Bundle Trust Board Meeting in Public Session 5 October 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 7th September 2021 *Chair* Item 5.1 Public Board Minutes September 2021v1.docx
5.2	Matters arising from the previous meeting/action log *Chair* Item 5.2 Public Action log September 2021.docx
6	Chief Executive Horizon Scan *Chief Executive* Item 6 Chief Executive's Report, 051021.docx
7	Patient/Staff Story *Director of Nursing* *Please be aware that sometimes our patient and staff stories can deal with very difficult subjects, which may affect you personally. If you are concerned about this the Trust Secretary can advise you of the subject to be discussed at the start of the meeting.*
7.1	BREAK
8	Strategic Objective 1 To Deliver high quality, safe and responsive patient services, shaped by best practice and our communities
8.1	Assurance and Risk Report from the Quality Governance Committee *Chair of Quality Governance Committee* Item 8.1 QGC Upward report September 2021v1.doc
9	Strategic Objective 2 To enable our people to lead, work differently and to feel valued, motivated and proud to work at ULHT
9.1	Assurance and Risk Report People and Organisational Development to follow *Director of Finance & Digital*
10	Strategic Objective 3 To ensure that services are sustainable, supported by technology and delivered from an improved estate
10.1	Assurance and Risk Report from the Finance, Performance and Estates Committee *Chair of Finance, Performance and Estates Committee* Item 10.1 FPEC Upward Report September 2021v1.docx
11	Strategic Objective 4 To implement integrated models of care with our partners to improve Lincolnshire's health and wellbeing
11.1	Teaching Hospital Status Update *Chief Executive* Item 11.1 University-Teaching Hospital Status.docx
12	Integrated Performance Report *Director of Finance & Digital* Item 12 IPR Cover Sheet September 2021.docx Item 12 IPR September 2021.docx
13	Risk and Assurance
13.1	Risk Management Report

Director of Nursing

Item 13.1 Strategic Risk Report - September 2021 v1 (002).docx

13.2 Board Assurance Framework

Trust Secretary

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

Item 13.2 BAF 2021-2022 v14.09.2021.xlsx

13.3 Upward Report from Audit and Risk Committee

Chair of Audit Committee

Item 13.3 Audit Committee Upward Report.docx

14 Any Other Notified Items of Urgent Business

15 The next meeting will be held on Tuesday 2nd November 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 7 September 2021

Via MS Teams Live Stream

Present

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

Non-Voting Members:
Mr Simon Evans, Chief Operating Officer
Mrs Jacqui Grice, Interim Director of People &OD

In attendance:
Mrs Jayne Warner, Trust Secretary
Mrs Karen Willey, Deputy Trust Secretary (Minutes)
Dr Maria Prior, Healthwatchact Representative
Mr Theophilus Joachim, Associate Specialist Trauma & Orthopaedic Surgery

Apologies
Ms Cathy Geddes, Improvement Director, NHSE/I
Mrs Alison Dickinson, Associate Non-Executive Director

1393/21	**Item 1 Introduction** The Chair welcomed Board members and members of the public who had joined the live stream to the meeting.
1394/21	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.
1395/21	The Chair highlighted that although national Covid-19 restrictions were lifted on the 19 July 2021 the NHS continued to operate under the advice of NHS England in regard to Infection Prevention Control measures including the requirement to follow social distancing rules, impacting on the ability to revert to Board meetings in the pre pandemic format. The Trust Board would continue to follow national advice and operate in accordance with procedures that had been implemented during the pandemic.
1396/21	The Chair moved to questions from members of the public. **Item 2 Public Questions** **Q1 from Jody Clark**

	We were assured that whatever services we lost during the Green Site Changes, would be restored or improved. But our fracture clinic has not been reinstated to see new fracture patients. Our residents with injured limbs, face 2 bus journeys for an initial appointment at Lincoln, who are already busy seeing their own patients! **A couple of slots have been provided for initial appointments for those that can't travel but needs consultant approval first and is nowhere near enough to meet the demands. When we have the required staff, plaster room and clinics to enable Grantham residents to be seen as new patients locally.** **And as you stated previously;** **"It has been agreed that services which were temporarily removed last year at Grantham Hospital will gradually be restored over the next few months with the A&E unit due to be returned by the end of June."** **So why hasn't our fracture clinic been returned as it was pre changes?** **I see in the chief executive report, mention of the Health Infrastructure Plan and submissions being drawn up. I wanted to ask if Grantham Hospital is included in the submissions being drawn up? Not necessarily in regards to a new hospital but any upgrades in the pipeline?** The Chief Operating Officer responded: In response to the first question both new and follow up patients were being seen at Grantham. In terms of capacity this tied in to the developments put in place for the e-trauma service. The Trust were proud of the development which had been in response to patient feedback where some patients were attending clinics and felt due to the activity this had been a wasted journey. The e-trauma system allowed consultations with patients without the need for them to attend appointments, this fundamentally changed how the fracture clinics worked across all sites. Due to this change the Trust were seeing less patients in terms of face to face fracture clinics. There were still busy clinics but in a different way due to balancing face to face and virtual consultations. When the Trust first restored the clinics it had not been possible to fully restore these, this was now resolved with full capacity for Grantham patients both new and follow up. The Chief Operating Officer noted that there appeared to be specific examples where patients who had wanted to be seen at Grantham had not been and asked that these individuals come forward so that this could be investigated. From the Trusts perspective the fracture clinic was now restored and offered and improved service as a benefit of Covid-19. With regard to the Health Infrastructure Plan the Chief Operating Officer confirmed that Grantham Hospital was included in the work of the plan.
1397/21	**Q2 from Vi King** **Please can I ask why new Factures/ E-trauma are being sent to LCH and PHB and not the full service returned to Grantham? Surely E-trauma could be directed to Grantham. Also, when people are asking for follow up appointments to be done at Grantham, they are being told no, unless they insist, they are at Grantham. Therefore, please can you**

	let me know when the full service is going to be returned to Grantham. Please can I ask why LCH and PHB have security, but Grantham does not? The Chief Operating Officer: The question had been responded to in the first public question however it was noted that there were some rare occasions where patients were diverted to Lincoln or Pilgrim to attend the trauma units for specialist work up where required. However the vast majority of patients should now be attending Grantham. The Chief Operating Officer again requested and specific examples be sent through to the Trust in order that these could be investigated. Regarding the second question the Chief Operating Officer noted surprise that there was a view of no security at Grantham. The Trust had security teams on all sites through both NHS employed staff and contracted staff from a security firm for additional staff. There had been a change to the way in which security worked across the sites as more visitors had been welcomed back to the sites and there were less restrictions. This particularly affected Grantham where the site had now moved from a green site with the restoration of accident and emergency services. There was not necessarily a need for such stringent access control however the Chief Operating Officer offered reassurance that there was security at Grantham hospital, noting that it was likely that security would always be needed at the hospital sites.
1398/21	**Q3 from Sue McQuinn** **The main notice boards outside Grantham Hospital currently display the following:** **Accident & Emergency Open 08.00-18.30** **GP Out of Hours** **There is no mention of the Out of Hours Enhanced Walk-In Service that's available from 6pm-10pm or further details of the bookable service that's available via 111 overnight. I'm not sure how people are expected to know about these services if they're not prominently displayed on entering the hospital grounds. Is it possible to have the boards amended to include this information?** **Could you also please advise what information the 111 service provider has been given regarding the revised services available at Grantham A&E? In particular, is Grantham given as the first option when suitable services are available at Grantham for those in the vicinity?** The Chief Operating Officer responded: The question had prompted the Trust to consider NHS 111 services and the difference between accessing Accident and Emergency for emergencies only and NHS 111, which was a better way to sign post to other available services. These were often delivered by primary or community care colleagues with patients rarely coming through to the Trusts' Accident and Emergency department. The Trust would consider the signage but would also consider NHS 111 as this should, for the vast majority of cases, be for people using the GP out of hours service for urgent appointments and not emergencies. NHS 111 does not only facilitate this out of hours but throughout the day. Signage across all sites would be considered as a result of the question raised.

	The Chief Operating Officer confirmed that the directory of services, available to both NHS 111 and ambulance services, had returned to the same narrative as was in place prior to the June 2020 changes put in place. People were sign posted to Grantham Hospital for local Accident and Emergency Services and it was confirmed that this was being used by NHS 111 with patients coming through the service.
1399/21	**Item 3 Apologies for Absence** Apologies for absence were received from Mrs Alison Dickinson, Associate Non-Executive Director and Ms Cathy Geddes, Improvement Director NHSE/I
1400/21	**Item 4 Declarations of Interest** The Chief Executive noted that he had agreed to extend his position with the Trust by a further 3 years through to 2024 noting that he had been on secondment from Lincolnshire Community Health Services NHS Trust (LCHS).
1401/21	The Chief Executive advised the Board that he had now resigned from his former position at LCHS to reflect the commitment being made to United Lincolnshire Hospitals NHS Trust, as such the declaration of interest would be amended to remove mention of being an employee of LCHS.
1402/21	The Chair offered thanks to the Chief Executive for signalling commitment and intent to remain leading the organisation in the position of Chief Executive.
1403/21	The Chair welcomed Jacqui Grice as Interim Director of People and Organisational Development noting that, if not already done so, the declarations register would be updated.
1404/21	**Item 5.1 Minutes of the meeting held on 3 August 2021 for accuracy** The minutes of the meeting held on 3 August 2021 were agreed as a true and accurate record.
1405/21	**Item 5.2 Matters arising from the previous meeting/action log** 579/21 – Staff Survey – The Chair noted that the action had been carried over for some time reflecting that this related to the triangulation of the staff survey and quality measures. The Interim Director of People and Organisational Development was requested to consider the action and advise when an update could be received.
1406/21	1286/21 – Establishment Review – The Chair noted that there was a timing issue for this piece of work noting that this was something for the Interim Director of People and Organisational Development to review and offer back to the Board an appropriate date of when the establishment review could be received.
1407/21	077/20 – Review of TOM and governance – Mrs Dunnett noted that this would now not be received by the Audit Committee in October due to operational pressures requesting that the narrative be amended.
1408/21	The Chair requested that the actions be reviewed and updated with appropriate dates for when the reports could be received by the Board. **Action, Trust Secretary – 5 October 2021**

1409/21	**Item 6 Chief Executive Horizon Scan including STP** The Chief Executive presented the report to the Board stressing how busy the system currently was and noting that this was not unique to Lincolnshire as health and social care was busy across the country.
1410/21	This was not only due to Covid-19 but also emergency and urgent care, planned care and long term conditions, which was being managed alongside the time of year where staff were taking annual leave as well as isolating or off sick. There had been a fantastic effort from all involved with flexibility across the system. The Chief Executive offered thanks to system colleagues for the support received.
1411/21	The Chief Executive advised that the Integrated Care System was made up of the Integrated Care Board (ICB), which would take on NHS responsibility alongside the abolition of the Clinical Commissioning Group (CCG), and the Integrated Care Partnership (ICP).
1412/21	Guidance had been received which was subject to legislation going through including guidance for the ICB in relation to governance, constitution, human resources framework and the readiness to operate and transfer functions from the CCG.
1413/21	Further guidance had recently been received in relation to thriving places, working with people and communities, clinical care and professional leadership and working with the voluntary and community sectors. The Chief Executive noted that this guidance could be made available should people wish to read this.
1414/21	The Chief Executive noted that recruitment process for the Chair of the ICB was ongoing with final interview due to take place at the ned of the week. The ICB Chief Executive post was now advertised, as was the case for all posts nationally, this was due to close towards the end of September.
1415/21	The Chief Executive advised Board members that Sarah Connery had been appointed as the Chief Executive at Lincolnshire Partnership NHS Foundation Trust and offered the congratulations of the Board.
1416/21	Due to the Chief Executive resigning from LCHS this had now created a vacancy at the Trust which was currently being recruited to with the process concluding the following week.
1417/21	The Trust was currently in the process of substantive recruitment to the Director of People and Organisational Development with the assessment centre taking place the next day and final interviews towards the end of the week.
1418/21	The Chief Executive was delighted to confirm that following an internal competitive process the Director of Nursing had been appointed as the Deputy Chief Executive, alongside all other responsibilities held as the Director of Nursing and Director of Infection Prevention and Control.
1419/21	A process was currently being put in place for interviews to take place for a replacement for the Director of Improvement and Integration whilst Mark Brassington was on secondment to the region.
1420/21	The Chief Executive noted had reported at the previous meeting that a Freedom to Speak Up Guardian had been appointed however the candidate had withdrawn before taking up the post. The Trust had gone back out to recruitment and been successful with the Chief

	Executive advising that a replacement Guardian had been appointed and should be in post later in the month.
1421/21	The Chief Executive advised the Board in relation to the system improvement plan that as a health system Lincolnshire was in System Oversight Framework (SOF) level 4 which had the most intense scrutiny. Therefore a system improvement plan was required and a System Improvement Director, Keith Spencer, had been appointed. The System Improvement Director had been working over the past few weeks to pull together a plan which once complete would be presented at a public session.
1422/21	The plan would have more focus, pace and delivery in the NHS in Lincolnshire and focused on transformation not just improvements. There would be a strong focus on care closer to home and home first meaning there would be less reliance on the hospital sector.
1423/21	Dr Gibson asked if there was any progress that could be reported on the Acute Services Revie and the consultation process that would be led by the CCG.
1424/21	The Chief Executive advised that the consultation should start imminently and would be a process led by the CCG and not the Trust.
1425/21	Mrs Dunnett requested an update on Covid-19 vaccinations for pregnant women and the communications being offered in this regard.
1426/21	The Director of Nursing noted that there was a national drive to increase vaccinations for expectant mothers noting that nationally there had been some difficulty about whether this was the right thing to do. The first parts of research in to coronavirus has been limited with regard to expectant mothers however research was progressing and there was a clear benefit being seen for those expecting to have the vaccination.
1427/21	The Trust was working with regional colleagues and the CCG with the vaccination being offered through antennal routes, supported with resourcing from the CCG. All midwifery and obstetric colleagues had been briefed on the requirements of receiving the vaccination and to offer the benefits and risks of receiving this, or not. The Trust was doing all it could to encourage uptake of the vaccination programme.
1428/21	The Chair noted that all advice and guidance being offered from the centre in relation to the ICS would be made available to Board colleagues. There was assurance that work in the system continued whilst the formal elements were awaited.
1429/21	The Chair noted the appointment of Sarah Connery and offered congratulations on a successful appointment asking that this be offered formally in a letter. **Action, Chair – 5 October 2021**
1430/21	The Chair noted the demand in pressures mentioned within the report and thanked the Executive Directors for their ongoing support, leadership and direction. The Trust Board: • **Noted the report and significant assurance provided**
1431/21	**Item 6.1 Covid-19 – Wave 3** The Chief Operating Officer presented the report to the Board noting that this described the position and actions in place to mitigate the effects of Covid-19 wave 3.

1432/21	The Board were advised that wave 3 posed a number of challenges that had not been experienced during either wave 1 or 2 during 2020 and in to 2021.
1433/21	The Chief Operating Officer noted the improvement in sickness absence levels noting that the previous month had demonstrated that the Trust had one of the highest levels of sickness of all acute Trusts in the Midlands. This position had improved due to the effect of managing Covid-19 track and trace and risk assessing the workforce in order to bring staff back in to work.
1434/21	The Board was advised that there were a number of new and greater challenges including critical care demand which had seen a substantial increase and an increase of inpatients. This was not from Covid-19 demand but normal routine, urgent and emergency care resulting in an increase in occupancy. Mutual aid had continued to be offer outside of the Lincolnshire system where there was a greater demand.
1435/21	Actions that had been described in the previous months report had been put in place to mobilise emergency and pandemic policies in order to respond. The Board were advised that the incident command response had been stood up with the approach taken to response to wave 1 and 2 being utilised in order to enable rapid decision making.
1436/21	Other important actions would be continued and extended beyond the original plan were around how the workforce was better managed and how the workforce could be targeted to support emergency care. This could mean that there was a trade off in planned care in order to respond to the immediate pressures being faced in accident and emergency.
1437/21	The Chief Operating Officer noted the intention to continue with the improvement items, particularly in relation to Same Day Emergency Care (SDEC) whereby those patients who did not require an overnight stay would be seen and treated. This would support capacity issues.
1438/21	There were 2 actions which were being look at in detail, these being visiting and quality impact assessments (QIAs) and how QIAs were managed, monitored and tracked through the incident command cell.
1439/21	The Director of Nursing noted that the Trust was fully aware of the difficulties that the visiting restrictions were having for patients and families as well as colleagues. These were in place due to national guidance however this had been reflected on, as had consistently been done in relation to the ever changing nature of the pandemic.
1440/21	The Director of Nursing advised that from 9 September a new approach to patient visiting would be in place which would allow the Trust to fit all future circumstances. There had been changes in the restrictions over the course of the pandemic but there would now be the introduction of a risk based approach to visiting.
1441/21	This would allow visitors on to the wards in line with the national guidance of low, medium and high risk areas which had been how the Trust had been managing the response from an infection, prevention and control perspective.
1442/21	Arrangements would be determined at patient level depending on their risk and the risk level of the area in which they were residing as an inpatient. This would ensure the Trust could maintain a consistent approach over the coming months taking in to account movement of patients within the hospital between different risk areas. This would also support maintaining national guidance in relation to visiting.

1443/21	The Director of Nursing stated that the Trust had maintained that national guidance had been followed in regard to infection control, personal protective equipment (PPE) and visiting and would continue to do so.
1444/21	All elements described within the paper, including visiting were underpinned by a QIA that had been undertaken as part of wave 1 or 2. These had been revised and the Trust continued to complete QIAs where changes were required. QIAs were reviewed by both the Medical Director and Director of Nursing who either approved or not depending on any further information that may be required.
1445/21	The Chair noted the difficulties in balancing infection control and being able to run operational elements of services in the right way but also recognised the need for people to visit loved ones to support patient experience.
1446/21	Mrs Libiszewski noted that the paper described this being potentially over a longer period than anticipated asking for an update on the plans for the flu campaign for staff, consideration of the reinstatement of normal governance arrangements that were light touch to maintain the flow of assurance and an update on the current nosocomial rate in the Trust.
1447/21	The Chair noted that a response regarding the flu campaign would be offered at item 9.1.
1448/21	The Director of Nursing noted that there were currently 58 positive patients across the Trust with a nosocomial rate of 3%, 2 patients of the 58. There were no Covid-19 outbreaks however a number of wards had contact patients with the wards being monitored for 28 days in line with national guidance.
1449/21	Due to pressures described there had been the stepping down of some regular meetings and groups that would ordinarily report through the governance structures. Work continued in the background with the Director of Nursing advising that oversight was maintained through the review of a significant number of quality markers across wards and departments in each division. The Director of Nursing along with a small number of senior members of the team reviewed that data and any issues identified were addressed through alternative routes. The Medical Director was taking a similar approach.
1450/21	Mrs Dunnett noted the press coverage in relation to the shortage of blood test tubes asking if this was a risk for the Trust and if there were any other supply concerns.
1451/21	The Chief Operating Officer advised that the Trust did not use the supplier who had issues with blood test tubes however had responded to the ask to all Trusts to reduce overall consumption of these items. This had been done in a number of ways including working closely with the labs in respect of sampling. This was a low risk for the Trust but continued to be monitored although it was believed this action would soon be stepped down.
1452/21	More broadly there had been no other national notifications of supply issues through the supply chain on critical products however this could change.
1453/21	The Director of Nursing noted that there were strong relationships with the regional and national teams who, through emergency planning routes offered information about potential supply change resource and disruption. The Trust had previous experience of responding quickly and positively to these situations.
1454/21	The Director of Finance and Digital noted the work of the procurement team thanking them for the work done in times where items had run low and the ability to respond to resolve issues. UK manufacturing had increased over recent months offering a level of stability of core items. There were concerns in relation to capital and the construction sector where the Trust would

	see some significant delay on some works. There would also be an impact due to the shortage of HGV drivers. Awareness of issues was being managed and monitored to ensure suppliers made their way to the organisation.
1455/21	Dr Prior was pleased to hear of the introduction of the risk based approach to visiting noting that there would need to be clear communication to ensure equity of the approach. Dr Prior asked if the issue with agency fill was likely to be resolved or improved in the near future.
1456/21	The Chief Operating Officer noted that there had been a recent call with the regional teams about the expected changes and behaviours of agency staff noting that this staff group were also affected by sickness and burnout. There was also an increased demand across the country for agency staff which was having an impact on availability.
1457/21	Alternative strategies would need to be considered such as the use of SDEC to reduce the number of patients staying overnight an in turn reducing the need for overnight staff. Other strategies were being considered rather than changing recovery trajectories.
1458/21	The Chair noted the list of actions agreed in order to make improvements on demand and flow requesting an update on the use of senior decision makes earlier in the process and the multiagency flow meetings that were taking place on a weekly basis to understand if this was having an impact.
1459/21	The Chief Operating Officer noted that there were 2 indicators being considered to identify relative success one of which was the number of patients seen and discharged within a 24 hours period, the detail of which would be reported to Finance, Performance and Estates Committee as part of the urgent care report.
1460/21	The multiagency meetings were taking place, sometimes with increased frequency and support received from LCHS however it was noted that domiciliary and social care were also experiencing staffing issues nationally. Staffing was being monitored however this was not having such a positive impact.
1461/21	The Chair noted that a Board Development session would be held in relation to the restoration of governance arrangements in light of the learning from Covid-19 and the ongoing challenges of staffing to ensure the Board was able to discharge its duties.
1462/21	The Board noted the significant staffing challenges and acknowledged the increase of risk 4175 as a consequence of the challenges outline in the paper, this would be reviewed when the risk register was considered. The Trust Board: • **Received the report noting the limited assurance**
1463/21	**Item 7 Patient Story** The Director of Nursing introduced the patient story offering thanks to Mr Palmer for offering his story in a well-articulated manner that described missed opportunities during his care with a clear message about listening to patients. Mr Palmer's story related to care, in part, through orthopaedics at Pilgrim Hospital.
1464/21	The Board, via a pre-recorded video, watched Mr Palmer's story of his experience in attending Pilgrim accident and emergency with hip, groin, thigh and knee pain. The Board understood from the video that the experience was less than desirable however noted the

	approach taken by Mr Palmer to support the Trust to make improvements in patient experience.
1465/21	The Chair offered thanks to Mr Palmer, who was understood to have joined the meeting virtually, for the story. The Board was grateful for the approach taken in wanting to work with the Trust to learn from the experience. The Trust Board had a genuine intent to learn from patient experience and to ensure lessons were learnt and propagated through the organisation.
1466/21	Professor Baker offered his thanks for the story and asked what level of confidence there was that should a patient attend with the same presentation the outcome would not be the same.
1467/21	Mr Joachim, Associate Specialist Trauma & Orthopaedic Surgery noted that the service was better equipped to have better outcomes but recognised that this was not yet fully in place and hoped that once achieved this would be the case across the Trust.
1468/21	Changes had been made within the service to ensure that patients were reviewed once admitted to ensure that a definite diagnosis was made. Ward rounds were conducted by the on-call consultant to ensure all patients were seen, particularly those admitted overnight and those who did not have a definite hip fracture.
1469/21	The Associate Specialist Trauma & Orthopaedic Surgery noted that there was further developments within the service to ensure that patients were appropriately reviewed, referred onward where necessary or managed within the Trust to have interventions whilst as an inpatient. These developments have been made alongside the East Midlands Spinal Network to ensure appropriate treatment was received.
1470/21	The Chief Executive also offered his thanks to Mr Palmer noting that as this was taken through the complaints process there had been no chance to write to offer apologies. The Chief Executive offered his sincere apologies for the experience of Mr Palmer and for the missed opportunities that were had.
1471/21	The Chief Executive was interested in the wider learning across the organisation and divisions noting that there was potential for these issues to be experienced in other areas of the Trust.
1472/21	The Director of Nursing noted that there was a lot of potential for good coming from the patient experiences being received. There was a need to recognise that patients know their conditions and issues far better that the clinicians who are there to help and support to make the situation better, more comfortable or to cure an ailment.
1473/21	If patients are not listened to then it is not possible to support them appropriately and this was clear in this example. The 'What matters to me' campaign would be spearheaded across the Trust to ensure that patients were listened to and heard. This also followed the national trail of Tommy Whitelaw and the work he continued to do around the care of his mother. If there was an understanding of what mattered to the patient there would have been an understanding of the issues. This was being piloted in orthopaedics with the Director of Nursing inviting Mr Palmer to engage in a further conversation with the Trust to understand how he may be able to help.
1474/21	The Director of Nursing noted that the Head of Patient Experience was building a library of patient and staff experience to share this across the organisation and build a wider framework around patient inclusivity and patient voices. This work was currently in its infancy however was developing.

1475/21	The Associate Specialist Trauma & Orthopaedic Surgery was grateful to patient who, despite failings, were there to support the Trust in order to make improvements noting that whilst there were a number of complaints received the service also received numerous positive stories and feedback.
1476/21	The Associate Specialist Trauma & Orthopaedic Surgery would welcome an opportunity to consider ways of working with the Board in order to improve experiences.
1477/21	The Chair noted the commitment of the Board to take experiences of patients and to improve. The Chair thanked the Associate Specialist Trauma & Orthopaedic Surgery for the honest reflection on the challenges and how practice had been changed. There was clear leadership to take the agenda forward and it was pleasing to note that this had been taken to the clinical governance meeting to share more widely. 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
1478/21	**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 24 August Meeting.
1479/21	Mrs Libiszewski noted that, as a result of Covid-19 wave 3 most reporting groups had been stood down however the Committee had been in receipt of a number of chairs reports. The Committee ran a shortened meeting with a reduced agenda.
1480/21	Mrs Libiszewski noted that objective 1a – harm free care, continued to be rated as amber with the Committee noting the work that was happening, led by the Director of Nursing in to maternity and a review of serious incidents that had been commissioned. The outcome of the review would be reported back to the Committee at a future date.
1481/21	The Committee received the Infection, Prevention and Control letter from NHS England/Improvement and would be discussed by the Board.
1482/21	The Committee remained concerned regarding the Medicines Quality Group and the ability to deliver the ambitious roadmap. It was noted that support was in place from the Transformation Team and the Committee looked forward to receiving further updates to see that the objectives had been achieved within the tight timescales.
1483/21	Concern was noted that the Patient Safety Group had been stood down however the Chairs report offered detail and some assurance to the Committee.
1484/21	The Committee continued to rate objective 1b – patient experience as red however noted that there had been changes in the way the Committee received patient experience information. As heard through the patient story there was work taking place across the Trust however the assurance reports needed to demonstrate this and data would need to be triangulated.
1485/21	The Committee received the terms of reference for the thematic review in maternity with the Committee asking if the Non-Executive Director Maternity Safety Champion should be included in the assurance process.

1486/21	Mrs Libiszewski advised the Board that there were no papers received in respect of objective 1c and as such this remained rated as red. Overall there were no changes made to the Board Assurance Framework ratings.
1487/21	The Committee received an updated in relation to Ionising Radiation (Medical Equipment) Regulations (IR(ME)R) inspection and a further verbal update following a meeting that had taken place earlier in the day.
1488/21	The Committee reviewed the Care Quality Commission actions and noted that all upward reports from the subgroups had included updates regarding the risk register.
1489/21	The Chair appreciated that the Committee had been reliant on reports from the subgroups however there was oversight that sat behind this as described earlier.
1490/21	The Chair sought clarity from Mrs Libiszewski on the issue of information and data being received in to the Committees noting this had also been raised by the Finance, Performance and Estates Committee and asked if this remained a challenge within the Integrated Performance Report.
1491/21	Mrs Libiszewski noted that there had been a question in the Committee about the Integrated Improvement Plan (IIP) and the difference if an action was taking place and if this was having an impact on the outcomes being measured. There was concern that the IIP was recording actions being carried out as green however performance indicators were not yet showing this as translating to improvements. The question had been asked to see if there was greater triangulation that could be received that would help to understand the timeframe of improvement and the impact on outcomes. It was suggested this information be received in the data information pack that the Committees received. It was noted that a meeting was due to be held in order to discuss data flows.
1492/21	The Chair thanked Mrs Libiszewski for the clarity noting the importance of ensuring all data was triangulated and easy to navigate. The Trust Board: • **Received the assurance report**
1493/21	**Item 8.1.2 NHSE/I IPC Visit Feedback – for information** The Director of Nursing presented the report to the Board reminding Board members of the Infection, Prevention and Control (IPC) visit conducted by the NHS England and Improvement (NHSE/I) Regional IPC Nurse in December 2019.
1494/21	The outcome of the visit resulted in an overall red rating for IPC practices within the Trust. There had been significant work within IPC, driven by the pandemic and changes in the robustness of IPC processes. As a result of the progress the Director of Nursing asked for the regional team to visit to review practice. The visit took place at the end of July with the outcome showing significant improvements in IPC across the 3 main sites.
1495/21	The regional IPC Nurse was incredibly impressed by what was seen in practice and the evidence provided beforehand. If this had been based only on clinical practice, the Trust would have been rated green across the Board as there were no breaches in practice in either clinical or housekeeping IPC. The known ongoing estates and facilities concerns had been reflected in the report and as such there was an overall rating of amber, this was a positive improvement.

1496/21	The outcome of the visit had been shared with both the Quality Governance Committee and Finance, Performance and Estates Committee. This had been shared with the Board to be open and transparent but also to meet the recommendation within the letter that this was shared with the Board.
1497/21	Whilst the letter was shared for information this demonstrated improvements from an external review of the Trusts IPC practices.
1498/21	The Chair noted the progress that had been made which demonstrated a clear improvement, particularly in clinical areas. The challenges in the estates and facilities were understood however this had been a good outcome.
1499/21	The Chair sought confirmation of the actions taken in respect on international nurse vaccinations and engagement in the divisional nursing teams.
1500/21	The Director of Nursing noted that immediate action had been taken during the time of the visit. International nurses had required a 2 week quarantine followed by a period of induction however action had been take and all international recruits were now fully vaccinated.
1501/21	Whilst a number of activities had been stepped down due to operational pressures the Director of Nursing advised that engagement with divisional nurses had been put in place. Some immediate short terms measures were in place to ensure oversight of all areas in relation to quality and patient safety metrics, including IPC. Weekly catch ups were in place with the divisional nurses and leads to ensure they were sighted. The Director of Nursing was confident that actions had been taken and this was reflected in the IPC Board Assurance Framework which was regularly updated and presented to the Quality Governance Committee. This was also available to Board members within iBabs along with the hygiene code.
1502/21	Professor Baker noted concern that there had not been sufficient assurance in respect of the estates issues that had been flagged and asked what the timescales were for the assurance to be offered.
1503/21	The Director of Nursing noted that the close working with the Chief Operating Officer and Director of Estates and Facilities to pick up elements of water decontamination and ventilation. The report reflected back the concerns the Trust had however there was a lot of work progressing and being overseen by the Director of Nursing as the Director of IPC.
1504/21	The Chief Operating Officer noted that there were a number of actions within the gift of the Trust and significant progress had been made ahead of the letter being received by the Board. The Trust had secured a new recruit in to the Estates Team which was a clinical post who would be both the Decontamination Lead as well as support the Estates Team with wider clinical interface.
1505/21	The Board were advised that this was an innovative position and one that not all Trusts had in place. Both the Chief Operating Officer and Director of Nursing felt that this was an important role to have in the Trust. Along with this recruitment there had been a number of smaller process elements that had been addressed as part of the estates team that substantial progress had been made on.
1506/21	The Chief Operating Officer noted that there were more substantial areas involving infrastructure and environment around ventilation and water safety. Water and decontamination were built in to the capital programme for the year where substantial progress was expected.

1507/21	The Board were advised that ventilation would be more difficult to address and whilst not at the front of the capital programme for the current year this was being engineered in to works. It was recognised that there was a substantial back log and under investment over the past decade.
1508/21	In order to ensure governance was in place written confirmation would be provided to the IPC Group regarding the level of completeness of actions with reporting being maintained to the Finance, Performance and Estates Committee, through the estates compliance report.
1509/21	The Chair noted that under the leadership of the Chief Operating Officer there was improved grip and control over estates and facilities issues. The Trust Board: • **Received the report and discussed the content and outcome of the NHSE/I IPC visit**
	Item 9 Objective 2 To enable our people to lead, work differently and to feel valued, motivated and proud to work at ULHT
1510/21	**Item 9.1 Assurance and Risk Report from the Interim Director of People and Organisational Development** The Chair noted that there were interim reporting arrangements in place whilst the Trust changed over to the new Non-Executive Director Chair of the Committee and bringing in the Interim Director of People and Organisational Development. In order to ensure the Board remained sighted on the issues of people and organisational development, the Interim Director had been asked to provide a report to the Board.
1511/21	The Interim Director of People and Organisational Development noted the system recruitment of Health Care Support Workers (HCSW) advising that there had been considerable turnover of previous recruits. Ahead of the next round of recruitment work was being undertaken across the system to gain an insight in to the reasons for leaving. It appeared that there were a number of reasons including staff not being mentally prepared for the role, this went to the heart of how the Trust recruited.
1512/21	Interim Director of People and Organisational Development advised that open days were being considered along with how existing staff were utilised to ensure recruits had the right aptitude and understanding of what the role would entail.
1513/21	Interim Director of People and Organisational Development advised the Board that the winter flu and Covid-19 vaccination programmes were progressing. The Trust had good practice in place already with learning being taken from previous years to plan for the next.
1514/21	The Trust had sufficient peer vaccinators in place and would be following the same plan as for the previous year ensuring there were plans in place for each site. A run through had been held and meetings had taken place with the staff networks. Communications were in place and would go live the following week for the flu vaccination programme.
1515/21	The Board were advised in respect of the Covid-19 booster programme that the Trust awaited the decision from the Joint Committee on Vaccination and Immunisation (JCVI) in order to commence the booster programme. Everything was in place to commence vaccinations if this was confirmed to go ahead.

1516/21	The Interim Director of People and Organisational Development noted the concern across the system in relation to staff fatigue and wellbeing noting that there were high levels of sickness. There was a lot of good practice in place to support wellbeing of staff but this was being carried across the nursing and organisational development teams. Conversations were being held to understand capacity going in to the winter to ensure there was support for mental wellbeing. There was a recognised need to recruit people with the right skills to ensure support was in place.
1517/21	Mrs Dunnett noted the downward trend in appraisal completion rates asking what action would be taken to address the issue. Mrs Dunnett also noted that the People and Organisational Development Committee would need to closely evaluate the impact of the new approach to recruitment of HCSWs over the coming months.
1518/21	The Chief Executive, first welcomed the Interim Director of People and Organisational Development to the Trust noting that a list of things to do had been discussed, including appraisals which required a fundamental review. It was noted a review of both the cycle of appraisals and the grading system would be required along with engagement of the workforce.
1519/21	The Interim Director of People and Organisational Development noted that 'what matters to you' had been the approach taken to work over the past few weeks and this approach was being proposed in respect of appraisals. These conversations took place throughout the year and there needed to be a way for these to be captured. Many staff would be having some form of appraisal however was not likely recognised as such.
1520/21	The Interim Director of People and Organisational Development noted the desire to consider group appraisals that would be helpful to domestic staff along with team objectives, there were a number of ideas for improvement however it was recognised that Covid-19 had had a negative impact.
1521/21	The Chair noted, as the Trust Wellbeing Guardian, that regular catch ups were held with the Wellbeing Team noting that discussions had been held with the Organisational Development and Occupational Health Teams about their experiences of providing the wellbeing service.
1522/21	The culture and leadership programme would rely heavily on the Organisational Development Team and as such there was a need to review the capacity of the teams in the current context of providing health and wellbeing support to the Trust. **Action, Interim Director of People and Organisational Development – 5 October 2021**
1523/21	The Chair noted that the Interim Director of People and Organisational Development was looking at the re-establishment of the People and Organisational Development Committee with the support of Non-Executive Director Professor Philip Baker and Associate Non-Executive Director Alison Dickinson. The Trust Board: • **Received the assurance report**
	Item 10 Objective 3 To ensure that service are sustainable, supported by technology and delivered from an improved estate
1524/21	**Item 10.1 Assurance and Risk Report from the Finance, Performance and Estates Committee**

	The Chair of the Finance, Performance and Estates Committee, Mr Woodward provided the assurances received by the Committee at the 26 August 2021 meeting.
1525/21	Mr Woodward confirmed that the Committee had worked to a reduced agenda due to the pressures within the Trust noting that this had been the third month of chairing the Committee and significant change in the quality of papers had been seen. Additional assurances were being received with further development underway which would offer an improved position to offer assurance to the Board.
1526/21	Mr Woodward referred to the recent IPC visit noting that the Committee had discussed a number of short term estates issues and actions and agreed a process to oversee the delivery of these. This would be reported back to the Committee.
1527/21	The Committee noted the ventilation issues which would require significant infrastructure changes and would require longer term solutions. The Executive Team would undertake a process to review the capital plan and would consider ventilation needs that would be captured as appropriate.
1528/21	Mr Woodward noted that the Committee had received the estates report containing an upward report from the Health and Safety Committee which was the first for some time. The Committee were pleased to receive the report which covered a number of issues.
1529/21	The Committee received the finance report which had alerted members to the challenge on nursing expenditure and agency use.
1530/21	The report had identified a number of challenges in relation to Cost Improvement Plans (CIP) and pressures in a number of areas resulting in the Trust being behind plan in the development of CIP. Work would be undertaken later in the month in order to bring further assurance to the Committee to discuss CIP for the second half of the year.
1531/21	Mr Woodward noted that the first half requirements, whilst a number were recurring savings identified, there had been a smaller number of transactional items and items one off in nature.
1532/21	The Board were advised that the first half forecast position of £1.8m above surplus was closer to being achieved however was still trailing slightly subject to some final adjustments due in September. The Committee were assured however of the understanding of the likely outturn.
1533/21	The Committee received a new reporting section on capital reflecting the importance of this over the next few years in order to resolve legacy estates issues. There were a number of key short term challenges including supply and capacity meaning that the Trust had not managed to spent capital in line with plan for the first 4 periods of the year. Whilst it was anticipated that the total amount would be spent in year there was a need to further develop a plan to work towards the year end.
1534/21	Mr Woodward advised that the reworked capital plan would be different to the original plan however further assurance would be offered to the Board once the information had been received by the Committee.
1535/21	Mr Woodward noted that the Committee had requested a spotlight on breast cancer screening due to being behind on trajectory with the Committee noting the amount of work that had been undertaken and the positive outcomes identified and delivered. Subject to any changes in volume it was anticipated that the trajectory would be recovered by the end of September 2021.

1536/21	The Chief Operating Officer noted that the update had covered all areas of the breast service with the most concerning element being the 14 day breast symptomatic screening where the Trust had reached an almost 0% achievement in the 14 day window and historically had reached a 25-16 day lead time.
1537/21	The Chief Operating Officer reflected on the tremendous job done by the team to identify strategies to maximise capacity and to work with primary care to, where possible, reduce demand, particularly for those patients who were referred and discharged with no further advised beyond the first consultation. As a result the team had not only managed to increase capacity substantially going forward but had been able to see many patients within the backlog. The Chief Operating Officer was pleased to say that the progress had been substantial with a 30% increase seen in the last reporting period. This was expected to jump again and be circa 90%.
1538/21	The Chief Operating Officer noted that the 62 day treatment standard had historically been strong however due to delays in the first stage this had been impacted for the first time in a number of years. This was now coming back in line and improvements were being seen. It was anticipated that breast surgery and treatment would be within the 62 day window by the end of September 2021. This would however continue to be monitored closely in case of an increase in demand.
1539/21	The Chair asked if there was learning to be taken from the recovery of the service to be shared across the organisation.
1540/21	The Chair Operating Officer noted that there was learning to be had from this noting that there had been 2 elements of complexity being organisational development intervention and demand and capacity issues. Learning had been shared internally and across the system with wider stakeholders. It was expected that there would be continued learning as a system. The Trust Board: • **Received the assurance report**
1541/21	**Item 10.2 Nuclear Medicine** The Chief Operating Officer presented the report to the Board noting that this offered limited assurance regarding a small but important service that had not seen substantial changes since prior to the formation of United Lincolnshire Hospitals NHS Trust.
1542/21	Therefore the configuration and operating model stemmed back to when there were multiple Trusts with the report drawing to attention the sustainability of the model of the service.
1543/21	The Chief Operating Officer noted concern regarding the ability to recruit and maintain the level of expertise required in the highly scientific service in terms of experience to deliver the service. Medical Physics experts work both in terms of education and practical experience for some time before being considered experts.
1544/21	The environment and specialist equipment also had a number of requirements in terms of the long term sustainability and expectation of the throughput for the number of cases for the equipment.
1545/21	The Chief Operating Officer advised that the examining service had been flagging concerns of sustainability over the course of the last 2 years and an update had been received through the division to the Executive Team. It was believed there was a substantial case for change in

	the way in which the service was delivered based on the limitations and challenges detailed within the report.
1546/21	It was felt that it would be the right time to start to engage and hold discussions about these challenges as a Board and progress the next logical stapes of engaging with the wider population and patients with a view to potentially changing service delivery in the future.
1547/21	The Chief Operating Officer requested that the Board noted the challenges and agreed the commencement of engagement with the Health Overview Scrutiny Committee, seeking advice from the Committee on the engagement process that should start as part of this.
1548/21	The Chair noted that the report set out for the Board an understanding of the case for change and offered some information that caused concern regarding the fragility of the service. It was positive to note that the process of engagement and involvement with the wider community had been recognised.
1549/21	Dr Gibson supported the concept that the services was greatly in need of a review noting the aged equipment in use and concern of the low number of patients being seen. Dr Gibson noted that the paper recommended 3 new gamma cameras however advised that 2 could suffice for the current level of demand.
1550/21	Dr Gibson also noted that the ability to resource the team in respect of physicists and technologists would be difficult due to only having 1 expert and offering the service across 3 sites. Dr Gibson suggested that this be reviewed with consideration of benchmarking against other centres that were operating.
1551/21	The Chief Executive welcomed the paper and the process of active engagement with scrutiny colleagues as to how engagement should be conducted. It was noted that there may need to be education of the service as part of the engagement process to ensure this was fully understood. The Trust Board: • **Received the paper noting the limited assurance** • **Endorse recommendations as detailed within the paper**
	Item 11 Objective 4 To implement integrated models of care with our partners to improve Lincolnshire's health and wellbeing
	No items
1552/21	**Item 12 Integrated Performance Report** The Director of Finance and Digital presented the report to the Board noting that relevant items for attention of the Board had been raised through the Committee upward reports.
1553/21	The format of the report had developed with the core charts for each indicator containing specific information about the background, what the SPC chart was detailing, issues and actions and the mitigations being taken.
1554/21	The Director of Finance and Digital noted that the report was moving in a direction of provide a greater level of clarity and assurance about what was happening against each metric.
1555/21	Various discussions had be held by the Committees in relation to the executive scorecard and the Director of Finance and Digital was due to meet with the Chairs of the Finance and Quality

	Committees in order to work through the detail and seek the level of clarity needed, to ensure the correct level of assurance was offered to the Committees.
1556/21	Work was due to take place over the next 2 months with a view that the November reporting cycle should have a completed product.
1557/21	The Director of Finance and Digital noted that a level of review have been undertaken on the divisional scorecards as to the metrics as these aggregated to underpin the executive scorecard. There had been significant shift forward in the direction of travel and actions taking place to offer assurance.
1558/21	The Board noted that operational pressures continued to impact on the transformational work and the ability for this to be embedded however there was a need to ensure all staff had sight of what they did and how this aggregated to the Board.
1559/21	The Chair noted the positive work in progress and was keen that this was properly aligned through the Committees to the Board.
1560/21	The Chair noted that duty of candour continued to cause concern noting the difficulty in embedding this in professional practice.
1561/21	The Director of Nursing advised that the data demonstrated some good performance in both verbal and written duty of candour however as indicated through the Quality Governance Committee this was false assurance. Actions were in place to strengthen governance arrangements within the divisions to support duty of candour. A level of support was required in order that there was a real understanding of duty of candour.
1562/21	There was work to do, both in terms of continuing to strengthen the process but also in the training and understanding of why this was undertaken and how it was done both verbally and written. The Trust were stronger in verbal duty of candour than written follow up.
1563/21	Mrs Dunnett noted the difficulties being face in supplies for builds and sought assurance that this would not impact on the medical school build.
1564/21	The Director of Finance and Digital noted that the Medical School remained on track for delivery with a 4 week contingency in place. The Trust were working carefully with the contractor in respect of supplies and how the Trust could make forward purchases to have materials on site ahead of time. This approach would be used for some other construction works.
1565/21	Dr Prior welcomed the introduction of the metrics regarding complaints and looked forward to seeing these populated on the executive scorecard. Concern was noted in relation to the third Nasogastric (NG) tube never event that had occurred recently reflecting that this appeared to be a procedural issue where training was not embedded.
1566/21	The Director of Nursing acknowledged the concerns noting that this was significant and a review of all of the related never events was being undertaken to determine what had been missed. The individual event remained under investigation however a review of the 3 never events and any near misses were being reviewed.
1567/21	The Board were advised of the Healthcare Safety Investigation Branch (HSIB) report in relation to NG tube placement that would also be considered to take in to account any national learning to ensure that the Trust were fully sighted.

1568/21	The review was underway and once concluded would be shared through the Quality Governance Committee however a number of immediate actions had taken place including a Trust wide safety alert, strengthened training on placement and monitoring and the checking of NG tubes.
1569/21	The Chair noted the focus being offered on this by both the Director of Nursing and Medical Director in order to understand the position and make improvements. The Trust Board: • **Received the report noting the limited assurance**
	Item 13 Risk, Governance and Assurance
1570/21	**Item 13.1 Risk Management Report** The Director of Nursing presented the report to the Board noting that this was the monthly report on strategic risks with the highest priority risks continuing to be related to the pandemic and the potential impact on patients, staff, visitors and continued provision of a full range of clinical services.
1571/21	As noted earlier in the meeting the Chief Operating Officer had noted a degree of uncertainty on the future course of the pandemic and the significant transmissibility of the delta variant which required careful monitoring.
1572/21	The report continued to offer 3 high level strategic risks, 2 of which were rated at the highest level and related to the local impact of the Covid-19 pandemic and the capacity to manage emergency demands, linked to the pandemic.
1573/21	The Board were advised of the further risk raised at 20 in relation to workforce engagement, morale and productivity.
1574/21	The Director of Nursing noted that the report also identified the key risk indicators linked to the Integrated Improvement Plan in order to further triangulate to strategic risks. As the reconfiguration of the risk register progressed, which was due to conclude by November, there would be a number of outstanding risk actions completed and full triangulation of strategic risk to the Board Assurance Framework.
1575/21	The appendix of the report offered a full range of strategic risks on the register in order to offer members of the Board full oversight.
1576/21	Mrs Libiszewski acknowledged the reason for many risks being overdue due to the desire to refine the register however raised concern that 2 of the top 3 risks were overdue for review and requested these be given priority for review.
1577/21	The Director of Nursing advised the Board that those risk were under constant review, particularly with the stepping up of gold command and the emergency preparedness response to wave 3 of Covid-19. It was accepted that more of an update could be offered within the report whilst formally maintaining the dates of review. This would be offered to the Committees in September.
1578/21	The Chief Operating Officer noted that for the risks associated with the pandemic these were reviewed through a monthly process that incorporated presentation to the Committees and capturing through the gold level risk and quality impact assessment process. There was a significant level of scrutiny of the risks however the review dates did not reflect this.

1579/21	The Chair noted the point made about the risks being under regular review noting that this needed to be represented appropriately in documentation to the Board to ensure there was an understanding of when formal reviews had taken place. The Trust Board: • **Accepted the top risks within the risk register** • **Received the report and noted the moderate assurance**
1580/21	**Item 13.2 Board Assurance Framework** The Trust Secretary presented the report to the Board noting that this had been considered by the Finance, Performance and Estates Committee and Quality Governance Committee during August as part of streamlined governance arrangements.
1581/21	Both Committees have reviewed the content and assurance ratings making no changes to the ratings presented.
1582/21	The Trust Secretary advised that the People and Organisational Development Committee had not met during August as the handover to the new Executive Director and Committee Chair took place.
1583/21	The Deputy Trust Secretary would meet with the Director of People and Organisational Development to work through further updates for those elements of the Board Assurance Framework however there were currently no changes in the assurance ratings.
1584/21	The Chair invited Professor Baker and the Director of People and Organisational Development to review the relevant items of the Board Assurance Framework once there was sufficient confidence in the data and progress being made. The Trust Board: • **Received the report and noted the limited assurance**
1585/21	**Item 13.3 Trust Board Voting Rights** The Chair noted that not all Board members had voting rights and as Board members left and joined the organisation these rights were reviewed. It was noted that there was a voting place vacant on the Board at Executive level, brought about by the secondment of the Deputy Chief Executive.
1586/21	The Trust Secretary advised that Board of the proposal for the voting rights of the Deputy Chief Executive to move to the Chief Operating Officer for the period of the secondment to enable there to be 5 voting Executive members of the Board.
1587/21	As the Chief Executive had alluded to earlier in the meeting the Deputy Chief Executive role was separate to the voting role and support was sought from the Board members for this arrangement.
1588/21	Once supported by the Board the Trusts' Standing Orders would be amended to reflect the change to voting rights and the Chief Operating Officer would be recorded as a voting member of the Board. The Trust Board: • **Received the report approving the Chief Operating Officer as a voting member of Board for the period of secondment of the Deputy Chief Executive**

1589/21	**Item 14 Any Other Notified Items of Urgent Business** No items
1590/21	The next scheduled meeting will be held on Tuesday 5 October 2021, arrangements to be confirmed taking account of national guidance

Voting Members	**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**	**1 June 2021**	**6 July 2021**	**3 Aug 2021**	**7 Sept 2021**
Elaine Baylis	X	X	X	X	X	X	X	X	X	X	X	X	X
Chris Gibson	A	X	X	X	X	A	X	X	X	X	A	X	X
Geoff Hayward	A	A	A	X	X	X	X	X	A	A	X		
Gill Ponder	X	X	X	X	X	X	X	X	A				
Neill Hepburn	X	X	X	X	X	X	X	X	X	X	A		
Sarah Dunnett	X	X	X	X	X	X	X	A	X	X	X	X	X
Elizabeth Libiszewski	X	X	X	X	X	X	X	X	X	X	X	X	X
Paul Matthew	X	X	X	X	X	X	X	X	X	X	X	X	X
Andrew Morgan	X	X	X	X	X	X	X	X	X	X	X	X	X
Mark Brassington	X	X	X	X	X	X	X	X	X	X	X	X	
Karen Dunderdale	X	X	X	X	X	X	X	A	X	X	X	X	X
David Woodward										X	A	A	X
Philip Baker												X	X
Colin Farquharson												X	X

PUBLIC TRUST BOARD ACTION LOG

Agenda item: 5.2

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

			provide further detail on the impact of EU Exit on the Trusts European Workforce.			
3 August 2021	1323/21	Assurance and Risk Report from the Finance, Performance and EstatesCommittee action	Audit Committee to review the missing outcomes data	Director of Finance & Digital	11/10/2021	Audit Committee meeting 11 October 2021
3 August 2021	1360/21	Urology Service Engagement Output	An update paper on the Urology Service Engagement output to be reported to Board in three Months.	Int Dir of Imp & Integration	02/11/2021	
7 September 2021	1408/21	Matters arising	Actions to be reviewed and update to provide appropriate dates for reports to be received	Trust Secretary	05/10/2021	Complete
7 September 2021	1429/21	Chief Executive Horizon Scan	Congratulatory letter to be sent to Sarah Connery	Chair	05/10/2021	Complete
7 September 2021	1522/21	Assurance and Risk Report from the Interim Director of People and Organisational Development	Review of OD Team capacity in providing health and wellbeing support to the Trust	Int Dir of People & OD	05/10/2021	Update provided from Int Director

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Public Trust Board*
Date of Meeting	*5 October 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 Lincolnshire system remains under significant operational pressure across all sectors. System partners are continuing to work together to support each other. From a ULHT perspective the pressures are most obvious in the ED but in flow terms there are pressures across the hospital. More work is needed across the system on tackling discharges for those patients who no longer require acute care in hospital. Delays in discharging these patients' causes flow problems elsewhere in the hospital, most noticeably in the ED.
b) Guidance has been received from NHSE/I and the Local Government Association entitled 'Integrated Care Partnership (ICP) engagement document: Integrated Care System (ICS) implementation'. This new guidance is to help systems prepare for the establishment of ICPs from April 2022. The guidance includes a description of how the ICP relates to other elements of the ICS.
c) The outcome of the recruitment process for the Chair of the Lincolnshire Integrated Care Board (ICB) is awaited. The recruitment process for the CEO role is underway, with the application process now having closed.
d) Maz Fosh has been appointed to the position of CEO of Lincolnshire Community Health Services NHS Trust.
e) A paper is going to the Board of NHS Lincolnshire CCG on 29th September relating to the Acute Services Review (ASR). The paper seeks CCG Board support for the ASR pre-consultation business case and also seeks agreement to the commencement of a 12 week public consultation exercise relating to 4 NHS services. These are Orthopaedics, Urgent and Emergency Care, Acute Medicine, Stroke Services. It is proposed that the consultation runs from 30th September to 23rd December. The Board paper is available on the CCG's website.
f) The vaccination programme is continuing. COVID vaccinations are now being offered to 12-15 year olds and the booster programme has also started, alongside the flu vaccination programme.

Trust Overview

a) At Month 5, the Trust reported an in-month surplus of £1.0m with a year-to-date position of a surplus of £0.4m. The forecast surplus for H1 is £1.2m which is adverse to plan by £0.6m. This is due to rule changes relating to the national Elective Recovery Fund.
b) No appointment was made following the recent selection process for a new Director of People and Organisational Development. The post will be re-advertised nationally and revised interim arrangements are being put in place in the meantime.
c) Interviews are taking place week commencing 4th October for the Interim Director of Improvement and Integration post.
d) The Trust's new Freedom to Speak Up Guardian, Deborah Elliott, has now commenced with the Trust.

e) The Trust's Hospital Hubs are now offering COVID vaccination booster jabs and Flu jabs to staff.
f) The system submitted a co-ordinated Expression of Interest to NHSE as part of the 'Health Infrastructure Plan: New Hospitals Programme.' Proposals were submitted by all three statutory NHS provider trusts in the county. ULHT submitted a substantial expression of interest relating to Lincoln County Hospital, Pilgrim Hospital Boston and Grantham and District Hospital.

Report to:	Trust Board
Title of report:	Quality Governance Committee Assurance Report to Board
Date of meeting:	21st September 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 2021/22 objectives. The Trust are responding to the third wave of Covid-19 and as such the meeting was held via Microsoft Teams with a reduced agenda and attendance to focus on key priorities. The Committee were mindful of the pressures being faced by the Trust. Due to operational pressures the Committee were not quorate at the commencement of the meeting however items discussed during this period were reviewed at the end of the meeting when the Committee was fully quorate.
	Assurance in respect of SO 1a Issue: Deliver harm free care **Safeguarding Group Upward report** The Committee received the report noting the 2 areas of escalation being training compliance and clinical restraint and holding. Progress had been seen previously in relation to training but it was noted this was slowing due to pressures within the organisation. The Committee noted that Lincolnshire Partnership NHS Foundation Trust had been approached in order to understand what support could be offered in relation to clinical restraint and training. **Infection Prevention and Control (IPC) Group Upward Report – Chairs report** The Committee received the Chairs report in lieu of the meeting being held noting the update provided in relation to Stenotrophomonas maltophillia and the completion of the replacement of filters on all sinks and taps at the Lincoln site in response. The Committee noted the work of the Ventilation Safety Group and direction in addition to the decontamination work for which the Trust had

	appointed a Decontamination/Estates Lead who was clinical by background. The Committee noted that the Decontamination Group had stepped back up and would report through to the IPC Group. **Patient Safety Group Upward Report – Chairs report** The Committee received the Chairs report in lieu of the meeting being held noting the position reported and the mitigating actions in place in relation to Medical Examiners. It was noted a number of Medical Examiners had been removed as part of mandatory removal 5 years post retirement, the Trust were awaiting the start of new Medical Examiners in post. **SI Report inc Never Events** The Committee received the report noting the position and the declaration of a second Never Event for this financial year. **High Profile Cases** The Committee received the report noting the content and was pleased to see the improved level of detail being reported. **Clinical Harm Oversight Group Upward Report** The Committee received the report noting that the AI solution in relation to harm reviews continued to be pursued with a hope that this would be in place during October. The Committee noted the position of the Trust but were assured that the Trust were not a significant outlier in respect of clinical harm. It was noted that the position was constantly evolving and the figures being reported were not the same cohort of patients month on month due to treatments taking place.
	Lack of Assurance in respect of SO 1b Issue: Improve Patient Experience **QIA re visiting Arrangements Standing Down** The Committee received the report due to concerns on the impact to patients and the changes to visiting arrangements at the Trust. The Committee noted concern that the QIA did not capture the bigger impact than just the loss of contact and the ability for relatives to advocate on the patients behalf. It was noted that the QIA did not appear to be patient centred. The Committee was advised that QIAs were regularly reviewed and that this would be taken through a further review taking in to account the comments made. **Complaints** The Committee received the report noting that the paper was clear in

	explaining the position. There had been a deterioration in the timescales of the closure of complaints due to operational pressures with support being considered from the central team in order to minimise any impact. **Maternity and Neonatal Oversight Group Upward Report** The Committee received the report noting the amount of work that was being undertaken through the group. The Committee noted the significant interest in maternity services nationally due to some high profile cases. The revised Clinical Negligence Scheme for Trusts standards for year 4 had been received with some significant changes to requirements. This was now being worked through however the Committee noted the continued issue with the interface of the data system used and the upload of data. The Committee noted the ongoing work in relation to the thematic review that had been commissioned with the Medical Director chairing the panel where the internal and external feedback would be received. **Patient Experience Group Chairs Report and Q1 Patient Experience report** The Committee received the Chairs report in lieu of the meeting being held along with the quarter 1 patient experience report noting the Trusts position in relation to urgent and emergency care patient experience. The Committee was disappointed to note that the Trust were in the bottom 10 for patient experience within the urgent and emergency care services and sought confirmation of the actions being taken to address this. The Committee noted that the work to address this was linked to the Trusts work in relation to Safety Culture and the Culture and Leadership Programme, being led by the Chief Executive, in order to change patient experience. The Committee noted that there were good pieces of work taking place but there were not shifting the overall experience of patients.
	Lack of Assurance in respect of SO 1c Issue: Improve Clinical Outcomes **Clinical Effectiveness Group Upward Report – Chairs report** The Committee received the Chairs report in lieu of the meeting being held noting the thorough review of papers. It was hoped that the next meeting would take place in October as this had been stood down for the past 2 months. The Committee raised concern in relation to audit outliers being advised that work was underway to consider more recent information in order to

	able to offer assurance on some of the outliers.
	Assurance in respect of other areas: **Quality Priorities Progress Report/Integrated Improvement Plan** The Committee received the report noting that this was improved however raised concern regarding disconnect of the scoring against the information provided/not captured such as dates. The Committee noted the intention of the Director of Nursing and Medical Director to review the safety culture work and the link to patient safety and culture as these are inextricably linked. **Committee Performance Dashboard** The Committee received the report noting that the Chair of the Committee had attended a meeting to review and discuss further development of the executive scorecard. The Committee noted current performance with particular focus on the pressures being seen in relation to 12 hour waits and the significant reduction in duty of candour. The Committee noted that this was primarily due to operational pressures within the organisation. The Committee noted the action being taken by the Governance Team in order to support the Divisions. The Committee noted that training sessions would be provided however emphasised the need to ensure that duty of candour was embedded within the organisation. **Ionising Radiation (Medical Exposure) Regulations** The Committee received the report noting the content and positive progress that had been made. **CQC Must and Should Do Actions Update** The Committee received the report noting that due to the progress made by the Trust an approach had been made to the Care Quality Commission (CQC) in order to remove or vary a number of Section 31 enforcement notices. The Committee were pleased to note that this had been accepted by the CQC and formal communication was awaited.
Issues where assurance remains outstanding for escalation to the Board	The Committee wished to alert the Board to the continued issues relating to the Maternity IT system and the issue of interfacing and upload of data in respect of the standards related to the Clinical Negligence Scheme for Trusts.
Items referred to other Committees for Assurance	The Committee noted that feedback was required from the Finance, Performance and Estates Committee in order to ensure concerns in relation to clinical records was being addressed.
Committee Review of corporate risk register	The Committee noted the risk register and the position of the reconfiguration and were advised that the timescales would be achieved

Matters identified which Committee recommend are escalated to SRR/BAF	None
Committee position on assurance of strategic risk areas that align to committee	The Committee considered the reports which it had received which provided assurances against the strategic risks to strategic objectives.
Areas identified to visit in dept walk rounds	None

Attendance Summary for rolling 12 month period

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

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

Report to:	Trust Board
Title of report:	Finance, Performance and Estates Committee Assurance Report to Board
Date of meeting:	23 September 2021
Chairperson:	David Woodward, Non-Executive Director
Author:	Karen Willey, Deputy Trust Secretary

Purpose	This report summarises the assurances received, and key decisions made by the Finance, Performance and Estates Committee (FPEC). The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board's response. This assurance committee meets monthly and takes scheduled reports from all Trust operational groups according to an established work programme. The Committee worked to the 2021/22 objectives. The Trust are responding to the third wave of Covid-19 and as such the meeting was held via Microsoft Teams with a reduced agenda and attendance to focus on key priorities. The Committee were mindful of the pressures being faced by the Trust.
Assurances received by the Committee	**Lack of Assurance** in respect of SO 3a A modern, clean and fit for purpose environment **Estates Statutory Compliance Report** The Committee received the report and verbal update on a number of recent issues that had taken place meaning that the organisation had been running in standby critical and critical incident for a period of time. The Committee noted that the issues had been addressed thanks to the commitment of the estates and facilities teams. The Committee noted the intention for further work to be done in shape of a 6 facet survey to be completed with support from system colleagues in order to further build the case for the Health Infrastructure Bid.
	Assurance in respect of SO 3b Efficient Use of Resources **Finance Report** The Committee received the report noting that at the end of month 5 the Trust were on plan with a delivery of just under £1m surplus in month. The Committee noted the planned forecast of £1.2m against the original £1.8m as a result of a reduction in elective recovery fund income as the change in thresholds had resulted in the Trust not meeting target. The Committee noted the position of Cost Improvement Plans noting that whilst there was capability in the Trust to deliver capacity issues were having an impact on deliverability.

	The in month and YTD surplus is in line with plan. The in month position is an improved £1m surplus inclusive of increased operating and patient care income, that is offset by an increasing cost base primarily in employee expenses. The Committee noted the continued staffing pressures resulting in agency and bank spend noting that further work would be required to transition bank staff to substantive roles. This would see a reduction in bank spend. The Committee received the financial bridge noting the content and recognising there would be Covid-19 pressures in Month 6 and H2. Further work would be required on the financial bridge to ensure additional detail was included once H2 contract negotiations had taken place. **Capital Report** The Committee received the detailed capital report noting that the information presented to the Committee offered assurance in the control of capital monies. The Committee noted the request to over commit capital by £2m. The Committee agreed to recommend to the Board that it approve the request to delegate authority to the Director of Finance and Digital and Chief Operating Officer to determine which schemes the monies would be allocated to. The Committee suggested that consideration be given to a further over commitment of the capital as it was concerned that £2m would not give enough flexibility, supporting up to £5m being brought to the Board. The Committee confirmed that it had no appetite to exceed the capital limit and overspend however supported the Director of Finance and Digital to explore if there was the possibility of an increased limit. The Board would also receive the capital report to ensure all members were aware of the position. **Lincolnshire Health Infrastructure Programme (HIP) Bid** The Committee received the final bid that had been further developed since being reported to the September Board noting that further communication regarding the bid would not be received until Spring 2022.
	Assurance in respect of SO 3c Enhanced data and digital capability **Information Governance Group Upward Report** The Committee received the report noting that Information Governance now sat under the remit of the Trust Secretary.

	Work was underway to strengthen the team and once this had been completed the structure of the group would be considered to ensure this was focused and prioritised. **Digital Services Assurance Report** The Committee received the report noting that the report focused on internal systems in respect of cyber risk and requested that future reporting also detail third party systems so that the Committee could be assured that should risks be present that these were mitigated.
	Assurance in respect of other areas: **Operational Performance against National Standards** The Committee received the report and noted the recent Quarterly Review System Meeting that had been held with NHS England/Improvement where thorough analysis of the performance of the Trust was undertaken. The Committee noted the position of 14 day breast cancer screening target which whilst predicted to be back on track by the end of September would now be more likely to recover in November/December due to a significant increase in demand. It was noted that the backlog had improved to 100 from 800. **Committee Performance Dashboard** The Committee received the reporting noting the content and paying particular attention to the recent issues within urgent care due to record levels of performance. The Committee noted that the Trust had had the largest number of 12 hour trolley waits recorded in the history of the organisation and had been experiencing ambulance handover delays. The Committee noted that emergency planning tools were being utilised to provide focus to this. The Committee noted that the risk register entry of 25 reflected the current pressures being faced. **Integrated Improvement Plan** The Committee received the report noting that this needed to start to include the longer term aspects of the IIP and ensuring consistency of reporting. The Committee noted that work was underway to further improve reporting and offer clear alignment.
Issues where assurance remains outstanding for	None

escalation to the Board	
Items referred to other Committees for Assurance	None
Committee Review of corporate risk register	The Committee received the risk register noting the risks presented
Matters identified which Committee recommend are escalated to SRR/BAF	No items identified
Committee position on assurance of strategic risk areas that align to committee	As above
Areas identified to visit in dept walk rounds	None

Attendance Summary for rolling 12-month period

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

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

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Public Trust Board*
Date of Meeting	*5th October 2021*
Item Number	*TO BE ADDED BY ADMIN*
4c: To become a University Hospitals Teaching Trust	
Accountable Director	*Sarah Hall*
Presented by	*Sarah Hall*
Author(s)	*Georgina Grace*
Report previously considered at	*ELT* *02/09/21* *To proceed with Option 3 set out in paper, and to submit for consideration at Trust Board*

How the report supports the delivery of the priorities within the Board Assurance Framework	
1a Deliver harm free care	
1b Improve patient experience	*X*
1c Improve clinical outcomes	
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	*X*
4c To become a university hospitals teaching trust	*X*

Risk Assessment	*Local project risks managed within project, risk to change in status outlined in this paper*
Financial Impact Assessment	*n/a*
Quality Impact Assessment	*Approved at QIA Panel on 21/09/21*
Equality Impact Assessment	*Insert detail*
Assurance Level Assessment	• *Limited*

Recommendations/ Decision Required	*Recommendation: To proceed with Option 3*
	Board to consider the implications of the change in UHA Guidance as at June 2021 and provide decision on ULHT direction of travel, taking into account the recommendation from University of Lincoln and ELT to proceed with Option 3.

Please Note: This paper has been written in collaboration with University of Lincoln as this is a collaborative programme of work.

UNIVERSITY OF LINCOLN

Executive Summary

It is a key priority for ULHT and UoL to work in partnership to achieve Teaching & University Hospital status and both organisations have recently embarked on this journey since May 2021.

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 workforce in the future.

As ULHT transitions into a Teaching University Hospital, work will need to focus on delivering the requirements of University Hospital Association (UHA) membership. The principles of UHA membership align to key themes: research, education, workforce and technology. The UHA have recently changed their guidance (as at the end of June 2021), which ULHT and the UoL became aware of in July 2021. Since then there has been consideration of what impact this change may have on the scope of the project, and this paper sets out the changes, along with potential impact and options for the onward direction of travel.

The key changes within the UHA Guidance Annex A criteria relate specifically to the area of research and are outlined below: -

	Pre June 2021 UHA Guidance (Previous version)	Post June 2021 UHA Guidance (Revised version)
	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	The Trust shall have in place with the University a Memorandum of Understanding on Joint Working for Effective Research Governance; it will actively investigate joint Research Offices to foster more efficient working;
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;	A core number of university principle investigators. There must be a minimum of twenty consultant staff with a substantive contract of employment with the university with a medical or dental school which provides a non-executive director to the Trust Board. These individuals must have an honorary contract with the Trust in question.
iii	For Trusts in England, an average Research Capability Funding of at least £100k average p.a. over the previous two years	For Trusts in England, an average Research Capability Funding allocation of at least £200k average p.a. over the previous two years.

The next sections of this paper will set out the impact and options for which both ULHT and UoL should consider with regard to the partnership journey they wish to take, in light of the change in national guidance.

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.

Previous board approval to embark on this journey was based on the previous UHA Guidance (pre June 2021) within which opportunities were seen to be achievable for full University Hospital status. However, the revised changes to the UHA Guidance (post June 2021) have seen significant and more stringent criteria to which both organisations have to adhere.

This paper is to outline these changes and ask that the board consider this impact and potential options which should now be considered in order to maintain reputational stature, continue to develop our collaborative working relationship and yet still achieve a key change in status with regard to realising the strategic ambition to become a Teaching or University Hospital.

2.0 Key messages

The most significant changes with the highest impact relates to: -

- The number of Clinical Academics that must be in place. This number has risen from 10 to 20, which now must be “Consultant staff with a substantive contract of employment at the university with a medical or dental school which provides a non-executive director to the Trust Board”.

  Previously there was no stipulation that this could not be staff from varied healthcare professions, and with this in mind it was anticipated that we would be able to demonstrate a commitment to growth in this area over a 2-3 year timeframe, with Year 1 seeing the introduction of approx. 4-5 staff.

  This change presents more of a challenge due to the requirement for the staff to be Consultants, and the increase in the number from 10 to 20. With the current vacancy rate at Consultant level within ULHT this may not be a criterion which can be as easily realised.

- The requirement for RCF Funding to be at a rate of £200k per annum, an increase from the previous £100k. Whilst ULHT have never realised this level

of RCF funding, it was anticipated that with the significant evidence of expected growth in our research department and capability, alongside the expected benefits which would be realised by the introduction of the 10 Clinical Academics, that evidencing the steps being taken to bridge the funding gap would be feasible in line with the pre June 2021 UHA Guidance. This however, is now more of a challenge due to the changes seen to the guidance.

- It has been acknowledged by the Department of Health and Social Care, in a meeting with ULHT Project Group members, that this change in guidance has the potential to significantly impact the success of Trust applications to become a University Hospital as it has made the criteria much harder to meet. The Department of Health and Social Care have suggested that they will be addressing this with Government Ministers, requesting that a review of the UHA Guidance is undertaken but the outcome of this is not expected until later in 2021 or early 2022 at the earliest. The Department of Health and Social Care have expressed interest in working with United Lincolnshire Hospitals Trust to gather detail of our experience of the UHA and the impact that the UHA Guidance changes have on our planned submission.

- The Department of Health and Social Care, and the UHA Guidance, suggests that it is possible to apply for Teaching Hospital status without the need to adhere fully to the whole of the UHA Guidance. The UHA Guidance states that to have a 'significant teaching commitment': -

> 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 and Social Care 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 and Social Care 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.

3.0 Project Headlines to Date

There has been significant progress since May 2021 with regards to the partnership working between ULHT and UoL, in line with the original UHA Guidance, to realise the potential of becoming a University Teaching Hospital. The key headlines are: -

- ULHT Steering Group in place, scheduled to meet fortnightly.

- UoL and ULHT Focus Group in place, scheduled to meet monthly.

- Draft Joint Strategy completed and currently with the UoL for review with a focus on education and research commitments.
- Sections, 4 and 6 (relating to Medical Education and Library Services) reviewed and evidence being collated to support all aspects of the criteria.

- External stakeholder engagement plan enacted, with responses from local MP's and other external bodies in full support of the vision. To date we have received 8 letters of support from external stakeholders including East Midlands Academic Science Network, HEE, HOSC, Local MPs, Nottingham University, NHSE/I, and the Clinical Research Network.

- UoL and ULHT have agreed that there is a requirement for ULHTs CEO to attend Health Committee meetings and this is being defined at present with regards to which committee this is best placed to be at UoL.

- Case of Need approved at ULHT CRIG for the progress to full Business Case for investment into the Research & Innovation Department at ULHT.

- UoL initial Senior Leadership Team (Executive) approval in place.

- Project being managed within the ULHT 'Aspyre' system using the Six Stage Methodology and aligned to the ULHT PMO function as part of the ULHT Integrated Improvement Plan.

4.0 Conclusion/Recommendations

It is acknowledged that this project and wider strategic vision is fully supported by both ULHT and UoL and that this has been done so in line with the previous UHA Guidance. Changes to this guidance were not known to either ULHT or UoL at the time of seeking initial Board approval, but it is important that it is brought to the attention of both organisational Board members to ensure there is an open, honest and transparent approach to the next steps that should be taken.

Below are the options for consideration, with relevant supporting comments in order to aid the decision making of the Board as to which is the best option for the organisations: -

Options

Option 1*: Continue with an application to become a full University Hospital acknowledging the gaps in our evidence with supporting statements which outline the plans to mitigate those gaps*

Considerations:

- The UHA may reject an application on the basis that we are unable to fully evidence all criteria set out in the revised guidance.

- This may have an impact on the reputation of both ULHT and UoL.
- This may mean that we are unable to apply again in the near future (clarity on this would need to be sought from the UHA).
- There will be significantly increased financial investment required to fund up to the 20 Clinical Academic posts, which both ULHT and UoL may be unable to support fully.
- The timeline to achieve this, if it is the preferred option, may need to be significantly extended in order to realise the full potential of the application.
- There is a risk that ULHT and UoL are unable to realise the mitigations, despite planning and best efforts and the application would therefore fail.

Option 2*: As per option 2, but with the inclusion of a statement in the application that in the event that UHA are unable to award University status, that they consider awarding Teaching Hospital status.*

Considerations:

- All of the above within Option 1
- There is a risk that the UHA do not welcome this within the application and therefore reject both applications.

Option 3*: That an application to become a Teaching Hospital is submitted, with a view to further applying for full University Hospital status in the future.*

Considerations:

- This would demonstrate the commitment to partnership working within both organisations as the Medical School becomes a core feature within Lincolnshire.
- This would support reputational growth for both organisations whilst still supporting the recruitment and retention of healthcare staff in Lincolnshire.
- This would fulfil part of the strategic vision to become a Teaching Hospital, and allow both organisations the capacity to strengthen their research capabilities (using the UHA Guidance as the benchmark for growth) with a view to making a full University application at a later date (which would require confirmation from the UHA that this can be done and within what timeframe).
- This would allow both organisations to address the financial investment required.
- The Research & Innovation Department at ULHT would be more advanced in their strategy for growth.
- It is suggested that ULHT would change the name on their Establishment Order to 'Lincolnshire Teaching Hospitals'.

Option 4: *That an application is not made at present, but that it is planned to be made at a later date in line with the Integrated Improvement Plan.*

Considerations:

- The management of the external stakeholder expectations after initial engagement has already been undertaken.
- Allows scope for growth without the pressure of a short timeframe for delivery.
- Mitigates the reputational risk, as long as the messaging can be carefully managed.
- Provides an opportunity to strength the partnership working and demonstrate deliverables in line with a Joint Strategy.

Option 5: *That an application of any nature is not pursued at this time, and the external messaging managed accordingly as stakeholders have been engaged on the basis of the previous UHA Guidance.*

Considerations:

- This does not demonstrate commitment to growth, and partnership working.
- It does not support the vision to grown research capability within Lincolnshire.
- It limits our ability to recruit and retain staff.
- It would impact organisational reputation and the ability to drive forward innovation for patient benefit.
- It does not realise any part of our strategic vision.

Option 6: *Create a Provider Group Model (similar to that which Kettering and Northampton have used) which includes our partners such as LCHS, LPFT and EMAS.*

Considerations:

- May not have to adhere to the UHA Annex A criteria as this would be a creation of a new Healthcare Group with each organisation sitting underneath this over-arching structure. Some clarity on this point could be further determined in order to ensure that it is clear what the model would look like, and what the key mandatory actions would be in their entirety.
- Trail blazer opportunity as this has not been done before as far as aware.
- Supports the creation of a research network within Lincolnshire with the opportunity for collaboration between partners.

Recommendations

It is recommended that one of the below options are supported to ensure that UoL and ULHT are able to continue their commitment to partnership working, whilst striving for a united vision to enhance the academic and research capability within Lincolnshire and enhance the reputational standing of both organisations.

> Option 3*: That an application to become a Teaching Hospital is submitted, with a view to further applying for full University Hospital status in the future.*

It should be noted that Option 3 is that which is particularly supported by the University of Lincoln, and was the option which was the favoured option as discussed at ELT on 1st September 2021.

Option 6: *Create a Provider Group Model (similar to that which Kettering and Northampton have used) which includes our partners such as LCHS, LPFT and EMAS.*

Added Notes:

06/09/21
Please note that this version of the Briefing Paper has been annotated to include the favoured option (Option 3) as discussed at ELT on 1st September 2021. This version of the Briefing Paper will be submitted to Trust Board in October 2021.

23/09/21
Further updated since original paper written: -

- University of Lincoln have confirmed that their Senior Leadership Team approved 'Option 3' and that they remain keen to work with ULHT.

- The UHA have advised that there is no time limit between applying for Teaching Hospital status and a future application to become a University Hospital Trust, this can be done at any time once the Trust meet all requirements of the UHA Annex A criteria.

- The Project Lead has requested confirmation from the UHA as to which specific criteria they require evidence submissions for Teaching only status – awaiting response. It is assumed that this will be Section 3 onwards as these are the key points that refer to training and education. Clarity has also been sought as to whether ULHT will still require a Non-Executive from the University in view of the change in application status.

Meeting	Trust Board
Date of Meeting	5th October 2021
Item Number	
Integrated Performance Report for August 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 and associated actions/escalations where appropriate*

Executive Summary

Quality

Patient Falls

There was 1 fall resulting in moderate harm and one fall resulting in severe harm in August 2021. Overall, inpatient falls have decreased in numbers from July. A new incident investigation pathway has been devised and is currently waiting for approval throughout September.

Pressure Ulcers

There were 44 (target of 28.3 month) category 2 and 1 (target of 4.3 a month) category 3 pressure ulcers in August 2021. There are a number of themes currently being observed relating to category 2 pressure ulcers relating to devices, delay in pressure relieving equipment and documentation. Actions to recover can be seen below.

Never Events

There was 1 new Never Event in August 2021, oral formulation of methadone incorrectly administered subcutaneously via syringe driver. The incident is under investigation and a Patient Safety Bulletin has been circulated throughout the organisation.

Medication incidents reported as causing harm

The number of reported incidents causing harm for the month of August was 23.8% more than double the national average of 10.8%. Actions to recover are cited below.

SHMI

The Trust is currently at 112.88 against target of 100. SHMI has increased during the COVID-19 pandemic. The Trust are currently in discussion with the system partners in rolling out the ME service for community deaths and learning can be generated for deaths within 30 days.

Participation in National Clinical Audits

The Trust is participating in 97% of all relevant national clinical audits. The Trust is in process of registering for the IBD audit which will make us 100% compliant.

eDD

The Trust achieved 87.7% with sending eDDs within 24 hours for August 2021 against a target of 95%. 6.7% of eDDs were not sent at all during the month of August 2021. eDD compliance has deteriorated again for the month of August. Paediatric eDD template being streamlined to aid completion and improve compliance.

Sepsis paediatric – based on July data

Screening compliance for paediatric inpatients was 83% in July which is below the 90% target. Administration of IVAB for paediatric inpatients was 75% in July, 3 out of 4 children received antibiotics within 1 hour. Screening compliance for paediatrics in ED was at 84.8% with administration of IVAB at 50% equating to 5 out of 10 children received their antibiotics within an hour. Weekly meetings with A&E to discuss compliance and share learning.

Duty of Candour (DoC)

Verbal compliance for August has significantly decreased to 18% against a 100% target. DoC training has been sourced from an external provide and is expected to be delivered from October onwards. The Risk team are currently reviewing compliance and supporting the Divisions on a daily basis.

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.

The Covid-19 2nd wave 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. Grantham has now been restored to its original function and purpose.

The Covid 3rd wave has seen less demand in terms of hospitalisation with numbers of inpatients ranging from 35 to 60. At the time of writing this executive summary, the Trust has 53 positive inpatients, of which 8 patients are requiring Intensive Care interventions. The main impact of the 3rd wave is the significant impact on staff absences due to the increased prevalence of positive cases within our population. Lincolnshire has had at times the highest sickness rate in the Midlands. This has impacted on the delivery of both urgent and planned care pathways.

This report covers August performance, and it should be noted that as the demands of Wave 3 have increased, the Trust has now moved back to a *Manage* phase whilst acknowledging the absolute need to combine the recovery and restoration of services. Guidance in how performance and recovery is approached is defined 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 and Planned Care Standards which are now being implemented, monitored, and reported going forwards.

A & E and Ambulance Performance

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

4-hour performance for August improved against July's performance of 64.93% being reported at 66.96%. This is the tenth time in twelve months the Trust's performance has been below the agreed trajectory.

There were 12 12-hr trolley wait, reported via the agreed process. Sub-optimal discharges to meet emergency demand was established as the main route cause. (As described in the Trust Risk Register entry 4175)

Performance against the 15 min triage target in August demonstrated an improvement of 4.36% compared with July. 87.98% in August verses 83.62% in July

Ambulance conveyances for August were, 4381, down by 6.17% against July. There were 629 >59minute handover delays recorded in August, an increase of 61 from July. Delays experienced at LCH and PHB are attributed conveyance pattern/grouped arrival times and increased levels of overcrowding in EDs. An increase of >120mins handovers has also been experienced in August as a result of this.

Length of Stay

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

Referral to Treatment

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

July demonstrated a decreased performance of 2.57% to 58.89%. The Trust reported 797 incomplete 52-week breaches for July end of month but has increased to 1241 in August. The Trust remains in a strong position when compared to other regional providers.

The Cancer/Elective Cell continued to meet weekly throughout the month of June and July with a weekly confirm and challenge meeting with surgical specialities led by senior clinical review and prioritisation cell to ensure capacity across all sites are maximised for the most critical patients. Cancer patients and clinically urgent remain a priority with a continued focus on 62+ day, 104+ days cancer patients and 40+, 52+ and 78+ week patients on the 18-week RTT PTL At the end of August 2021 the Trust had 2 patients who were waiting longer than 104weeks. Both patients had dates for their treatment.

Waiting Lists

Overall waiting list size has decreased in August to 51,707. Work continues between OPD and the CBUs regarding the returning to a standard 'polling' approach as part of our restoration plans.

A recovery plan for ASIs has been developed and including a recovery trajectory. As of week commencing 6th September ASI numbers have increased to 759 but remains in line with the trajectory.

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

DM01

DM01 for August 2021 was received for review and sign off at 14:45, 16th September 2021. On review, anomalies were uncovered and further investigation is required.

Cancelled Ops

Validated figures were only received 16th September 2021 post submission time.
Future timely submission will be picked up by the Deputy Chief Operating Officer and Associate Director of Performance.

Cancer

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

63% of the 14 day breach performance was attributed to the Breast Service in respect of the One-stop appointments. A demand verses capacity gap existed and recovery continues. This also applied to the Symptomatic Breast service. A spotlight on Breast Cancer services was presented in the July planned care FPEC paper.

The impact of COVID-19 on the delivery of the cancer pathways remains evident for 31 day and 62 day standards.
62 Day pathway backlogs are not reducing – 368 as of 9th September 2021 verses 232 on 12th August 2021 key divers for this increase in delay are related to the wave 3 and increase in urgent care vs capacity impact. A number of operations have been cancelled and relatively few cases at PHB and LCH are scheduled going forward to prevent on the day cancellations continuing.

July 62 day performance: Head & Neck 13.3%, Breast = 52.6%, Colorectal = 41.0%, Upper GI = 44.8%.

Workforce

Mandatory Training – The Trend for completion of mandatory training remains strong and static despite the current pandemic. Most course are now online whilst there is no face to face training. New training programmes and systems are being used to update the current training packages and review various platforms to deliver the storage and collation of uptake and performance data. A review of core learning is underway to ensure the training that staff are being asked to complete is appropriate and should be mandatory.

Sickness Absence – Sickness has continued to rise in August, albeit this is usual for this seasonal time due to the school summer holidays and the inability to take time off and the increased reduction in staffing due to Annual Leave. It also needs to be acknowledged the impact on wellbeing for staff following the impact of the last 20 months and the instability of 'normal' working lives. The rules for isolating has changed and therefore we have seen a decrease in those staff needing to isolate. Compliance of the Attendance management system continues to be embedded and HR/OD staff have been supporting divisions to undertake Call-backs, fill in 'blank reasons' and manages the process to support frontline managers.

Staff Appraisals – With the focus on wave 3, all meetings were stood down over the past month and this has impacted appraisal rates. The engagement around WorkPal as a new system has also slowed down considerably with the pause of all non-essential training.

Agency Spend –There will need to be a step change in spend levels across all professions, but current spend is being driven by the vacancy gaps in nursing and the need to keep medicine and emergency care medical staffing at appropriate levels. The interim Director of People has met with Medicine to agree a focus on workforce planning and rotas in order to better understand their workforce need and stop the last minute, expensive spend on agency locums. Stronger governance and planning will be put in place and once the model has been proven to work it will be rolled out to other divisions. From next week the central medical staffing team will have additional resource to focus on the medium term issues.

Finance

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

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

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

The Trust has delivered a £1.0m surplus for the month of August (in line with plan) and a £0.4m surplus year to date (in line with plan).

The capital programme for 2021/22 currently stands at £33.7m for the full year; actual capital expenditure of £5.7m has been incurred YTD against a submitted plan YTD of £11.8m.

The month end cash balance is £52.4m which is a reduction of £1.7m against cash at 31 March 2021.

Paul Matthew
Director of Finance & Digital
September 2021

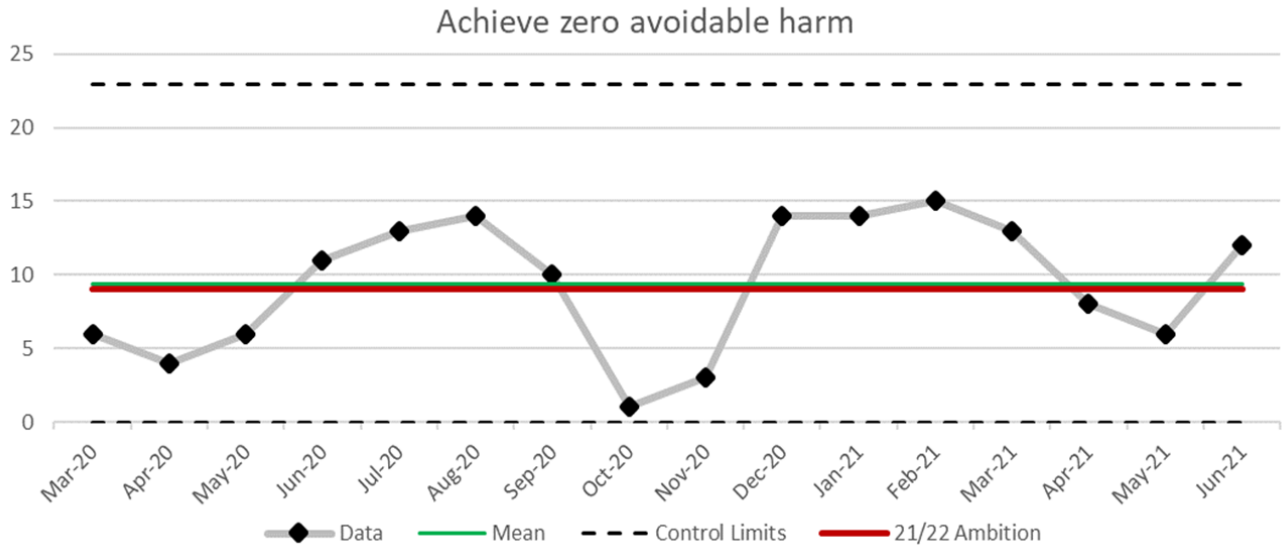
Statistical Process Control Charts

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

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

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

An example chart is below:



Statistical Process Control Charts

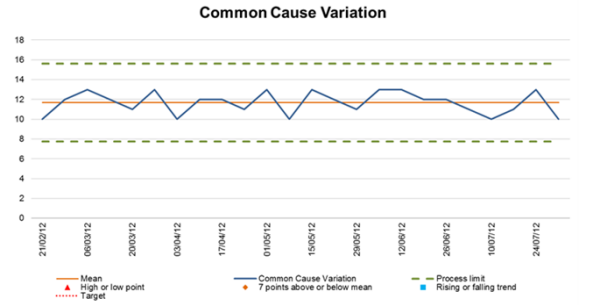
Normal variations in performance across time can occur randomly- without a direct cause, and should not be treated as a concern, or a sign of improvement, and is unlikely to require investigation unless one of the patterns defined below applies.

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

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

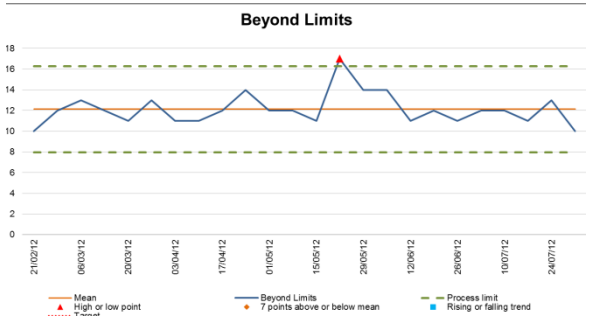
Icons are used throughout this report either complementing or as a substitute for SPC charts. The guidance below describes each icon:

Normal Variation



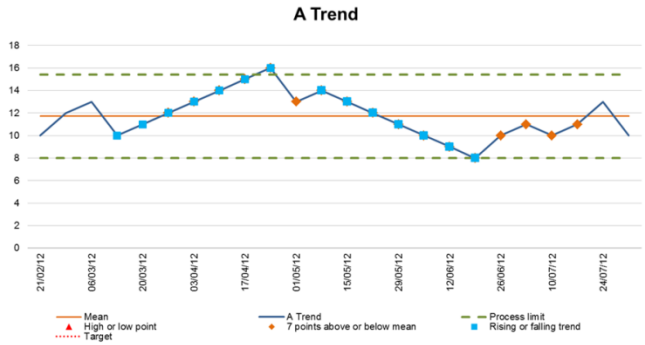
Extreme Values

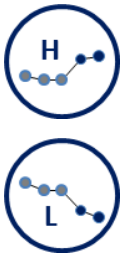
There is no Icon for this scenario.



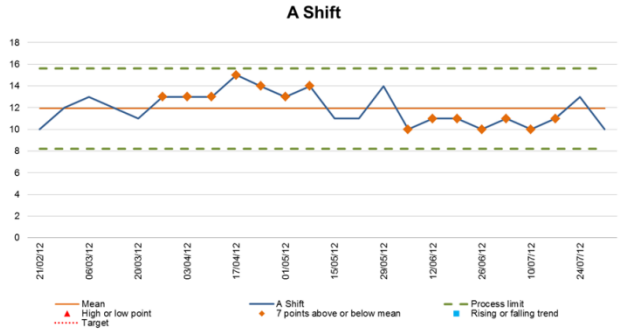
Statistical Process Control Charts

A Trend (upward or downward)





A Trend (a run above or below the mean)



Where a target has been met consistently

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

Where a target has been missed consistently

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

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

EXECUTIVE SCORECARD

Strategic Goal	Domain	Measure ID	Measure	Measure Definition	Baseline	21/22 Ambition	£'000	2021/2022 Jun	Jul	Aug	Latest month pass/fail to ambition	Trend variation
Strategic Metrics	Patients	1	Top 25% for acute Trusts for 'Overall' Inpatient experience	Results in recommending our services to friends and family	4th quartile	3rd quartile		Q4 (90.21%)	Q4 (88.57%)			
	Patients	2	Achieve zero avoidable harm	Serious incidents (including Never Events) of harm - Moderate, severe and death.	15	9		12	12	9		
	Patients	3	Top 25% for SHMI	Summary Hospital-level Mortality Indicator	4th quartile	4th quartile		Q4 (112.05)	Q4 (112.55)	Q4 (112.88)		
	People	4	Top 25% for acute Trusts across all 10 themes in the staff survey	In year monitoring via staff survey on staff morale and leadership.		+10% improvement						
	Partners	26	Deliver 62 day combined cancer standard (77%)	Patients that start a first treatment for cancer within two months (62 days) of an urgent GP referral, including NHS cancer screening services.	69.20%	77%		63.20%	61.50%			
	Partners	27	Total wait in Emergency Department over 12 hours (<1% of patients)	Number of Patient ED attendances waiting more than 12 hours from arrival to transfer, admission or discharge as a percentage of ED attendances.	3.60%	<1%		5.80%	10.03%	11.45%		
	Partners	28	Urgent Treatment (P2) treatment turnaround time is less than 4 weeks	Waiting time from receiving patient referral until treatment is given.	6.7	<4 weeks						
	Partners	29	Deliver Outpatient activity through non-face to face	Increase volume of Outpatients activity for pre-booked telephone and web-based sessions, between consultant and patient		25%		33.70%	32.93%	31.77%		
	Services	9	Deliver a breakeven revenue position	Financial status - Revenue monthly variance to plan		Breakeven	£'000	£0.00	£0.00	£1.00		
	Services	10	Deliver £200m capital plan	Financial status - Capital monthly actuals	£15m	£39m	£'000	£1,592.80	£1,410.50	£1,651.50		
Local Projects	Patients	11	No. of medication errors causing harm is <10%	Medication incidents reported as causing harm (low /moderate /severe / death), as a percentage of total medication incidents.	20%	13%		22.92%	25.63%	23.85%		
	Patients	12	Reduce no. of patient fall incidents	Number of Falls reported (including no harm)	200	159 (-20.5%)		131	164	141		
	People	13	% of staff saying proud to work for ULHT	Staff survey on morale and leadership		+10% improvement						
	Partners	14	First non elective admission by 10am	Daily situation reporting before 10am, on unplanned admissions of patients for specific General and Acute wards.	48%	60%		57.45%	61.90%	56.57%		
	Services	15	Reduce agency spend by 25%	Reduction in hospital recruiting to posts as temporary cover (non permanent salaried positions). Agency - monthly actuals	£44m	£33m (-25%)	£'000	£3,417	£3,745	£3,787		
Watch Metrics	Patients	16	Reduce complaints around discharge by 50%	Where patient has been discharged from hospital but is unsatisfied in the way the discharge was handled	n/a							
	Patients	17	Reduce complaints about the experience in A&E by 50%	Patient experience complaints about treatment of A&E	n/a							
	Patients	18	Time to screening and treatment for sepsis (1 hour)	Number of sepsis incidents reported - % of 8 metrics passing to 90%	37.5% (3/8)	62.5% (5/8)		75.00%	50.00%			
	Patients	19	Reduce incidence of pressure ulcers	Number of Pressure Ulcers reported on ward- Category 2, 3, 4 & Unstageable	58	45		44	54	48		
	People	20	% of staff that feel trusted and valued	Staff survey on morale and leadership								
	People	21	No. of managers trained in coaching skills	Staff survey on morale and leadership								
	Partners	22	Increase the proportion of patients seen by a decision maker within one hour	Patient arrival to the time seeing a A&E doctor, within 1 hour.	50%			57.87%	48.39%	52.22%		
	Partners	23	Reduction in the new to follow up ratio	Reduction in the number of follow up outpatient activities undertaken.	1:2.28			1:1.45	1:1.46	1:1.56		
	Partners	24	First OPA within 4 weeks	Number of outpatients seen within 4 weeks of their referral to hospital. Includes external referrals only (from GP, Dentist, Optician) for all urgency types (2WW, Urgent, Routine) to consultant led services (non-telephone).	51%			55.88%	53.11%	47.67%		
	Services	25	Improve CIP performance to a minimum of 4% by 2021/22	Improving the financial performance through proactive monitoring of Cost Improvement Plan (CIP) - monthly variance to plan	1.7%		£'000	-£562.00	£1,573.67	-£781.00		

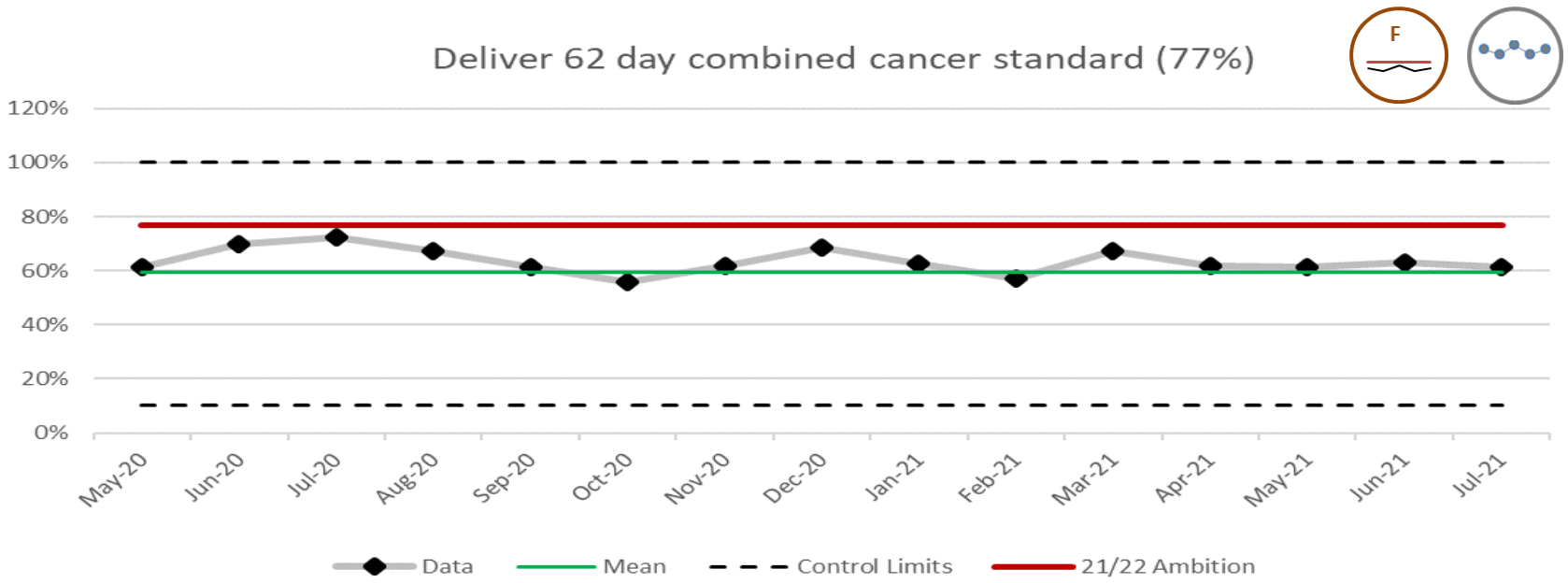
(Grey means data unavailable, red is missing)

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

Quality | Operational Performance | Workforce | Finance

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Jul-21
61.5%
Variance Type
Metric is currently experiencing Common Cause Variation
21/22 Ambition
77%
Achievement
Metric is consistently failing to ambition
Executive Lead
Chief Operating Officer

Background:

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

What the chart tells us:

We are currently at 61.5% against a 77% target

Issues:

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

Reduced clinic throughput due to social distancing / IPC requirements, especially in waiting areas. Patient acceptance & compliance with swabbing and self-isolating requirements. Patients not willing to travel to where our service and / or capacity is. Managing backlogs significantly in excess of pre-COVID levels for Colorectal, Urology, Gynaecology, Lung, Upper GI and Head & Neck. Lost treatment capacity due to short notice cancellation of patients (unwell on the day of treatment or day before), not allowing time to swab replacement patients.

Actions:

28 Day standard identified as Trust's cancer performance work stream in the Integrated Improvement Program for 2021-22. Two substantive Medical Oncologists were recruited, one is due to start in November 2021 (covering Breast, Renal and Urology). Unfortunately, the second post has gone back out to advert after the applicant withdrew. Dedicated admin resource has been identified within the Colorectal, Urology, Breast and Gynae CBU's to support clinical engagement. Following this model and with funding from EMCA, The Medicine Division have had 2 full-time Navigator posts commence. Funding has also been identified for the Head & Neck CBU and the recruitment process is underway.

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

Mitigations:

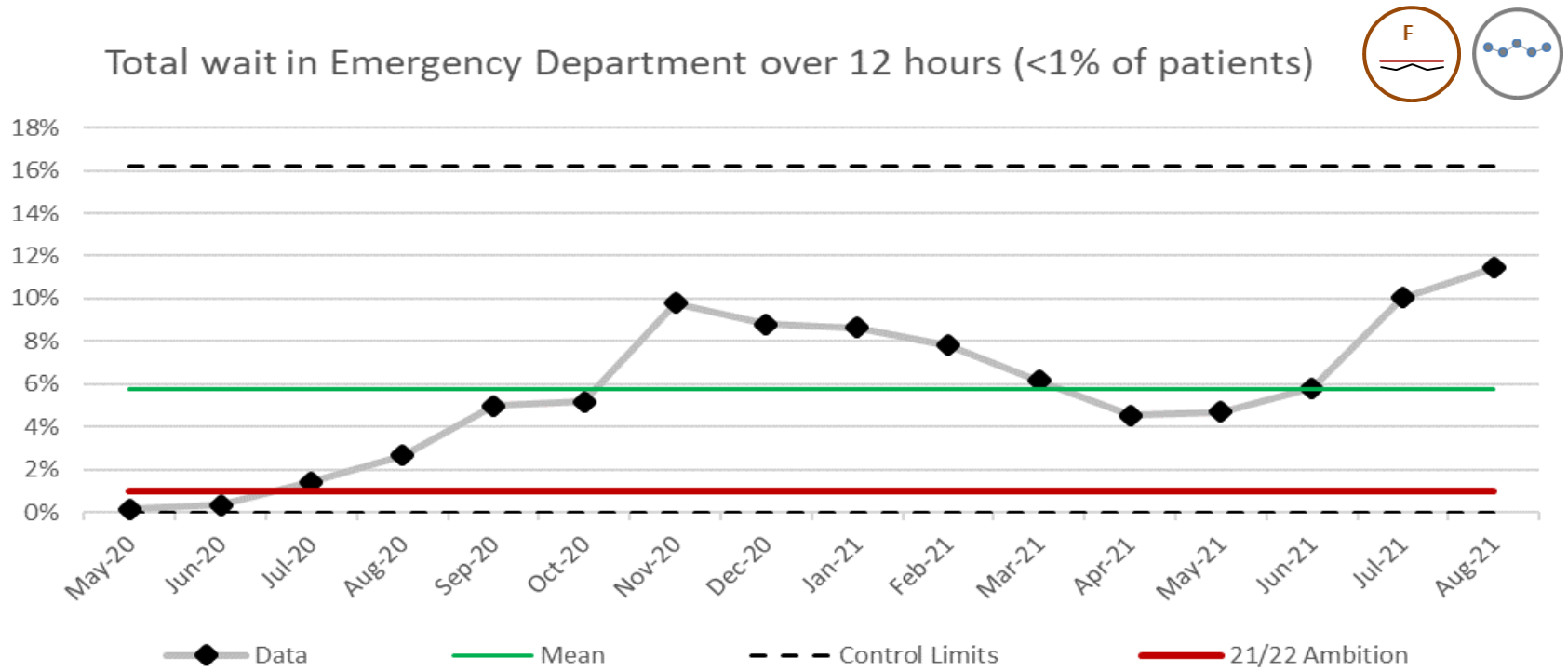
Theatre capacity is returning to Pre-covid levels. A review of colorectal theatre list scheduling in order to better align with clinician availability continues and Grantham Theatres have now returned to undertaking suitable Level 1 colorectal work. Work continues within the Surgery Division in order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

2 H&N consultant posts have been recruited, 1 started in April 2021, and another commenced in July 2021.

Quality | Operational Performance | Workforce | Finance

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Aug-21
11.45%
Variance Type
Metric is currently experiencing Common Cause Variation
21/22 Ambition
1%
Achievement
Metric is consistently failing to ambition
Executive Lead
Chief Operating Officer

Background:

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

What the chart tells us:

August experienced an increase in the numbers of patients with an aggregated time of arrival great then 12 hours.11.45% (1067)
of all patients attending the Emergency Department against an agreed target of <1%.

Issues:

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

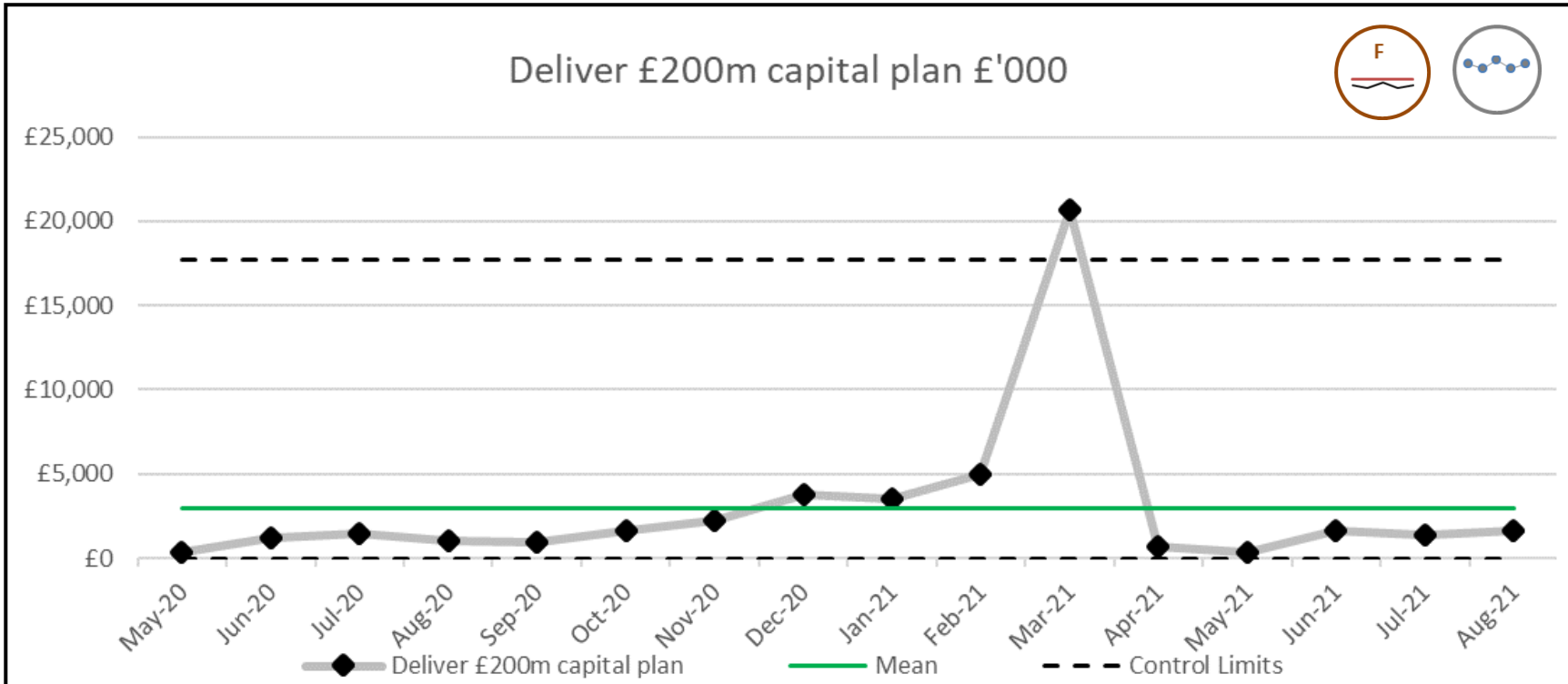
Actions:

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

Mitigations:

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

Quality | Operational Performance | Workforce | Finance



Aug-21
£1,651,500
Variance Type
Metric is currently experiencing Common Cause Variation
21/22 Ambition
£39 Million for the year
Achievement
Metric is consistently failing to ambition
Executive Lead
Director of Finance

Background:
The Trust has a capital programme to deliver of £33.7m, and will remain at c£33.7m until CDH funds are received.

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

Issues:
The Trust has a large capital programme to deliver in 2021/22, and delivery of the programme is at greater risk if the actual expenditure profile is heavily weighted in the final two quarters.

As at the end of July, expenditure YTD of £5.7m is £6.1m behind plan, requiring expenditure of £28.0m in the remainder of 2021/22 to deliver the programme in full.

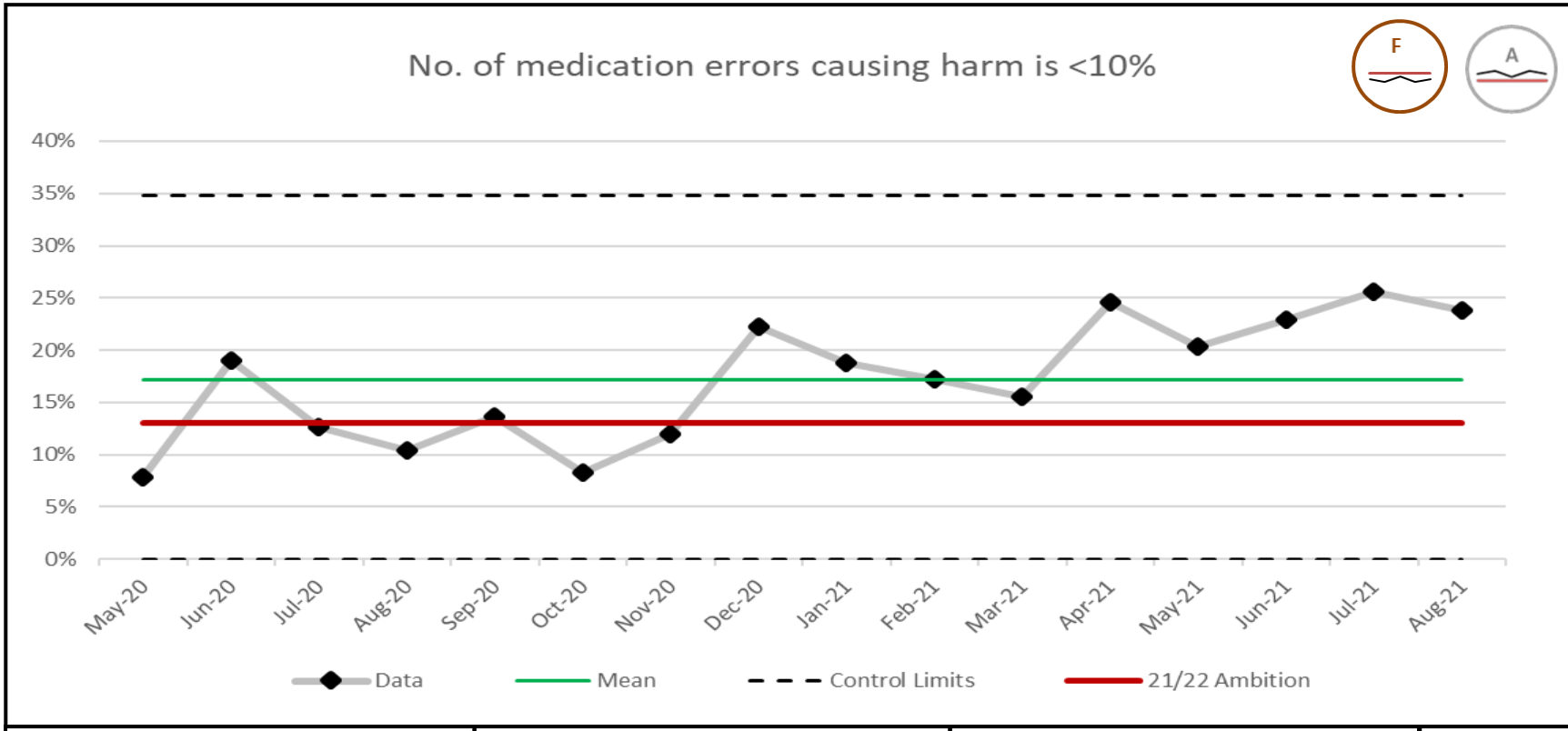
Actions:
To ensure that the capital programme will be delivered in full, the programme is being managed via Capital Delivery Group (CDG).

Forecasting meetings are being set up in August/September with scheme leads that will highlight areas of slippage, risk and mitigations. Details to be shared and managed through CDG.

Mitigations:
Where slippage exists, agree local decision to re-allocate based on the 'transition' year agreement at Financial Leadership Group (FLG) for 2021/22. Where this isn't possible, agree the next scheme within the 'System' based on the current known priority.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Aug-21
23.8%
Variance Type
Metric is currently experiencing Special Cause Variation – above the mean
21/22 Ambition
13%
Achievement
Metric is consistently failing to ambition
Executive Lead
Director of Nursing

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

What the chart tells us:
In the month of August the number of incidents reported was 130. The number of incidents causing some level of harm (low /moderate /severe / death) is 23.8 more than double the national average of 10.8

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

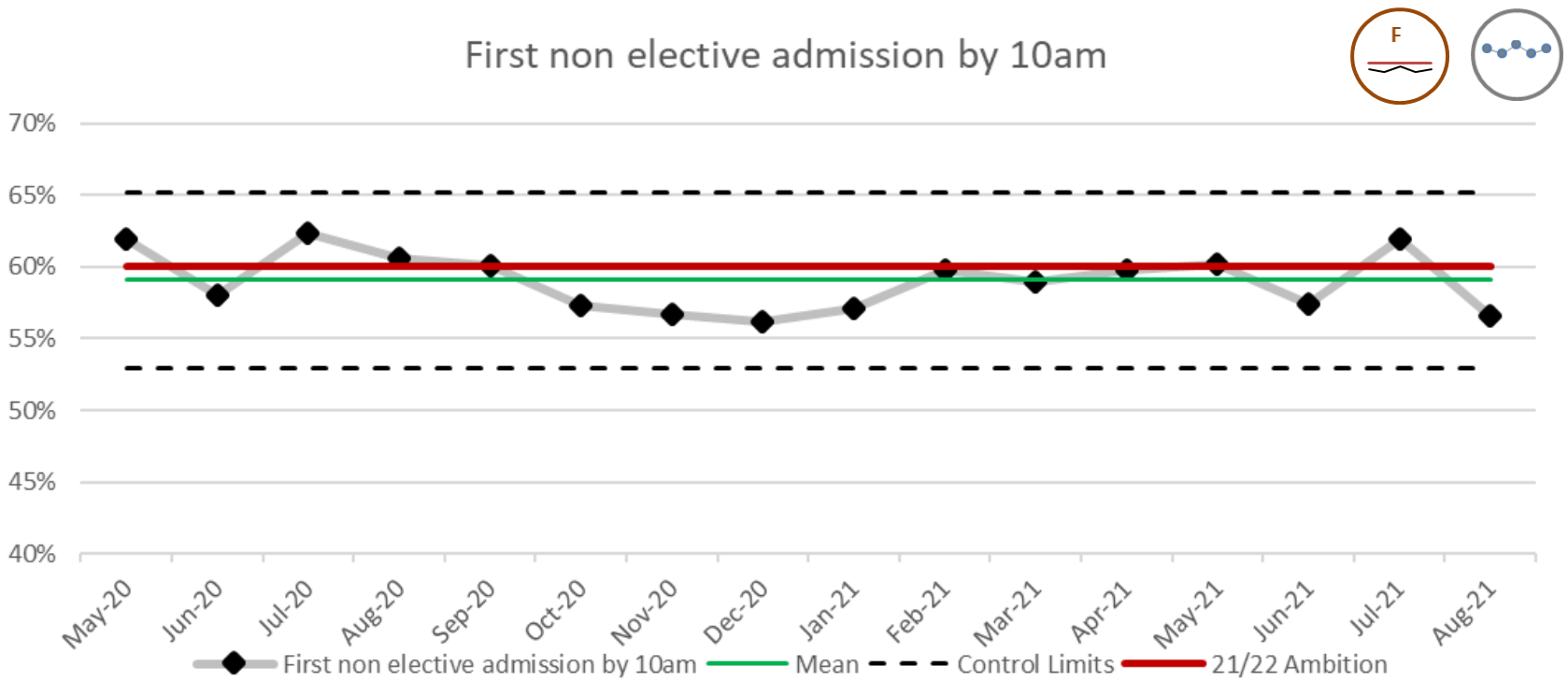
Actions:
A medicines management project group has been set up to tackle on going medicines incidents. This aims to raise the profile of medicines management.

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

Quality | Operational Performance | Workforce | Finance

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Aug-21
56.57%
Variance Type
Metric is currently experiencing Common Cause Variation
21/22 Ambition
60%
Achievement
Metric is consistently failing to ambition
Executive Lead
Chief Operating Officer

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

What the chart tells us:
August experienced a decrease in the numbers of non-elective admission before 10am.
Compliance was 56.57 (551 patients) against a target of 60% which is.
This equates to 43 less patients being admitted before 10am.

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

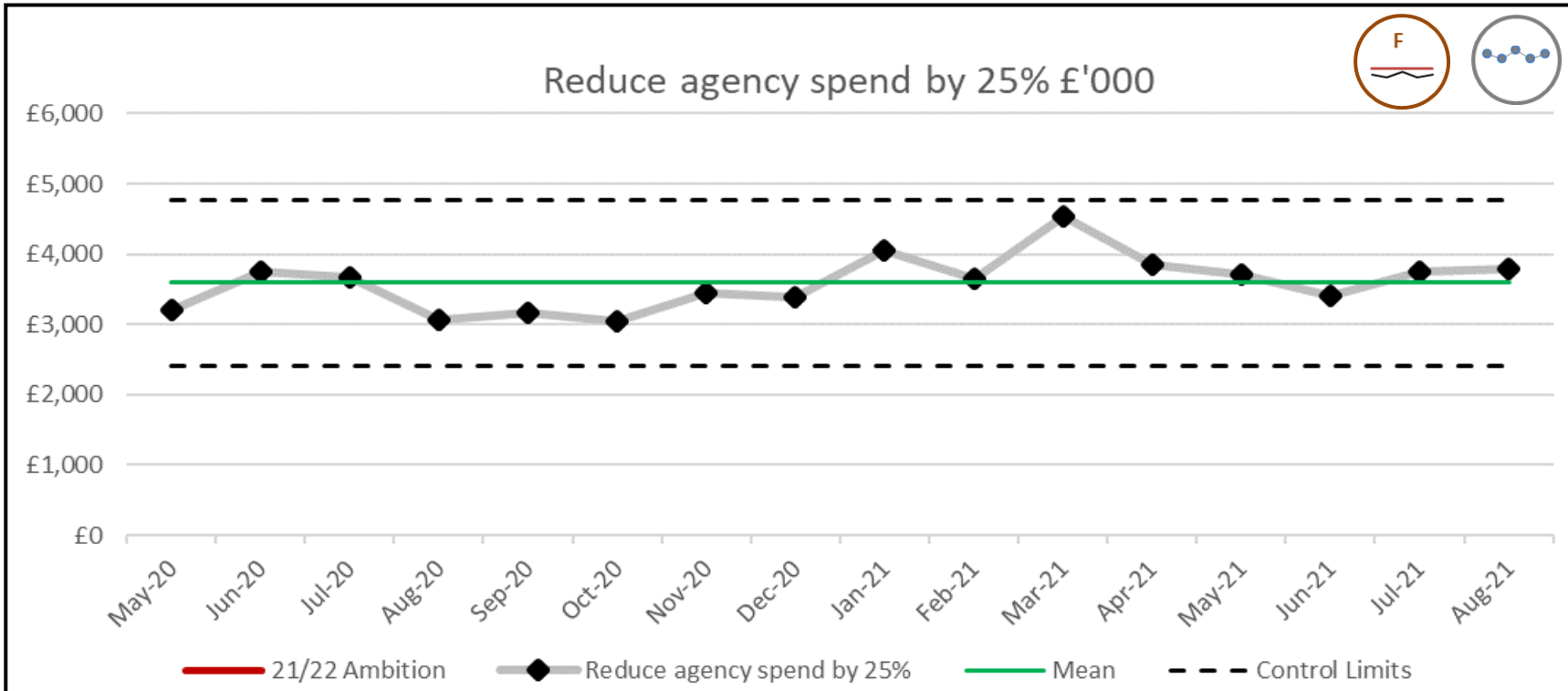
Actions:
Identification of '10 by 10' patients the previous day, ensuring all discharge arrangement are complete and communicated clearly.
Extended opening hours of the discharge lounge incorporating a pull model/in reach to the wards.
Forward look over 72 hours against discharge planning and readiness to leave.

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

Quality | Operational Performance | Workforce | Finance

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Aug-21
£3,787,000
Variance Type
Metric is currently experiencing Common Cause Variation
21/22 Ambition
£33 Million for the year
Achievement
Metric is consistently failing to ambition
Executive Lead
Director of Finance

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

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

Issues:
The Trust has traditionally spent most on Medical and Dental Agency than on any other staff category. However, a continued focus upon a Plan for Every Post has meant that Medical and Dental is £0.3m favourable to the IIP plan.

Increased Agency spend on Nursing and Midwifery & Housekeeping, though, has driven total Agency spend YTD £4.4m above plan.

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

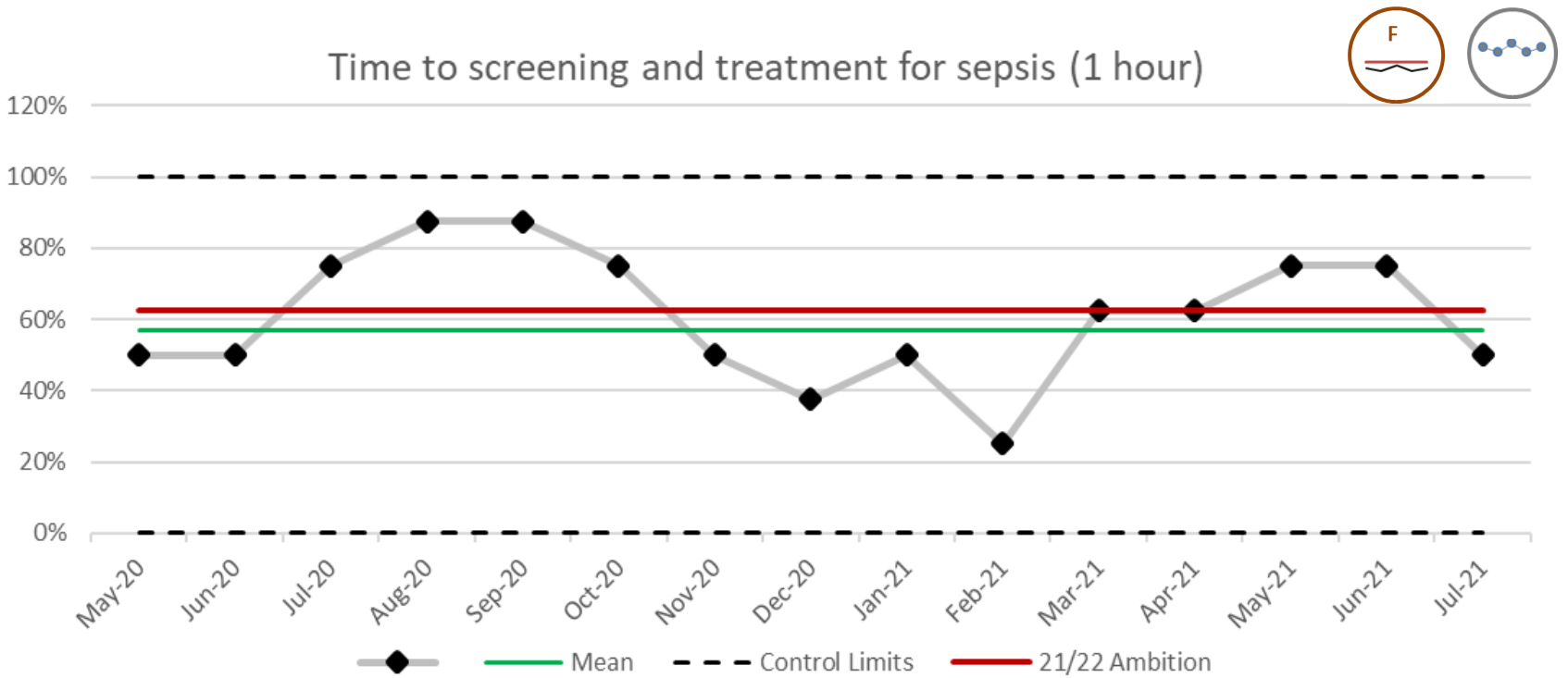
Alternative roles to fill longstanding vacancies are being reviewed, and exit plans have been requested for admin/managerial roles.

Mitigations:
Although covid surge has meant that non-essential meetings are currently paused, there remains a continued focus upon Plan for Every post across all staffing categories. The Trust also continues to review opportunities in the following areas: convert Agency staff to NHS locums; reduce our usage of higher tier agencies; reduce our reliance on Agency staff by increasing the Staff Bank.

Quality | Operational Performance | Workforce | Finance

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



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

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

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

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

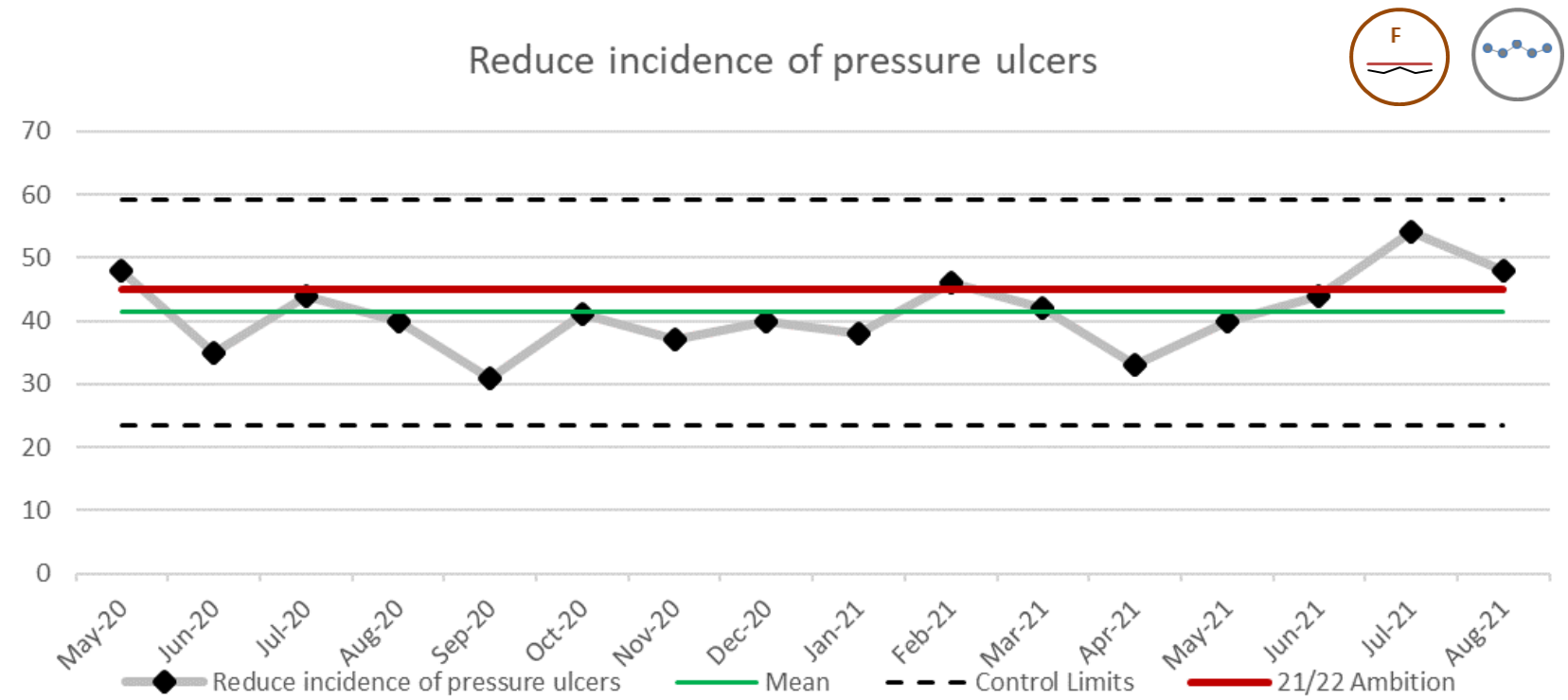
Actions:
There is ongoing training happening within departments when workloads allow and there has been Simulation training over both sites. Sepsis practitioners are currently doing walk rounds of areas struggling and offering any support or advice if needed.

Mitigations:
Staff involved in delayed screens or treatment are being involved in carrying out the harm reviews so that lessons can be learned at the time.
Nurses in charge of departments have also been asked to have an oversight of any elevated PEWS scores so they can encourage staff to complete the screens.

Quality | Operational Performance | Workforce | Finance

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Aug-21
48
Variance Type
Metric is currently experiencing Common Cause Variation
21/22 Ambition
45
Achievement
Metric is failing to ambition
Executive Lead
Director of Nursing

Background:
Total pressure ulcers including Category 2,3,4 and unstageable.

What the chart tells us:
The total number of reported hospital acquired pressure ulcers for categories 2, 3, 4 and Unstageables is 48, a decrease of 6 from July 2021

Issues:
There are a number of themes currently being observed relating to category 2 pressure ulcer incidents which will be areas of focus to improve.

Actions:
A new Pressure Ulcer Incident and Investigation pathway will be presented at next Skin Integrity Group (SIG).

Patient Pressure Ulcer Incident support panels will improve the quality of investigations and ensure timely learning and actions.

Mitigations:
Skin Integrity Group (SIG) are sighted on areas with increased incidences where deep dives are to be undertaken.
Monitoring and support will continue to be provided from the Quality Matron and Tissue Viability Team to areas experiencing an increased number of pressure ulcers, to identify themes, learning and actions.

Quality | Operational Performance | Workforce | Finance

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

PERFORMANCE OVERVIEW - QUALITY

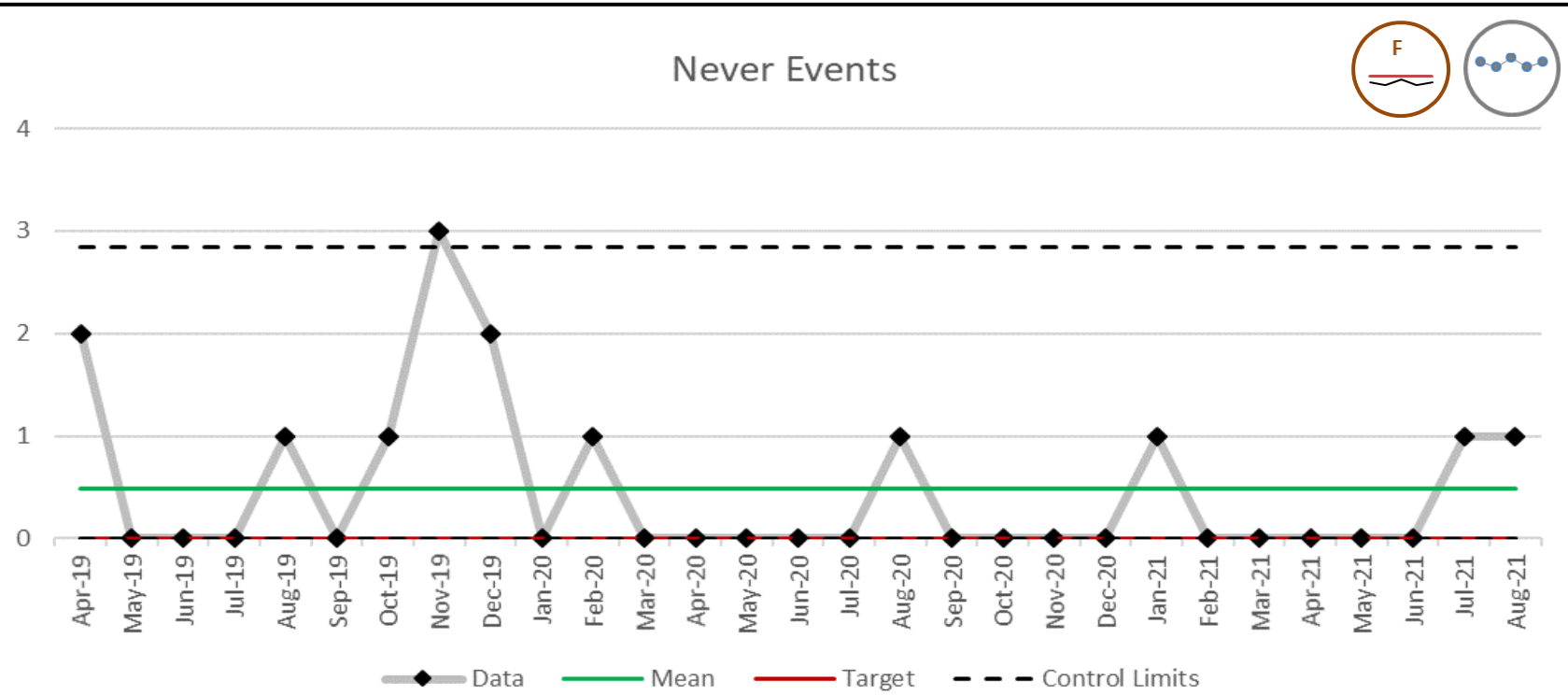
5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target per month	Jun-21	Jul-21	Aug-21	YTD	Pass/Fail	Trend Variation
Deliver Harm Free Care	Clostridioides difficile position	Safe	Patients	Director of Nursing	9	5	7	3	21	P	
	MRSA bacteraemia	Safe	Patients	Director of Nursing	0	0	1	0	1	P	
	MSSA bacteraemia cases counts and 12-month rolling rates of hospital-onset, by reporting acute trust and month using trust per 1000 bed days formula	Safe	Patients	Director of Nursing	TBC	0.04	0.03	0.07	0.06		
	E. coli bacteraemia cases counts and 12-month rolling rates, by reporting acute trust and month using trust per 1000 bed days formula	Safe	Patients	Director of Nursing	TBC	0.14	0.17	0.13	0.13		
	Catheter Associated Urinary Tract Infection	Safe	Patients	Director of Nursing	1	3	2	0	5	P	
	Falls per 1000 bed days resulting in moderate, severe harm & death	Safe	Patients	Director of Nursing	0.19	0.04	0.01	0.07	0.03	P	
	Pressure Ulcers category 3	Safe	Patients	Director of Nursing	4.3	0	0	1	3	P	B
	Pressure Ulcers category 4	Safe	Patients	Director of Nursing	1.3	0	0	0	1	P	
	Pressure Ulcers - unstageable	Safe	Patients	Director of Nursing	4.4	7	6	3	24	P	
	Venous Thromboembolism (VTE) Risk Assessment	Safe	Patients	Medical Director	95%	96.08%	95.40%	95.20%	96.41%	P	
	Never Events	Safe	Patients	Director of Nursing	0	0	1	1	2	F	
	Reported medication incidents per 1000 occupied bed days	Safe	Patients	Medical Director	4.3	5.13	5.29	4.33	4.96	P	
	Medication incidents reported as causing harm (low /moderate /severe / death)	Safe	Patients	Medical Director	10.7%	22.9%	25.6%	23.8%	23.44%	F	A

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

PERFORMANCE OVERVIEW - QUALITY

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Jun-21	Jul-21	Aug-21	YTD	Pass/Fail	Trend Variation
Deliver Harm Free Care	Patient Safety Alerts responded to by agreed deadline	Safe	Patients	Medical Director	100%	67.0%	100%	None issued	55.67%		
	Hospital Standardised Mortality Ratio - HSMR (basket of 56 diagnosis groups) (rolling year data 3 month time lag)	Effective	Patients	Medical Director	100	No Data	114.30	No Data	115.61		
	Summary Hospital Mortality Indicator (SHMI) (rolling year data 6 month time lag)	Effective	Patients	Medical Director	100	112.05	112.55	112.88	111.74		
	The Trust participates in all relevant National clinical audits	Effective	Patients	Medical Director	100%	95.00%	97.00%	97.00%	95.80%		
	eDD issued within 24 hours	Effective	Patients	Medical Director	95%	92.30%	88.70%	87.70%	90.84%		
	Sepsis screening (bundle) compliance for inpatients (adult)	Safe	Patients	Director of Nursing	90%	93.5%	90.0%		90.38%		
	Sepsis screening (bundle) compliance for inpatients (child)	Safe	Patients	Director of Nursing	90%	95.3%	83.0%		86.58%		
	IVAB within 1 hour for sepsis for inpatients (adult)	Safe	Patients	Director of Nursing	90%	93.8%	95.0%		93.70%		
	IVAB within 1 hour for sepsis for inpatients (child)	Safe	Patients	Director of Nursing	90%	100.0%	75.0%		93.75%		
	Sepsis screening (bundle) compliance in A&E (adult)	Safe	Patients	Director of Nursing	90%	92.4%	90.0%		92.60%		
	Sepsis screening (bundle) compliance in A&E (child)	Safe	Patients	Director of Nursing	90%	86.7%	84.8%		87.12%		
	IVAB within 1 hour for sepsis in A&E (adult)	Safe	Patients	Director of Nursing	90%	95.5%	93.3%		94.69%		
	IVAB within 1 hour for sepsis in A&E (child)	Safe	Patients	Director of Nursing	90%	87.5%	50.0%		71.88%		
	Rate of stillbirth per 1000 births	Safe	Patients	Director of Nursing	4.20	3.34	2.66	2.86	2.97		
Improve Patient Experience	Mixed Sex Accommodation breaches	Caring	Patients	Director of Nursing	0	Submission suspended during Covid					
	Duty of Candour compliance - Verbal	Safe	Patients	Medical Director	100%	54.00%	45.00%		61.00%		
	Duty of Candour compliance - Written	Responsive	Patients	Medical Director	100%	28.00%	18.00%		39.67%		



Aug-21
1
Variance Type
Metric is currently experiencing Common Cause Variation
Target
0
Target Achievement
Metric is failing the target
Executive Lead
Director of Nursing

Background:
Never Events are deemed to be externally reportable incidents that have been defined by the NHS as 'wholly preventable where nationally available systemic barriers have been locally implemented.

What the chart tells us:
There has been 1 Never Event in August.

Issues:
Oral formulation of methadone incorrectly administered subcutaneously via syringe driver.

Actions:
Serious Incident procedure initiated leading to local investigation and rapid review – declared to commissioners as SI 5/8/21 within approved timeframe.

Mitigations:
Investigation team identified and Governance support assigned.

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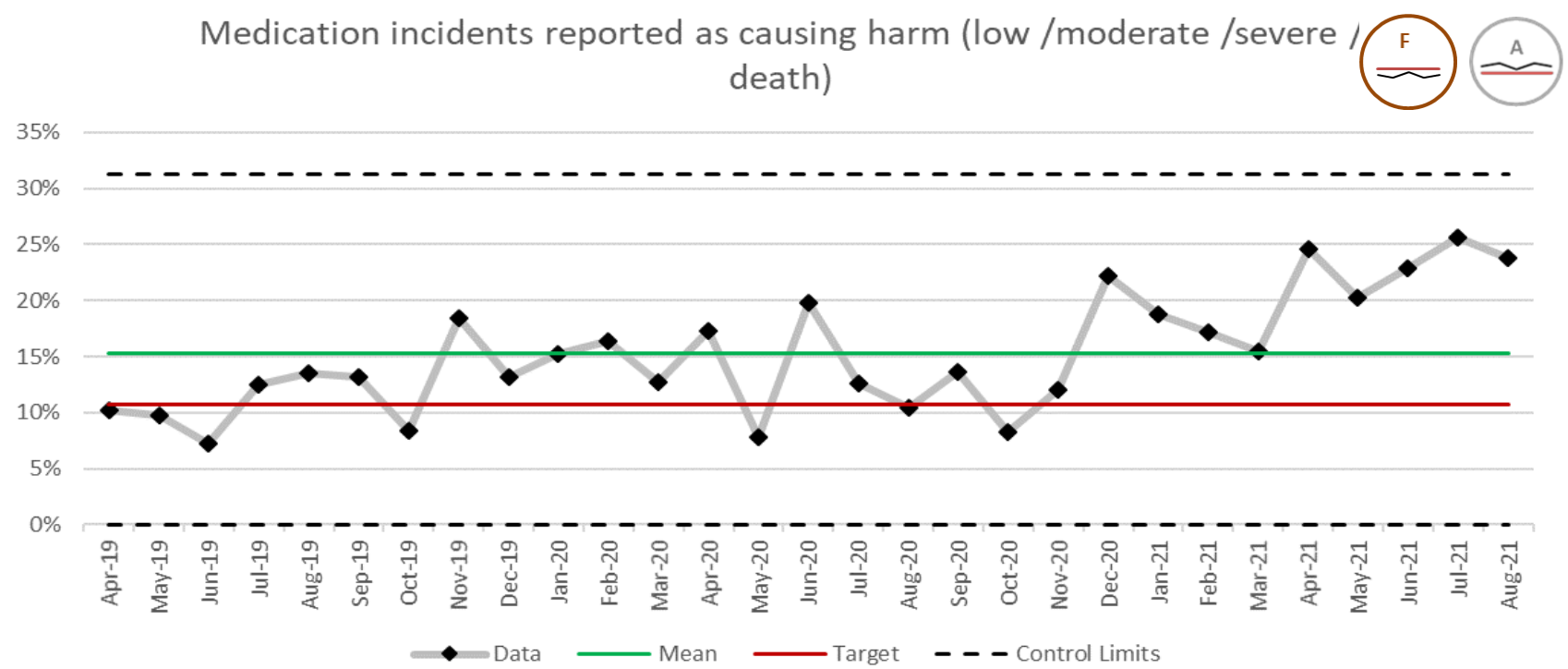
NHS United Lincolnshire Hospitals NHS Trust



Aug-21
23.8%
Variance Type
Metric is currently experiencing Special Cause Variation – above the mean
Target
10.7%
Target Achievement
The metric has consistently failed to target
Executive Lead
Medical Director

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

What the chart tells us:
In the month of August the number of incidents reported was 130. The number of incidents causing some level of harm (low /moderate /severe / death) is 23.8 more than double the national average of 10.8.

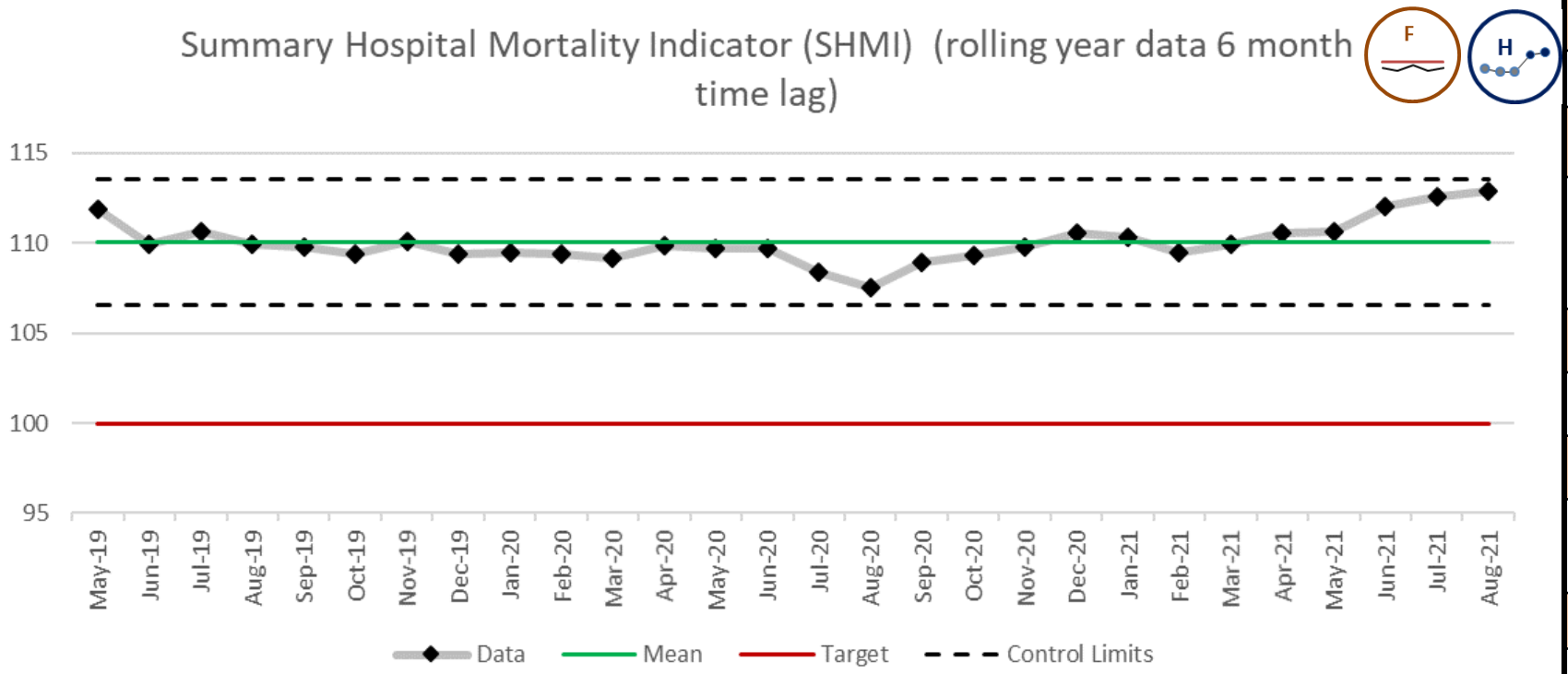
Issues:
Medication incidents causing harm is more than double the national average. The majority of incidents are at the point of administration of medication and the main error is omitting medicines.

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

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

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Aug-21
112.88
Variance Type
Metric is currently experiencing Special Cause Variation – high trend
Target
100
Target Achievement
The metric has consistently failed to target
Executive Lead
Medical Director

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

What the chart tells us:
The Trust's SHMI has had an increasing trend during the COVID-19 pandemic.

Issues:
The COVID-19 pandemic has impacted on the Trust's SHMI, with the SHMI predominantly influenced by the higher site-specific SHMI at Boston, related to 30 day out-of-hospital mortality in the community, low uptake of ReSPECT documentation, relatively low percentage of comorbidity coding, and differences in palliative care coding / service provision.

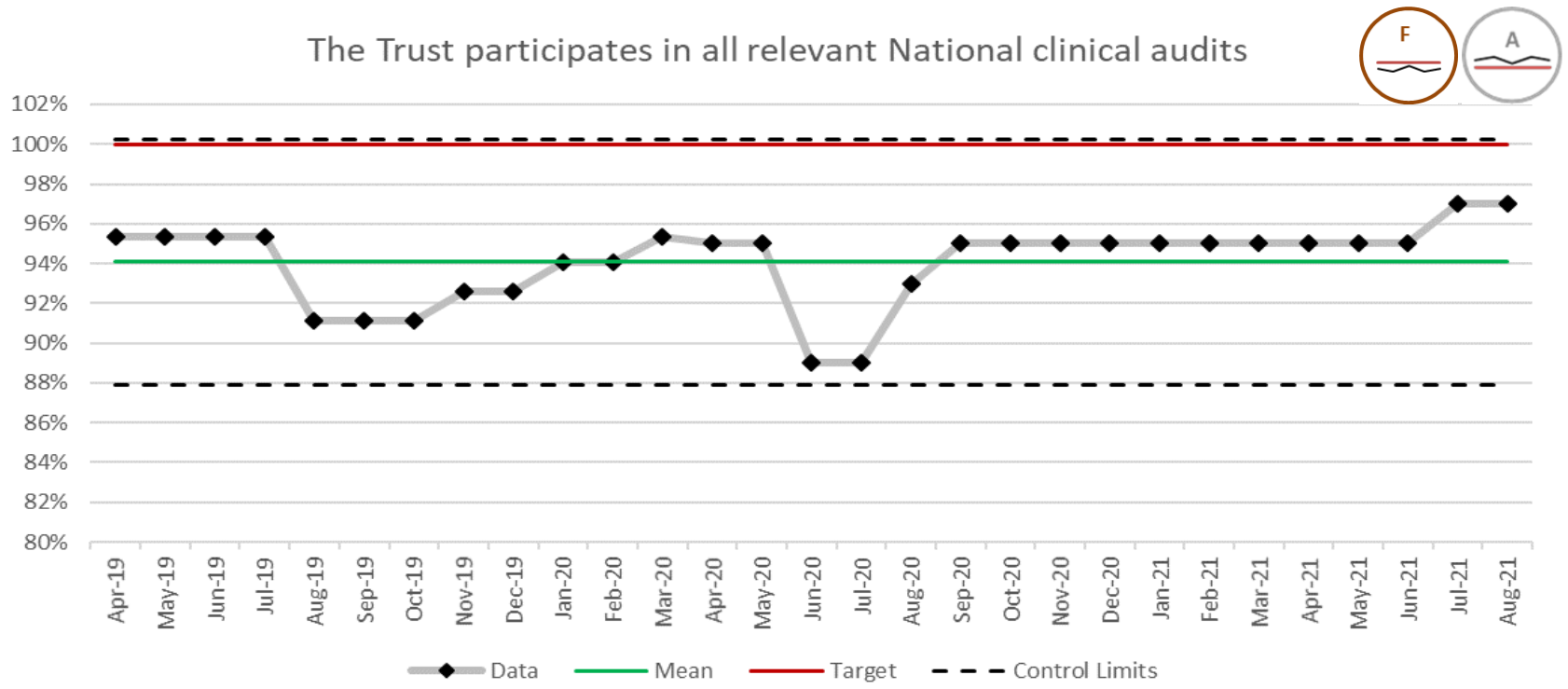
Actions:
Any diagnosis group alerting is subject to a case note review.

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

Collaborative work to be undertaken looking at factors influencing the OOH SHMI across the system.

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

Medical Examiner Officers have started within the Trust.



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

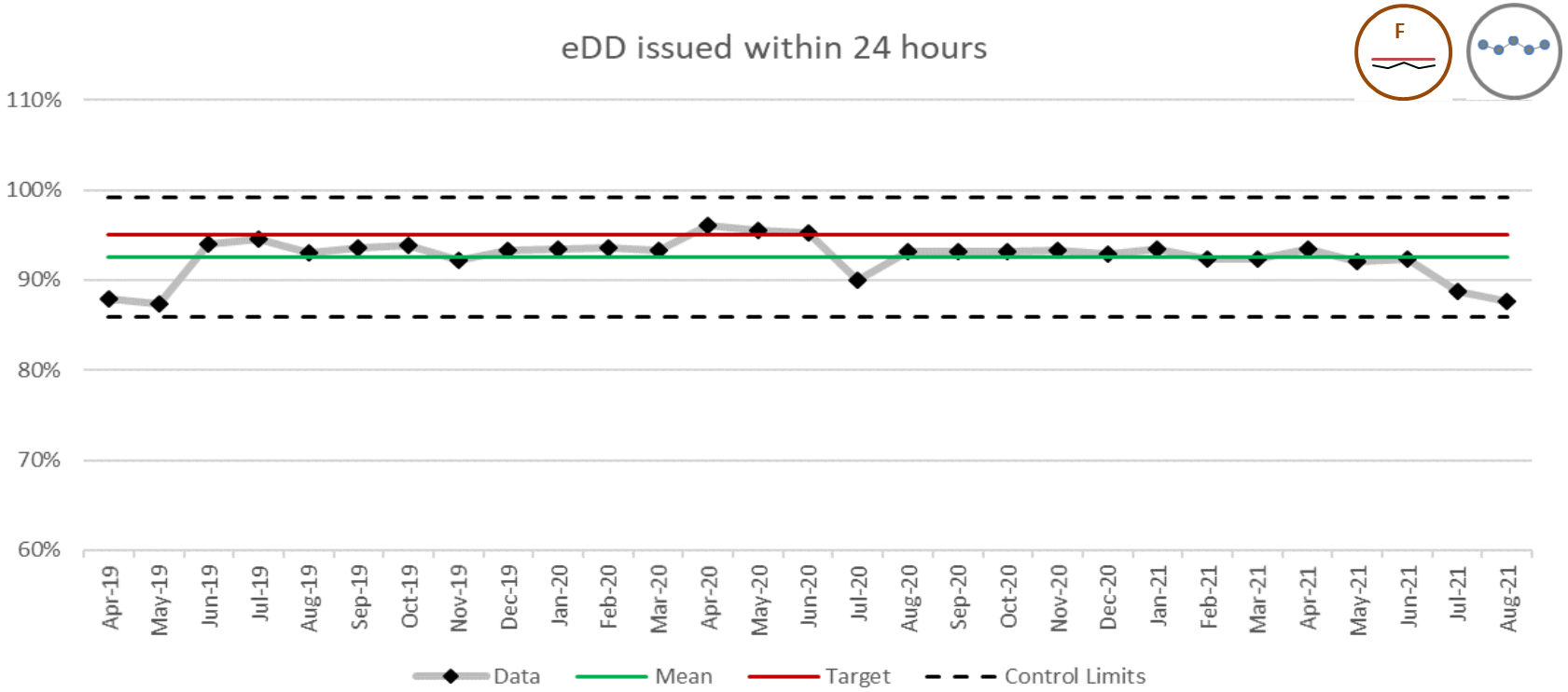
Background:
% participation in relevant National Clinical Audits.

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

Issues:
Slow participation in the IBD Audit.

Actions:
Monitored by the Clinical Effectiveness Group.

Mitigations:
Inflammatory Bowel Disease (IBD) participation agreed by the Division, participation due to commence within the next month. Participation fee purchase order and data sharing agreement sign off in progress.



Aug-21
87.7%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
95%
Target Achievement
The metric is consistently failing the target
Executive Lead
Medical Director

Background:
Percentage of electronic discharge documents (eDDs) sent to GP within 24 hours of discharge.

What the chart tells us:
The Trust achieved 87.7% compliance with sending eDDs within 24 hours for August 2021 against a target of 95%. 6.7% of eDDs were not sent at all during the month of August 2021.

Issues:
eDD compliance has deteriorated markedly in August 2021 (from 92.3% in June 2021).

Actions:
Paediatric eDD template being streamlined to aid completion.
Actions implemented within paediatrics to help improve compliance including SOP for addressing incomplete eDDs.
Backlog of historic unsent eDDs to be dispatched to GPs enabling wards to better monitor current ward lists and compliance.
eDD group to be disestablished after above actions implemented and each Division will be accountable for their eDD performance.

Mitigations:
A medical workforce cell has been implemented that is tasked with the improvement in medical cover at peak periods where eDDs are delayed.
eDD doctor role is to be maintained and thus mitigate delays through workforce shortages.

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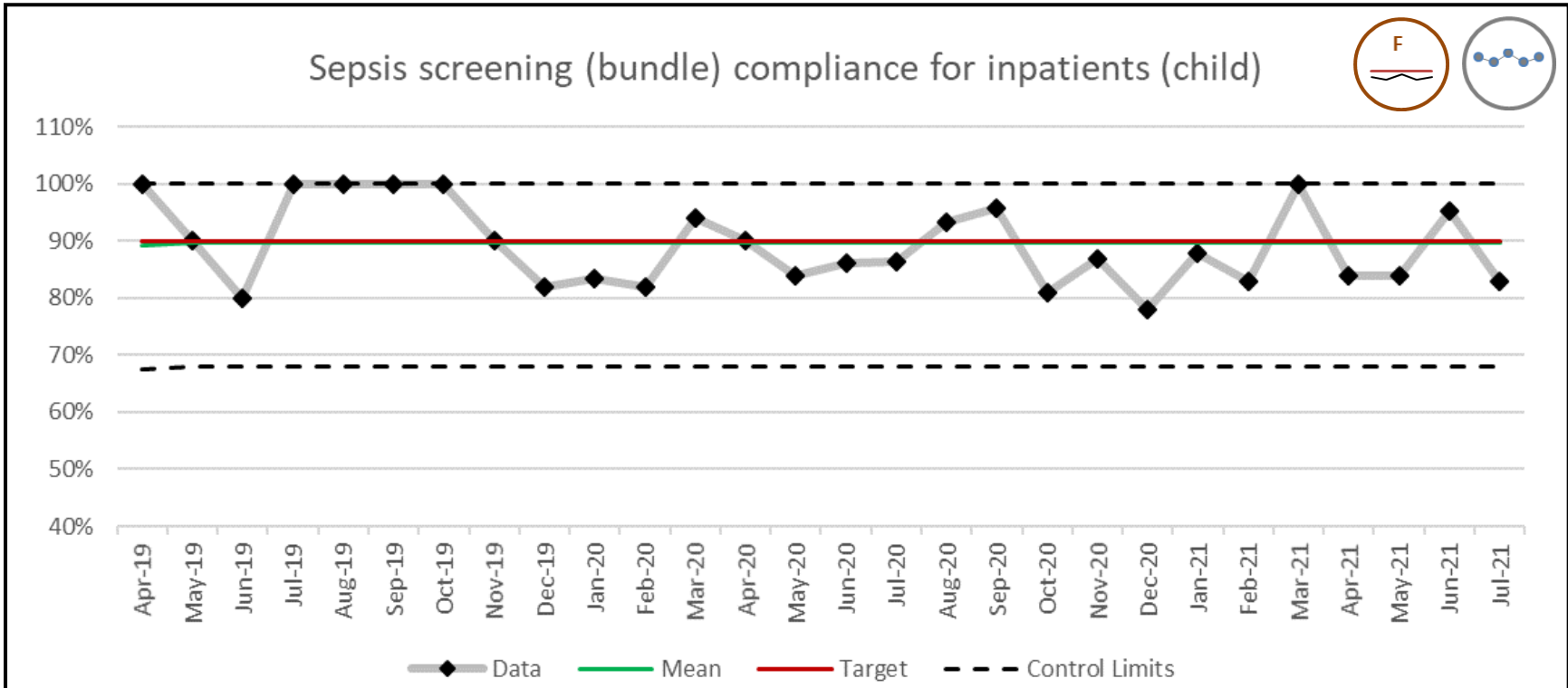
NHS United Lincolnshire Hospitals NHS Trust



Jul-21
83%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
The metric is failing the target
Executive Lead
Director of Nursing

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

What the chart tells us:
There has been a decline in the compliance of completing Sepsis screens for inpatients this month to 83% which is below the required 90% target.

Issues:
This decline has coincided with increased numbers of admissions and acuity as well as an increase in staffing issues. This is however no excuse for missing screens.

Actions:
The Nurse's in charge have been asked to observe patients scoring above 5 in their areas and encourage staff to do their screens in a timely manner.
Further training has been offered to all staff including new starters.
Training has also been organised for the new intake of Doctors who will be starting in August.

Mitigations:
Harm reviews completed for all patients with missed screens and no harm found.
The Nurses on the wards are being encouraged to complete their own harm reviews. This will also be extended to medical staff if applicable.

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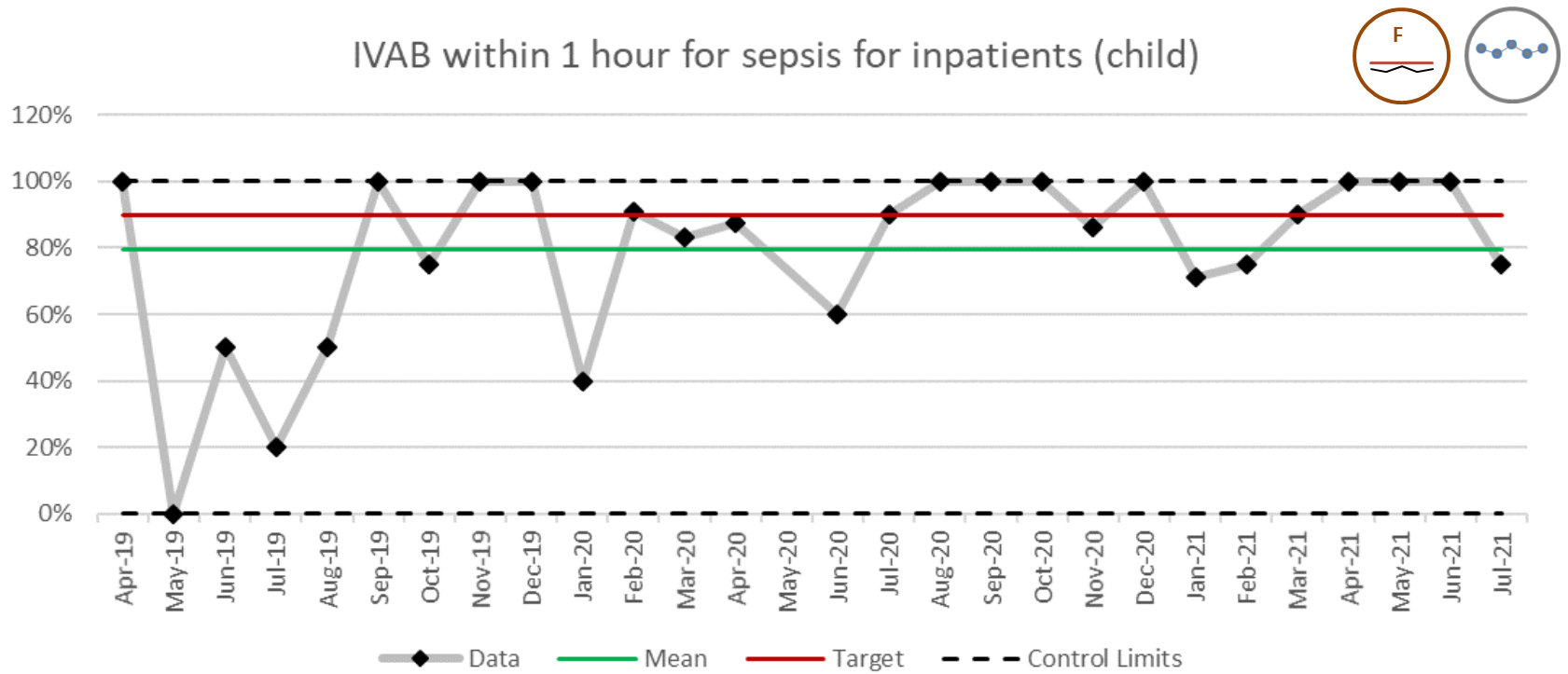
NHS United Lincolnshire Hospitals NHS Trust



Jul-21
75%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
The metric is failing the target
Executive Lead
Director of Nursing

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

What the chart tells us:
There has been a fall this month below the required 90% target. 3 out of the 4 patients received their antibiotics within the hour.

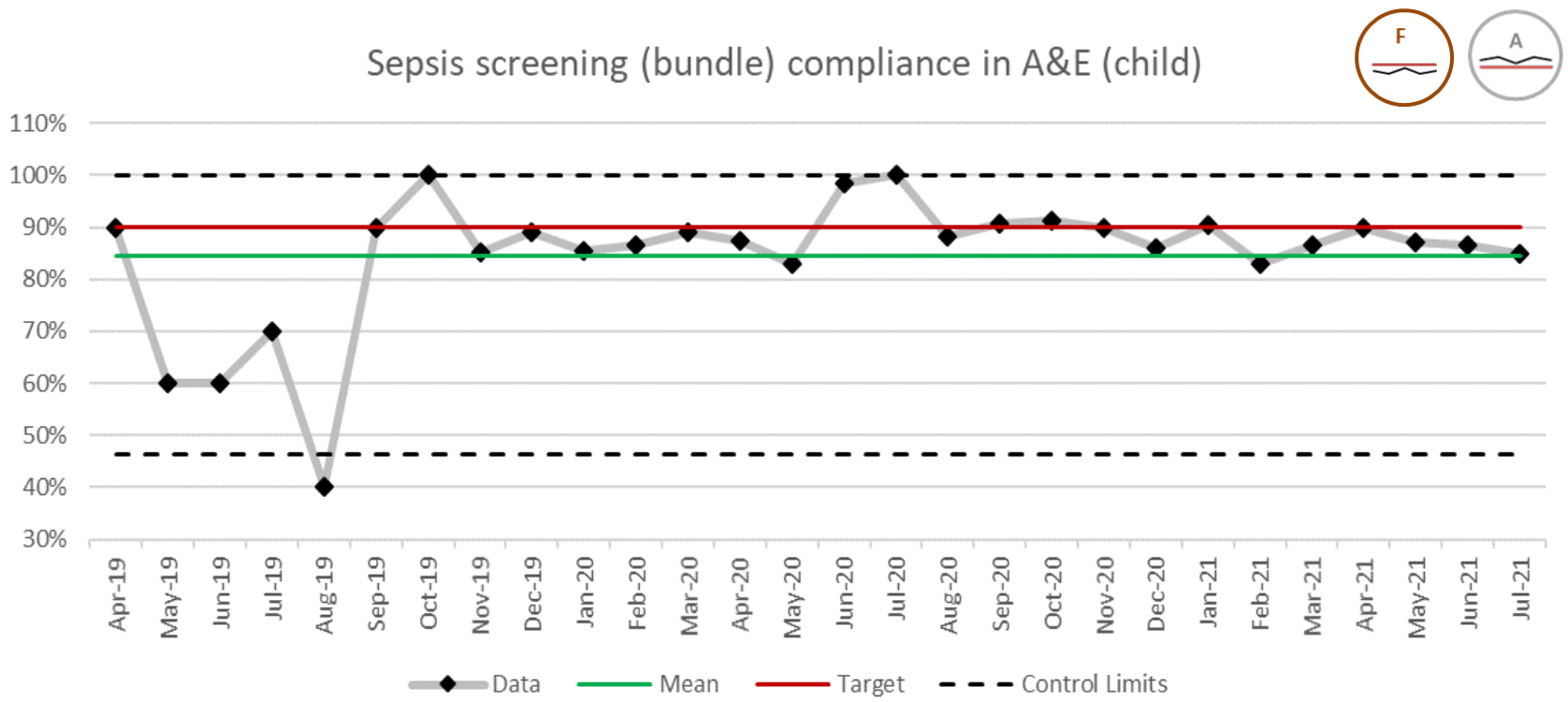
Issues:
The delay was caused by the staff having trouble obtaining IV access for the child in order to administer antibiotics.

Actions:
Medical and Nurse training will, in future, encourage staff to either give IM antibiotics if possible, or to use the IO route if the child is unwell and deteriorating. Bloods and cultures can be taken later if required but antibiotics should not be delayed.

Mitigations:
All incidence will be discussed at Clinical Governance meetings with an action plan to be established.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Jul-21
84.8%
Variance Type
Metric is currently experiencing Special Cause Variation – above the mean
Target
90%
Target Achievement
The metric is consistently failing the target
Executive Lead
Director of Nursing

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

What the chart tells us:
Screening compliance in ED is 84.4% which is below the 90% target.

Issues:
ED is seeing a large number of new / Temporary / Agency staff that may still require training. ED is also seeing an increasing number of Paediatric Patients and higher acuities. This has also coincided with staffing shortages and this gives them limited time for training etc.

Actions:
There are new paediatric areas at both Lincoln and Pilgrim ED, a dedicated children's competent nurse should look after all the child admissions including doing their triage. Scenario training is taking place on both sites and has had a good attendance. Harm reviews are being carried out for all delayed / missed screens and ED staff are involved in carrying these out. Paediatric Doctors are seeing patients in ED when available to aid fast assessment.

Mitigations:
There are ongoing weekly Sepsis meetings for ED at present, Issues are discussed at these and action plans are put in place quickly to try and assist the department compliance. Previous action plans are also reviewed at these meetings. Issues are discussed at Paediatric Governance.

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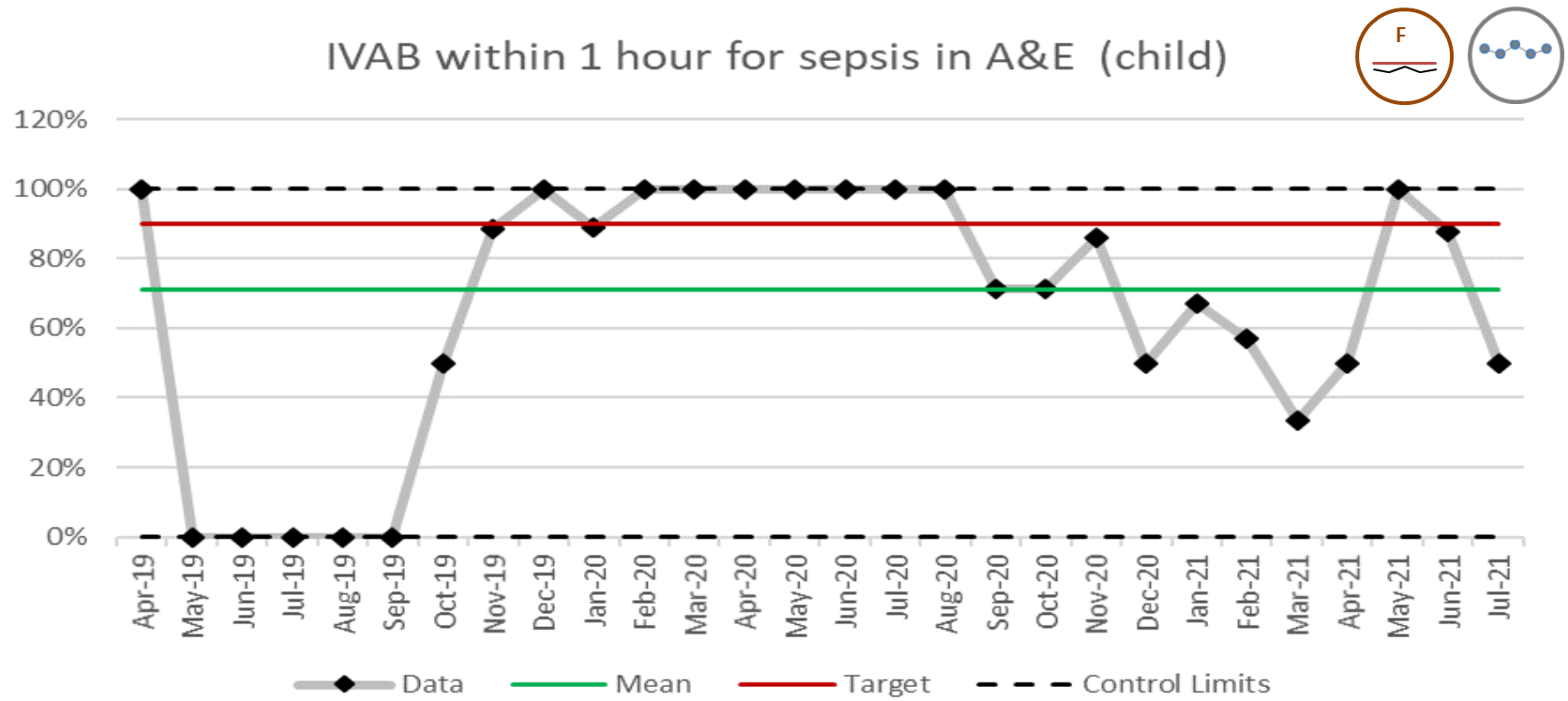


Jul-21
50%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
The metric is consistently failing the target
Executive Lead
Director of Nursing

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

What the chart tells us:
The compliance in ED this month for IVAB is 50.0%, 5 out of 10 children received antibiotics within 1 hour.

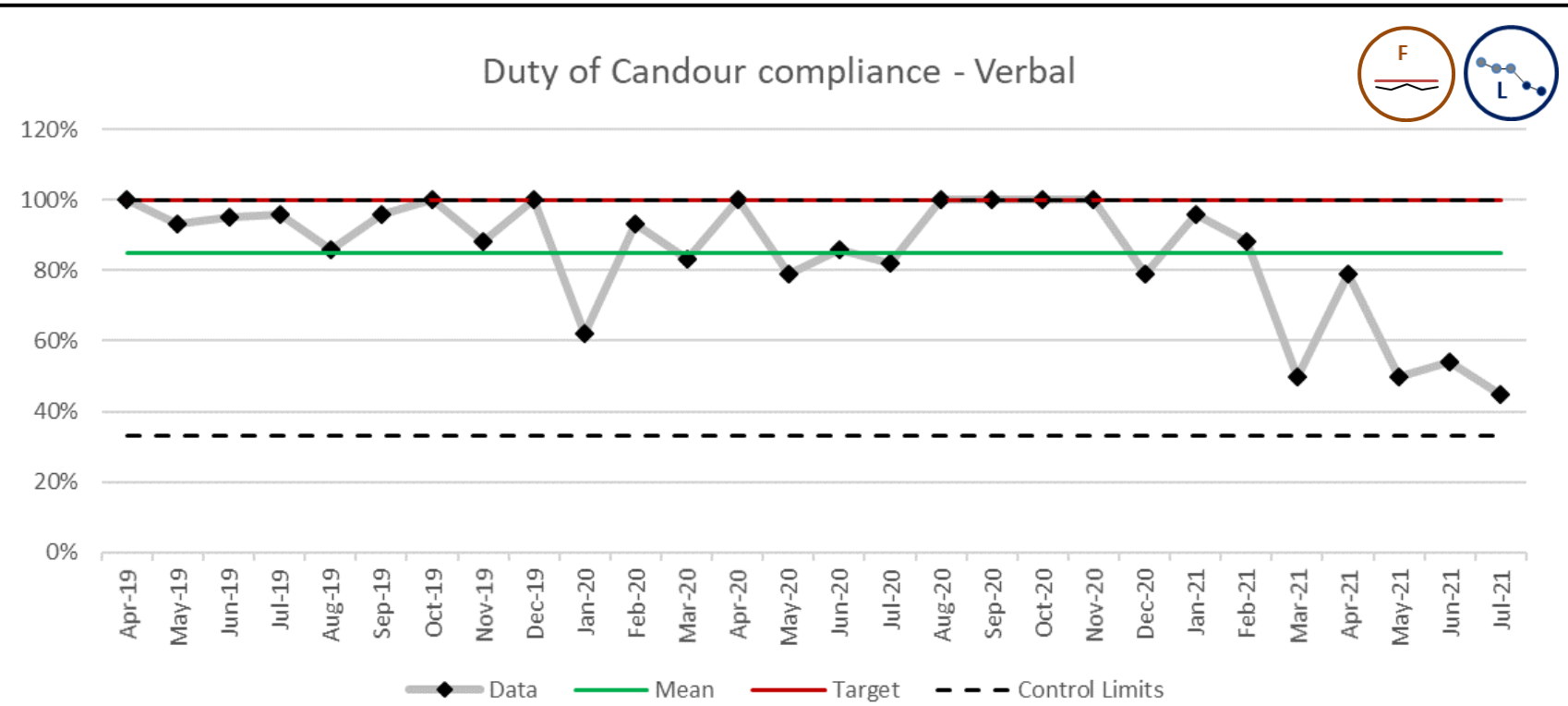
Issues:
The main reasons that antibiotics are being given late are either problems getting IV access, waiting to be transferred to the wards to see paediatrics or due to staffing / workload they are not getting done in a timely manner.

Actions:
A harm review was completed for all children and there was found to be of no harm. The ward areas are supporting ED to look after children and Paediatric Drs are being asked to see children in the department rather than waiting to be moved to the ward.

Mitigations:
Discussed at ongoing weekly Sepsis meeting. If ED need assistance with looking after children within the department they are phoning the paediatric wards. Wards are offering help if they are able to.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Jul-21
45%
Variance Type
Metric is currently experiencing Special Cause Variation – low trend
Target
100%
Target Achievement
Metric is consistently failing the target
Executive Lead
Medical Director

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

What the chart tells us:
Verbal compliance for July is at 45% against a 100% target.

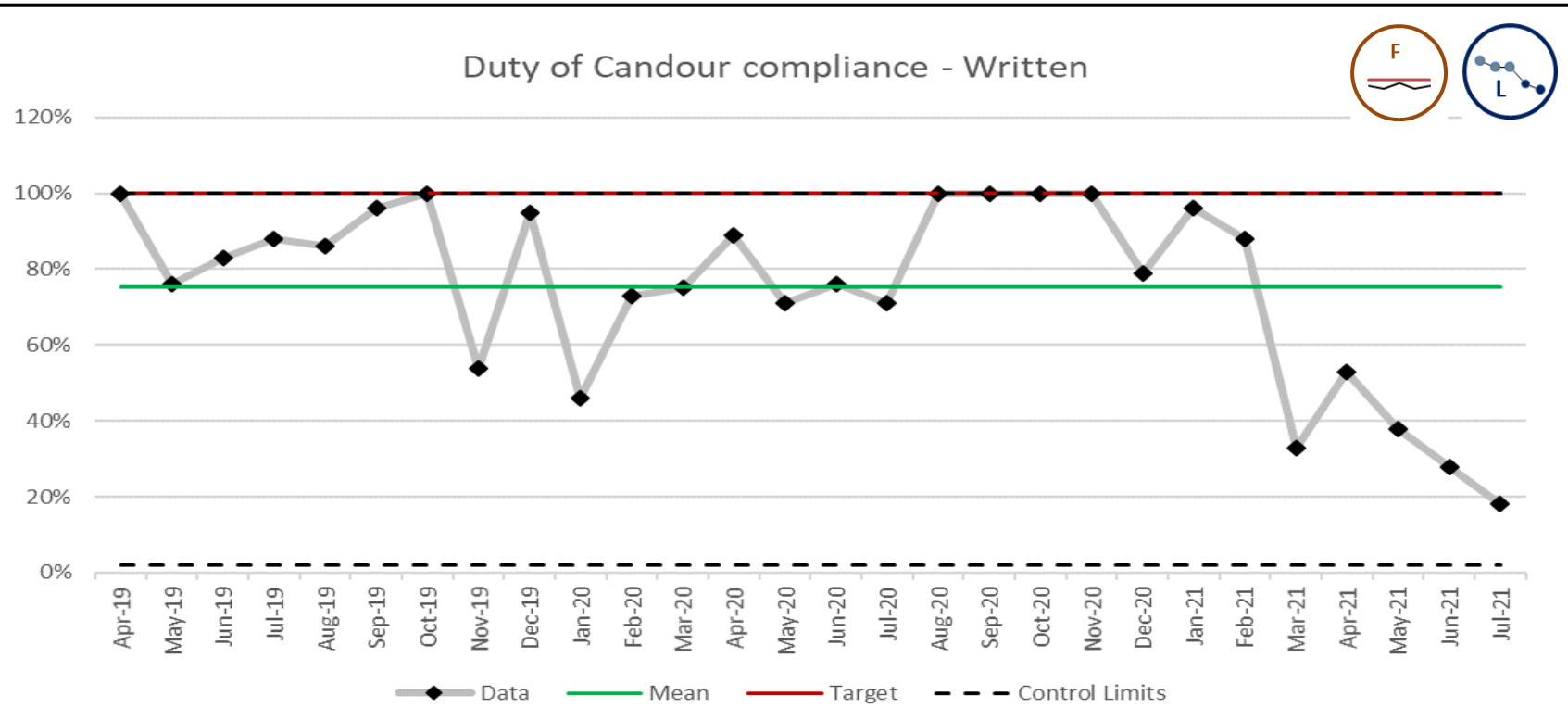
Issues:
Divisions are not recognising when duty of candour applies and should be carried out.
A lack of understanding of the purpose of the Duty of Candour.

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

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

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

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



Jul-21
18%
Variance Type
Metric is currently experiencing Special Cause Variation – low trend
Target
100%
Target Achievement
Metric is consistently failing the target
Executive Lead
Medical Director

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

What the chart tells us:
Verbal compliance for July 2021 is at 18% against a 100% target.

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

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

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

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

PERFORMANCE OVERVIEW – OPERATIONAL PERFORMANCE

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	Jun-21	Jul-21	Aug-21	YTD	YTD Trajectory	Latest Month Pass/Fail	Trend Variation	Kitemark
Improve Patient Experience	% Triage Data Not Recorded	Effective	Patients	Chief Operating Officer	0%	0.31%	0.36%	0.46%	0.38%		F		
Improve Clinical Outcomes	4hrs or less in A&E Dept	Responsive	Services	Chief Operating Officer	83.12%	70.74%	64.93%	66.96%	69.88%	83.12%	F	B	
	12+ Trolley waits	Responsive	Services	Chief Operating Officer	0	1	9	12	25	0	F		
	%Triage Achieved under 15 mins	Responsive	Services	Chief Operating Officer	88.5%	88.23%	83.62%	87.98%	87.41%	88.50%	F		
	52 Week Waiters	Responsive	Services	Chief Operating Officer	0	787	797		3965	0	F	A	
	18 week incompletes	Responsive	Services	Chief Operating Officer	84.1%	61.49%	58.89%		59.46%	84.10%	F		
	Waiting List Size	Responsive	Services	Chief Operating Officer	37,762	49,925	50,565		n/a	n/a	F		
	62 day classic	Responsive	Services	Chief Operating Officer	85.4%	67.00%	60.73%		62.36%	85.39%	F		
	2 week wait suspect	Responsive	Services	Chief Operating Officer	93.0%	81.73%	83.07%		80.26%	93.00%	F		
	2 week wait breast symptomatic	Responsive	Services	Chief Operating Officer	93.0%	14.53%	20.59%		10.98%	93.00%	F	B	
	31 day first treatment	Responsive	Services	Chief Operating Officer	96.0%	91.67%	90.81%		92.32%	96.00%	F		
	31 day subsequent drug treatments	Responsive	Services	Chief Operating Officer	98.0%	100.00%	100.00%		99.57%	98.00%	P		
	31 day subsequent surgery treatments	Responsive	Services	Chief Operating Officer	94.0%	83.33%	77.78%		80.82%	94.00%	F		
	31 day subsequent radiotherapy treatments	Responsive	Services	Chief Operating Officer	94.0%	95.54%	95.24%		97.16%	94.00%	P		
	62 day screening	Responsive	Services	Chief Operating Officer	90.0%	57.14%	76.67%		73.82%	90.00%	F	A	

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NHS United Lincolnshire Hospitals NHS Trust

PERFORMANCE OVERVIEW – OPERATIONAL PERFORMANCE

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	Jun-21	Jul-21	Aug-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%	84.12%	75.36%		78.92%	85.00%	F		
	Diagnostics achieved	Responsive	Services	Chief Operating Officer	99.0%	68.46%	66.35%		69.17%	99.00%	F	A	
	Cancelled Operations on the day (non clinical)	Responsive	Services	Chief Operating Officer	0.8%	1.95%			1.57%	0.80%	F		
	Not treated within 28 days. (Breach)	Responsive	Services	Chief Operating Officer	0	15			24	0	F		
	#NOF 48 hrs	Responsive	Services	Chief Operating Officer	90%	89.89%	86.36%	94.81%	90.72%	90%	P		
	#NOF 36 hrs	Responsive	Services	Chief Operating Officer	TBC	77.53%	74.24%	74.03%	77.30%				
	EMAS Conveyances to ULHT	Responsive	Services	Chief Operating Officer	4,657	4,685	4,669	4,381	4,612	4,657	P		
	EMAS Conveyances Delayed >59 mins	Responsive	Services	Chief Operating Officer	0	349	568	629	408	0	F		
	104+ Day Waiters	Responsive	Services	Chief Operating Officer	10	49	48	67	253	50	F		
	Average LoS - Elective (not including Daycase)	Effective	Services	Chief Operating Officer	2.80	2.49	3.21	2.81	2.85	2.80	F		
	Average LoS - Non Elective	Effective	Services	Chief Operating Officer	4.50	4.23	4.43	4.70	4.38	4.5	F		
	Delayed Transfers of Care	Effective	Services	Chief Operating Officer	3.5%	Submission suspended				3.5%			
	Partial Booking Waiting List	Effective	Services	Chief Operating Officer	4,524	15,001	15,193	16,098	15,434	4,524	F	B	
	Outpatients seen within 15 minutes of appointment	Effective	Services	Chief Operating Officer	70.0%	40.0%	40.5%	43.0%	42.00%	70.00%	F		
	% discharged within 24hrs of PDD	Effective	Services	Chief Operating Officer	45.0%	41.0%	39.9%	42.1%	41.83%	45.00%	F		

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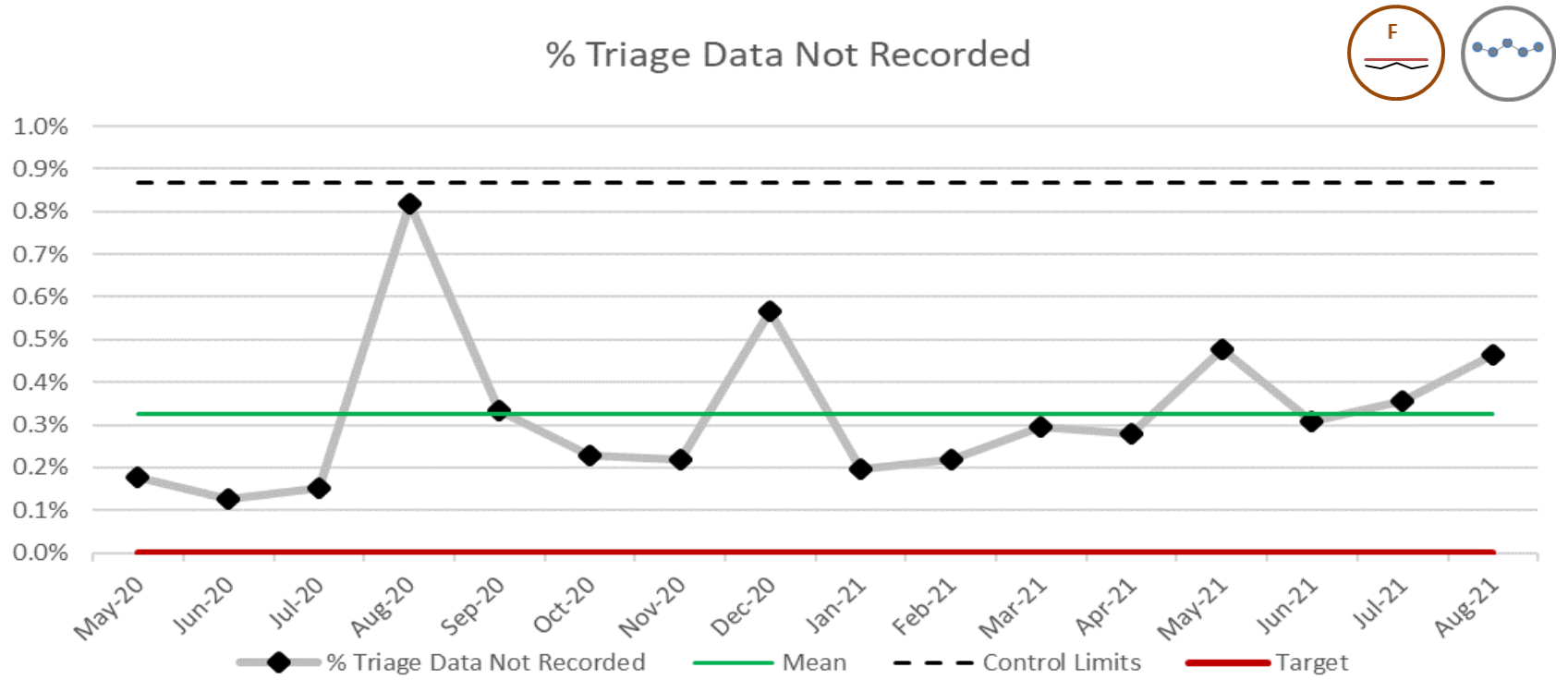

Aug-21
0.46%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
0%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:
Percentage of triage data not recorded.

What the chart tells us:
4.6% of emergency attendance triages not recorded at PHB and LCH.
August demonstrated a 1% negative variation compared with July.

Issues:

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

Actions:

- Increased access to MTS training and time to input data and a planned upgrade to Medway to access the most up to date version of MTS
- Increased registrant workforce to support 2 triage streams to be in place.
- To move to a workforce model with Triage dedicated registrants and remove the dual role component.

Mitigations:

- Earlier identification of recording delays via Emergency Care 'Teams chat'.
- Increased nursing workforce following a targeted recruitment campaign.
- Twice daily staffing reviews to ensure appropriate allocation of the ED workforce to meet this indicator.
- The Urgent and Emergency Care Clinical Business Unit undertake daily interventions regarding compliance (recording and undertaking).

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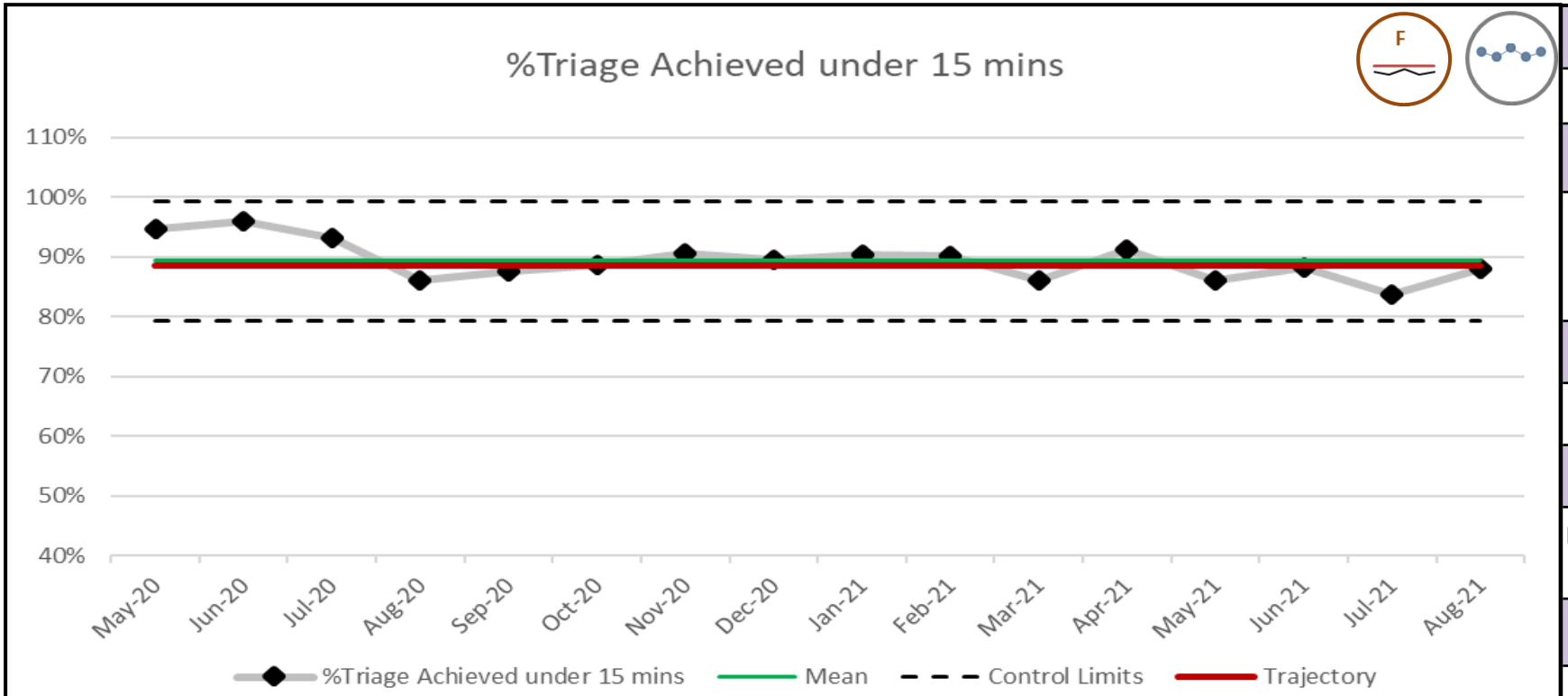

Aug-21
87.98%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
88.5%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:

Percentage of triage achieved under 15 minutes.

What the chart tells us:

2.02% of emergency attendances were not triaged with 15 minutes of arrival. The compliance against this target is 87.98%. August demonstrated an improvement of 2.86% compared with July. This metric is below the agreed target of 90%.

Issues:

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

Actions:

Increased access to MTS training.
Increased registrant workforce to support 2 triage streams to be in place via Emergency Department recruitment campaign.
To move to a workforce model with Triage dedicated registrants and remove the dual role component.
This metric forms part of the Emergency Department safety indicators and is monitored/scrutinised at 4 x daily Capacity and Performance Meetings.
Dedicated Emergency Department space for Children and Young Persons (CYP) are now in place at PHB and LCH. This will ensure adult and CYP are triaged within the 15-minute standard.

Mitigations:

The two Band 8a Senior Nurse Leads maintain oversight and support in periods of either high attendance demand or when the second triage stream is compromised due to duality of role issues.
Early escalation and rectification are also managed through the Emergency Department Teams Chat.
A twice daily staffing meeting staffing meeting in in operations 7 days a week and a daily staffing forecast is also in place including skill mix and competencies.

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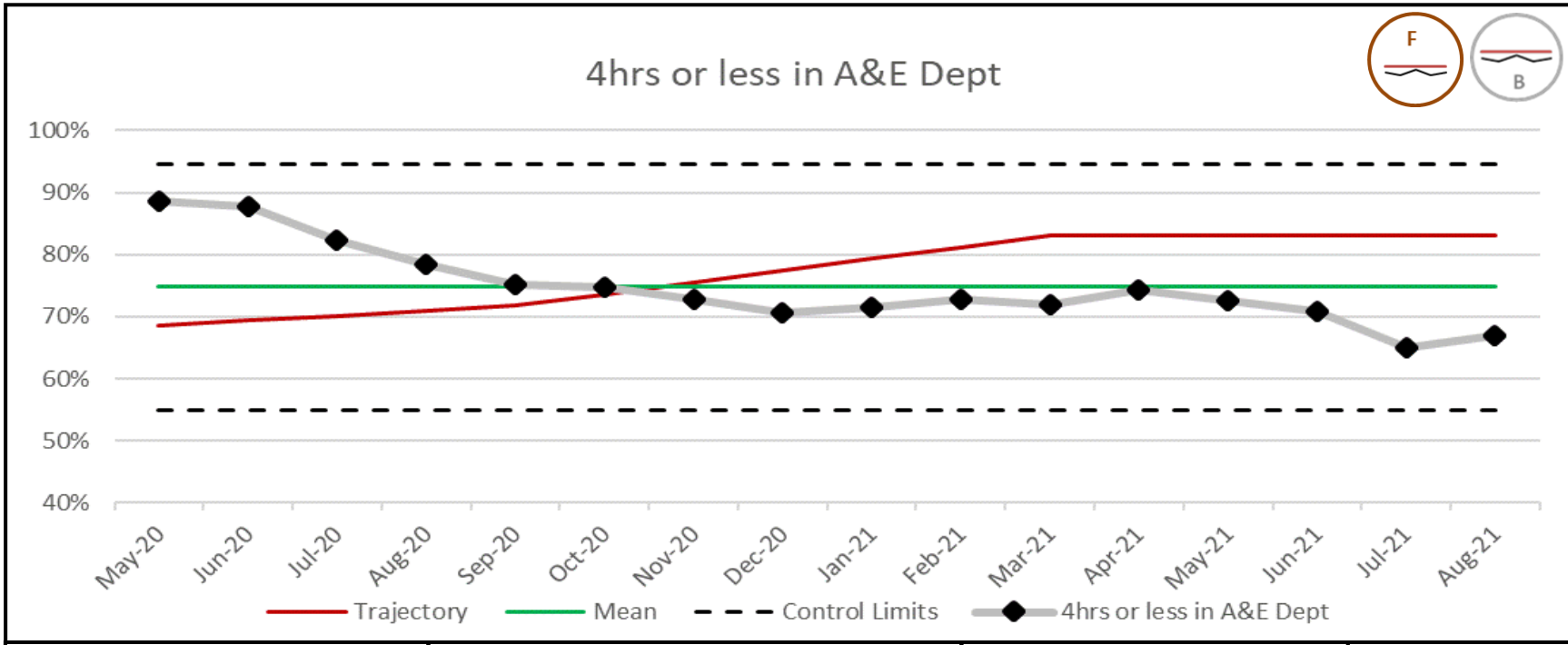

Aug-21
66.96%
Variance Type
Metric is currently experiencing Special Cause Variation – below the mean
Target
83.12%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
The current 4-hour transit target performance for August was 66.96% at day 2 reporting. The agreed compliance trajectory for June is 83.12%. August experienced a slight improvement in performance against the agreed trajectory. August out turned at 66.96% compared to 64.93% in July. A 2.03% positive variance compared to July but a 16.16% negative variance to the agreed performance trajectory.

Issues:
The Emergency Departments saw a 6.84% decrease in attendances in August 2021 compared to July 2021. A comparison to July 2019 denotes a decrease of 6.86%. 17,417 combined attendances (ED and UTC) in August compared to 18,695 combined attendances in July.
Inadequate discharges to meet the admission demand remains an issue.
Ongoing medical and nursing gaps that were not Emergency Department specific.
Of the 17,417 recorded attendances for type 1 and type 3 across the Trust, type 1 attendances accounted for 11,643 and type 3 accounted for 5,774. This reduction on type 1 and type 3 attendances is across all 3 acute sites.

Actions:
Reducing the burden placed upon the Emergency Departments further will be though the continued development of Same Day Emergency Care (SDEC), an increased SDEC footprint is planned for September 2021.
Maximising the Right to Reside (R2R) information to ensure timely and effective discharges for all pathway zero patients.
A twice daily report is sent to all Divisions. Twice daily System calls are in place to maximise pathway 1, 2, and 3 patients. This is led by the Lead Nurse for Discharge in partnership with System Partners.

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

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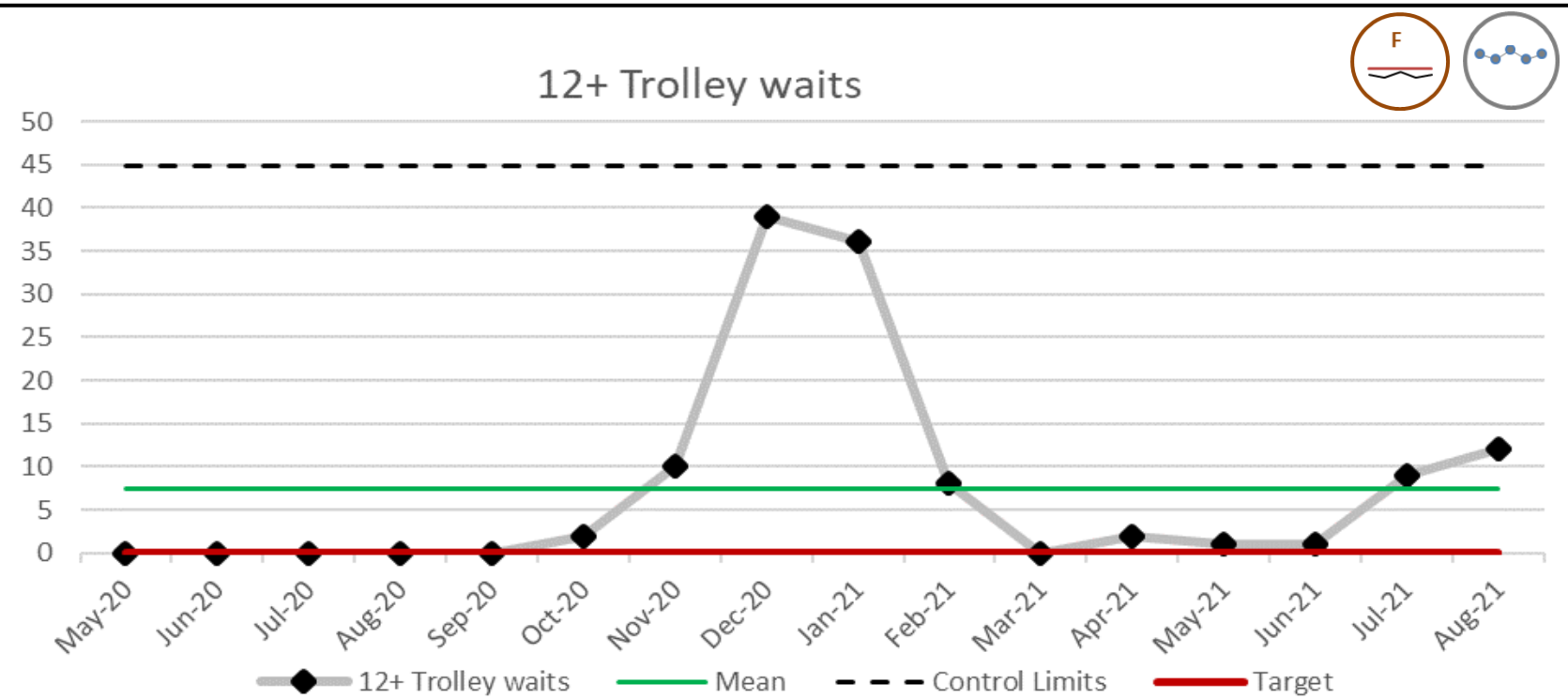

Aug-21
12
Variance Type
Metric is currently experiencing Common Cause Variation
Target
0
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
July experienced12 x 12hr trolley waits.

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

Actions:
Every reported 12hr trolley wait is subject to an immediate clinical review to ascertain whether it is deemed a 'true' 12hr trolley wait breach and is signed off by the Clinical Lead for ED.
The Trust continues to work closely with national regulators in reviewing and reporting these breaches. A timeline for the 12 trolley waits with the greatest total time in ED is submitted to NHSe/i at 11am the next day by the Deputy Chief Operating Officer.
A daily review of all potential 12hr trolley waits is in place 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.

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

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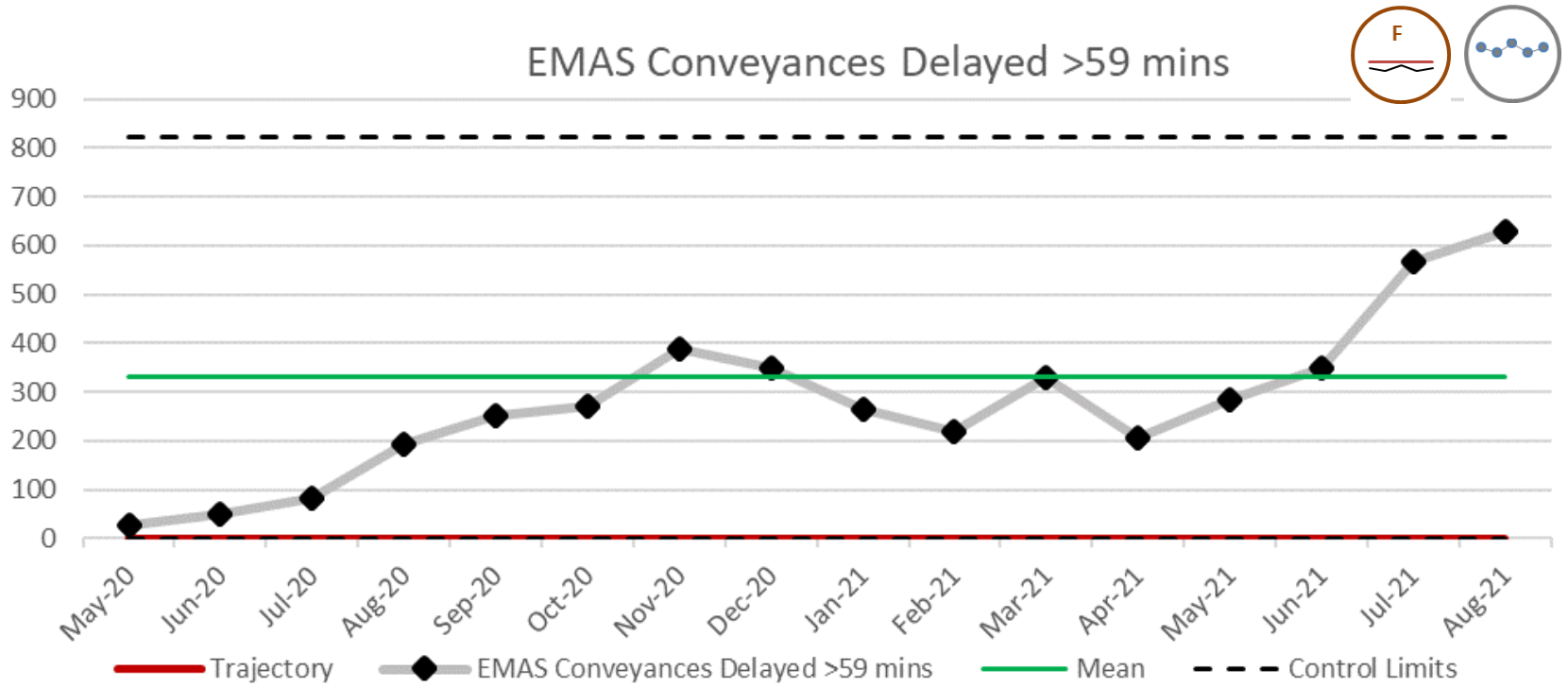

Aug-21
629
Variance Type
Metric is currently experiencing Common Cause Variation
Target
0
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:

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

What the chart tells us:

August experienced an increase in greater than 59 minutes handover delays. 629 in August compared to 568 in July. This represents a 9.70% increase.
What the chart does not tell us is the increase of >4hrs and >3hrs in August 2021 but LCH experienced the largest increase in terms of >59mins.

Issues:

The pattern of conveyance and prioritisation of clinical need attributes to the delays.
Increased conveyances continue to profile into the late afternoon and evening coincides with increased 'walk in' attendances causing a reduce footprint to respond to timely handover.
Poor flow and discharges continue to result in the emergency departments being unable to de-escalate due to an increase number of patients waiting for admission.
LCH experienced the highest number of >59-minute handover delays and is featured in the combined UEC/Planned Care FPEC report.

Actions:

All ambulances approaching 30 minutes without a plan to off load are escalated to the Clinical Site Manager and the in hours Operational Silver Commander to secure a resolution.
Daily messages to EMAS crews to sign post to alternative pathways and reduce conveyances to the acute setting.
Active monitoring of the EMAS inbound screen to ensure the departments are ready to respond.

Mitigations:

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

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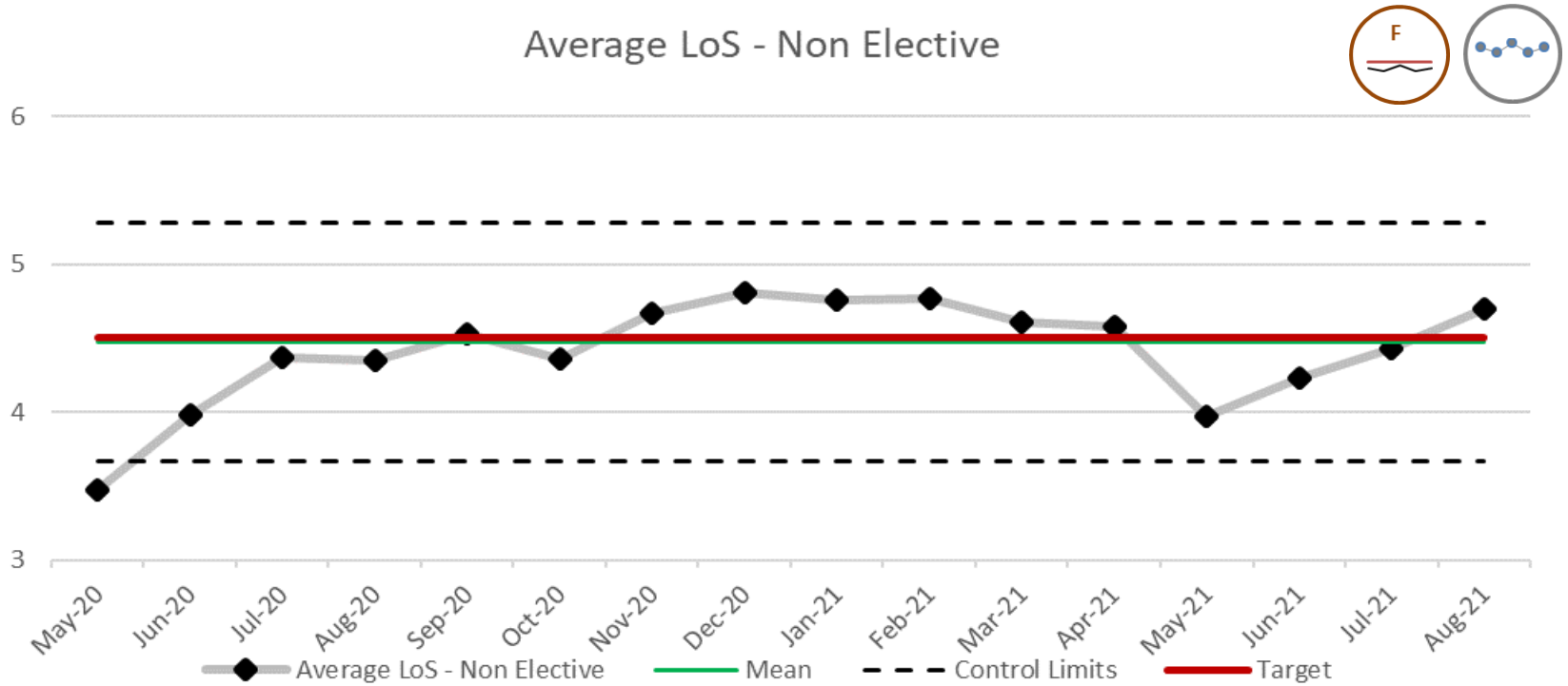

Aug-21
4.7
Variance Type
Metric is currently experiencing Common Cause Variation
Target
4.5
Target Achievement
Metric is failing the target
Executive Lead
Chief Operating Officer

Background:
Average length of stay for Non-Elective inpatients.

What the chart tells us:
The agreed target is 4.5 days verses the actual of 4.7 days July was 4.43 days versus 4.70 days in August. A negative variance of 0.27.

Issues:
Increasing numbers of stranded (211) and super stranded (68) patients.
PCR turnaround delays impacting on the discharge of pathway 1, 2 and 3 patients.
Increasing length of stay of all pathways 1-3/ The most significant increase in volume of bed days is Pathway 1 Domiciliary care. Higher acuity of patients requiring a longer period of recovery.
Increased medical outliers leading to delays in senior reviews.

Actions:
Focused discharge profile through right to reside data.
Cancellation of SPA time to allow for daily consult review of all patients.
Medically optimised patients discussed twice daily 7 days a week with system partners to ensure plans in place.
Use of rapid PCRs to ensure no delay once social care plans secures.
Maximise use of all community and transitional care beds.

Mitigations:
Divisional Bronze Lead supports the escalation of delays to the relevant divisions and Clinical Business Units.
Reduced corporate and divisional meetings to allow a more proactive focus on increasing daily discharges.
However this is not sustainable.

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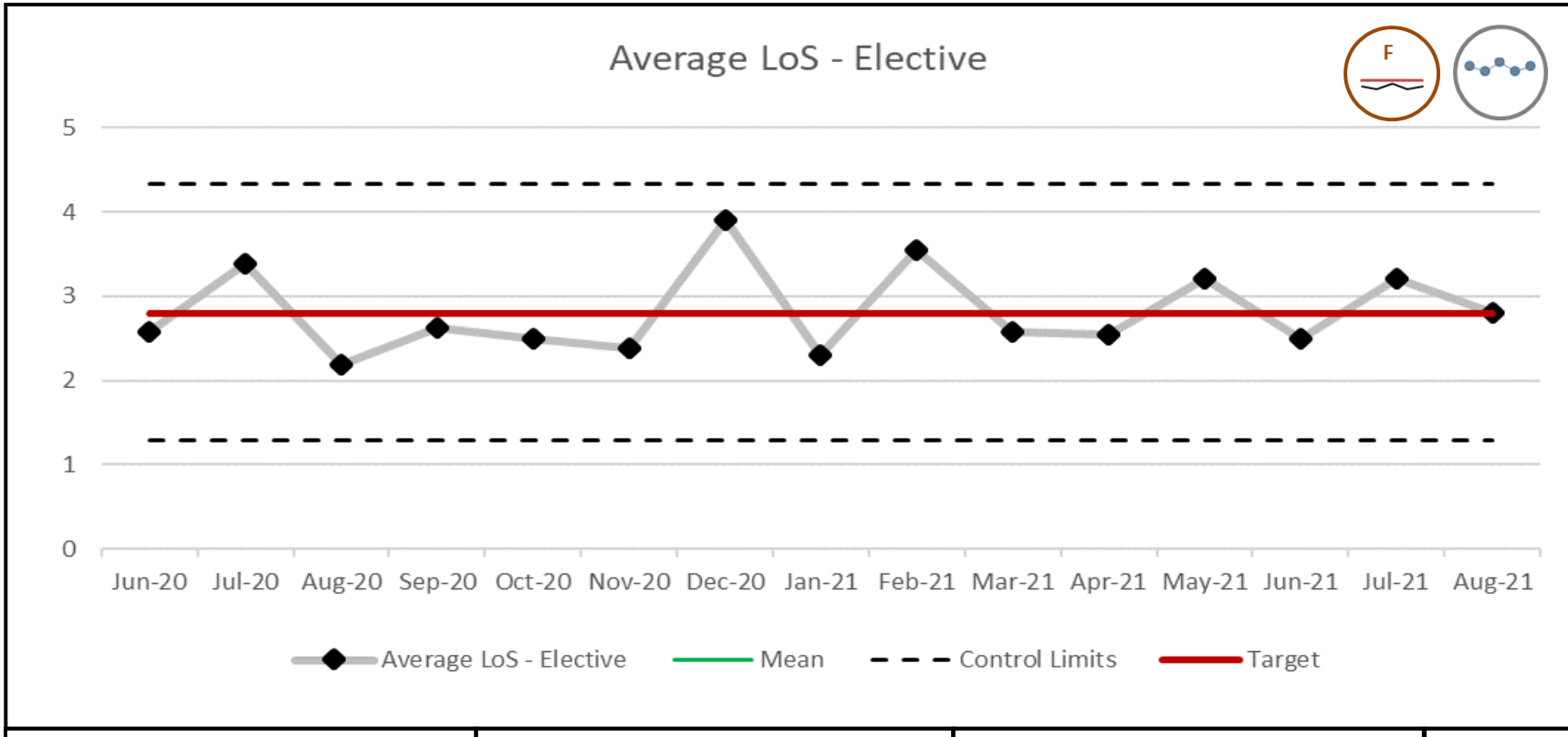

Aug-21
2.81
Variance Type
Metric is currently experiencing Common Cause Variation
Target
2.80
Target Achievement
Metric is failing the target
Executive Lead
Chief Operating Officer

Background:

Average length of stay for Elective inpatients.

What the chart tells us:

The average LOS for Elective stay has decreased from 3.21 days in July to 2.81 days in July. This is a decrease of 0.4 days and represents an decrease of 12.47 %
The trajectory for Elective LOS is 2.8 days

Issues:

Complexity of patients now being admitted which will impact on post-operative recovery and LOS.
Increase in Elective patients on pathways 1, 2 & 3.
There still remains an issue with distorted figures associated with outliers in previous dedicated elective beds and also coding.

Actions:

The reduction in waiting times is being monitored weekly.
A Planned Care Rhythm of the day, week and month is being finalised which will especially focus on speciality waiting lists where patients have been identified as having increased morbidity which will impact of increased LOS.
Timely ITU 'step down' of level 2 care to level 1 'wardable' care within 4 hours of identification.
The complete review and allocation of 'P' codes continues to progress
Weekly cancelled operations meeting is being instigated with an ALOS predictor against procedure normal LOS vs patient specific indicators

Mitigations:

6-4-2 weekly theatre scheduling meeting will identify those patients that will need an extended LOS and consideration for increased optimisation to reduced predicted LOS. This meeting is now attended by the planned care lead.
All elective areas are to now escalate pre-operatively any post-operative requirements that may lead to an extended LOS outside of the expected LOS.
Maximum use of GDH for low risk patients.

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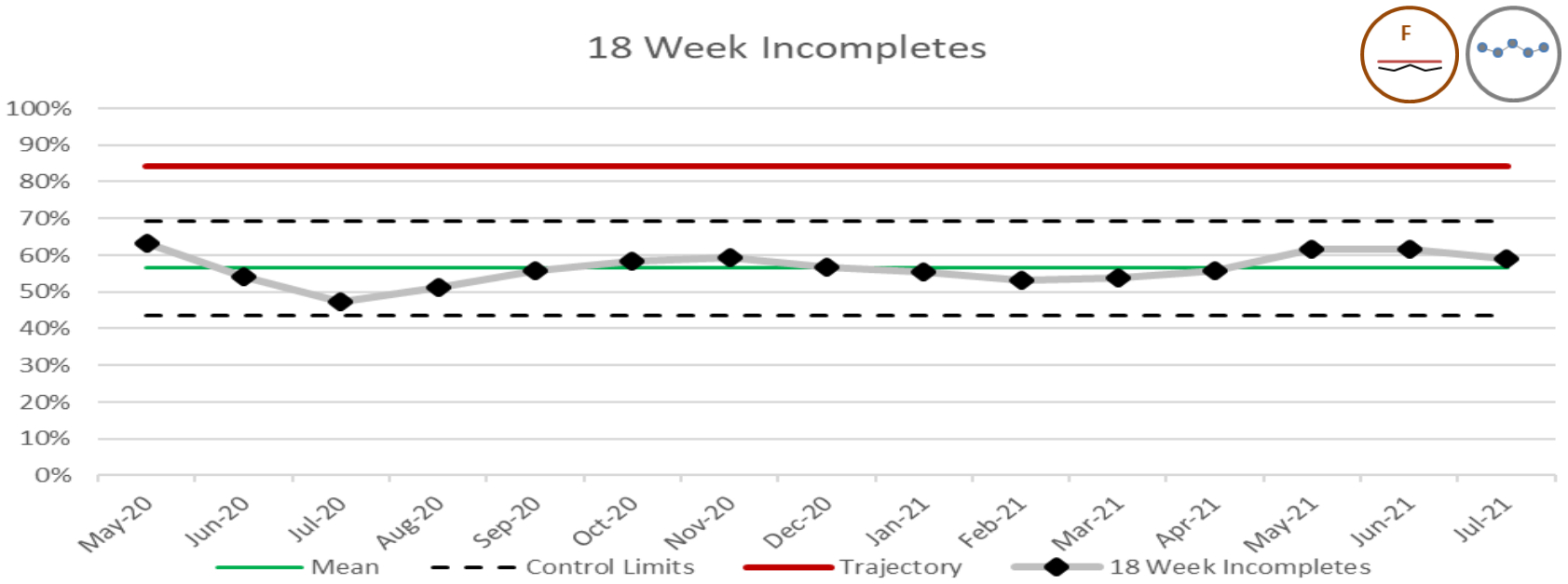
NHS United Lincolnshire Hospitals NHS Trust



Jul-21
58.89%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
84.1%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background

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

What the chart tells us:

There is significant backlog of patients on incomplete pathways. July saw RTT performance of 58.89% against a 92% target, which is 2.6% down on June.

Issues:

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

- Ophthalmology – 3001(reduced by 304)
- ENT – 3355 (increased by 372)
- Gynaecology – 1899 (Increased by 159)
- Dermatology – 1095(reduced by 624)
- General Surgery1379 (Increased by 45)

Actions:

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

Mitigations:

Patient pathways are tracked and discussed at the weekly PTL meeting which is now attended by the planned care lead.

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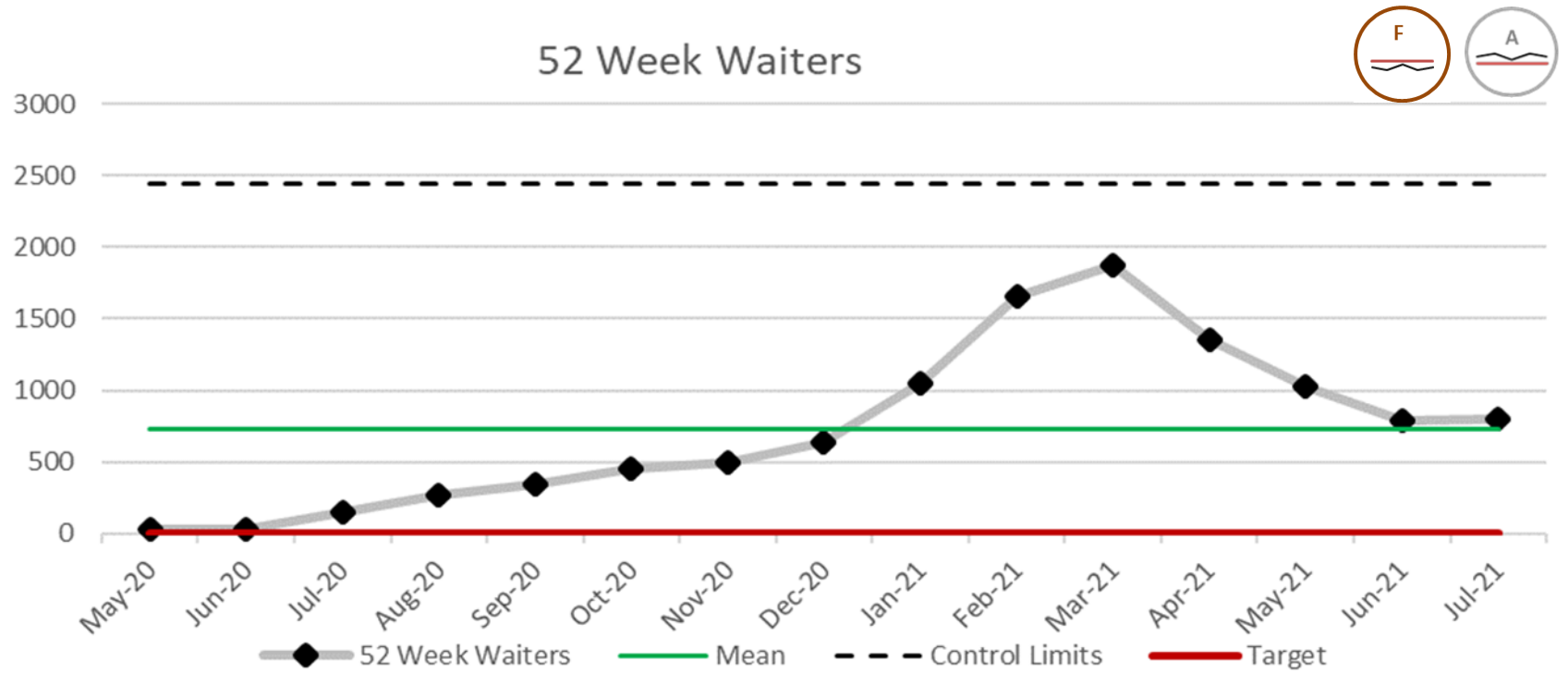

Jul-21
797
Variance Type
Metric is currently experiencing Special Cause Variation – above the mean
Target
0
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
The Trust reported 797 incomplete 52 week breaches. An increase of 10 from May.
The number of 52 week breaches has been steadily reducing since March 2021 but has gone up last month by 10.

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

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

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

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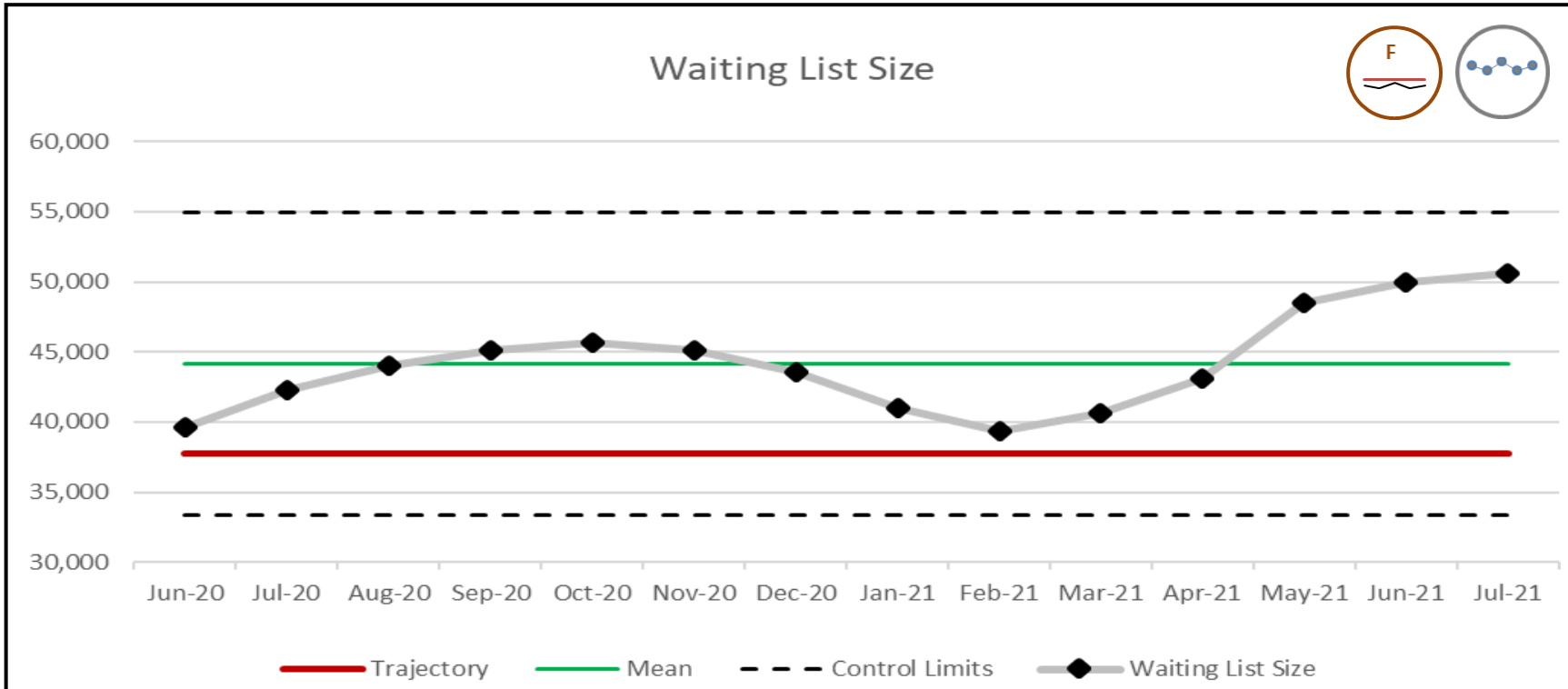
NHS United Lincolnshire Hospitals NHS Trust



Jul-21
50,565
Variance Type
Metric is currently experiencing Common Cause Variation
Target
37,762
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
Overall waiting list size has increased from June, with July showing an increase of 640 to 50,565.
The incomplete position for July 2021 is now approximately 11,533 more than the March 2018 39,032) target.

Issues:
Patients on the ASI list have now been added to the open referrals list; this has caused an increase in the overall waiting list size.
The top five specialties showing an increase in total incomplete waiting list size from May are:

- Ophthalmology +685
- Trauma and Orthopaedics + 160
- Community Paediatrics + 56
- Breast Surgery + 56
- Nephrology +29

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

- Dermatology -328
- ENT -280
- Neurology -280
- Gynaecology – 136
- Maxillo-Facial Surgery - 95

The Trust reported 5,818 over 40 week waits; an increase of 1,286 from July.
The numbers of patients waiting over 26 weeks increased by 29.

Actions/Mitigations:
The longest waiting patients continue to be monitored and discussed at the weekly PTL meeting, to ascertain if there are any issues preventing the patient from being booked. Capacity issues are also discussed in the meeting to help find solutions.

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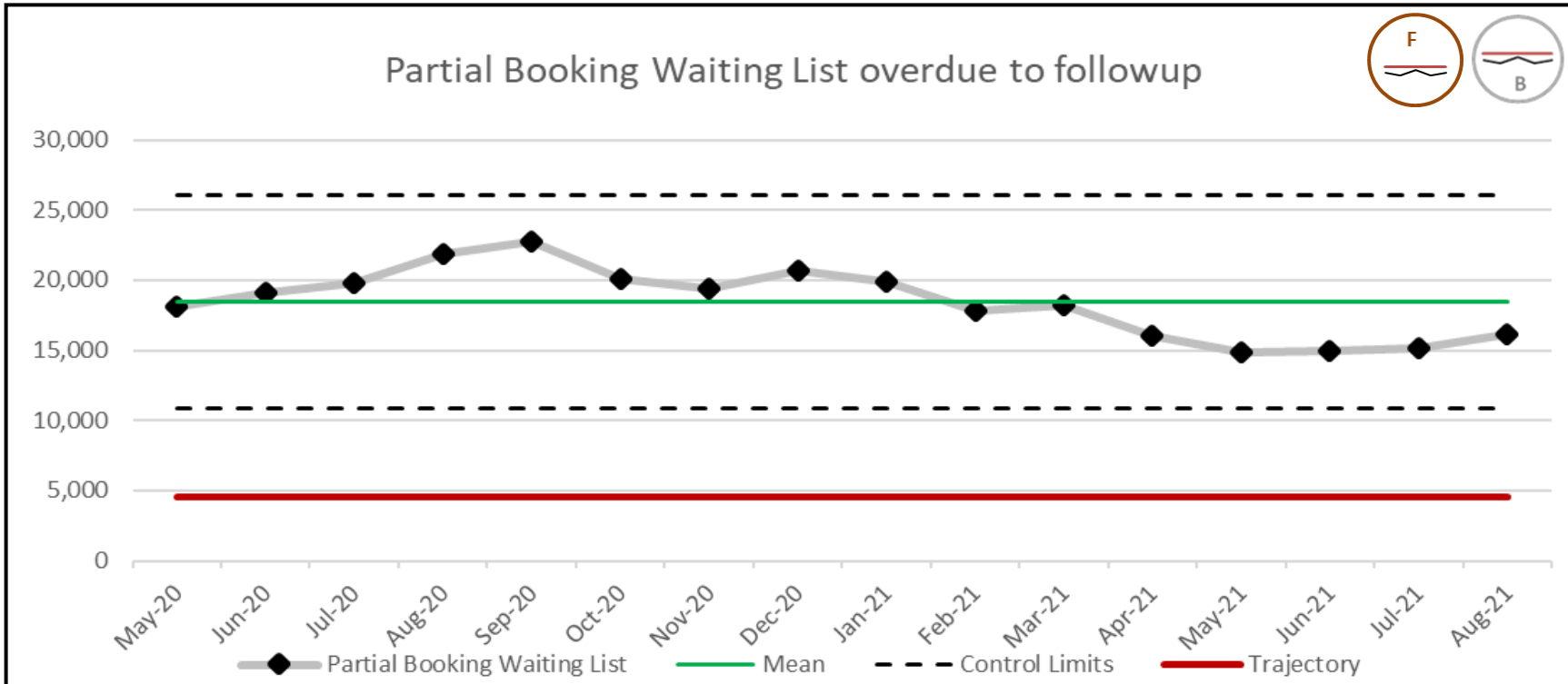
NHS United Lincolnshire Hospitals NHS Trust



Aug-21
16,098
Variance Type
Metric is currently experiencing Special Cause Variation – low trend
Target
4,524
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 16,098 against a target of 4,524.
Due to Covid the number of patients overdue a follow up appointment significantly increased. Recovery work has taken place and reduced the number of patients overdue but this has started to increase since last month.

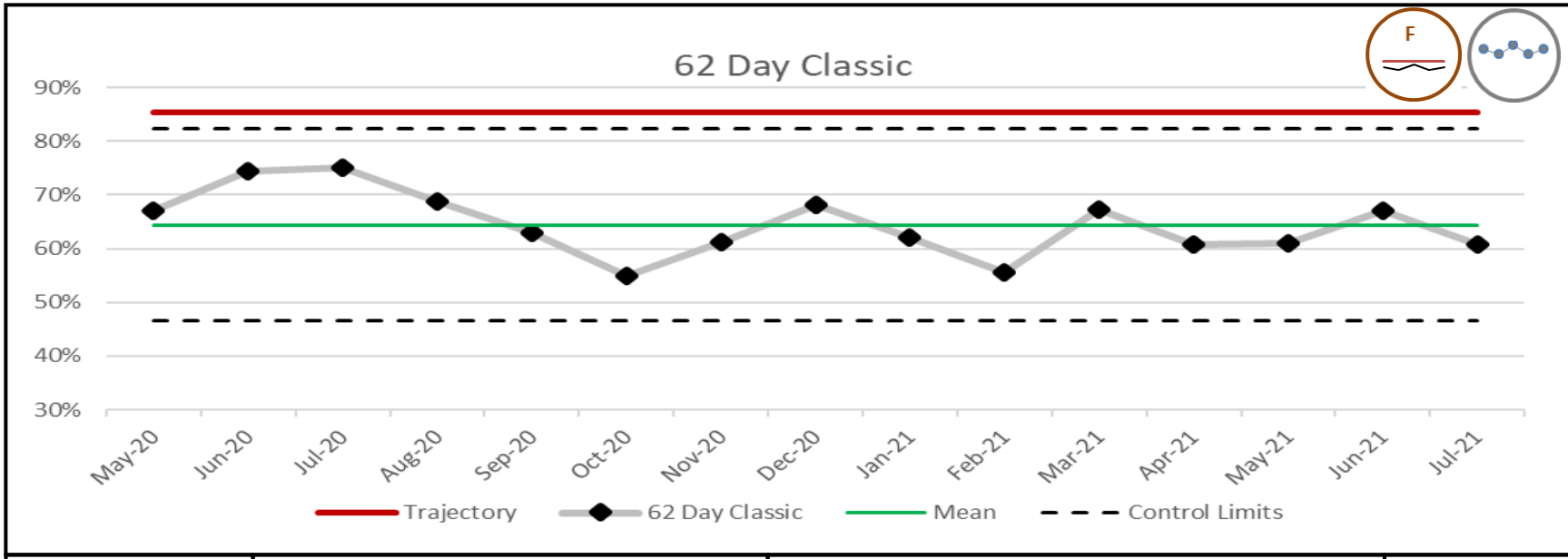
Issues:
The organisation is pressured in a number of areas that has taken priority over outpatients. The issues include conflicting priorities, increasing demand, resources, space, aligning requirements.

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

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

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Jul-21
60.73%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
85.4%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

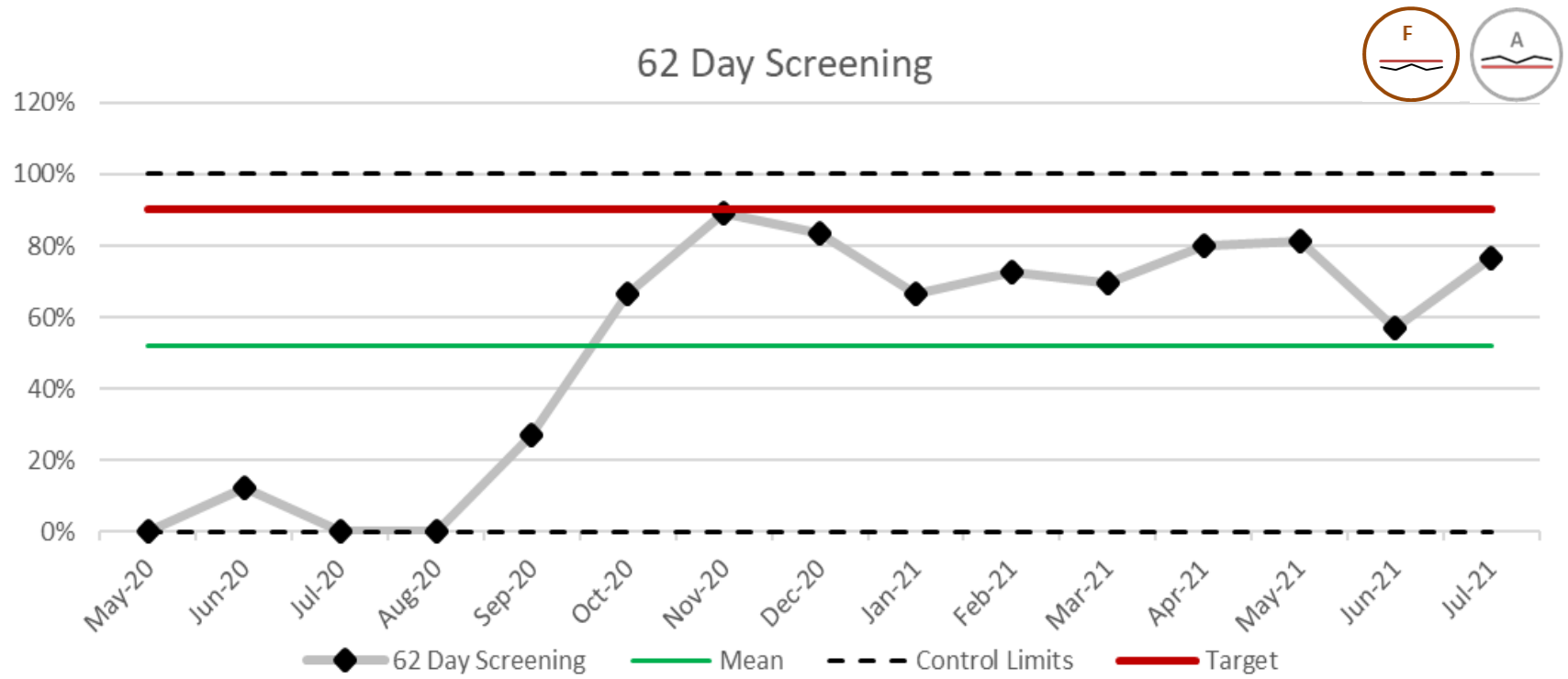
Background:
Percentage of patients to start a first treatment within 62 days of a 2ww GP referral.

What the chart tells us:
We are currently at 60.73% against an 85.4% target.

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

Actions:
28 Day standard identified as Trust's cancer performance work stream in the Integrated Improvement Program for 2021-22. Two substantive Medical Oncologists were recruited, one is due to start in November 2021 (covering Breast, Renal and Urology). Unfortunately, the second post has gone back out to advert after the applicant withdrew. Dedicated admin resource has been identified within the Colorectal, Urology, Breast and Gynae CBU's to support clinical engagement. Following this model and with funding from EMCA, The Medicine Division have had 2 full-time Navigator posts commence. Funding has also been identified for the Head & Neck CBU and the recruitment process is underway.
Endoscopy are in the early stages of undertaking a review around the Bowel Cancer Screening age extension and endoscopy staffing. The intention is to increase the clinical endoscopist workforce with less reliance on consultants and also to increase administrative support by converting fixed term into substantive posts. Work to enhance the early identification of patients requiring Pre-Diagnosis CNS support is ongoing.

Mitigations:
Theatre capacity is returning to Pre-covid levels. A review of colorectal theatre list scheduling in order to better align with clinician availability continues and Grantham Theatres have now returned to undertaking suitable Level 1 colorectal work. Work continues within the Surgery Division in order to access sufficient HDU post op care via the weekly meetings and to ensure that theatre capacity is fully utilised once full pre-op capacity returns.
2 H&N consultant posts have been recruited, 1 started in April 2021, and another commenced in July 2021.



Jul-21
76.67%
Variance Type
Metric is currently experiencing Special Cause Variation – above the mean
Target
90%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

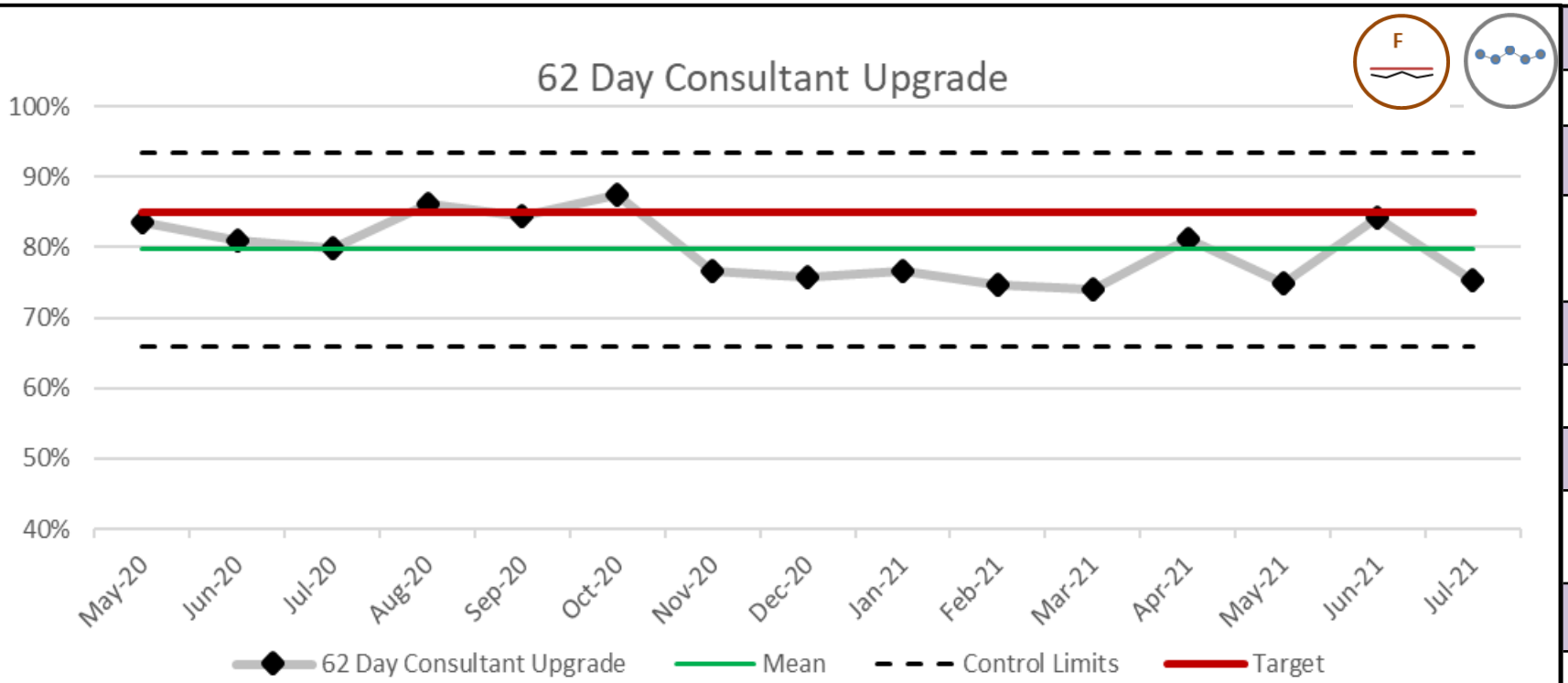
Background:
Percentage of patients to start a first treatment within 62 days of referral from an NHS cancer screening service.

What the chart tells us:
We are currently at 76.67% against a 90% target

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

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

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



Jul-21
75.36%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
85%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 75.36% against an 85% target

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

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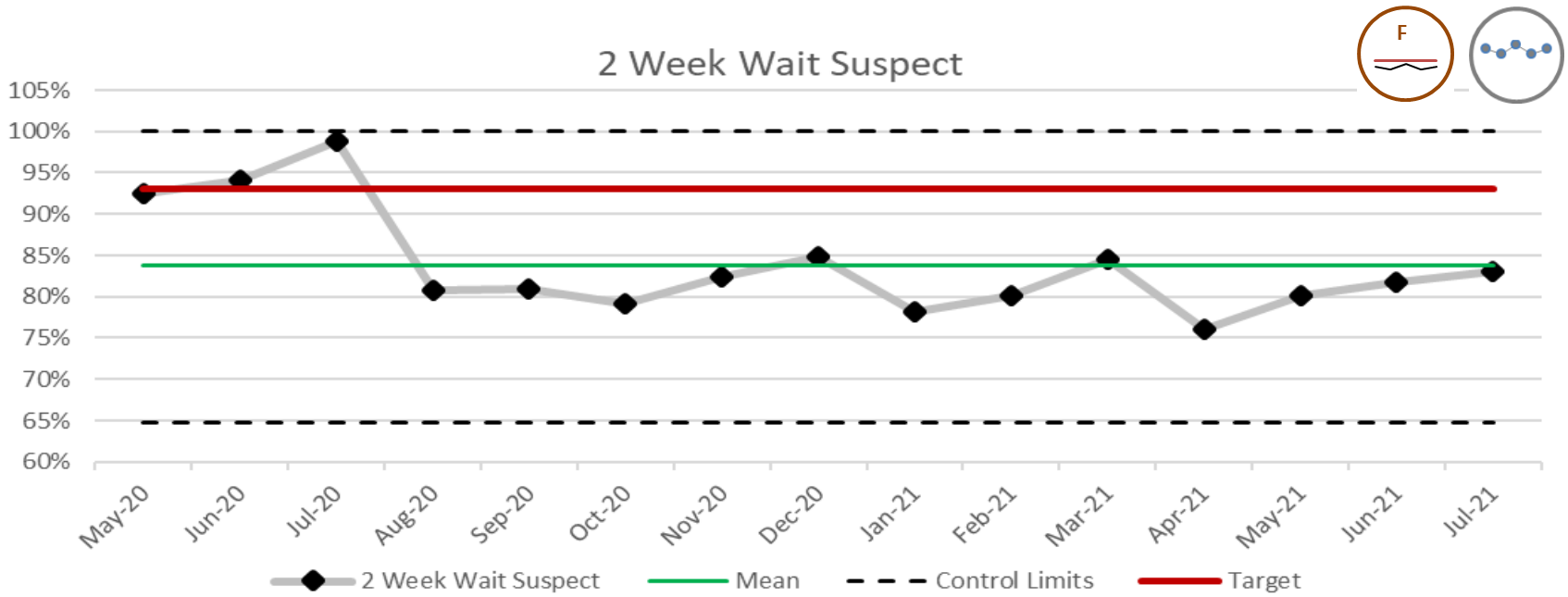
Mitigations:
See mitigations on previous page – 62 day classic.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Jul-21
83.07%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
93%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

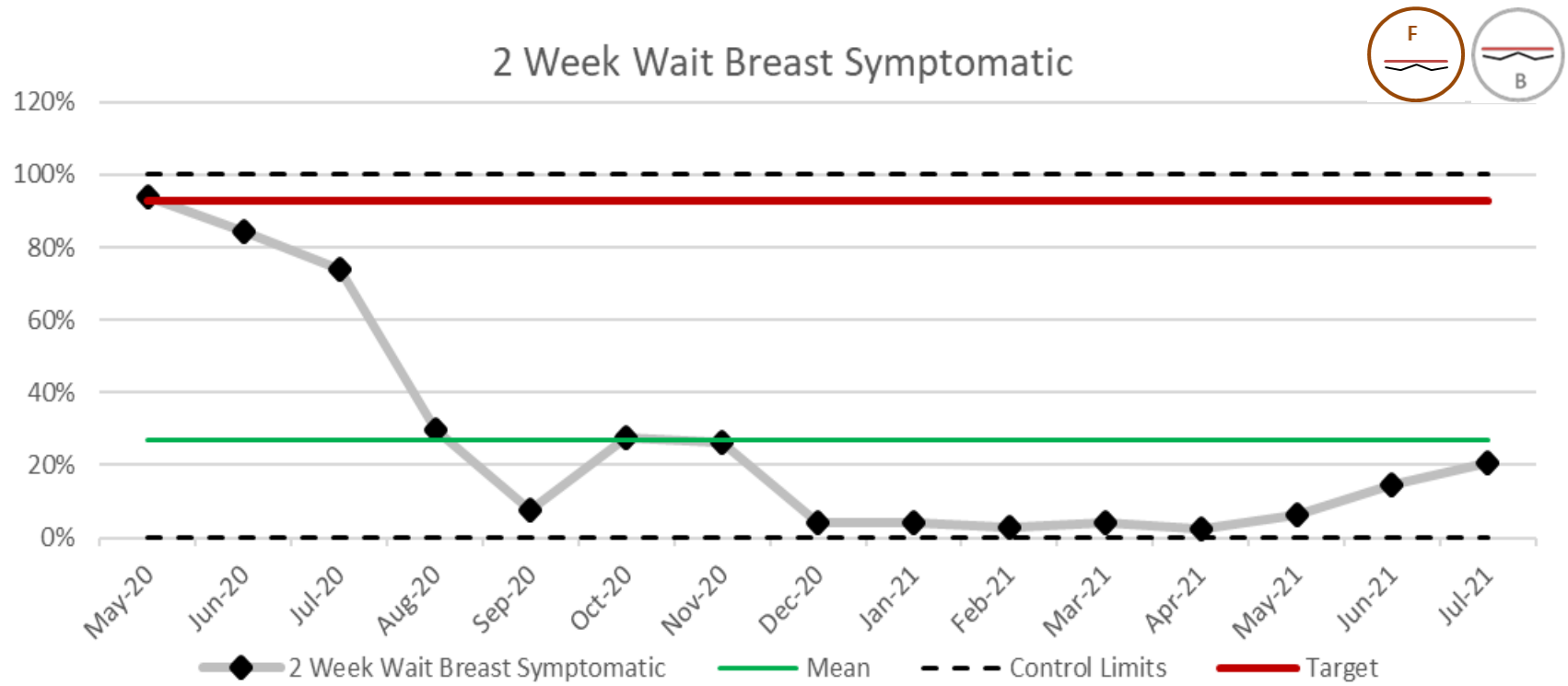
Background:
Percentage of patients seen by a specialist within two weeks of 2ww referral for suspected cancer.

What the chart tells us:
We are currently at 83.07% against a 93% target.

Issues:
The Trust's 14 Day performance continues to be significantly impacted by the current Breast Service One-Stop appointment alignment issues - 63% of the Trust's 14 Day breaches were within that tumour site. The other tumour sites that considerably under-performed include Gynaecology (61.4%), Lung (66.3%) and Upper GI (85.7%), with Urology only narrowly missing the target (94.8%). All other tumour sites achieved the standard. Reduced clinic throughput due to social distancing / IPC requirements, especially in waiting areas. Patient acceptance & compliance with swabbing and self-isolating requirements. Patients not willing to travel to where our service and / or capacity is.

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

Mitigations:
Further respiratory consultant posts will secure lung clinic capacity and support the pilot to appoint lung patients within 48 hours – one Consultant post commenced in August, unfortunately another has withdrawn from the recruitment process.
Breast clinic capacity has now been restored to pre-COVID levels and additional clinics to clear the backlog are being sought and will continue to be until the backlog is cleared.



Jul-21
20.59%
Variance Type
Metric is currently experiencing Special Cause Variation – below the mean
Target
93%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 20.59% against a 93% target.

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

Actions:
A comprehensive review of Breast Services is ongoing following the final report issued by NHSI support.
Initial demand and capacity reviews have been completed and additional capacity has been identified to reduce backlog and increase overall achievement of 2ww.
NHSI support.

Mitigations:
Breast clinic capacity has now been restored to pre-COVID levels and additional clinics to clear the backlog are being sought and will continue to be until the backlog is cleared.

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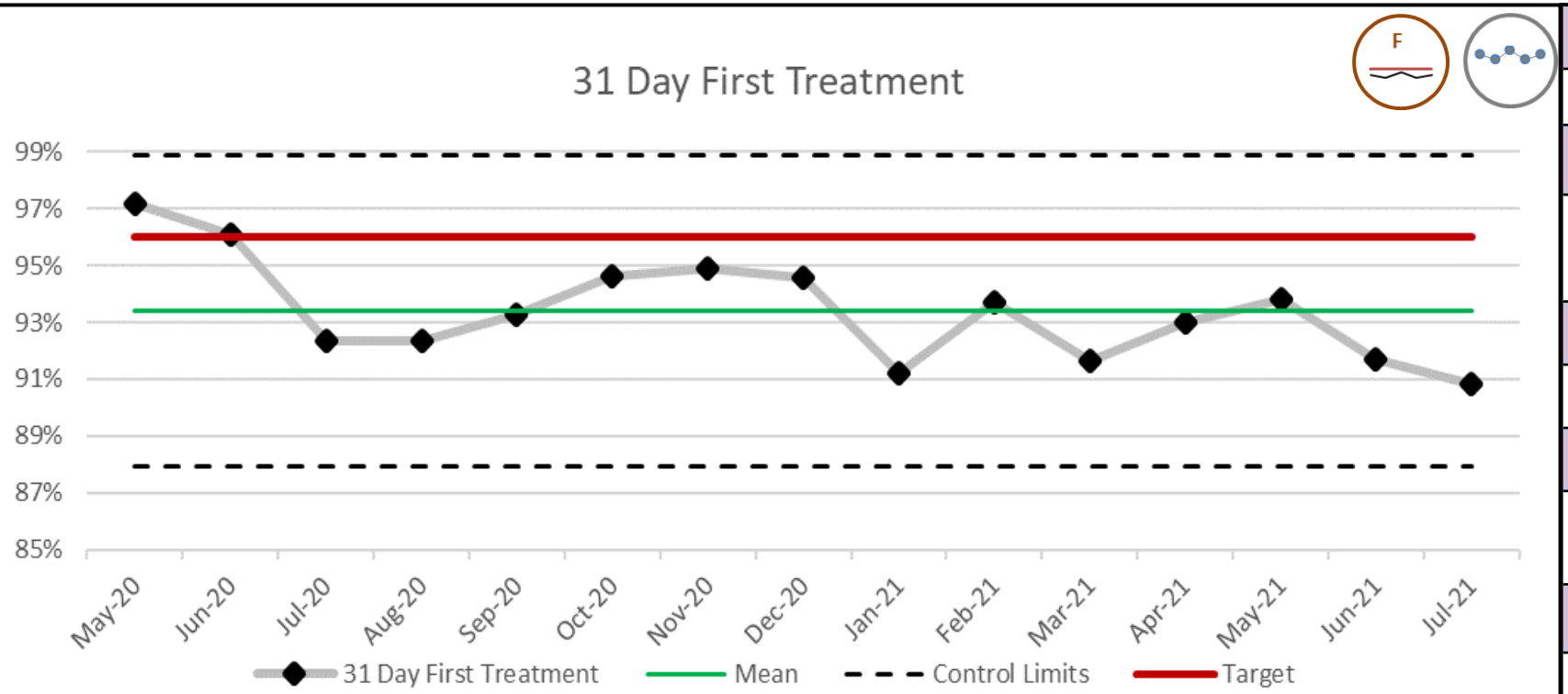

Jul-21
90.81%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
96%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 90.81% against a 96% target.

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

Actions:
Two substantive Medical Oncologists were recruited, one is due to start in November 2021 (covering Breast, Renal and Urology). Unfortunately, the second post has gone back out to advert after the applicant withdrew.

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

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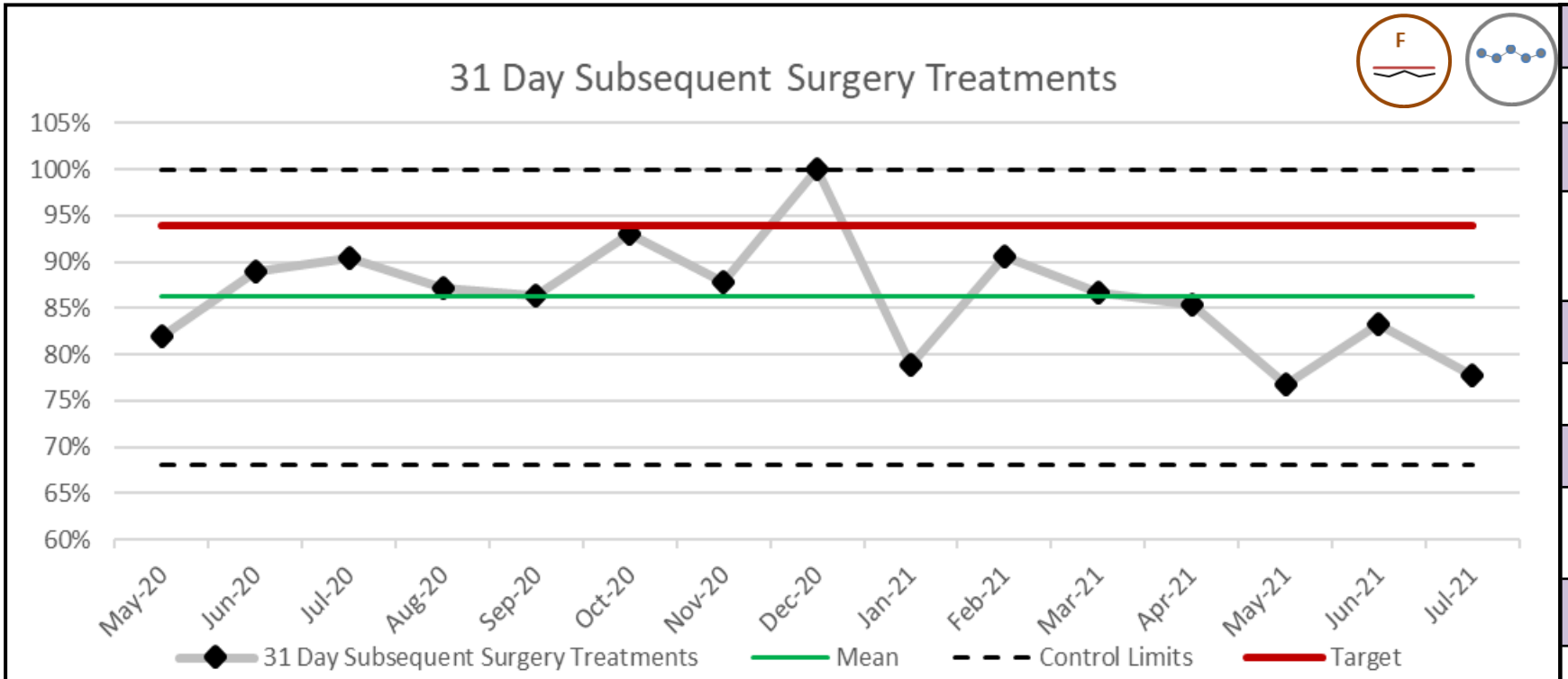

Jul-21
77.78%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
94%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 77.78% against a 94% target.

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

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

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

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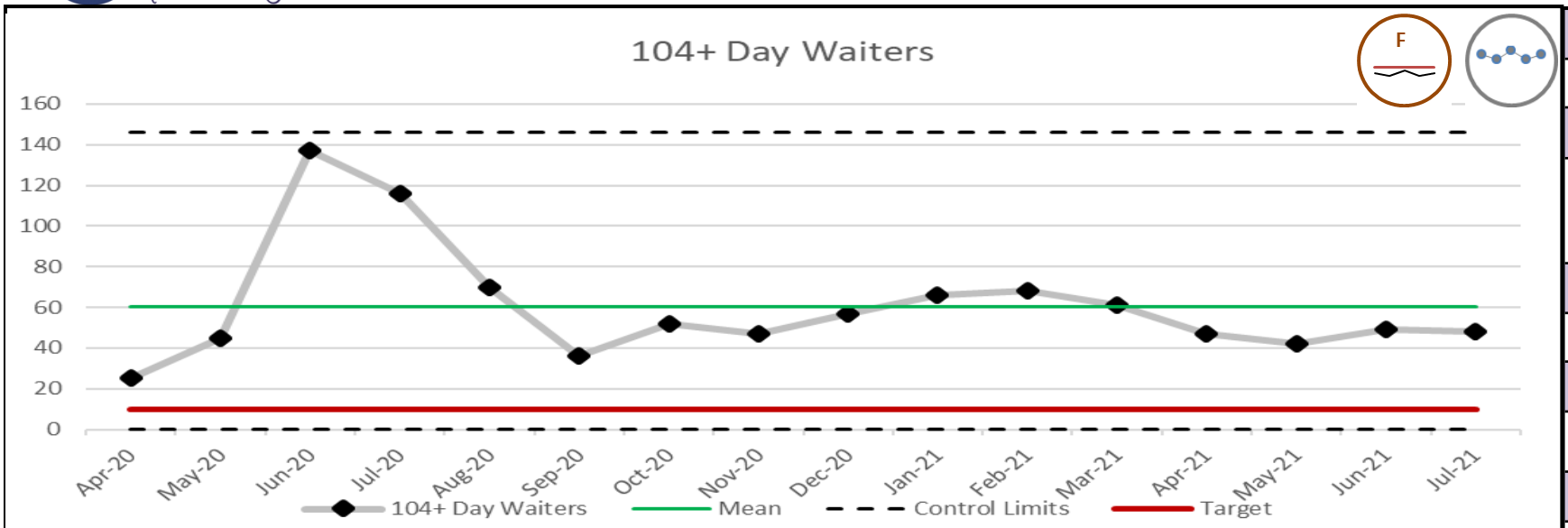

Jul-21
67
Variance Type
Metric is currently experiencing Common Cause Variation
Target
10
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:
Number of cancer patients waiting over 104 days.

What the chart tells us:
As of 9th of September, the 62 Day backlog is at 368 patients. The agreed target is <40. As of 9th September the 104 Day backlog is at 68 patients. The agreed target is <10.
The current position by tumour site is: 36 Colorectal, 8 Urology 7 Lung, 6 Head & Neck, 4 each Gynaecology & Upper GI, 2 Breast and 1 Skin.

Issues:
Patient engagement in diagnostic process (reluctance to visit hospitals due to perceived COVID-19 risk, including those waiting for vaccines or the 3 week 'effectiveness' period) – this is starting to improve.
Reduced clinic throughput due to social distancing / IPC requirements, especially in waiting areas.
Patient acceptance & compliance with swabbing and self-isolating requirements. Patients not willing to travel to where our service and / or capacity is.
Reduced theatre capacity across the Trust, all Specialties vying for additional sessions. Managing backlogs significantly in excess of pre-COVID levels for Colorectal, Urology, Head & Neck, Upper GI, Lung and Gynaecology. Lost treatment capacity due to short notice cancellation of patients (unwell on the day of treatment or day before), not allowing time to swab replacement patients. Approximately 9% of these patients require support from the Pre-Diagnosis CNS as they have mental or social care needs that have the potential to significantly impact on the length of their pathway.

Actions:
28 Day standard identified as Trust's cancer performance work stream in the Integrated Improvement Program for 2021-22. Two substantive Medical Oncologists were recruited, one is due to start in November 2021 (covering Breast, Renal and Urology). Unfortunately, the second post has gone back out to advert after the applicant withdrew. Dedicated admin resource has been identified within the Colorectal, Urology, Breast and Gynae CBU's to support clinical engagement. Following this model and with funding from EMCA, The Medicine Division have had 2 full-time Navigator post commence. Funding has also been identified for the Head & Neck CBU and the recruitment process is underway.
Endoscopy are in the early stages of undertaking a review around the Bowel Cancer Screening age extension and endoscopy staffing. The intention is to increase the clinical endoscopist workforce with less reliance on consultants and also to increase administrative support by converting fixed term into substantive posts.

Mitigations:
Theatre capacity is returning to Pre-covid levels. A review of colorectal theatre list scheduling in order to better align with clinician availability continues and Grantham Theatres have now returned to undertaking suitable Level 1 colorectal work. Work continues within the Surgery Division in order to access sufficient HDU post op care via the weekly meetings and to ensure that theatre capacity is fully utilised once full pre-op capacity returns.
2 H&N consultant posts have been recruited, 1 started in April 2021, and another commenced in July 2021.Work to enhance the early identification of patients requiring Pre-Diagnosis CNS support is ongoing.

PERFORMANCE OVERVIEW - WORKFORCE

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	Jun-21	Jul-21	Aug-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%	91.26%	90.89%	90.39%	90.02%		F		
	Number of Vacancies	Well-Led	People	Director of HR & OD	12%	11.31%	11.57%	12.13%	10.62%		F		
	Sickness Absence	Well-Led	People	Director of HR & OD	4.5%	4.97%	5.05%	5.09%	5.02%		F		
	Staff Turnover	Well-Led	People	Director of HR & OD	12%	11.69%	12.01%	12.46%	11.65%		F		
	Staff Appraisals	Well-Led	People	Director of HR & OD	90%	72.19%	67.95%	62.79%	70.86%		F		
					£'000	£'000	£'000		£'000				
	Agency Spend	Well-Led	People	Director of HR & OD	-£2,757	-£3,417	-£3,745	-£3,787	-£18,515		F		

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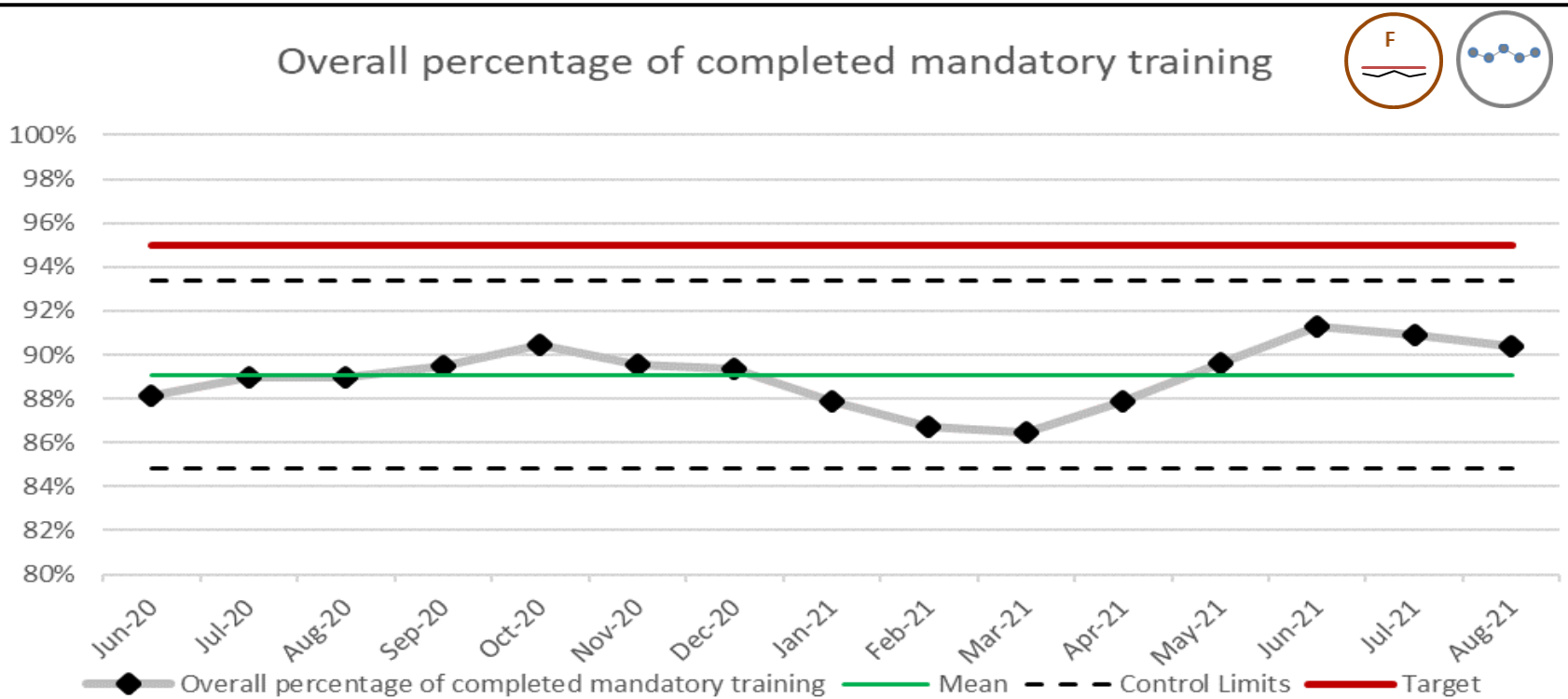

Aug-21
90.39%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
95%
Target Achievement
Metric is consistently failing to target
Executive Lead
Director of HR & OD

Background:
Overall percentage of completed mandatory training.

What the chart tells us:
Compliance with mandatory training continues to remain high for the last 3 months than that was in the previous months.

Issues:
- A review is being undertaken in regards to what training is required by who and at what level
- Front line staffing having an increased difficulty in ensuring protected time due to current pandemic
- All Training currently stood down due to the Major Critical Incident of the Trust.

Actions:
- Recruitment to a temp core learning support staff member to join OD
- Administration tasks being incorporated by the Hr Ops team including the inputting of the online induction uptake.
- Communications link to be updated with core learning and pay progression information.

Mitigations:
See actions

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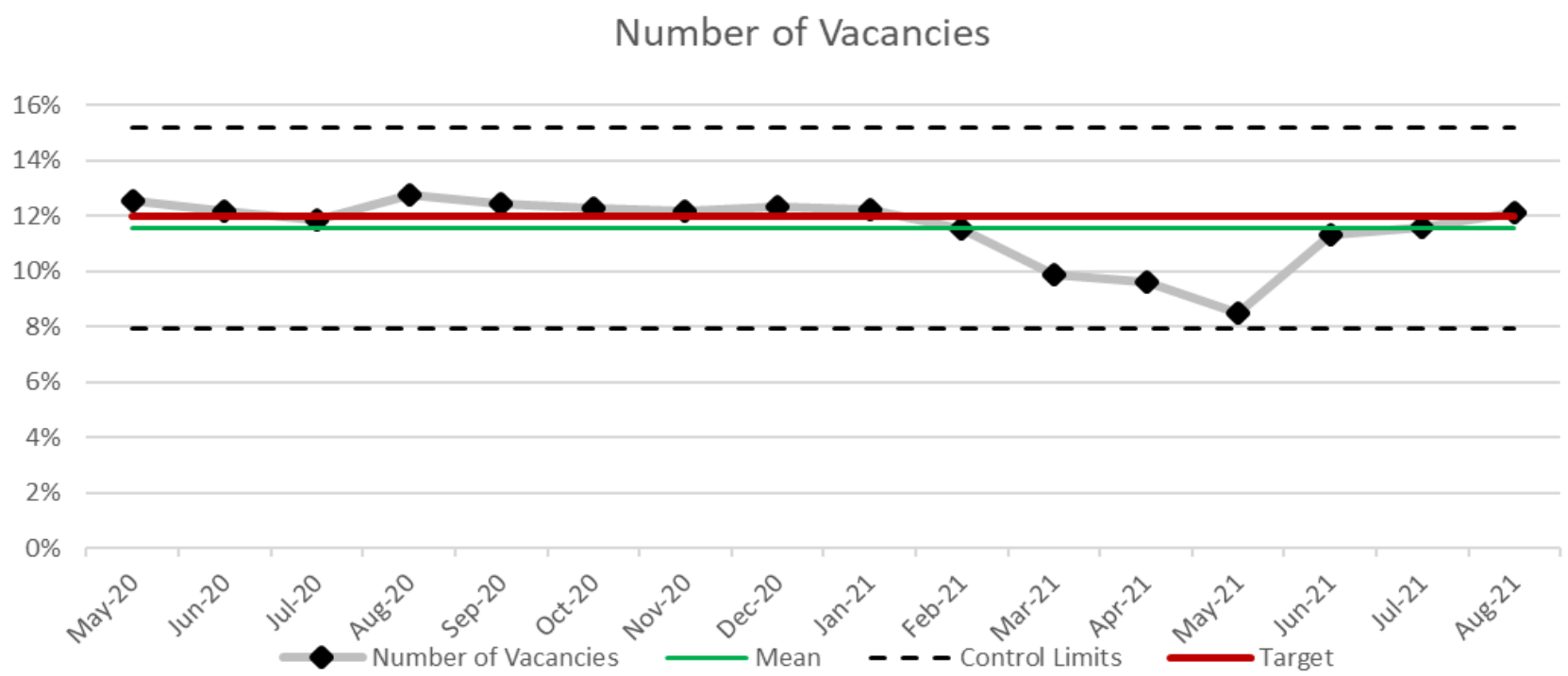

Aug-21
12.13%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
12%
Target Achievement
Metric is failing to target
Executive Lead
Director of HR & OD

Background:
% of vacancies.

What the chart tells us:

Issues:

Actions:

Mitigations:

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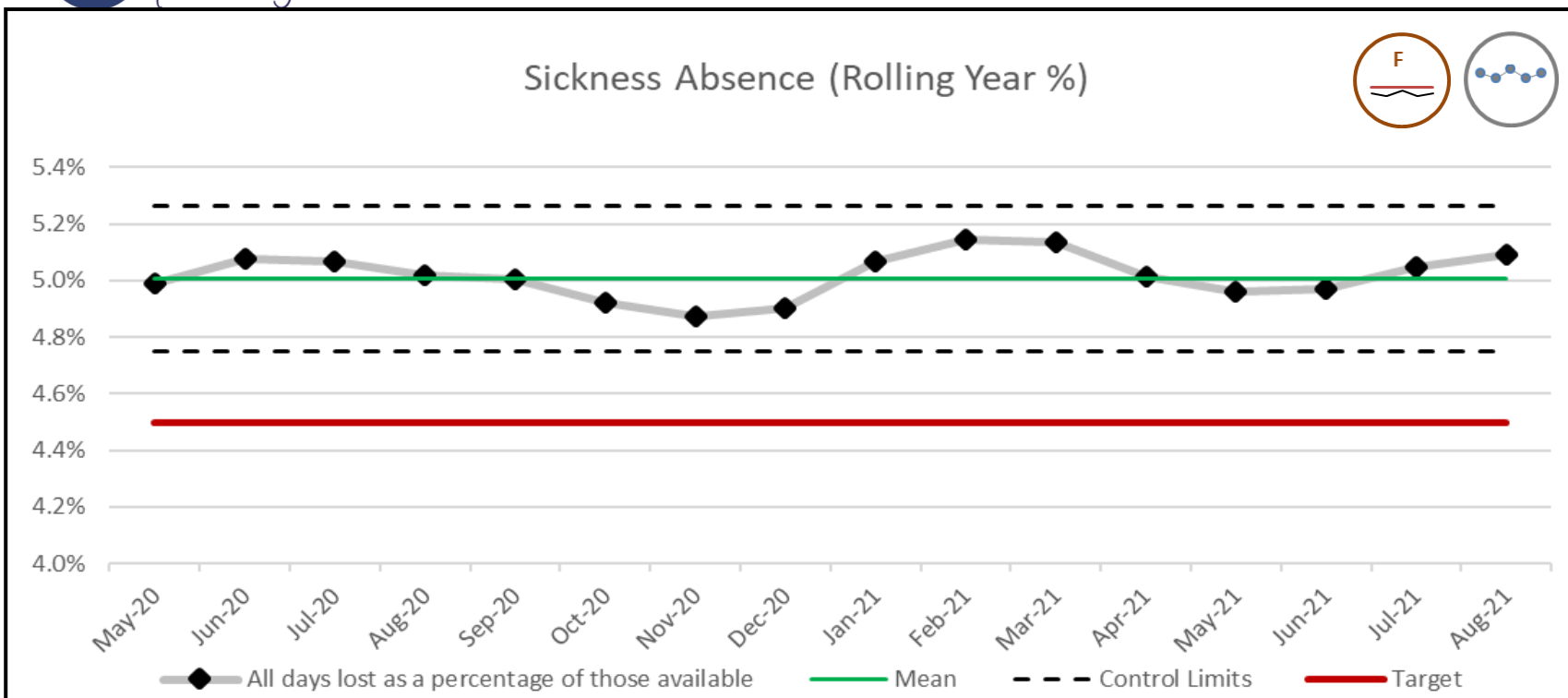

Aug-21
5.09%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
4.5%
Target Achievement
Metric is consistently failing to target
Executive Lead
Director of HR & OD

Background:
% of sickness absence rolling year.

What the chart tells us:
The chart shows us that sickness was reducing after Covid Wave 2. However, absence has continued to increase since June initially with increased COVID cases. Absence has continued to rise in August, which is expected due to AL and School holidays and the impact on career arrangements

Issues:
- Hospital pressures due to the significant rise in attendances into hospital impacting on staffing and in particularly employees wellbeing
- As Wave 3 COVID continues with an increase in numbers both in the hospitals and community
- Lifting of restrictions and school holidays

Actions:
- Continued review of absence data to ensure that it remains clean and updated,
- Wellbeing calls to staff to support timely referrals and support.
- Additional staff to continue to support absence management and support frontline managers
- Discussions with Occupational Health about the need for proactive support via OT and Physio to stop absence and staff

Mitigations:
- Reporting data is much cleaner and accurate due to additional support to divisions
- Sickness is static to where it was in Wave 2
- Corporate staff supporting redeployment to support the wards

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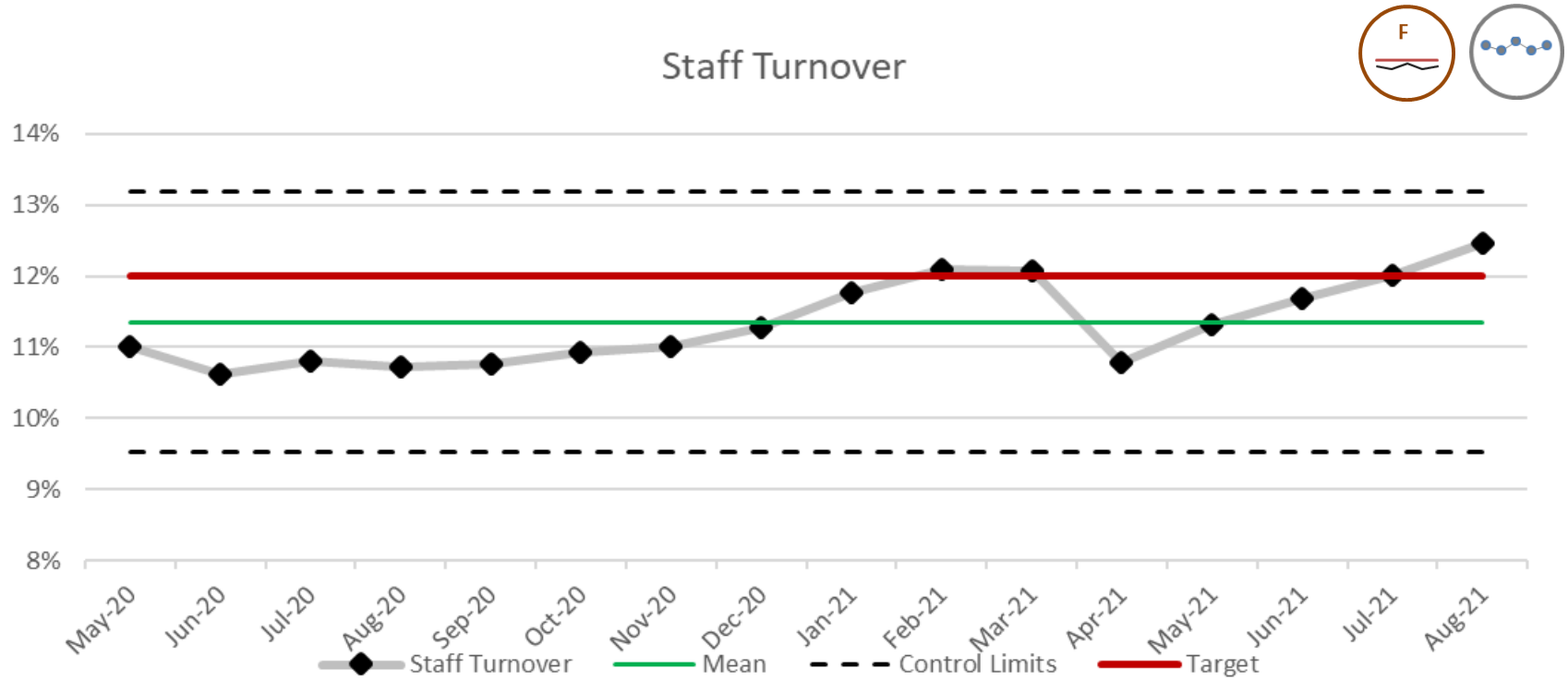

Aug-21
12.46%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
12%
Target Achievement
Metric is failing to target
Executive Lead
Director of HR & OD

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

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

Issues:

- An increasing % of nurses are at retirement age and will seek flexible work arrangements to come back on.
- Increased turnover from the HCSW recruitment drive done earlier in the year

Actions:

- Flexible working is now a contractual entitlement for staff. The flexible working policy will be published towards the beginning of October.
- The work being done through the Culture and Leadership Programme will directly impact turnover as a result of 'challenging behaviour'.

Mitigations:
See actions

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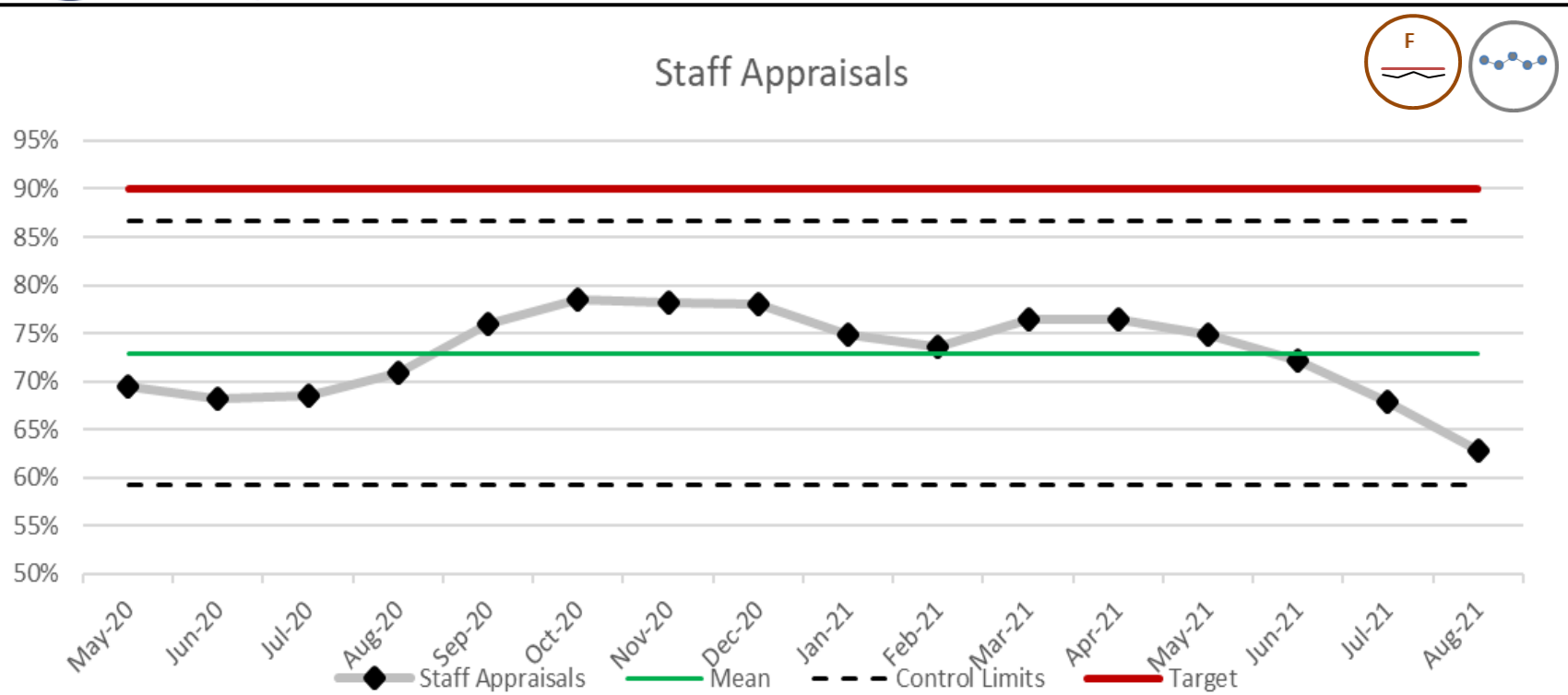

Aug-21
62.79%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
Metric is consistently failing to target
Executive Lead
Director of HR & OD

Background:
% completion is currently 62.79%.

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

Issues:
- Impact of Covid – Wave 3
- Appraisal completion not business as usual for managers.
- WorkPal system yet to be embedded – adoption rates have increased month on month
- Appraisal completion directly linked to pay progression. If appraisal is not completed, then the individual is not eligible to pay progression. Individual's manager is also not eligible.

Actions:
- Wave 3 and operational pressures has had an impact on appraisal completion
- Appraisal completion to be focussed through the divisions once we come out of Wave 3.
- The Divisions have included completion of appraisal in their IIP major projects.
- Link to Culture and Leadership Programme – appraisal to be the norm as part of the leader of staff

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

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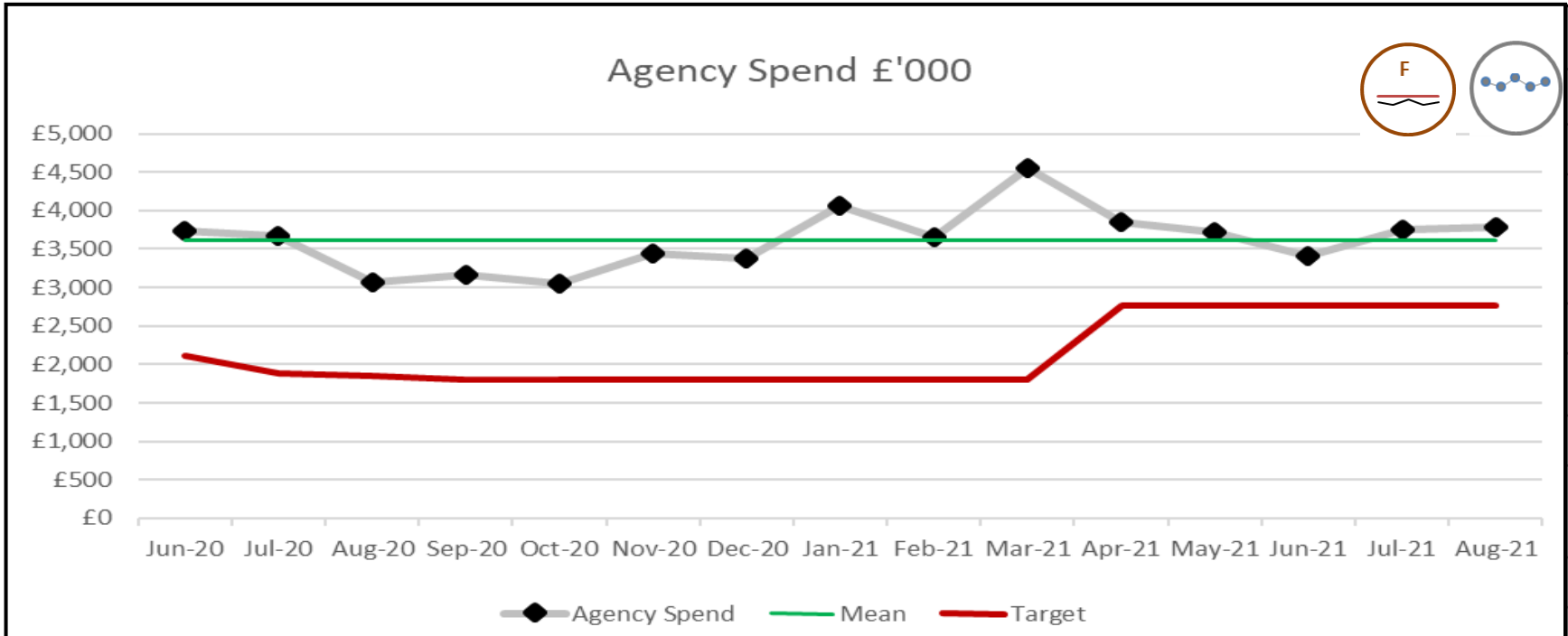

Aug-21
£3,787,000
Variance Type
Metric is currently experiencing Common Cause Variation
Target
£2,757,000
Target Achievement
Metric is consistently failing to target
Executive Lead
Director of HR & OD

Background:
Agency spend £'000

What the chart tells us:
Agency spend continues above target spend as it has done for the last 12 months.

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

Nursing
- Continued additional capacity created additional shifts.
- Opening of Grantham Hospital created additional demand.

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

Nursing
- Weekly monitoring of Agency use and spend
- Strengthened controls through 2x daily staffing meetings
- Ongoing recruitment
- All booking reasons scrutinised.

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

Nursing
- Nursing and therapy Workforce Transformation Group being set up, due to start in August.
- Refocused and continued efforts on achieving the ambition.

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

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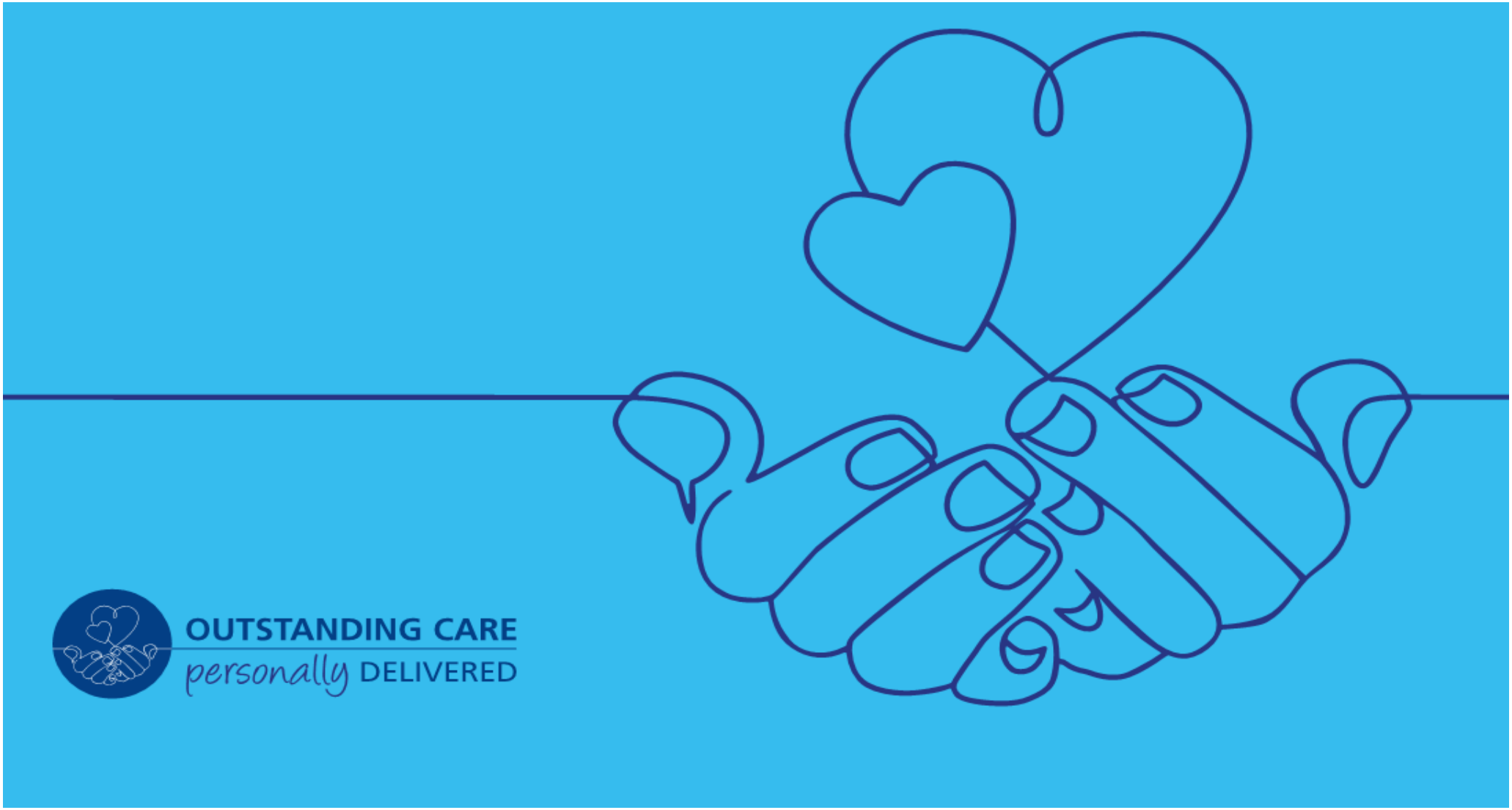
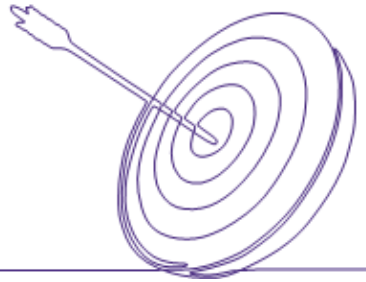


Quality | Operational Performance | Workforce | Finance

Finance Spotlight Report



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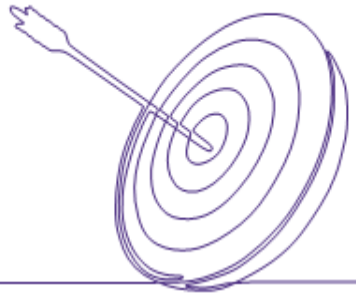
	Current Month			Year To Date			Forecast		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
Operating income from patient care activities	50,316	50,758	442	253,636	251,406	(2,230)	303,741	301,387	(2,354)
Other operating income	2,519	2,815	296	12,862	13,625	763	15,380	16,355	975
Employee expenses	(33,940)	(35,533)	(1,593)	(173,071)	(174,754)	(1,683)	(206,821)	(207,717)	(896)
Operating expenses excluding employee expenses	(17,285)	(16,495)	790	(89,906)	(87,098)	2,808	(106,730)	(105,147)	1,583
Net Finance Costs	(639)	(640)	(1)	(3,168)	(3,169)	(1)	(3,807)	(3,807)	(0)
Other gains/(losses) including disposal of assets	0	15	15	0	92	92	0	92	92
Surplus/(Deficit) For The Period/Year	970	920	(50)	353	102	(251)	1,764	1,163	(601)
Remove capital donations/grants I&E impact	6	57	51	30	282	252	36	37	1
Adjusted financial performance surplus/(deficit)	**976**	**977**	**1**	**383**	**384**	**1**	**1,800**	**1,200**	**(600)**

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

- The above table shows that in line with plan the Trust has delivered a £1.0m surplus for the month of August and a £0.4m surplus year to date, but forecasts a surplus of £1.2m or £0.6m adverse to plan.

- The adverse forecast variance is primarily due to operational pressures including increasing COVID and NEL patient numbers and severe substantive staff shortages, which in turn have led to pressure in pay and reduced capacity to deliver restore plans and attract the associated Elective Recovery Fund (ERF) income.

Finance Spotlight Report (Key areas of focus - Income)



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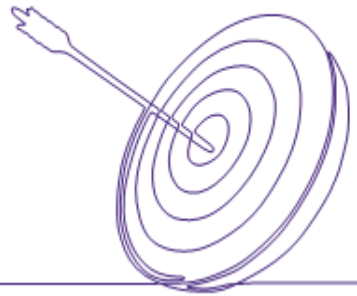
- The overall YTD income position is £1.5m adverse to plan, driven by lower than planned levels of ERF income:
  - The Patient Care income position includes an adverse movement to plan of £3.5m in relation to ERF income, and an accrual of £0.2m for ERF risk.
  - The Patient Care income position also includes favourable movements to plan of £1.1m in relation to pass through income, and £0.4m in relation to additional block funding allocations not known at the time of plan submission and over performance on other variable income streams such as CRU and Private Patients.
  - The Other Operating Income position includes a favourable movement to plan of £0.5m in relation to variable income streams such as non patient care recharges, car parking income and catering income.
  - Other Operating Income also includes additional top up funding of £0.3m favourable to plan in relation to the costs of the Covid vaccination programme, Covid testing and the SIREN study.
- To deliver the Trust financial plan for H1 ERF income of £4.2m was required, the Trust forecasts to achieve of £3.6m of ERF income a £0.6m shortfall.
- Shadow monitoring of activity on a Tariff basis determined that actual activity of £32.3m was delivered in the current month, such that actual activity delivered is £16.9m lower than the income the Trust received. However, the income is inclusive of COVID, Top Up, Restore and BAU allocations.

Finance Spotlight Report (Key areas of focus - Pay)



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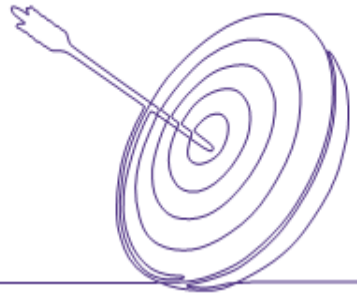
- The YTD Pay position is £1.7m adverse to plan having moved adversely to plan in-month by £1.7m; actual Pay expenditure in August was £0.8m higher than in July; the increase includes a planned £0.2m increase in relation to bank holiday enhancements, and unplanned costs of £0.3m in relation to incentive bank rates and an unplanned increase of £0.2m in other bank Pay.
- The YTD Pay position does not include any accrual for the A4C pay award; no accrual for the A4C pay award has been included on the advice of NHSE/I, and the cost of the A4C pay award will be offset by an additional income stream. This approach is consistent with STP partners and has been confirmed in writing by NHSE/I.
- The YTD Pay position includes an accrual of £60k per month as an estimate of the YTD impact of the Flowers Case, and also includes £0.2m in relation to the cost of the Covid Vaccination Programme.
- The August Pay position includes expenditure of £3.8m on Agency staff and £3.9m on bank staff, or £7.6m in total on temporary staffing; this represents an increase of £0.5m compared to July driven by an increase of £0.5m in expenditure on bank staff; the increase in bank expenditure in August includes an increase of £335k in expenditure on Nursing and Midwifery Bank staff following the introduction of incentive bank rates for this staff group in August.
- The IIP priorities included a 25% reduction in Agency expenditure compared to 2019/20, and current month and YTD expenditure are £1.0m and £4.7m adverse respectively if we assume the expenditure target is phased in equal twelfths during 2021/22.

Finance Spotlight Report (Key areas of focus - Other)



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- The YTD Non Pay position is £2.8m favourable to plan having moved favourably to plan in-month by £0.8m; actual Non Pay expenditure in August was £1.2m lower than in July; the reduction is driven by £0.5m reduction in expenditure on drugs and clinical supplies and services (reflecting lower activity volumes) and £0.4m release of technical savings within Premises.

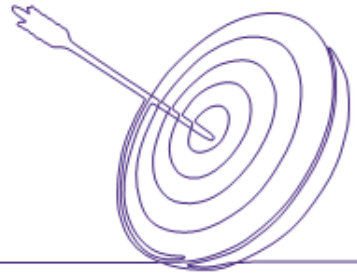
- CIP of £3.954m has been delivered YTD by 2021/22 savings schemes, which is £0.7m adverse to the plan to deliver CIP savings of £6.4m in H1; this comprises of CIP delivery £3.920m in relation to 2021/22 schemes and £34k in relation to approved 2021/22 Investment. Monitoring of the FYE of 2020/21 schemes has identified that savings of £1.934m have been delivered YTD, which is £25k adverse to plan. While delivery of CIP savings is overall, though, only £0.7m adverse to plan, the majority of savings delivery (£3.4m or 86.5%) is in relation to non recurrent savings rather than recurrent savings.

- Capital expenditure as at M5 of the financial year equated to c£5.7m against a submitted plan of c£11.8m

- The month end cash balance is £52.4m which is a reduction of £1.7m against cash at 31 March 2021.

- BPPC performance is 91% / 88% by value / volume of invoices paid for the five months to August. (The in month performance 95%/ 86% by value / volume). Work has been undertaken and options identified for consideration to further improve performance. Drugs invoices received and processed through Pharmacy would appear to be the area where most significant improvement could be made – taking August alone, circa 46.4% of invoices passed through pharmacy, with performance in this area averaging 85.9% for the year to date. Options will be pursued through the Divisional FRM.

Finance Spotlight Report (Forecast Update)



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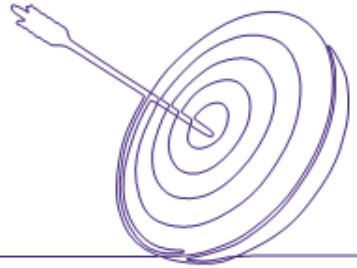
- The Trust submitted a revised H1 financial plan to deliver a £1.8m surplus.
- This was inclusive of a requirement to deliver a CIP of £6.4m, an ERF achievement of £4.2m, and investment plans in relation to COVID, Restore and Service Developments.
- The wave 3 COVID patient numbers alongside increased volume and acuity of NEL patients and substantive staffing pressures is resulting in;
  - ❖ The use of high cost drugs, agency staff and bank staff; these costs are forecast to continue in H1 to meet patient care demand.
  - ❖ Reduced capacity and focus to deliver Divisional CIP requiring the release of technical non-recurrent CIP to deliver the CIP target.
  - ❖ Reduced capacity to deliver the service restoration plans to meet planned care activity trajectories and access the planned levels of ERF.
- The delivery of the ERF target has also been impacted due to the threshold increase from 85% to 95% from 1st July. Combined with the operational pressures, this has resulted in a reduced ERF forecast of £3.6m, or £0.6m lower than the £4.2m achievement required to meet the Trust's planned surplus of £1.8m.
- **In summary, the above deteriorations and improvements have resulted in a revision to the financial forecast to a £1.2m surplus, or £0.6m adverse to the £1.8m H1 plan.**

Finance Dashboard



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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;

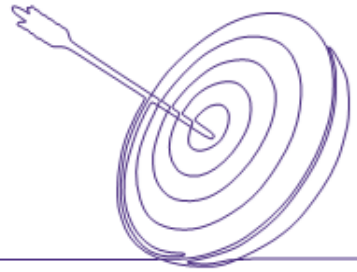
Clinical Services
People
Clinical Support Services
Corporate Services, Procurement, Estates and Facilities
Finance

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	Forecast
	31/03/2019	31/03/2020	31/03/2021	YTD AUG 2021	31/03/2022
Capital service cover metric	(10.40)	(1.73)	0.06	2.97	3.12
Capital service cover rating	4	4	4	1	1
Liquidity metric	(98.73)	(128.28)	3.71	3.69	2.43
Liquidity rating	4	4	1	1	1
I&E margin metric	(19.71%)	(7.62%)	0.38%	0.14%	0.24%
I&E margin rating	4	4	2	2	2
Agency metric	77.00%	110.00%	113.00%	112.00%	112.00%
Agency rating	4	4	4	4	4
I&E margin: distance from financial plan - metric	(2.80%)	0.70%	n/a	0.60%	(0.05%)
I&E margin: distance from financial plan - rating	4	1	n/a	1	2

Balance Sheet



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	31 March 2021	31 August 2021	
		Plan	Actual
	£000	£000	£000
Intangible assets	4,600	3,842	3,815
Property, plant and equipment	247,119	253,403	247,359
Receivables	2,790	2,781	2,778
Total non-current assets	**254,509**	**260,026**	**253,952**
Inventories	6,510	6,728	6,802
Receivables	25,935	15,625	21,330
Cash and cash equivalents	54,042	47,699	52,391
Total current assets	**86,487**	**70,052**	**80,523**
Trade and other payables	(69,643)	(58,723)	(60,804)
Borrowings	(402)	(555)	(555)
Provisions	(2,056)	(2,178)	(2,213)
Other liabilities	(1,587)	(2,943)	(3,983)
Total current liabilities	**(73,688)**	**(64,399)**	**(67,555)**
Total assets less current liabilities	**267,308**	**265,679**	**266,920**
Borrowings	(3,624)	(3,471)	(3,471)
Provisions	(4,069)	(4,040)	(3,941)
Other liabilities	(12,075)	(11,865)	(11,866)
Total non-current liabilities	**(19,768)**	**(19,376)**	**(19,278)**
Total assets employed	**247,540**	**246,303**	**247,642**
Financed by			
Public dividend capital	677,570	677,570	677,570
Revaluation reserve	27,522	27,232	27,289
Other reserves	190	190	190
Income and expenditure reserve	(457,742)	(458,689)	(457,407)
Total taxpayers' equity	**247,540**	**246,303**	**247,642**

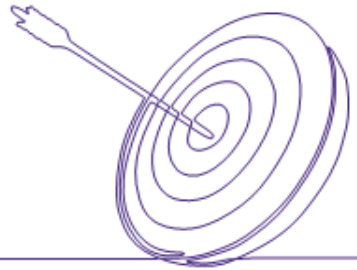
Note 1: The revised H1 financial plan submitted in May did not include a full monthly balance sheet and cashflow. The plan presented here, whilst not submitted, underpinned the actual submission.

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

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

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 (£1.4m).
Capital creditors have dropped from March and are now at £3.6m.
BPPC for August was 95% / 86% as measured by value / volume of invoices paid.

Cashflow reconciliation– April - Sept 2021 (H1)



United Lincolnshire Hospitals NHS Trust

	Full Year 2020/21	31 August 2021	
		Plan	Actual
	£000	£000	£000
Operating surplus / (deficit)	8,778	1,940	3,179
Depreciation and amortisation	13,674	6,493	6,244
Impairments and reversals	3,121	-	-
Income recognised in respect of capital donations	(3,923)	(250)	-
Amortisation of PFI deferred credit	(503)	(210)	(209)
(Increase) / decrease in receivables and other assets	16,119	10,319	4,617
(Increase) / decrease in inventories	527	(218)	(292)
Increase/(decrease) in trade and other payables	16,987	(5,255)	(2,630)
Increase/(decrease) in other liabilities	(2,085)	1,356	2,396
Increase / (decrease) in provisions	1,556	122	57
Net cash flows from / (used in) operating activities	**54,251**	**14,297**	**13,362**
Interest received	12	-	-
Purchase of intangible assets	(1,245)	-	-
Purchase of property, plant and equipment	(39,483)	(20,640)	(15,106)
Proceeds from sales of property, plant and equipment	625	-	94
Net cash flows from / (used in) investing activities	(40,091)	(20,640)	(15,012)
Public dividend capital received	409,664	-	-
Loans from Department of Health and Social Care - re	(377,859)	-	-
Other loans received	2,544	-	-
Interest paid	(2,522)	-	(1)
PDC dividend (paid)/refunded	(5,662)	-	-
Net cash flows from / (used in) financing activities	26,165	-	(1)
Increase / (decrease) in cash and cash equivalents	**40,325**	**(6,343)**	**(1,651)**
Cash and cash equivalents at 1 April - brought forward	13,717	54,042	54,042
Cash and cash equivalents at period end	**54,042**	**47,699**	**52,391**

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

Note 2: The cash position is broadly as expected at £52.4m against plan £47.7m.

Note 3: The principle reason for the variance is a shortfall of £5m against planned capital payments. This is linked to delays in the capital programme.

Meeting	*Trust Board*
Date of Meeting	*5th October 2021*
Item Number	*Item number allocated by admin*
Strategic Risk Report	
Accountable Director	*Dr Karen Dunderdale, Director of Nursing*
Presented by	*Dr Karen Dunderdale, Director of Nursing*
Author(s)	*Matt Hulley, Risk & Incident Manager*
Report previously considered at	*N/A*

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

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

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

Executive Summary

- This Strategic Risk Report focuses on the highest priority risks currently being managed within the Trust.
- Key risk indicators for all Very high risks (those rated 20-25) have been updated with available data, as evidence of the current extent of risk exposure
- The effect of the 'Delta Variant' on ULH services requires careful monitoring
- Of note 55% of all strategic risks are now overdue their review date which is an improvement on last month's figure of 87%. This will continue to be addressed as part of the ongoing roll out and review of the Risk Register reconfiguration.
- In addition to the scheduled review, risks are also discussed at the Gold meetings and relevant cells daily during this period of increased pressure.

Purpose

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

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

1. Introduction

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

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

1.2 This report is focussed on those strategic risks with a current rating of very high risk (a score of 20-25). A summary of the full strategic risk register is also provided for reference. Of note 55% of all strategic risks are now overdue their review date, an improvement on last month's report (last month's figure was 87%). This will continue to be addressed as part of the ongoing roll out and review of the Risk Register reconfiguration.

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

2. Strategic Risk Profile

2.1 There 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):

- Total number of Covid-19 inpatient admissions – as of 27 September there had been 3,517 Covid-19 inpatient cases within ULHT; this is an increase of 379 since 23 July, indicating an increase in inpatient admission rates
- Number of current inpatient admissions due to Covid-19 – 19 at Lincoln and 18 at Pilgrim as of 27 September; previous figures were 16 at Lincoln and 7 at Pilgrim as of 23 July 2021.
- Patient deaths due to Covid-19 – total of 892 as of 27 September, compared with 841 as of 23 July 2021.
- Serious Incidents where the pandemic response is a contributory factor – to the end of June 2021 there were 30 completed SI investigations that cited the pandemic response; an average of 3.5 incidents per month between March and July 2020; an average of 1 per month between August and December 2020 with a declining average of 0.5 incidents per month within 2021. No further SIs relating to Covid have been declared since April 2021

Gaps in control & mitigating actions:

- England Covid alert level is at Level 3 (epidemic is in general circulation)
- Cases of the Delta 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 are used for site access; PPE use; social distancing; patient admissions & discharges; staff rapid testing; use of essential equipment & oxygen
- Essential information to all staff is now being provided to staff through the weekly ULHT Bulletin which has replaced the SBAR

2.2 There is 1 strategic finance, performance or estates risk with a current rating of Very high risk. This risk was also considered at the Quality Governance Committee due to the impact on patient safety as a result of capacity issues.

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

Key Risk Indicators (KRIs):

KPI	In Month Target (%)	June (%)	July (%)	August (%)	YTD (%)	Last month Pass/Fail	Trend Variation
A&E waiting times	83.12	70.74%	64.93%	66.96%	69.88%		
Ambulance Conveyances Delayed >59 minutes	0	349	568	629	408		

- A&E waiting times against the constitutional standard – 4-hour performance for August was 66.96%, an increase in comparison to July's 64.93%, but still below the target of 83.12%.
- Ambulance conveyances for August was 629, an increase in comparison to July's 568 and still a lot higher than the target of 0 per month. Delays experienced at LCH and PHB are attributed to volume and conveyance pattern.

Gaps in control & mitigating actions:

- The trust has met with NHSEi regional executive team to review gaps and mitigations on two occasions the latest 19th July 2021.
- It is recognised that across the region the combination of pressure to recover backlogs, increased urgent care admissions above expected levels, increased Covid presentations (although below Wave 1 and 2) coupled with workforce availability issues have created a particularly challenging environment for acute trusts to operate safely in.
- Improvement measures and the U&EC improvement plan whilst will help alleviate some pressures currently do not fully address the combined issues of demand vs capacity and workforce availability.
- In Wave 1 and Wave 2 of the Covid-19 response the Trust identified a Risk Score of 25 for Covid-19 pandemic impact. Although many of the elements of this risk are the same as those described in the Covid-19 score 25 risk, this risk Capacity to manage emergency demand (4175) more accurately describes the main risk the Trust is experiencing.
- Specific concerns relate to ambulance handover delays, increased non-elective admissions, stranded and super-stranded patients

- Lincoln site reconfiguration plans & business case for investment on Pilgrim site (with government funding)
- The U&EC improvement programme has undertaken an internal review of process, key stakeholders and original milestones where off track clear rectification plans are now in place
- Partnership working within the system will support a more proactive response and delivery to system need. U&EC Partnership Board currently leads the system response to the risk described.
- Harm reviews are being carried out for all patients affected by waiting more than 12 hours in A&E following a decision to admit and ambulance handover delays of more than 2 hours

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

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

KPI	In Month Target (%)	May 21 (%)	Jun 21 (%)	Jul 21 (%)	YTD (%)	Last month Pass/Fail	Trend Variation
Staff Appraisal Rates	90	74.92	72.19	67.95	72.87		

Key Risk Indicators (KRIs):

- Staff appraisal rates were 67.95% in July, below the target of 90%.
- People Pulse survey results – almost 900 staff completed the first survey (in July 2020), a response rate of around 12%; 85% of staff felt informed (+0.6 vs NHS overall); 63% felt confident in local leaders (equal to NHS overall); 61% felt supported (-5.7 vs NHS overall); 59% felt they had a good work-life balance (-2.5 vs NHS overall).
- NHS National Staff Survey (NSS) results – some improvement in results of 2019 staff survey across two thirds of the questions, still below average for acute trusts; less than 50% of staff would recommend ULHT as a place to work; the Trust's score for the bullying & harassment theme in the NSS stayed relatively unchanged in 2019 at 7.6 against a national average of 7.9.

Gaps in control and mitigating actions:

- Work on morale is part of the Integrated Improvement Plan and a number of work-streams within it, including introduction of an individual performance management/appraisal e-learning programme from November & implementation of new WorkPal online appraisal system, which has been deferred to the New Year.

- New approaches to interacting with staff during Covid response; feedback has been positive and was reflected in results from the NHS Pulse Survey.

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

3. Conclusions & recommendations

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

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

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

ID	Title	Clinical Business Unit	Risk Type	Rating (current)	Risk level (current)	Review date
4175	Capacity to manage emergency demand	Urgent & Emergency Care CBU	Service disruption	25	Very high risk	13/09/2021
4558	Local impact of the global coronavirus (Covid-19) pandemic	Operations	Harm (physical or psychological)	25	Very high risk	31/12/2021
4083	Workforce engagement, morale & productivity	Human Resources & Organisation Development	Reputation / compliance	20	Very high risk	30/06/2021
4403	Compliance with electrical safety regulations & standards	Estates & Facilities	Reputation / compliance	16	High risk	31/03/2021
4404	Major fire safety incident	Estates & Facilities	Harm (physical or psychological)	16	High risk	30/09/2021
4480	Safe management of emergency demand	Urgent & Emergency Care CBU	Harm (physical or psychological)	16	High risk	31/12/2020
4383	Substantial unplanned expenditure or financial penalties	Finance & Digital	Finance	16	High risk	31/12/2021
4300	Availability of medical devices & equipment	Medical Directorate	Medical equipment	16	High risk	31/12/2021
4156	Safe management of medicines	Pharmacy CBU	Harm (physical or psychological)	16	High risk	30/09/2021
4144	Uncontrolled outbreak of serious infectious disease	Nursing Directorate	Patient safety (physical or psychological harm)	16	High risk	31/12/2021
4142	Delivery of harm free nursing care	Nursing Directorate	Patient safety (physical or psychological harm)	16	High risk	31/12/2021
4044	Compliance with information governance regulations & standards	Corporate Services	Reputation / compliance	16	High risk	30/06/2021
3690	Compliance with water safety regulations & standards	Estates & Facilities	Reputation / compliance	16	High risk	31/03/2021
3720	Critical failure of the electrical infrastructure	Estates & Facilities	Service disruption	16	High risk	31/03/2021
3688	Quality of the hospital environment	Estates & Facilities	Reputation / compliance	16	High risk	31/03/2021
4003	Major security incident	Estates & Facilities	Harm (physical or psychological)	16	High risk	31/03/2022
4556	Safe management of demand for outpatient appointments	Outpatients CBU	Harm (physical or psychological)	12	High risk	30/09/2021

ID	Title	Clinical Business Unit	Risk Type	Rating (current)	Risk level (current)	Review date
4581	Heating (Trust Wide)	Estates & Facilities	Harm (physical or psychological)	12	High risk	31/03/2021
3520	Compliance with fire safety regulations & standards	Estates & Facilities	Reputation / compliance	12	High risk	30/09/2021
4081	Quality of patient experience	Nursing Directorate	Patient experience	12	High risk	31/12/2021
4082	Workforce planning process	Human Resources & Organisation Development	Service disruption	12	High risk	31/03/2021
3689	Compliance with asbestos management regulations & standards	Estates & Facilities	Reputation / compliance	12	High risk	31/03/2021
4043	Compliance with clinical governance regulations & standards	Nursing Directorate	Regulatory compliance & standards (including performance targets)	12	High risk	31/12/2021
4145	Compliance with safeguarding regulations & standards	Nursing Directorate	Regulatory compliance & standards (including performance targets)	12	High risk	31/03/2021
4146	Effectiveness of safeguarding practice	Nursing Directorate	Patient safety (physical or psychological harm)	12	High risk	31/03/2021
4157	Compliance with medicines management regulations & standards	Pharmacy CBU	Reputation / compliance	12	High risk	30/06/2021
4181	Significant breach of confidentiality	Corporate Services	Reputation / compliance	12	High risk	31/12/2020
4179	Major cyber security attack	Finance & Digital	Information Governance: Data confidentiality & integrity	12	High risk	31/12/2021
4176	Management of demand for planned care		Service disruption	12	High risk	31/12/2020
4362	Workforce capacity & capability (recruitment, retention & skills)	Human Resources & Organisation Development	Service disruption	12	High risk	30/06/2021
4481	Availability & integrity of patient information	Finance & Digital	Service disruption	12	High risk	31/01/2022
4401	Safety of the hospital environment	Estates & Facilities	Harm (physical or psychological)	12	High risk	31/03/2021
4402	Compliance with regulations and standards for mechanical infrastructure	Estates & Facilities	Reputation / compliance	12	High risk	31/03/2021

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

ID	Title	Clinical Business Unit	Risk Type	Rating (current)	Risk level (current)	Review date
4368	Efficient and effective management of demand for outpatient appointments	Outpatients CBU	Reputation / compliance	8	Moderate risk	30/09/2021
4382	Delivery of the Financial Recovery Programme	Finance & Digital	Finance	8	Moderate risk	31/12/2020
4182	Compliance with ICT regulations & standards	Finance & Digital	Reputation / compliance	8	Moderate risk	20/12/2021
4177	Critical ICT infrastructure failure	Finance & Digital	Service disruption	8	Moderate risk	31/12/2021
4180	Reduction in data quality	Finance & Digital	Reputation / compliance	8	Moderate risk	31/12/2020
4138	Patient mortality rates	Medical Directorate	Reputation / compliance	8	Moderate risk	31/12/2021
4141	Compliance with infection prevention & control regulations & standards	Nursing Directorate	Regulatory compliance & standards (including performance targets)	8	Moderate risk	31/12/2021
4143	Nursing profession staffing levels	Nursing Directorate	Workforce (including capacity & capability, engagement & morale, health & well-being etc.)	8	Moderate risk	31/12/2021
3503	Sustainable paediatric services at Pilgrim Hospital, Boston	Children & Young Persons CBU	Patient safety (physical or psychological harm)	8	Moderate risk	01/09/2021
3687	Implementation of an Estates Strategy aligned to clinical services	Estates & Facilities	Service disruption	8	Moderate risk	31/03/2021
3721	Critical failure of the mechanical infrastructure	Estates & Facilities	Service disruption	8	Moderate risk	31/03/2021
3722	Energy performance and sustainability	Estates & Facilities	Finance	8	Moderate risk	31/03/2021
3951	Compliance with regulations & standards for aseptic pharmacy services	Pharmacy CBU	Reputation / compliance	8	Moderate risk	30/09/2021
4579	Delivery of the new Medical Education Centre	Improvement & Integration Directorate	Reputation / compliance	8	Moderate risk	31/12/2020
4502	Compliance with regulations & standards for medical device management	Medical Directorate	Regulatory compliance & standards (including performance targets)	8	Moderate risk	31/12/2021
4526	Internal corporate communications	Chief Executive	Reputation / compliance	8	Moderate risk	31/12/2020
4528	Minor fire safety incident	Estates & Facilities	Harm (physical or psychological)	8	Moderate risk	30/09/2021

ID	Title	Clinical Business Unit	Risk Type	Rating (current)	Risk level (current)	Review date
4553	Failure to appropriately manage land and property	Estates & Facilities	Finance	8	Moderate risk	31/03/2021
4486	Clinical outcomes for patients	Medical Directorate	Harm (physical or psychological)	8	Moderate risk	31/12/2021
4400	Safety of working practices	Estates & Facilities	Harm (physical or psychological)	6	Low risk	30/09/2021
4061	Financial loss due to fraud	Finance & Digital	Finance	4	Low risk	31/12/2021
4277	Adverse media or social media coverage	Chief Executive	Reputation / compliance	4	Low risk	31/12/2020
4385	Compliance with financial regulations, standards & contractual obligations	Finance & Digital	Reputation / compliance	4	Low risk	31/12/2021
4386	Critical failure of a contracted service	Finance & Digital	Service disruption	4	Low risk	31/12/2020
4387	Critical supply chain failure	Finance & Digital	Service disruption	4	Low risk	31/12/2020
4388	Compliance with procurement regulations & standards	Finance & Digital	Reputation / compliance	4	Low risk	31/12/2020
4438	Severe weather or climatic event	Corporate Services	Service disruption	4	Low risk	31/12/2020
4439	Industrial action	Corporate Services	Service disruption	4	Low risk	31/12/2020
4440	Compliance with emergency planning regulations & standards	Corporate Services	Reputation / compliance	4	Low risk	31/12/2020
4467	Impact of a 'no deal' EU exit scenario	Corporate Services	Service disruption	4	Low risk	01/10/2021
4469	Compliance with blood safety & quality regulations & standards	Medical Directorate	Regulatory compliance & standards (including performance targets)	4	Low risk	31/12/2021
4482	Safe use of blood and blood products	Medical Directorate	Patient safety (physical or psychological harm)	4	Low risk	31/12/2021
4483	Safe use of radiation (Trust-wide)	Diagnostics CBU	Harm (physical or psychological)	4	Low risk	30/09/2022
4514	Hospital @ Night management	Operations	Service disruption	4	Low risk	31/12/2020
4567	Working Safely during the COVID - 19 pandemic (HM Government Guidance)	Estates & Facilities	Reputation / compliance	4	Low risk	30/06/2021

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*5 October 2021*
Item Number	*Item*
Board Assurance Framework (BAF) 2021/22	
Accountable Director	*Andrew Morgan Chief Executive*
Presented by	*Jayne Warner, Trust Secretary*
Author(s)	*Karen Willey, Deputy Trust Secretary*
Report previously considered at	*N/A*

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

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

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

Executive Summary

The relevant objectives of the 2021/22 BAF were presented to the Quality Governance Committee and Finance, Performance and Estates Committee during September. The Board are asked to note the updates provided within the BAF.

Assurance ratings have been provided for all objectives and have been confirmed by the Committees. There have been no changes to assurance ratings in this month.

The Board are asked to note that the People and Organisational Development Committee did not meet during September whilst the transition to the new Committee Chair is underway and as such objectives 2a and 2b have not been reviewed by the Committee.

The following assurance ratings have been identified:

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

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

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

Ref	Objective	Exec Lead	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Control Gaps	How identified control gaps are being managed	Source of assurance	Assurance Gaps - where are we not getting effective evidence	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating
SO1	**To deliver high quality, safe and responsive patient services, shaped by best practice and our communities**												
						Developing a Safety Culture - Group, lead & plan in place to support the delivery of an improved patient safety culture (PSG)	Human Factors training delayed due to Covid-19 Definition of Safety Culture Ambition Operational pressures have meant that meetings have not taken place.	External Safety Culture company engaged to deliver focus groups at all levels through the organisation and support development of safety culture ambition Project lead continues to review project and complete highlight reports as appropriate.	Safety Culture Surveys Action plans from focus groups and Pascal survey findings Update reports to the Patient Safety Group and upwardly reported to QGC				
						Robust Quality Governance Committee, which is a sub-group of the Trust Board, in operation with appropriate reporting from sub-groups. (CG)	Operational pressures have meant that QGC meeting has been reduced.	All papers have been considered and discussed by exception. Assurances provided to QGC include feedback from gold and relevant cells as outlined below.	Upward reports from QGC sub-groups 6 month review of sub-group function				
						Effective sub-group strucutre and reporting to QGC in place	Due to operational pressures, not all sub-groups have met and others have had a reduced agenda.	All papers have either been discussed by exception or a chair/vice chaire upward report completed following review of the papers.	Sub-Group upward reports to QGC				
						IPC policies and procedures are in place in line with the requirements of The Health and Social Care Act (2008). Code of Practice on the prevention and control of infections and related guidance "Hygiene Code" (IPCG)	Policies not in line with the requirements of the Hygiene Code and some have not been reviewed and updated.	Planned programme of IPC policy development and update in line with Hygiene Code requirements.	IPC programmes of surveillance and audit are in place to monitor policy requirements. Divisional audit processes with progress and exception reporting to IPCG, IPC Site meetings and IPC related Divisional forums. Associated action and development plan documentation. Very good progress with monthly IPC ratification. Work on decontamimnation-related policies. This will lead to compliance of policy aspects of the Hygiene Code	Some aspects of reporting require further development.	Reporting to and monitoring by IPCG and other related forums, e.g. Site meetings.		

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

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

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						Robust process in place to monitor delivery against the CQC Must Do and Should Do actions and regulatory notices (Delivering on all CQC Must Do actions and regulatory notices) (CG)	Remaining Confirm and Challenge session postponed due to Covid-19	Confirm and challenge session to be reinstated from end of September.	Monthly report to QGC and Trust Board on Must and Should dos				
1b	Improve patient experience	Director of Nursing	Failure to provide a caring, compassionate service to patients and their families Failure to provide a suitable quality of hospital environment	3688 4081	CQC Caring	Patient Experience Group, which is a sub-group of the Quality Governance Committee, in place meeting monthly Robust Complaints and PALS process in place (PEG)	Patient Experience Group reinstated in its new format and ToR, the group needs to develop its maturity Meeting stood down due to operational pressures.	The group meets monthly, has developed a work reporting plan Papers reviewed and Chair's report provided. Any risks to quality and safety are discussed at the relevant cell meeting, eg, quality cell and issues escalated to gold as appropriate. Quality Impact Assessments undertaken as part of the response to operational pressures are discussed at the quality cell.	Upward reports to QGC monthly and responds to feedback Review of ToR in July 2021 Quarterly Complaints reports identifying themes and trends presented at the Patient Experience Group Patient Experience Group upward report	Divisional assurance reports to PEG providing limited assurance; further work needed to improve this. Will be monitored through PEG.	Head of Pt Experience revising divisional assurance report template and have discussions with divisional clinical leads re: requirements for the reports.	Quality Governance Committee	R
						Patient Experience & Carer plan 2019-2023	Number of objectives in the plan paused due to Covid Pandemic; this means the plan need a full review.	Objectives being reviewed with updated timeframes going forward for inclusion in the IIP and other improvement plans at Directorate level. Patient & Carers Experience Plan to be reviewed by end Sept 21 and present to Oct PEG	Patient Experience & Carer Plan progress report to Patient Experience Group and IIP Support and Challenge meetings with monthly highlight reports.	Limited assurance until the plan is reviewed.			
						Quality Accreditation and assurance programme which includes section on patient experience.	Lack of alignment of findings in accreditation data to patient experience plans. Accreditation visits paused due to operational pressures.	Head of pt experience to have access to accreditation data. Deep dives into areas of concern as identified in quality meetings and accreditation reports. Update reports to PEG and QGC as required. Matrons audits continue to take place. Any risks to quality and safety identified are discussed at the quality cell and issues escalated to gold as appropriate.	Reports to PEG and upwardly to QGC	Visits are cancelled when the organisation is in surge leading to delays in reporting.	Scheduled visits for the year. Pt Experience team to have sight of hotspots / concerns and can inreach to provide support.		
						Redesign our communication and engagement approaches to broaden and maximise involvement with patients and carers (PEG)	Reaching out project (Hard to Reach groups) still in development; diversity of current patient representatives and panel members is narrow; 15 new panel members recruited; contact still to be made with some community groups. Experts by Experience group slow to gain traction and engagement.	Patient Panel has agenda and representatives that attend Patient Experience group to feedback and ensure continuity of messaging Sensory Loss group upwardly reports to Patient Panel.	Upward reports and minutes to the Patient Experience Group IIP reporting to Support & Challenge group.	Diversity of patient engagement and involvement.	CCG colleagues exploring development of a Health Inequalities cell to combine efforts in reaching out. Experts by Experience to be championed by Cancer Board. Breast Mastalgia expert patient group to be developed for pathway design.		

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
						Care after death / last offices Procedure & Guidelines Sharing information with relatives Visiting Procedure Patient information	Inconsistency in applying end of life visiting exceptions.	Swan resource boxes distributed to all areas Wedding boxes created for a number of key wards and within Chaplaincy services. Exceptions guidance re-issued. Monitor through complaints & PALs.	Report to PEG through cmplaints & PALs reports; upward reports from Visiting Review working group.	Visiting experience section within complaints & PALs reports.	Complaints/PALs reports to include visiting concerns; divisional assurance reports to include visiting related issues.		
						Inclusion Strategy in place (PEG)	Lack of diversity in patient feedback and engagement	Equality, Diversity and Inclusion Lead is member of Patient Experience Group.	EDI 1/4rly report to PEG;	EDI Reports not being received by PEG	Head of Pt Experience to discuss with EDI lead to agree a way forward.		
						Robust process in place for annual PLACE inspection accompanied by PLACE LITE (PEG)	PLACE Lite Process needs to be embedded as Business as Usual	PLACE Lite visits are being scheduled for the year across the organisation.	PLACE report to go to Patient Experience Group quarterly and upwardly reported to QGC	National PLACE programme currently paused due to pandemic;	PLACE Lite continues & reports to PEG.		
1c	Improve clinical outcomes	Medical Director	Failure to provide effective and timely diagnosis and treatment that deliver positive patient outcomes	4558	CQC Responsive CQC Effective	Getting it Right First Time Programme in place with upward reports to CEG and QGC (CEG)	Due to Covid there is a delay in implementing GIRFT recommendations although some visits have started to take place again.	Quarterly reports to Clinical Effectiveness Group GIRFT project Manager in post	Upward reports to QGC and its sub-groups KPIs in the integrated governance report	Divisions not having oversight of their workstreams	Workstreams to be presented at PRMs	Quality Governance Committee	R
						Clinical Effectiveness Group as a sub group of QGC and meets monthly (CEG)	Some issues with quaoracy due to operational pressures however attendance has improved Prevous two meetings cancelled due to operational pressures.	September papers reviewed and upward report produced for QGC by the chair/vice chair. Any risks to quality and safety are discussed at the relevant cell meeting, eg, quality cell and issues escalated to gold as appropriate. Quality Impact Assessments	Effective upward reporting to QGC				
						Clinical Audit Group in place and meets monthly (CEG) with quarterly reports to QGC	There are outstanding actions from local audits Due to operational pressures, quoracy has been an issue.	Audit Leads present compliance with their local audit plan and actions. Support being provided from central team to close outstanding overdue actions	Reports generated for Clinical Audit group and CEG detailing status of local audits and number of open actions	Clinical Audit Leads may not attend to present their updates	Rolling attendance in progress and names of Clinical Audit Leads not attending will be escalated to the Triumvirate		
						National and Local Audit programme in place and agreed (CEG) - signed off by QGC	Audit findings do not always demonstrate the necessary improvements	Increased focus on reporting outcomes from audit Revision of Clinical Audit Policy to strengthen	Reports from the National Audit Programmes including outlier status where identified as such Relevant internal audit reports				

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
						Process for monitoring the implementation of NICE guidance and national publications in place (CEG) and upwardly reported through QGC	Guidance relating to completion of baseline asssessment not always followed although due to some changes to how the processes are monitored, compliance has improved.	Increased resources to help clear backlog of NICE guidelines and technical appraisal assessments	Reports on compliance with NICE / Tas				
						Process in place for taking part in the Patient Related Outcome Measures (PROMs) project (CEG)			Quarterly reports to CEG and upwardly reported to QGC	Business Units not sighted on their performance due to no reporting during COVID-19	National reports to be presented at Governance Meetings once produced		
						Quarterly Learning Lessons Newsletter in place at both Division and Trust wide level (CEG)	Staff may not access emails to review newsletters						
SO2	**To enable our people to lead, work differently and to feel valued, motivated and proud to work at ULHT**												
2a	A modern and progressive workforce	Director of People and Organisational Development	Vacancy rates rises Turnover increases Sickness absence rises Under-investment in education & learning Failure to engage organisation in continuous improvement Failure to transform the medical & nursing workforce	4362	CQC Safe CQC Responsive CQC Effective	NHS people plan & system people plan & four themes:- - Looking after our people - Belonging in the NHS - New ways of working & delivering care - Growing for the future	Awaiting sign off of system people plan		Reported progress on the implementation of the NHS People Plan and the Lincolnshire System Workforce Plan NB New indicators being developed for the 21/22 financial year			People and Organisational Development Committee	**A**
						Workforce planning and workforce plans	Overall vacancy rate declining but increasing for clinical roles.	IIP Project - Embed robust workforce planning and development of new roles					
						Recruitment to agreed roles - plan for every post		Pipeline report shows future vacancy position International nurse recruitment & cohort recruitment	Internal Audit - Recruitment follow up				
						Focus on retention of staff - creating positive working environments		IIP Projects - appraisal, mandatory training, talent management	Modern Employer targets Rates of appraisal/mandatory training compliance				
						Embed continuous improvement methodology across the Trust		Training in continuous improvement for staff	Staff survey feedback				
						Reducing sickness absence	Sickness absence rate higher than average	Embedding of AMS	Sickness/absence data Turnover rates Vacancy rates				

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						Ensuring access to the personal and professional development that enables people to deliver outstanding care and ensures ULHT becomes known as a learning organisation	IIP projects in early stage of delivery	IIP projects - education and learning	Reported progress on the implementation of the NHS People Plan and the Lincolnshire System Workforce Plan NB New indicators being developed for the 21/22 financial year				
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					
						Effective communication mechanisms with our staff - ELT Live, managers cascade, intranet etc.		Reviewing the way in which we communicate with staff and involve them in shaping our plans	Staff survey feedback - engagement score, recommend as place to work				
						Leadership & Management training. (Improving the consistency and quality of leadership and line management across ULHT)		Continue to implement new leadership programme e.g training on well-being conversations	Pulse surveys - " Have your say" Number of staff attending leadership courses				
						Perception of fairness and equity in the way staff are treated		IIP Project - Address the concerns around equity of treatment and opportunity within ULHT so that the Trust is seen to be an inclusive and fair organisation	WRES/ WDES Data Internal Audit - Equality, Diversity and Inclusion				
						Staff networks	Some staff networks stronger than others	Continued work to embed the networks and provide them with effective support	Protect our staff from bullying, violence and harassment - measure through National Staff Survey				
						Demonstrate that we care and are concerned about staff health and wellbeing		Embed programme focused on staff wellbeing	Reports on progress in implementing the NHS People Plan and the Lincolnshire System Workforce Plan Number of Schwartz rounds completed (once implemented)				
						Focus on junior doctor experience key roles:- - Freedom to speak up Guardian - Guardian of safe working - Well-being Guardian	Identified FTSU capacity in Trust as insufficient	Budget identified for post and recruitment exercise commenced for full time FTSU Guardian Junior doctor forum	GMC junior doctor survey				

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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 received and Audit Committee considered in June noting 'partial assurance with improvement required can be given on the overall adequacy and effectiveness of the Trust's framework of governance, risk management and control. Completeness of risk registers Annual Governance Statement			Audit Committee	A
						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.		

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3a	A modern, clean and fit for purpose environment	Chief Operating Officer	Longer term impact on supplier services (including raw materials) who are supporting the improvement, development, and maintenance of our environments. Availability of funding to support the necessary improvement of environments (capital and revenue)	3720 3520 3688 4403 3690	CQC Safe	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.		Finance, Performance and Estates Committee	R
						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.			
						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.		
						Continued progress on improving infrastructure to meet statutory Health and Safety compliance		Water/Fire safety meetings are in place and review of controls are part of external validation from authorised engineers.	Reports from authorised engineers Response times to urgent estates requests Estates led condition inspections of the environment Response times for reactive estates repair requests Progress towards removal of enforcement notices				
						Delivering £6.4m CIP programme in H1 21/22 and estimated full Year 21/22 CIP value of £15.4m.	Operational ownership and delivery of efficiency schemes	Divisional Financial Review Meetings - paused due to COVID - reinstated from May 21. Request to all Divisions to provide detailed CIP recovery plans.	Delivery of revised CIP Achievement of both ULHT and STP financial Plan	Model Hospital Benchmarking/Reporting - paused due to COVID - reinstated from May 21 (update brought to FPEC in May)	Gaps are being reviewed monthly with Divisions through FRMs		
						Delivering financial plan aligned to the Trust and Lincolnshire STP financial plan / forecast for 2021/22	Urgent and unplanned Restore and Covid related costs	Lincolnshire STP financial plan Lincolnshire STP collective management of financial risk Savings plan, monitoring and reporting.	Delivery of the Trust and System financial plans for H1	Granular detailed CIP implementation plans.	Internally through FRMs and upwards into FPEC, externally through the STP reporting structure including Finance Leadership Group upwards to the Executive Leadership Group.		

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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 Restoration and Recovery and third COVID wave.	4382 4383 4384	CQC Well Led CQC Use of Resources	Reduce agency spend by 25% from the 19/20 baseline as per IIP priority	Reliance on temporary staff to maintain services, at increased cost	Centralised agency & bank team	Delivery of the IIP 25% agency reduction target.	Granular detailed plan for every post plans.	Through the Medical and Nursing Workforce Transformation Groups and through FRMs upward into FPEC	Finance, Performance and Estates Committee	R
						Utilising Model Hospital, Service Line Reporting and Patient Level Costing data to drive focussed improvements to be restarted from Q2	Lack of up-to-date and robust benchmarking information due to the usefulness of the 20/21 cost collection exercise being reduced related to COVID.	Refresh of internal costing and SLR information for roll out in the Trust in Q2 21/22.	SLR and PLICs information	CQC Use of Resources - paused due to COVID	Improvement in the CQC Use of Resources is part of the Trust 21/22 IIP		
						Implementing the CQC Use of Resources Report recommendations	Lack of up-to-date and robust benchmarking information due to the usefulness of the 20/21 cost collection exercise being reduced related to COVID.	Refresh of internal costing and SLR information for roll out in the Trust in Q2 21/22.	SLR and PLICs information	CQC Use of Resources - paused due to COVID	Improvement in the CQC Use of Resources Trust scoring is part of the Trust 21/22 IIP and performance is reported through PMO upward reports.		
						Working with system partners to deliver the Lincolnshire Plan.	Urgent and unplanned Restore and Covid related costs	Lincolnshire STP financial plan Lincolnshire STP collective management of financial risk Savings plan, monitoring and reporting.	Delivery of the Trust and System financial plans for H1	Granular detailed CIP implementation plans.	Internally through FRMs and upwards into FPEC, externally through the STP reporting structure including Finance Leadership Group upwards to the Executive Leadership Group.		
						Detailed activity modelling aligned to resource requirements to support Trust and System Restoration.	Impact of Wave 3 and increasing acuity of NEL patients creating bed and staffing resource pressures to deliver restoration plan.	Trust Restoration plan and through Restoration and Recovery daily Trust meetings. Lincolnshire STP activity plan Lincolnshire STP collective management of restoration of planned care activity	Reporting against the Trust and System Restoration plan and national Trajectories.				
3c	Enhanced data and digital capability	Director of Finance and Digital	Tender for Electronic Health Record is delayed or unsuccessful Major Cyber Security Attack Critical Infrastructure failure	4177 4179 4180 4182 4481	CQC Responsive	Improve utilisation of the Care Portal with increased availability of information -	Cyber Security and enhancing core infrastructure to ensure network resilience. .	Digital Services Steering Group Digital Hospital Group Operational Excellence Programme Outpatient Redesign Group	Number of staff using care portal	Schemes paused to enable tactical response to Covid-19. Limited progress being made where possible. .	Management of control gaps being reintroduced in a phased way as impact of Wave 2 reduces. Nationally mandated ICS Minimum Viable Product shared record must be in place by September 2021. Hence, work ongoing with partner organisations to ensure their data is within the Care Portal. IG sharing issues resolved but some technical ones remain.	Finance, Performance and Estates Committee	A
						Commence implementation of the electronic health record	Roll-out IT equipment to enable agile user base Redeployment of staff as a result of Trust response to Covid-19.	Digital Services Steering Group Digital Hospital Group e-HR Programme Steering Group	Delivery of 20/21 e HR plan		EPR OBC to be approved by NHSE/I OBC requirments being worked thorugh with NHSE/I		
						Undertake review of business intelligence platform to better support decision making			Delivering improved information and reports Implement a refreshed IPR	IPR refresh being completed in July 2021 for June 2021 reporting.	Steady implementation of PowerBI through specific bespoke dashboards and requests.		

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						Implement robotic process automation	Lack of expert knowledge available within and to the Trust (experts in short supply nationally) Business case under development						
						Improve end user utilisation of electronic systems	Business case for additional staff under development						
						Complete roll out of Data Quality kite mark			Ensuring every IPR metric has an associated Data Quality Kite Mark	Information improvements aligned to reporting needs of Covid-19.	A number of metrics have had a review and these are awaiting formal sign off. They will then appear in the IPR. Remaining metrics have a work plan and deadlines associated with completion.		
SO4	**To implement integrated models of care with our partners to improve Lincolnshire's health and well-being**												
4a	Establish new evidence based models of care	Director of Improvement and Integration	Failure of specialty teams to design and adopt new pathways of care Failure to support system working Failure to design and implement improvement methodology		CQC Caring CQC Responsive CQC Well Led	Supporting the implementation of new models of care across a range of specialties	Specialty strategies not in place	Requirement for specialty strategies now part of strategy deployment and will commence August 2021	Reports -ELT / TLT -Committees -Board -System -Region	Impact of specialty changes	New performance framework will address and the upward report regarding IIP	Finance, Performance and Estates Committee	A
						Improvement programmes for cancer, outpatients and urgent care in progress	Recovery post COVID and risk of further waves Urgent Care Transformation team not yet established	Outpatient Improvement Group Cancer Improvement Board Urgent and Emergency Care Board.	Improvement against strategic metrics % of patients in Emergency Department >12 hrs (Total Time) Delivery against 62 day combined standard Urgent Treatment (P2) turnaround time Deliver outpatient activity non face to face		Reporting via FPEC		
						Development and Implementation of new pathways for paediatric services - in progress, included in 21/22 plans.	Engagement exercise required to seek further views regarding the proposed revised model	CYP Group re-established	Board report July 2021				
						Urology Transformational change programme	Engagement exercise required to seek further views regarding the proposed revised model	Urology steering group in place reporting through IIP	Board report July 2021				
						Pre op Assessment Modernisation							
						Support Creation of ICS - Lincolnshire designation 1st April 2021	Delay to review and adoption of legislation	Weekly ICS meetings Provider Collaborative Steering Group	SLB reports and upward reports by CEO / Chair				

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						Support the consultation for Acute Service Review (ASR) Phase 1 - PCBC with national team	Awaiting CCG to review and sign off approach to consultation	Weekly ASR meetings	SLB reports and upward reports by CEO / Chair				
						Implementing the Outstanding Care Together Programme to support the Organisation to focus on high priority improvements - in progress	Disruption due to COVID has resulted in a less mature approach to strategy deployment, broad understanding across the organisation, progress on building capacity and capability.	OCTP Exec led pillar meetings continue ELT/TLT oversight Board / system reporting	Weekly ELT updates Monthly TLT updates Quarterly board reports Quarterly board development sessions				
4b	To become a University Hospitals Teaching Trust	Director of Improvement and Integration	Failure to develop research and innovation programme Failure to develop relationship with university of Lincoln and University of Nottingham Failure to become member of university hospital association		CQC Caring CQC Responsive CQC Well Led	University Hospital Teaching Trust Status Developing a business case to support the case for change			Progress with application for University Hospital Trust status			People and Organisational Development Committee	R
						Increasing the number of Clinical Academic posts	UHA recently changed the criteria which has some challenges in terms of RCF funding and Clinical Academic posts which have increased from 10 to 20.	Working closely with DHSC who are reviewing the criteria when MPs return from summer break to consider discussions with the UHA as to how Trusts can best achieve against this changed criteria.	Numbers of Clinical Academic posts RD&I Strategy and implementation plan agreed by Trust Board				
						Improve the training environment for students			GMC training survey Stock check against checklist Internal Audit - Education Funding				
						Developing an MOU with the University of Lincoln	Time = limited timescales to complete final version (by Oct 2021). Draft MOU and Joint Strategy with the UoL for their review and further discussion late August 2021.	Monthly meeting between UoL and ULHT	RD&I Strategy and implementation plan agreed by Trust Board				
						Develop a portfolio of evidence to apply for membership to the University Hospitals Association	UHA recently changed the criteria which has some challenges in terms of RCF funding and Clinical Academic posts which have increased from 10 to 20.	Working closely with DHSC who are reviewing the criteria when MPs return from summer break to consider discussions with the UHA as to how Trusts can best achieve against this changed criteria.	UHA Steering Group review of evidence collated (chaired by Director/Dep Director within Improvement & Integration Directorate). UHA review of submitted evidence once completed - to consider award of status. Report to TLT. Report to People and OD Committee.	Section 6 (Medical Education) = large section of the criteria which requires Medical Education Team to dedicate resource to the collation of this information.	Project Lead working closely with Team to collate.		

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The BAF management process

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

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

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

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

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

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

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

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

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*5 October 2021*
Item Number	*Item 13.3*
Audit Committee Upward Report	
Accountable Director	*Sarah Dunnett, Audit Committee Chair*
Presented by	*Sarah Dunnett, Audit Committee Chair*
Author(s)	*Jayne Warner, Trust Secretary*
Report previously considered at	*N/A*

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

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

Recommendations/ Decision Required	• *Ask the Board to note the upward report*

Executive Summary

The Audit Committee met via MS Teams on the 3rd September 2021, this was in line with the revised reporting timetable and process for the 2020/21 annual accounts and report. Tthe Committee considered the following items:

External Audit VFM Progress Report and the final Annual Audit Report 2020/21 incorporating VFM findings

The Committee took the two reports noting that they received them on behalf of the Trust Board. The Committee noted that the report provided assurances that progress was being made but significant weaknesses had been identified and these all required an audit recommendation to be issued. The External Auditors advised that all recommendations were areas already embedded within the Trust Board Assurance Framework and would be monitored through existing governance frameworks.

The Report highlighted the five areas of significant weaknesses which had been identified.

- Special Measures
- Capital Backlog and Fire Safety Notices
- Workforce Agency Spend and Staffing Indicators
- Financial Sustainability
- Judicial Review Outcome

It was acknowledged by the External Auditors that whilst the Trust had lots of challenges it was largely comparable with many other acute Trusts.

The Director of Finance & Digital was asked to advise the Committee of the process which the draft had taken in the organisation and how the Trust would track the recommendations to see improvement in the 2021/22 financial year. The Committee were advised that the report had been considered by the Executive Leadership Team and feedback had been given. Actions would be monitored through the Board Assurance Framework received monthly at Board and through Audit Committee quarterly.

The Committee formally received the Annual Audit Report. Confirmed the audit certificate would now be received which would be incorporated in to the Annual Report and Accounts for publication.