnett noted that the report had been received in response to public audit issues that had occurred at another Trust noting that members of the Audit Committee, particularly Non-Executive Directors were encouraged to engage with members of the finance team, as is done through Board to Ward visits, in order to talk about the teams experiences of working in the Trust and issues of concern that may wish to be raised. This supported the culture and leadership work being implemented by the Trust.
795/21	The Chair noted the positive learning from the report and was pleased that this had been reviewed by the Committee. The issue of policies was noted however there was a clear

	narrative within the report that this was being addressed and the Board would look forward to seeing improvements. The Trust Board: • **Received the report noting the moderate assurance**
796/21 797/21 798/21	**Item 13.4 Corporate Governance Manual (Standing Orders and SFIs)** The Trust Secretary presented an extract of the Corporate Governance Manual to the Board noting that the updates brought the manual up to date with the EU Exit. The changes had been agreed by the Audit Committee and were recommended upward to the Board for approval in order to bring the manuals up to date. The Chair noted that the Audit Committee had conducted due diligence on the changes noting the report offered significant assurance. The Trust Board: • **Received the report noting the significant assurance** • **Approved the changes to the Corporate Governance Manual**
799/21	**Item 14 Any Other Notified Items of Urgent Business** There were no other notified items of urgent business
800/21	The next scheduled meeting will be held on Tuesday 1 June 2021, arrangements to be confirmed taking account of national guidance

Voting Members	**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**	**4 May 2021**
Elaine Baylis	X	X	X	X	X	X	X	X	X	X	X	X	X
Chris Gibson	X	X	X	X	A	X	X	X	X	A	X	X	X
Geoff Hayward	A	A	A	A	A	A	A	X	X	X	X	X	A
Gill Ponder	X	X	X	X	X	X	X	X	X	X	X	X	A
Neill Hepburn	X	X	A	X	X	X	X	X	X	X	X	X	X
Sarah Dunnett	X	X	X	X	X	X	X	X	X	X	X	A	X
Elizabeth Libiszewski	X	X	X	X	X	X	X	X	X	X	X	X	X
Paul Matthew	X	X	X	A	X	X	X	X	X	X	X	X	X
Andrew Morgan	X	X	X	X	X	X	X	X	X	X	X	X	X
Mark Brassington	X	X	X	X	X	X	X	X	X	X	X	X	X
Karen Dunderdale	X	X	X	X	X	X	X	X	X	X	X	A	X

PUBLIC TRUST BOARD ACTION LOG

Agenda item: 5.2

Trust Board date	Minute ref	Subject	Explanation	Assigned to	Action due at Board	Completed
4 February 2020	077/20	Assurance and Risk Report Quality Governance Committee	Review of TOM and governance to be presented to the Board	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	*1 June 2021*
Item Number	*Item number 6*
Chief Executive's Report	
Accountable Director	*Andrew Morgan, Chief Executive*
Presented by	*Andrew Morgan, Chief Executive*
Author(s)	*Andrew Morgan, Chief Executive*
Report previously considered at	*N/A*

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

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

Recommendations/ Decision Required	• *To note*

Executive Summary

System Overview

a) The system has submitted a balanced financial plan for the first half of 2021/22 (H1), albeit with identified risks. Further work is underway on mitigating the risks and on planning for the second half of the year (H2). It is anticipated that the NHS will return to a more normal financial regime in H2 following the revised financial arrangements put in place during the COVID pandemic. The return to the more normal financial regime will bring with it increased financial risk.
b) The Pre-Consultation Business Case (PCBC) for the Acute Services Review (ASR) is still in the national approval process. A decision is imminent. Approval of the PCBC would allow the CCG to put in place arrangements for public consultation to begin.
c) Work is continuing across the Health and Care system around the development of the Lincolnshire Integrated Care System (ICS), pending the passing of the necessary legislation set out in the White Paper. Planning is still based on the ICS assuming statutory status in April 2022. It now looks likely that the second reading of the Bill in Parliament will not take place until July 2021.
d) Interviews are currently taking place for the System Improvement Director (SID) for Lincolnshire. This fixed-term post, for approximately one year, is part of the national Recovery Support Programme that the NHS is Lincolnshire has entered into. The SID will focus on the system priority areas of care close to home: workforce planning and redesign; and the flow of patients through the system. Work is also being done to identify the key metrics for the Recovery Support Programme, including the exit criteria.
e) A positive Quarterly System Review Meeting was held with NHSE/I in the Midlands on 19th May. Good progress was noted in a number of areas and Lincolnshire was also commended for its good system working, including with local authorities. The need to continue the effective working that was developed during the pandemic was highlighted, as was the need for continued work on elective recovery and the financial position.

Trust Overview

a) As part of the system financial plan mentioned above, the Trust has also submitted a balanced financial plan for H1, again with identified risks. The position in H2 will be particularly challenging bearing in mind the Trust's underlying deficit. Potential income form the Elective Recovery Fund has yet to be factored in to the Trust's position. This is being worked through with colleagues across Lincolnshire and NHS Midlands.
b) The Trust had a very positive Well Led domain review with the CQC on 6th May. This was part of the CQC's Transitional Monitoring Approach (TMA) that has been in place during the pandemic. A number of different TMA reviews have been held with the Trust, on matters such as Infection Prevention and Control, Children and Young Peoples services and diabetes. All of these TMAs and the regular engagement that takes place

with the CQC should position the Trust well for when the CQC carries out its next inspection of the Trust. The date for this is not known.

c) The Trust was pleased to be able to open the new Urgent Treatment Centre at Lincoln County Hospital on 5th May. This new £3.5m facility includes a new reception and waiting area that complies with the latest social distancing guidance, 10 treatment rooms, a new X-ray and dedicated triage areas. The UTC has been built adjacent to the A&E department, allowing patients to be booked in at reception, assessed and treated in the right place for their needs. This service is a partnership with Lincolnshire Community Health Services NHS Trust who manage the UTC.

d) The Trust's new Medical Director, Dr Colin Farquharson, will start with the Trust on 2nd August 2021. Colin is currently employed as a Consultant Cardiologist and Deputy Medical Director at Northern Lincolnshire and Goole NHS Foundation Trust. In the meantime, Dr Neill Hepburn has kindly agreed to remain in post as Medical Director, prior to returning to full time clinical practice in the Trust.

e) The Trust has engaged the services of the Executive Search firm Odgers Berndtson to assist in the recruitment of the new Director of People and Organisational Development. The current post holder Martin Rayson is leaving the Trust at the end of July 2021.

Report to:	Trust Board
Title of report:	Quality Governance Committee Assurance Report to Board
Date of meeting:	18th May 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 and would move to the 2021/22 objectives from the June meeting.
	Lack of Assurance in respect of SO 1a Issue: Deliver harm free care **Patient Safety Group Upward Report** The Committee received the report noting the concern of clinical records standards due to the variety of systems used. The Committee noted that the Trust were not yet in a position to put in place an electronic patient record. The Committee noted the work in relation to NIV and were assured that the modular ward was on track to be delivered at Lincoln. The Committee requested that the group received an update in respect of the actions being taken regarding NIV in order that this could be upwardly reported to the Committee. **Serious Incident Summary Report** The Committee noted the report receiving the current position with new, open and closed incidents. The Committee were pleased to note that the requested downgrades in relation to 12 hour trolley waits had been approved by the Clinical Commissioning Group and demonstrated the robustness of the harm reviews undertaken by the teams. The Committee noted the system working in relation to serious incidents which promoted learning across the system however noted that this was impacting on the timeliness of closing incidents.

	Clinical Harm Review The Committee received the report noting the increasing backlog. The Committee were advised that despite the backlog progress was being made to complete harm reviews. It was noted that the process of harm reviews was iterative and continued to develop as these were conducted. **High Profile Cases** The Committee received the report noting that there were no new cases in month and a number of outstanding actions had been closed following the previous meeting. The Committee noted the need for clarity of the purpose of the report to ensure that this enabled the Committee and Board to be sighted on any areas of concern and to be assured that action was being taken. **Safeguarding Group Upward Report** The Committee received the upward report noting the concerns regarding capturing of training for F1 and F2 doctors had been considered by the People and Organisational Development Committee and that training would move to e-learning from the September cohort. The Committee noted the positive progress that had been made within the team during the pandemic recognising that there was a need for roles to be appointed to in order for delivery of the service operationally. The Committee were advised of the establishment of specialist groups to support the safeguarding agenda noting specifically the Mental Health Oversight Group would report directly to the Committee. The Committee raised concern regarding legislative changes and responsibilities of acute providers noting that funding would need to be considered in order to deliver Liberty Protection Safeguards.
	Lack of Assurance in respect of SO 1b Issue: Improve Patient Experience **Patient Experience Group Upward report** The Committee received the upward report from the group noting the progress of work being undertaken by the Communication Working Group. A detailed action plan had been developed and would be reported to the group in June. The Committee noted the appetite of the organisation to engage differently with patients and to embed this in to the Trust however work needed to be coordinated across the system in order the avoid duplication. **Patient Experience Q4 Report** The Committee received the quarter 4 patient experience report noting

	that the national survey action plans were due to be discussed by the Patient Experience Group. Despite Covid-19 delaying the survey the Trust had continued to progress. The Committee would continue to see the outcome of the national surveys through upward reporting from the Patient Experience Group. The Committee noted that the Dignity Pledge was due to be finalised and had been launched alongside the nursing and midwifery framework. The Committee were advised of the positive feedback that had been received by the Trust following the introduction of the Thanks and Praise social network platform in November 2020. **Complaints report** The Committee received the quarter 4 complaints report noting the more formal report style and the intention to offer more rounded reporting in future. The report offered an update on learning and themes identified from complaints demonstrating triangulation and greater involvement of the divisions. The Committee were pleased to receive the detailed report noting the improvement in the work being undertaken. **Mixed Sex Accommodation Assurance Report** The Committee noted the development of the previous mixed sex accommodation guidance to policy. A compliance audit on mixed sex accommodation would be undertaken across the Divisions in September 2021. **Patient Story** The Committee received the patient story relating to maternity services, noting this had previously been presented to the Patient Experience Group. The story related to maternity services and offered the experience of a new mother during her antenatal journey. The Committee noted the negative experience on the new mother due to communication with the midwife. As no formal complaint had been received and no further detail the story had been widely shared within the service in the hope that the midwife would be able to reflect on their behaviour. It was hoped that following presentation of the story and this being upwardly reported to the Committee that the Mother would come forward with confidence that her experiences were being heard. **Maternity and Neonatal Oversight Group** The Committee received the upward report from the group noting that the meeting had been positive. The Committee were advised that the Trust had been advised of the buddy organisation noting that there would be an opportunity for two way learning between the Trusts.

	The Committee were pleased to note the positive regional feedback for the Maternity Clinical Negligence Scheme for Trusts (CNST) with the Trust on track to submit on 15th July. The Committee were pleased to note that a review of the submission would be conducted by the Non-Executive Director Maternity Safety Champion. The Committee noted the triangulation of data in relation to foetal growth and monitoring following the latest review which had had a significant impact and reduction in still births. Development of SPC chart reporting continued in order to offer more detailed reporting. The Committee were pleased to note the increase in the homebirth rate to double the national average for the Trust. Training funding had also been ring-fenced and separately aligned to the division. The Committee received the Ockenden action plan noting this was a work in progress however was received by the Committee to offer oversight. A final draft would be received at the next oversight group. The Non-Executive Director Maternity Safety Champion offered a verbal update to the Committee noting the updates offered by the Director of Nursing aligned with the view of the Champion. The Committee were advised that a formal written report of the Non-Executive Maternity Champions engagement was being produced with themes including communication, induction of labour, consent and fear of being left alone during labour. The Committee would continue to maintain oversight of the Ockenden report and action plan in order to upward report to the Board.
	Lack of Assurance in respect of SO 1c Issue: Improve Clinical Outcomes **Clinical Effectiveness Group Upward report, Clinical Audit Annual Progress and Clinical Audit Forward Programme** The Committee noted that the Trust were participating in the Inflammatory Bowel Audit and that actions were in place as a result of the Trust being an outlier for audits that had been conducted. The Committee noted that the Group had a better understanding of audit activity within the Trust and a review of speciality audits was being conducted. The size of the Clinical Audit Programme for 2021/22 was noted and a request made from the Committee to consider streamlining in order to ensure focus on national and local priorities.

	The Committee were advised that there was a structure review within the Clinical Governance Department which would place additional resource in to Clinical Audit enabling more support to the Divisions.
	Assurance in respect of other areas: **Self-Assessment Action plan** The Committee received the updated self-assessment action plan noting that the actions were either closed or had been scheduled to the work programme. **Board Assurance Framework** The Committee noted that the Board Assurance Framework had not been received however were satisfied that the 2021/22 document had been approved through the Board Development session and would be updated by Executive Directors prior to being presented to the June 2021 Board meeting **Committee Performance Dashboard** The Committee received the dashboard noting the extensive consideration of the Integrated Improvement Plan that had taken place during the Board Development Session. It was noted that the scorecard was iterative and there was need to understand this in the context of other data received by the Committee. The Committee noted the need for reporting to be refined and for the inclusion of SPC charts in order to offer narrative reporting alongside data. The Committee noted the refinement of the metrics continued to ensure appropriate reporting to the Committee. **PRM Report** The Committee noted that the new style PRM meetings would commence in the coming month with a new style assurance report due to be received by all Committees from June 2021. **Quality Account** The Committee received the draft Quality Account noting that the Trust had continued to develop an account whilst national guidance was awaited on the requirement to publish an account. It was noted that the Quality Account met the requirements set out in the guidance with work remaining in progress to ensure completion of the account ahead of the 30th June submission deadline. The Committee noted that there was no requirement for the account to be audited this year. The Committee offered feedback on the draft account noting that this offered a fair reflection of the position of the organisation however some additions were requested. Stakeholder engagement was being sought on the Quality Account however it was noted that it would not be possible to

	afford the normal time frame for comments to be offered. The Committee noted the three priorities within the account and were assured that these were in line with the Integrated Improvement plan. The priorities presented to the Committee were: • Improving Respiratory Services – Aim to develop a Trust Wide Respiratory service providing safe, effective and quality care • Developing a Safety Culture – Building on the foundations of a patient safety culture and a patient safety system to achieve the NHS safety vision to continuously improve patient safety • Improving Patient Experience – Engaging and involving our patients in care is central to patient-centred care The Committee requested that the objectives be SMART. The Quality Account would be circulated for comment and virtual approval to Committee members in order to meet the publishing timescale.
Issues where assurance remains outstanding for escalation to the Board	None
Items referred to other Committees for Assurance	
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 due to be adopted
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	J	J	A	S	O	N	D	J	F	M	A	M
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									X	X	X	X

Director												
Neill Hepburn Medical Director	X	X	X	X	X	C	X	X	X	X	X	X
Karen Dunderdale Director of Nursing	X	X	X	X	D	X	A	X	X	X	X	X
Simon Evans Chief Operating Officer	X	X	A	X	D	C	C	C	C	C	C	X

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

Report to:	Trust Board
Title of report:	People and OD Committee Assurance Report to Board
Date of meeting:	12th May 2021
Chairperson:	Sarah Dunnett, Deputy 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 following approval of the BAF by the Board.
Assurances received by the Committee	**Assurance is respect of SO 2a** **Issue: A modern and progressive workforce** **Safer Staffing** The Committee received the report for assurance in respect of staffing levels noting the updates that had been provided around the transformation work being conducted. The Committee noted concern regarding the increase in agency use and reduction in bank use however were advised of the greater scrutiny being applied to agency use by the Divisional Nurses. The Committee noted the significant progress in respect of the Nursing Workforce Transformation Programme and were advised that funding had been secured through NHS England/Improvement in order to support a sustainable plan once the transformation work had been concluded. A domestic recruitment campaign was being considered. **Birth Rate Plus** The Committee received the outcome of the Birth Rate Plus review noting that since the previous review conducted in 2017 there had been a reduction in the birth rates at Lincoln and Pilgrim hospitals but an increase in acuity. The outcome of the report demonstrated the need for a slight increase in the midwifery establishment in order to staff to a 1:23 ratio. It was

	noted that Continuity of Carer was being staffed with acute midwives and in order to increase the offer there was a need for an increase to be made in the establishment. The Committee noted that an expression of interest had been made in order to bid for funding to support the Ockenden recommendations and fund the required uplift. The Committee raised concern about the ability to attract midwives to the Trust being advised that an element of the required uplift could be recruited from student cohorts and a pipeline was in place. The Committee recommended the report onward to the Board.
	Assurance in respect of SO 2b **Issue: Making ULHT the best place to work** **Guardian of Safe Working quarterly update** The Committee received the quarterly report noting the development of the report and the Guardian role within the organisation. The Committee were pleased to see the proactive approach being taken by the Guardian noting that there had been positive developments with the relationship between the Guardian and Junior Doctors. The Committee noted that a number of safety concerns had been raised and were advised that issues were addressed in a timely manner with the Divisions being responsive to issues raised.
	Assurance in respect of other areas: **Committee Assurance Report** The Committee received the report noting that since the introduction of the attendance management system there had been an increase in return to work interviews following sickness. The Committee noted that significant number of staff who had received the 1st dose of the Covid-19 vaccination however were advised that staff had been receiving 2nd doses at other sites and Occupational Health were following up with staff to confirm vaccinations had been received.

WorkPal had been launched in the organisation which would offer the opportunity to reinforce the importance of ongoing individual performance management processes. The system would offer structure to conversations and assessments supporting staff appraisals.

The Committee were advised, following the referral from the Quality Governance Committee that job matching delays were impacting on job structures within the organisation. A deep dive had been shared with the workforce strategy group and it was noted that there were issues with staff being released to support the panels. Support was being requested from the Divisions in order to support the backlog moving forward.

The Committee noted the impact on the international nurse recruitment following the increase in Covid-19 cases on the Indian subcontinent with a number of nurses not yet able to travel. Work was being undertaken to support the recruitment position and to support those nurses not yet on-boarded to ensure they were retained and did not suffer hardship.

Bank and agency use continued to be tracked with the Committee noting an overall reduction in use from the previous year. It was noted that there had been a slight increase in the position in March.

The Committee were pleased with the level of assurances received noting the actions being taken and systems being put in place to support staff.

Referral from the Quality Governance Committee re Core Learning
The Committee were advised that a review of core learning was being undertaken to determine the scope with subject matter experts for each core learning module supporting the identification of target groups.

Core learning categories were currently allocated to ESR categories hence the issues that had arisen. This appeared to be impacting those clinical staff, classified as nurses but working in corporate roles.

Staff were being asked to raise issues of training, not appropriate to role, being assigned to ensure that records could be amended. Staff not completing training was impacting on compliance rates and this needed to be addressed.

	The Committee noted concern about the ability for staff to be released to access training and were advised that this was being considered by the Education Training Group. The Committee were advised that there was not considered to be a major risk associated with core learning however recognised that this would be reviewed and would feed in to the development of the Trusts relationship with staff. **Internal Audit recommendations** The Committee received an update on the outstanding internal audit recommendations noting that actions were being taken to address these. The Committee requested an update on the progress of the outstanding actions and would continue to monitor the progress being made.
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	**J**	**J**	**A**	**S**	**O**	**N**	**D**	**J**	**F**	**M**	**A**	**M**
Geoff Hayward (Chair)	No meeting held due to Covid-19	X	X	X	X	X	X	X	A	X	A	X
Sarah Dunnett		X	X	X	X	X	X	A	X	X	X	X
Non-Voting Members												
Martin Rayson		X	X	X	X	X	X	X	X	X	X	X
Simon Evans		X	D	D	D	C	C	C	C	C	C	D
Karen Dunderdale		X	X	X	X	C	C	C	C	C	X	A

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

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NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*1st June 2021*
Item Number	*Item 8.2*
Nursing & Midwifery Framework	
Accountable Director	*Dr Karen Dunderdale, Director of Nursing*
Presented by	*Dr Karen Dunderdale, Director of Nursing*
Author(s)	*Dr Karen Dunderdale, Director of Nursing*
Report previously considered at	*NMAAF* *30th April 2021* *Approved*

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

Recommendations/ Decision Required	• *The Trust Board are asked to note the contents of the Nursing & Midwifery Framework*

Executive Summary

The Nursing & Midwifery Framework was developed as a result of asking staff two questions:

What does outstanding care look like?
How do you know you are delivery it?

A variety of responses in various forms were sent to the Director of Nursing and the senior nursing and midwifery team collated the responses and teased out the 4 principles which reflect the organisations commitment to quality and the expectations of high quality nursing care:

- Improve Patient Safety
- Ensure a Positive Patient Experience
- Enhance Professionalism
- Improve Clinical Leadership closest to the patient

The aim of the Nursing & Midwifery Framework is to develop a culture that places quality at the heart of everything that we do, where we deliver a positive patient experience and improve outcomes to achieve 'Outstanding Care, Personally Delivered' and where staff feel proud, valued and happy to be part of our organisation.

The framework was officially launched at the “Be Proud, You are Awesome” ULHT Virtual Nursing & Midwifery Celebration Conference on 12th May 2021, and was well received.

NHS
United Lincolnshire Hospitals
NHS Trust

Nursing and midwifery framework

2021-2026

Introduction

The challenge we face is to reshape and redefine nursing and midwifery services to embrace the complexities of the 21st Century. Our vision for nursing and midwifery should combine compassion, dignity and respect with some of the most advanced technologies, which together provides the cornerstone of our commitment to patients and their families. A nursing and midwifery framework is critical in establishing a coherent direction by which nurses and midwives can develop and deliver appropriate, knowledgeable and skilled practice.

Nurses and midwives need a range of technical skills, and a high level of education to enable them to be effective and be critical thinkers, and decision makers. However, it is not just what we do, but how we do it, that is important, and the core values of care, compassion, dignity and respect cannot be overestimated.

It has been suggested that nurses and midwives should focus on basic nursing care. However, there is no such thing as “basic care”. Often things that are described as basic are anything but basic to the patient. Often interventions are counted in terms of cost, when we should actually be thinking of them in terms of value to the patient. Some of the things that really matter have no obvious cost but are of great value. As well as investing in tangible resources, we also need to invest time and effort in creating a culture of trust, collaboration, and respect.

There is plenty of evidence to support the view that staff satisfaction increases patient satisfaction and vice versa, and it is therefore essential that we support the development of the next generation of nurses and midwifery role models, to ensure that nursing, and nurses and midwives, are still valuable and valued, and are central to the business of the Trust.

To develop nursing and midwifery, we will need new roles and skills that fall outside of traditional professional boundaries to ensure we deliver care which is safe and responsive to all of our patients.

Aim of the Nursing and Midwifery Framework

The quality of the patient experience has been identified as a key priority within United Lincolnshire Hospitals NHS Trust. The aim of the nursing and midwifery framework is to develop a culture that places quality at the heart of everything that we do, where we deliver a positive patient experience and improve outcomes to achieve 'Outstanding Care, Personally Delivered' and where staff feel proud, valued and happy to be part of our organisation.

In developing this framework we have spoken to nurses and midwives across all our services. We have asked nurses & midwives to consider what outstanding care looks like and how we know we are providing that care with dignity, respect and compassionate reflecting the Trusts values. To underpin this framework we believe it is right to align it to the Integrated Improvement plan to strengthen the assurances we give about the quality of nursing and midwifery care.

This nursing and midwifery framework is critical in establishing a coherent direction by which nurses and midwives can develop and deliver appropriate, compassionate, knowledgeable and skilled practice. This framework is applicable to all registered nurses and midwives, health care support workers and ward support staff.

There are four principles in this framework which reflect the organisations commitment to quality and the expectations of high quality nursing care.

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Principles

- Improve patient safety
- Ensure a positive patient experience
- Enhance professionalism
- Improve clinical leadership closest to the patient

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Improve Patient Safety

Aim: The safety of our patients is pivotal to everything we do and nurses and midwives must take responsibility for prevention and reducing risks to patients, clients, visitors and themselves. We want every nurse and midwife to take this responsibility seriously and to understand the role they play in reducing risks.

Nurses and midwives are closest to the patient and have a key role to play in protecting patients from adverse events. We will focus on those areas that are high risk and which our colleagues can influence, including falls, healthcare acquired infection, skin integrity, nutrition and hydration, medicines management, management of the deteriorating patient and the management of the patient journey within the outpatient departments.

Objectives

- We will ensure that ward staffing establishments are reviewed by the divisional nurse/midwifery and director of nursing, in order to ensure the appropriate skills are available to deliver a high quality of care to our patients.
- We will ensure that robust safe recruitment and retention plans will be in place, along with succession planning strategies, for all staff groups in order to ensure safe and effective clinical teams which is linked to competency development and service development ensuring forward planning.
- We will develop a recruitment and retention strategy for nurses and midwives that attracts exceptional applicants.
- Nurses and midwives will be well informed about each person in their care and accountable for assessing, implementing, evaluating and documenting the care they provide.
- Our senior nurses and midwives will ensure that the patients' environment is cleaned to the highest standard and will be empowered to take action to address any issues that may arise.
- All nurses and midwives will be responsible for ensuring a safe and clean environment.
- We will use key performance indicators to monitor and review safety issues such as pressure ulcers, nutrition and hydration, falls, hand-washing, deteriorating patient.
- We will strive to reduce our health care associated infections by monitoring key nursing and midwifery indicators in relation to infection.
- A multi-disciplinary approach will be taken in the fight against infection with both the Director of Nursing and Medical Director, jointly leading on the infection control agenda.
- All nurses and midwives will comply with Trust policies for infection prevention and control.
- All nurses and midwives will comply with safeguarding policies and procedures ensuring patients and family members are protected from abuse and neglect.
- Staff will continue to be involved in root cause analysis, to enable understanding of why safety issues occur along with the lessons learnt enabling practices can be changed if required.
- We will foster a culture of incident reporting.
- We will ensure that every lapse in care is investigated.
- We will commence schwartz rounds to allow staff to connect and learn vicariously from episodes of harm.
- We will endeavour to provide the highest level of maternity care and will aim towards achieving the standard of 1 midwife to 28-birth ratio.
- We will aim to provide 1-1 midwifery care to any woman in established labour.

Ensure a positive patient experience

Aim:

Our patients and clients will be treated with compassion, dignity and respect at all times and will be encouraged to participate in all aspects of their care planning and delivery. We will improve the care we provide by actively listening to patients and their carers to better understand their needs, concerns and wishes. Our eyes will see well cared for patients, our ears will hear our patient's tell us their thoughts.

Objectives

- We will ensure that the patients and clients under our care will be kept well informed and will be treated with compassion, dignity and respect. When required we will provide clarity regarding their care and, where appropriate, their relatives and carers.
- We will ensure that patients will be treated with patience, understanding, compassion and sympathy
- We will identify patients who lack capacity making reasonable adjustment to their care ensure that it is always delivered in their best interest
- We will continue to work towards ensuring our services are accessible to the needs of our patients and service users, in line with the Accessible Information Standard.
- We will ensure we develop a culturally competent and confident workforce, to ensuring culturally
- intelligent care is delivered.
- We will care for our patients in an environment that provides them with privacy dignity, and respect and takes into account their spiritual and religious needs.
- We will actively seek to involve patients in forums for discussion and feedback.
- We will continue to ask our patients for feedback on how we are doing and act on the results.
- We will ensure that when we review pathways and develop new services we will encourage active participation of patients.
- We will listen to and use patient stories and case studies to help us understand patients' experience, ensuring that issues are acted on at ward, division and Trust Board level
- We will use experiences of spiritual and religious care in staff training.
- We will use complaints and issues raised by patients and relatives to help us understand how we can improve care.
- We will ensure that feedback received from patients and their carers is acted upon to improve the quality of our service.
- We will ensure we have identified Dignity Champions in all patient areas.
- We will develop spiritual/religious care champions.
- We will talk to our seldom heard groups to ensure we are inclusive of all patients and clients.
- We will be actively involved in using technology to support the care and treatment of patients.

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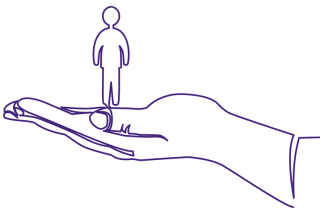

Enhance professionalism

Aim:

The nurses and midwives within in our Trust will visibly portray the behaviours, attitudes and values expected of a professional nurse or midwife and of their governing body and will use the NMC Code as a guide for their everyday practice thereby enhancing confidence in caring for and caring about our patients.

Objectives

- We will behave in a way that is open, transparent and honest.
- We will apply the Trust values in all communication (written and verbal and nonverbal).
- We will embed the agreed standards of behaviours in our workplace.
- We will ensure that patients and colleagues are treated with respect and dignity.
- We will ensure that nurses and midwives feel able and supported to challenge unacceptable behaviours and support will be given for all staff to promote an environment where unacceptable behaviours are not tolerated.
- We will ensure professional attitudes and compliance with Trust policies at all time by both staff and students.
- We will ensure strict adherence to the Trust Dress Policy.
- Strengthen the role of our Matrons and Ward managers and their ability to act.
- Nursing roles will be clarified to ensure professional standards and the purpose of nursing is shared in the Trust.
- We will engage staff to learn from their experiences and work to improve morale
- We will establish a mechanism for reward and recognition of outstanding performance.
- Support will be given to our nurses and midwives in identifying the knowledge and skills they require to perform their roles within their clinical teams.
- We will actively engage in regular clinical supervision, coaching and mentorship that enhance the profession.
- We will embrace and support the Nursing and Midwifery Council revalidation process.
- We will develop new roles and flexibility at the boundaries of professional roles linked to service development.
- All staff will actively participate and be responsible for delivery of their objectives through annual appraisal.
- We will continue to develop and enhance our strategic partnerships with education commissioners, HEI. In doing so we will ensure a robust quality assured educational practice placement learning experience.
- We will ensure that we can equip nurses and midwives to work with advances in technology and information technology in clinical practice.
- We will ensure that we can equip nurses and midwives with the skills to lead care delivery and redesign in multi-professional settings and across organisational boundaries.
- We will ensure mentors and support of pre-registration nurses are in place to enable students to achieve their learning needs.

Improve clinical leadership closest to the patient

Aim:

Strong leadership at all levels within the organisation is essential. This is critical in developing clinical teams and both ensuring and improving standards of care. We will actively promote the development of nursing and midwifery leadership skills and will maximise opportunities for learning. We will ensure that we have robust assurance processes in place to provide both the internal and external assurances that are required. We will deliver care which is built on evidence which has a strong research base.

Objectives

- We will ensure our nurses and midwives will lead by example in the clinical area and act as role models to our more junior staff and students.
- Our nurses and midwives will feel empowered and compelled to intervene every time they see standards below what is expected.
- Nurse and midwife leaders will be visible and known to staff within the Trust.
- We will be honest and act with integrity.
- We will ensure each ward and department has a vision for their area which encompasses what will/does good care look like here.
- We will ensure a commitment that ward managers will have a protected time allowance so they are not rostered for clinical duties. This will enable them to provide clear clinical leadership and work to support their teams.
- We will provide access to leadership programmes/coaching and external mentoring, for our nurses and midwives in order to develop our future leaders and enhance the skills of those in leadership roles at present.
- All nursing and midwifery staff will attend mandatory training in line with the Trust's policy.
- We will ensure access to appropriate learning and development opportunities for nurses and midwives in line with the clinical needs of the patients in their care.
- We will ensure mentors and support of pre-registration nurses are in place to enable students to achieve their learning needs.
- We will ensure all senior nurses (band 6 and above) have quality improvement training to empower them to lead and support local improvement changes.
- All nurses will complete their mandatory training in safeguarding. There will be appropriate reporting of cases and evidence that people using the services, families and the public will be safer as a result.
- Nurses will participate in the development of the Trust's information technology strategy, including patient monitoring, electronic patient records, e-prescribing and e-rostering to ensure delivery of effective patient care.
- We will actively engage in quality improvement projects with a multi-disciplinary team to ensure learning across disciplines to avoid silo working and improve pathways of care.
- We will improve the profile of nursing and midwifery research in the Trust.
- Make use of research undertaken by our nurses and midwives at undergraduate and post-graduate level and support its publication.
- We will encourage and share innovation and best practice in nursing and midwifery service delivery within the Trust.
- We will utilise national examples of service innovation and modernisation

Conclusion

This nursing and midwifery framework sets out our commitment to ensuring that all our patients experience a high standard of dignity, respect and compassionate care and treatment. Nursing and midwifery will aim high to ensure a reputation that drives credibility, excellence, innovation and progressive care that ensures individual professionals are clear about the opportunities United Lincolnshire Hospitals NHS Trust provides.

Every nurse and midwife should go home at the end of a shift happy with the knowledge that they have done a good job and have made a positive difference to someone's life.

This framework will be reviewed annually through the Nursing Midwifery Allied Health Professional Advisory Forum (NMAAF)

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NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Public Trust Board*
Date of Meeting	*Tuesday 1 June 2021*
Item Number	*Item 8.3*
Birth Rate Plus Report: Initial Analysis & Proposed Next Steps	
Accountable Director	*Dr Karen Dunderdale, Director of Nursing*
Presented by	*Dr Karen Dunderdale, Director of Nursing*
Author(s)	*Libby Grooby, Interim Head of Midwifery*
Report previously considered at	*Maternity & Neonatal Oversight Group – Wednesday, 5 May 2021* *People & OD Committee – 12 May 2021* *Quality Governance Committee 18 May 2021*

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

Recommendations/ Decision Required	*The committee is asked to:*
	• *note the report and findings*
	• *note & support the proposed next steps & recommendations*

Executive Summary
The report provides the initial analysis of the report arising from the recent Birth Rate Plus Review, commissioned by the Trust in November 2020 and report received in March 2021. The report also outlines the proposed next steps.

Background

The Maternity Service operates a traditional model with intrapartum service provision delivered on Pilgrim and Lincoln County sites. Despite the falling birth-rate both nationally and locally, the complexity of women and associated obstetric complications is rising for example the number of safeguarding cases, the number of women with high BMI, diabetes and smoking in pregnancy. This is supported in our NHS Digital benchmarking data that shows we have higher smoking rates and social complexity than other peer services.

ULHT is currently staffed to the Birth rate Plus recommendations of 2017. Since 2017 the birth rate on both sites has reduced, but it was determined that the acuity of the women had significantly increased. Following a midwifery establishment review in August 2020 the recently appointed Director of Nursing and the interim Head of Midwifery concluded that a Birth rate plus review was required to assess the decrease in activity against the increase in acuity. This was commissioned in November 2021 and at the end of March 2021 the report was received by the Trust.

BR+ Safe Midwifery Staffing Ratio March 2021

Birth Rate Plus® (BR+) is a framework for workforce planning and strategic decision-making and has been in use in UK maternity units for a significant number of years.

The principles underpinning the BR+ methodology are consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings, and have been endorsed by the RCM and RCOG. The interim NHS People Plan and the NHS Long Term Plans recommend services to be using evidence-based approaches to staffing by 2023

Birthrate Plus (BR+) works on the assumption that all women will receive one to one care during labour with additional establishment built in depending on the acuity of the population served. The review also assumes that the service works to NICE Antenatal Care guidance (number of antenatal contacts). In addition to this BR+ will attribute a skill mix to the required workforce; the percentage for this will depend on the acuity of the population.

Case mix is categorised into five categories (1-V): 1 being a woman with a low risk pregnancy and straightforward birth with “V” being a woman with a complex pregnancy and/or birth. The acuity within the population denotes the WTE required to safely run a maternity service as it takes into consideration activity and acuity, as well as specialist midwifery services and managerial responsibilities.

The recent report shows an increase in dependency of the women who access the services on both sites. Taking the increase in dependency into account the report recommends safe staffing ratios for the maternity service should move from the current ratio of 1:27 to 1:23 for both the Lincoln and the Pilgrim sites.

The below tables evidence the staffing requirements outlined in the report, ULHT current position and the variance in establishment:

BIRTH RATE PLUS RECOMENDATION		
Description	**Total**	**Skill Mix**
Clinical wte (Inc. A-Equip)	205.71	
90% RMs		185.67
10% MSWs in P/N Care 90/10 ratio is recommended by BR+, although states this is a local decision		14.79
MSW - Pilgrim (outside scope of 90/10)		5.26
Non-clinical Midwifery	22.05	
TOTAL WTE per Unit	**227.76**	

ULHT CURRENT FUNDING		
Description	**Total**	**Skill Mix**
Clinical wte (Inc. A-Equip)	197.69	
RMs		181.17
MSWs in P/N Care		11.26
MSW - Pilgrim (outside scope of 90/10)		5.26
Non-clinical Midwifery	26.56	
TOTAL WTE per Unit	**224.25**	

VARIANCE		
Description	**Total**	**Skill Mix**
Clinical wte (Inc. A-Equip)	8.02	
RMs		4.49
MSWs in P/N Care		3.53
Non-clinical Midwifery	-4.51	
TOTAL WTE per Unit	**3.51**	

The variance table above confirms our view that our allocation of non-clinical midwifery is too high. However, this is mainly related to the need to allocate clinical time to the specialist and this work is currently underway. If we were to switch between clinical and non-clinical midwives, overall our maternity service is 3.51 WTE short of clinical midwives based on the BR+ recommendation.

Continuity of Carer (CoC)

The report also gives a summary of the required staffing for core services and Continuity of carer as per the table below.

	Baseline	20% CoC	35% CoC	51% CoC	75% CoC	100% CoC
Total Clinical WTE	200.47	205.51	209.16	213.24	218.85	224.92
Variance		5.05	8.69	12.57	18.40	24.45

In conclusion-

- The current midwifery staffing funded establishment is 3.51 WTE in deficit.
- There is further work needed within the division to separate out the clinical element of the specialist roles.
- To implement CoC to 51% as planned would require an addition uplift of 12.57 WTE clinical midwives across the sites.

Next steps

- The Trust is awaiting the outcome of a national expression of interest bid to support implementation of the Ockenden recommendations. This bid includes uplift to BR+ recommendations and support for CoC to 35%.
- Review clinical element to specialist roles and re define the roles.
- Review additional need for specialist roles in line with Ockenden
- 5-year action plan to be generated to support the recruitment and retention of midwives to achieve the Ockenden plan and CoC.

This paper was discussed in detail at the Maternity Neonatal oversight group chaired by the Director of nursing and was upwardly reported for information to the People & OD committee and the Quality Governance Committee.

Recommendations
The Trust Board are asked to note the findings from Birth Rate +
The Trust Board are asked to support the proposal to develop a 5 year plan in line with the predictions for BR+ and CoC
The Trust Board are asked to note the findings from BR+

Dr Karen Dunderdale, Director of Nursing
Libby Grooby, Interim Head of Midwifery
April 2021

Report to:	Trust Board
Title of report:	Finance, Performance and Estates Committee Assurance Report to Board
Date of meeting:	20 May 2021
Chairperson:	Chris Gibson, Non-Executive Director
Author:	Karen Willey, Deputy Trust Secretary

Purpose	This report summarises the assurances received, and key decisions made by the 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 and would move to the 2021/22 objectives from the June meeting following approval of the BAF by the Board.
Assurances received by the Committee	**Lack of Assurance** in respect of SO 3a A modern, clean and fit for purpose environment **Estates Statutory Compliance Report** The Committee received the report which contained a detailed update from across the Estates portfolio. The Committee noted a number of actions taking place to address required infrastructure improvements that had been delayed due to the impact of Covid-19. The Committee noted the outcome of recent PLACE assessments and were disappointed in relation to privacy, dignity and wellbeing. It was noted that some scores were heavily impacted by the design and physical estate of the hospitals. The ward refurbishment programme would help to address the issues identified. The Committee noted the positive impact of Authorising Engineers which would enable a roadmap for critical infrastructure to be developed and provide clearer priorities for the use of capital funding. The Committee noted the number of fire risk assessments that required review, recognising that Covid-19 had restricted the ability for experts to access areas, and supported the prioritised process for completion of renewed risk assessments.

	Assurance in respect of SO 3b Efficient Use of Resources **Finance Report** The Committee noted that the financial regime for the first half of 2021/22 remained the same as H2 of 2020/21 with the expectation of a break even position across the Lincolnshire system at the end of H1. The Committee noted a £900k deficit at the end of month 1 in line with expectations which was driven by the need to deliver Cost Improvement Programmes (CIP) in the first half. The Trust had an expectation to deliver £4m CIP with the requirement for delivery in quarter 2. Non-pay income was reported favourable to plan and included variable income relating to drugs and devices that offset the vaccination programme and translated to an adverse variance. Pay was reported as £300k adverse to plan at month 1 with the Committee noting that there was no accrual building for the potential pay award in year as this will be funded separately when agreed. The Committee noted agency costs relating to backfill for a number of Doctors who were unable to return to the country due to Covid-19. The Nursing Workforce and Medical Workforce Transformation Programmes had been reinstated with support from Finance. The Committee were advised of the Elective Recovery Fund following the release of new guidance that offered an opportunity to gain funding for elective activity above pre-defined thresholds. The Committee noted that work was underway to address missing outcome data relating to OP activity prior to the June submission deadline. The Committee received the CRIG upward report for information. **2021/22 Financial Plan – Capital** The Committee received the capital plan and were pleased to see a comprehensive plan in place early in the year. It was noted that the Capital Delivery Group process was being updated in order to drive the agenda forward and ensure assurance could be provided. The Committee supported the proposed distribution of the remaining £10.1m funding which reflected management of risk and progress of priority schemes. **Revenue Planning** The Committee received the report noting the submission to NHSE/I was due to be made the next week. The system had submitted a break even

	plan for H1 noting there was circa £9.5m of risk in the plan that required bridging as a system. The report summarised the end of the financial year 2020/21 and draft plans for 2021/22 noting the change in financial regime. Key building blocks were in place and there would be an opportunity to influence investments. It was noted that any costs associated with recovery from Covid-19 would go through appropriate governance processes. There was investment to recover to 85% of 2019/20 activity levels however it was noted that where possible performance would be stretched to support recovery above this and gain access to further elective recovery funding. Due to the volume of information presented to the Committee it was agreed that this document would, following sign off, be reviewed in further detail by the Committee in order to ensure there was clarity of the commitment and plans in place to deliver.
	Assurance in respect of SO 3c Enhanced data and digital capability **Information Governance Group Upward Report** The Committee received the report noting the content with some concern regarding achievement of the required training. The Committee noted that failure to achieve IG training levels would mean that the Trust would not be able to achieve the Data Security and Protection Toolkit. Support was being offered across the Trust to remind staff of the requirement to complete the training.
	Assurance in respect of other areas: **Board Assurance Framework** The Committee noted that the Board Assurance Framework had been reviewed at a recent Board Development session and would be updated by Executive Directors prior to being presented to the June 2021 Board meeting for formal approval. It would then form the basis for the Committee agenda and reports. **Committee Performance Dashboard** The Committee received the report noting gradual improvements in performance as Covid-19 moved to being treated as endemic. The Committee noted the move from treating patients based on waiting time to those most clinically urgent and queried how this would be monitored to ensure this was delivered correctly. It was noted that the Trust would follow national planning guidance and reporting. The Committee noted the development of the dashboard following the development of the executive scorecard and alignment to year 2 of the

	integrated improvement plan. Appropriate benchmarking against both local Trusts and a peer group of similar Trusts was recommended. **Cancer Performance Report – aligned to the restore objectives** The Committee received the report noting this was now aligned to 2021/22 planning criteria for the restoration of cancer services, with specific objectives and improvement targets. The Committee noted ongoing concerns with the recovery of cancer services, in particular the poor performance of the 2 week wait breast service. The Committee noted Breast 2 week performance was reported at 4% and was only climbing slowly. There had been an increase in capacity of the service and work on the interface of breast surgical and radiological services in order to address the backlog. The Committee noted there had been a comprehensive review by NHSE/I of breast services and requested that a summary report including actions be presented to the Committee at a future meeting. The Trust was operating above 92% for the 14 day standard across other services. The Committee noted the 62 day wait backlog had reduced from July 2020 but more recently plateaued, exclusively in relation to urology, ENT and colorectal services. It was noted that all theatres would be running to full capacity in June and that the increase of acuity of patients seen at Grantham Hospital would support recovery of the backlog. **Urgent Care Performance Report** The Committee received the report noting that new standards for urgent care were being put in place. Due to the Covid-19 pandemic there had been limited development time for these new standards however the Trust were actively engaging with the changes. The Trust would use the new standards in shadow form until there was an official change from the national standards. The clinical benefits of the new standards, and the need for clear communication, were noted. **PRM Upward report** The Committee received the report noting the discussions held by the divisions. The Committee noted that future reporting would be in line with the new PRM structure and would focus on assurance. **Integrated Improvement Plan 2020/21** The Committee received the final report of the year 1 integrated improvement plan noting the closure of some objectives for year 1 and detailing those objectives being transferred to year 2.

	The Committee noted that this very clear report would be useful to the Committees of the Board in order to support progress against the Board Assurance Framework. **Integrated Improvement Plan Year 2 - 2021/22** The Committee received the year 2 integrated improvement plan noting the additions that had been made to the report following comments received at the Board Development Session. The Committee noted that appropriate elements of the plan would be reported to all the relevant Committees offering updates on the delivery of the strategic initiatives and local and major projects.
Issues where assurance remains outstanding for escalation to the Board	No additional items to raise.
Items referred to other Committees for Assurance	None
Committee Review of corporate risk register	The Committee reviewed the risk register noting the top risk associated with the Committee. The Committee reflected on the need to ensure that risks were appropriately captured and reflected within the risk register as the new format of the report commenced.
Matters identified which Committee recommend are escalated to SRR/BAF	No items identified
Committee position on assurance of strategic risk areas that align to committee	As above
Areas identified to visit in dept walk rounds	Department walk around currently suspended

Attendance Summary for rolling 12-month period

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

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

United Lincolnshire Hospitals
NHS Trust

Integrated Improvement Plan (IIP)
Year 2: 2021 - 2022

OUTSTANDING CARE *personally* DELIVERED

Foreword

“As we recover from a very challenging year, we are able to look forward to the year ahead with a renewed sense of hope and positivity. Despite the challenges we have faced as a hospital trust dealing with a global pandemic, we have also been able to achieve some key objectives on our improvement journey. One of the highlights has been the completion of the new Urgent Treatment Centre (UTC) at Lincoln County Hospital, which will improve emergency care for both our patients and our people. We have also welcomed over 50 international nurses and over 200 new Healthcare Support Workers during the year, who have helped support our people, patients and services with their valuable skills.

Elaine Baylis, Chair

Looking ahead to this year, we have some amazing things we are hoping to achieve and a number of exciting challenges on our improvement journey. We have strong plans in place and excellent people supporting our vision to provide Outstanding Care, Personally Delivered. A flavour of some of the other key areas we are looking at in 2021 – 2022 are reducing medication errors, improving care for respiratory patients, modernising pre-operative assessments, implementing a robust policy management system and improving the patient cancer journey.

Andrew Morgan, CEO

Our improvements will take shape in a variety of ways, which may include investment and construction, utilising technology and re-shaping pathways with our patients’ voices at the centre of what we do. No matter how these changes come about, there are some key elements that will be the same - our people and partners making change a reality together.

We know we have a long way to go in terms of improving our organisational culture, and this year we launch our culture and leadership programme, to help us move forward in making working life better at ULHT. We cannot make improvements without our people, but our improvements are also for all of our people and patients. The following update sets out our intentions for 2021 – 2022 as part of our wider Integrated Improvement Plan (IIP). **It’s important we all take these next steps forwards together.”**

Welcome

This Plan for 2021/22 demonstrates our intentions and ambitions for the coming year. It is Year 2 of our Integrated Improvement Plan (IIP).

The IIP sets out our 5-year strategic direction for the Trust (2020-2025)

Context

Lincolnshire is the second largest county in the UK and has one of the fastest growing populations, projected as 838,200 by 2033

United Lincolnshire Hospitals NHS Trust (ULHT) is a rural acute NHS Trust, of over 8000 colleagues, serving Lincolnshire's 757,000 residents from 3 ULHT-run Acute Hospital sites, 4 Community-run Hospitals, and numerous GP-run facilities around the County.

Lincolnshire is the second largest county in the UK and is characterised by dispersed centres of population in large towns and the city of Lincoln, and otherwise largely rural communities. Transport networks are underdeveloped resulting in transport times of around 1 hour between the 3 Acute hospital sites.

In an average year, we treat more than 150,000 accident and emergency patients, over 600,000 outpatients and over 140,000 inpatients, and deliver over 5,000 babies.

We are the lead provider of elective care and urgent inpatient care for Lincolnshire Clinical Commissioning Group (formerly 4 Clinical Commissioning Groups), and an integral part in the forming of the Lincolnshire Integrated Care System, in line with National expectation. This changes how we build plans, and how we fund our services, and will ensure we work collaboratively to spend the Lincolnshire pound in the most effective way for our community.

ULHT in the Lincolnshire System

Integrated Care Systems (ICSs) are new partnerships between organisations that meet health and care needs across an area. The priorities for the ICS are ones we will deliver together

Lincolnshire is served by an Integrated Care System (ICS) as of April 2021, and ULHT are one of the providers within this ICS.

ICSs should serve 4 fundamental purposes:

1. Improving population health and healthcare
2. Tackling unequal outcomes and access
3. Enhancing productivity and value for money
4. Helping the NHS to support broader social and economic development

Lincolnshire ICS has 3 overarching priorities for this year 2021 – 2022, due for revue in Quarter 2 of the year:

1. **Covid-19 Vaccination Programme**
2. **Restoration and Recovery of Services moving into endemic**
3. **Delivery of Strategic Priorities**

Strategic Priorities

- ICS Development
- Long Term Plan Refresh (5 year strategic direction for Lincolnshire)
- Acute Service Review Consultation and delivery of outcomes
- Primary Care Network Development
- Health Inequalities
- Population Health
- Personalisation
- Clinical Forums and Learning Networks
- Estates and Capital Strategy
- People Plan
- BAME Workforce
- Digital
- Communication and Engagement

Developing our Plan: Year 2 of the IIP

Review of the National, Regional and System priorities for 2021/22

Development of Strategic Direction within the Organisation: Initiatives and Projects

Integrated Planning: Restore, Quality, Performance, Activity, Workforce and Finance, aligned to System Priorities

Year 2 of the IIP developed, adjusted and agreed with the Board, Executives and divisional colleagues

Year 2 of the Integrated Improvement Plan agreed by Trust Board

Within ULHT we have worked to ensure the organisational planning process takes into account:

- Position against year 1 IIP objectives
- Restoration of services following the pandemic
- 5-year strategic direction of the organisation and system
- National planning guidance
- Clinical priorities

The structure of our plan

The second year of IIP has been developed through conversations with the divisional teams, executive leads, system partners and national bodies. Its purpose is to ensure we deliver meaningful change in the areas we stand to make the greatest impact on quality, safety and effectiveness for our patients, colleagues and partners. It is made up of:

4 Strategic Objectives: **Patients**, **Services**, **People** and **Partners**
these will remain unchanged for 2020-2025.

12 five year priorities: Against the objectives, there are a total of 12 priorities for delivery by the end of the 5 years.

10 Strategic Metrics these will evidence that change is happening in line with our strategic objectives. They are our critical success measures, and will remain in place until 2025.

4 Strategic Initiatives these are multi-year, must-do, can't fail projects and are executive led. They use the Transformation change methodology

5 Local Projects these are themes set annually to address a number of specific areas of improvement where large areas of the organisation play their part using the Outstanding Care Improvement System

38 Major Projects these typically require project management support, have a set start and finish point (normally for 1 year) and will be worked on using our Transformation change support.

The IIP 2020 – 2025

The IIP (2020 - 2025) sets out 4 Strategic Objectives for our organisation: **Patients, Services, People** and **Partners**. Each Strategic Objective has a set of 5-year priorities, with Strategic Metrics to measure the improvement. Delivery of this will enable us to deliver our vision: Outstanding Care, Personally Delivered.

Vision

Outstanding Care Personally Delivered

Values

Patient Centred | **Compassion** | **Respect** | **Excellence** | **Safety**

Strategic Objectives

Patients	Services	People	Partners
To deliver high quality, safe and responsive patient services, shaped by best practice and our communities	To ensure that services are sustainable, supported by technology and delivered from an improved estate	To enable our people to lead, work differently and to feel valued, motivated and proud to work at ULHT	To implement new integrated models of care with our partners to improve Lincolnshire's health and wellbeing

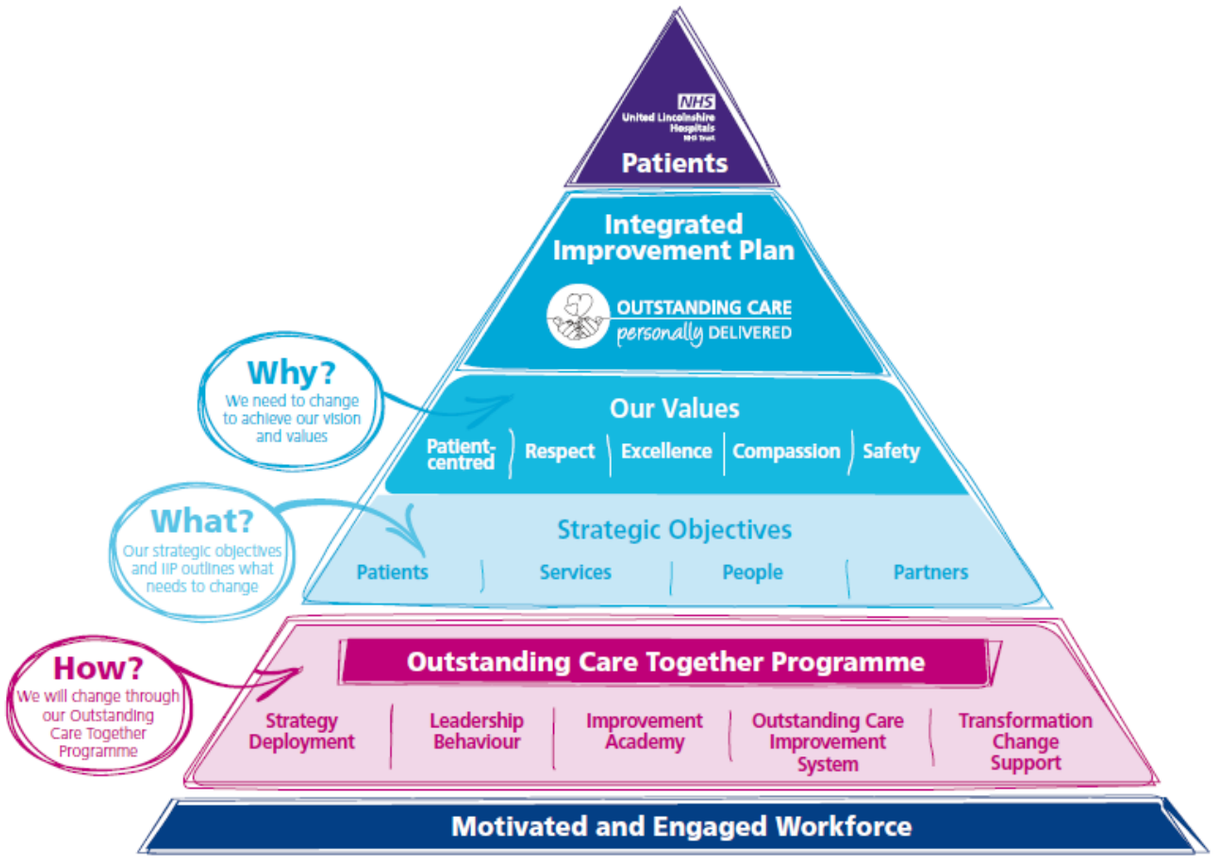
5 year Priorities

Patients	Services	People	Partners
• Deliver harm free care • Improve patient experience • Improve clinical outcomes	• A modern, clean and fit for purpose environment • Efficient use of our resources • Enhanced data and digital capability	• A modern and progressive workforce • Making ULHT the best place to work • Well led services	• Establish new evidence based models of care • Advancing professional practice with partners • Becoming a University Hospitals Teaching Trust

Strategic Metrics

Patients	Services	People	Partners
• Achieve zero avoidable harm • Top 25% for acute Trusts 'overall' inpatient experience • Top 25% for SHMI	• Deliver £200m capital plan • Deliver a breakeven revenue position versus plan	• Top 25% for acute Trusts across all 10 themes in the staff survey	• % Patients in Emergency Dept >12hrs (total time) • Deliver 62 Day combined standard • Urgent treatment P2 Turnaround time • Deliver outpatient Activity Non face-to-face

We have developed the Outstanding Care Together Programme to support Improvement across our organisation as highlighted within the IIP



The Outstanding Care Together Programme has five pillars;

1. Strategy Deployment enables us to identify a reduced number of improvement priorities and for them to be cascaded throughout the whole organisation

2. Leadership Behaviour develops new leadership styles and capability moving us towards a coaching and supportive style

3. Improvement Academy develops our approach to improvement and increases the number of people trained and involved in improvement

4. Outstanding Care Improvement System is a set of routines, behaviours and tools which ensure daily continuous improvement and performance, and give colleagues time and space to implement change in their area of the organisation

5. Transformation Change Support is a 6-stage approach to support larger projects often including some help from the Delivery Team

Our 2021/22 Priorities

This is how the Metrics, Initiatives and Projects all align to our 4 Strategic Objectives: **Patients**, **Services**, **People** and **Partners** this will ensure Quality, Safety and Effectiveness in our delivery of care.

The detail for our Major Projects and expected impact on our Strategic Metrics in 21/22 are available in the next few slides

	Patients	Services	People	Partners	How we will deliver against these priorities:
5 year Priorities	Deliver Harm Free Care	A modern, clean and fit for purpose environment	A modern and progressive workforce	Establish new evidence-based models of care	
	Improve Patient Experience	Efficient use of our resources	Making ULHT the best place to work	Advancing professional practice with partners	
	Improve Clinical Outcomes	Enhanced digital and data capability	Well-led services	Becoming a University Hospitals Teaching Trust	
Strategic Initiatives	**Deliver and Embed Outstanding Care Together Programme**				**Transformation Change Support**
	Developing a Safety Culture		**Resetting our Culture and Leadership**	**Integrated Care**	
Local Projects	Reduce incidents of patient falls	Reduce agency spend	% Staff saying "Proud to work at ULHT"	First Non-elective admission by 10am	**Outstanding Care Improvement System**
	Reduce medication errors	Improve clinical outcomes			
Major Projects	16	9	7	6	**Transformational Change Support**

Major Projects

There are 38 Major Projects that have been identified to improve quality and safety for completion in 2021/22. These typically require project management support, have a set start and finish point (normally for 1 year) and will be worked on using our Transformation change support

Patients	Maintaining our HSMR and improving our SHMI	Review of pharmacy model and service	Trust-wide Children's standards
	Ensure continued delivery of the hygiene code	Development and implementation of new pathways for Paediatric services	Maternity Transformation
	Ensuring early detection and treatment of deteriorating patients	Delivering on all CQC Must Do actions and regulatory notices	Recovery planning
	Fractured Neck Of Femur Rehab	Gastroenterology Transformation	Ensuring safe surgical procedures.
	Ensuring a robust safeguarding framework is in place to protect vulnerable patients and staff	Ensuring our Respiratory patients receive timely care from appropriately trained staff in the correct location	Improving the safety of Medicines management
	Redesign our communication and engagement approaches to broaden and maximise involvement with patients and carers.		
Services	Commence implementation of the Electronic Health Record	Pre-Operative Assessment Modernisation	Implementing the CQC Use of Resources Report recommendations
	Delivering financial plan	Delivering Cost Improvement programme	Urology Transformational Change Programme
	Implement a single new business intelligence platform that supports decision making and drives improvement	Continued progress on improving infrastructure to meet statutory Health and Safety compliance.	Continual improvement towards meeting PLACE assessment outcomes
People	Ensuring access to the personal and professional development that enables people to deliver outstanding care and ensures ULHT becomes known as a learning organisation	Embed Robust workforce planning and development of new roles	Delivery of annual appraisals and mandatory training
	Talent Management - Creating a framework for people to achieve their full potential	Implementing a robust policy management system	Improving the consistency and quality of leadership and line management across ULHT
	Address the concerns around equity of treatment and opportunity within ULHT, so that the Trust is seen to be an inclusive and fair organisation		
Partners	Community Hospital Review	Improvement programmes for outpatients	Improvement programmes for cancer
	Urgent Care Improvement Programme	University Hospital Teaching Trust Status	Support the consultation for Acute Service Review

Strategic Metrics

10 Strategic Metrics have been identified to measure our success against our strategic objectives in 2025. They will also evidence that change is happening each year in line with our strategic objective ambition. The table below sets out our ambition for March 2022.

Metric	Baseline	March 2022 Ambition
Achieve zero avoidable harm*	15	9
Top 25% for acute Trusts for 'Overall' Inpatient experience	4th Quartile	3rd Quartile
Top 25% for SHMI	4th Quartile	4th Quartile
Deliver £200m capital plan	£15m	£39m
Deliver a breakeven revenue position versus plan		Breakeven
Top 25% for acute Trusts across all 10 themes in the staff survey		10% Improvement
% Patients in Emergency Dept >12hrs (total time)	3.6%	<1%
Deliver 62 Day combined standard	69.2%	77%
Urgent Treatment (P2) Turnaround Time	6.7 days	<4 days
Deliver Outpatient Activity Non face-to-face		>30%

*Serious incidents (including Never Events)

Finance

We submit our financial plan as part of the Lincolnshire Healthcare System. Due to the pandemic, we have been asked to submit a finance plan for the first 6 months of the year only

Lincolnshire has submitted a balanced plan for the first half of 2021/22 as per national planning time-period requirements. Our organisational elements of this submission are as follows:

- We plan to receive c£312m of income between Lincolnshire CCGs, Other patient care and Other operating income sources.
- We plan to spend c£318m in delivering activity and services aligned to the agreed expectations of restoration
- We plan to deliver c£6m of efficiency savings within the first 6 months of the year. Areas of focus include improving the efficiency of our clinical and non-clinical services aligned to benchmarking information.
- Lincolnshire 'System' has an expected capital envelope of c£58m for 2021/22. Within this ULHT currently has agreed a capital programme of c£34m for the full financial year with a view accessing further funding as allocations are made available through national capital programmes. Schemes will cross all areas of the Trust including Estates, Medical Devices, Digital and Service Developments.

Risk

We have three very high Risks identified at a strategic level within the organisation as we moved into 2021 – 2022.
These are risks identified using available data, and are reported at Public Board Meetings

Local Impact of the global Coronavirus (COVID-19) Pandemic

The current and future impacts of the pandemic on our organisation are still the greatest risk to delivery we currently face. There are a range of mitigating actions in place such as the vaccination programme, infection prevention & control measures, but we must acknowledge that the movement from pandemic into endemic continues to present uncertainty.

Capacity to manage emergency demand

As we nationally move from pandemic into endemic, patient numbers in emergency care continue to climb, and in some cases exceed pre-pandemic levels. Our plans for improving access in Urgent & Emergency Care rely heavily on partnership working within the Lincolnshire System, and are detailed in the IIP.

Workforce engagement, morale and productivity

Our National Staff Survey results reflect the risk level we have for engagement and morale in the organisation, and this will directly productivity. Actively mitigating this risk is a focus in National Planning Guidance, and in our Integrated Improvement Plan Year 2, but it is important to acknowledge the scale of risk, and its potential to impact negatively on how effectively we can implement the IIP.

Thankyou

If you would like further information, please visit ulh.nhs.uk

The National Planning Guidance for the NHS is available here

You may also be interested in reading our Integrated Improvement Plan in full here

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Public Trust Board*
Date of Meeting	*1st June 2021*
Item Number	*Item 10.1*
Title	*Restoration of Services to Grantham Final Phase and Progress*
Accountable Director	*Simon Evans – Chief Operating Officer*
Presented by	*Simon Evans – Chief Operating Officer*
Author	*Angus Maitland – Deputy Chief Operating Officer*
Report previously considered at	*N/A*

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

Risk Assessment	*4558 – Local Impact of the Global Coronavirus (Covid-19) Pandemic*
Financial Impact Assessment	*Financial Impacts have been analysed through the submission of system restoration processes and are captured in future financial forecasting.*
Quality Impact Assessment	*Completed and updated please see Appendix A*
Equality Impact Assessment	*Equality Impact Assessment Previously Completed requires no further changes as a result of action described in this paper.*
Assurance Level Assessment	*Significant*
Decision Required	*Trust Board is asked to note the progress made to date in delivering restoration. Furthermore the board is asked to support the reintroduction of the emergency pathway commencing on 30th June 2021 and continued provision of other elective services with the assurances described herein.*

Executive Summary

On 16th March 2021 the Trust Board agreed with recommendations to restore in full the June 2020 operating model to Grantham and District Hospital.

Having completed the first three phases of restoration of services to Grantham and District Hospital and other Trust sites in line with the recommendations, nearly all outpatient services, including therapies, diagnostics and sexual health services, have been successfully restored to the relevant site.

During the phases of restoration, significant enhancements of the physical site and services have been made compared to June 2020. This sets the Grantham hospital site up strongly as a core part of NHS services in Lincolnshire now and for the future.

Trust Board members are asked to endorse their decision of March 16th 2021 to restore the emergency pathway and medical beds to Grantham with a commencement date of 30th June. If approved, this decision will not only honour the decision made on 16th March 2021 but also the commitment made on June 11th 2020 that changes made during the height of Covid-19 were temporary in nature.

Assurances described within this report indicate that this can now be safely delivered, both in terms of Public Health and staffing considerations. As with any complex operational implementation, final decisions on exact timing will be taken by executive directors subject to assurances on safety and certainty of delivery prior to formal reopening.

In addition to restoration of the full emergency pathway at Grantham and District Hospital, Trust Board members are asked to note that the site will move to adopt the same infection, prevention and control principles as the other Trust sites. This will enable the reopening of the remaining services in the Emerald Suite, including on-site breast screening and clinics, as well as a gradual resumption of hydrotherapy services and the return of the remaining administration staff to site.

The decision to establish a Grantham Green Site in 2020 to ensure patient safety and services through the worst pandemic in living memory has been highly successful, as evidenced by the outstanding outcomes, particularly the fact that there was not a single post-operative case of Covid-19 in patients. With the substantial easing of the pandemic, it is now time to confirm the full redeployment of the site and its services to support our patients and population.

Trust Board Assurance

In approving the staged restoration of services in the Trust, Trust Board members asked for further assurance before committing to the restoration of the emergency medical pathway at Grantham hospital. This was to reflect a further review of the clinical evidence, together with an update on safe staffing for the wards and emergency pathway. In addition to this, the Trust has looked to deliver additional capital enhancements to vacated areas, which are being factored into the timing of some moves.

Public Health evidence

We have received an updated review of clinical evidence from colleagues in Public Health, Lincolnshire. They reviewed the most recent publicly-available evidence on the effect of vaccination on the pandemic and also looked at recent modelling data to show the likely future progression of the pandemic this summer.

At the time of the March 16th 2021 Trust Board meeting, the evidence on the efficacy of the vaccine for large scale populations was still at an early stage.

By early May 2021 there is now a large (and still growing) body of evidence supporting the efficacy of the vaccines deployed, both in terms of 1st and 2nd dose.

This efficacy is proven in terms of sharp reductions in transmission, hospitalisation and death. As at 20th May 2021:

- Over 70% of all adults (and over 90% of all those in the first 9 cohorts) in Lincolnshire have had a 1st dose vaccination
- Over 40% of all adults (and over 60% of all those in the first 9 cohorts) in Lincolnshire have had a 2nd dose vaccination.

The Lincolnshire system is well on track to meet the national target for all adults to have been offered a 1st dose vaccine by the end of July 2021, and has recently accelerated the programme of 2nd dose vaccinations in those in the first 9 cohorts.

The level of confidence in almost universal adult coverage of the adult population in Lincolnshire is important, because a key element in the decision of the Trust to create the original Grantham Green Site was to minimise the risk of transmission to those undergoing elective treatment, whether endoscopy, surgery or chemotherapy, because of their particular vulnerability.

By 30th June 2021 virtually all adults undergoing surgery at Grantham will have had the opportunity to receive at least one dose of a vaccine and all of the more vulnerable cohorts, meaning those over the age of 50 and any adult classified as clinically extremely vulnerable, will have had the opportunity to receive both doses.

While this does not completely eradicate the risk of receiving, or suffering from, Covid-19, the risks will have been greatly reduced, and all higher risk patients will have had

the opportunity to exercise a choice as to whether they receive a vaccination prior to admission for a procedure.

Since the easing of restrictions was announced on 22nd February 2021, the modelling has suggested that there is likely to be a 3rd wave in the pandemic around August. The scenarios for this show a large degree of variation, but with a peak below that of the 2nd wave, not least due to the extent of antibodies which have built up in the population. The national, and NHS, alert levels for the Covid-19 pandemic are both now at level 3.

Variants to the virus remain a significant cause for concern, partly due to the pace of transmission some variants cause but also because the efficacy of the vaccine initially is uncertain until there is further evidence.

The Public Health review of evidence highlights the need for continued high standards of infection prevention and control measures to be observed by all of the population to reduce the risk of transmission.

Infection Prevention and Control advice

Following the Trust Board's approval of recommendations to restore previously-run services to Grantham and District Hospital, the Trust has successfully managed a controlled, staged, return of services since the beginning of April, not just to Grantham but, as in the case of chemotherapy, to our other main sites.

As part of a measured approach, given the absence of strong clinical evidence available and the limited roll out of the vaccine programme at the time, the Trust has kept a segregated area in the centre of the hospital for patients at particular risk, such as patients attending for an elective procedure, endoscopy or chemotherapy. This has been well observed by staff, patients and the public.

In addition, all front line staff continue to take twice weekly lateral flow tests and have had daily temperature checks on site. Patients being treated in the low risk elective area are all swabbed and tested in advance of their attendance.

A Trust wide approach to management of low, medium and high risk areas has been rolled out, supported by clear signage and instructions on the precautions required.

Social distancing, commitment to 'hands, face, space and ventilation', as well as minimising the number of people in clinical and operational areas, have all helped reduce risk of transmission.

The number of patients in hospital in the Trust with Covid-19 varies on a daily basis but is (mid-May) fewer than 10, compared to more than 70 in March and a peak of over 250 in January 2021. There have been no known cases of Covid-19 infection for elective patients at Grantham and District Hospital.

The Trust is now in a position to recommend that the measures in place at other Trust sites can be replicated at Grantham with effect from 21st June. This will align to the national easing of lockdown measures and will mean that preparations can be made for the restoration of all remaining services. At this point, the formal segregation of low and medium risk areas, such as corridor restrictions and use of the restaurant, will stop.

All staff, patients and public will be required to continue to maintain the enhanced infection prevention and control measures appropriate for a pandemic. Good practice, such as the limited access to certain clinical areas, will be maintained as advised by the IPC team in conjunction with specific services.

Restoration of the emergency and inpatient pathway and assurance on safe staffing

Plans are well advanced for a safe restoration of the emergency pathway to the operating model which existed in June 2020 prior to the changes to the Grantham site.

The opportunity has been taken not just to restore the services, including numbers of beds, but to enhance the model, and make it more robust in relation to the pandemic.

This has meant appropriate segregation of elective and emergency pathways as well as enhancement of ward and other areas to incorporate improved levels of infection prevention and control. This will enable us to support the reduction of elective surgery waiting lists while retaining a full emergency pathway.

The main elements are:

- Accident and Emergency department 8am to 6.30pm with integrated support from the community in-reach and psychiatry teams.
- Out of Hours service, with walk in service to 10pm.
- Acute Assessment Centre [AAC]
- Emergency Admission Unit [EAU], incorporating up to 4 level 1 beds for Medical patients
- Two further Medical wards, in addition to the EAU, with the second ward reintroduced at the end June in line with the emergency pathway, and the third ward reintroduced on completion of enhancements to the ward and in time for the growth in emergency pressures in the autumn.
- Integrated surgical unit (Wards 1 and 2) incorporating day case and up to 4 level 1 beds.

Patients presenting with, or developing, symptoms of Covid-19 will not be admitted to, or managed at, Grantham and District Hospital. This is because the facilities, and support infrastructure such as rapid access to intensive care in case of deterioration, are not all available on site. Patients with Covid-19 symptoms will be admitted to either Lincoln County Hospital or Pilgrim Hospital Boston.

The decision to implement a dedicated rehabilitation ward at Grantham will not be followed through at this time. Priority has been given to restoration of the emergency pathway, with all inpatient wards being required for this purpose.

Ward Staffing

A thorough review of all of the Grantham ward establishments has taken place, to ensure that staffing is matched to patient acuity and demand. All staff have been offered a 1:1 discussion to check their intentions as part of the return of a full service. We are now matching staff to the relevant roles, and recruiting as required.

Following a long period of service suspension, a significant number of nursing vacancies developed at Grantham, partly due to turnover but also due to other opportunities which arose over that period within the Trust. A Trust-wide task group led by the Deputy Director of Nursing is working to fill these vacancies within surgical and medical wards.

The surgical service is already functioning well and vacancies can be filled gradually to match the steady increase in volumes of surgery.

The medical service requires the greater level of focus and there will be a need for short term measures to support the initial service as we build a fully substantive workforce.

The Trust has been successful in implementing a large-scale recruitment process for the Trust as a whole and this learning is being drawn upon to support the filling of these posts.

As part of the overall approach, recruitment will also be initiated for the third medical ward, which will open once enhancement works have been undertaken, in time for the expected growth in emergency pressures in the autumn.

This position is developing by the day and further updates can be provided as required at the Trust Board meeting.

Medical Staffing

Substantive consultants who were in post before the pandemic will return to their original posts in line with their job plans. A small number have left the Trust or will not return, and these will be replaced initially by locum consultants until substantive recruitment is in place.

Middle grade and other junior medical staff in post, who are either still on the Grantham site or working elsewhere, will return to Grantham.

Draft rotas indicate a small number of gaps across the sub-consultant level teams, which will be covered with temporary and agency staff.

The Deanery has been approached to ask for indications as to the level of staffing which will be provided in the next group of staff from the August rotation onwards. Confirmation of this is awaited.

Medical specialities to cover A&E, AAC, EAU and the wards will include Urgent and Emergency Medicine, Care of the Elderly, Respiratory Medicine and Gastroenterology.

Capital and estates works and enhancements

The Trust has completed several enhancements to the site already and has decided to commit to additional enhancements while there is the opportunity of vacant space. There have also been some substantial investments relating to improvements in services and capacity on site during the last 12 months.

- Installation of new MRI and CT with improved patient facilities
- Installation of two temporary theatres
- Substantial improvements to core infrastructure such as radiator covers, fire doors and some replacement water services have been made
- Enhancements to the Emergency Admissions Unit
- Redecoration and upgrade of the women's outpatient and ante-natal area
- Redecoration of the general outpatient area
- Part of the Kingfisher Unit (children's outpatients) is being upgraded
- The Imaging department general patient areas have been redecorated
- The main administration centre (formerly Ward 7) is being refloored and redecorated prior to the return of staff from the South Kesteven District Council offices. Plans to upgrade the top floor of the tower block into additional offices have therefore been discontinued for the time being, as there is currently sufficient administration space.
- Ward 6 is receiving a significant enhancement to meet updated Health and Safety and IPC compliance as well as improving the environment.
- Plans are being worked through to undertake a similar enhancement exercise for the Day Case Unit to make it appropriate for permanent use as an inpatient ward.

Due to some challenge with specific lead times, while the date for restoration of the emergency pathway will remain unchanged at 30th June 2021, Ward 6 enhancements will not be completed for a further month. The Day Case Unit will therefore be adapted for short-term inpatient use by 30th June to ensure availability of the second acute ward. Funding for enhancement of the day case unit (3rd medical ward) is still subject to formal approval in the context of the overall ward improvement budget for the Trust.

Considerations are ongoing about the medium-term future use of the Gonerby Road facility, which very successfully supported the delivery of outpatient, therapy and diagnostic services during the pandemic. At present the site is still being well used as a site for diabetic retinopathy and aortic aneurysm screening.

All other leased and rented sites will no longer be required from 1st July 2021.

This paper is an opportunity for the Trust to formally acknowledge its thanks to all of the partners in Grantham who made available their facilities at short notice in 2020. They have been very welcoming to our staff and patients and have supported the continued provision of services throughout the pandemic.

Patient and public engagement

An extensive patient experience gathering exercise was carried out around the creation and ongoing monitoring of the Grantham Green Site model, between December 2020 and March 2021. In total, more than 1,300 local people shared their experiences as patients using hospital services provided to the people of Grantham and surrounding areas over the previous year.

The exercise is part of the system's ongoing patient and public involvement work that informs the development of services offered to the local population, and was made up of a patient survey and one-to-one patient interviews.

The themes and key messages that emerged from analysis of the interviews and survey responses are reported in the full report, which can be accessed on our website at:https://www.ulh.nhs.uk/about/have-your-say/sharing-your-views/public-engagement-outcomes/

Themes:

Travel, choice and location - Getting to any hospital is a concern for many. Patients highlighted concerns (additional distance, length of time taken, additional cost) when attending a hospital other than Grantham. Patients from across the area described similar concerns (cost, poor public transport, reliance on others) in accessing Grantham Hospital.

Satisfaction - Overall, patients expressed high levels of satisfaction with services at Grantham Hospital and Gonerby Road, saying there was nothing to improve, they were treated well, or they had a positive experience with the staff. Only a small number indicated dissatisfaction of any kind. Patients in general felt that communication with patients was generally good.

Impact of green site protocols- Patients said attending Grantham resulted in a less stressful visit, less anxiety, being given peace of mind, or had a positive impact on their general wellbeing. A small number of people found the changes stressful or concerning.

Patients said the COVID-19 measures, testing, self-isolating, social distancing and green site status meant they felt safe when attending Grantham Hospital (including A&E/urgent care) and Gonerby Road.

Concerns over traveling for urgent care were expressed throughout the survey. Patients also said they had to attend their appointments remotely. Some survey responses reported poor experiences of remote appointments with others suggesting

they are inappropriate, and some patients encountered technical problems, preventing them from attending.

Patients also took the opportunity to praise staff.

The full engagement findings have been shared with the service managers and clinical leads within the Trust for further consideration, to ensure that any key issues identified can be reviewed and action taken.

The results have also been shared with the patient experience team, for further analysis, trend-identification and action where required.

We continue with ongoing patient experience gathering around all of our services as they return to the Grantham site, including FFT, Patient Opinion and surveys and will continue to feed these findings into further service development.

Communications activities continue around the Green site changes and restoration of services to the Grantham site, for staff, stakeholder and public audiences, to ensure clarity on the location of services and when any changes are made.

A Quality Impact Assessment [QIA] and Equality Impact Assessment [EIA] were submitted with the Trust Board papers in March 2021. There is no change to the EIA as it covered all restored services. An updated QIA has however been submitted in relation to the information and actions for this paper.

Staff engagement

There has been a high level of staff engagement and support for staff at the different Grantham sites throughout the planning and implementation of the restoration of services.

There have been:

- Trust and site-wide communications through Executive Director live sessions on Teams.
- Regular newsletters specifically in relation to Grantham service restoration as well as updates as part of general Trust communications
- Face to face and Teams meetings with individual staff and teams to plan their own service and be involved in the timing and nature of return
- Full engagement of every department in the implementation of enhanced infection prevention and control measures required as a condition of the return of services to site
- Staff welfare and wellbeing support provided face to face and remotely, as required

- Full engagement of staff side members in all core aspects of the restoration. Staff side members have also been instrumental in ensuring feedback and advice is received relating to plans, actions and communications
- Weekly team leader brief and question and answer sessions
- Specific meetings for all SKDC teams to update on progress and plan for return
- The significant enhancements to the site have been planned together with relevant department teams and leads

Summary and recommendations

Trust Board members have already approved the restoration of the June 2020 operating model to Grantham and District Hospital at their meeting on 16th March 2021.

Since March 16th, the number of patients with Covid-19 has reduced considerably both in hospital and in the community and the national pandemic alert has reduced to Level 3. This still means that the epidemic is in general circulation.

Trust Board members are asked to note the progress made to date in delivering restoration, and are asked to note and support the following elements of assurance to reintroduce the emergency pathway and to support the elective pathway:

1. The Public Health review of clinical evidence points to a high level of efficacy in the Covid-19 vaccines, and widespread uptake. By the end of July 2021 all adults attending for a procedure will have been offered the opportunity of a vaccine. Even if, as expected, there is a spike in transmission in the summer, this is very likely to be much lower than the 2nd wave and to have a much lower impact on hospitalisation.
2. The Trust, as well as the wider NHS and society, has learned a great deal about the transmission of Covid-19 and the efficacy of infection prevention and control measures. The prevention measures, such as lateral flow tests for staff and swabbing of at risk patients, will continue, as will the core measures in place across all of the Trust. The separate elective and emergency pathways will be maintained, but there will no longer be a formal segregation of low and medium risk parts of the site.
3. Ward staffing will be up to a level to safely maintain elective pathways and to restore the first two medical wards on 30th June, with further work being undertaken to recruit to the third ward in line with the planned ward enhancements.
4. Medical staffing will be up to a level to safely staff the emergency pathway on 30th June.
5. The enhancement of Ward 6 will support the reintroduction of the June 2020 operating model, which will be reintroduced on 30th June 2021. The third medical ward will be reintroduced in time for anticipated winter pressures.

The Trust, staff, patients and public of Grantham and Lincolnshire can look forward with confidence to a strong future for the Grantham and District Hospital site and services.

Appendix A Updated Quality Impact Assessment

Quality Impact Assessment										
	Yes/No (If Yes complete the following)	Risk Description	Initial Assessment				Post Mitigation			
			Impact	Likelihood	Consequence	Rating	Mitigations	Likelihood	Consequence	Rating
Impact on Duty of Quality (CQC/ Constitutional Standards)?	Yes/ Positive	Move back to Grantham will increase capacity of clinics diagnostics and other services. CQC Registrations may also require updating as services restore and change locations.	Waiting times including constiutitional standards (cancer 18 and 52 week waits) positively impacted.	1	1	1	Additional capacity will be maintained at Gonerby Road to add flexibility around capacity if required, especially for screening services.	0	0	0
Impact on Patient Safety?	Yes - positive impact	N/A Positive impact	This will reduce pressure on inpatient beds at Lincoln or Pilgrim Hospitals, and on the beds of out of county providers.	0	0	0		0	0	0
Impact on Clinical Outcomes?	Yes - positive impact	The number of patients receiving elective surgery will not decrease, but outpatient services and diagnostic services will increase numbers also.	Cancer patients and those deemed clinically urgent will be able to receive the diagnosis / treatment they require which would impact positively on their outcomes & morbidity and mortality rates	0	0	0	N/A	0	0	0
Impact on Clinical Outcomes?	Yes - potential for adverse impact	Potential for closure of elective services if an outbreak or peri-operative Covid-19 patient occurs. Resulting in much larger reduction in operating capacity	Much larger reduction in elective services if an outbreak occurs or patients contract Covid-19 on elective pathways.	3	5	15	Maintenance of strict adherence to IPC guidance will positively mitigate this risk, including swabbing of patients and lateral flow tests for staff.	2	4	8
Impact on Patient Experience?	Yes - positive im	Patients previously unwilling to travel and/or travelling for services who had a poorer experience now have services closer to home	Introduction of greater range of local services so patients may now choose to attend hospital, and those already travelling will have a reduced travel burden.	0	0	0		0	0	0
Impact on Patient Experience?	Yes - Negative	Patients' confidence in services being both low and medium risk on a site may reduce. Previously high confidence for patients that appreciated a 'Green site'	Patients may choose not to attend hospital if confidence reduces	2	4	8	Public messaging, signage in hospitals and maintenance of IPC excellence will help reduce risk	1	4	4
Impact on Staff Experience?	Yes	Return of impatient medical wards may require additional recruitment and establishment of new teams and acquisition of skills.	Insufficient staffing and or unhappy staff because of movements again.	1	4	4	Staff engagement activities and drop in sessions, together with risk assessments where concerned about mixture of services. Continued IPC Excellence and use of PPE	1	3	3

Meeting	*ULHT Private Trust Board*
Date of Meeting	*1st June 2021*
Item Number	*Item 10.2*
Strategic Objective 4c - To become a University Teaching Hospitals Trust	
Accountable Director	*Mark Brassington, Deputy CEO and Director for Improvement & Integration*
Presented by	*Mark Brassington*
Author(s)	*Georgina Grace, Strategy Manager*
Report previously considered at	*NA*

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

Risk Assessment	*Initial risk review outlined in document. Full risk review required.*
Financial Impact Assessment	*Not completed at this stage – may be required if investment required through Steering Group reviews.*
Quality Impact Assessment	*NA at this stage*
Equality Impact Assessment	*NA at this stage*
Assurance Level Assessment	• *Limited*

Recommendations/ Decision Required	• *Trust Board to support the ambition for a 1st April 2022 go live*
Executive Summary	

A key priority for the Trust is to achieve Teaching & University Hospital status which is linked to the strategic objectives as outlined in the Integrated Improvement Plan.

Achieving Teaching & University Hospital status is the first step in a long-term programme that will enhance our research partnerships to drive innovation and develop new treatments more quickly, as well as investing in academic partnerships to strengthen our workforce in the future.

This paper presents an overview of what it means to be a Teaching University Hospital and the benefits that it will bring, and actions that have been taken to date to develop our understanding of the process, and the next steps required to realise this vision for the future.

As the Trust transitions into a Teaching University Hospital, work will need to focus on delivering the requirements of University Hospital Association (UHA) membership, using this to lever and enable demonstrably high quality care.

The principles of UHA membership align to key themes: research, education, workforce and technology. UHA membership requires the Trust to provide evidence of compliance against a set of criteria, and in order to achieve this a Teaching & University Hospital Steering Group has been formed.

The Trust will need to work closely with the University of Lincoln to develop joint clinical and academic roles which will help to support the development of international research leadership and embed research and academia into teaching and clinical practices to improve the health of our local population. This will also require the Board to have a Non-Executive Director from the Universities Leadership Team and for our CEO to be a governor of the University.

By working in partnership with key stakeholders we are confident that we can continue to drive improvement and ensure that our patients receive the best possible care, and shape a commitment to health, wellbeing, education, training, research and innovation opportunities in Lincolnshire.

Whilst this programme of work had commenced within the Trust prior to the pandemic, it has recently moved under the portfolio of the Improvement & Integration Directorate who will lead the programme of work moving forward.

Following a revisit of the requirements, and conversations with other Trusts who have recently achieved Teaching & University Hospital status, the project has an aim to drive this piece work forward to submit an application pack to the University Hospitals Association to support becoming a Teaching University Hospital status by 1st April 2022.

Being awarded Teaching & University Hospital status will provide the Trust an opportunity to further develop the reputation of United Lincolnshire Hospitals Trust at a local and national level.

1.0 Purpose

While the University of Lincoln and United Lincolnshire Hospitals Trust already work in partnership, we are committed to our role as a civic organisation and wish to build on this partnership in order to enhance our joint clinical and academic excellence to improve health and wellbeing of the people in Lincolnshire.

By expanding the provisions of joint healthcare education, training and research we will create new opportunities for our staff, patients and students, help address the workforce challenges faced by the healthcare system, and enhance the reputation of the University and United Lincolnshire Hospitals Trust.

Once successful in our application to become a Teaching University Hospital, and by working together with the University of Lincoln, we will able to translate the knowledge from our research into improved outcomes of patients. We will embed this knowledge in key teaching and clinical practice for the benefit of our students, patients and clinicians. By working together, we will innovate to create better healthcare products and solutions, as well as a better environment.

United Lincolnshire Hospitals Trust has a real opportunity to meet its vision of becoming a University Teaching Hospital and creating a sustainable healthcare provision in the future.

2.0 What does the process involve?

The University Hospitals Association (UHA) is a unified voice of university hospitals who bring together experts and organisations to create a national forum that allows members to share best practice.

They translate the research, education, experiences and concerns of their members into a powerful collective force for change. They inform both government policy and the wider world to deliver better patient outcomes and ultimately improve the health of the UK.

The UHA Annex A sets out the circumstances under which it is appropriate for an NHS provider to consider including the word “university” in its name and how NHS Trusts can apply to be identified as having a “significant teaching commitment”.

The Trust will need to collate evidence against each of the six areas outlined in Annex A in order to complete a full application submission. The criteria are as detailed in Appendix 1 of this paper.

3.0 Risks

1. **That the UHA do not award Teaching & University Hospital status to the Trust.**

   Likelihood: Medium
   As the application is being made in line with the criteria set by the UHA in Annex A it is not expected that an application will be unsuccessful providing that all criteria are able to be evidenced prior to the application submission. However, it must be acknowledged within this risk that there is the potential for this to occur in view of the pace at which the Trust will need to act in order to achieve this ambition.

   Impact: High
   In the event that the UHA do not award Teaching & University status this would have a high impact on the Trust's ambition to achieve its strategic objective of becoming a teaching hospital in the short term.

   Mitigation: The supporting evidence will be regularly reviewed by the Teaching & University Hospital Steering Group to ensure that evidence is robust and meets the criteria within the UHA Annex A.

2. **That the Trust do not meet the 1st April 2022 go live target date.**

   Likelihood: Medium
   Being able to achieve this is dependent upon the Trust's ability to evidence all criterion with Annex A of the UHA document.

   Impact: Medium
   If the go live date is not met by 1st April 2022 this will not prevent the Trust from achieving Teaching & University Hospital status in the future. However, all key stakeholders will have been involved in the project stating 1st April 2022, so this has the potential to impact on the reputation of ULHT if the target is not met.

   Mitigation: Robust management of the programme of work through project management overseen by the Trust Deputy Chief Executive. The Steering Group will review items for escalation where appropriate.

3. **That there may be financial investment required to meet some aspects of the UHA Annex A criteria.** *For example, in order to ensure there are enough University principle investigators with honorary contracts at ULHT.*

   Likelihood: Medium
   If there are not enough clinical/academic researchers already within the Trust, there may be a requirement to recruit more in order to meet Part 1.c.i of Annex A of the UHA Teaching & University Hospital criteria which is to have a "minimum of ten University staff with honorary contracts".

   Impact: Medium

It is anticipated that the Trust will already have in place a number of these posts through current contractual agreements, with a range of formality, in place with the University of Lincoln. However, a full scoping exercise needs to take place in order to clarify this.

Mitigation: Through the Steering Group a review of the current contract agreements in place will be undertaken and a gap analysis completed where relevant to identify potential investment required.

4. **That the Trust may not meet Part 1.c.iii requirements with regards to Research Capability Funding (RCF).** *Annex A states that the Trust shall evidence significant research activity including; an average Research Capability Funding (RCF) of at least £100k average p.a over the previous two years.*

   Likelihood: High
   Currently the Trust are not able to evidence this level of RCF activity over the previous two years.

   Impact: Medium
   This is a focus area for the UHA and robust evidence will need to be submitted which demonstrates the Trust's ability to deliver against this criterion. If this is not able to be evidenced, there is the possibility that the UHA will not award Teaching & University Hospital status.

   Mitigation: The Steering Group will review the requirements and obtain advice and guidance from key stakeholders who are able to advise in detail. This will include the DHSC point of contact who has specific knowledge within this area, and who has indicated that not being able to evidence a full historical £100k RCF should not prevent a Trust from being able to achieve Teaching & University Hospital status.

4.0 Progress to Date

As part of the project scoping for this work, initial contact has been made with colleagues from other Trusts and supporting organisations with experience of the process. Actions undertaken to date are: -

a. Discussion with Portsmouth Trust who have recently been awarded Teaching & University Hospital status following a successful application to the UHA.

   Portsmouth have shared document templates which United Lincolnshire Hospitals Trust are permitted to use in support of their application.

b. Initial conversation with NHSE/I representatives about the Trust's ambition to apply for Teaching & University Hospital status.

NHSE/I have provided a Memorandum of Understanding (MOU) template which the Trust are able to use to support their application.

c. Introductory conversation with DHSC point of contact. There is full support from DHSC for the Trust to embark on a journey to Teaching & University Hospital status.

d. Support gained from Health Education England via Postgraduate Dean (East Midlands)

e. Identified key stakeholders and drafted initial letter of intent to share with them.

f. Introductory email sent to the UHA to open communication links.

g. Re-launched the Steering Group meetings with an initial introduction to the new SRO and project structure on 7th May 2021 with actions to commence the next steps allocated.

5.0 Next Steps

It is essential to initiate a discussion with the wider university with regard to our potential relationship. This will be broader than the Medical School also involving School of Health and Social Care and / or School of Pharmacy. This discussion is due to take place on 26th May. The output of these and future discussions will be a formal agreement as to how we will work together.

To collate a portfolio of evidence as per Annex A of the UHA Teaching & University Hospital status document. This will be achieved by comprehensively reviewing each criterion at the Teaching & University Hospital Steering Group, with progress monitored by the Chair. There will be a focus initially on the research section of Annex A where the majority of the collaborative work with the University is required.

External stakeholders will be approached including people such as NHSE/I, HEE, MPs, University, CQC and key local authority and health colleagues to seek formal support for our application.

Steering Group dates will be arranged for the coming twelve months and will take place on a fortnightly basis. Key internal stakeholders will be invited to the Steering Group meetings with representation, if and when required, from external partners in order to robustly develop a successful application for submission on behalf United Lincolnshire Hospitals Trust to the UHA.

The UHA will advise of the planned application submission dates once they are confirmed for the remainder of 2021 and an appropriate submission date identified by the Steering Group.

Project documentation will be completed accordingly and will include a project timeline (Gantt Chart) which can be used to monitor and review progress against plan. It is intended that the evidence collation will take place between May to December 2021, with mobilisation between January to March 2022. The DHSC have requested 8 weeks

to complete the required process with ministers to amend our establishment order. Therefore all documentation will be required by the end of the calendar year.

There will need to be consideration during the mobilisation phase with regard to the new name of the Trust, branding, digital implication and marketing. There will be a financial cost associated with renaming the organisation.

6.0 Conclusion/Recommendations

It is recognised that identifying an NHS provider as having teaching and/or university status denotes it as an important national teaching and research resource and helps its ability to recruit and retain the best staff.

Therefore, it is recommended that Trust Board supports the ambition to apply for Teaching & University Hospitals Trust status with a 1st April 2022 target date whilst acknowledging the associated risks.

University Hospital Association

Teaching & University Hospital Status

The voice for better healthcare

A powerful collective force for change

About us

UHA is the unified voice of university hospitals. We're bringing both experts and organisations together, to create a national forum that allows members to share best practice.

We translate the research, education, experiences and concerns of our members into a powerful collective force for change. We inform both government policy and the wider world to deliver better patient outcomes and ultimately improve the health of the UK.

University hospitals

It is recognised that identifying an NHS provider as having teaching and/or university status denotes it as an important national teaching and research resource and helps its ability to recruit and retain the best staff.

This document sets out the circumstances under which it would be appropriate for an NHS provider to consider including the word "university" in its name and how to do so. It also sets out how NHS trusts can apply to be identified as having a "significant teaching commitment".

Identifying as a university hospital trust

UHA represents university hospital trusts' unique interests in partnership with other national bodies.

NHS Trusts

Legislation requires that the Secretary of State for Health approve any amendments to an NHS trust's Establishment Order, including a change to the name to include the word "university". In reaching this decision, he or she will first seek advice from Department of Health officials, who require that any application to change the name of an NHS trust has the prior explicit, written support of NHS Improvement, the NHS trust in question and the local medical and/or dental school.

In addition, it has been agreed between the Department of Health and the University Hospital Association (UHA) that any NHS trust seeking to include the word "university" in its title will be required to have applied for UHA membership and for UHA to have agreed that the terms of its membership have been met. The most current membership criteria (developed in conjunction with the Medical Schools Council and agreed with the Department of Health) are at Annex A.

UHA is the key leadership body across the UK promoting the tripartite interests of university hospitals: service, teaching and research. It represents university hospital trusts' unique interests in partnership with other national bodies.

NHS Foundation Trusts

NHS foundation trusts are not required to seek external approval of any proposed name changes. To effect a name change, a foundation trust needs to make an amendment to its constitution, for which the foundation trust would require the approval of more than half of the members o f both the foundation trust's council of governors and its board of directors voting in favour of the change (section 37(1) of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012). Foundation trusts are required to adhere to NHS England's NHS identity guidelines and should discuss any proposed name change with NHS Improvement.

When consideration is being given to including the word "university" in its name, given the commitments and responsibilities this entails, it is recommended that foundation trusts apply the same standards that are applied to NHS trusts. This means that a foundation trust should only consider including the word "university" in its title if it has applied for and meets the criteria for membership of UHA as set out in Annex A.

Having a significant teaching commitment

NHS Trusts

The National Health Service Act 2006 states that the first NHS trust order made in relation to an NHS trust must specify that "where the NHS trust has a significant teaching commitment, a provision to secure the inclusion in the non-executive directors….a person from a university with a medical or dental school specified in the order". If an NHS trust supports medical or dental training or research, it can apply to the Department of Health for an amendment to its Establishment Order to recognise this status.

There is no definition of what constitutes a "significant teaching commitment" and an NHS trust seeking such designation is not required to meet the full requirements of UHA membership to be considered to have a "significant teaching commitment". However, in developing its advice to ministers on whether the designation should be granted, Department of Health officials look to written support from the associated medical and/or dental school confirming that the trust meets the key principles contained in Annex A.

If an NHS trust's Establishment Order is duly amended, it will be required to include among its non-executive directors one from the associated medical and / or dental school.

If an NHS trust has a significant teaching commitment in other clinical professions, the parties involved may wish to enter into a similar arrangement to foster partnership working at board level. It will not be possible, however, for this to be formally designated in the trust's Establishment Order.

NHS Foundation Trusts

At least one member of the hospitals council of governors must be appointed by the university.

There is no equivalent legal provision for a foundation trust to be designated as having a "significant teaching commitment" specifically. If any of a foundation trust's hospitals includes a medical or dental school provided by a university, however, at least one member of the council of governors must be appointed by that university. The foundation trust may choose a representative of that university or any other institution with which it works in partnership as a non-executive director (NHS Act 2006).

Department of Health, NHS Improvement, University Hospital Association (formerly Association of UK University Hospitals), Medical Schools Council September 2017

Annex A

1. **In terms of research:**
   a. The Trust shall have in place with the University a Memorandum of Understanding on Joint Working for Effective Research Governance;
   b. The Trust shall demonstrate that it is working collaboratively with the Faculty to develop an agreed joint research strategy;
   c. There shall be evidence of significant research activity within the Trust, much of which will involve collaboration with University staff. This will include:
      i. A core number of University principle investigators (minimum of ten University staff with honorary contracts) to be based on site;
      ii. The research output to be REF returnable;
      iii. For Trusts in England, an average Research Capability Funding of at least £100k average p.a. over the previous two years.

2. **The Faculty and University Hospital shall maintain strategic links and a close working relationship, which shall include:**
   1. University representation on the Trust's Local Awards Committee for considering nominations for Clinical Excellence Awards;
   2. University representation on the Trust's Advisory Appointments Committees for Consultant posts;
   3. Board membership of a non-Executive Director from the Faculty;
   4. The Trust's Chief Executive attending formal meetings with the Faculty Dean's Advisory Committee.

3. **The Trust shall provide for the University practice placements for undergraduate medical students and for students from at least one other healthcare profession**
   (dentistry, nursing, or one or more of the allied health professions).

4. **The Trust shall provide for undergraduate students appropriate library facilities, IT facilities with Internet access, and teaching facilities. There may be integrated provision for postgraduate and undergraduate education.**

5. **The Trust shall have a Lead Placement Contact approved by the Faculty of Medicine, to be responsible for undergraduate education, for each of the professions for which it provides placements.**

6. **The Trust must be able to demonstrate to the University that it provides high quality clinical education. This will require evidence of the following:**
   a. Flexibility:
      i. Flexibility in light of any changing needs of the Faculty in respect of undergraduate education;
   b. Appropriate human resources:
      i. Ability on part of Trust staff to deliver the curriculum and assessments determined by the Faculty;
      ii. Provision by Trust staff of appropriate student supervision as agreed with the Faculty. This may involve staff from a range of professions and grades;
      iii. The participation by core Trust teaching staff in appropriate training;
   c. A collaborative working partnership:
      i. The availability of Trust staff to provide teaching and supervision and to respond to student queries and problems in a timely manner;
      ii. Collaboration between Trust staff and University staff, for example, regarding curriculum development;
      iii. Full cooperation by Trust staff in monitoring and evaluating the quality of education provision, and in facilitating student evaluation;
      iv. The readiness of Trust staff to respond to feedback from students and the Faculty;
      v. Evidence of action by trust on Faculty quality assurance measures;
   d. Resources:
      i. Provision of appropriate support staff, equipment and accommodation for Lead Placement Contracts;
      ii. Provision for students of access to lockers and appropriate facilitates;
   e. For Trusts in England, evidence of compliance with:
      i. The Learning and Development (LDA) between the Trust and Health Education England;
      ii. The Service Level Agreement (SLA) between the Trust and the Faculty.

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Meeting	Trust Board
Date of Meeting	1st June 2021
Item Number	Item 11
Integrated Performance Report for April 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

Pressure Ulcers Category 4

There has been 1 hospital acquired Category 4 pressure ulcer reported for the month of April against a trajectory of 1.3. The incident is being investigated under the Serious Incident Framework. Actions to recover can be seen below.

Medication Incidents reported as causing harm

April has seen an increase in medication incidents with harm at 24.6% 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.

Regulation 28

The Trust received A Regulation 28 in April following a coroner's inquest in the absence of a representative from the Trust. The coroner was not assured that the action plan had been fully implemented to prevent future deaths. The Regulation 28 Report was received on 22nd April 2021 and the Medical Director responded with the completed up to date action plan on 4th May 2021.

Mortality

HSMR

HSMR for the rolling 12 months is showing at 115.45 for the Trust which is an increase from the previous month and is now showing in the 'High' banding. Due to the Covid-19 pandemic the rises in the HSMR were 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 are included.

SHMI

ULHT are in Band 2 within expected limits with a score of 110.57 an increase from the last reporting period. SHMI includes both deaths in-hospital and within 30-days of discharge and is reflective up to November 2020.

The Trust participates in all relevant National Clinical Audit

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

eDD

The Trust achieved 93.5% compliance with sending eDDs within 24 hours for April 2021. 96.8% were sent anytime during the month of April 2021.

Sepsis based on March 2021 Data

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

Screening compliance for adult inpatients has remained static at 86.4% against a trajectory of 90%. The majority of missed screens are for non- infective patients. The relaxation of ward restrictions has allowed for the sepsis practitioners to re-commence teaching in the clinical area and this should improve engagement and provide targeted support.

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

Compliance for Children's antibiotics within an hour in ED has dropped to 33% 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.

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

Compliance has slightly increased to 86.5% for this month with 12 missed or delayed screens. Harm reviews showed that 10 of these were found to have an alternate cause and were not sepsis. Datix forms were completed for 2 which showed low level harm.

Duty of Candour – March 2021 Compliance

The Trust achieved 100% compliance with the Duty of Candour in March 2021, for in person notification (verbal) and 75% compliance for written follow-up. Thus equated to 6 non-compliant written follow-ups from 24 incidents 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 March and April 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. Additionally new Emergency care standards are now being implemented, monitored and reported going forwards.

A & E and Ambulance Performance

Whilst the summary to below pertains to April data and performance, the Urgent Care Constitutional Standards are being reviewed and will be outlined in the Urgent Care FPEC paper. This will include recommendations in terms of amending the Urgent Care IPR dashboard.

4-hour performance for April was improved against March performance of 71.98% and has been provisionally reported at 74.23% against a trajectory of 83.12%. This is the sixth time in nine months the Trust's performance has been below the agreed trajectory, however, this performance was against a backdrop of a significant increase in attendances of 7.37% from March, and 15.61% above pre-covid attendances (April 2019).

Performance against the 15 min triage target demonstrated an improvement against March standing at 91.15% from 85.96%, a positive movement of 5.19%.The recording of triage improved marginally by 0.02% in April when compared with March's performance.

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

Ambulance conveyances for April were, 4481, 107 lower than in March a decrease of 2.34%. There were 207 >59minute handover delays recorded in April an improvement of 207 from March. Delays experienced at LCH are attributed to volume and conveyance pattern, however this pattern is well known and consistent and familiar to the department. All handover delays continue to be reported to the CCG by EMAS but done so in the context of the overall site position.

There were two 12hr trolley waits in April compared to March (0), both were clinically validated as true breaches and both attributed to challenges in flow. Both breaches have been deemed as avoidable.

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 continues to aid 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 April delivering 4.58 ALOS compared with 4.61 ALOS in March, but remains slightly above the Trust 4.50 day target.

Patients with a long length of stay (LLOS) reduced in April decreased by 10 from March down to 60 from 70.

An 8 week intensive discharge support programme is in place led by ECIST/NHSe/i.

Multi agency discharge meetings continue to take place twice daily. All patients on pathways 1, 2 and 3 are reviewed, with a noted increase in discharge of medically optimised patients across the entire week (7days).

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

Referral to Treatment

It is important to view and read this in the context of the current National Covid Restore Agenda, and the move away from a focus on constitutional standards to the expectation of 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. March demonstrated an increased performance by 0.9% to 53.94% and reflects the ongoing focus on cancer and clinical urgency across a limited theatre and OPD base (in March) owing to the ongoing support of the required 150-200% capacity for ITU for this period. The Trust reported 1877 incomplete 52 week breaches for March end of month, and remains regionally in a relatively strong position. Weekly PTL meeting have been 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.

The Cancer/Elective Cell met three times weekly throughout March with a weekly confirm and challenge meeting with surgical specialities led by senior clinical review and prioritisation 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 increased slightly from February 1292 to 40,660 in February. The number of incomplete pathways is now approx. 1628 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. A recovery plan for ASIs is in development and will include a recovery trajectory.

The Trust reported 3,310 over 40week waits a reduction of 844 from February. The numbers of patients waiting over 26 weeks reduced slight by 3 from February's figure, to 10,623 reflecting the work undertaken to clinically prioritise and treat the most clinically urgent patients first. The longest waiting patients continue to be tracked and discussed weekly with escalation as appropriate and reported bi-weekly to NHSE/I.

Cancelled Operations

'On the Day' Cancelled Operations achieved the national target in March, reporting 0.76% against the 0.8% target, an improvement from February's performance of 1.14%, reflecting the improving access to HDU beds throughout March , and ongoing oversight of lists via the twice weekly review meetings and weekly confirm and challenge sessions.

The 28 day target significantly improved from 12 breaches in February to 3 in March.

Diagnostics

Diagnostics access performance continues to improve with March's performance standing at 69.91% against February's reported performance of 68.94%.

Endoscopy, continues to book cancer patients within 7-10 days and is now also booking routines, with improvements in Gastroscopy reporting 18 breaches compared to 85 compared in February and 298 in January; Cystoscopy improving from 194 in January down to 114 in February and 74 in March.

CT continues to improve with 118 breaches in March compared with 146 in February and 306 in January.

Neurophysiology LCH reported 74 breaches compared to 96 in February and 456 for January , and Pilgrim reporting 121 in March compared with 177 in February

Audiology - Audiology Assessments had 0 breaches for February and March.

Cardiology continues to be challenged with echocardiography having 2641 breaches in March compared to 2051 in February, although echocardiography Stress /TOES imprevmed slightly with 55 breaches in March compared to 58 breaches in February and 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 87.96%)

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 March increased 11.7% compared with February for the 62 Day Classic Cancer Target achieving 67.2% but still below the national average (73.9%). Early indication is that April will however be circa 60%.

As of 7th May there are 216 patients in the 62 day backlog (down from a peak of 441); 47 patients over 104 days (down from 163 in mid-July). Approximately 34% of these patients require support from the Pre Diagnosis CNS. Colorectal, Head and Neck, 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. In addition the Trust has been successful in appointing two Head and Neck consultants with one commencing in post in April 21 and the other in July 21, as well as the successful appointment of two Medical Oncologists, commencing in post in July and October 21 respectively. In the meantime an agency medical oncologist will be in post from May.

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.

The temporary pausing of green pathways owing to Covid-19 related pressures in March 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 Trust did not achieve the 31 day treatment performance which deteriorated slightly and continued 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.

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.

Workforce

Vacancy Rate

The overall vacancy rate continued to decline in April. However clinical vacancies rose slightly. The table at page 30 is worthy of attention. It is taken from our monthly pipeline report. It shows the position as of April 2020, the position now and the projection through the next six months, taking account of recruitment in train and expected turnover.

It shows the progress made on recruiting nurses, both registered and unregistered in the last year and the continued impact of the international nurse recruitment programme (albeit with a slight risk to that programme owing to the situation in India). The number of medical vacancies has not declined in the last 12 months and recruitment was impacted by COVID. However there is now a strong pipeline of medical (as well as AHP) recruitment through the next six months.

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. We now have 6 staff suspended:

4 x 1 month
1 x 3 months
1 x 4 months

This is an increase on the 2 reported last month.

Finance

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

The Lincolnshire system submitted a breakeven financial plan for H1 of 2021/22; the system submission is inclusive of a breakeven position for the Trust and a requirement for the Trust to deliver efficiency savings of £6.2m in H1.

The Trust is in the process of finalising its financial plan for submission on 24th May 2021.

The Trust has delivered a £0.9m deficit for the month of April, or £6k favourable to plan.

Capital expenditure for Month 1 of the financial year equated to c£0.7m against a submitted plan of £1.4m.

The capital programme for 2021/22 currently stands at £33.7m for the full-year, with c£23m agreed at Trust Board in May to proceed and c£10m of proposals being assessed before full sign-off.

The month end cash balance is £50.5m which is a decrease of £3.5m against cash at 31 March 2021.

Paul Matthew
Director of Finance & Digital
May 2021

EXECUTIVE SCORECARD

Strategic Goal	Domain	Measure ID	Measure	Baseline	21/22 Ambition	2020/2021 Feb	2020/2021 Mar	2021/2022 Apr
Strategic Metrics	Patients	1	Top 25% for acute Trusts for 'Overall' Inpatient experience	4th quartile	3rd quartile	91.29%	91.16%	
	Patients	2	*Achieve zero avoidable harm*	15	9	15	13	8
	Patients	3	Top 25% for SHMI	4th quartile	4th quartile	Q4 (109.45)	Q4 (109.90)	Q4 (110.57)
	People	4	Top 25% for acute Trusts across all 10 themes in the staff survey		+10%			
	Partners	26	*Deliver 62 day combined cancer standard (77%)*	69.20%	77%	57.30%	67.20%	
	Partners	27	*Total wait in Emergency Department over 12 hours (<1% of patients)*	3.60%	<1%	7.82%	6.15%	4.55%
	Partners	28	*Urgent Treatment (P2) treatment turnaround time is less than 4 weeks*	6.7	<4 w eeks			
	Partners	29	*Deliver Outpatient activity through non-face to face*		25%	41.74%	39.07%	36.67%
	Services	9	Deliver a breakeven revenue position		Breakeven			
	Services	10	Deliver £200m capital plan	£15m	£39m			
Priority Objectives	Patients	11	No. of medication errors causing harm is <10%	20%	13%	17.20%	15.54%	24.64%
	Patients	12	*Reduce no. of patient fall incidents*	200	159 (-20.5%)	145	124	118
	People	13	*% of staff saying proud to work for ULHT*		+10%			
	Partners	14	*First non elective admission by 10am*	48%	60%	59.76%	58.96%	
	Services	15	Reduce agency spend by 25%	£44m	£33m (-25%)			
Watch Metrics	Patients	16	Reduce complaints around discharge by 50%	n/a				
	Patients	17	Reduce complaints about the experience in A&E by 50%	n/a				
	Patients	18	*Time to screening and treatment for sepsis (1 hour)*	37.5% (3/8)	62.5% (5/8)	25.00%	62.50%	62.50%
	Patients	19	*Reduce incidence of pressure ulcers*	58	45	46	42	33
	People	20	% of staff that feel trusted and valued					
	People	21	No. of managers trained in coaching skills					
	Partners	22	*Increase the proportion of patients seen by a decision maker within one hour*	50%		62.57%	55.47%	
	Partners	23	Reduction in the new to follow up ratio	1:2.28		1:1.48	1:1.53	1:1.45
	Partners	24	*First OPA within 4 weeks*	51%		58.24%	59.02%	
	Services	25	Improve CIP performance to a minimum of 4% by 2021/22	1.7%				

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

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

PERFORMANCE OVERVIEW

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target per month	Feb-21	Mar-21	Apr-21	YTD	Pass/Fail	Trend Variation
Deliver Harm Free Care	Clostridioides difficile position	Safe	Patients	Director of Nursing	9	6	3	4	4	P	
	MRSA bacteraemia	Safe	Patients	Director of Nursing	0	2	0	0	0	P	
	MSSA bacteraemia cases counts and 12-month rolling rates of hospital-onset, by reporting acute trust and month using trust per 1000 bed days formula	Safe	Patients	Director of Nursing	TBC	0.04	0.08	0.11	0.11		
	E. coli bacteraemia cases counts and 12-month rolling rates, by reporting acute trust and month using trust per 1000 bed days formula	Safe	Patients	Director of Nursing	TBC	0.12	0.08	0.08	0.08		
	Catheter Associated Urinary Tract Infection	Safe	Patients	Director of Nursing	1	Not available					
	Falls per 1000 bed days resulting in moderate, severe harm & death	Safe	Patients	Director of Nursing	0.19	0.20	0.11	0.02	0.02	P	
	Pressure Ulcers category 3	Safe	Patients	Director of Nursing	4.3	2	1	1	1	P	B
	Pressure Ulcers category 4	Safe	Patients	Director of Nursing	1.3	1	0	1	1	P	
	Pressure Ulcers - unstageable	Safe	Patients	Director of Nursing	4.4	5	8	5	5	F	
	Venous Thromboembolism (VTE) Risk Assessment	Safe	Patients	Medical Director	95%	97.70%	97.53%	97.57%	97.17%	P	
	Never Events	Safe	Patients	Director of Nursing	0	0	0	0	0	P	
	Reported medication incidents per 1000 occupied bed days	Safe	Patients	Medical Director	4.3	6.4	5.56	5.25	5.25	P	
	Medication incidents reported as causing harm (low /moderate /severe / death)	Safe	Patients	Medical Director	10.7%	17.20%	15.5%	24.6%	24.60%	F	

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

PERFORMANCE OVERVIEW

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Feb-21	Mar-21	Apr-21	YTD	Pass/Fail	Trend Variation
Deliver Harm Free Care	Patient Safety Alerts responded to by agreed deadline	Safe	Patients	Medical Director	100%	100%	none due	none due		P	
	Hospital Standardised Mortality Ratio - HSMR (basket of 56 diagnosis groups) (rolling year data 3 month time lag)	Effective	Patients	Medical Director	100	105.20	109.11	115.45	115.45	F	H
	Summary Hospital Mortality Indicator (SHMI) (rolling year data 6 month time lag)	Effective	Patients	Medical Director	100	109.45	109.90	110.57	110.57	F	
	The Trust participates in all relevant National clinical audits	Effective	Patients	Medical Director	100%	95.00%	95.00%	95.00%	95.00%	F	A
	eDD issued within 24 hours	Effective	Patients	Medical Director	95%	92.30%	92.30%	93.40%	93.40%	F	
	Sepsis screening (bundle) compliance for inpatients (adult)	Safe	Patients	Director of Nursing	90%	86.2%	86.4%	Data not available yet	86.53%	F	
	Sepsis screening (bundle) compliance for inpatients (child)	Safe	Patients	Director of Nursing	90%	83.0%	100.0%	Data not available yet	87.72%	P	
	IVAB within 1 hour for sepsis for inpatients (adult)	Safe	Patients	Director of Nursing	90%	86.6%	92.0%	Data not available yet	90.67%	P	
	IVAB within 1 hour for sepsis for inpatients (child)	Safe	Patients	Director of Nursing	90%	75.0%	90.0%	Data not available yet	87.23%	P	
	Sepsis screening (bundle) compliance in A&E (adult)	Safe	Patients	Director of Nursing	90%	91.0%	91.9%	Data not available yet	92.48%	P	A
	Sepsis screening (bundle) compliance in A&E (child)	Safe	Patients	Director of Nursing	90%	83.0%	86.5%	Data not available yet	89.53%	F	
	IVAB within 1 hour for sepsis in A&E (adult)	Safe	Patients	Director of Nursing	90%	94.7%	92.0%	Data not available yet	95.27%	P	
	IVAB within 1 hour for sepsis in A&E (child)	Safe	Patients	Director of Nursing	90%	57.0%	33.3%	Data not available yet	78.01%	F	
	Rate of stillbirth per 1000 births	Safe	Patients	Director of Nursing	4.20	2.44	2.86	2.89	2.89	P	B

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	Feb-21	Mar-21	Apr-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%	86.72%	86.49%	87.90%	87.90%		F	B	
	Number of Vacancies	Well-Led	People	Director of HR & OD	12%	11.54%	9.88%	9.60%	9.60%		P	B	
	Sickness Absence	Well-Led	People	Director of HR & OD	4.5%	5.14%	5.13%	5.01%	5.01%		F		
	Staff Turnover	Well-Led	People	Director of HR & OD	12%	12.09%	12.07%	10.78%	10.78%		P	H	
	Staff Appraisals	Well-Led	People	Director of HR & OD	90%	73.65%	76.43%	76.42%	76.42%		F	A	
					£'000	£'000	£'000	£'000	£'000				
	Agency Spend	Well-Led	People	Director of HR & OD	TBC	-£3,651	-£4,546	-£3,848	-£3,848			H	

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	Feb-21	Mar-21	Apr-21	YTD		Latest Month Pass/Fail	Trend Variation	Kitemark
Improve Patient Experience	Mixed Sex Accommodation breaches	Caring	Patients	Director of Nursing	0	0	0	1	1		F		Timeliness, Completeness, Validation, Process
	% Triage Data Not Recorded	Effective	Patients	Chief Operating Officer	0%	0.22%	0.30%	0.28%	0.28%		F		
	Duty of Candour compliance - Verbal	Safe	Patients	Medical Director	100%	88.00%	50.00%		88.33%		F		
	Duty of Candour compliance - Written	Responsive	Patients	Medical Director	100%	88.00%	33.00%		83.58%		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	Feb-21	Mar-21	Apr-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%	72.84%	71.98%	74.23%	74.23%	83.12%	F	B	
	12+ Trolley waits	Responsive	Services	Chief Operating Officer	0	8	0	2	2	0	F	?	
	%Triage Achieved under 15 mins	Responsive	Services	Chief Operating Officer	88.5%	90.02%	85.96%	91.15%	91.15%	88.50%	P		
	52 Week Waiters	Responsive	Services	Chief Operating Officer	0	1662	1877		7020	0	F	H	
	18 week incompletes	Responsive	Services	Chief Operating Officer	84.1%	53.04%	53.94%		56.66%	84.10%	F	B	
	Waiting List Size	Responsive	Services	Chief Operating Officer	37,762	39,368	40,660		n/a	n/a	F		
	62 day classic	Responsive	Services	Chief Operating Officer	85.4%	55.48%	67.23%		65.30%	85.39%	F		
	2 week wait suspect	Responsive	Services	Chief Operating Officer	93.0%	80.08%	84.51%		85.08%	93.00%	F		
	2 week wait breast symptomatic	Responsive	Services	Chief Operating Officer	93.0%	2.84%	4.07%		35.67%	93.00%	F	B	
	31 day first treatment	Responsive	Services	Chief Operating Officer	96.0%	93.68%	91.62%		94.04%	96.00%	F		
	31 day subsequent drug treatments	Responsive	Services	Chief Operating Officer	98.0%	97.73%	99.24%		98.64%	98.00%	P		
	31 day subsequent surgery treatments	Responsive	Services	Chief Operating Officer	94.0%	90.63%	86.67%		88.49%	94.00%	F		
	31 day subsequent radiotherapy treatments	Responsive	Services	Chief Operating Officer	94.0%	93.18%	95.00%		92.74%	94.00%	P		
	62 day screening	Responsive	Services	Chief Operating Officer	90.0%	72.73%	69.57%		47.41%	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	Feb-21	Mar-21	Apr-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%	74.77%	73.96%		79.46%	85.00%	F		
	Diagnostics achieved	Responsive	Services	Chief Operating Officer	99.0%	68.94%	69.91%		57.02%	99.00%	F	A	
	Cancelled Operations on the day (non clinical)	Responsive	Services	Chief Operating Officer	0.8%	1.14%	0.76%		1.44%	0.80%	P		
	Not treated within 28 days. (Breach)	Responsive	Services	Chief Operating Officer	0	12	3		121	0	F		
	#NOF 48 hrs	Responsive	Services	Chief Operating Officer	90%	100.00%	100.00%	90.14%	90.14%	90%	P		
	#NOF 36 hrs	Responsive	Services	Chief Operating Officer	TBC	93.75%	100.00%	78.87%	78.87%				
	EMAS Conveyances to ULHT	Responsive	Services	Chief Operating Officer	4,657	3,835	4,588	4,481	4,481	4,657	P		
	EMAS Conveyances Delayed >59 mins	Responsive	Services	Chief Operating Officer	0	218	328	207	207	0	F	A	
	104+ Day Waiters	Responsive	Services	Chief Operating Officer	5	68	61	47	47	5	F		
	Average LoS - Elective (not including Daycase)	Effective	Services	Chief Operating Officer	2.80	3.54	2.57	2.55	2.55	2.80	P		
	Average LoS - Non Elective	Effective	Services	Chief Operating Officer	4.50	4.77	4.61	4.58	4.58	4.5	F		
	Delayed Transfers of Care	Effective	Services	Chief Operating Officer	3.5%	Submission suspended				3.5%			
	Partial Booking Waiting List	Effective	Services	Chief Operating Officer	4,524	17,800	18,220	16,046	16,046	4,524	F	L	
	Outpatients seen within 15 minutes of appointment	Effective	Services	Chief Operating Officer	70.0%	54.3%	48.8%	44.4%	44.42%	70.00%	F		
	% discharged within 24hrs of PDD	Effective	Services	Chief Operating Officer	45.0%	32.4%	42.3%	43.3%	43.29%	45.00%	F		

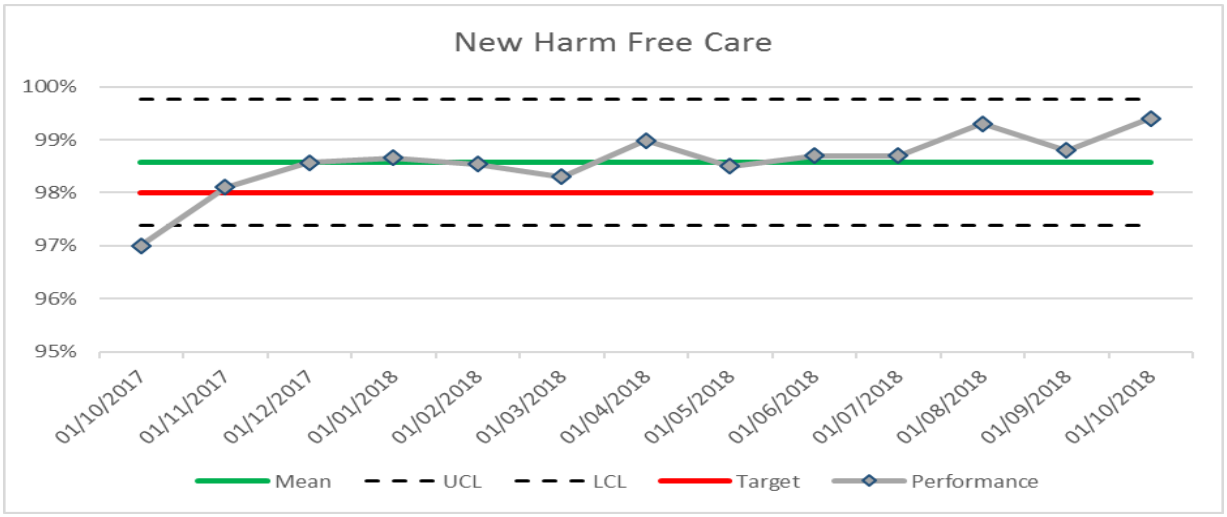
STATISTICAL PROCESS CONTROL CHARTS

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:



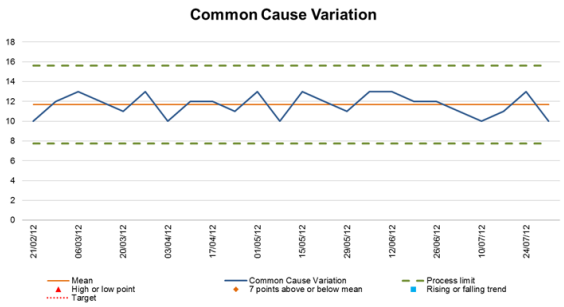
Normal variations in performance across time can occur randomly- without a direct cause, and should not be treated as a concern, or a sign of improvement, and is unlikely to require investigation unless one of the patterns defined below applies.

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

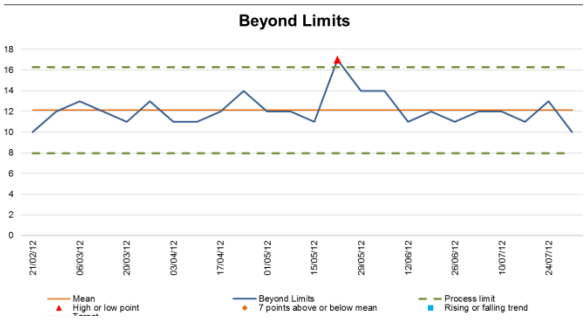
- Normal variation – (common cause) fluctuations in data points that sit between the upper and lower control limits
- Extreme values – (special cause) any value on the line graph that falls outside of the control limits. These are very unlikely to occur and where they do, it is likely a reason or handful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

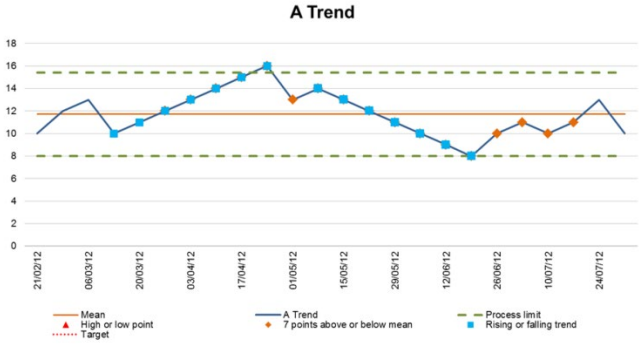


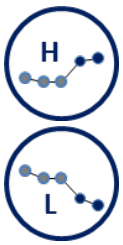
Extreme Values



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 consistentl

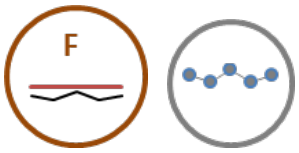
Where the target has been missed for at least 3 of the most recent data points in a row, or in a string of 7 of the most recent data points, at least 5 out of the 7 data points have missed.

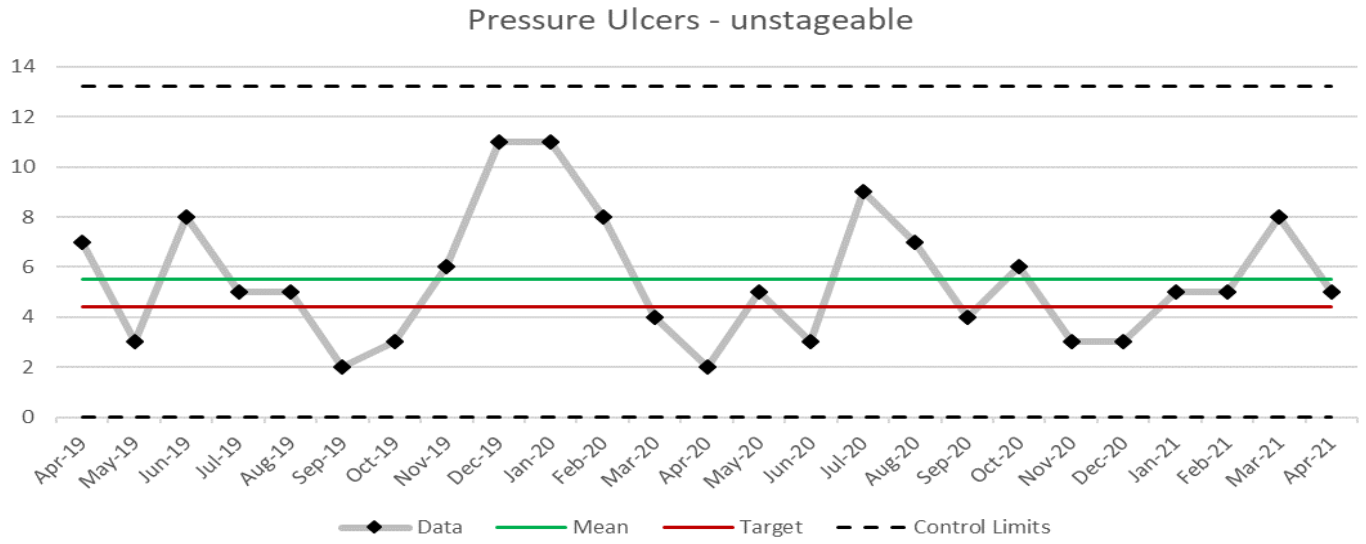
DELIVER HARM FREE CARE – PRESSURE ULCERS

Executive Lead: Director of Nursing

CQC Domain: Safe

Strategic Objective: Patients





Challenges/Successes

One Category 4 pressure ulcer has been reported in April 2021 by PHB. This originated from a community acquired Category 2, which deteriorated to a hospital acquired Unstageable pressure ulcer and subsequently evolved further to Category 4. The Tissue Viability Team were involved from admission and a management plan was put into place. It was anticipated at the time of the Unstageable pressure ulcer being reported that it was likely to deteriorate further.

Actions to Recover

- A Rapid review was undertaken and a Serious Incident Investigation has been commissioned. The final report will be reviewed once available at the Skin Integrity Group.
- The Tissue Viability Team has made contact with the ward manager, to identify any targeted local support required. It was agreed:
    - All ward staff will complete the Tissue Viability e-Learning by the end of June 2021. Monitoring of compliance will be available on ESR core learning.
    - The link nurse intends to utilise educational resources available from the Tissue Viability website and those promoted during the Focus on Fundamentals month.
    - Cascade training on the use of Waterlow risk assessment will be facilitated by the Tissue Viability Team with the link nurse.

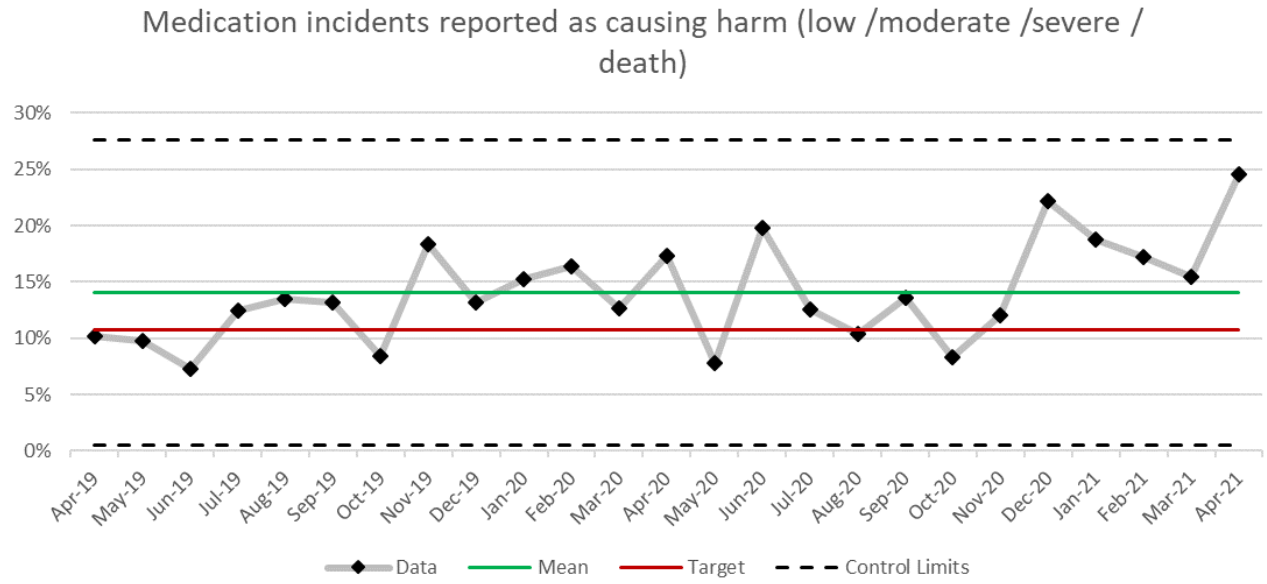
- The Ward Manager shared the details of the incident with the team to discuss potential care delivery issues.

DELIVER HARM FREE CARE – MEDICATION INCIDENTS CAUSING HARM

Executive Lead: Medical Director

CQC Domain: Safe

Strategic Objective: Patients



Challenges/ Successes

In the month of April the number of incidents reported was 138. 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

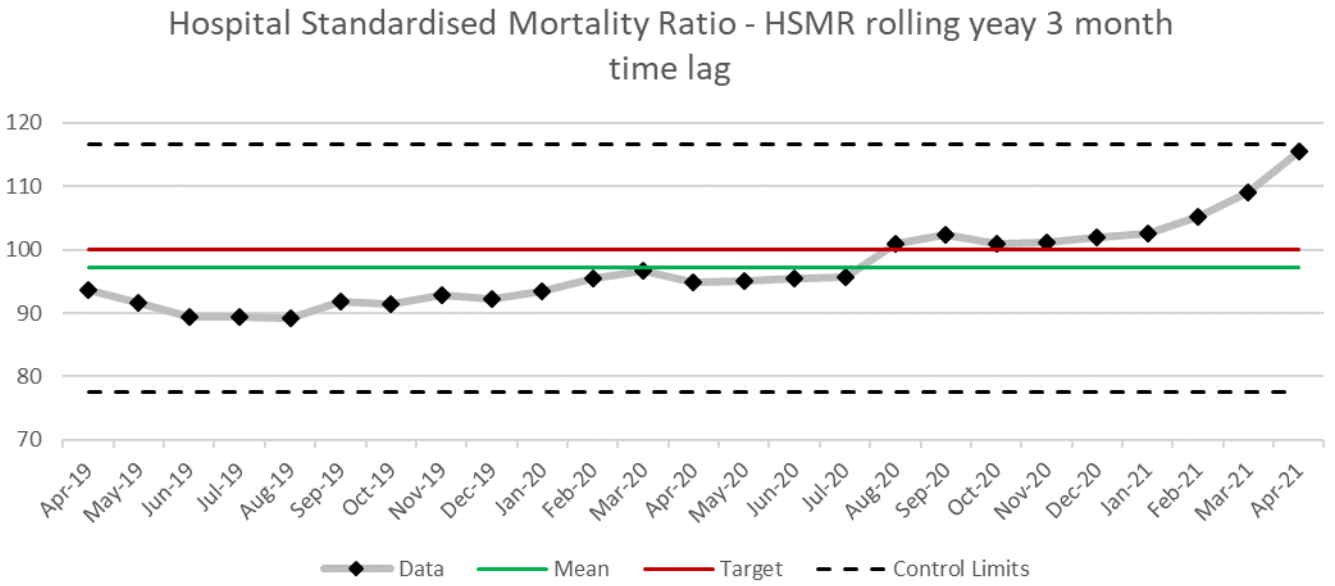
Each CBU pharmacist has been sent the medication incident reports and will work with wards to make improvements.

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 115.45 which is within the 'High' banding. Due to the COVID-19 pandemic the rises in the HSMR were to 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 are included.

Alerts:

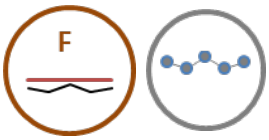
Primary Diagnosis Group	Trust/Site	Months Alerting	Comments
Acute and unspecified renal failure	TRUST	1	First month alert
Acute bronchitis	TRUST	1	First month alert at Trust
Cardiac dysrhythmias	TRUST	1	First month alert at Trust
Chronic obstructive pulmonary disease and bronchiectasis	TRUST	1	First month alert
Coronary atherosclerosis and other heart disease	TRUST	3	Third month alert at Trust, Division of Medicine has been requested to provide assurances at the next MorALS meeting.
Other liver diseases	TRUST	7	A casenote review has been completed, with a paper presented at MorALS.
Pleurisy pneumothorax pulmonary collapse	TRUST	3	Review has been completed which identified failings in documentation and coding, potentially increasing HSMR.
Septicemia (except in labour)	TRUST	6	Clinical Governance has held meetings with the Sepsis Practitioners to discuss this issue and a casenote review has been completed, with a paper presented at MorALS
Skin and subcutaneous tissue infections	Grantham	2	Clinical Governance has completed a diagnostic on this alert, with cases reviewed by a Medical Examiner.

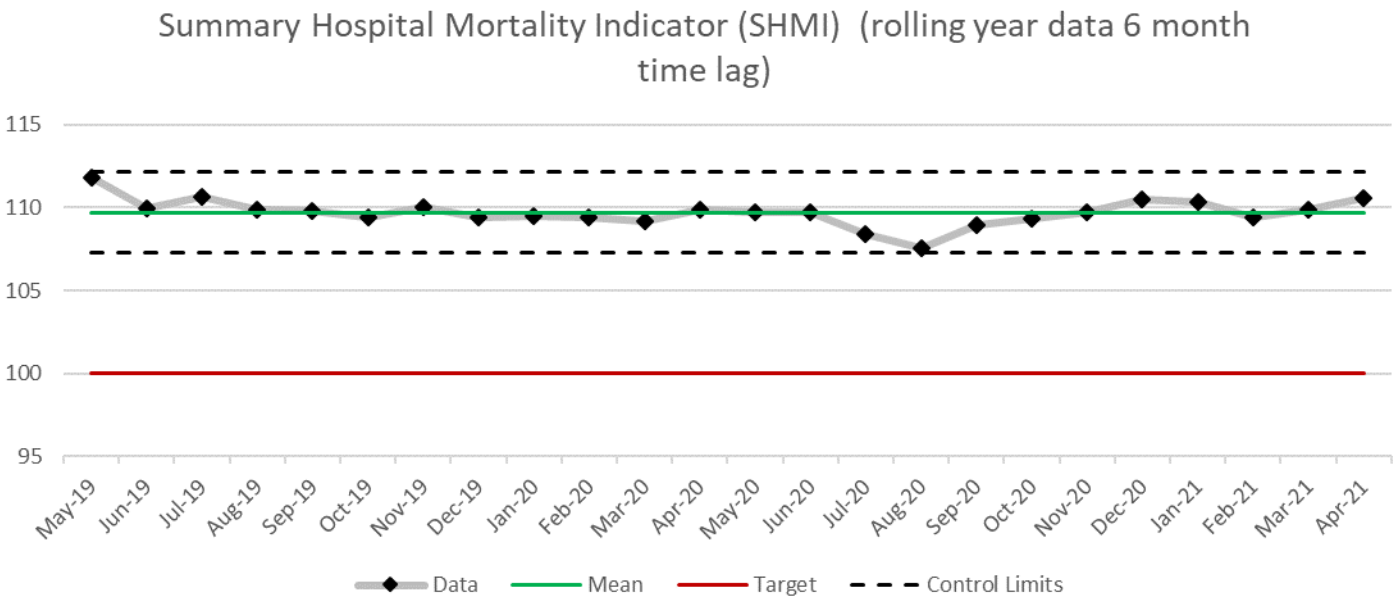
DELIVER HARM FREE CARE – MORTALITY SHMI

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 110.57; an increase from the last reporting period.

SHMI includes both deaths in-hospital and within 30 days of discharge. The data is reflective up to November 2020.

Current in-hospital SHMI is 101.77.

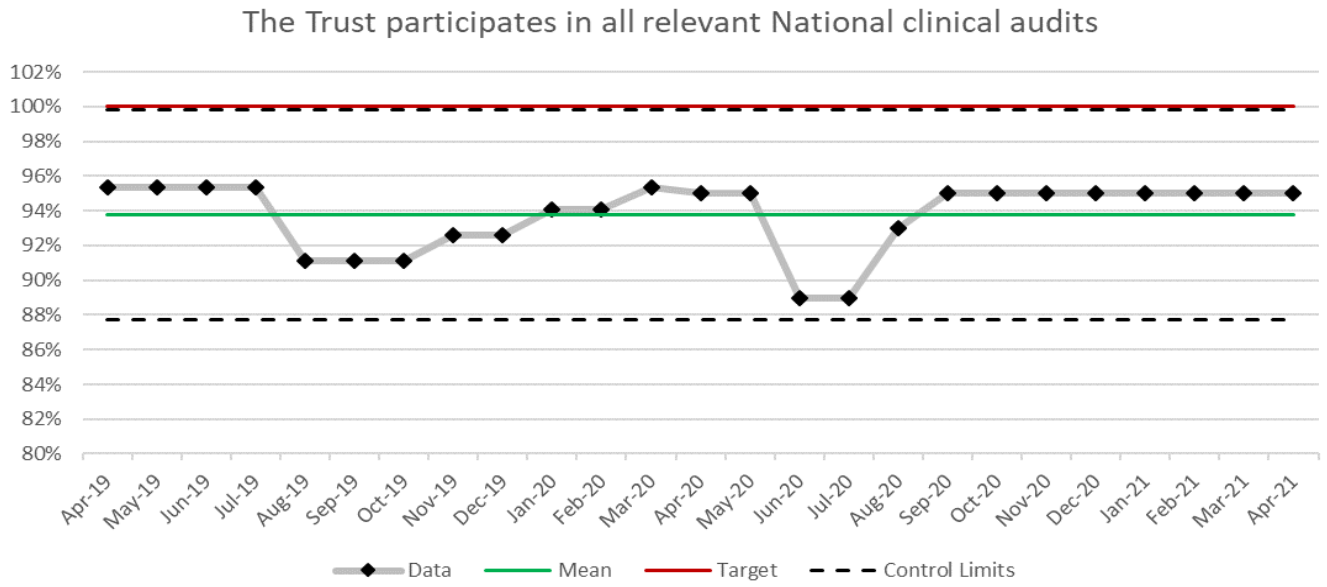
NHS Digital are excluding all data in regard to COVID-19. NHS Digital shows that 1.8% of spells (1280 spells), have been excluded due COVID-19 coding. The national average is 2.4%.

DELIVER HARM FREE CARE – THE TRUST PARTICIPATES IN ALL RELEVANT NATIONAL CLINICAL AUDITS

Executive Lead: Medical Director

CQC Domain: Effective

Strategic Objective: Patients



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

- None Participation in the National IBD audit has been clarified with the Clinical Director for Medicine the Trust is in the process of registering to participate in this audit.

Elective procedures cancelled in line with NHS England Guidance.

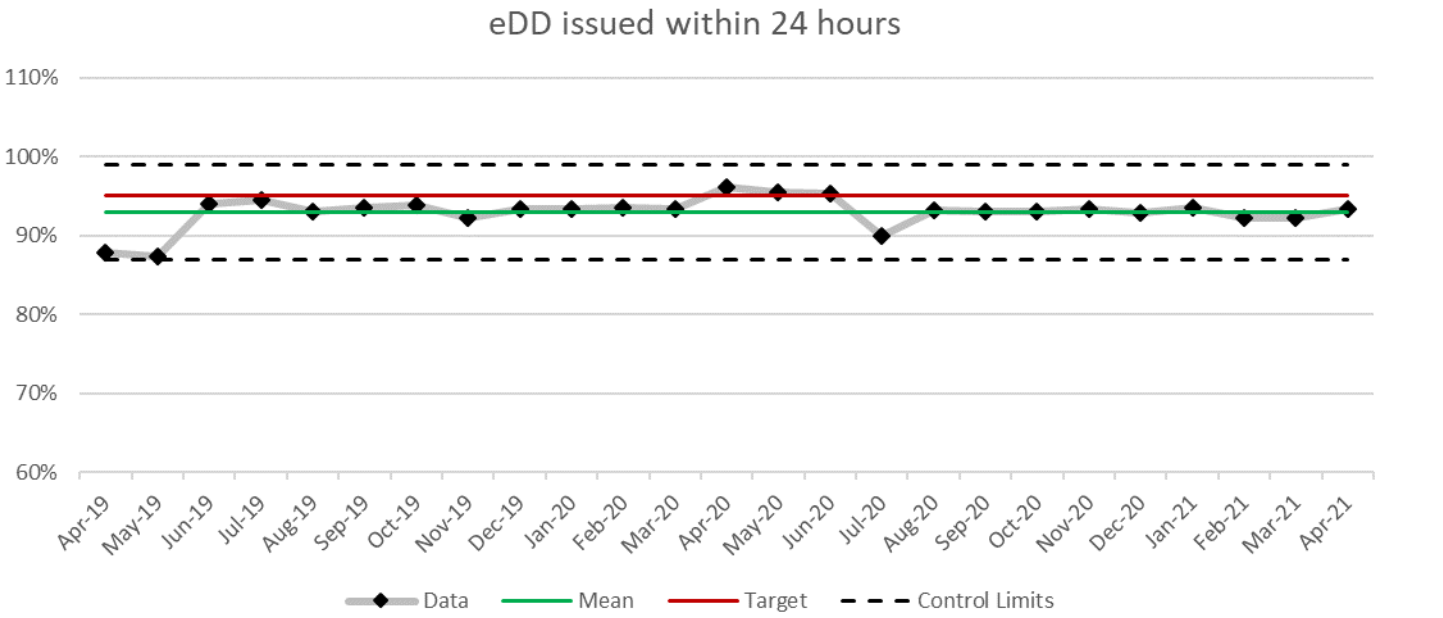
- Procedures that are now taking place this should improve participation as the Trust returns to normal working.

DELIVER HARM FREE CARE – eDD ISSUED WITHIN 24 HOURS

Executive Lead: Medical Director

CQC Domain: Effective

Strategic Objective: Patients



Challenges/Successes

The Trust achieved 93.5% compliance with sending eDDs within 24 hours for April 2021. 96.8% were sent anytime during the month of April 2021.

Actions in place to recover:

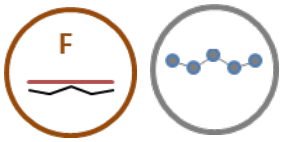
- Paediatric eDD template being streamlined.
- eDD policy developed and sent for publishing.

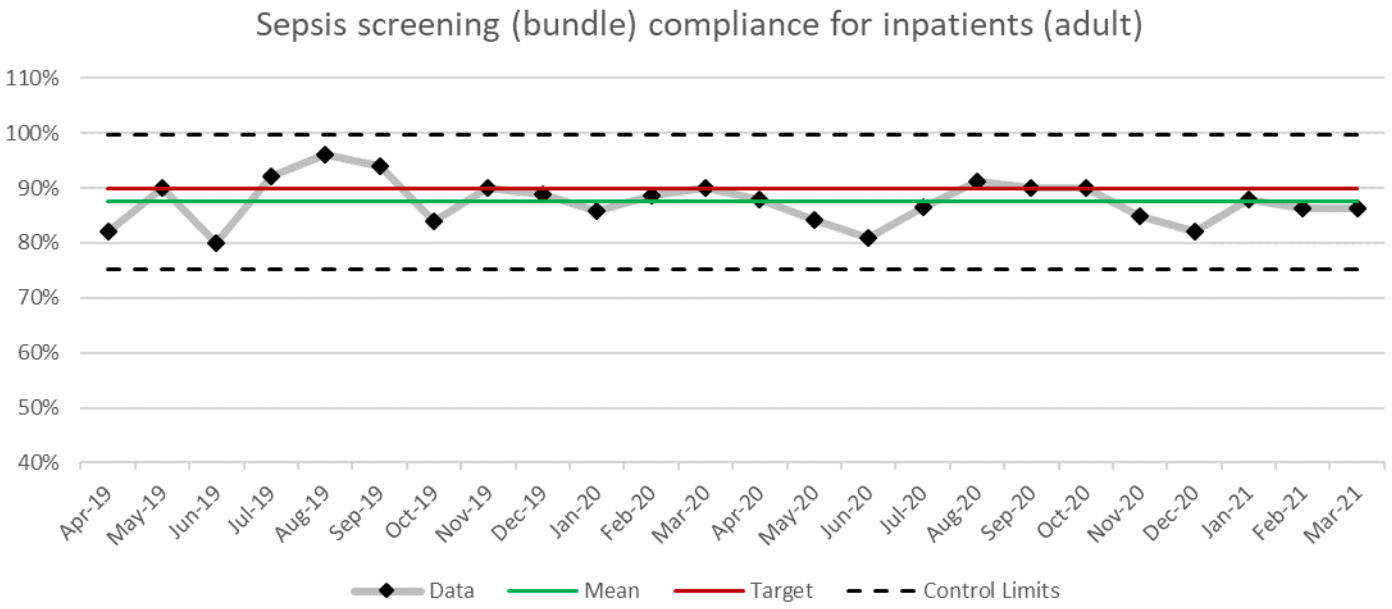
DELIVER HARM FREE CARE – SEPSIS SCREENING (BUNDLE) COMPLIANCE

Executive Lead: Director of Nursing

CQC Domain: Safe

Strategic Objective: Patients





Challenges/Successes

The compliance for March has remained static with 86%. The medical wards still face considerable challenges as services are restored and this is reflected in a slight dip in compliance. The majority of missed screens are for non- infective patients. Missed screens that were attributable to Agency nurses have increased and this is a new theme from previous months

Actions in place to recover

The relaxation of ward restrictions has allowed for the sepsis practitioners to re-commence teaching in the clinical area and this should improve engagement and provide targeted support. The roll out of the Train the Trainer programme has been on hold for the last year but the core + panel has reconvened and we are due to present to this on 19th May.

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

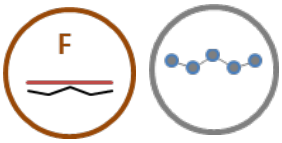
A survey that will gauge the preparedness of Agency nurses prior to commencement with the Trust has been devised and this will assist in ensuring they receive the support that they require.

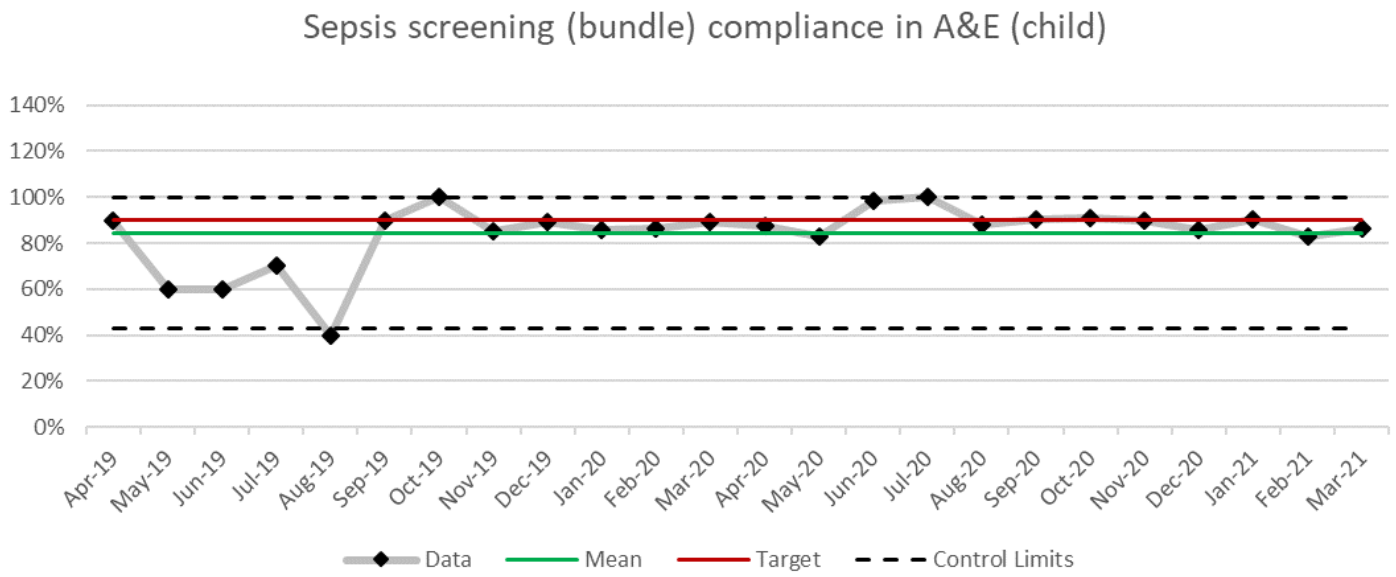
DELIVER HARM FREE CARE – SEPSIS SCREENING (BUNDLE) COMPLIANCE

Executive Lead: Director of Nursing

CQC Domain: Safe

Strategic Objective: Patients





Challenges/successes

Compliance has increased slightly this month to 86.6% but this is still below acceptable figures. There were 12 missed or delayed screens. Harm reviews showed that 10 of these were found to have an alternate cause and were not sepsis. Datix forms were completed for 2 which showed low level harm. Both were treated for Sepsis and had a prolonged course of treatment. It is difficult to say whether this is due to delay or severity of illness. One of the investigations failed to find a cause for the delay. There is still some weariness among staff to complete screens.

Actions in place to recover

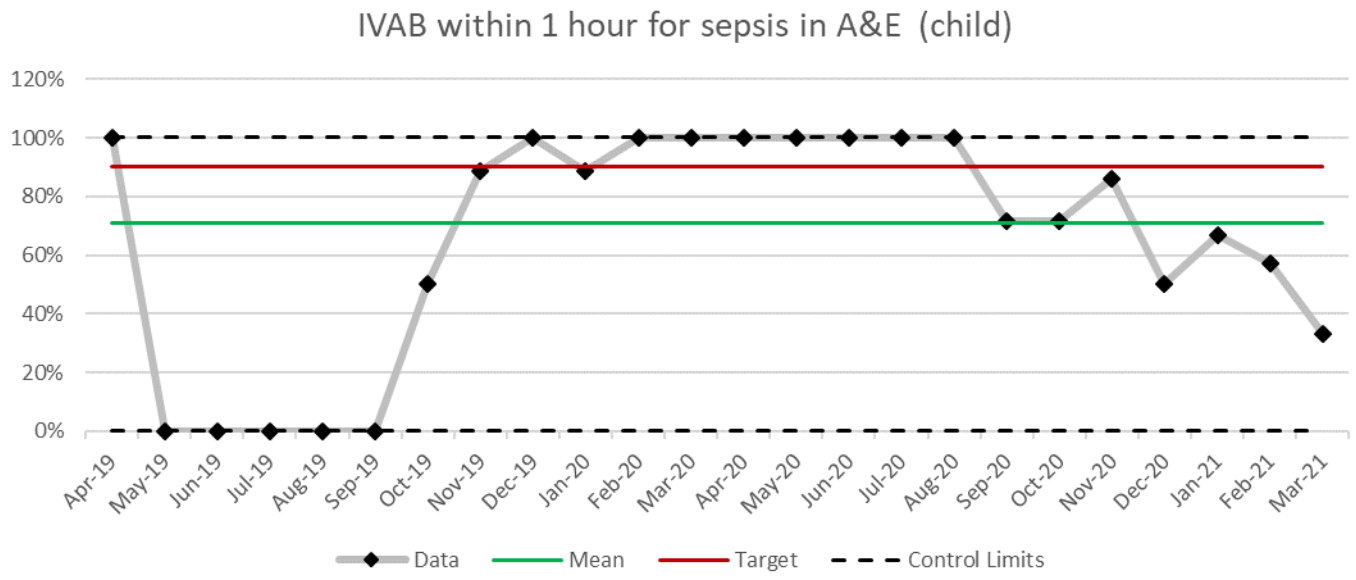
There have now been 2 study days at Pilgrim for adult Nurses, these have had a paediatric focus and the Sepsis Practitioner has delivered sessions on both. There was good engagement for both sessions so hopefully these can be rolled out further and trust wide. The Children and young people's Sepsis Practitioner had also met with the ED Sisters and the aim is that she will become more visible in ED, with regular walk rounds, in order to assist staff or answer and questions in regards to Sepsis.

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 a disappointing 33%which is well below the 90% standard. There were 2 missed antibiotics out of 3 patients requiring them. There is still a reluctance to treat in the department despite being advised by a Paediatrician to do so. A Datix was completed for each of the missed antibiotics for further investigation. Harm reviews were completed on both patients, both required a longer course of antibiotics but it is difficult to determine if this was due to the delay.

Actions in place to recover

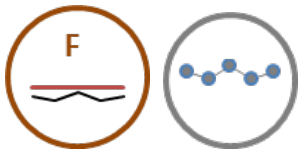
One of the investigations failed to find a clear cause for the delay, the other is still under investigation. This has been addressed at consultant level via the governance process and it has now been mandated that patient move should not happen prior to completion of the sepsis bundle. There are now ongoing quarterly trust wide meetings between ED and the Paediatric areas to help enable better team working between the two. Adult Nurses at Boston have also attended two Paediatric focused study days in which Sepsis and Case studies around Sepsis have been discussed. It is hoped that this training can be carried forward to Lincoln also.

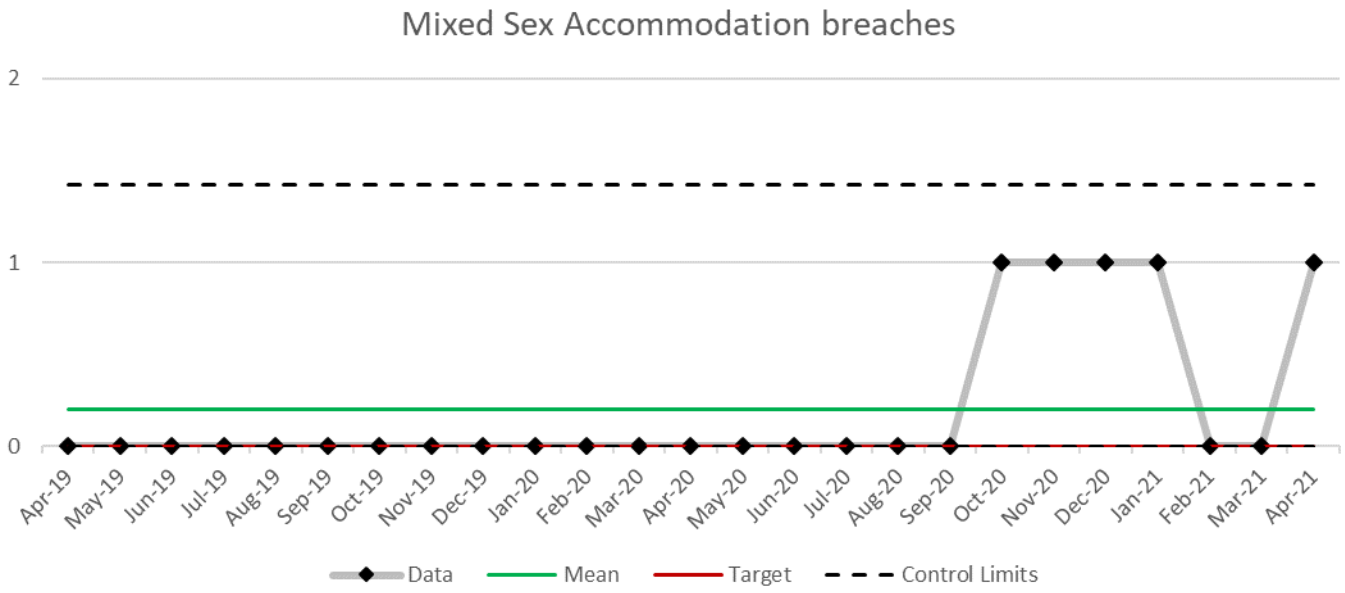
IMPROVE PATIENT EXPERIENCE – MIXED SEX ACCOMMODATION

Executive Lead: Director of Nursing

CQC Domain: Caring

Strategic Objective: Patients



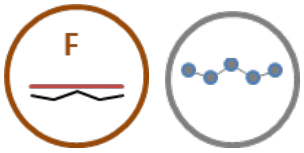


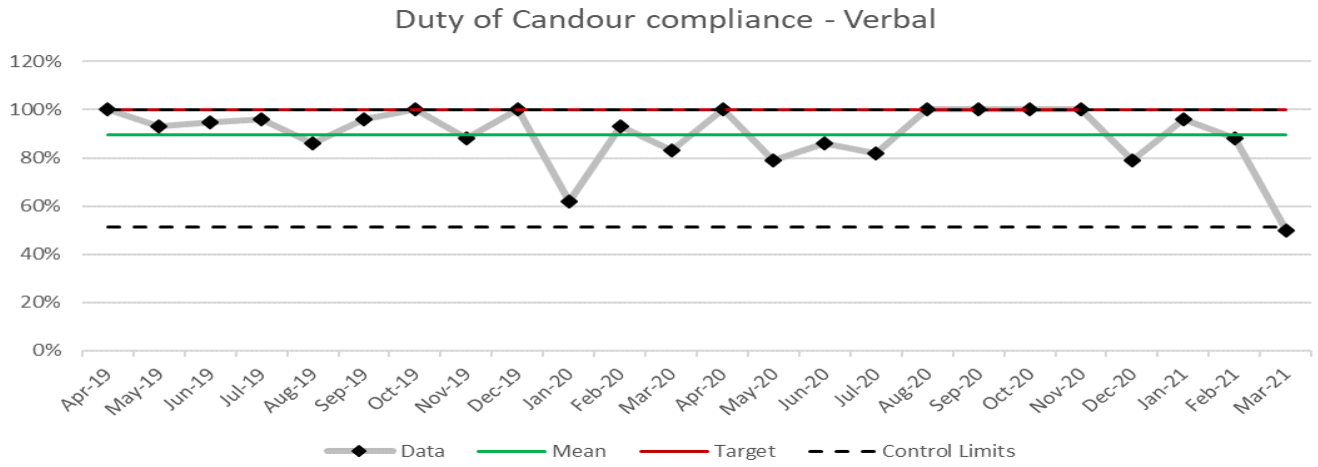
IMPROVE PATIENT EXPERIENCE – DUTY OF CANDOUR

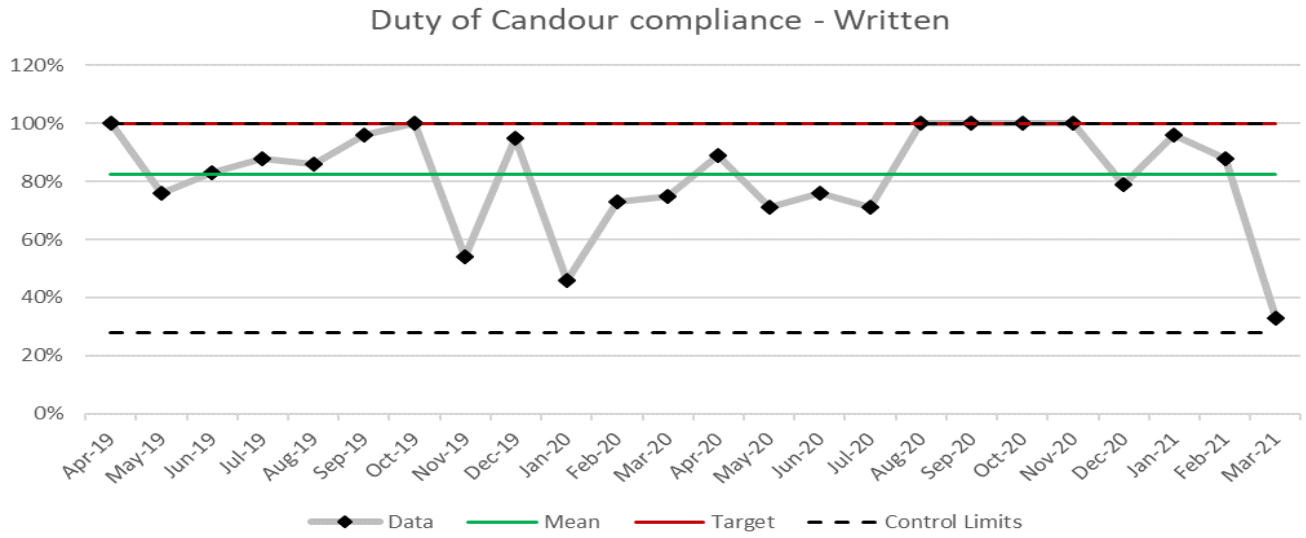
Executive Lead: Director of Nursing

CQC Domain: Caring

Strategic Objective: Patients







Challenges/Successes

- The Trust achieved 100% compliance with the Duty of Candour in March 2021, for in person notification (verbal) and 75% compliance for written follow-up
- There were 6 non-compliant written follow-ups from 24 incidents that were notifiable.
- 4 of the non-compliant incidents occurred within Medicine Division; 1 incident occurred in Family Health; 1 incident occurred in Surgery Division.

Actions in place to recover:

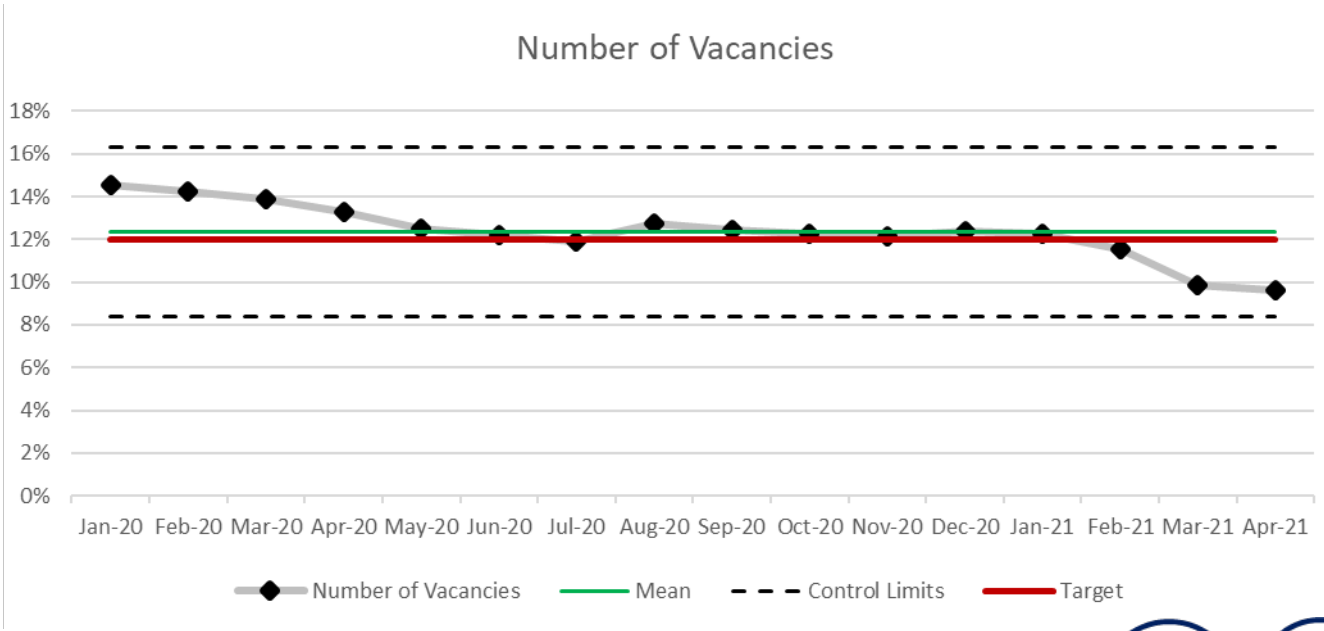
- The Risk & Incident now notify the divisional triumvirate on the next working day of all incidents where Duty of Candour applies, highlighting those that require completion
- Amendments have also been made to Datix to provide additional guidance and prompts for Duty of Candour when reviewing the incident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

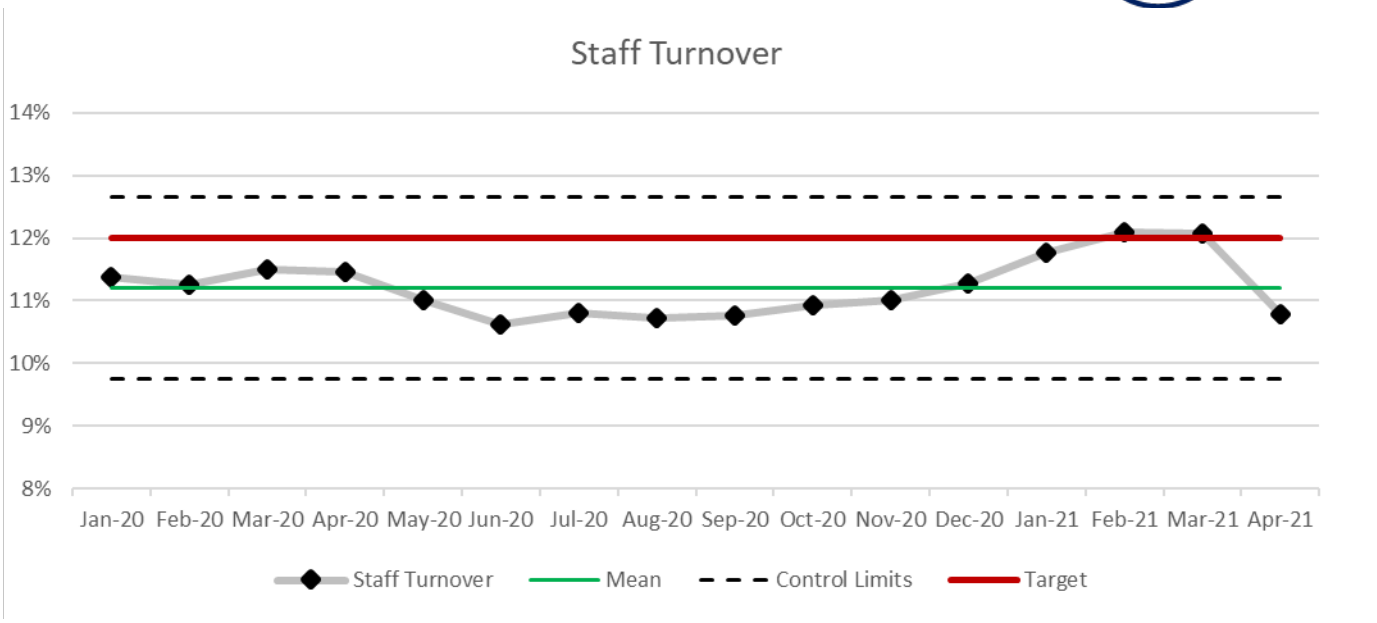
A MODERN AND PROGRESSIVE WORKFORCE – TURNOVER & VACANCIES

Executive Lead: Director of HR & OD

CQC Domain: Well-Led

Strategic Objective: People





Overview

There has been a change in the calculation of turnover in this financial year, to include only permanent staff (i.e. not those on fixed-term contracts). This has significantly reduced our turnover figure, but gives a more realistic picture of the staff churn that we can actually influence.

We continue to have a strong focus on the retention of staff, looking beyond the overall figure to look at turnover in particular staff groups.

Over the last 12 months, we have also had a high response rate (79%) to our exit interview survey. The data from our exit survey shows:

- 36% of respondents (198) chose lack of development as their reason for leaving. Lack of development includes lack of growth opportunities, lack of promotion, further training/education
- 18% of respondents (96) chose retirement
- 14% of respondents (77) said they were leaving because of a lack of work life balance
- 11% of respondents (66) said they were leaving because of incompatible relationships at work

Combining the data from our staff survey and the exit survey our focus pan-Trust over the next year must include:

- Turnover needs to be tracked closely at a Divisional level and by staff group and plans made within the Divisions to address retention
- This will link to our response to the staff survey results and our Culture & Leadership programme will seek to address issues of engagement, the extent to which staff feel cared for and line manager experience, which all contribute to retention
- Wellbeing is a key focus in order to address retention.
    - A manager training programme is being put in place to help managers address and manage wellbeing of teams
    - The wellbeing champions/ally project is being reviewed and revised in order to make wellbeing support more accessible.
- Building managerial capability – developing and supporting our managers to be 'people managers' at different levels – supervisory, first time managers, manager of managers and mangers of business.
- Flexible working as a key instrument to retain staff – especially in nursing, AHP and admin and clerical staff groups. Previous analysis has also shown that over 30% of our nursing workforce will reach retirement age over the next 3 years. Given tax implications, any retiring returnee will want to come back to reduced, flexible hours of work. Flexible working is also a key element of the People Plan. A member of the OD Team is part of a national task and finish group looking at issues around flexibility.
- Enhanced engagement with and focus on team integration for new staff (43% of staff who completed the exit survey have been at ULHT for less than 2 years)
- Our new Education and Learning Plan – with a focus on becoming a learning organisation, where people can develop their careers
- New models of working where we can weave individual development and flexible working into service delivery

In terms of the new international nurses, we are undertaken the following to reflect their particular needs and to ensure we retain them:

- Implementing a 'Cultural Inclusivity' programme, which will be showcased as 'best practice' across the region at a NHSEI event in June/July.

- Pastoral care is provided from 'Day 0' – first contact with the trust at interview and with dedicated recruitment support throughout the process. The IR recruitment support team provide a constant source of support with regards to answering processing all recruitment paperwork, quarantine paperwork, quarantine accommodation, organising food shopping, ensuring that water and snacks are in the transport from the airport, welcome cards on arrival, rooms within the accommodation are prepared, engagement with the local community schools, with welcome posters drawn by junior school children. The IR recruitment support team are also on hand to answer all of those questions that arise when relocating, providing information about Lincolnshire and using 'Be in Lincolnshire' materials as part of the re-settlement assurance.

Whilst the overall vacancy rate has reduced the rate for clinical staff groups has increased, particularly for AHPs.

Our pipeline report (which is considered monthly at the Trust Leadership Team) does show a strong pipeline for clinical roles. The following table compares the current vacancy position to the same period last year. It incorporates:

- Trac pipeline activity over the next 6 months (where a candidate has been appointed)
- Data on other recruitment activity which is in train
- Deduction of posts where no recruitment activity is currently planned (due to potential restructure and savings)
- An estimate of future turnover by staff group
- A predicted vacancy position based on the above.

It sows positive progress in the last 12 months across many staff groups (excluding medical and AHPs), but potentially a much more positive position across all staff groups in six months' time.

This reflects the success of our HCSW and international nurse recruitment programmes, as well as strong pipelines for medical roles and a focus on AHP roles. It is also evident that the quality of medical candidates is improving. The crisis in India is impacting our nurse pipeline, but we are looking to source from other countries, as well as running a domestic campaign for registered nurses.

Cohort recruitment is proving very successful and we will run further cohort campaigns to sustain a pool of HCSWs and explore its potential for admin roles additionally.

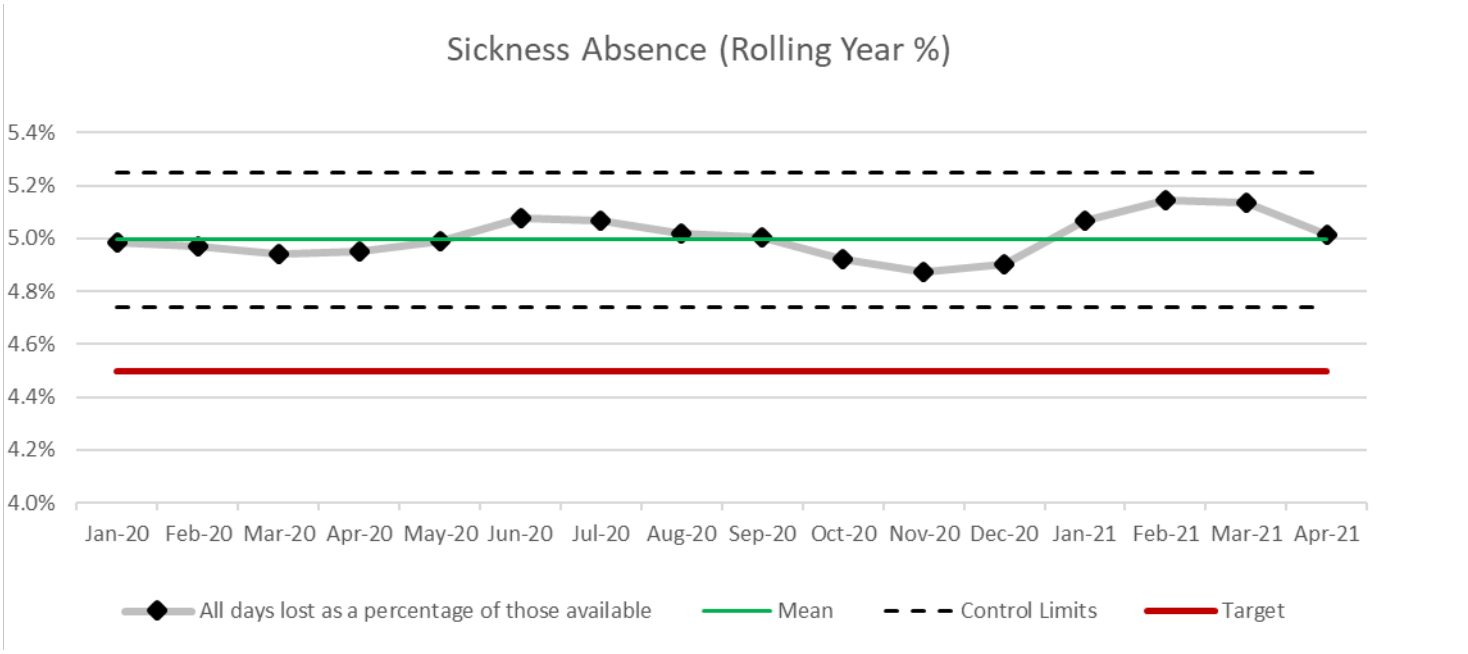
The deadline for EU nationals to apply for settled status in the UK is 30th June 2021. The Settlement Scheme will allow EU, EEA and Swiss citizens to continue to live and work in the UK beyond June 2021, meaning they will not need to apply for visas when the new immigration system takes effect. We have around 400 staff in this category recorded on ESR. We have publicised the need to apply for settled status over the course of the last year. We are currently following up to understand the status of these individuals and to manage any risk for the Trust around this.

A MODERN AND PROGRESSIVE WORKFORCE – SICKNESS

Executive Lead: Director of HR & OD

CQC Domain: Well-Led

Strategic Objective: People



Overview

Sickness has reduced as the incidence of COVID declined. It is now back to pre-COVID levels. Our target however remains 4.5%. We are using our new Attendance Management System (AMS) as the way in which we can embed the good practice that will support further reductions in absence. The system itself will not deliver improvement, so we measure engagement levels with the system.

Return to work interviews are key and overall 65.4% are being undertaken. Prior to implementation of the system, this figure was at around 50%. Some services are at 90%, so there are low performers that we are following up. Managers are expected to call those who report sick on the same day, to support an early return to work. This is a new requirement and at present only 26.6% are taking place (or being recorded on the system as having taken place). This is a real focus for the ER team who are managing the project, alongside ensuring sickness meetings with staff who hit trigger points take place.

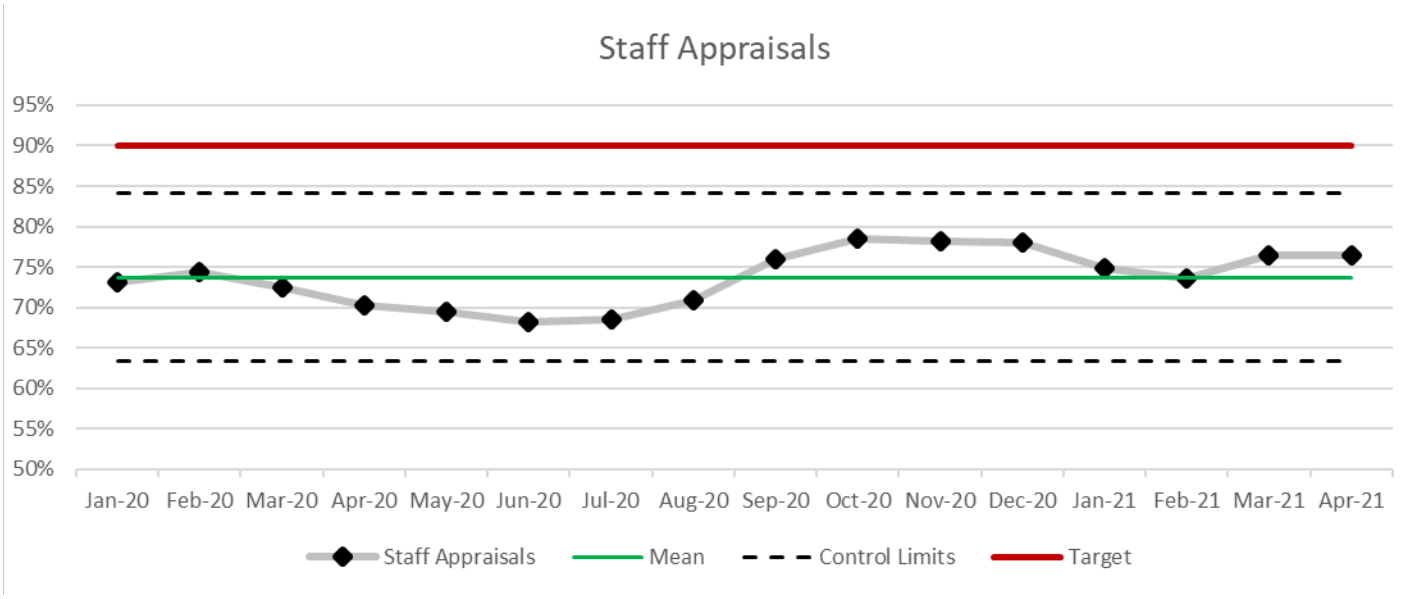
By way of comparison In February, the LCHS sickness absence rate was 4.2% and LPFT 4.6%. The ULHT March figure was 5.1%. It has now reduced to 5%.

A MODERN AND PROGRESSIVE WORKFORCE – APPRAISALS

Executive Lead: Director of HR & OD

CQC Domain: Well-Led

Strategic Objective: People



Overview

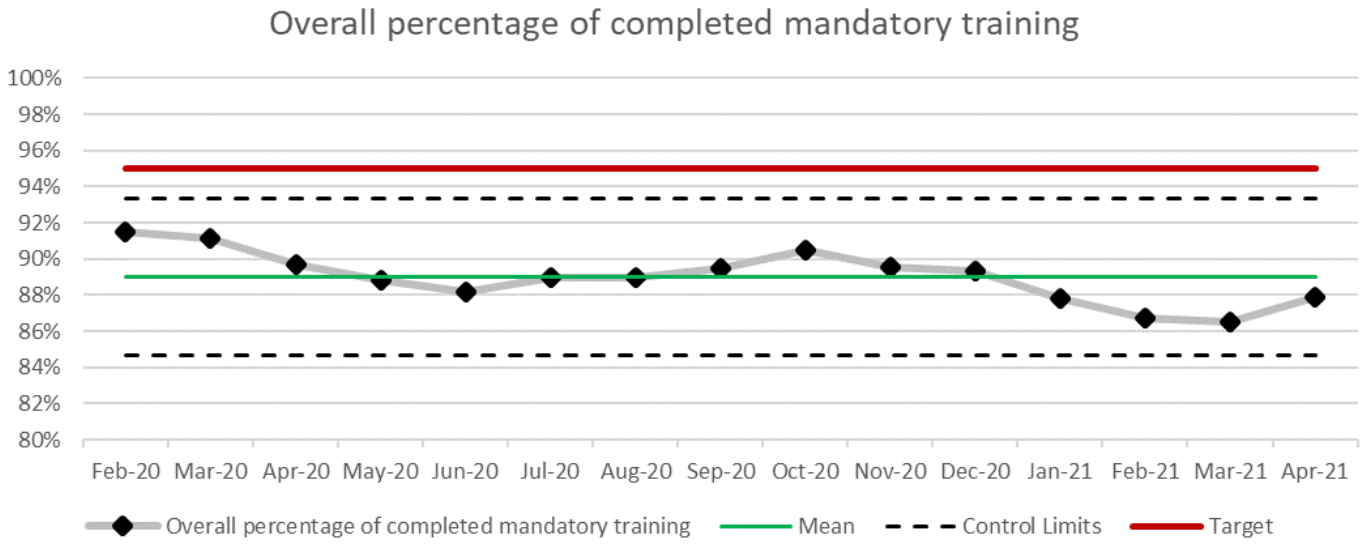
Medical appraisal rates remain around 95%. However AfC appraisal rates have not improved, which is disappointing. There is variation between Divisions and we are following up through HRBPs at that level to address areas of concern. The launch of the new WorkPal system (on 11th May), which will underpin our approach to individual performance management going forward, is an important moment to re-set the dial on appraisal.

A MODERN AND PROGRESSIVE WORKFORCE – CORE LEARNING

Executive Lead: Director of HR & OD

CQC Domain: Well-Led

Strategic Objective: People



Overview

The rate of completion has picked up in April, reflecting the focus we have placed on this in the last month. We are highlighting in PRMs the need in particular to complete the core learning modules for information governance and fire safety.

Under the guidance of the Education and Learning Group we have undertaken a review of core learning. The basic structure has been found to be sound. There is a subject matter expert for each topic, who is responsible for the quality of content and works with the module developer in IT. Core learning is overseen by a Core Learning Panel, which is representative of the organisation.

There is an issue about the quality of some modules and steps will be taken to upgrade them (using national "E-Learning For Health" material where possible). Subject matter experts will be required to do a formal annual review, utilising more systematically user-feedback. This will be overseen by the Panel.

We recognise that some of the mapping of core learning modules to individuals may be out-of-date. We will ask subject matter experts to review, but in order to manage the task, we will probably ask individuals also to review and identify where they believe a requirement for core learning is unnecessary and this can be agreed or otherwise by the subject matter expert.

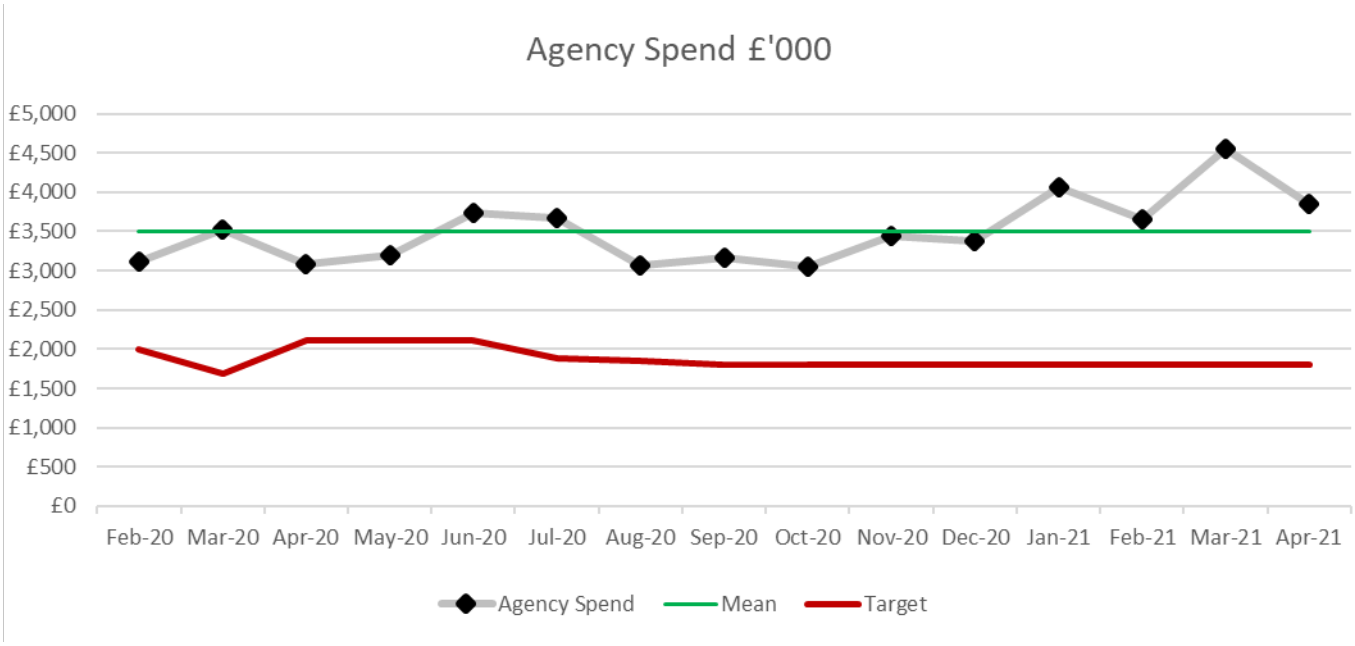
We do wish to re-emphasise that there is an individual responsibility to complete core learning. To assist people we will be proposing that protected learning time is set aside or consistently applied where it is already built into rotas. We will also explore further the model in NUH, where one day is set aside for core learning for staff.

EFFICIENT USE OF OUR RESOURCES – AGENCY SPEND

Executive Lead: Director of HR & OD

CQC Domain: Well-Led

Strategic Objective: People



Overview

The increase in spend in March has been reduced. It was evident that was due to a significant amount of annual leave being taken in March, the consequence of leave having been built up during COVID. There is evidence that the downward trend will continue in May.

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.

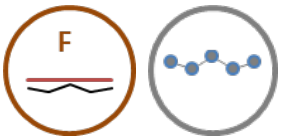
The Nursing Workforce Transformation Group has started to exert more grip and control on nursing agency spend through the Divisional Nurses. This is beginning to bear fruit in terms of reduced spend through the second part of April and into May.

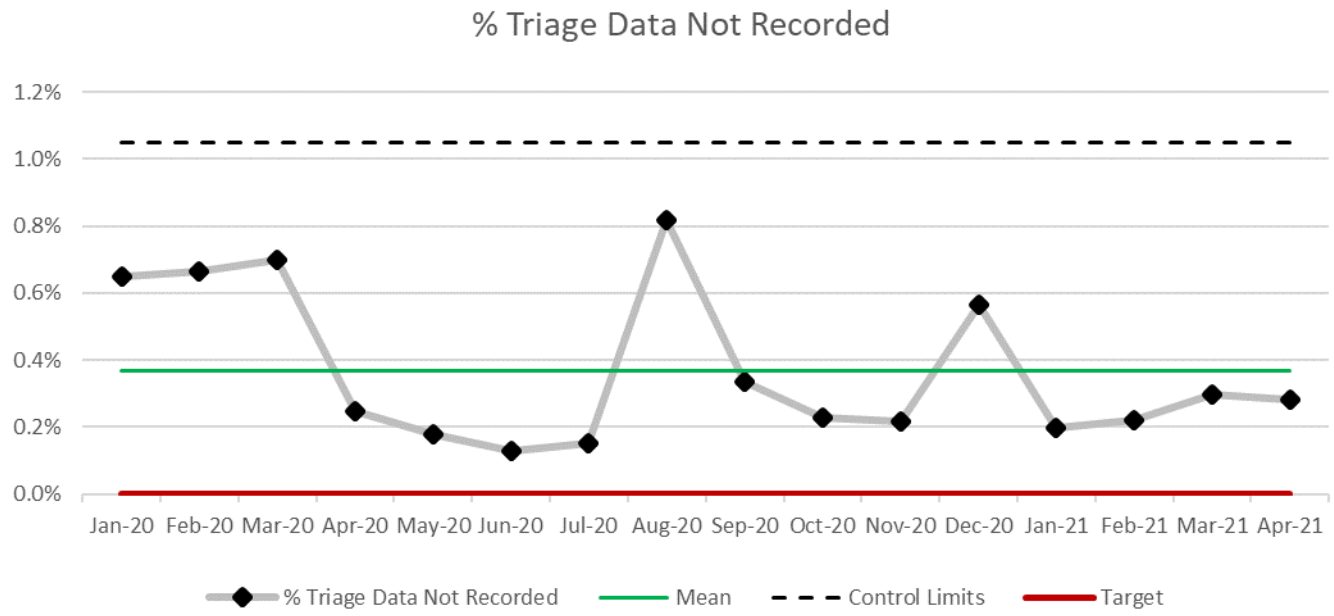
IMPROVE PATIENT EXPERIENCE – % TRIAGE DATA NOT RECORDED

Executive Lead: Chief Operating Officer

CQC Domain: Effective

Strategic Objective: Patients





Challenges/Successes

- April demonstrated a 0.02% positive variation in performance compared with March.
- Improvement has been seen on both sites. However, a new performance indicator has been added to the 08:30hrs Capacity meeting to discuss and ensure 2 triage streams are always in place across both acute sites. This will now be monitored at all 4 Capacity meetings.
- The newly applied indicator will also ensure that both PHB and LCH have sufficient staff trained in triage per shift to meet the Nationally agreed compliance target.
- % Triage achieved under 15 minutes has demonstrated an improvement in April. 91.15% in April compared to 85.96% in March. A positive shift of 5.19%.
- The UEC Operational Leads continue to be proactive in addressing recording compliance in real time but April has experienced deterioration out of hours and particularly at PHB.

Actions in place to recover:

- Emergency Department staffing levels are reviewed by the staffing Hub x 2 daily and an emphasis on securing templated staffing is in place. The newly applied indicator will assist this.
- Training continues to be in place.
- The Deputy Divisional Nurse and Lead Nurse for Urgent and Emergency has undertaken 2 interventions regarding triage compliance (recording and undertaking) at PHB and LCH. This has demonstrated a positive impact.
- 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.
- LCH has instigated an Urgent and Emergency Care 'Teams Chat' that also escalates recording performance. This is to be rolled out to PHB in May. *Note – the PHB 'chat* went live 8th May 2021.

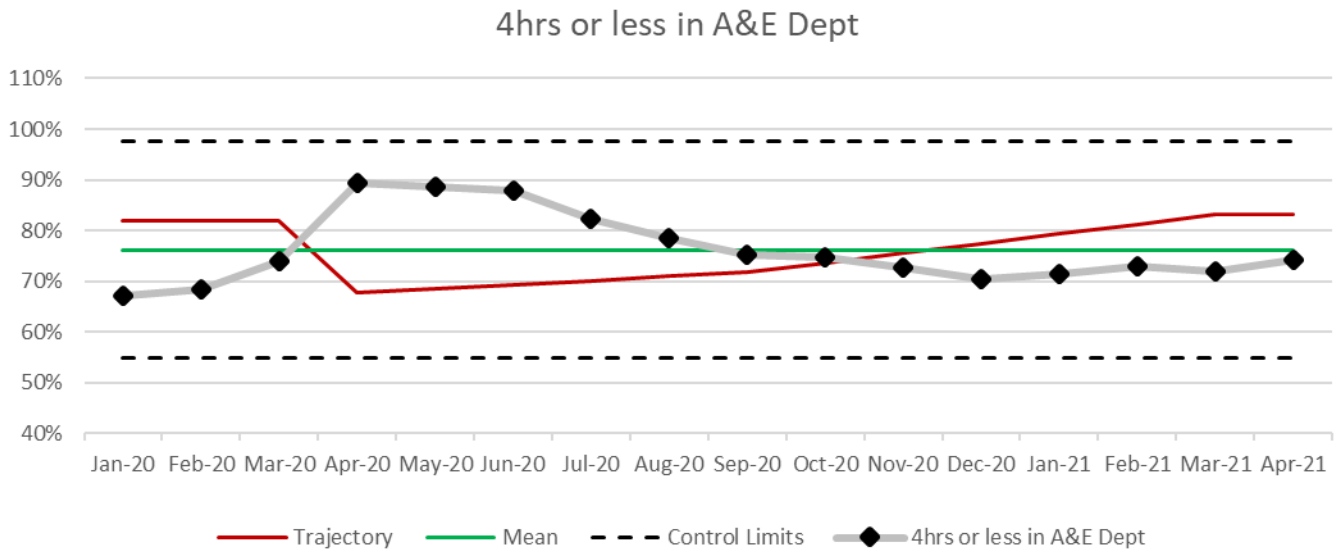
Triage time is a key patient safety performance indicator and forms an essential part of the department huddles. Performance against this safety indicator is scrutinised at the 4 x daily Capacity and Performance meetings where assurance must be given and demonstrated.

IMPROVE CLINICAL OUTCOMES – 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.

Comparison data for UEC attendances – April 2019 (pre covid) was 14,348. April 2020 was 9072 and April 2021 17,002. This is an overall increase against pre-covid activity of 15.61%

- April ED type 1 and streaming saw 17,002 attendances verses 15,749 in March (+1253 attendances). This represents a 7.37% increase. By site LCH experienced an 8.20% increase in attendances, PHB saw an increase of 4.86%. Grantham also experienced an increase in UTC attendances of 10.69%.
- April overall outturn for A&E type 1 and primary care streaming delivered 74.23% against an agreed trajectory of 83.12%.
- This demonstrates an improvement in performance of 2.25% compared with March outturn.
- Performance continues below the agreed trajectory by 8.89%. 2021/2022 performance trajectories have not been agreed as yet.
- By site, for April, LCH delivered 69.98%, a 3.86% improvement on March's performance (66.12%), PHB delivered 69.74%, a deterioration of 2.42% on March's performance (72.16%). GDH achieved 98.73% which was an improvement of 0.87% compared to March (97.86%). This includes type 1 and type 3 activity.
- The highest days of delivery by the Emergency Departments only was on 3rd April when LCH achieved 80.42% and also on 3rd April when PHB achieved 776.29%. The performance uplift from the UTCs was 89.42% at LCH (89.89%) and 9.51% at PHB (85.80%). Conversely, the lowest days of delivery by the Emergency Departments only was 1st April when LCH only achieved 39.44% and 7th April, when PHB only achieved 37.30%. The performance uplift from the UTCs activity was 16.58% (56.02%) and 24.05% (61.35%) respectively.
- Streaming at GDH, LCH and PHB experienced 355 >4hr transit time breaches in April compared with 408 in March, a decrease of 53 and overall improvement of 13%. The highest number of breaches proportionate to attendances was PHB. Steaming experienced an increase of 1243 attendances in April. 8343 compared with 7191 in March. This represents a 14.74% increase.
- 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:

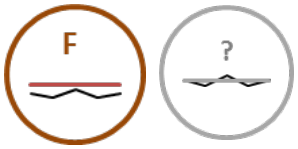
- The Restore and Recovery phase is underway. There is nationally driven review of the current Urgent Care Constitutional Standards which will be described in more detail in the FPEC Urgent Care paper, in the meantime, the revised Urgent and Emergency Care Delivery Programme led by General Manager, will continue at pace, with the overall outcome of reducing the burden on our Emergency Departments. The focus will remain on improved access to ambulatory pathways (SDEC), reduced conveyance to the Emergency Departments via EMAS by securing alternative treatment pathways and system wide pathways for older persons and those needing to access Mental Health support.
- A new national set of metrics will be introduced, and the trust is currently being benchmarked against these in shadow form.
- The Trust is now 6 weeks into an 8-week intensive support programme supported by NHSe/i and ECIST to ensure timely discharges, resulting in improving flow and reducing the number of patients in the Emergency Departments waiting for beds.

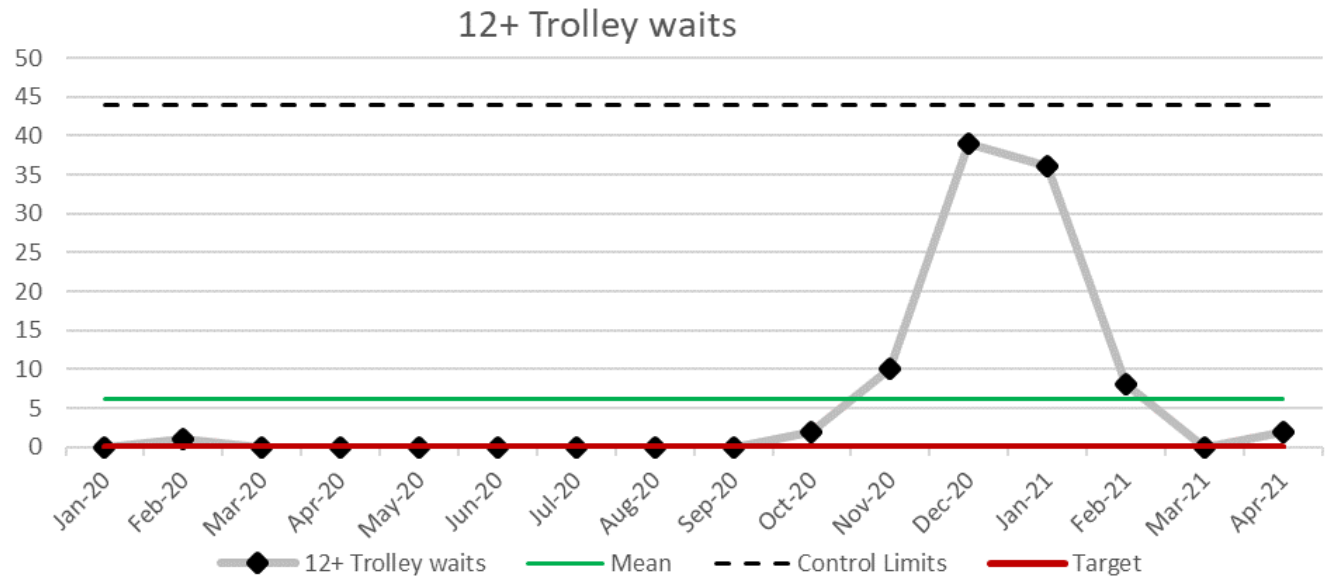
IMPROVE CLINICAL OUTCOMES – 12HRS + TROLLEY WAITS

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services





Challenges/Successes

- The Trust experienced and recorded 2 x 12hr hour trolleys waits in April compared to 0 in March. Both were clinically validated as true breaches, and both attributed to flow issues. These were reported as per the local and regional agreement and processes.
- Both were deemed as avoidable.
- The Trust continues to work closely with national regulators in reviewing and reporting these breaches. A timeline for the 12 trolley waits with the greatest total time in ED is submitted to NHSe/i at 11am the next day by the Deputy Chief Operating, Urgent Care.
- A daily review of all potential 12hr trolley waits is in place should this be required. This is led by the Chief Operating Officer. All involved specialities are expected to attend.
- System Partners and Regulators remain actively engaged and offer practical support in situational escalations. There have been no declared critical incidents in April.

Actions in place to recover:

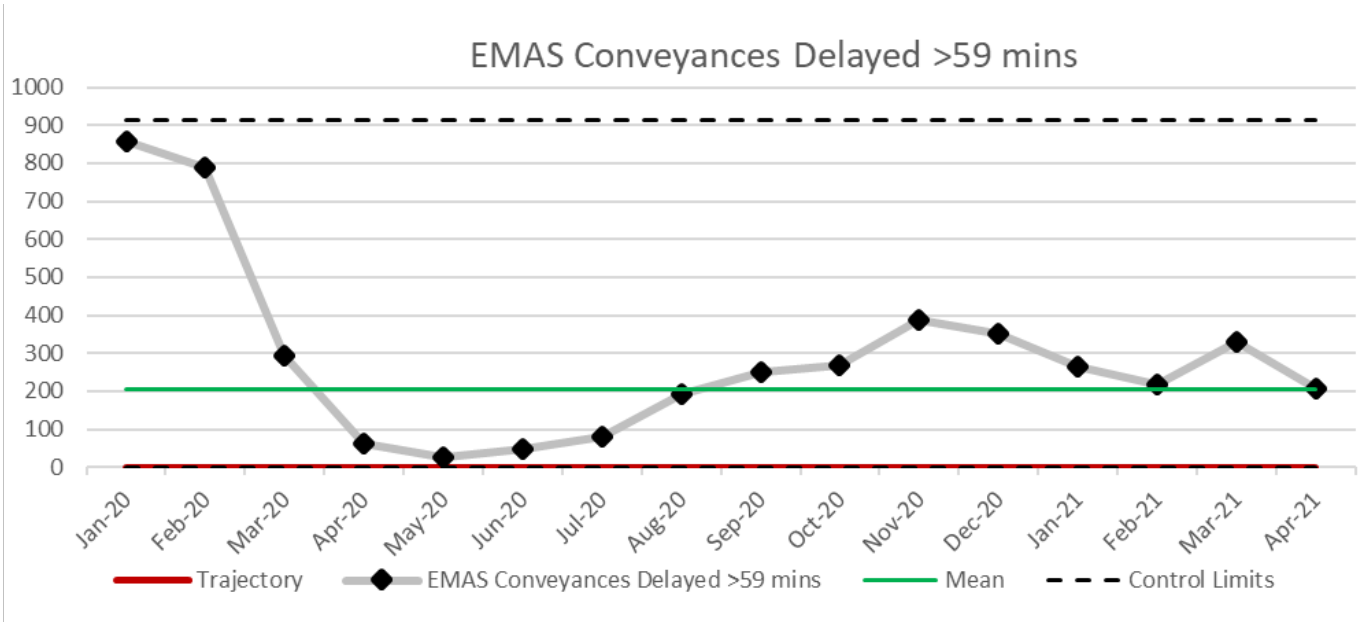
- Through the 4 x daily Capacity and Performance meetings, plans against the flow interventions required avoid any potential 12hr trolleys are agreed and the responsibility/accountability to secure and ensure effective and timely intervention is held by the relevant CBU.
- A multi-disciplinary approach to unblock discharge delays across all sites on pathways 1, 2 & 3 is in place and is robust. Twice daily System MDT meeting are in place and have become very effective. The ULHT Trust wide Discharge Lead ensures traction and delivery
- Every inpatient without a true reason to reside is now featured through the 4 x daily Capacity and Performance Meetings. Each CBU is held to account.
- The internal Discharge Cell chaired by the Trust wide Lead Nurse for Discharge, supported by the Deputy Chief Operating Officer – Urgent Care and the Director for Patient Safety are, alongside the Divisions, challenges the pathway zero discharge processes. There is an intensive support programme led by ECIST and NHSe/i providing challenge, confirm and rigor to our processes.
- Each System Partner is held to account for any patient in the Emergency Departments that do not require admission to ULHT. Timescales for securing onward non-acute care is both managed and escalated.

IMPROVE CLINICAL OUTCOMES – AMBULANCE HANDOVER >59

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services



Challenges/Successes

The Trust received 4481 EMAS conveyances in April compared to 4588 in March. This represents a 2.34% decrease.

- April reported 95.12% of handovers at LCH were <59 minutes and 95.63% at PHB. This is an improvement against the March performance.
- April reported 207 >59-minute hand over delays. This is a decrease of 121 on the March figure of 328. This represents a 36.90% decrease in >59-minute ambulance handover delays. LCH had 124 >59-minute ambulance conveyances in April compared with 178 in March. This represents a 30.40% reduction compared with March. PHB had 83 > 59-minute ambulance handover delays in April compared to 150 in March. This represents a 44.67% reduction.
- April demonstrated an increase in >120mins handover delays overall by 11.95%. >120 mins at LCH in April was 37 compared to 23 in March, an increase of 37.84%. PHB >120 mins decreased from 36 in March to 30 in April, a reduction of 16.67%
- Delays experienced at LCH can be attributed to volume and conveyance pattern. However, the pattern is well known and consistent. This familiar to the departments.
- 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 reported to the CCG by EMAS but are done so in context of the overall site position.

Actions in place to recover

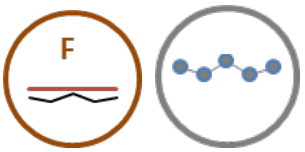
- As part of restore and recovery and following confirmation of additional monies to enhance our urgent care facilities, work has progressed at pace to bring these plans to fruition. This will result in larger footprints for RAT. This measure will ensure a significant reduction >59mins handover delays for both LCH and PHB.
- Dedicated UEC Project Management resource has been supported by the Innovation and Integration Team. This support will ensure the UEC Trust Teams to affect a sustainable change with a particular focus on SDEC to reduce unnecessary admissions and generate improved bed flow.
- Work continues within the System to reduce the overall ambulance conveyances to ULHT through implementing robust alternative pathways via Think 111 and CAS but more work is required.
- All ambulances approaching 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.

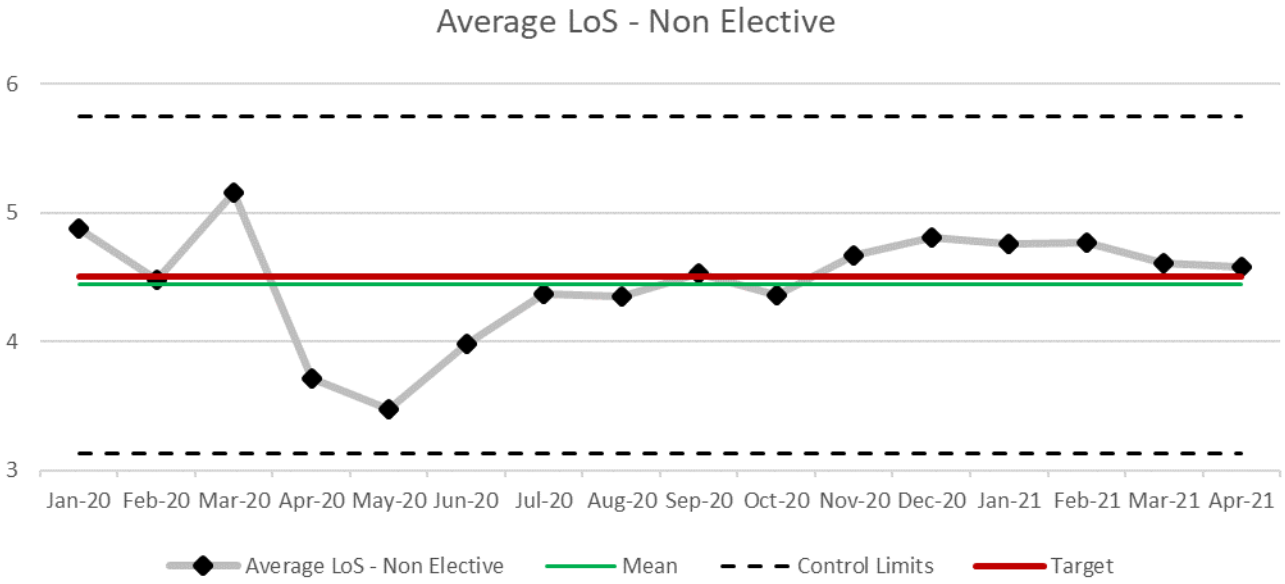
IMPROVE CLINICAL OUTCOMES – AVERAGE LOS NON-ELECTIVE

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 April, delivering 4.58 ALOS compared to 4.61 ALOS in March. This represents a positive variation of 0.03 days but remains above the trust target of 4.50 days.
- LCH ALOS increased from 4.97 days in March to 5.03 days in April. PHB deceased from 4.30 days in March to 4.23 in April. GDH demonstrated an increase from 0.29 days in March to 0.38 days in April.
- 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 and is chaired by the Lead Nurse, Discharge (Trust wide).
- An 8 weeks intensive discharge support programme is in place led by ECIST/NHSe/i. We are now in week 6 of the programme.
- Project Salus is now in pace within the Surgical Division, Clinical Support Services Division and the Division of Family Health. This is now being embedded within the Division of Medicine and Emergency Care.
- The ward refurbishment and cleaning programmes have continued during April but with some disruption and delays.
- The C-19 fifth wave impact and modelling for ULHT has been completed and the ICC is monitoring and will advise the Trust. The next wave prediction is 21st June 2021.
- During April the numbers of patients with a LLOS decreased. 60 in April compared to 70 in March. A decrease of 10 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

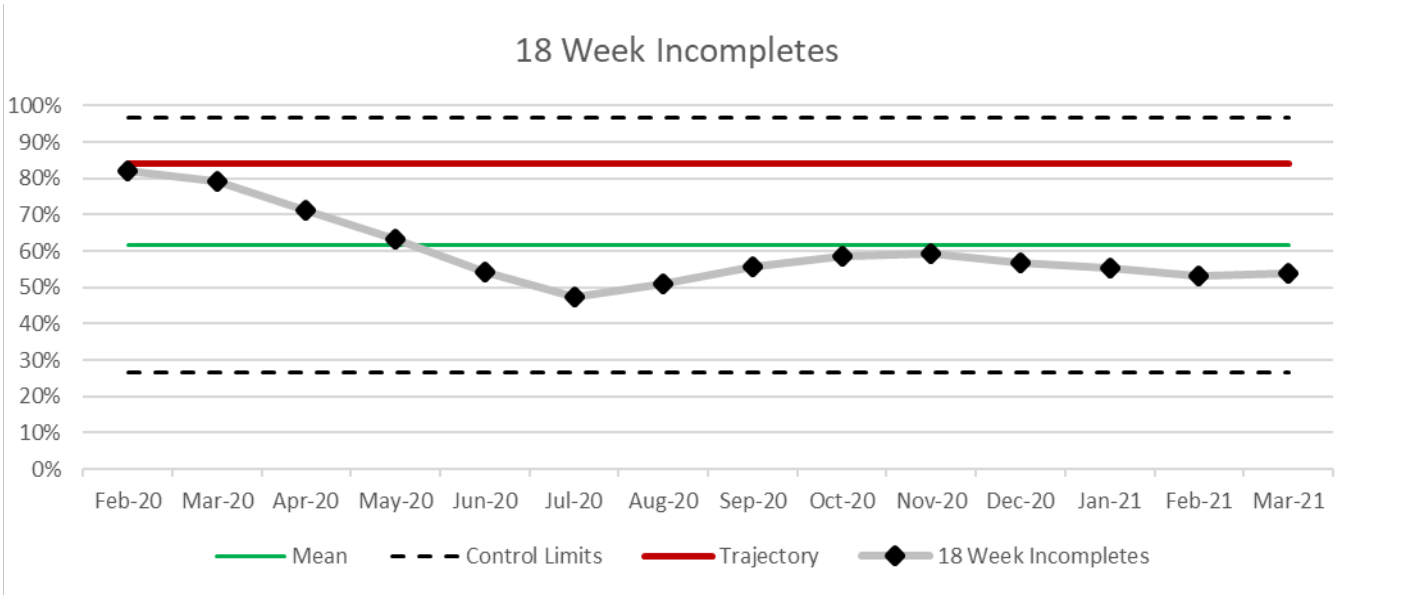
- Multi-agency discharge meetings continue take twice place daily, seven days a week. A Line by line reviews take place against each patient on pathway 1, 2 and 3. This process is robust and an increase the discharge of medically optimised patients across the entire week (7days) has being realised.
- 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 delivery group, led by the Trust wide discharge lead, continues to support the delivery of this and in addition, the Trust continues to be actively involved in an 8 week intensive discharge support programme led by ECIST/NHSe/i.
- As the COVID +ve demand continues to reduce, 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 and also April.

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.

March saw RTT performance of 53.94% which is 0.9% up on February.

811 - Interventional Radiology was the lowest performing specialty, with performance decreasing from 37.14% last month to 36.00% (-1.14%). Neurology is performing slightly worse this month with a 2.07% decrease from 56.72% last month to 54.65% in March.

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

- Ophthalmology - 3540 (Increased by 328)
- Ent - 2555 (Increased by 148)
- Trauma & Orthopaedics - 1676 (Reduced by 96)
- Gynaecology – 1485 (Increased by 156)
- Maxillo-Facial Surgery + Orthodontics + Oral Surgery - 1483 (Increased by 14)

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 and Gynaecology. Trauma & Orthopaedics however, has shown a slight increase in performance. The re-introduction of routine elective work for non-admitted activity continues to utilise video and telephone consultations, with 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 March were:

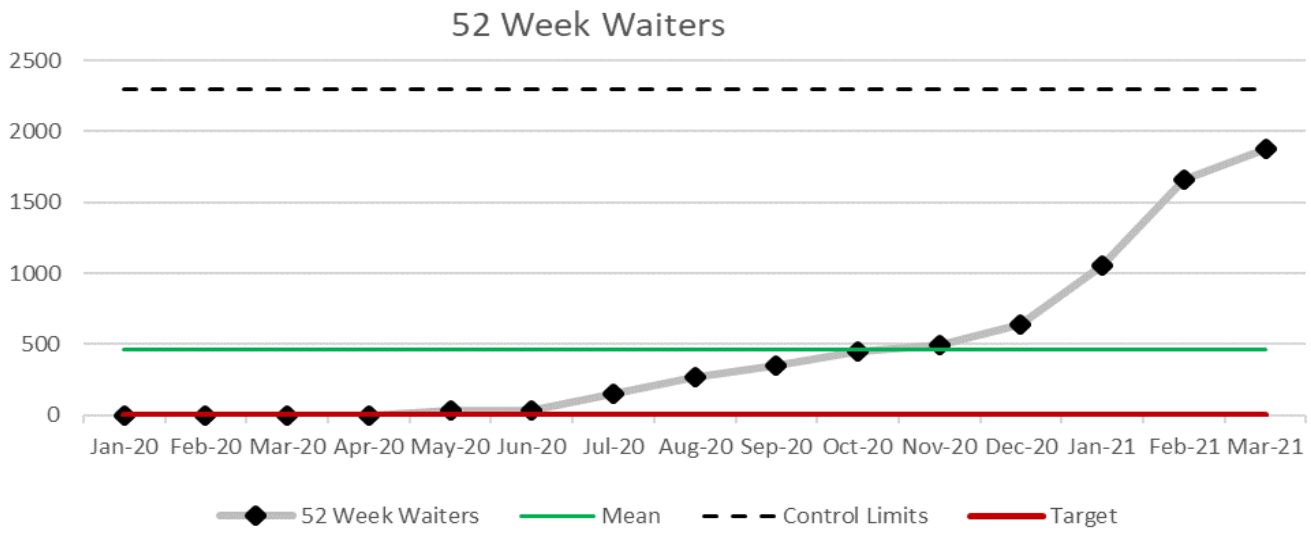
- Breast Surgery 95.09%
- Clinical Haematology 96.71%
- Clinical Physiology 100.00%
- Transient Ischaemic Attack 100%
- Medical Oncology 100%
- Clinical Oncology 96.65%

IMPROVE CLINICAL OUTCOMES – 52 WEEK WAITERS

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services



Challenges/Successes

The Trust reported 1,877 incomplete 52 week breaches for March end of month. An increase of 215 from February. 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.

Harm reviews will be completed by the relevant division for each patient. A root cause analysis (RCA) will be completed as a whole, covering all patients within a specialty that have waited longer than 52 weeks for treatment due to the effect of the pandemic.

The Clinical Harm Oversight group, led by the Chief Operating Officer continues to 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

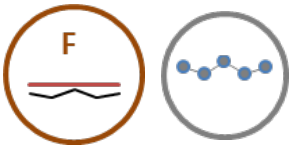
Recovery plans continue to be implemented; accounting for a changing environment.
Across the Trust outpatient services continue to use all available media to consult with patients.

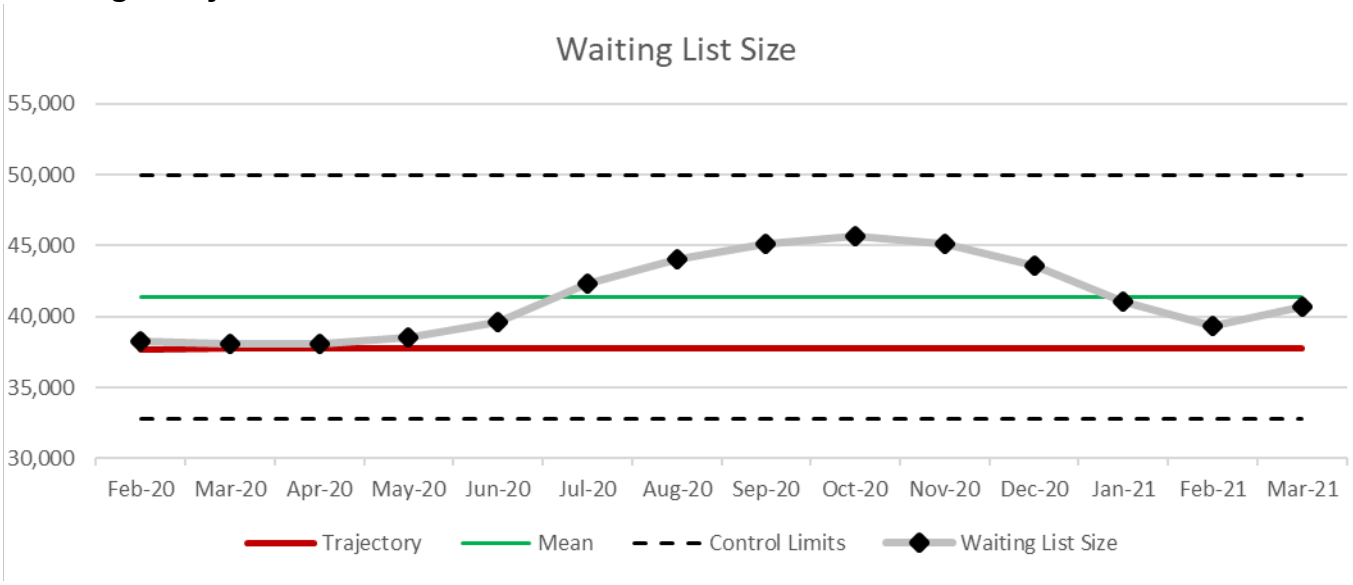
IMPROVE CLINICAL OUTCOMES – WAITING LIST SIZE

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services





Challenges/Successes

Overall waiting list size has increased from February, with March showing an increase of 1,292 to 40,660. The incompletes position for March is now approx. 1628 more than the March 2018 (39,032) target. This does not however, account for the approximately 10,319 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 February are:

- 502 – Gynaecology +421
- 130 – Ophthalmology +370
- 103 - Breast Surgery +322
- 120 - Ent +239
- 101 - Urology +236

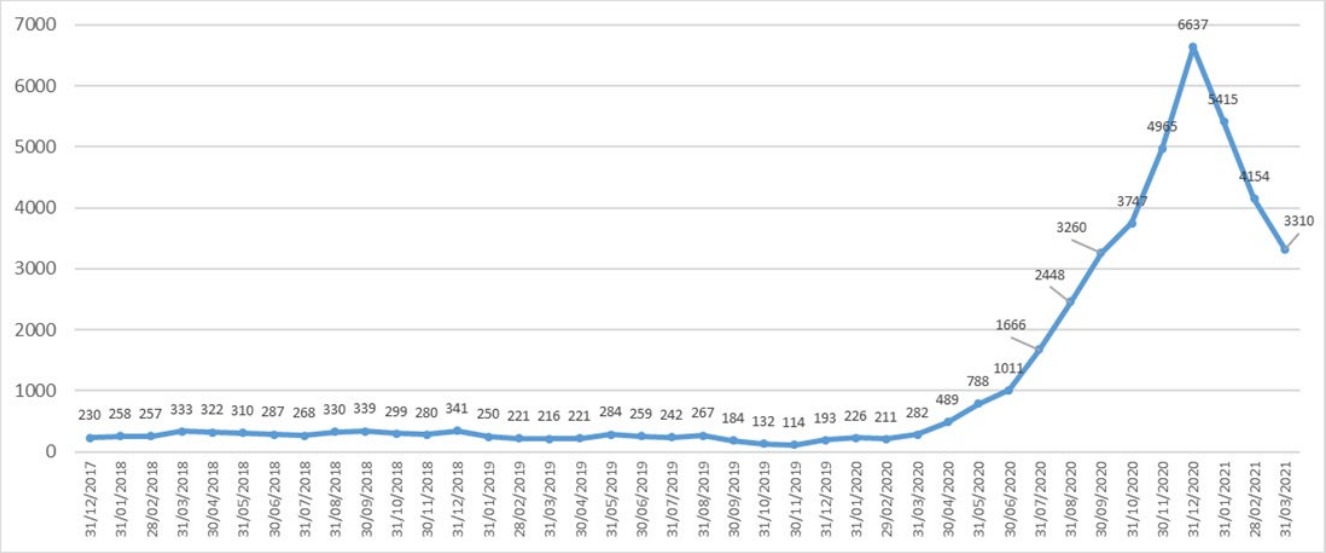
The five specialties showing the biggest decrease in total incomplete waiting list size from February are:

- 320 - Cardiology - 246
- 110 - Trauma & Orthopaedics -237
- 301 - Gastroenterology -166
- 302 - Endocrinology -86
- 290 - Community Paediatrics -66

Actions in place to recover

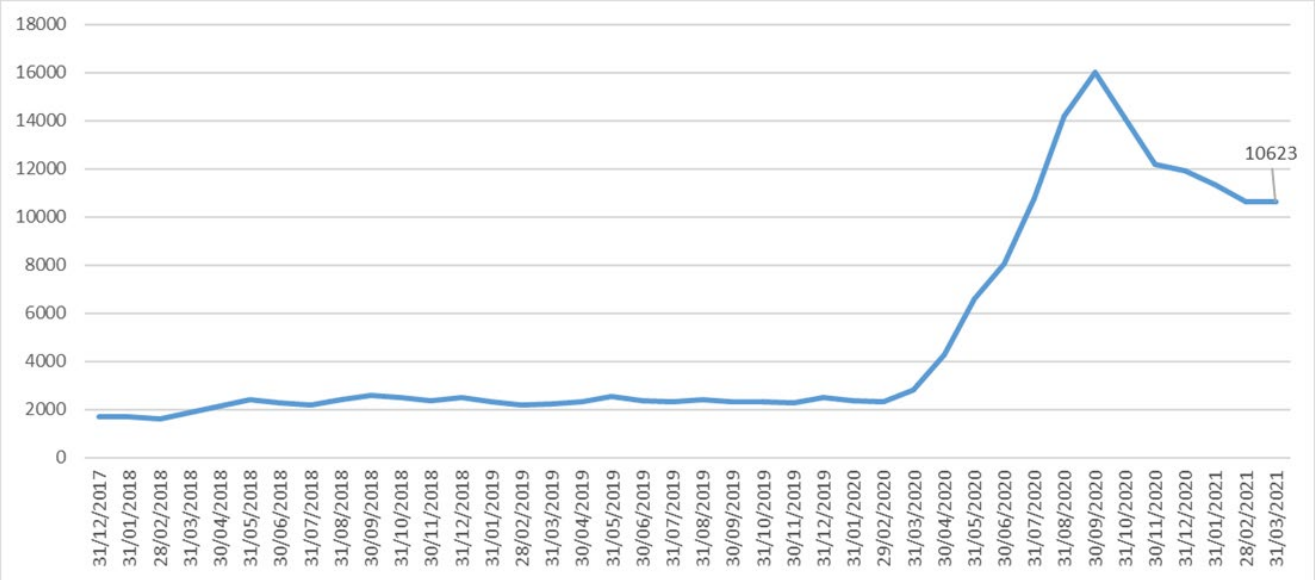
The longest waiting patients continue to be tracked and discussed at the weekly PTL meeting. March showed 3,310 patients waiting 40 weeks and above as the chart below shows. February to March saw a decrease of patients waiting over 40 weeks, -844. Twenty-eight specialties reduced their position compared to last month, with Ophthalmology showing the best improvement of -175 patients. Colorectal Surgery however, showed an increase in position (+8).

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 31st March, shows a decrease of 3 patients from February. Twenty-three specialties decreased their position with the largest decrease being seen in Cardiology, - 103. The largest increase was seen in ENT, +121.

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 42 pathways as waiting over 80 weeks for first definitive treatment.

- 100 - General Surgery 23
- 502 - Gynaecology 7
- 120 - Ent 4
- 110 - Trauma & Orthopaedics 3
- 107 - Vascular Surgery 2
- 144 - Maxillo-Facial Surgery 2
- 143 - Orthodontics 1

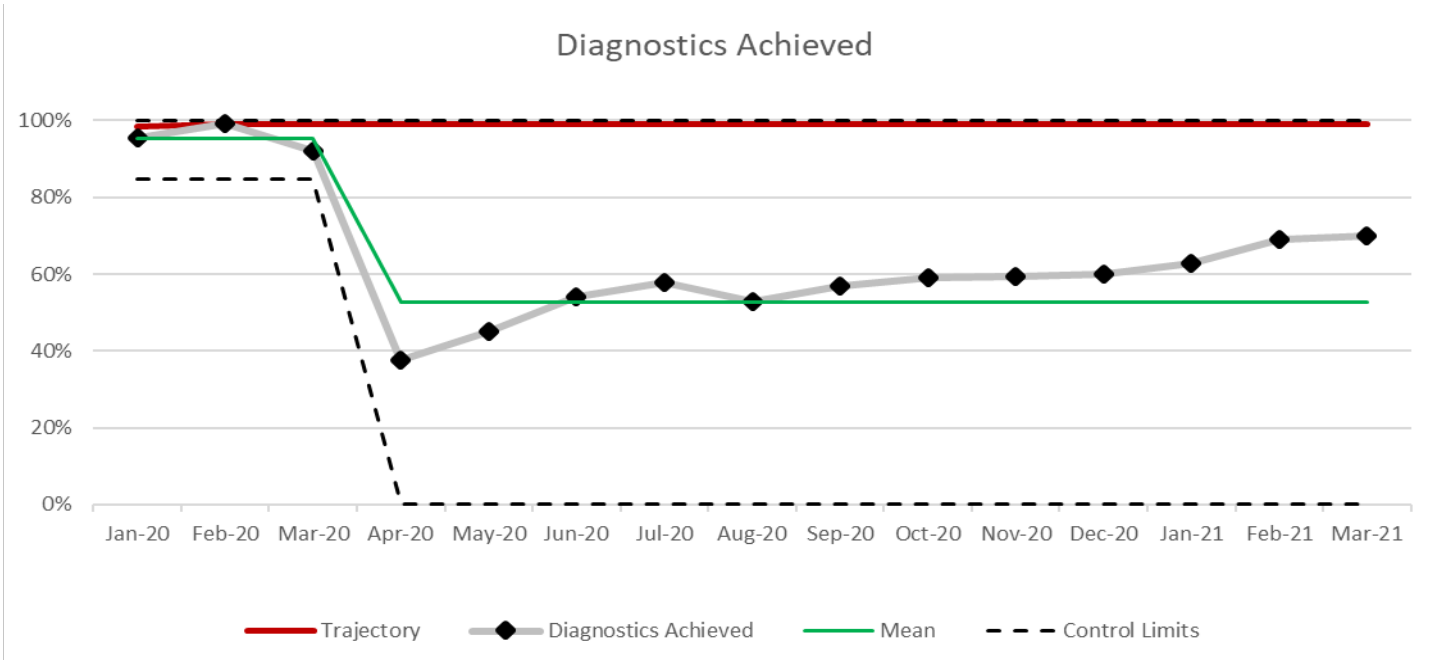
These patients are discussed at a weekly meeting with NHSE/I and CCG colleagues.

IMPROVE CLINICAL OUTCOMES – DIAGNOSTICS

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services



DM01 69.91% which is an improvement from last month of 68.94%

Challenges/Successes:

CT

- Much improved position of 118 breaches for March compared to 146 in February the majority these are cardiac and are booked outside breach date. Sourcing and retaining agency staff to man the additional CTs is difficult.

MRI

- 57 breaches in March compared to 62 in February, majority these are cardiac and general anaesthetic patients.

Physiological Sciences.

- Neurophysiology - peripheral neurophysiology LCH is reporting 74 breaches for March compared to 114 in February.
- Audiology - Audiology Assessments had 0 breaches in March.
- Waiting lists are monitored weekly.
- Neurophysiology at Pilgrim this reporting 121 breaches in March compared to 177 in February.

Endoscopy

- Gastroscopy had a much to improve position of only 18 breaches in March compared to 85 in February.
- Cystoscopy carried out within endoscopy had 74 breaches in March compared to 114 in February.
- Colonoscopy had 492 breaches in March compared to 489 in February. These are the planned patients all live patients are being carried out within 41 days.

.**Cardiology**

- Cardiology – echocardiography had 2641 breaches for March compared to 2051 for February.
- Cardiology - echocardiography Stress /TOES had 55 breaches in March compared to 58 in February.

The main concern for the DM01 for the Trust is the cardiac position as this is pulling the overall performance down. There have been discussions to start reducing the breaches relating to echo's. Cardiology are submitting a Case of Need for additional resources to start reducing the backlog and breaches.

DM01 Performance with cardiac excluded is 87.96%

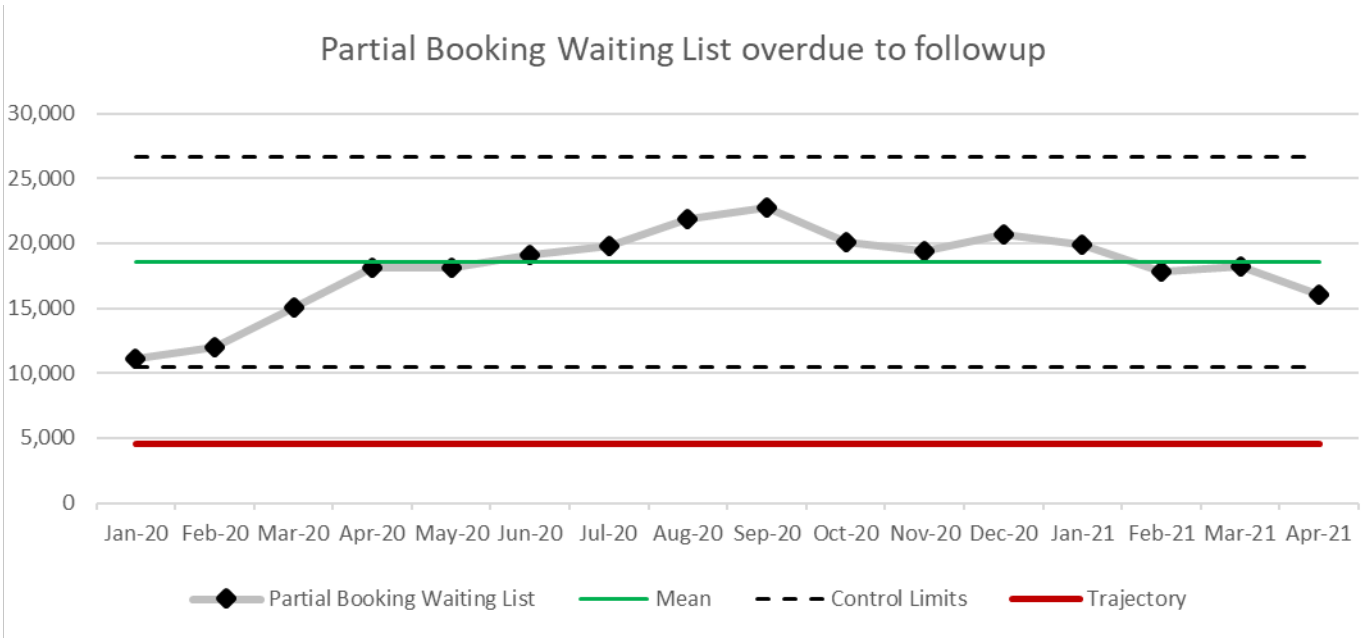
DM01 Cardiac performance 30.80%
DM01 Endoscopy performance 65.70%
DM01 Neurophysiology performance 68.50%
DM01 radiology performance 96.80%
DM01 Audiology performance 100.00%

IMPROVE CLINICAL OUTCOMES – PARTIAL BOOKING WAITING

Executive Lead: Chief Operating Officer

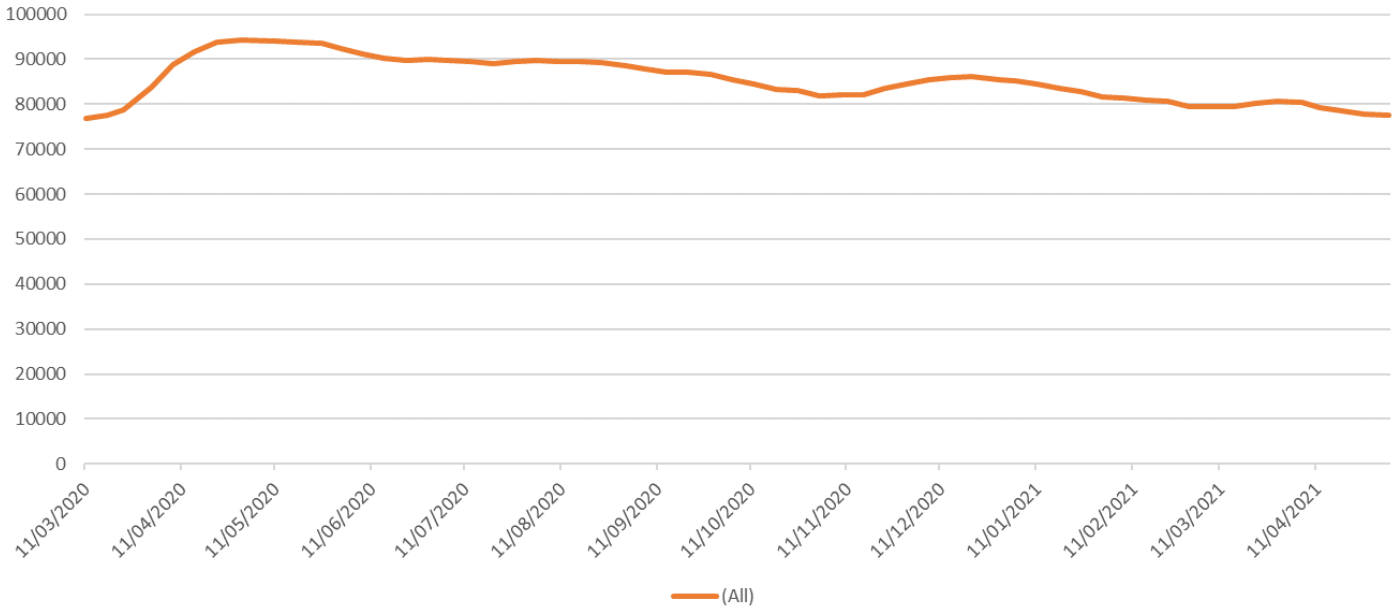
CQC Domain: Responsive

Strategic Objective: Services



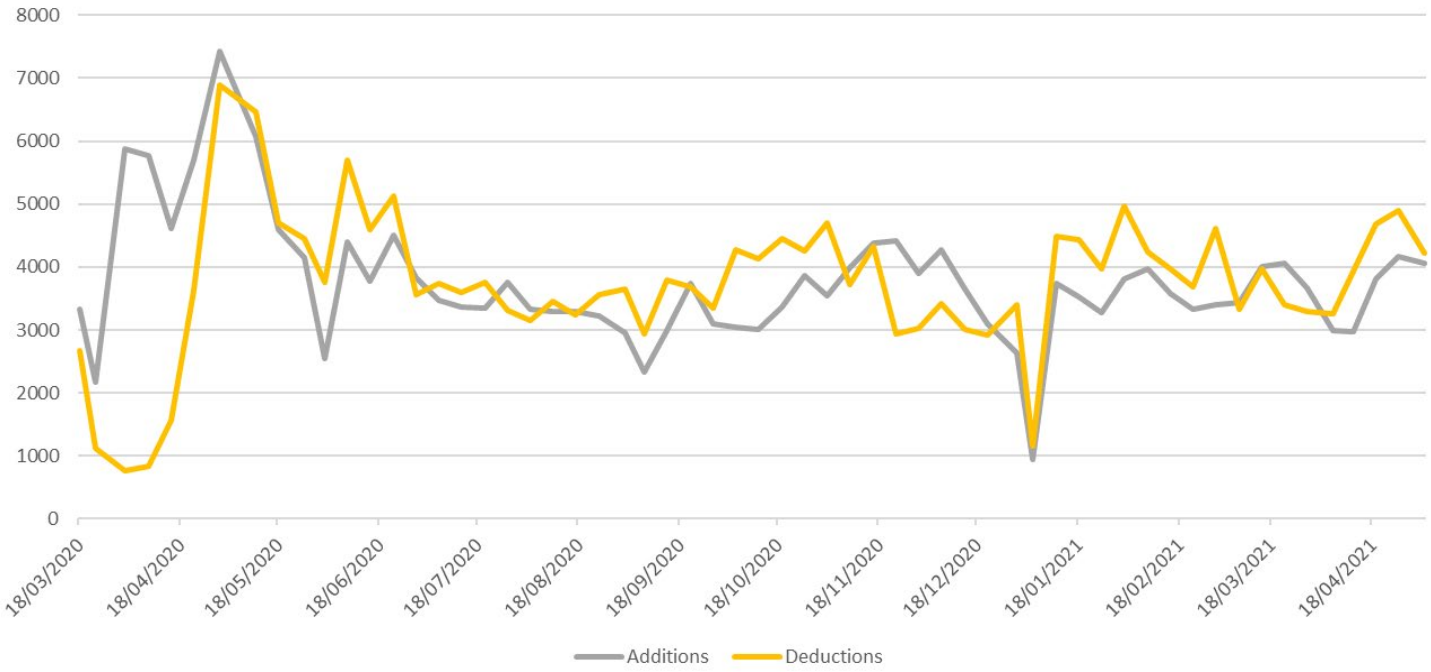
Challenges/Successes:

The Trust has been working hard to reduce the PBWL since the significant increases to PBWL due to the number of Covid patients. The main challenge is to balance the Trust priorities and resources to maintain the downward trend in patients on the PBWL. The success is the continued downward trend to the PBWL.



Actions in place to recover:

The Trust is currently going through the process of implementing speciality level restoration plans in line with the National guidance. The plans are focused on clinical urgency and activity levels. The fortnightly PBWL meeting is continuing to monitor progress, challenge and offer support were necessary. The majority of specialities continue with the administrative validation, clinical triage, and the scaling up of technology enabled care. The plans will be reviewed looking at the appropriate use of validation, PIFU (patient Initiated Follow Ups) and video consultations / telephone consultations.

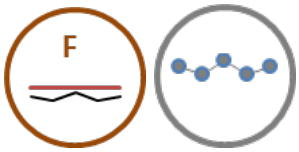


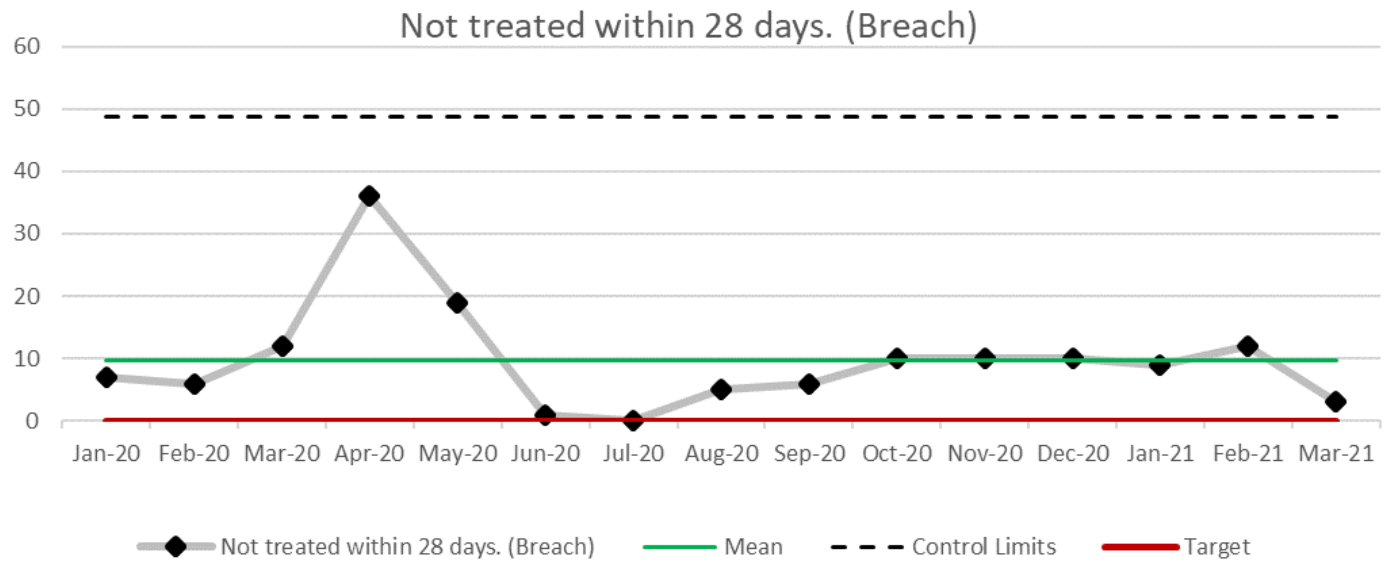
IMPROVE CLINICAL OUTCOMES – CANCELLED OPS

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:

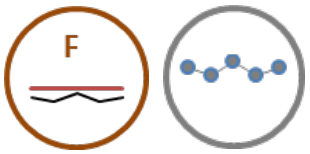
A daily review is in place to identify the root causes of all non-clinical cancellations and undertake remedial action to prevent re-occurrences

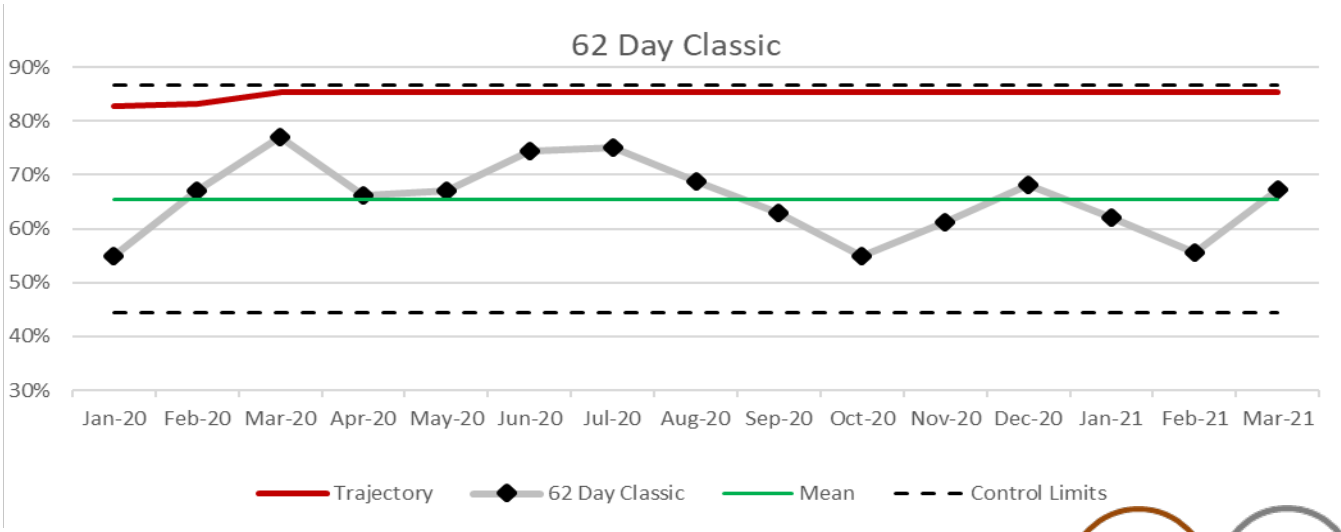
IMPROVE CLINICAL OUTCOMES – CANCER 62 DAY

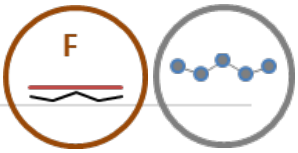
Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services



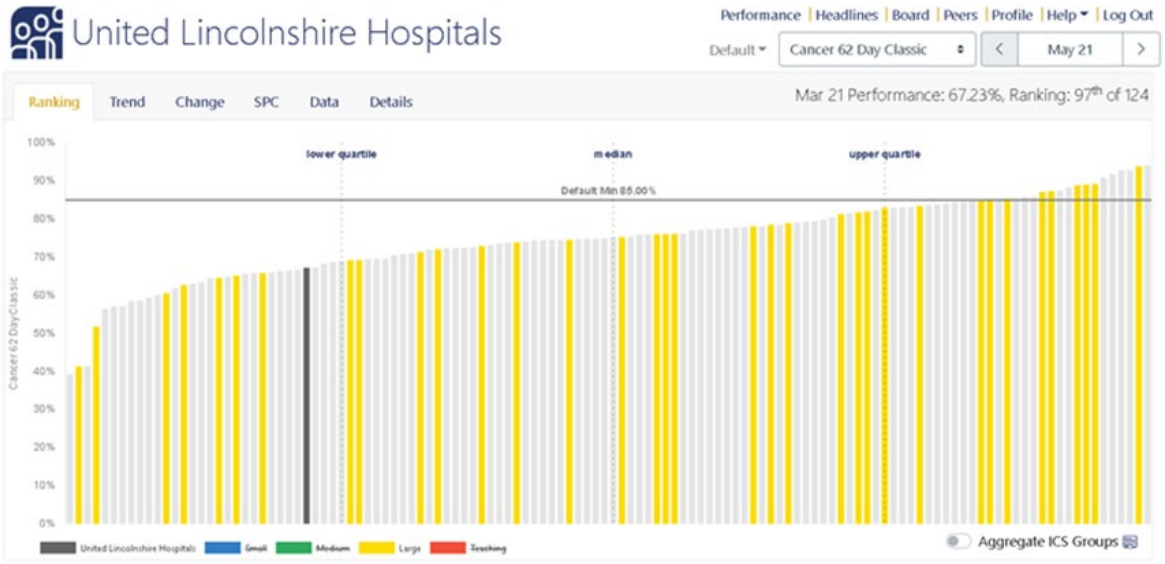




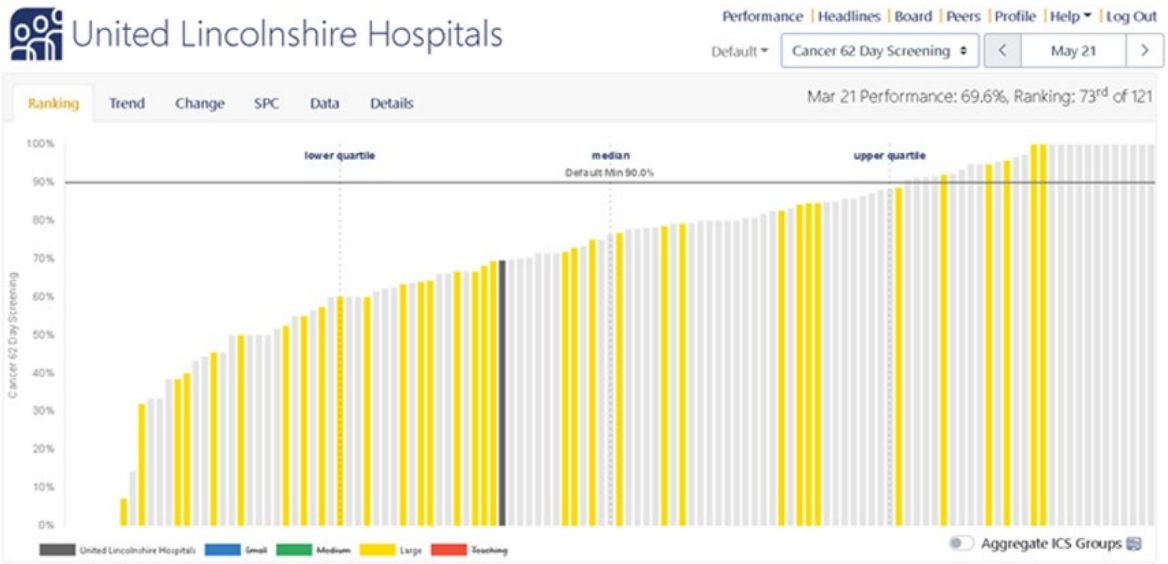
Challenges/Successes

In March our 62 Day Classic performance increased by 11.7% compared to February, at 67.2% placing us both below the national average (73.9%) and just in the lower quartile.

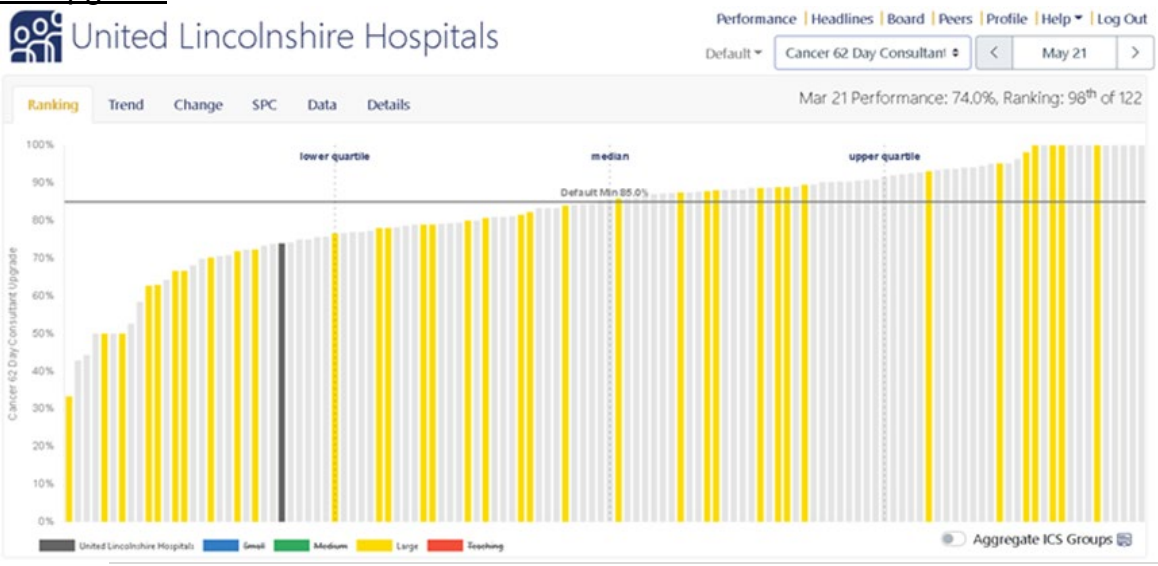
62 Classic



62 Screening



62 Upgrade



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

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 (e.g. 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
- 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, Upper GI and Urology
- Lost treatment capacity due to short notice cancellation of patients (unwell on the day of treatment or day before), not allowing time to swab replacement patients

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

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

- Funding from EMCA is in place for full-time Cancer Navigator posts to support Surgery, Medicine and Family Health. Recruitment processes are underway.

- 2 H&N consultant posts have been recruited, 1 started in April 2021, and another is due to start in July 2021.

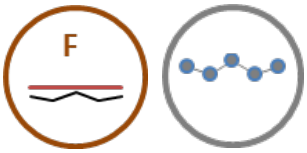
- 2 substantive Medical Oncologists have been recruited to. One due to start in July 2021(covering Breast, Renal and Urology) and another due to start in October 2021 (covering Gynae and Breast). One agency Medical Oncologist will be in post for 6 months, commencing 24th May (covering UGI / LGI and CUP).

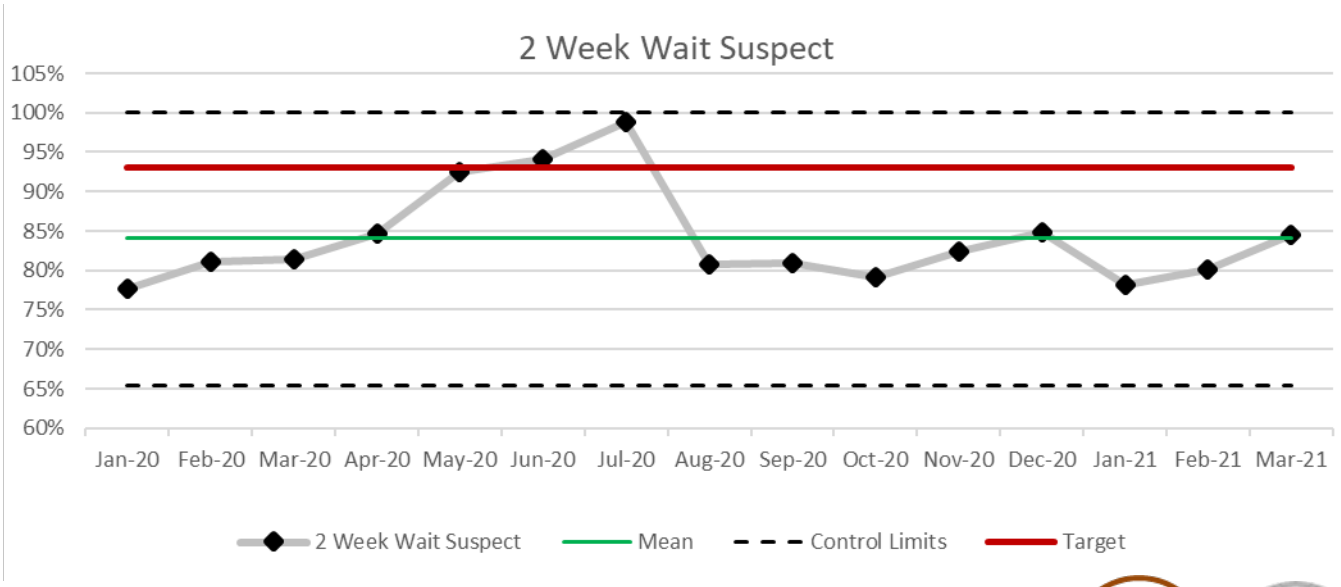
IMPROVE CLINICAL OUTCOMES – CANCER 2 WEEK WAIT

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services

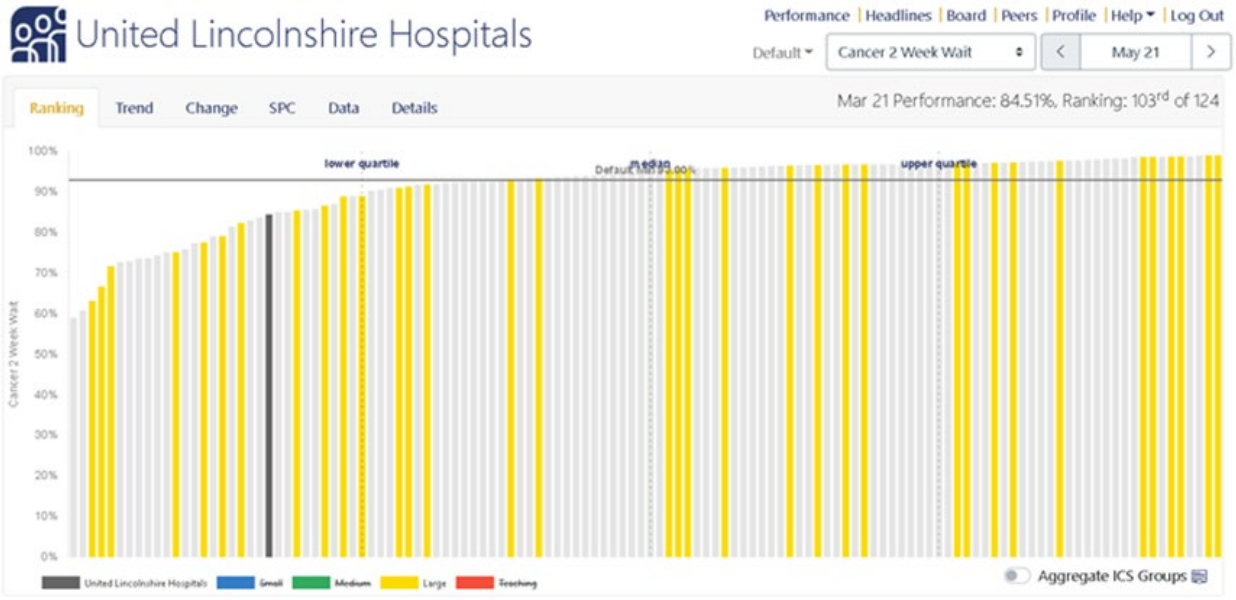




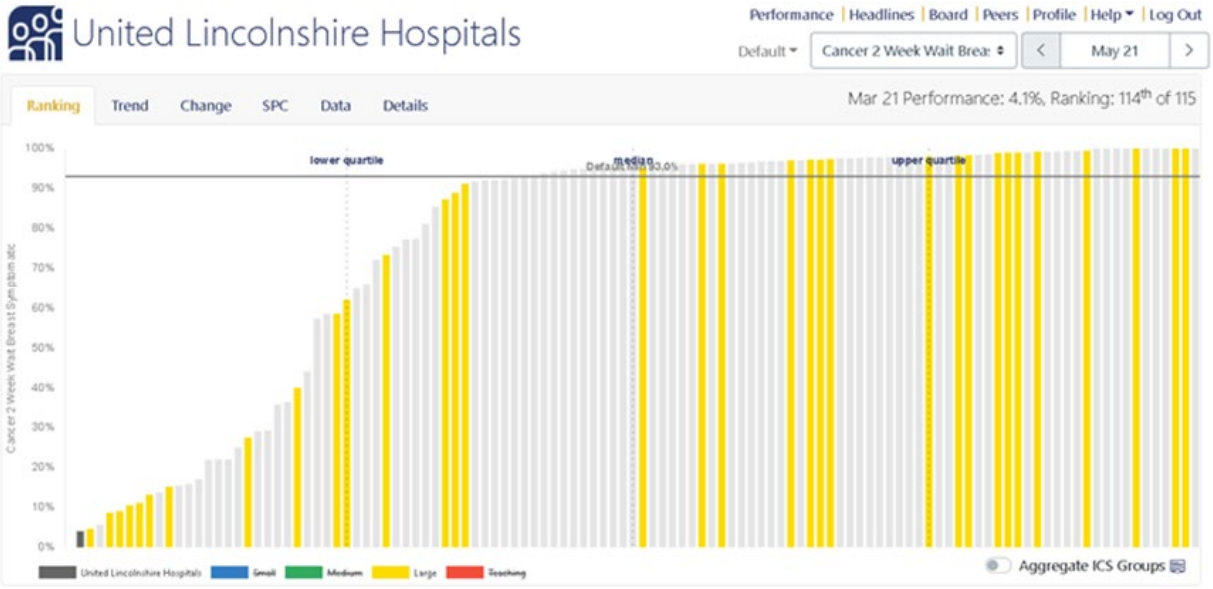
Challenges/Successes

The Trust's 14 Day performance continues to be significantly impacted by the current Breast Service One-Stop appointment alignment issues - 58% of the Trust's 14 Day breaches were within that tumour site. The other tumour sites that considerably under-performed include Gynaecology (19%) and Upper GI (11%). 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:

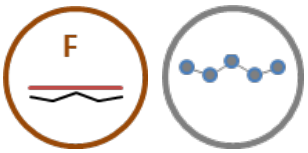
- Work continues to align all the 2ww Referral forms to NG12.
- Breast Services review (following final report from NHSI support).
- Gynaecology Direct Access ultrasound pathway due to commence.
- Lung Direct Access pathway now Trust wide.
- Pilot to appoint Lung patients within 48 hours trialled.
- Pilot of triaging all Skin 2ww referrals due to commence in July.
- 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.

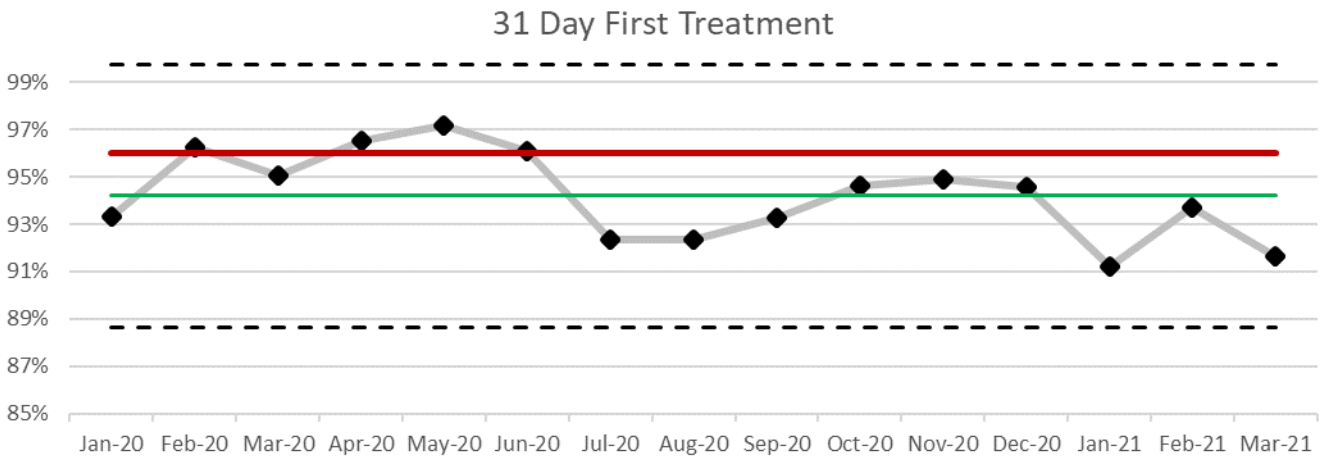
IMPROVE CLINICAL OUTCOMES – CANCER 31 DAY

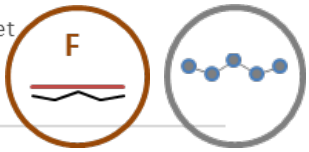
Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services



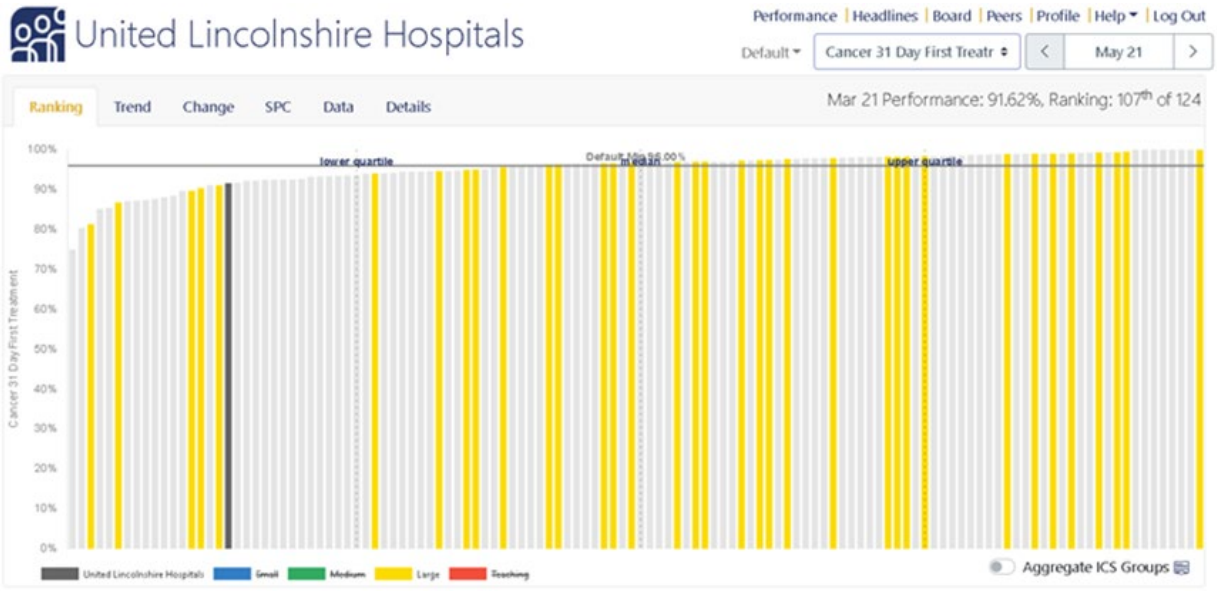




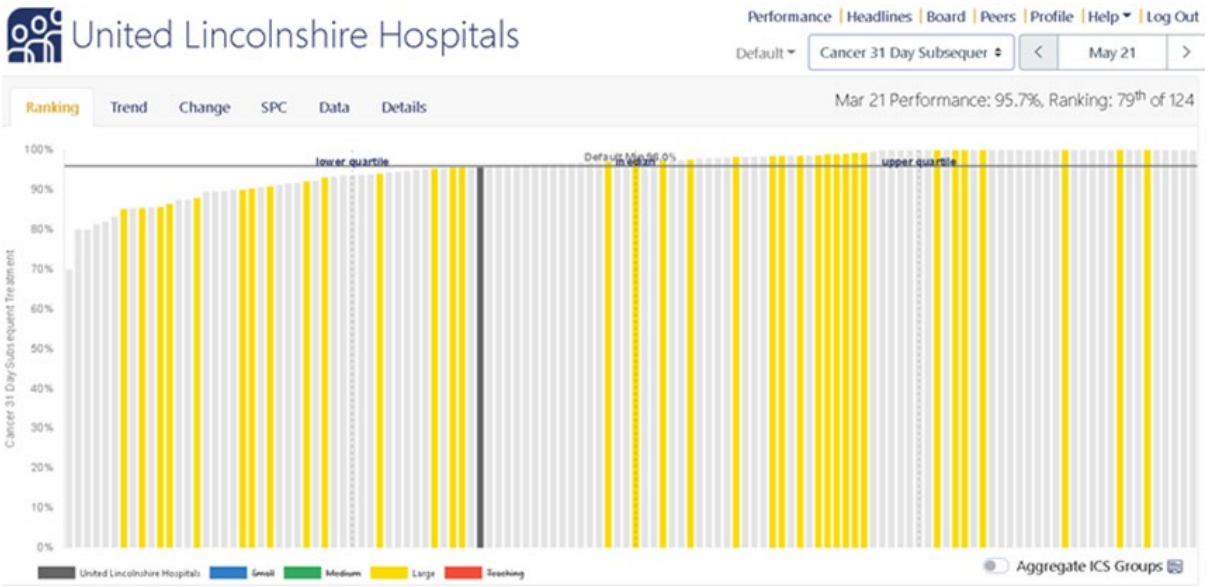
Challenges/Successes

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:

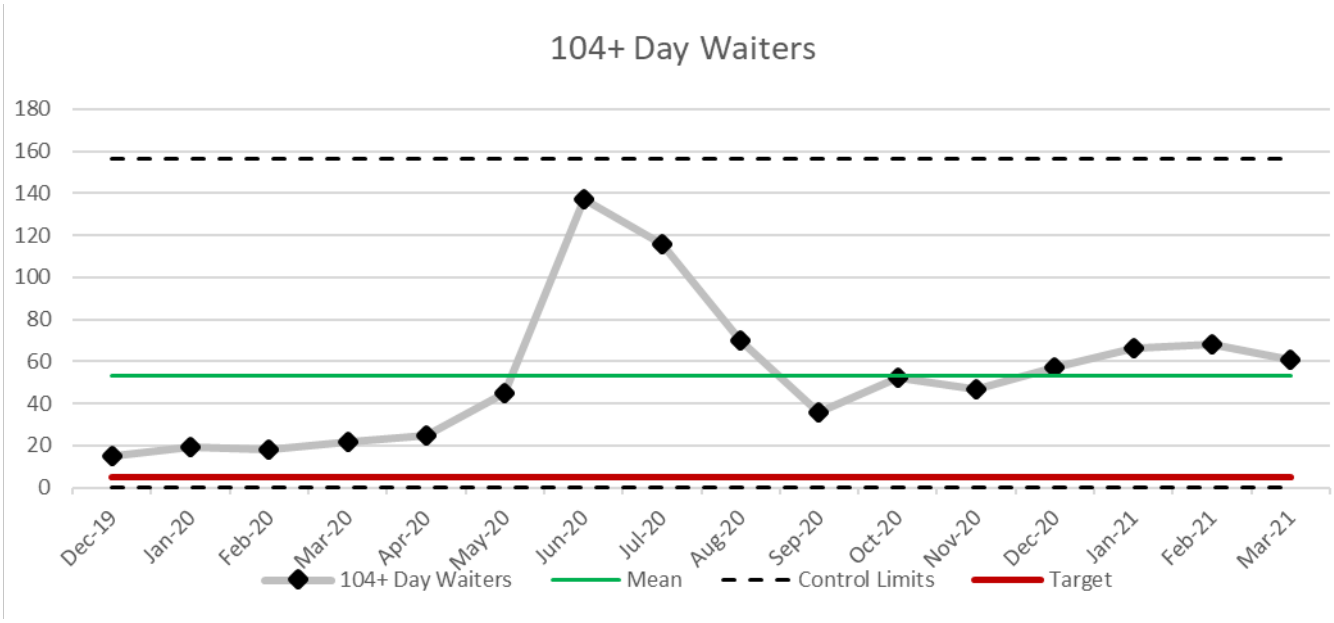
- Review of Colorectal theatre list scheduling to better align with clinician availability and consideration of moving level 1 patients to Grantham.
- 2 H&N consultant posts have been recruited to, 1 started in April 2021, and another is due to start in July 2021.
- 2 substantive Medical Oncologists have been recruited to. One due to start in July 2021(covering Breast, Renal and Urology) and another due to start in October 2021 (covering Gynae and Breast). One agency Medical Oncologist will be in post for 6 months, commencing 24th May (covering UGI / LGI and CUP).

IMPROVE CLINICAL OUTCOMES – CANCER 104+ DAY WAITERS

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

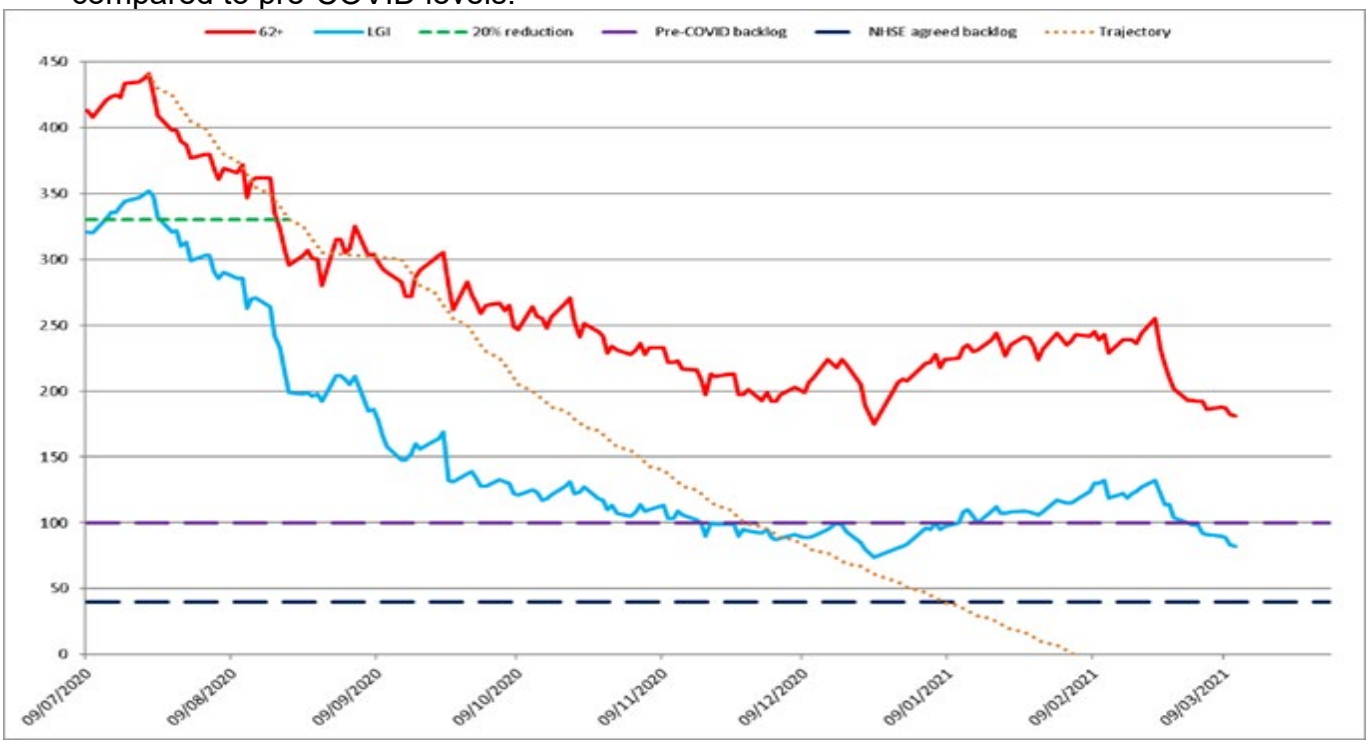
Strategic Objective: Services



Challenges/Successes

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

- As of 7th of May the 62 Day backlog is at 216 patients (from 441, target – below 40) **51% Reduction.**
- In August Colorectal patients accounted for c.70% of backlog and is now c.36%.
- Of the other tumour sites, Head & Neck, Breast, Upper GI, and Urology remain outliers compared to pre-COVID levels.



104y Waiters as of 6th of May is at 47 (from 163, target – below 10) **71% Reduction**

- 25 Colorectal
- 7 Head & Neck
- 5 Urology
- 3 Upper GI
- 2 each Breast, Lung and Gynaecology
- 1 Haematology

Approx. 34% of these patients require support from the Pre Diagnosis CNS as they have mental or social care needs that have the potential to significantly impact on the length of their pathway. Work to enhance the early identification of these patients is ongoing.

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 (e.g. 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, Upper GI and Urology.
- Lost treatment capacity due to short notice cancellation of patients (unwell on the day of treatment or day before), not allowing time to swab replacement patients

Actions in place to recover:

- 28 Day standard identified as Trust's single cancer performance work stream in the Integrated Improvement Program for 2021-22.
- 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.
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- 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.
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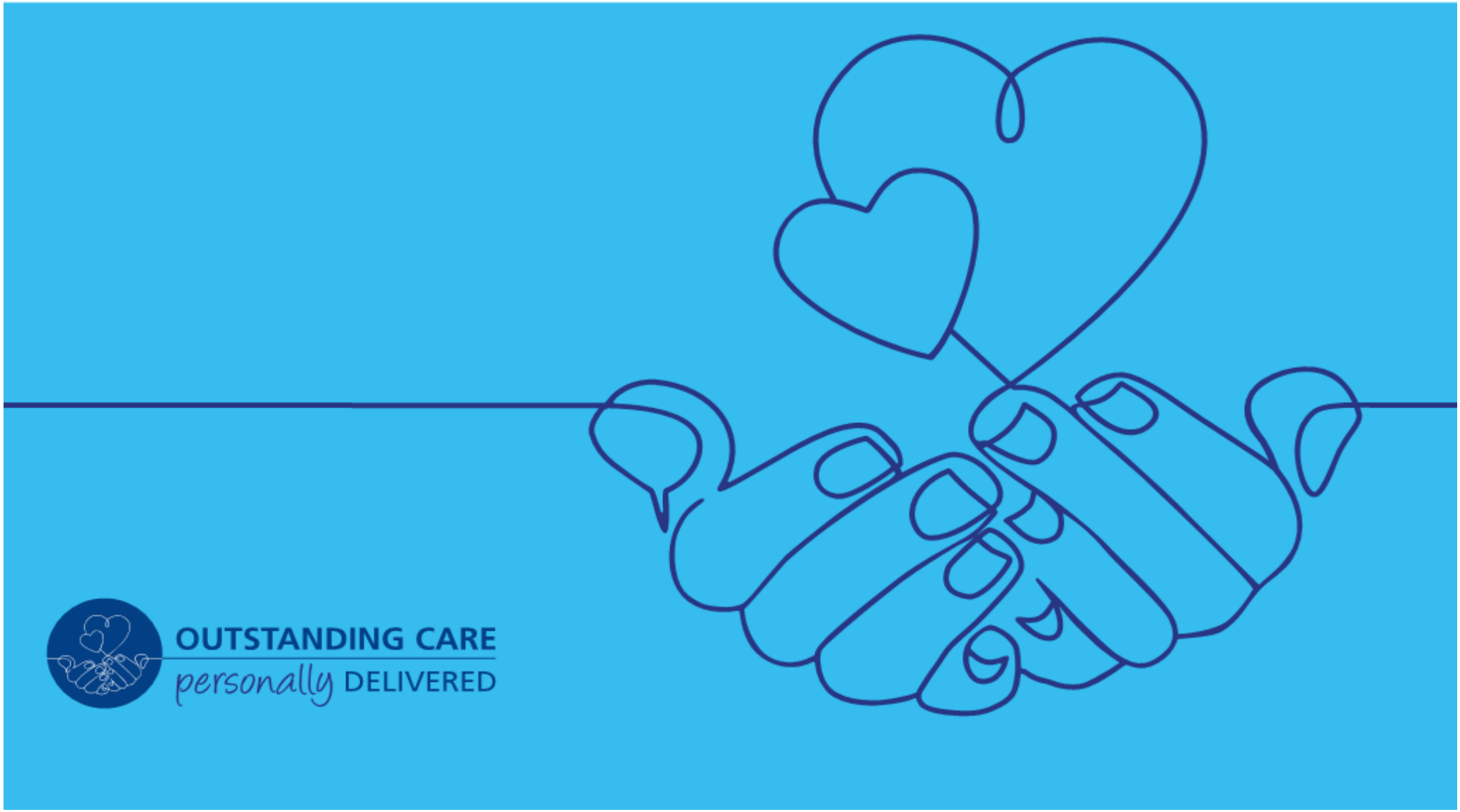
Financial Position Month 1 2021/22
Finance Report
5 Year Priority – Efficient Use of Resources

NHS
United Lincolnshire Hospitals
NHS Trust



Finance Spotlight Report

NHS
United Lincolnshire Hospitals
NHS Trust

Category	Current Month			Year to Date		
	Plan £000's	Actual £000's	Variance £000's	Plan £000's	Actual £000's	Variance £000's
Operating income pat care act	49,407	49,765	358	49,407	49,765	358
Other operating income	2,513	2,728	215	2,513	2,728	215
Employee Expenses	(34,882)	(35,170)	(288)	(34,882)	(35,170)	(288)
Operating expenses excluding employee expenses	(17,319)	(17,690)	(371)	(17,319)	(17,690)	(371)
Net Finance Costs	(646)	(611)	35	(646)	(611)	35
Other gains/(losses) including disposal of assets	0	0	0	0	0	0
Surplus/(Deficit) for period	**(927)**	**(978)**	**(51)**	**(927)**	**(978)**	**(51)**
Remove capital donations/grants I&E impact	0	56	56	0	56	56
Adjusted financial performance surplus/(deficit)	**(927)**	**(921)**	**6**	**(927)**	**(921)**	**6**

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

- Without the planned system support, funding for lost Other Operating Income and top up block funding, the Trust would have reported a Year End deficit of £196.8m.

- The Lincolnshire system submitted a breakeven financial plan for H1 of 2021/22; the system submission is inclusive of a breakeven position for the Trust and a requirement for the Trust to deliver efficiency savings of £6.2m in H1.

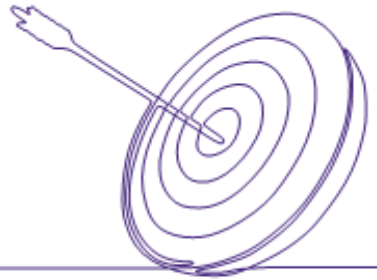
- The Trust is in the process of finalising its financial plan for submission on 24th May 2021, and as a result the phasing of the Trust's H1 plan is still being finalised; noting that the plan column of the above table is still being finalised, the above table shows that the Trust has delivered a £0.9m deficit for the month of April, or £6k favourable to plan. (to note the Trust submission will only change the phasing not the overall envelope)

Finance Spotlight Report (continued)

United Lincolnshire Hospitals NHS Trust

- The Month 1 Income position is £0.6m favourable to plan; the favourable Income position includes £0.4m of variable top-up funding for drugs and devices, and £0.2m of income to offset the costs of the Covid Vaccination Programme in April.
- Shadow monitoring of activity on a Tariff basis determined that actual activity of £29.1m was delivered in Month 1, such that actual activity delivered is £20.0m lower than the income the Trust received. However the income is inclusive of COVID, Top Up, Restore and BAU allocations.
- The Month 1 Pay position is £0.3m adverse to plan.
- The April Pay position does not include an accrual for the A4C pay award as this has not been agreed nationally; no accrual has been included on the advice of NHSE/I, pay award costs are anticipated to be offset by an income stream.
- The April Pay position includes an estimate of £0.4m for the cost of Bank Holiday Enhancements for the two Bank Holidays in April, an accrual of £60k as an estimate of the impact of the Flowers Case in April, and £0.2m in relation to the cost of the Covid Vaccination Programme in April.
- The April Pay position includes expenditure of £3.8m on Agency staff and £3.2m on Bank staff; this represents a reduction of £1.1m compared to March (if we remove the impact of technical items at year end); This is broadly aligned to plan, further reductions are required in Q2 to deliver the CIP target.

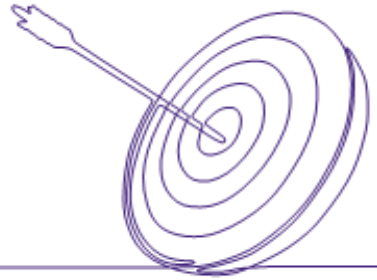
Finance Spotlight Report (continued)



United Lincolnshire Hospitals NHS Trust

- The Month 1 Non Pay position is £0.4m adverse to plan.
- Non Pay expenditure of £17.7m in April is £0.3m higher compared to March (if we remove the impact of technical items at year end).
- The April Non Pay position includes Inflation costs including notably an increase of £0.2m in relation to CNST, Non Recurrent expenditure of £0.1m in relation to Injury Benefit, and £0.2m in relation to the Rapid Recruitment project.
- In 2021/22, efficiency savings will be referred to as CRES (Cost Reduction Expenditure Savings) rather than as CIP. For Month 1, no update on CRES delivery is tabled this is aligned to national expectations in the planning guidance, plans continue to be reviewed. Reporting will begin from Month 2.
- Capital expenditure for Month 1 of the financial year equated to c£0.7m against a submitted plan of £1.4m.
- The capital programme for 2021/22 currently stands at £33.7m for the full-year, with c£23m agreed at Trust Board in May to proceed and c£10m of proposals being assessed before full sign-off.
- The month end cash balance is £50.5m which is a decrease of £3.5m against cash at 31 March 2021.

STP 21/22 H1 Finance Submission



United Lincolnshire Hospitals NHS Trust

The Lincolnshire System submitted a balanced HY1 21/22 plan.

ULHT detailed plan submission for H1 is 24th May and will be aligned to the system plan.

The Trust have the opportunity to re-phase the plan within the parameters of the figures contained in the table.

System and individual organisation CIP delivery will be required to achieve the financial trajectories in the plan.

The plan contains £0 for Elective Recovery Fund (ERF), this is an opportunity for the system.

	ULHT	LCHS	LPFT	CCG	Total
Calculated HY1 Expenditure (Pre-Investment & CIPP/QIPP)	-319,934	-51,417	-61,516	-393,084	-825,951
Investments	0	-2,729	-5,481	-5,954	-14,164
CIPP/QIPP	6,412	1,843	1,319	10,958	20,531
Re-Profiled Expenditure	2,000	0	3,681	8,135	13,816
HY1 Predicted Expenditure	**-311,522**	**-52,303**	**-61,997**	**-379,945**	**-805,768**
Provider Income Non-Lincs CCG	59,752	6,827	15,867	0	82,446
Resource Allocation	251,770	45,476	46,130	368,623	711,999
System Development Funding				11,323	11,323
System Income	**311,522**	**52,303**	**61,997**	**379,946**	**805,768**
System Position	**0**	**0**	**0**	**0**	0

Finance Dashboard

NHS
United Lincolnshire Hospitals
NHS Trust

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

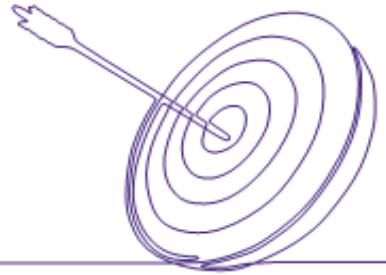
Clinical Services
People
Clinical Support Services
Corporate Services, Procurement, Estates and Facilities
Finance

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

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

Finance and use of resources rating	Full Year	Full Year	Full Year	Actual
	31/03/2019	31/03/2020	31/03/2021	YTD APR 2021
Capital service cover metric	(10.40)	(1.73)	0.06	1.33
Capital service cover rating	4	4	4	3
Liquidity metric	(98.73)	(128.28)	3.71	3.31
Liquidity rating	4	4	1	1
I&E margin metric	(19.71%)	(7.62%)	0.38%	(1.80%)
I&E margin rating	4	4	2	4
Agency metric	77.00%	110.00%	113.00%	133.00%
Agency rating	4	4	4	4
I&E margin: distance from financial plan	4	1	n/a	3

Capital Spend



United Lincolnshire Hospitals NHS Trust

Scheme Summary	YTD Plan £000	YTD Actual £000	YTD Variance £000
Fire	100.0	110.4	-10.4
Estates - General	100.0	177.0	-77.0
Estates - Ward Refurbishments	0.0	0.0	0.0
Estates - Medical School	0.0	3.6	-3.6
Estates - Lincoln & Pilgrim ED - Stage 1	250.0	57.4	192.7
Estates - Lincoln ED - Resus - Stage 2	100.0	14.3	85.7
Estates - EPC	0.0	0.3	-0.3
Estates - CIR	567.0	115.0	452.0
Medical Equipment	29.0	0.0	29.0
Digital	246.0	230.6	15.5
Service Developments	0.0	0.0	0.0
Pilgrim A&E / UTC	0.0	19.6	-19.6
Funding yet to be allocated	0.0	0.0	0.0
Total	1,392.0	728.1	663.9

Scheme Summary	Full Year Plan £000	Forecast Actual £000	Forecast variance £000
Fire	2,251.0	2,251.0	0.0
Estates - General	1,253.2	1,253.2	0.0
Estates - Ward Refurbishments	500.0	500.0	0.0
Estates - Medical School	2,400.0	2,400.0	0.0
Estates - Lincoln & Pilgrim ED - Stage 1	462.0	462.0	0.0
Estates - Lincoln ED - Resus - Stage 2	8,000.0	8,000.0	0.0
Estates - EPC	0.0	0.0	0.0
Estates - CIR	4,033.5	4,033.5	0.0
Medical Equipment	440.3	440.3	0.0
Digital	3,145.7	3,145.7	0.0
Service Developments	131.5	131.5	0.0
Pilgrim A&E / UTC	981.0	981.0	0.0
Funding yet to be allocated	10,108.4	10,108.4	0.0
Total	33,706.6	33,706.6	0.0

All key stakeholders are involved in ensuring schemes are being monitored and managed and providing exception reporting on issues to CDG fortnightly.

Capital funding levels for 2021/22 are now planned to be c£33.7m. Trust Board, in May, discussed the proposed capital plan for 2021/22 that outlined c£23m of 'contractually committed' schemes and a further c£10m of proposed schemes. Agreement was reached that the c£23m could proceed.

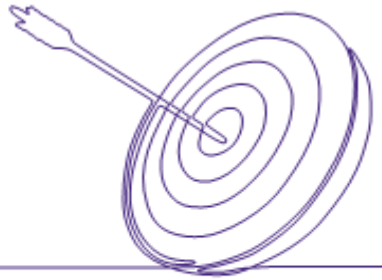
The capital plan was submitted to NHSE/I on the 12th April with a plan for M1 equating to c£1.4m.

Spend incurred in M1 equated to c£0.7m, and whilst this is below the plan submitted, due to the timeframes on agreeing the capital programme, this has still been a significant level of spend incurred.

Key areas of variance are:

- CIR scheme installation, electrical/water/LST radiators, progressing but behind submitted plan by £0.5m
- Completion of the Pilgrim and Lincoln ED (Phase 1) scheme is behind submitted plan by £0.2m
- Lincoln ED Resus scheme behind submitted plan by £0.1m

Balance Sheet



NHS
United Lincolnshire Hospitals
NHS Trust

	31 March 2021 £000		30 April 2021 Actual £000
Intangible assets	4,600		4,442
Property, plant and equipment	247,119		246,755
Receivables	2,790		2,781
Total non-current assets	**254,509**		**253,978**
Inventories	6,510		6,728
Receivables	25,935		23,089
Cash and cash equivalents	54,042		50,548
Total current assets	**86,487**		**80,365**
Trade and other payables	(69,643)		(62,559)
Borrowings	(402)		(402)
Provisions	(2,056)		(2,040)
Other liabilities	(1,587)		(2,943)
Total current liabilities	**(73,688)**		**(67,944)**
Total assets less current liabilities	**267,308**		**266,399**
Borrowings	(3,624)		(3,624)
Provisions	(4,069)		(4,179)
Other liabilities	(12,075)		(12,033)
Total non-current liabilities	**(19,768)**		**(19,836)**
Total assets employed	**247,540**		**246,563**
Financed by			
Public dividend capital	677,570		677,570
Revaluation reserve	27,522		27,464
Other reserves	190		190
Income and expenditure reserve	(457,742)		(458,661)
Total taxpayers' equity	**247,540**		**246,563**

Note 1: The financial plan submitted in April was limited to I&E and Capital. The May submission will incorporate a full balance sheet against which future 'actual' performance will be monitored.

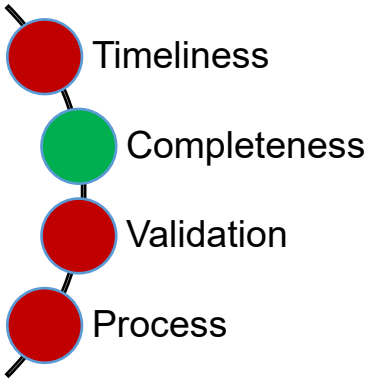
Note 2: Trade and other receivables continue to be supressed at pre-pandemic levels with the continuation of block contract payments for the first half of 2021/22.

Note 3: Cash balances remain significantly increased on 2019/20 levels. Whilst Trusts are no longer to be paid one month in advance, the continued block payment regime and high level of capital creditors from 2020/21 mean cash balances remain high.

Note 4: Trade Payables remain below pre-pandemic levels with the Trust continuing to pay suppliers well within the 30 day target. Staff related creditors are however at higher levels than historically seen, with increases due to annual leave (£8.1m) and 'Flowers' accruals. Capital creditors have dropped from March but remain high at £7.8m.
BPPC for April was 92% / 88% as measured by value / volume of invoices paid.

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	*1st June 2021*
Item Number	*Item 12.1*
Strategic Risk Report	
Accountable Director	*Dr Karen Dunderdale, Director of Nursing*
Presented by	*Dr Karen Dunderdale, Director of Nursing*
Author(s)	*Matt Hulley, Risk & Incident Manager*
Report previously considered at	*N/A*

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

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

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

Executive Summary

- This Strategic Risk Report focuses on the highest priority risks currently being managed within the Trust 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
- The effect of the 'Indian Variant' on ULH services requires careful monitoring

Purpose

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

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

1. Introduction

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

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

1.2 This report is focussed on those strategic risks with a current rating of very high risk (a score of 20-25). A summary of the full strategic risk register is also provided for reference.

2. Strategic Risk Profile

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

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

Key Risk Indicators (KRIs):

- Number of Covid-19 confirmed cases within Lincolnshire – as of 21st May 2021 there had been 3,062 Covid-19 inpatient admissions within ULHT

- Number of Covid-19 in-patients – 0 at Lincoln and 5 at Pilgrim on 21st May 2021;
- Patient deaths due to Covid-19 – total of 834 on 21st May 2021 compared with 831 as of the 26 April 2021
- Covid-related incidents – between March 2020 and May 2021 there were 1,095 incidents that cited the pandemic response as a factor, with higher than average numbers between November 2020 and January 2021; this includes 17 Moderate harm incidents linked to the pandemic response; 15 Severe harm; and 2 Deaths

Gaps in control & mitigating actions:

- England Covid alert level is at Level 3 (epidemic is in general circulation)
- Cases of the Indian variant of COVID-19 are increasing across the country and the situation is being monitored closely.
- Intensive care capacity to be increased to 200% if required.
- 3 vaccines have now been approved by the MHRA and are being rolled out across the country; there are several approved treatments for Covid-19 symptoms that are now in use.
- Operational Gold Command in place to manage the ULHT response – control protocols 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 90% of staff have now had the first jab and over 76% 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 for April was 74.23% an improvement against March's performance however, performing below the planned in month target of 83.12%.
- Ambulance conveyances for April were 4481, 107 lower that in March a decrease of 2.34% The Trust saw a decrease in >59-minute ambulance handover delays, with 207 in April compared to 328 in March

Gaps in control & mitigating actions:

- Specific concerns relate to ambulance handover delays, increased non-elective admissions, stranded and super-stranded patients
- Lincoln site reconfiguration plans & business case for investment on Pilgrim site (with government funding)
- The U&EC improvement programme has undertaken an internal review of process, key stakeholders and original milestones where off track clear rectification plans are now in place

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 – was 76.43% in March 2021 and 73.58% YTD against a target of 90%
- People Pulse survey results – almost 900 staff completed the first survey (in July 2020), a response rate of around 12%; 85% of staff felt informed (+0.6 vs NHS overall); 63% felt confident in local leaders (equal to NHS overall); 61% felt supported (-5.7 vs NHS overall); 59% felt they had a good work-life balance (-2.5 vs NHS overall).
- NHS National Staff Survey (NSS) results – some improvement in results of 2019 staff survey across two thirds of the questions, still below average for acute trusts; less than 50% of staff would recommend ULHT as a place to work; the Trust's score for the bullying & harassment theme in the NSS stayed relatively unchanged in 2019 at 7.6 against a national average of 7.9.

Gaps in control and mitigating actions:

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

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

3. Conclusions & recommendations

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

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

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

ID	Title	Risk Type	Rating (current)	Risk level (current)	Review date
4083	Workforce engagement, morale & productivity	Reputation / compliance	20	Very high risk	30/06/2021
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
4556	Safe management of demand for outpatient appointments	Harm (physical or psychological)	12	High risk	30/06/2021
4481	Availability & integrity of patient information	Service disruption	12	High risk	31/12/2020
4581	Heating (Trust Wide)	Harm (physical or psychological)	12	High risk	31/03/2021
3520	Compliance with fire safety regulations & standards	Reputation / compliance	12	High risk	30/09/2021
4081	Quality of patient experience	Patient experience	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	Regulatory compliance & standards (including performance targets)	12	High risk	31/03/2021
4145	Compliance with safeguarding regulations & standards	Regulatory compliance & standards (including performance targets)	12	High risk	31/03/2021
4146	Effectiveness of safeguarding practice	Patient safety (physical or psychological harm)	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
4362	Workforce capacity & capability (recruitment, retention & skills)	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
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	30/09/2021
4480	Safe management of emergency demand	Harm (physical or psychological)	16	High risk	31/12/2020
4383	Substantial unplanned expenditure or financial penalties	Finance	16	High risk	30/09/2021
4300	Availability of medical devices & equipment	Medical equipment	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	Patient safety (physical or psychological harm)	16	High risk	31/03/2021
4144	Uncontrolled outbreak of serious infectious disease	Patient safety (physical or psychological harm)	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
4424	Delivery of planned improvements to quality & safety of patient care	Regulatory compliance & standards (including performance targets)	8	Moderate risk	31/12/2020
4476	Compliance with clinical effectiveness regulations & standards	Reputation / compliance	8	Moderate risk	31/12/2020
4441	Compliance with radiation protection regulations & standards	Reputation / compliance	8	Moderate risk	30/06/2022
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	30/09/2021
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	Patient safety (physical or psychological harm)	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	Regulatory compliance & standards (including performance targets)	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
4579	Delivery of the new Medical Education Centre	Reputation / compliance	8	Moderate risk	31/12/2020
4384	Substantial unplanned income reduction or missed opportunities	Finance	8	Moderate risk	30/09/2021
4502	Compliance with regulations & standards for medical device management	Regulatory compliance & standards (including performance targets)	8	Moderate 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	30/09/2021
4553	Failure to appropriately manage land and property	Finance	8	Moderate risk	31/03/2021
4486	Clinical outcomes for patients	Harm (physical or psychological)	8	Moderate risk	31/12/2020
4497	Contamination of aseptic products	Harm (physical or psychological)	10	Moderate risk	30/06/2021
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	30/09/2021

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
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	Regulatory compliance & standards (including performance targets)	4	Low risk	31/12/2020
4482	Safe use of blood and blood products	Patient safety (physical or psychological harm)	4	Low risk	31/12/2020
4483	Safe use of radiation (Trust-wide)	Harm (physical or psychological)	4	Low risk	30/06/2022
4514	Hospital @ Night management	Service disruption	4	Low risk	31/12/2020
4567	Working Safely during the COVID - 19 pandemic (HM Government Guidance)	Reputation / compliance	4	Low risk	30/06/2021
4400	Safety of working practices	Harm (physical or psychological)	6	Low risk	30/09/2021

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*1 June 2021*
Item Number	*Item 12.2*
Board Assurance Framework (BAF) 2021/22	
Accountable Director	*Andrew Morgan Chief Executive*
Presented by	*Jayne Warner, Trust Secretary*
Author(s)	*Karen Willey, Deputy Trust Secretary*
Report previously considered at	*N/A*

How the report supports the delivery of the priorities within the Board Assurance Framework	
1a Deliver harm free care	*X*
1b Improve patient experience	*X*
1c Improve clinical outcomes	*X*
2a A modern and progressive workforce	*X*
2b Making ULHT the best place to work	*X*
2c Well Led Services	*X*
3a A modern, clean and fit for purpose environment	*X*
3b Efficient use of resources	*X*
3c Enhanced data and digital capability	*X*
4a Establish new evidence based models of care	*X*
4b 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 receive the final 2020/21 Board Assurance Framework and note the end of year position*
	• *Board to approve the 2021/22 Board Assurance Framework as presented*

Executive Summary

The Board are asked to note the year end position of the 2020/21 BAF as reported.

Work has been undertaken to align the 2021/22 BAF with year 2 of the Integrated Improvement Plan ensuring that there is clear read across of the strategic objectives. Following discussion and agreement of the proposed format and alignment at the Board Development Session on 18 May the BAF was circulated to the Executive Directors for review and update.

Indicative assurance ratings have been provided however the BAF has not yet been presented to the Board Committees to confirm the updates and position. The BAF will be presented to the June Committees in order to offer challenge and assurance of the ratings provided.

The following assurance ratings have been identified within the BAF and a comparison against the 2020/21 year end position provided for reference

Objective		Rating at start of 2020/21	Year end position 2020/21	Assurance rating May 2021/22
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	A	A
2b	Making ULHT the best place to work	R	R	R
2c	Well led services	A	A	A
3a	A modern, clean and fit for purpose environment	R	R	R
3b	Efficient use of resources	G	G	G
3c	Enhanced data and digital capability	A	A	A
4a	Establish new evidence based models of care	R	A	A

4b	To become a University Hospitals Teaching Trust *(previously objective 4c)*	**A**	**R**	**R**
4b	Advancing professional practice with partners	**G**	**A**	Strategic objective not carried forward to 2021/22 BAF

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

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SO3	**To ensure that services are sustainable, supported by technology and delivered from an improved estate**												
3a	A modern, clean and fit for purpose environment	Chief Operating Officer	Covid-19 impact on supplier services who are supporting the improvement, development, and maintenance of our environments. Availability of funding to support the necessary improvement of environments (capital and revenue)	3720 3520 3688 4403 3690	CQC Safe	Develop business case to demonstrate capital requirement Delivering environmental improvements in line with Estates Strategy Continual improvement towards meeting PLACE assessment outcomes Review and improve the quality and value for money of Facility services including catering and housekeeping Continued progress on improving infrastructure to meet statutory Health and Safety compliance	Business Case is not fully signed off and articulates a level of capital development that cannot be rectified in any single year. 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

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						Working with system partners to deliver the Lincolnshire Plan. Detailed activity modelling aligned to resource requirements to support Trust and System response to Phase 3. Financial Reporting to Board							
3c	Enhanced data and digital capability	Director of Finance and Digital	Tender for Electronic Health Record is delayed or unsuccessful - Paused as a result of Covid response, restarted in Jan 21. Tactical response to Covid-19 may impact in-year delivery. Major Cyber Security Attack Critical Infrastructure failure	4177 4179 4180 4182 4481	CQC Responsive	Improve utilisation of the Care Portal with increased availability of information - Impacted by Covid-19 as paused. Commence implementation of the electronic health record - Paused as a result of Covid response, restarted in Jan 21. Undertake review of business intelligence platform to better support decision making Implement robotic process automation Improve end user utilisation of electronic systems Complete roll out of Data Quality kite mark	Cyber Security and enhancing core infrastructure to ensure network resilience. Roll-out IT equipment to enable agile user base. Redeployment of staff as a result of Trust response to Covid-19.	Digital Services Steering Group Digital Hospital Group Operational Excellence Programme Outpatient Redesign Group	Number of staff using care portal Delivery of 20/21 e HR plan Number of RPA agents implemented Ensuring every IPR metric has an associated Data Quality Kite Mark Delivering improved information and reports Implement a refreshed IPR	Schemes paused to enable tactical response to Covid-19. Limited progress being made where possible. Information improvements aligned to reporting needs of Covid-19. IPR paused in line with IIP work and expected to be in place for M1 reporting 21/22.	Management of control gaps being reintroduced in a phased way as impact of Wave 2 reduces. Steady implementation of PowerBI through specific bespoke dashboards and requests. Continue to review this as part of wider BI platform Workplan being drafted to ensure compliance before end of Financial year where possible, delayed by resource availability.	Finance, Performance and Estates Committee	A
SO4	**To implement integrated models of care with our partners to improve Lincolnshire's health and well-being**												
	[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]	

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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**

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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

Board Assurance Framework (BAF) 2020/21 - May 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

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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 (Developing a 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 Safety Culture Surveys				
						Patient Safety Group which is a sub group of the Quality Governance Committee in place meeting monthly. (Reduce incidence of patient falls)	Disruption to existing governance arrangements during the pandemic	Patient Safety Group & sub-group meetings have continued to take place throughout the pandemic	Quality and Safety Risk Report Patient Safety Group (incorporating sub-groups) and the Clinical Effectiveness Group Patient safety indicators in the IPR				
						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.	Flu vaccination rates		IPC identified gaps are being managed and monitored by reporting and gap analysis to the IPCG .		
						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.	IPC Assurance Framework FLOW audits CQC Ratings and progress on delivery of Must Do and Should Do actions and regulatory notices				
						Process in place to monitor delivery of the Hygiene Code (Ensure continued 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.					

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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 maintain and provide access to comprehensive clinical records	4558 4480 4142 4353 4146 4556 4481	CQC Safe	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.	Monitoring nosocomial infection rates			Quality Governance Committee	R
						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					
						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					
						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	Mortality Report				
						Monthly mortality report in place to track achievement of SHMI/Mortality targets (Maintaining our HSMR and improving our SHMI)	Gaps in the number of structured judgement reviews undertaken Impact of Covid-19 on coding triangles	Funding available to train an additional 40 members of staff to undertake structured judgement reviews by the end of March 2021	National Clinical Audits Dr Foster alerts HSMR and SHMI data				
						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	Incident Management Report				
						Theatre Safety Group developed (Ensuring safe surgical procedures)	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 (Reduce medication errors) (Improving the safety of medicines management) (Review of Pharmacy model and service)	Lack of e-prescribing leading to increase in patient safety incidents	Replacement of manual prescribing processes with an electronic prescribing system; improvements to medication storage facilities; strengthening of Pharmacy involvement in discharge processes	Upward Report of the: Medicines Quality Group				

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			Failure to prevent Nosocomial spread of Covid-19			Medical devices safety group in place which received relevant reports							
						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. (Ensuring early detection and treatment of deteriorating patients)	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	Audit of response to triage, NEWS, MEWS and PEWS Sepsis Six compliance data				
						Ensuring a robust safeguarding framework is in place to protect vulnerable patients and staff (Ensuring a robust safeguarding framework is in a place to protect vulnerable patients and staff)	?? 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.	Upward Report of the: Safeguarding Group Safeguarding, DoLS and MCA training and monitored monthly with appropriate escalation				
						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 (Delivering on all CQC Must 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					
						Maternity Transformation							

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						Development and implementation of new pathways for Paediatric services							
						Trust wide Children's standards		Oversight by Children and Young People Oversight Group monthly					
1b	Improve patient experience	Director of Nursing	Failure to provide a caring, compassionate service to patients and their families Failure to provide a suitable quality of hospital environment	3688 4081	CQC Caring	Patient Experience Group, which is a sub-group of the Quality Governance Committee, in place meeting monthly Robust Complaints and PALS process in place	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		Quality Governance Committee	R
						Patient Panel meeting monthly and reporting into the Patient Experience Group. (Redesign our communication and engagement approaches to broaden and maximise involvement with patients and carers)	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			
						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					
						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	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. 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				

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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	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				Quality Governance Committee	R
						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	Reports from the National Audit Programmes Relevant internal audit reports Relevant internal audit reports				
						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	Reports from Divisions on compliance with NICE / TAs / local and national audit				
						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					
						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							

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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	Vacancy rates rises Turnover increases Sickness absence rises Under-investment in education & learning Failure to engage organisation in continuous improvement Failure to transform the medical & nursing workforce	4362	CQC Safe CQC Responsive CQC Effective	NHS people plan & system people plan & four themes:- - Looking after our people - Belonging in the NHS - New ways of working & delivering care - Growing for the future	Awaiting sign off of system people plan		Reported progress on the implementation of the NHS People Plan and the Lincolnshire System Workforce Plan NB New indicators being developed for the 21/22 financial year			People and Organisational Development Committee	**A**
						Embed robust workforce planning and development of new roles	Overall vacancy rate declining but increasing for clinical roles.						
						Recruitment to identify roles - plan for every post & cohort recruitment		Pipeline report shows future vacancy position International nurse recruitment & cohort recruitment					
						Focus on retention of staff (Delivery of annual appraisals and mandatory training)			Modern Employer targets Rates of appraisal/mandatory training compliance				
						Creating a framework for people to achieve their full potential (Creating a framework for people to achieve their full potential- Talent Management)		Core Learning Review Roll out of workpal					
						Embed continuous improvement methodology across the Trust			Staff survey feedback				
						Reducing sickness absence	Sickness absence rate higher than average	Embedding of AMS	Sickness/absence data Turnover rates Vacancy rates				
						Ensuring access to the personal and professional development that enables people to deliver outstanding care and ensures ULHT becomes known as a learning organisation	IIP projects in early stage of delivery	Delivery of IIP projects as set out in controls	Reported progress on the implementation of the NHS People Plan and the Lincolnshire System Workforce Plan NB New indicators being developed for the 21/22 financial year				

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2b	Making ULHT the best place to work	Director of People and Organisational Development	Further decline in demand Failure to address examples bullying & poor behaviour Lack of investment or engagement in leadership & management training Perceived lack of listening to staff voice Under-investing in staff engagement with wellbeing programme Failure to respond to GMC survey Ineffectiveness of key roles Staff networks not strong	4083	CQC Well Led	NHS People Plan & System People Plan & four themes:- - Looking after our people - Belonging in the NHS - New ways of working & delivering care Growing for the future	Awaiting sign off of system people plan Delivery of IIP projects in early stage of delivery	Delivery of IIP projects as set out in controls				People and Organisational Development Committee	R
						Trust values & staff charter - Resetting our Culture & Leadership programme	Poor staff survey results in 2020 (although in pulse survey more positive)	Creation of Learning Together Forum					
						Reviewing the way in which we communicate with staff and involve them in shaping our plans		Review findings of comms survey	Staff survey feedback - engagement score, recommend as place to work				
						Leadership & Management training. (Improving the consistency and quality of leadership and line management across ULHT)		Continue to implement new leadership programme e.g training on well-being conversations	Pulse surveys - " Have your say" Number of staff attending leadership courses				
						Address the concerns around equity of treatment and opportunity within ULHT so that the Trust is seen to be an inclusive and fair organisation			WRES/ WDES Data				
						Staff networks	Some staff networks stronger than others		Protect our staff from bullying, violence and harassment - measure through National Staff Survey				
						Embed programme focused on staff wellbeing			Reports on progress in implementing the NHS People Plan and the Lincolnshire System Workforce Plan Number of Schwartz rounds completed (once implemented)				
						Focus on junior doctor experience key roles:- - Freedom to speak up Guardian - Guardian of safe working - Well-being Guardian	Identified FTSU capacity in Trust as insufficient	Budget identified for post and recruitment exercise commenced for full time FTSU Guardian Junior doctor forum	GMC junior doctor survey				

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2c	Well led services	Chief Executive	Current risk register configuration not fully reflective of organisations risk profile Current systems and processes for policy management are inadequate resulting in failure to review out of date or policies which are not fit for purpose	4277 4389	CQC Well Lead	Delivery of risk management training programmes	Training delayed due to Covid-19	Corporate support offer made to divisions	Third party assessment of well led domains Internal Audit assessments Risk Management HOIA Opinion Completeness of risk registers Annual Governance Statement	HOIA Opinion will be received in April 2021		Audit Committee	A
						Shared Decision making framework	Councils suspended due to Covid-19		Number of Shared decision making councils in place	8 councils established. Target for 2021 was 6	Feedback tools to review progress/success		
						Implementing a robust policy management system		Review of document management processes New document management system - SharePoint Single process for polices	Numbers of in date policies	Movement on policies still not fast enough	Clinical and Corporate Policies and Guidelines now managed through single process by Trust Secretary Report to Audit Committee quarterly Report to ELT fortnightly		
						Ensure system alignment with improvement activity							
SO3	**To ensure that services are sustainable, supported by technology and delivered from an improved estate**												
						Develop business case to demonstrate capital requirement	Business Case is not fully signed off and articulates a level of capital development that cannot be rectified in any single year.	Interim case for £9.6M of CIR has been reviewed and approved by NHSE with the majority of schemes due to deliver in 2020/21 Capital Delivery Group has oversight of the delivery of key capital schemes.	Capital Delivery Group Highlight Reports	Infrastructure case has tackled £9.6M of the overall £100m+ backlog.	Estates improvement and Estates Group review compliance and key statutory areas. Development of 2021/22 Capital Programme will continue to ensure progress against remaining backlog of critical infrastructure. Capital Delivery Group will monitor the delivery of key capital programmes and ensure robust programme governance.		
						Delivering environmental improvements in line with Estates Strategy		Estates improvement forum and improvement team monitor progress through and has restarted now Wave 2 Covid has passed.		Collation of Audits across all areas during Covid are partial due to availability of high viral load areas.			
						Continual improvement towards meeting PLACE assessment outcomes	PLACE assessments have been suspended and delayed for a period during COVID		PLACE assessments	PLACE Assessments have been reduced to PLACE/light in lieu of access and staffing restrictions during Covid.			
	A modern, clean and fit for	Chief Operating	Longer term impact on supplier services (including raw materials) who are supporting the improvement, development, and maintenance of our	3720 3520								Finance, Performance	

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
3a	A modern, clean and fit for purpose environment	Chief Operating Officer	and maintenance of our environments. Availability of funding to support the necessary improvement of environments (capital and revenue)	3688 4403 3690	CQC Safe	Review and improve the quality and value for money of Facility services including catering and housekeeping	Value for Money schemes have been delayed during COVID		MiC4C cleaning inspections Staff and user surveys 6 Facet Surveys	6 Facet Survey are not recent and require updating.	IPC Cell/Group and upward reporting of cleanliness is reported through to QGC. Water Safety and Fire Safety Groups will report through alongside Health and Safety Groups to relevant sub-committees and provide a more comprehensive view offering assurance were it is possible and describing improvement where it is not. The appointment of Authorised engineers in key statutory areas will give responsible person/Executive arms length oversight of assurance gaps to fill.	Finance, Performance and Estates Committee	R
						Continued progress on improving infrastructure to meet statutory Health and Safety compliance		Water/Fire safety meetings are in place and review of controls are part of external validation from authorised engineers.	Reports from authorised engineers Response times to urgent estates requests Estates led condition inspections of the environment Response times for reactive estates repair requests Progress towards removal of enforcement				
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 £6.4m CIP programme in H1 21/22 and estimated full Year 21/22 CIP value of £15.4m.	Operational ownership and delivery of efficiency schemes	Divisional Financial Review Meetings - paused due to COVID - reinstated from May 21	Delivery of revised CIP Achievement of both ULHT and STP financial Plan	Model Hospital Benchmarking/Reporting - paused due to COVID - reinstated from May 21 (update brought to FPEC in May)	Gaps are being reviewed monthly with a view to reintroduce as soon as operational pressures allow.	Finance, Performance and Estates Committee	G
						Delivering financial plan aligned to the Trust and Lincolnshire STP financial plan / forecast for 2021/22	Urgent and unplanned Restore and Covid related costs	Lincolnshire STP financial plan Lincolnshire STP collective management of financial risk Savings plan, monitoring and reporting.					
						Reduce agency spend by 25% from the 19/20 baseline as per IIP priority	Reliance on temporary staff to maintain services, at increased cost	Centralised agency & bank team					
						Utilising Model Hospital, Service Line Reporting and Patient Level Costing data to drive focussed improvements to be restarted from Q2				CQC Use of Resources - paused due to COVID			
						Implementing the CQC Use of Resources Report recommendations							

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 Restoration.		Internal Audit: Integrated Improvement Plan CIP - Paused Temporary Staffing - Complete Education Funding - TBC Estates Management - Q4 Workforce Planning - Complete			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.		
3c	Enhanced data and digital capability	Director of Finance and Digital	Tender for Electronic Health Record is delayed or unsuccessful Major Cyber Security Attack Critical Infrastructure failure	4177 4179 4180 4182 4481	CQC Responsive	Improve utilisation of the Care Portal with increased availability of information -	Cyber Security and enhancing core infrastructure to ensure network resilience. .	Digital Services Steering Group Digital Hospital Group Operational Excellence Programme Outpatient Redesign Group	Number of staff using care portal	Schemes paused to enable tactical response to Covid-19. Limited progress being made where possible. .	Management of control gaps being reintroduced in a phased way as impact of Wave 2 reduces.	Finance, Performance and Estates Committee	A
						Commence implementation of the electronic health record	Roll-out IT equipment to enable agile user base Redeployment of staff as a result of Trust response to Covid-19.		Delivery of 20/21 e HR plan Number of RPA agents implemented				
						Undertake review of business intelligence platform to better support decision making			Delivering improved information and reports Implement a refreshed IPR	IPR paused in line with IIP work and expected to be in place for M1 reporting 21/22	Steady implementation of PowerBI through specific bespoke dashboards and requests. Continue to review this as part of wider BI platform		
						Implement robotic process automation							
						Improve end user utilisation of electronic systems							
						Complete roll out of Data Quality kite mark			Ensuring every IPR metric has an associated Data Quality Kite Mark	Information improvements aligned to reporting needs of Covid-19.	Workplan being drafted to ensure compliance, delayed by resource availability.		

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
SO4	**To implement integrated models of care with our partners to improve Lincolnshire's health and well-being**												
4a	Establish new evidence based models of care	Director of Improvement and Integration	Failure of specialty teams to design and adopt new pathways of care Failure to support system working Failure to design and implement improvement methodology		CQC Caring CQC Responsive CQC Well Led	Supporting the implementation of new models of care across a range of specialties			Reports -ELT / TLT -Committees -Board -System -Region			Finance, Performance and Estates Committee	A
						Improvement programmes for cancer, outpatients and urgent care in progress, programme for theatres was on hold, and has been included in 21/22 plans		Outpatient Improvement Group Cancer Improvement Board Urgent and Emergency Care Board.	Improvement against strategic metrics % of patients in Emergency Department >12 hrs (Total Time) Delivery against 62 day combined standard Urgent Treatment (P2) turnaround time Deliver outpatient activity non face to face				
						Development and Implementation of new pathways for paediatric services - in progress, included in 21/22 plans.		CYP Group re-established					
						Urology Transformational change programme		Urology steering group in place reporting through IIP					
						Pre op Assessment Modernisation							
						Support Creation of ICS - Lincolnshire designation 1st April 2021		Weekly ICS meetings Provider Collaborative Steering Group					
						Support the consultation for Acute Service Review (ASR) Phase 1 - PCBC with national team		Weekly ASR meetings					
						Implementing the Outstanding Care Together Programme to support the Organisation to focus on high priority improvements - in progress		OCTP Exec led pillar meetings continue ELT/TLT oversight Board / system reporting					

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4b	To become a University Hospitals Teaching Trust	Director of Improvement and Integration	Failure to develop research and innovation programme Failure to develop relationship with university of Lincoln and University of Nottingham Failure to become member of university hospital association		CQC Caring CQC Responsive CQC Well Led	University Hospital Teaching Trust Status Developing a business case to support the case for change			Progress with application for University Hospital Trust status			People and Organisational Development Committee	R
						Increasing the number of Clinical Academic posts			Numbers of Clinical Academic posts RD&I Strategy and implementation plan agreed by Trust Board				
						Improve the training environment for students			GMC training survey Stock check against checklist				
						Developing an MOU with the University of Lincoln			RD&I Strategy and implementation plan agreed by Trust Board				
						Develop a portfolio of evidence to apply for membership to the University Hospitals Association							

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