Bundle Trust Board Meeting in Public Session 2 March 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 2 February 2021 *Chair* Item 5.1 Public Board Minutes February 2021v1.docx
5.2	Matters arising from the previous meeting/action log *Chair* Item 5.2 Public Action log February 2021.docx
6	Chief Executive Horizon Scan Including STP *Chief Executive* Item 6 Chief Executive's Report 230221.docx
7	Staff Covid 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 February 2021v1.doc Item 8.1 Maternity Safety Reporting Feb 2021 v3.docx
9	Strategic Objective 2 To enable our people to lead, work differently and to feel valued, motivated and proud to work at ULHT
9.1	Assurance and Risk Report from the People and Organisational Development Committee *Vice Chair of People and OD Committee* Item 9.1 POD - Upward Report - February 2021v2.docx
9.2	Board Wellbeing Guardian Role *Trust Secretary* Item 9.2 Wellbeing Guardian.docx
10	Strategic Objective 3 To ensure that services are sustainable, supported by technology and delivered from an improved estate
10.1	Assurance and Risk Report from the Finance, Performance and Estates Committee *Chair of Finance, Estates and Performance Committee* Item 10.1 FPEC Upward Report February 2021.docx
11	Strategic Objective 4 To implement integrated models of care with our partners to improve Lincolnshire's health and wellbeing
12	Integrated Performance Report *Director of Finance & Digital* Item 12 Integrated Performance Report - Trust Board Final.docx
13	Risk and Assurance

13.1 Risk Management Report

Director of Nursing

Item 13.1 Trust Board - Strategic Risk Report - March 2021 v2.docx

13.2 Board Assurance Framework

Trust Secretary

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

Item 13.2 BAF 2020-2021 v23.02.2021.xlsx

14 Changes to Trust Board Membership

Trust Secretary

Item 14 Board Membership.docx

15 Any Other Notified Items of Urgent Business

16 The next meeting will be held on Tuesday 6th April 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 2 February 2021

Via MS Teams Live Stream

Present

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

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

In attendance:
Mrs Jayne Warner, Trust Secretary
Mrs Karen Willey, Deputy Trust Secretary (Minutes)
Mrs Anna Richards, Associate Director of Communications
Ms Cathy Geddes, Improvement Director, NHSE/I

Apologies
Dr Maria Prior, Healthwatch Representative

001/21	**Item 1 Introduction** The Chair welcomed Board members and members of the public who had joined the live stream to the meeting. In line with guidance on Covid-19 the Board continue to hold meetings open to the public through the use of MS Teams live. In line with policy, papers had been published on the Trust website a week ahead of the meeting and the public able to submit questions in the usual manner.
002/21	The Chair moved to questions from members of the public. **Item 2 Public Questions** **Q1 from Councillor Charmaine Morgan** **'How do the criteria published reflect the ongoing progress made in rapid testing and vaccinations? When therefore do you foresee the return of all services, incl A&E, back at GDH?**

	Of course this reflects the statements made to LCC health scrutiny cttee in June 2020 when board members repeatedly stated, in response to members questions, that the changes were 'only temporary'.' The Chief Operating Officer responded: The question had been submitted ahead of the Board papers being published as the answer to the question was provided in the papers. The second paper presented to the Board for the temporary green site recommendations would respond to the points raised in relation to vaccinations and the changing profile of Covid-19. This would be covered in more detail later in the meeting. The changes made at Grantham were temporary and were in response to the pandemic, the paper presented demonstrated this position and the Trust would continue to work to the timescales described in the June 11th paper. **Q2 from Jody Clark** **Looking at the Grantham update, it is really good to see that our UTC has a consistent demand and so many patients have received treatment for life threatening conditions. It was concerning to see so many patients being seen and admitted at Pilgrim and Lincoln. We hear about travelling issues a lot and just wanted to ask if any help can be given to patients coming from so far across Lincolnshire? Or parking concessions given to those waiting for their loved ones to be discharged?** The Chief Operating Officer responded: Some issues had been raised by some patients accessing services not only at Lincoln and Pilgrim but also Grantham. It was recognised that patients were travelling to Grantham and that the temporary measures were affecting many patients, not just those in Grantham. Due to this the Trust had taken some measures, as described in the paper later on the agenda, around additional transport services, this continued to be reviewed going forward. In addition there had been changes made in the provision of car parking and concessions. Parking charges had been reinstated. This remained under review to ensure charges were appropriate and transport provision was also being reviewed. The Chief Operating Officer thanked Ms Clark for highlighting the number of patients accessing services safely during Covid-19.
003/21	**Item 3 Apologies for Absence** Apologies for absence were received from Dr Maria Prior, Healthwatch Representative
004/21	**Item 4 Declarations of Interest** There were no declarations of interest which had not previously been declared.
005/21	**Item 5.1 Minutes of the meeting held on 1 December 2020 for accuracy** The minutes of the meeting held on 1 December 2020 were agreed as a true and accurate record.

006/21	**Item 5.2 Matters arising from the previous meeting/action log** The Chair noted that those items included on the action log had either been deferred or a full update provided within the log.
007/21	**Item 6 Chief Executive and Executive Director's Organisational Update** The Chief Executive presented the report to the Board noting that the report also included updates from the Executive Directors.
008/21	The Chief Executive noted the role of the Trust in relation to the vaccination programme advising that the Trust had been involved from the outset through the hospital hubs and played one part of the whole system programme to vaccinate the population. From 2 February two large vaccination sites had been established, one in Boston and one in Lincoln and were being run by Lincolnshire Community Health Services NHS Trust (LCHS).
009/21	A focus was being provided to the top 4 cohorts to be vaccinated and there were targets to be met by mid-February. The Chief Executive hoped that it was being seen through national media how well the programme was delivering.
010/21	The Trust was providing a main focus to vaccinating health and social care workers through the hub at Lincoln. The Boston hub has been put on hold in order to support the large vaccination site in Boston.
011/21	The Chief Executive reported that 90% of staff had received the seasonal flu vaccination noting that this was considerably higher than previous years.
012/21	Following the panel meeting in November for the Acute Services Review (ASR) and a letter received in December the Trust were now responding to the 7 recommendations made with a view to the ASR being sent to the national panel for approval.
013/21	Work was underway with colleagues across the system to complete the Integrated Care System (ICS) designation pack. National policy determined that all systems should be an ICS from April 2021 and NHS England had consulted on what an ICS should look like from April 2022. The designation of Lincolnshire as an ICS continued to be developed and an update would be provided to the Board when available.
014/21	The Chief Executive advised that there was nothing to report in relation to the country leaving the European Union but that this was kept under review.
015/21	The Chief Executive was pleased to advise the Board of the successful completion of the Dixon Ward refurbishment. The Trust had won two awards one for Estates and Facilities and one for Clinician of the Year at the Healthcare Financial Management Association (HFMA) Awards.
016/21	It was noted that the national alert level in relation to the Covid-19 pandemic remained at alert level 5 with the NHS escalation level at 4. Both levels of alert were the highest possible, sites remained busy and wave 2 Covid-19 inpatients number for the Trust had been far in excess of those seen in wave 1.
017/21	There were encouraging signs that these figures had peaked and were now declining however the hospitals remained busy, particularly the intensive care units (ICU). Ongoing work was being conducted to ensure the right flow was in place along with discharges and management of patients attending accident and emergency.

018/21	The current staff sickness absence rate was 9% however it was noted that of the 700 staff absent, circa 230 related to Covid-19, the remainder were usual sickness such as musculoskeletal, stress and other issues.
019/21	The Chief Executive noted that due to the position of Covid-19 the report indicated the efforts made to support staff through wave 1 and 2 and moving forward. There was a continued approached to personal protective equipment, risk assessments and adaptions made to environments to support staff to continue to work or work from home. The well-being hubs that had been established were offering support through both national and local resource.
020/21	The Trust continued to work on availability of staff across the Trust both in those high pressured areas such as ICU but also in filling vacancies. The Trust were part of the national directive to ensure that there were no healthcare support worker vacancies.
021/21	The Director of Finance and Digital offered an update in relation to the national financial regime advising that the Trust had broken even for the first 6 months of the year due to direct funding of expenditure. The second half of the year had seen a fixed envelope of funding for the Lincolnshire System and offered £87m more than the same period for the previous year.
022/21	An agreement had been reached across the System to achieve a breakeven position for provider organisations. The financial plan in place had been agreed prior to wave 2 of Covid-19 and this had seen some challenges.
023/21	The Trust had income of £1.9m favourable to plan due to receiving funding and pass through income, this was however matched to expenditure.
024/21	The Director of Finance and Digital reported the pay position as £1.4m adverse to plan driven by high requirements for staffing and the incentive payments put in place to address challenges within the staffing position. Costs were now also being incurred in relation to the vaccination programme.
025/21	Non-pay was reported as £300k favourable to plan, some of which had been offset to increase the pay position.
026/21	The Board were advised that there had been £13.4m spent on capital which was £6.8m behind plan. The Trust had an ambitious programme that needed to be caught up by 31st March 2021.
027/21	Overall the system had planned a deficit of £4m for the second half of the year, this had now been revised to a breakeven position due to the surplus position being reported at month 9.
028/21	Dr Gibson noted that there were Covid-19 variants in the country and asked if the Kent, UK variant was present in Lincolnshire and if it was not, was a third wave anticipated should this arrive.
029/21	The Director of Nursing noted that as an acute provider the information received regarding swabs only related to positive or negative results and that treatment was the same regardless of the variant. Public Health do however look at the strains and the Kent variant was noted as being within the Lincolnshire System however was on a decline. In response to a third wave, this was not expected based on the Kent variant as this was already in the area.
030/21	Mrs Dunnett congratulated the Trust on the achievement of the flu vaccination rates and the Finance Team and Consultant on the achievement of the HFMA award.

031/21	Mrs Dunnett noted the initiative of international recruits and asked what support was being put in place not only professionally but the wider pastoral support.
032/21	The Director of People and Organisational Development was pleased that the Trust had been able to identify additional recruits but noted that this did bring challenges. There would be an increase in the professional support being offered and NHS England/Improvement (NHSE/I) had linked the Trust to another provider who offered a good support programme in order to maximise the chances of the recruits passing the Objective Structured Clinical Exam (OSCE) programme.
033/21	It was noted that a proportion of those recruited previously had failed the OSCE programme and it was hoped the development of the support package would see an increase in success rates. Alongside the professional support there was a need for additional pastoral care.
034/21	The Trust had been successful in a bid for funding to support the programme and this would enable the Trust offer wrap around support which focused on accommodation, welcome and an introduction to living in Lincolnshire. There would be the ability to provide ongoing support in order to create a sense of community, enabling recruits to settle well and therefore wish to remain. With the support of NHSE/I and link to a well performing Trust there was confidence that the Trust would be able to put a good package in place.
035/21	Assurance on the success of this process would be reported through the People and Organisational Development Committee.
036/21	Mrs Libiszewski asked what specific support was in place and would be in place on an ongoing basis for those staff working within critical care, including those who did not usually work in the environment.
037/21	The Director of Nursing noted the fantastic work of staff within critical care. Currently the service was working in surge capacity and registered staff were being supported by non-critical care staff who had been upskilled and provided with training. These ‘buddies’ were typically theatre practitioners or staff who had previously worked within a critical care environment.
038/21	Critical care would undertake debriefing and these continued regardless of the pressures. There had been an increase in counselling capacity and support had been offered by the regional Director of Nursing from mental health providers to critical care staff.
039/21	Proactive support was offered to staff and staff were also coming forward to seek support. The Trust had put wobble rooms in place in order to offer a space to staff to take a few minutes to reflect in a calm environment. Chaplaincy were offering pastoral support to colleagues who wished to access talking support.
040/21	The Board were advised that there had been an increase in the number of patients dying as a result of Covid-19 and staff were dealing with more death and bereavement in all area. Bereavement support was also being offered by chaplaincy staff.
041/21	The Chief Operating Officer advised that the Trust were part of the large critical care network in the midlands and the NHS were working collaboratively to ensure services were provided to all patients who required them. Currently the Trust had put forward nearly 50% of all intensive care capacity to support other systems, across the region, as Lincolnshire had not seen the same demand for intensive care and ventilation. Should the Trust need support in the future this would be offered by other providers in the same way in which the Trust were taking patients from other areas.

042/21	The Director of People and Organisational Development noted that a report had been published in relation to the mental health issues of critical care staff, particularly drawing on the experience of London. This was not only about immediate support to staff but the longer term impact. There was expected to be a long period of recovery for staff and the impact may not be felt for several months. The Trust were ensuring that there was both internal and external support for staff from Lincolnshire Partnership Foundation NHS Trust. This would be a long term programme of support for staff.
043/21	Mrs Libiszewski asked what support was being offered to families who had a loved one moved a long distance for care.
044/21	The Chief Operating Officer advised that support was in place for families and relatives of patients who were moved and there continued to be a risk based approach to the visiting of patients within the hospitals. This was no different for ICU and families were, on occasion, invited to visit where appropriate and safe to do so due to the high levels of the virus in the ICU environment.
045/21	The Critical Care Network had a function in place to support patients, transferred for non-clinical reasons, and their families in terms of travel and transport. This was a work in progress due to the level of transfers being seen and distances of the moves, however this was expected to gain momentum over the course of the coming weeks.
046/21	Mrs Ponder asked what support was in place for corporate staff who had been redeployed to support frontline teams.
047/21	The Chief Operating Officer advised that corporate staff were working across a number of areas but with restricted duties, depending on the experience and skill set of staff. Feedback from corporate teams had been extremely positive and clinical teams had also found this to be a positive experience. Debriefs were being offered and this continued as part of the workforce hub and redeployment cell to ensure staff were not exposed to situations that they may be unprepared for or able to manage effectively.
048/21	The Chair noted the need to continue to have an overview on the delivery of services and the health and well-being of staff and was pleased that the Trust were playing a role in the vaccination programme.
049/21	The Chair acknowledged that the Acute Services Review needed to be progressed to the national team for review and the Trust would continue to support the progress of this due to the importance to the Trust.
050/21	The Chair thanked staff, on behalf of the Board, for the brilliant effort being made to work in the circumstances being faced, this had been going on for some time but there was resilience and ongoing support to care for patients. The Chair was pleased that the Trust had been able to share in the national response for patients in ICU. The Trust Board: • **Noted the update and significant assurance provided**
051/21	**Item 6.1 Green Site Quarterly Review** The Chair advised the Board that there were 2 papers in relation to the changes at Grantham Hospital. The first being the quarterly review which intended to provide detailed progress on

	the temporary arrangements and provide assurance to which the extent of the primary intentions set in June 2020 were being achieved.
052/21	This was the second review and substantially built on the report provided in September 2020 and responded to the recommendations approved, the Board needed to be assured that the recommendations had been actioned and an understanding of the position provided.
053/21	The Board would also need to consider if any of the criteria to revert to the substantive model had been met in the last quarter.
054/21	The Chair noted that the second paper intended to stimulate discussion on the action the Board would be required to take post 31st March 2021.
055/21	The Chief Operating Officer presented the paper to the Board noting that this referenced the quarter October to December 2020.
056/21	As indicated by the Chief Executives report, this reflected a difficult period for the Trust which saw the peak of wave 2, with over 250% of hospitalised Covid-19 cases compared to those seen in the previous wave.
057/21	In the same period the Trust saw almost normal level of non-Covid-19 activity which had put additional pressure on the hospitals that had not been seen before. Wave 1 had seen a reduction in other types of emergency activity and a significant reduction in planned care however the report described the return to normal levels of referral activity from primary care, particularly cancer pathways. The Trust were pleased that there appeared to be a level of confidence from the public to access services however this did place the Trust under increased stress.
058/21	This increase had been anticipated and went back to the 3 primary aims of the green site being infection, prevention and control (IPC), delivering at scale and providing a resilient solution that would not fail should the Trust be under the kind of stress seen in wave 2.
059/21	The Chief Operating Officer was pleased to advise the Board that there had been achievement of the aims described in the 11th June 2020 Board paper and of the 6 priorities identified 5 were met substantially and one partially met.
060/21	It was noted that the national context had changed with a step down of the emergency response to the pandemic being seen in the first quarterly report. For quarter 2 there had been an increase in the level from 3 to 4 that then saw the national alert level of Covid-19 move to level 5. This was suggesting that the NHS could be compromised on its ability to respond to patient need. The NHS moved back in to a command and control structure and the Trust were receiving instruction on how to respond.
061/21	The Chief Operating Officer highlighted the information on the assessment of service delivery.
062/21	It was noted that planned surgical activity was at greatest risk when the arrangement were first put in place as there was not a solution that offered the level of protection from Covid-19 and in the volumes required. The Chief Operating Officer was pleased to report that not only did the Trust manage to maintain some of the waiting list but during the quarter this had started to reduce.
063/21	This was a positive position for the Trust and the necessary capacity was put in place resulting in the ability to increase the number of patients being operated on. Through November and December the Trust started to feel the effect of wave 2 and capacity had to be reduced in order to be able to respond to urgent and critical care in that period.

064/21	Chemotherapy activity had not only achieved the plan but also significantly exceeded what had been set out. The changes in service provision had resulted in Grantham Hospital taking activity from Lincoln and Pilgrim and had delivered more activity that was being provided previously across all 3 sites. Activity levels had been maintained during December at the high volumes.
065/21	Outpatient capacity had experienced more of an impact from urgent care and wave 2 overall however had a lower level of risk across general outpatient areas should a delay be experienced. Where increases in demand were seen throughout wave 2 clinical capacity had been moved in order to address these areas. December had seen a significant reduction in capacity however the plan set out had been achieved. During October to December the Trust had increased specialties on offer in the Grantham area including at the hospital site, Health Centre and Gonerby Road site.
066/21	The Trust had set out to provide activity and access to urgent care services at Grantham Hospital and across Lincolnshire that maintained circa 20k attendances per annum at Grantham. This represented 80% of urgent care activity at Grantham, whilst this had been achieved it was however recognised that some areas, such as attendances, were above the initial prediction. Overall the Trust had maintained the original aim to provide urgent care to people in Grantham, in particular the Urgent Treatment Centre (UTC) was a success in terms of access and success to patients.
067/21	The Chair thanked the Chief Operating Officer for the comprehensive report noting that whilst performance was not perfect it was a strong performance with a significant number of patient having benefited as a consequence.
068/21	Dr Gibson noted the difficulties of hospital acquired infections and the challenge for all hospitals. There had been success in delivering at scale on elective activity at Grantham without generating hospital acquired infections. The increase from 800 to 1600 patients a month was significant.
069/21	Dr Gibson noted that the data suggested that between 2-3 patients a day were admitted to either Lincoln or Pilgrim who would normally have been admitted to Grantham. Dr Gibson asked if there was any evidence of harm or adverse outcomes to those patient being admitted to a different hospital.
070/21	The Chief Operating Officer advised that there had been no significant incidents or harm recorded as a result of transfers. There had also been no harm as part of a delay of ambulance transfers, there was some confidence about this as if an ambulance delay occurred an immediate harm review was undertaken. Pre-Covid-19 the Trust were already seeing a number of patients transferring, at the peak of admissions 87% were admitted at Grantham, the remaining percentage were transferred, since the introduction of the model this figure had changed by 4%. There had not been a substantial impact on those patient groups.
071/21	Mrs Ponder noted that the activity levels described the UTC at Grantham as having a below average percentage of patients referred to A&E and asked why and what analysis had been done to understand if patients had come to harm.
072/21	The Chief Operating Officer noted that the concern regarding harm had been addressed previously but noted that the UTC model at Grantham was different to others. At Grantham there was a Same Day Emergency Care Unit that could care for patients who would potentially transfer to an A&E. Due to having other services on site, patients could be treated and discharged the same day. Some patients would go on to be transferred however by having an increase in the spectrum of services there had been less transfers.

073/21	The Chief Operating Officer advised the Board that the remainder of the report was supported by over 400 pages of analysis with some of this being published at a later date.
074/21	The Chief Operating Officer described the approach to quality and safety and there was a continuation of the use of quality reporting systems as done for all other services including incident reporting, quality updates through divisional teams and reporting in to Quality Governance Committee.
075/21	There had been no serious incidents reported as a result of the green site model which was a criterion that would trigger the model to be reverted should there be a significant clinical concern. It the model disproportionality increased risk the Trust would revert.
076/21	During the running of the model there had been a focus on IPC and it was noted that no patients had contract Covid-19 perioperative, it was known that this was the single greatest risk to mortality identified as part of the temporary change. A number of international papers published had identified the increased risk to mortality should Covid-19 be contract post operatively or whilst under anaesthetic.
077/21	The Board were advised that during the consideration to establish a rehabilitation ward on the site a patient had contracted Covid-19, this was likely to have been due to transfers or possible false negative test results. This was managed effectively and did not affect the green flow or surgical activity.
078/21	As part of quality and safety there remained a substantial risk to patients waiting long periods for treatment, this was a high risk areas and the Trust were keeping this under review.
079/21	There had been a significant increase in the scope of patient and staff experience as it was noted that the first review was lacking in responses from patients. There had been many hundreds of survey responses and thousands of Friends and Family Test scores and feedback received in relation to the services. This provided rich data and information from all services.
080/21	The Board were advised that 39% of surveys were from patients who had accessed services at other hospitals and there was also now a broader spectrum of general public feedback. Some of these received from patients who had not recently accessed services but wished to share their opinion on what was important to them and how they saw the temporary changes.
081/21	It was reassuring to see that there had been a number of very high scores from people accessing Grantham and in particular the level of satisfaction and safety in accessing the green site.
082/21	A number of positive comments were received about the recent services that had been established however it was noted that the scores for the new site at Gonerby Road were not as positive as for the other well established locations.
083/21	A number of comments were received regarding improvements of which some had been acted upon, including the range of services, security and facilities offered at Grantham. The Chief Operating Officer reflected that there was more to do but that this system of receiving feedback would continue to be used until the model stopped.
084/21	157 staff responses had been received with feedback primarily from those working at Grantham on the green site model. Whilst there were concern regarding IPC, personal protective equipment (PPE) and underlying concerns regarding Covid-19 the feedback was particularly positive on reflection of being able to operate a green site.

085/21	Work continued with the Trade Unions and weekly updates were taking place, there was also individual contact points on a daily basis through the Gold Command Meetings.
086/21	The recommendations from the first quarterly report had been captured within the report in detail however it was noted by the Chief Operating Officer that operational management and site presence at Grantham was not. Following feedback from staff there was a need to provide more senior intervention. This had been addressed through a dedicated senior clinical site manager and rota of senior Divisional Managing Directors and Executives spending time at the site.
087/21	Mrs Libiszewski was pleased to see the breadth of the patient experience that had been captured noting the Trust was supporting the need of the whole population of Lincolnshire and not just those presented at the UTC. It was clear that there were patients who wanted to access treatments regardless of the need to travel and this was important feedback.
088/21	Mrs Libiszewski noted that travel was something that was continually highlighted as an issue in Lincolnshire and was keen to understand what progress was being made with the County Council with regard to the Travel Plan.
089/21	The Chief Operating Officer did note that there were some respondents who did not feel safe to attend appointments and so had not attended the hospitals for treatment, however there were people prepared to travel to Grantham in order to received treatment.
090/21	Work continued with the County Council to develop Travel Plans however due to other priorities during Covid-19 this was not moving at pace. The Trust had a part to play with commissioning colleagues to ensure that the necessary transport was provided for those patients who required it.
091/21	The Chair reflected that a number of questions that Board members wished to pose had been responded to through the detailed presentation of the report.
092/21	The Chief Executive thanked the Chief Operating Officer and colleagues for the work on producing the paper to consider the options around Grantham and enacting these so quickly. This was a high profile topic for the Trust and there continued to be concern that these changes would not be temporary. The Chief Executive stressed that the decision was taken in response to the pandemic and whilst it caused some inconvenience this had been the right decision for the right motives.
093/21	The Chair endorsed the comments made and looked to the recommendations and decision required by the Board within the paper. The Board were being invited to continue with the model as planned and there had not been anything presented that would meet the criteria to revert. On the contrary the outcomes had been extremely positive.
094/21	The Trust Board members supported the recommendations within the paper and approved the continuation of the green site model until 31st March 2021. The Trust Board: • **Received the report noting the significant assurance** • **Approved the recommendation to continue with the Green site model at Grantham as planned through to 31st March 2021.**

095/21	**Item 6.2 Temporary Green Site Recommendations** The Chair noted that that paper followed on from the previous report and proposed a number of future recommendations beyond 31st March 2021 for Grantham hospital and other local services. This contextualised the position in the previous paper but as highlighted the country remained in a high national alert status and the NHS were experiencing high levels of demand that presented a high level of risk to the organisation.
096/21	The Chief Operating Officer advised that the paper presented a more live position having now moved through wave 1 and 2 and in to wave 3. Wave 3 for Lincolnshire did not appear to be following a similar path for others. This could be due to the different variants of Covid-19 in Lincolnshire. The Board were advised that the Kent variant, whilst in the county was less than in other areas. This variant was of particular importance in any future model due to how transmissible this was. It was reported as 30-70% more transmissible however was not the only variant. In England there was 2 variants that were the focus however there were others that should be considered.
097/21	The Chief Operating Officer noted that the vaccination programme was progressing well with high levels of the vaccine being delivered. Those patients who were more vulnerable were being vaccinated and were more likely to access services at the Trust. If the vaccination programme was successful this would help to reduce transmission and symptoms.
098/21	There were currently no publications about the implication for patients accessing surgery who had received the vaccination and the risk of exposure to Covid-19 as such no information existed that would support a decision to move to mixed Covid-19 free and Covid-19 positive pathways.
099/21	With this in mind and the variant modelling and forecast of Covid-19 infections the first recommendation being made to the Board was that the Trust commission a report to consider all available evidence, working in conjunction with Public Health England and academic institutions to gain a better evidence base and understanding in order to operate safe services in the future.
100/21	As the report was not available to the Board at this time. The Chief Operating Officer suggested that this report was considered at the next Board meeting in order to consider the best possible decision.
101/21	Mrs Ponder asked if it was realistic to expect the report to be completed by mid-March to inform a decision.
102/21	The Chief Operating Officer advised this was likely the earliest that a decision could be made however an extraordinary Board meeting may be required to consider the outcome of the report. Over the next 2 weeks there would be a better understanding of the timescales. The Trust had access to the evidence as part of the vaccination programme which could be used to support the report.
103/21	The Chair noted that the Board would need to take account of all information available whenever being asked to make a significant decision. It was right to at least explore this and bring the information available back to the Board.
104/21	Mrs Libiszewski noted that whilst this was being considered locally the Trust continued to operate under national direction and as such there would need to be a level of confidence that the intelligence for Lincolnshire was similar in nature nationally. This would need to be considered in the wider national context.

105/21	Mrs Dunnett sought assurance that Public Health colleagues would be able to support the Trust within the timescales presented
106/21	The Chief Operating Officer advised that contact had been made and whilst it was early days there had been positive indications. A greater understanding would be achieved in the coming weeks.
107/21	Recognising the end of wave 2 and coming in to wave 3, depending on how this progressed there would be a move in to the recovery phase to reinstate services where possible to the maximum possible level.
108/21	There was a view to continue with the additional capacity at Grantham regardless of reverting the model as this would offer additional flexibility and capacity that could not have been offered should the green model not have been established. If this had to be reintroduced to support recovery this would prove a significant cost.
109/21	The process of reverting the model back to pre-Covid-19 model of care would require operationalisation to cease the green site. Originally this took a 12 week cycle to establish for all services and as such there was a great deal of work to do in order to revert.
110/21	The Chief Operating Officer advised that in order to revert at pace recommendation 4 to consider the lead time to plan services reverting proposed that work commenced to plan rotas, configuration of the hospital and all logistics including workforce change. This would enable a quicker reversion should this be agreed in March.
111/21	A significant amount of work had been conducted in to staff, patient and public engagement and a recommendation was put forward to the Board that this continue in the way that had been described in the quarterly review.
112/21	The Chief Operating Officer recognised that making a decision now about reverting the model would be a poor choice that was not supported by evidence. The recommendation was to make the decision in March using the information available and undertake the work to prepare to revert should the decision be taken in March.
113/21	The Chair noted the need for the Board to be in full receipt of as much information as possible along with proper analysis of how to move forward. It was positive to know that plans would be in place to bring back the substantive model at short notice.
114/21	Dr Gibson noted that the decision would need to be embedded in the national response to Covid-19 and that the Trust would be part of an ICS from April 2021 and suggested that there may need to be engagement with regional and local system colleagues regarding any recommendations made.
115/21	The Chair noted that the Trust were engaged with partners in this regard, however the decision to be made would be done so by the Trust Board. The view of colleagues would be considered however the decision for the operating model, until such a time that the Commissioners wished to make a change was for the Board to make.
116/21	The recommendation put forward for engagement and involvement was to ensure that the right decisions were being taken for the public across Lincolnshire and to ensure that they remained aware of the Trusts decisions. The activity being undertaken was considered sufficient in response to the temporary measures.

117/21	The Chief Executive offered support for the 5 recommendations and supported comments made that a decision could not be taken without further work to gather evidence to support the decision of the Board.
118/21	There remained scepticism of the view of the changes being temporary and the Chief Executive again confirmed that these were not permanent changes. The work now was to ensure that any changes made to revert the model back to the pre-June 2020 decision was done as safely as possible.
119/21	The Chair underlined the point made noting the June decision was a temporary arrangement and the reasons for the decision had been made clear to both the public and staff. The Board would need to be assured that it was safe to revert the model and the recommendations put to the Board would lead to a position in March where a decision could be taken. It would not be appropriate to make a decision for the reasons outlined and work would be put in place to ensure that a decision could be made at a future date. The Board would receive back the information to support a decision to be made in March. The Trust Board: • **Received the report noting the significant assurance** • **Reviewed and confirmed the 5 recommendations described within the report** • **Would review a subsequent paper for decision at March 2021 Board**
	Item 7 Objective 1 To Deliver high quality, safe and responsive patient services, shaped by best practice and our communities
120/21	**Item 7.1 Assurance and Risk Report Quality Governance Committee**
121/21	The Chair of the Quality Governance Committee, Mrs Libiszewski provided the assurances received by the Committee at the 15th December 2020 and 19th January 2021 meetings noting that there had been both reduced attendance and agenda due to the Trust responding to the Covid-19 pandemic.
122/21	Mrs Libiszewski noted that the mortality review submission had been required to NHSE/I and it was important to note that the strategy received previously by the Board had put the Trust in a strong position with only minor issues to be refreshed.
123/21	An update had been provided from the System Ethics Cell that had continued to meet and review the approach across Lincolnshire to ensure appropriate care for patients during the pandemic.
124/21	The Committee had received the Integrated Improvement Plan update relevant to the Committee and noted that this had been linked to the Care Quality Commission action plan.
125/21	The Committee were receiving monthly updates in relation to maternity services with the Head of Maternity reporting the maternity dashboard, Clinical Negligence Schemes for Trusts (CNST) submission, Healthcare Safety Investigation Branch (HSIB) investigations, continuity of carers and birth rate plus. Progress in relation to birth rate plus would be reported to the People and Organisational Development Committee.
126/21	The Board would discuss the Ockenden Review however there was a refreshed approach to reporting in to the Committee of maternity issues to ensure that this took in to account the recommendations of the first review.

127/21	Significant work was taking place across a range of harm review processes in the organisation and a task and finish group was now established but not yet reporting in respect of harm reviews to the Committee or the outcomes and mitigating actions being taken. Monthly updates were requested by the Committee until the process was embedded in the organisation.
128/21	The Committee received an update on the Infection, Prevention and Control (IPC) visit and the action plan developed by the Director of Infection Prevention and Control. This would be reviewed monthly as part of the IPC reporting and progress was being made on the outstanding actions.
129/21	Mortality updates continued to be received and the approach developed continues.
130/21	The Committee had significantly reviewed reporting arrangements in to the Committee following the disbandment of the Quality and Safety Oversight Group with terms of reference and work programmes for these groups having been presented along with how the groups would provide assurance going forward. The approach would strengthen reporting and assurance from the Committee to the Board.
131/21	Mrs Libiszewski advised that a Maternity and Neonatal Oversight Group would be established and would strengthen reporting arrangements. It was also noted that Internal Audit had considered reporting groups across the Trust, not just for the Committee however the findings would be incorporated in to the work being undertake in relation to the governance structure.
132/21	The Committee had received the outcome of the Committee Self-Assessment and whilst this had been positive the Committee felt this was narrow in review and suggested future assessments include stakeholders and the wider groups reporting in to the Committee to support the review of the approach of the Committee.
133/21	Concerns continued in relation to sepsis and treatment and whilst this was disappointing the Committee understood that practitioners have been redeployed during the last wave of the Covid-19 pandemic. Performance was variable and regular updates would be received through the Committee Performance Dashboard.
134/21	Mrs Libiszewski noted that the robustness of the Quality Impact Assessment process was still not evident and a number of approaches had been taken during the pandemic. Monthly updates had been requested to ensure this became embedded.
135/21	The Committee received the Internal Audit report in relation to Medicines Management noting the significant number of management actions required, this would be monitored by the Committee.
136/21	Mrs Libiszewski advised that the risk register needed to be considered and updates were required, this was an ongoing issues and whilst it was understood why this was not a priority during Covid-19 it was a key element for the Committee and the Board to ensure risks were updated and mitigating actions were taking place.
137/21	The Director of Nursing noted that a framework was being developed to reconfigure the risk register in order to ensure clarity and sight of the risks. In addition there was a need to ensure staff understood how to use and raise risks on the register. The outline framework was due to be presented to the Executive Team in the next 2 weeks.
138/21	The Chair welcomed the development of the framework due to the risk register being raised on a regular basis through the Committee assurance reports. There was concern regarding harm reviews but the Chair was pleased to hear that this was being addressed by the

	Committee and there was an emphasis on receiving reports, this was endorsed at Board level.
139/21	The Chair was pleased that there was a focus on strengthened governance and that there was a focus of the Committee on maternity services.
140/21	The Chair hoped that the Quality Impact Assessment process would be finalised in the near future with the Committee receiving assurance. The Trust Board: • **Received the assurance report**
141/21	**Item 7.2 Ockenden Review** The Chair advised the Board that following independent review of failings in to quality and safety of the care to babies, mothers and their families at Shrewsbury and Telford NHS Trust, the interim report had been published on 10th December 2020.
142/21	The report was a difficult read and raised a number of issues. Trusts were now being asked to carry out a review following the report and the Board would need to receive assurance on maternity services.
143/21	The Board were required to respond to the immediate actions requested and a letter had been received in to the Trust setting out the requirements. A submission had been made with oversight from the Chair and Chief Executive. One of the main points was that the Board required proper oversight and discussion of maternity services in light of the report and toolkit provided.
144/21	This was a responsibility for the Board and whilst presented by the Director of Nursing there was a role for all Board members both Executive and Non-Executive to be assurance of the quality and safety of services.
145/21	The Director of Nursing presented the report to the Board against the background set by the Chair and reiterated the point made by Mrs Libiszewski that the Quality Governance Committee have received reports for the last 3 months, along with attendance from the Family Health Division.
146/21	The Trust had needed to undertake a clear response to the report and this was welcomed. A high level gap analysis on the immediate and essential actions was undertaken supported by the Board and Local Maternity and Neonatal System (LMNS) along with the NHS Improvement Maternity Improvement Advisor who was working with the Trust. The gap analysis had been included within the papers for Board members.
147/21	The Trust had been requested to complete the assurance and assessment tool that would be submitted by 15th February and had been reviewed by the LMNS and Maternity Advisor who had offered minor adjustments. Overall sign off from the system had been received.
148/21	The template offered from completion was standard however when reviewed, as a small group of the Board, it was identified that, if not involved in the process, it was difficult to identify the risks.
149/21	4 areas had been identified where further work was required including Board and LMNS report and oversight arrangements. In agreement with the Quality Governance Committee the Director of Nursing would like to offer the maternity dashboard and assessment tool to the

	Board through the upward report of the Committee which would be supported by the Maternity and Neonatal Oversight Group, chaired by the Director of Nursing.
150/21	A further area of focus was on external reviews and serious incident reports. There had been no requirement previously for external reviews to be conducted but these had been done as best practice. This would be strengthened and reported in to the oversight group.
151/21	The Director of Nursing noted that there were plans in place regarding high risk pregnancy planning and processes however there was a need for further work through continued documentations for personalised care and support planning.
152/21	Difficulties continued with the maternity safety dashboard submissions due to the interface with the electronic collection and data submissions and work was being conducted to ensure deadlines were met for maternity submissions.
153/21	The Director of Nursing advised of a further paper included that offered oversight and a summary of the actions identified in response to the maternity assurance action plan. This made clear the actions emerging from the Ockenden report that had been reviewed.
154/21	A final area for consideration would be the obtaining of data and intelligence together with the softer information of what was happening within the service from staff delivering the service and how cultural intelligence and information was pulled together. Cultural surveys had been undertaken previously and the intention was to review these and to recommence cultural surveys.
155/21	The recommendation regarding the information to be received by the Board was for the maternity dashboard and assurance report to be supplied to the Quality Governance Committee from the oversight group. It was however important that the Board had access to all of the information whilst ensuring the work of the Quality Governance Committee was not undermined. The Director of Nursing therefore suggested that arrangements were put in place that would allow the Board to access all information ensuring that there was good governance in place.
156/21	The Chair welcomed the approach as this would provide a clear line of reporting from the sub groups through to the Quality Governance Committee and in to the Board. As described the full detail would be provided to Board colleagues.
157/21	Mrs Libiszewski asked if there was a timescale for the completion of Birth Rate Plus.
158/21	The Director of Nursing advised that a comprehensive review of birth rate plus had been concluded looking at midwifery in the acute sector and community care. This was being finalised with the continuity of carer element and it was anticipated that the review would be available in the coming weeks. The intention would be to report the respective elements to the People and Organisational Development Committee and Quality Governance Committee in March of April to then report to Board for sign off.
159/21	Some emerging findings were already being seen and there would be a need to make some adjustments to midwifery staff to support each element of the service, this was not unexpected and a small level of investment may be required.
160/21	In relation to system support the Board were advised that there was support from the Chair of the LMNS with regular conversations being held and issues flagged as part of the maternity transformation programme.

161/21	Mrs Ponder noted that there had been investment in a maternity IT solution however there appeared to be an issue with this and asked what the timescale was for either a strategic or a tactical solution.
162/21	The Director of Finance and Digital noted that the issues needed to be separated. The system had been procured through the procurement process relatively recently and offered a maternity electronic patient record. The operational issues were being worked on in relation to a tactical solution with the division involved to seek a resolution. Some elements had been resolved in respect of the data collection, the remaining issue was now relating to the extraction of data. Discussions were ongoing however there were no clear timescales as this would rely on the supplier completing development work on their system. This was a priority for the Trust and further information would be provided, as this became available.
163/21	The Chair noted that the Board Development programme contained an item relating to maternity and CNST and suggested that this would be included within those discussions and any developments brought back to the Board.
164/21	The Trust Board: • **Received the reporting noting the moderate assurance** • **Approve the proposed QGC and Board reporting** • **Support ongoing focus from the Board on this service**
	Item 8 Objective 2 To enable our people to lead, work differently and to feel valued, motivated and proud to work at ULHT
165/21	**Item 8.1 Assurance and Risk Report People and Organisational Development Committee**
166/21	The Chair of the People and Organisational Development Committee, Mr Hayward provided the assurances received by the Committee from the 10th December 2020 and 14th January 2021 meetings noting that the reports received by the Board had addressed those issues that had been raised through the Committee assurance reports.
167/21	The Trust Board: • **Received the assurance reports**
	Item 9 Objective 3 To ensure that service are sustainable, supported by technology and delivered from an improved estate
168/21	**Item 9.1 Assurance and Risk Report from the Finance, Performance and Estates Committee** The Chair of the Finance, Performance and Estates Committee, Mrs Ponder provided the assurances received by the Committee from the 17th December 2020 and 22nd January 2021 meetings.
169/21	Mrs Ponder noted that the finance update had been addressed through the Chief Executives report and that other items discussed by the Committee had been addressed through reports received by the Board.
170/21	The Chair noted the narrative from the December meeting in relation to the ongoing health and safety group reporting and asked what action was being taken to improve reporting.

171/21	Mrs Ponder noted that this was not a new discussion and was an area that the Committee had experienced difficulty with in the past. It had been agreed that specific coaching would be provided to the author of the report to ensure that assurances were reported to the Committee. It was hoped that these changes would be reflected in the next report from the group.
172/21	The Chair noted the importance of the correct reporting being received in order to provide upward assurance to the Board. The change of leadership in this area was noted however there needed to be a balance in order to receive assurances. The Trust Board: • **Received the assurance report**
	Item 10 Objective 4 To implement integrated models of care with our partners to improve Lincolnshire's health and wellbeing
	No items
173/21	**Item 11 Integrated Performance Report** The Director of Finance and Digital presented the report to the Board advising this was December 2020 data and noting specifically the need for discussion in relation to medicine management and 12-hour trolley wait breaches.
174/21	The Chief Operating Officer advised that there had been a significant increase in 12-hour trolley waits which had been discussed at the Finance, Performance and Estates Committee. One aspect of this related to adverse reporting and a failure to correctly report 12-hour trolley waits over the course of October through to December 2020. The process, whilst notified to NHS England was taking place, had not resulted in a submission of the relevant data in the technical submissions.
175/21	The reported presented to the Board was correct and had been adapted to ensure the correct data was presented. There had also been a radical redesign of the 12-hour trolley wait process in order to ensure that this did not recur.
176/21	Secondarily the number of 12-hour trolley waits had increased and was a reflection of the difficulties of wave 2 of Covid-19 that had been discussed previously at the meeting. The Trust had experienced difficulties with identifying flow and available bed capacity for patients within specific groups to ensure infection, prevention and control measures were taken forward and managed effectively.
177/21	A suite of actions had been put in place and the Chief Operating Officer was pleased to advise that improvement was starting to be seen in data throughout the end of January 2021 and in to the beginning of February.
178/21	The Chair noted that 52 week wait breaches were also identified as a concern and whilst the reasons for this were understood sought clarity on plans in place to resolve this going forward.
179/21	The Chief Operating Officer advised that the 52 week wait position was extremely high and that this would continue to increase for a further 2 periods before improvement would be seen, partly due to legacy reporting but also due to pressure on elective services. The Trust remained in a positive position against regional colleagues however this was expected to deteriorate further over the next few months.

180/21	The Medical Director provided an update in relation to medicines management and a number of issues highlighted within the report. These had been recognised and work was underway with the pharmacy team in order to increase capacity. Interim resource had now been secured in order to provide focus to the work required. One element of the work was the relationship between pharmacists and interaction with ward staff and how duties were conducted.
181/21	The Board were advised that the Medicines Quality Group was in the embryonic phase and was a key task would be to focus on the development of the group. It was positive that harm was being recognised and reported as this confirmed some of the findings of the external audit report and the impetus was now to resolve these issues and change the way in which pharmacy services worked.
182/21	A business case was in place in order to increase the capacity of the team but a review of how duties were undertaken would been required.
183/21	The Chief Executive provided assurance to the Board in relation to the 12-hour trolley waits that there had been communication with NHS England to advise of the issues and pressures being faced by the Trust. NHS England had been advised of the reporting issues and were aware of the improvements that had been made.
184/21	The Trust had historically a good position in relation to 12-hour trolley waits and 52 week waits and it was a disappointing position to be in due to Covid-19 pressures however there was a determination to recover the position. The Trust Board: • **Received the report and limited assurance noting current performance**
	Item 12 Risk and Assurance
185/21	**Item 12.1 Audit Committee Upward Report** The Chair of the Audit Committee, Mrs Dunnett, provided an update to the Board from the meeting held on 15th January 2021.
186/21	Progress with Internal Audit was noted as this had been negatively impacted due to the current circumstances of the Covid-19 pandemic and the ability to access staff to complete reviews. The Board were advised that Internal Audit had agreed with Executive Directors the priority audits that would require completion in order for a Head of Internal Audit Opinion to be provided at the end of the current financial year. The Committee were assured of the ability for this to be delivered.
187/21	It was noted that 4 audits had been issued including the Medicines Management report that was clearly being addressed.
188/21	Mrs Dunnett advised the Board that whilst the Trust had a good framework in place to review and update policies this had been impacted by Covid-19 and it was noted there had been some slippage in progress in clinical review.
189/21	The Chair noted some emerging themes from the Committee reports to the Board with the need to ensure that close attention was paid to strengthen governance processes.

190/21	The Board noted the assurance rating provided in relation to the well-led objective within the Board Assurance Framework that was attributed to the Audit Committee. The Trust Board: • **Received the report**
191/21	**Item 12.2 Risk Management Report** The Director of Nursing presented the report to the Board advising of a very high risk in relation to quality and safety due to the local impact of the Covid-19 pandemic, this had remained significantly high over the past few month.
192/21	The Board were advised of one very high strategic risk relating to finance, performance and estates regarding the capacity to manage emerging demand and of two people and organisational development risks due to workforce capacity and the engagement and morale of the workforce.
193/21	Appended to the report was a summary of all risks recorded within the strategic risk register. As anticipated the highest risks at present continued to be related to Covid-19 and the potential impact on patients, staff and visitors and the ability to continue the provision of a full range of services.
194/21	The Chair noted the reduction of risks relating to the financial expenditure of the Trust and the financial recovery programme.
195/21	The Trust Board accepted the top 4 risks presented on the strategic risk register and were satisfied of the robustness of the mitigations in place intended to manage and reduce the risk. The Trust Board: • **Accepted the top risks within the risk register** • **Received the report and noted the moderate assurance**
196/21	**Item 12.3 Board Assurance Framework** The Chair noted that the Board Assurance Framework (BAF) had been reviewed by each of the Committees and noted that, as agreed at the previous Board meeting, the format had started to revert from an entirely covid focussed framework.
197/21	The Trust Secretary noted that the Committees were working to provide detailed updates to the BAF following the revision with the Finance, Performance and Estate Committee having moved assurance ratings for 2 objectives within the past month.
198/21	The Chair reflected on the difficulty of detailed updates having been provided due to the truncated version of the BAF however thanked colleagues for the continued review and progress of achievement towards objectives.
199/21	It was noted that following discussions by the Trust Board the information presented did not change the ratings presented within the BAF. The Trust Board: • **Received the report and noted the limited assurance**
200/21	**Item 13 Any Other Notified Items of Urgent Business**

	There were no other notified items of urgent business
	The next meeting will be held on Tuesday 2 March 2021, arrangements to be confirmed taking account of national guidance

Voting Members	**3 Mar 2020**	**7 Apr 2020**	**5 May 2020**	**2 June 2020**	**11 June 2020**	**7 July 2020**	**4 Aug 2020**	**1 Sept 2020**	**6 Oct 2020**	**3 Nov 2020**	**1 Dec 2020**	**2 Feb 2021**
Elaine Baylis	X	X	X	X	X	X	X	X	X	X	X	X
Chris Gibson	X	X	X	X	X	X	X	A	X	X	X	X
Geoff Hayward	X	X	A	A	A	A	A	A	A	A	X	X
Gill Ponder	X	X	X	X	X	X	X	X	X	X	X	X
Neill Hepburn	X	X	X	X	X	A	X	X	X	X	X	X
Sarah Dunnett	X	X	X	X	X	X	X	X	X	X	X	X
Elizabeth Libiszewski	A	X	X	X	X	X	X	X	X	X	X	X
Paul Matthew	X	X	X	X	X	X	A	X	X	X	X	X
Andrew Morgan	X	X	X	X	X	X	X	X	X	X	X	X
Victoria Bagshaw												
Mark Brassington	X	X	X	X	X	X	X	X	X	X	X	X
Karen Dunderdale	X	X	X	X	X	X	X	X	X	X	X	X

PUBLIC TRUST BOARD ACTION LOG

Agenda item: 5.2

Trust Board date	Minute ref	Subject	Explanation	Assigned to	Action due at Board	Completed
1 October 2019	1576/19	Smoke Free ULHT	Post implementation review to be presented to the Board	Rayson, Martin	~~07/04/2020~~ ~~03/11/2020~~ 01/12/2020	Agenda Item for Private Board December. Deferred due to covid pressures
4 February 2020	077/20	Assurance and Risk Report Quality Governance Committee	Review of TOM and governance to be presented to the Board	Evans, Simon	~~07/04/2020~~ ~~07/07/2020~~ 03/11/2020	Further work commissioned. Report now expected March 2021

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Public Trust Board*
Date of Meeting	*2 March 2021*
Item Number	*Item 6*
Chief Executive's Report	
Accountable Director	*Chief Executive*
Presented by	*Andrew Morgan, Chief Executive*
Author(s)	*Mark Brassington, Deputy Chief Executive*
Report previously considered at	*N/A*

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

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

Recommendations/ Decision Required	• *To note*

Executive Summary

1. Introduction

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

2. CEO System Overview

- Vaccination across Lincolnshire remains a very positive position with high take up of the vaccine. Our hospital vaccination hubs have been in hibernation following the successful completion of providing first doses to health care workers and associated groups. Second dose vaccines in our hospital hubs will commence from 1st March.
- Focus within the system remains on emerging from wave 2 of COVID and winter demand. As COVID pressures from new hospital admissions ease there is an increased focus on restoring services.
- An updated Pre Consultation Business Case for the Acute Services Review (ASR) was submitted on 16th February. We expect it to proceed to the two stage national panel for review.
- Our final designation pack for becoming an Integrated Care System has been submitted to NHSE/I on 12th February. A regional panel considered this on 22nd February. Once the case is supported it will be submitted for national sign off.

3. CEO Trust Overview

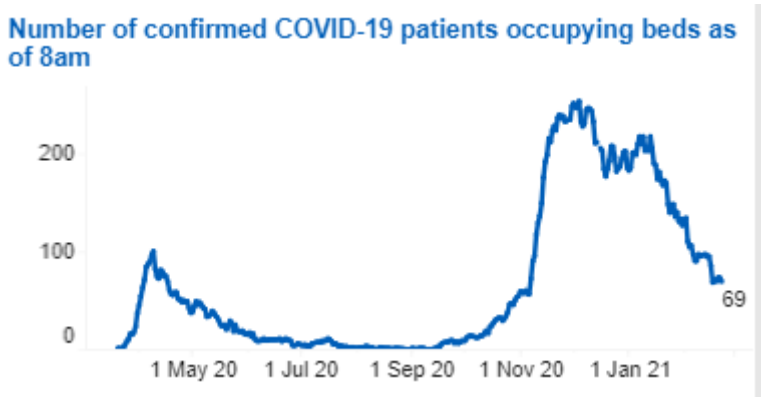
- The number of Covid positive inpatients continues to reduce. Our intensive care units remain busy operating at over 100% normal levels. We continue to care for patients in our intensive care units from outside of Lincolnshire.
- As Covid numbers reduce it allows us the opportunity to review the many temporary arrangements that were put in place to enable us to successfully manage our response to the pandemic. One of those is the designation of the Grantham site that will be considered at an extra-ordinary Board meeting on 16th March. We are also reviewing how we organise patient flow within each of our sites to manage the ongoing presence of Covid, albeit at expected lower levels.
- We have been successful in securing an additional £31.1m of capital investment into ULHT this financial year. This is in addition to our internal capital plan of £13.6m. This has resulted in an overall plan of £44.7m enabling us to progress a number of safety, environmental and new build projects as well as upgrading a significant amount of medical equipment.
- As part of becoming an Integrated Care System there is an expectation that there will be a functioning provider collaborative. We are at the early stages of working with our provider colleagues to explore what this

would mean for us and further updates will be provided in the coming months as this develops.

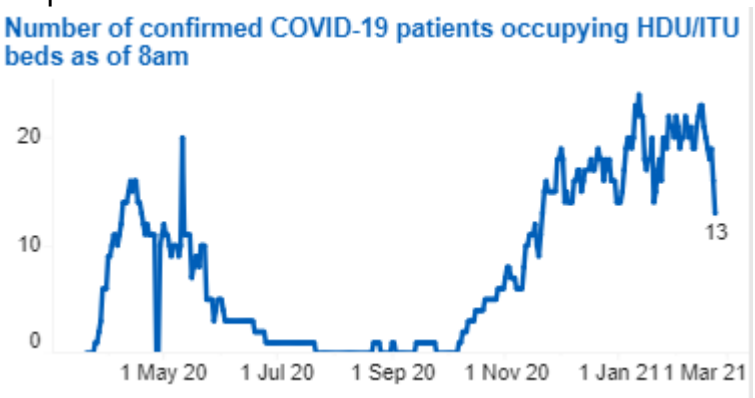
- Finally I am pleased to share that we have recently recruited 227 colleagues into Health Care Support Worker roles across ULHT. This is a great addition to our workforce. Thank you to Health Education England and NHS England and Improvement for their help and support in this project.

4. Covid – Incident and Operational Update

Throughout January and into February the Trust has seen an overall reduction in overall numbers of Covid-19 +ive patients. At the end of January 2021 the Trust still had signficiantly more Covid-19 patients than at the previous peak in April 2020.



Whilst the reduction in overall Covid-19 inpatient demand has a reduced one of the major differences to wave 1 demands is the significantly higher demands on critical care units at Pilgrim and Lincoln hospitals. This was most notable in January and February 2021 with up to 200% of normal maximum capacity being occupied in one or another unit. Sustained periods of 140%-180% have put significant pressures on teams working within the departments both from the regular ICU teams but also from other departments who have been redeployed to help.



Lincolnshire patient needs have not driven all of the demand on critical care. A mixture of both the need to support other systems across the region (with up to 60% of all beds being occupied by patients from other areas) and Lincolnshire combined demand has resulted in the very high levels of occupancy. Unlike

general inpatient demand critical care continues to operate at very high levels with new admissions each day, and this is anticipated to continue into March and April. In order to support the increased demands of critical care a number of services in outpatients, theatres and other ward beds have had to be postponed/suspended temporarily. Clinically urgent and cancer services have continued throughout January and February despite this requirement to redeploy teams to support critical care with the exception a small number of cancer surgical proceeds that also required critical care. Unfortunately, because of the extremely high Covid-19 demands a number of these complex surgeries have had to be cancelled.

5. Virtual Ward

On 13 January 2021 NHSE directed NHS Trusts to develop a 'Covid-19 acute virtual ward' (CVW) which would facilitate early, supported discharge for patients with a suspected or confirmed Covid-19 diagnosis and an improving clinical trajectory.

The national desire for this model has been reaffirmed however and communications from NHSE/I have outlined current ambulance turn around delays. NHSE/I have directed that the CVW should be implemented urgently to help manage current demand.

Working as a Health System ULHT linked with LCHS to fulfill this instruction building upon their pre-existing Clinical Advice Service. A joint Task and Finish Group chaired by Dr Owen has met twice weekly, with specialist input from Dr Jim Campbell Consultant in Respiratory Medicine who has returned from retirement.

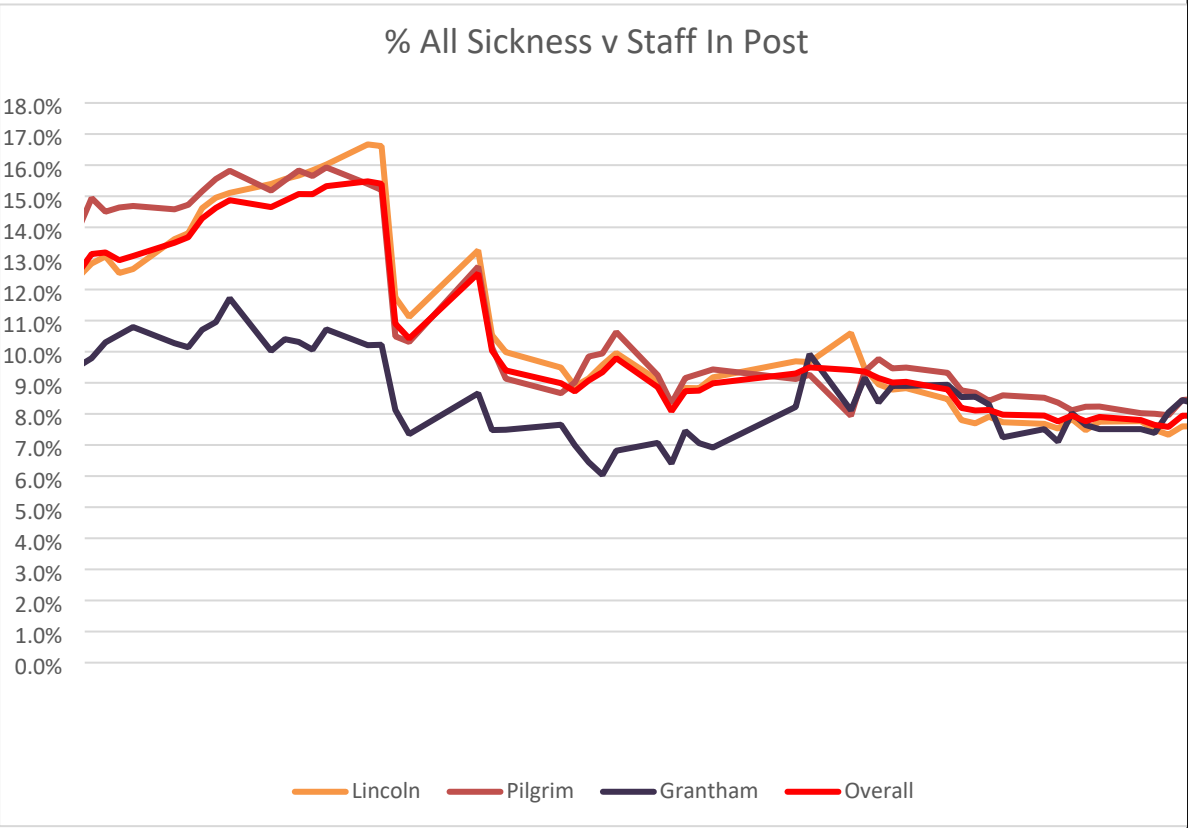
To ensure the requirements of the national mandate are met, and the best possible patient care is delivered, it has been proposed that the CVW development continues but that the model will be an LCHS provided service with in-reach/oversight from ULHT

6. Covid and Clinical Harm Reviews

It is well recognised that patients may be harmed not only by clinical treatment, but also as a result of the need to be on a waiting list for clinical treatment, as this may result in deterioration of their physical or mental condition. The response to the Covid pandemic has resulted in clinical activity being redirected to the acute response and away from 'routine' elective work. This is a national problem and all acute Trust find are learning to manage this problem. To quantify and address this issue a Task and Finish Group has been established. To date the circumstances in which a harm been has been identified and process mapping completed. These include: any patient on a 2 week wait referral who is diagnosed with cancer and waited more than 21 days, any patient who is treated after 104 days on a cancer pathway, any patient on a 12-week urgent referral who waited more than 12 weeks and 6 days, any un-booked patient on a time critical follow-up on the partial booking waiting list beyond their expected follow-up date and any patient who is confirmed as a 52-week incomplete on an RTT pathway.

7. Staff Absence

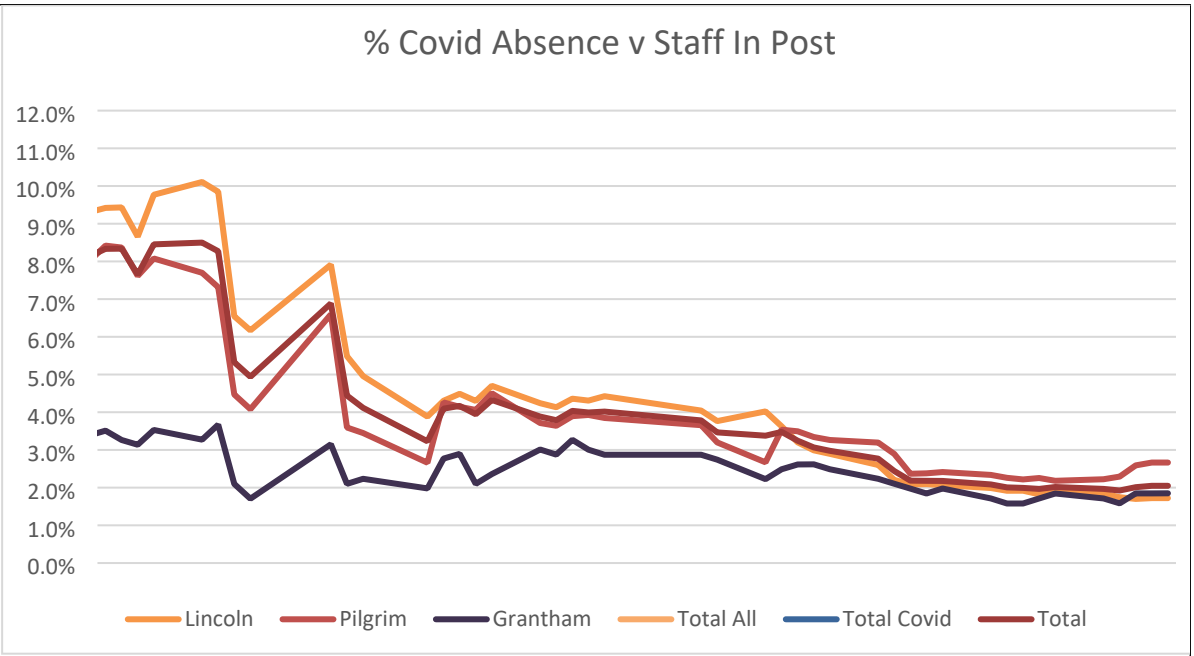
As at 22nd February, the overall percentage sickness absence rate was 7.97%. The chart below shows the sickness rate since 1st December.



As reported previously, an exercise was undertaken in December to review all recorded absence in our systems and ensure absence records had been closed by managers when staff had returned to work. This is reflected in the significant reductions in sickness rates in mid-December shown in the graph above.

Since the end of January, overall sickness has stabilised around 7.5%, although there are still pockets of higher sickness (Registered Nursing being one example).

The chart below shows COVID-related sickness only over the same period. This shows a gradual decline through January and February. There is an increase in the last few days of this reporting period, notably at Pilgrim, which we will keep under review.



Non-COVID sickness is higher than it was in the same period last year. The amount of long-term absence has not altered and the percentage of sickness due to stress and anxiety has not changed. Unfortunately the increase is recorded against the "other absence" category in ESR.

We have brought in additional resources in both the Employee Relations Team and Occupational Health to assist in managing core absence. There is a particular focus on managing the well-being of our staff in order to prevent absence and support the return to work and this is detailed below.

Our use of the Absence Management System consistently across the Trust, will provide us with better, more consistent data. We are working to embed the use of the system by the end of June 2021.

8. Keeping our staff safe

We have a framework in place to ensure our staff are safe at work, which is under regular review. This comprises the following:

PPE - There is regular communication about the appropriate use of PPE and the need to maintain social distancing. We have recently launched a new communications campaign, reminding staff of their responsibilities. There has been a significant reduction in the number of staff outbreaks, from over 20 to 3.

Risk Assessments - 96% of all our staff and 100% of our BAME staff have had a COVID risk assessment. We are working through the implications for those staff who are at greater risk, of the changes being made to the Grantham site and the introduction of the High, Medium and Low risk categorisation of patients. The guidance to staff needs to reflect that all our sites are now "safer" and we will be living with COVID for some time to come. PHE guidance, on which our risk

assessments are based, has not yet changed, but may well do as vaccination coverage extends.

Personal Health Checks - All staff have now been issued with a personal thermometer to enable them to monitor their own temperature and they are advised do so twice a day. We are now reissuing lateral flow tests, so that our staff can continue to test themselves twice a week to identify if they are COVID-positive.

Vaccinations - 90% of the target group of "frontline staff" have now had their flu vaccine, achieving the target set by NHSI/E. the figures for COVID vaccinations are given below:

Staff Numbers (ESR)	Vaccinated	Not Vaccinated	Total Staff on ESR	% vaccinated
ULHT Staff	7984	1056	9040	88.3%
Staff "At Risk"	251	11	262	95.8%
BAME Staff)	958	176	1134	84.5%

We continue to follow up on those staff who have yet to have their first vaccinations, both through general communications and individually, to understand whether they have reservations about having the vaccine that we can address. Second vaccinations will commence on 1st March.

9. Well-Being

An extensive well-being offer has been in place through the COVID pandemic. This has been adapted to reflect additional national and system support available, feedback from our staff (channelled through the Staff Wellbeing Group) and changing circumstances. Most recently we have focused on our ICU staff (recognising the particular pressures associated with increasing their capacity), supporting staff with childcare responsibilities given the continued closure of schools and ensuring easy access to the mental health support provided by LPFT (notably their Steps For Change programme).

There is increasing recognition, as the number of COVID patients reduces, that alongside the "recovery" of services to deal with patient back-logs, there will need to be a "recovery" phase for our staff. This is being considered at a national level, but also in our ULHT recovery planning.

Our well-being offer will underpin this and the actions planned are as follows:

- We will, through messages from our senior leaders, and OD plans, refocus on the work around Civility Saves Lives to reinforce to all staff that compassionate and inclusive leadership and being kind to each other will have a significant impact on the wellbeing of all our staff. Timescale: February onwards

- We will consistently let staff know that it's "OK not to be OK" and this will start by being role modelled at very senior manager level. Executives will be asked, through ELT Live, blogs and so on to share how they are feeling, to show they have struggled at times and share what has helped them. Timescale: immediate

- We will design and implement mandatory training for managers in how to hold mental health wellbeing conversations so they can provide appropriate support for staff who may become unwell. Timescale: Training to commence March 2021

- We will refresh our current list of HWB Champions and Mental Health First Aiders to ensure that those on the list are willing and active to support colleagues. Timescale: March 2021

- We will launch the Wellbeing Guardian role which has been taken on by Elaine Baylis. Timescale: March 2021

- We will continue to work and build partnerships with LPFT so that ULHT staff have access to the appropriate level of wellbeing, emotional and psychological support they require, with a particular focus on staff in ICU. Timescale: March 2021

- With clinical colleagues, we are exploring the model from Birmingham of Staff Safety Wellbeing Officers, who are ICU staff, who work additional shifts in a wellbeing capacity. Timeline: February

- Saying thank you to staff is known to be important. We will schedule a number of events, led by Executive colleagues, to thank our staff. The first event will be in w/c 15th March, which is the 1 year anniversary of admitting the first COVID patient to ULHT. We will schedule events and Executive and Divisional Lead walkrounds through the year. All shift patterns will be covered. Timeline: February

- We are working with our system partners to establish a Lincolnshire Mental Wellbeing Hub and will be interviewing for the Hub Co-ordinator with system colleagues on 16th February 2021.

We recognise that specific support for our staff will need to be in place for the next year at least. However, the intent is that this should develop into a new and on-going health and wellbeing offer for our staff, supported by the new Board Guardian role.

10. Increasing Supply

Formal redeployment of corporate staff has now ceased, although clinical staff continue to be redeployed, most notably to fulfil "buddy roles" in ICU, to support the increased capacity there.

The NHSE/I supported recruitment programme is progressing well. To date we have made the following accepted job offers:

International Registered Nurse Recruitment – 126
HCSW – 196

There will be further work on the international recruitment pipeline, to achieve the target of 200 new appointments by October 2021. The support from NHSE/I enable us to better support those candidates to pass their OSCE exams and enhance the pastoral care we are able to give to ensure those candidates have a good experience when they start with us and wish to remain.

11. National Finance Regime

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

12. ULHT Month 9 Financial Headlines

- The Trust has delivered a surplus of £9k for the month of January after planned support from the Lincolnshire system of £12.0m
- The Trust has delivered a breakeven position YTD after planned support from the Lincolnshire system of £48.1m; £0.5m of planned support from the Lincolnshire system was not required in order to deliver a breakeven YTD position at the end of January.
- The income position is £2.1m favourable to plan driven by passthrough income and other non-recurrent benefits including education income, both that have offsets in expenditure.
- The pay position in January is £1.5m adverse to plan; the year to date pay position is £3.6m adverse to plan.
- Actual Pay expenditure of £35.0m in January is c£0.2m higher than £34.8m in December.
- The increase includes the impact of enhanced bank rates, Bank Holiday enhancements payable under Agenda for Change for New Year's day, and expenditure in relation to the Vaccination Programme
- Including Depreciation, the Non Pay position is £0.3m favourable to plan in January and year to date is £1.5m favourable to plan.
- The reported position includes £0.7m higher than planned expenditure year to date in relation to the additional costs of Covid.
- The reported position also includes £0.3m of expenditure in relation to the Covid Vaccine Programme for which the Trust will be funded on a retrospective basis through a validation process
- Capital expenditure YTD stands at c£16.9m which remains c£6.8m behind revised plan.
- The month end cash balance is £68.1m which is an increase of £54.4m against cash at 31 March 2020.
- The forecast CRL expenditure remains on track, with the newly formed Capital Delivery Group providing oversight.
- The month end cash balance is £63.3m which is an increase of £49.6m against cash at 31 March 2020.

13. System Month 9 Financial Position

- Against the STP income envelope the Lincolnshire system submitted a planned year-end deficit of £4m.
- 100% of this deficit position sits within the CCG with the three Provider trusts planning a zero break-even position.
- The overall system position reported at Month 10 is breakeven. This represents a favourable variance against plan of £3.4m, this is primarily driven by a favourable position in the CCG.
- The system-wide year-end forecast position is breakeven a £4m favourable forecast to plan.

Report to:	Trust Board
Title of report:	Quality Governance Committee Assurance Report to Board
Date of meeting:	22nd February 2021
Chairperson:	Liz Libiszewski, Non-Executive Director
Author:	Karen Willey, Deputy Trust Secretary

Purpose	This report summarises the assurances received and key decisions made by the Quality Governance Assurance Committee (QGC). The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board's response. This assurance committee meets monthly and takes scheduled reports from all Trust operational groups according to an established work programme. The Committee worked to the 2020/21 objectives. The Trust are responding to the second wave of Covid-19 and as such the meeting was held via Microsoft Teams with a reduced agenda and attendance to focus on key priorities. The Committee were mindful of the pressures being faced by the Trust.
	Lack of Assurance in respect of SO 1a Issue: Deliver harm free care **Incident Management Report** The Committee received the report noting that this provided themes and trends which would support the Committee to discharge responsibilities. Clarity was sought with regard to nosocomial infections and outbreaks with the Committee being advised that each infection was pulled together as an outbreak and monitored through an external panel reporting mechanism. This panel had been stood down as there were currently no outbreaks either Covid-19 or otherwise. The Committee were advised of work being undertaken in relation to nosocomial infections in anticipation of a national publication, this would feed through to the Committee. The Committee raised concern around divisional investigations and the time taken for these to be conducted. Consideration was being given to the support that could be offered to the divisions from the central governance team to ensure improvements were made. The Committee noted the concern regarding ophthalmology incidents due to waiting times and were advised that immediate action had been taken resulting in Louth Hospital delivering an additional service which had significantly reduced the waiting list. These incidents were incorporated in to the harm review process.

	Medicines Management Group upward report The Committee received the report and noted that it was not clear if the previous internal audit report recommendations had been included within the current findings or closed down. Work would be undertaken to determine the position and identify any action that was required. **Maternity Assurance Report** The Committee were pleased to note that the Maternity Safety Champion Non-Executive Director was now a member of the Committee. The Committee were advised that the Maternity and Neonatal Oversight Group had been developed and the first meeting was scheduled to take place in March. The Committee noted that the report had been further refined following the publication of the Ockenden review. The Committee noted that the maternity safety highlight report required further refinement in order that clarity could be provided for the data presented. The Committee reviewed the CNST compliance update noting that there had been some progress with the technical issues experienced with the maternity system. It was noted that the achievement of the training standard continued to be difficult due to current circumstances and that this was rated red. The Committee received an update in relation to Healthcare Safety Investigation Branch investigation being advised that there were no issues that had required referral during January. Reports had been received for 2 outstanding cases and action was being taken to address the findings. The Committee were advised of a serious incident that had been reported during January noting that immediate action had been taken as a result. The Committee were advised that the Trust had responded to Ockenden report to advise that the Trust were compliant with the 2017 birth rate plus. The outcome of the latest birth rate plus was awaited and would be presented to the People and Organisational Development Committee. The Committee noted that the report would be presented to the Board in order that the maternity reporting requirements were met. **Harm Reviews** The Committee received the reporting noting the need for clarity on the link between harm reviews and high profile cases. There was concern that it was not yet clear on the potential harm that had not yet come to light as reviews were yet to take place.

	The Committee were advised that an electronic solution was being sought in order to stratify and segment harm however there had not yet been a suitable solution identified. The policy in order to progress this however was being developed. The level of risk was not yet known and the Committee acknowledged that the Board would need to be made aware of the current position. It was recognised that this was a national issue due to the impact of Covid-19 however the Trust were developing a strong process to move this forward. The Committee requested that harm reviews were reported on a monthly basis to ensure assurances were received. **High Profile Cases** The Committee received the report noting the cases reported, the Committee noted the resolution of 2 cases since the previous report that were now rated as low risk. The Committee noted the low surface temperature action plan was progressing well and there was a view that the task and finish group would step down with any outstanding actions being monitored through the Quality Governance Committee and Finance, Performance and Estates Committee until completed. The lessons learned actions for the Committee would also be submitted. **IPC Group upward report** The Committee received the report noting the action plans that had been presented following the NHS England IPC visit to the Pilgrim Site. The Committee were advised that a response had been received to the clarification sought as a result of the visit and NHS England were happy with progress to date. The Committee noted that there were a number of actions that required review due to the completion dates having passed but significant progress was noted. **Patient Safety Group Upward report** The Committee were pleased to receive a clear report providing highlights and actions being taken. The Committee reiterated concern over the size of the agenda of the group. The report identified that following a review of the stroke service and SSNAPP data the service had moved to an A rating. The changes to the service had been necessary due to fragility and in response to Covid-19. Action was now being taken to reinstate speciality wards with a new IPC approach as these had been lost in the response to Covid-19. The Committee were assured that the model put in place was the right one offering the best results to patients.

	The Committee recognised that there had been an impact on patient safety due to Covid-19 however the report demonstrated the issues and action being taken to address these concerns.
	Lack of Assurance in respect of SO 1b Issue: Improve Patient Experience **Patient Experience Group Upward report** The Committee received the report noting that further development of the group and report were required in order to provide assurances. The Committee sought assurance on how the themes identified from the range of information available were identified and taken forward by the group to impact on care delivery. The Committee noted the need for the inclusion agenda to sit with the group in order to upwardly report to the Committee and noted that learning from Covid-19 would also require inclusion. **Complaints report – quarter 3** The Committee received the report nothing that future reports would contain themes and trends for complaints. This would also tie in to patient experience to ensure that this was considered in the round.
	Lack of Assurance in respect of SO 1c Issue: Improve Clinical Outcomes **Clinical Effectiveness Group Upward report** The Committee received the report noting the concerns raised to the Committee with regard to national audit outliers. The Committee noted the need for Standard Operating Procedures to be updated in a timely manner and a proposal had been considered to address the delays. The Committee raised concern regarding the respiratory staffing issue and were advised that this was a fragile service. Work was being undertaken to improve the service with the development of a Trust Wide Team and investment in the environment. The one team approach would support recruitment to the team and address staff shortages.
	Assurance in respect of other areas: **Committee self-assessment action plan** The Committee received the draft action plan requesting refinement of actions to ensure completion dates could be identified and to ensure clarity was provided over the responsible owner of actions. The Committee noted that widening of the self-assessment to others

	engaged with the Committee would support the Committee development session. **Terms of Reference for Committee Reporting Groups** The Committee received the terms of reference and forward reporting schedules for both the Committee and the reporting groups. Subject to minor amendments the reporting groups terms of reference and forward reporting schedules were approved by the Committee. It was proposed that these would be used from 1st April 2021. The Committee also received a revised upward report template for use by the reporting groups noting that this would provide improved reporting and offer review of the BAF and risk register through the reporting groups. Concern was noted by the Committee in relation to the expectations of divisional attendance at the reporting groups and were advised that this would be kept under review. **Committee Performance Dashboard** The Committee noted the difficulty in sustaining improvement with the sepsis indicator acknowledging that practitioners were supporting clinical practice to respond to Covid-19. Disappointment was noted in relation to duty of candour however there had been a clear explanation as to the reason for the position. The Committee noted the positive position in relation to pressure ulcers and were pleased to see that performance has been maintained despite the challenges being faced by staff. The Committee were advised that there had been a further 2 MRSA Bacteraemia notified in the financial year bringing the total to 4. A review had been undertaken by the Director of Infection, Prevention and Control and a failure to follow policy identified. Action was being taken to address issues identified. A further Never Event had been recorded relating to a misplaced nasogastric tube with the Committee noting that this was the second never event of this nature in the year. A full review was taking place of the case and the previous cases to ensure improvement actions were in place. The Committee were advised that work was underway to review the indicators within the dashboard to ensure reporting of the appropriate measures to the reporting groups and the Committee. The kite mark documentation was currently being completed. **Quality Impact Assessments** The Committee received the report requesting that this continued to be

	received on a monthly basis to ensure that the process was being embedded. The Committee were pleased with the level of detail presented enabling an understanding of the schemes that had been rejected. The Committee requested that the implications of the large schemes on clinical services be detailed.
Issues where assurance remains outstanding for escalation to the Board	The Committee recognised the need to inform the Board of the current position of the harm review process due to the level of risk not yet having been identified. The Committee had requested that the paper be presented to the Private Board.
Items referred to other Committees for Assurance	None
Committee Review of corporate risk register	The Committee reviewed the risk register noting that the overall patient safety risk had been raised following discussions at the Patient Safety Group.
Matters identified which Committee recommend are escalated to SRR/BAF	None
Committee position on assurance of strategic risk areas that align to committee	The Committee considered the reports which it had received which provided assurances against the strategic risks to strategic objectives.
Areas identified to visit in dept walk rounds	Department walk around currently suspended.

Attendance Summary for rolling 12 month period

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

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

Meeting	Trust Board
Date of Meeting	2 March 2021
Item Number	

Maternity Safety Update

Accountable Director	Karen Dunderdale, Director of Nursing
Presented by	Libby Grooby – Interim Head of Midwifery/Lead Nurse
Author(s)	Libby Grooby – Interim Head of Midwifery/Lead Nurse
Report previously considered at	Monthly update to Quality Governance Committee

How the report supports the delivery of the priorities within the Board Assurance Framework	
1a Deliver harm free care	*X*
1b Improve patient experience	*X*
1c Improve clinical outcomes	*X*
2a A modern and progressive workforce	
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	The Trust Board is asked to: • note the monthly update

Executive Summary

Maternity Safety Update:

- The report provides the current position in respect of compliance against the standards for CNST and supports the requirements of reporting to the Trust Board as highlighted in the Ockenden report.

- Areas of risk for CNST standards continue to be standard 2 and standard 8. Work is ongoing with system C to address the compliance with the Maternity Services Data Set (MSDS). Issues with training compliance, due to the impact of the pandemic have been raised by trusts nationally. Work continues to improve the achievement of this standard under the continued pressures of being able to release staff.

- Work is also underway to further refine reporting and assurances in relation to maternity quality and safety. This includes the setting up of a Maternity & Neonatal Oversight Group chaired by the Director of Nursing. Terms of Reference for this group have been drafted and have been submitted to the Quality Governance Committee for approval.

Maternity Safety Highlight Report

Trust: United Lincolnshire Hospitals NHS Trust | Date: January 2021

CNST: 10 Steps-to-safety		
1	Perinatal review tool	
2	MSDS	
3	ATAIN	
4	Medical Workforce	
5	Midwifery Workforce	
6	SBLCB	
7	Patient Feedback	
8	Multi-professional training	
9	Safety Champions	
10	Early notification scheme	

Saving Babies Lives Care Bundle (SBLCB) V2		
1	Reducing smoking	
2	Fetal Growth Restriction	
3	Reduced Fetal Movements	
4	Fetal monitoring during labour	
5	Reducing pre-term birth	

RAG RATING

RED	Off track, needs support
AMBER	Off track, but within control
GREEN	On track
BLUE	Completed & embedded

Outliers – Red flags	National Rate	Trust Rate
IOL	**<32%**	**39.83% ↓**
C-Sections	**<30%**	**35.56% ↓**
Mandatory Training	**>95%**	**81.82% ↑**
PROMPT Training	**>90%**	**74.4% ↑**

Number of	
On-going HSIB investigations	**Serious Incidents**
2 – Reports received. Awaiting sign off by SI committee No other referrals in process.	**1 –** PPH/hysterectomy LCH site

Continuity of Carer		
Compliance	**16.7% booked on pathway in month** **On target to reach 35% by end March 2021**	
LMS target	**35% (March 2021)** **Action plan in place to meet target.**	
Progress against action plan	• **Team 1 Gainsborough - Launched August 2019** • **Team 2 Sleaford - Launched September 2020** • **Team 3 Skegness - Launch January 2021** • **Team 4 Wolds - Launch awaited**	

OUTSTANDING CARE personally DELIVERED

Family Health Division
Maternity Services

Transforming Perinatal Safety
Update to Board/LMNS January 2021

Introduction

The report provides the update to the Trust Board / LMNS as at 31 January 2021. Since the last report, the report template has been reviewed to ensure compliance with all reporting requirements to Trust Board.

Following review of the board report template, it has been recognised that some information could be captured more effectively within the maternity dashboard, therefore work is underway to review the dashboard and the target KPIs in order to streamline and strengthen reporting and ensure that the data reported is meaningful and supportive of the need for Trust boards to be sighted on maternity safety.

CNST Compliance Update

No.	Safety Action	Current RAG
1	Perinatal Mortality Review Tool (PMRT)	
2	Maternity Services Dataset (MSDS)	
3	Avoidable Term Admissions Into the Neonatal Unit (ATAIN)	
4	Medical Workforce	
5	Midwifery Workforce	
6	Saving Babies' Lives Care Bundle (SBLCB) V2	
7	Maternity Voices Partnership	
8	'In-house' multi-professional maternity emergencies training	
9	Bi-monthly meetings between Safety champions and Board level champions	
10	NHS Resolution's Early Notification Reporting	

CNST Summary

Reporting processes and data collection are robust and put the Trust in an advantageous position. However, compliance in relation to Action 2 remains at risk due to the digital system and its inability to submit the relevant data to the MSDSv2. Training compliance is also a challenge, however there is an action plan in place to support compliance.

The Trust's Safety Lead has reviewed all evidence with the CNST lead from an external organisation to ensure evidence is robust and supports compliance. This was supported by the Maternity Improvement Advisor and ULHT action plan and the evidence template was shared.

Monthly standard updates/concerns

Safety Action 2: MSDS

NHS Resolution have updated trusts on the Maternity Incentive Scheme, including the deadline for trust declarations moving to 15 July 2021. NHS Digital supplemented that announcement in an e-mail to trusts to explain that the wording on action 2, item 3 had changed to the following.

Trust Boards to confirm to NHS Resolution that they have fully conformed with the MSDSv2 Information Standards Notice, DCB1513 And 10/2018, which was expected for April 2019 data, or that a locally funded plan is in place to do this, and agreed with the maternity safety champion and the LMS. This should include submission of the relevant clinical coding in MSDSv2 in SNOMED-CT.

Work is ongoing to ensure compliance with the 11 required tables for CNST compliance. Actions are being agreed for the remainder of Information Standards Notice (ISN).

Safety Action 8: 'In-house' multi-professional maternity emergencies training

Further updates from NHS resolutions to clarify the requirements for this standard are awaited. Challenges have arisen due to:

- the ability to release staff for training during the Pandemic
- stopping face to face training
- ability for anaesthetists and critical care staff to attend training due to increased requirements in ICU

Safety Action 9: Trust safety and Board level champions' communication and escalation

The Trust has successfully appointed band 7 team leaders for the Wolds and Skegness continuity of carer teams (CoC). The focus will now be to formulate teams in Lincoln and Boston so that the CoC pathway is directed towards women from BAME backgrounds, women living in low socio-economic households and for women

with English as their second language. Recruitment for the city teams awaits the return of Birthrate+ report before this project can continue.

Ockenden Immediate and Essential Actions Update –

Since the last meeting, Trust Board and LMNS reporting has been agreed.

An ante-natal care review is underway to include demand and capacity work, development of specialist clinics, personalised care planning improvement. Scoping for demand and capacity will be completed this month.

Actions that require further support in the implementation of the Ockenden requirements include:-

- System support is required to secure expert clinical opinion on cases of fetal death, maternal death, neonatal rain injury and neonatal death.

- Further guidance is awaited on the role of the independent senior advocate role from NHSE

Red Flag Update

As mentioned above, the dashboard is currently being reviewed to ensure that the data captured is meaningful and supports the trust in identifying areas of safety concern.

ULHT remain red for induction of labour (IoL) rate and caesarean section rate. The increased IoL rate is mainly due to changes in practice in line with national drivers. However, local audits, benchmarking exercises, and quality improvement initiatives have been undertaken. A new IoL pathway has been soft launched at Lincoln Hospital with the expectation to roll out pan trust after the system has been tested. This is in place to ensure that all IoL are reviewed and classed as being required.

The PPH >1.5L rate has previously been consistently >3% and therefore given a red rating. A local audit was carried out and multiple quality improvement initiatives launched. In January 2021, the rate of PPH had improved and was in the amber rating for the first time in 7 months. The national target remains <2% however, nationally trusts are exceeding this target. Although the Trust is over the target, in comparison to national statistics (2016/17), it is not an outlier.

The percentage of staff attending the prompt and mandatory study attendance is below the target of 90% and 95% respectively but continues to improve.

Incident Reviews

HSIB investigations

ULHT had no maternal deaths and no cases in January 2021 where babies met the HSIB investigation criteria.

The final report has been received from the HSIB in relation to a reported intrapartum death from 2020. Some safety recommendations were identified which had already been included in the action plan developed by the Trust following the reporting of the incident.

Update on Key issues from SIs (non HSIB)

The Trust declared 1 SI in maternity in January 2021 which related to a postpartum haemorrhage following an emergency caesarean section.

Number of incidents logged graded as moderate or above and what actions are being taken

There was 1 moderate incident for January 2021 for Obstetrics regarding a delay in escalation to the Paediatric Team.

During January 2021, 5 maternity cases were discussed at the SI Rapid Review meeting. All learning from these incidents has been shared through Governance meetings, team meetings and Newsflash.

Service User Voice Feedback

The Trust continues to facilitate Face Book live sessions, where service user feedback is encouraged, and questions answered. The Trust has received positive feedback regarding the birth choices clinic.

As at 1 February 2021, the total number of open complaints for obstetrics, community midwifery and neonates was 8.

Following the introduction of lateral flow testing for women and partners in Maternity, in line with national guidance, and in response to significant feedback obtained via social media platforms, FAQ were developed.

Staff Feedback from Frontline Champions and Walk-Abouts

A staff engagement session is held weekly and led by senior midwives, usually the Head of Midwifery and the Deputy Head of Midwifery. These sessions are well attended and provide frontline staff the opportunity to escalate concerns as well as update themselves with current affairs within the Trust.

Safety champion staff engagement sessions are held bi-monthly via Teams.

Conclusion

In efforts to respond in a timely manner to the Ockendon report, the Trust has advanced the service to improve safety for service users. Our ability to report assurances to Trust Board has developed to include a much more detailed explanation of incidents and compliance with programmes such as Saving Babies Lives version 2.

The Trust is aware of any areas of concern and have the systems in place to monitor actions and audit progress. Quality initiatives are derived from National reports, incident reporting, the dashboard and new evidence which focuses the Trusts intention towards the safety of service users and their families.

Report to:	Trust Board
Title of report:	People and OD Committee Assurance Report to Board
Date of meeting:	11th February 2021
Chairperson:	Sarah Dunnett, Non-Executive Director (Deputising for Committee Chair)
Author:	Karen Willey, Deputy Trust Secretary

Purpose	This report summarises the assurances received and key decisions made by the People and OD Assurance Committee. The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board. This assurance committee meets monthly and takes scheduled reports according to an established work programme. The Committee worked to the 2020/21 objectives. The Trust are responding to the second wave of Covid-19 and as such the meeting was held via Microsoft Teams with a reduced agenda and attendance to focus on key priorities. The Committee were mindful of the pressures being faced by the Trust.
Assurances received by the Committee	**Assurance is respect of SO 2a** **Issue: A modern and progressive workforce** **Delivering Personal and Professional Development 2021** The Committee received the report noting that through the appointment of the Organisational Development Lead for Education there was a focus on the work and implementation of the action plan. The Committee noted that this incorporate recommendations made in recent internal audit reports. Whilst the plan was in place, limited assurance was provided on implementation, which was a work in progress. The Committee noted that the audit recommendations relating to core learning would be closed by the end of March 2021 and there had been good progress on the education funding audit recommendations. For outstanding recommendations there were a number of interdependencies, including the implementation of a new intranet, although progress was still being made .

	The Committee noted the intention to further develop the training needs analysis for the Trust noting that this would be linked and embedded within the appraisal system. The Committee were pleased to see the action that had been taken so far, including additional resource. The Committee acknowledged that this work linked t through to the wider cultural approach of the organisation and value placed on education, learning and development for all staff.
	Assurance in respect of SO 2b **Issue: Making ULHT the best place to work** **Guardian of Safe Working** The Committee received the report and were pleased to note the development of the report in providing assurance to the Committee. Feedback would be provided to the Guardian to offer thanks for the work invested in developing the report. The Committee noted that the British Medical Association (BMA) had written to the Medical Director to commend the process that the Trust had followed in relation to the engagement with junior doctors in the decision-making process for rotas and working patterns during Covid-19. The report raised a number of concerns safety and the Committee sought assurance on the actions being taken to address these. There were a number of patient safety concerns identified and the Committee asked for the report to be referred to the Quality Governance Committee in order to seek assurance that these had been acted on.
	Assurance in respect of other areas: **Reverse Mentoring Cohort 1 Report** The Committee received the evaluation report noting that there had been a number of staff involved in the pilot of the reverse mentoring programme. It was noted that, whilst this had been introduced during the Covid-19 pandemic, that there was enough evidence from the evaluation to prove the concept useful to the organisation. Work would be undertaken to reflect on the evaluation and consider the roll out of the programme across the Trust.

Committee Assurance Report

The Committee received the report noting that this offered assurance for objectives 2a and 2b.

The Committee noted that there had been significant staff absence throughout Covid-19 however this had now reduced and was reported as 7.7%. Issues with reconciliation of sickness figures continues however the introduction of the absence management system would support this being resolved.

The Committee noted the ongoing success of the vaccination programmes for both seasonal flu and the Covid-19 vaccine. The Trust had performed well compared to others for the uptake of the flu vaccine. The Committee also noted the positive position with the completion rates for BAME risk assessments.

The Trust had been approached by NHS England/Improvement to write a case study identifying the actions taken that had resulted in the high uptake of the vaccine. The Committee reflected on this noting that this had been the result of the high levels of engagement with staff throughout the pandemic.

The Committee were pleased to note the ongoing and considerable amount of work in relation to staff well-being and noted that there was now consideration to the longer-term welfare of staff. A review of the support offered would be undertaken and any gaps identified. This would be reported back to the Committee.

The Committee were updated on the current position of recruitment noting that there had been a significant number of offers made for both international nurses and healthcare support workers. The Clinical Education Team had been restored from redeployment in order to support the new recruits. The Committee continue to seek assurance on support to new recruits, both professional and pastoral.

The Trust had also been asked to produce case studies for the recruitment programmes of work in order to support other Trusts who were experiencing difficulties with recruitment.

	The Committee noted that progress was being made in respect of job planning however not at the pace desired. It was acknowledged however that the position was greatly improved from the previous year and there was now a focus to deliver. The Committee discussed the need for a plan for recovery of people alongside services and noted that discussions would need to be held through the System People Board to ensure the right support was in place for the workforce. The Committee noted that workforce planning remained in progress with a need to ensure that all aspects of the workforce were captured including cultural work. **Committee self-assessment action plan** The Committee received the action plan following the outcome of the self-assessment and noted the proposed actions to improve the function of the Committee.
Issues where assurance remains outstanding for escalation to the Board	None
Items referred to other Committees for Assurance	Guardian of Safe Working Report – to seek assurance from the Quality Governance Committee that the Patient Safety concerns raised had been addressed.
Committee Review of corporate risk register	The committee received and reviewed the risk register noting that this was a comprehensive report which had flagged risks in relation to specialities.
Matters identified which Committee recommend are escalated to SRR/BAF	No areas identified
Committee position on assurance of strategic risk areas that align to committee	No areas identified
Areas identified to visit in ward walk rounds	Department walk around currently suspended.

Attendance Summary for rolling 12 month period

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

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

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*2 March 2021*
Item Number	*Item 9.2*
Board Wellbeing Guardian	
Accountable Director	*Elaine Baylis, Trust Chair*
Presented by	*Elaine Baylis, Trust 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	*Insert risk register reference*
Financial Impact Assessment	*Insert detail*
Quality Impact Assessment	*Insert detail*
Equality Impact Assessment	*Insert detail*
Assurance Level Assessment	*Insert assurance level* • *Moderate*

Recommendations/ Decision Required	• *The Board are asked to note the arrangements being put in place for Wellbeing Guardian*

Executive Summary

The official guidance on Wellbeing Guardians was produced in October, 2020 by an NHS England/Improvement Expert Advisory Board. This set out the recommendation for Trusts to create a Board level Assurance role which supports the explicit responsibility of the CEO and Board members in ensuring the health and wellbeing of 'NHS people'.

This paper sets out, in brief, the role and the wider responsibilities of the Board.

Wellbeing Guardians

The Wellbeing Guardian takes an assurance role at Board level, in which they look at the organisation's activities through a holistic health and wellbeing lens. Their purpose is to:

- question decisions which might impact on the wellbeing of ULH staff
- challenge behaviours which are likely to be detrimental
- challenge the Board to account for its decisions and their impact on the health and wellbeing of ULH staff.
- remind the board to consider any unintended consequences of organisational actions and review them with a view to mitigating these.

The role is considered best suited to a Non-Executive Director who does not need to have specialist knowledge about wellbeing, but should be confident and competent in their ability to check and challenge the executive team on behalf of the board.

Operating in an inclusive manner, the Wellbeing Guardian will actively encourage a dispersed model of wellbeing leadership which engages ownership and advocacy across the organisation, valuing and building upon existing internal resource. As this becomes routine practice for the Board, the requirement for the Wellbeing Guardian to fulfil this role should reduce over time.

Taking into account the impact that the pandemic has had on our staff, the need to ensure that the organisation responds appropriately to the health and wellbeing of the workforce and to indicate the importance that the Trust Board attaches to this issue the Trust Chair will take on the role of Wellbeing Guardian.

The Chair will work closely with the Director of People and OD to ensure that priority actions are embedded across the Trust. The People and OD Committee will receive regular reports on progress and these will be reported to the Board through the usual upward reporting mechanism.

Who can be a Wellbeing Guardian?

- Where organisations have non-executive directors (NEDs), it is recommended that it is one of them who is appointed into the Wellbeing Guardian role.
- Where organisations do not have a NED (for example in primary care or in a CCG), it is recommended that an equivalent role fulfils the responsibilities the Wellbeing Guardian. For example, this could be the Clinical Director of a Primary Care Network (PCN).
- The Wellbeing Guardian should:
  - Care about people, find ways to connect with staff and staff networks and listen well
  - Work closely with and support the HR Director and other executives who lead in this area
  - Feel confident in challenging the Board and other senior leaders, questioning decisions that could impact on the wellbeing of our NHS people, and challenging behaviours or aspects of the culture that are likely to be detrimental to others.
  - Be fully cognisant of the protected characteristics outlined in the Equality Act and be committed to ensuring that disparities on the basis of a protected characteristic are eradicated.

Check list – Phase One

To support systems with the rollout of the Wellbeing Guardian role, the Board is invited to use this checklist to help inform their thinking and support the delivery of this role.

Step	Yes/No
Have we completed our NHS Health and Wellbeing Diagnostic assessment to assess current health and wellbeing performance and identify priority activities? If not, do we need any support in completing this?	
Have we as the board agreed which priority actions should be included in the Wellbeing Guardian role description and how the nine principles will be phased in?	
Do we currently have any NEDs appointed to our board? If not, what similar role is in place?	
Have we identified a suitable candidate for the Wellbeing Guardian?	
Do we now feel confident to move on to phase two?	

One page summary of the 9 board principles supported by the wellbeing guardian

Principle One
The health and wellbeing of our NHS people and those learning and working in the NHS should not be compromised by the work they do for the NHS.

Principle Two
Where an individual or team is exposed to a particularly distressing clinical event, board time should be made available to assure the board and the wellbeing guardian that the wellbeing impact on those NHS staff and learners has been checked.

Principle Three
Regular assurance will be provided to the wellbeing guardian to ensure that wellness induction (previously wellbeing 'check-in') are being provided to all new NHS people on appointment and to all learners on placement in the NHS, as outlined in the 2019 NHS Staff and Learners' Mental Wellbeing Review's recommendations.

Principle Four
The wellbeing guardian will receive assurance that all our NHS people and those learning in the NHS have ready access to a self-referral, proactive and confidential occupational health service that promotes and protects wellbeing.

Principle Five
The death by suicide of any member of our NHS people or a learner working in an NHS organisation will be independently examined and the findings reported through the board to the wellbeing guardian.

Principle Six
The NHS will ensure that all our NHS people and learners have an environment that is both safe and supportive of their mental and psychological wellbeing, as well as their physical wellbeing.

Principle Seven
The NHS will ensure that the cultural and spiritual needs of our NHS people and those learning in the NHS are protected, and equitable and appropriate wellbeing support for overseas NHS people and learners working in the NHS.

Principle Eight
The NHS will ensure the wellbeing and make the necessary adjustments for the nine groups protected under the Equality Act 2010 (including consideration for how intersectionality may impact wellbeing).

Principle Nine
The wellbeing guardian will provide suitable challenge to the board to be assured that the organisation is working with system leaders and regulators, to ensure that wellbeing is given the same weight as other aspects in organisational performance assessment.

Report to:	Trust Board
Title of report:	Finance, Performance and Estates Committee Assurance Report to Board
Date of meeting:	18 February 2021
Chairperson:	Gill Ponder, Non-Executive Director
Author:	Karen Willey, Deputy Trust Secretary

Purpose	This report summarises the assurances received, and key decisions made by the Finance, Performance and Estates Committee (FPEC). The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board's response. This assurance committee meets monthly and takes scheduled reports from all Trust operational groups according to an established work programme. The Committee worked to the 2020/21 objectives. The Trust are responding to the second wave of Covid-19 and as such the meeting was held via Microsoft Teams with a reduced agenda and attendance to focus on key priorities. The Committee were mindful of the pressures being faced by the Trust.
Assurances received by the Committee	**Lack of Assurance** in respect of SO 3a A modern, clean and fit for purpose environment **Issue: Assurance Report Health and Safety Group** The Committee received the report noting that future reports would be integrated within a suite of reports in relation to estates and facilities. The Committee were advised that a meeting was scheduled with Staff Side and ACAS where it was expected that issues regarding the group would be resolved. Engagement had been improved during the pandemic with a health and safety cell established and Staff Side engaged in the day to day management and operation of the Covid-19 response. The Committee were advised that there had been substantial progress made in relation to the low surface temperature works despite the challenges of the environment due to Covid-19. The Committee noted that the British Safety Council had been invited to conduct a Covid-19 assurance review which would result in a 6-day visit following the submission of evidence. Once the report was received an action plan and gap analysis would be developed.

	Issue: Estates Statutory Compliance Report The Committee received the report noting the improvement in the information presented, particularly the inclusion of the dashboard to demonstrate compliance. The Committee noted a number of high risk areas that had not had fire works completed and were advised that this was due in part to the impact of Covid-19. There was an expectation that there would be an increase in costs to complete the works however this was being reviewed in line with the capital plan for 2021/22. Lincolnshire Fire and Rescue would be informed of the position however it was hoped that they would be appreciative of the position when applying the test in May/June and reviewing enforcement actions as additional measures could be taken to mitigate the remaining risks. The Committee noted the dashboard detailing the assurances in respect of relevant authorised engineers and were advised that this would develop to demonstrate the full compliance position of the Trust.
	Assurance in respect of SO 3b Efficient Use of Resources **Issue: Finance Report including System Finance Report** The Committee received the report noting the breakeven position at the end of January 2021 and the adjustment to the system forecast to a breakeven position at year-end. The Committee noted that the penalty incurred by the Trust for non-delivery of elective activity during September and October was being appealed due to the impact of Covid-19. If successful, the Trusts position would improve by £0.5m. It was noted that there had been income gains during the second half of the year resulting in £1.3m of additional income. The Trust had incurred Covid-19 costs that were £0.7m higher than planned however it was noted that planning had taken place ahead of wave 2. The pay position in January was reported as £1.5m adverse to plan resulting in a year to date position of £3.6m adverse. January had seen a significant increase in agency costs and Executive focus was being provided to understand the position and take action to bring this down. The Committee were advised that the bank incentive rate was due to run until 7th March, a review would be undertaken prior to this with consideration to step the incentive rates down. Non-pay remained favourable at £0.6m due to reduced elective activity levels and CIP had continued to deliver at £0.5m favourable to plan. The Committee were advised that detailed discussions relating to the capital programme would take place at the next Board Development

	session however noted additional income had been confirmed from the Department of Health relating to applications previously declined. Work was underway to ensure these monies were spent appropriately in the remainder of the year. **Issue: Addendum to Pilgrim ED outline business case** The Committee received the addendum to the outline business case noting the preferred way forwards outlined in the report. The Committee recognised that funding of £21.3m had been secured however there remained a £15m funding gap for the option that would offer best value for money and the most appropriate facilities to meet the needs of patients. The funding gap would in part be met through regional support for 20 21/22 however the remaining gap would need to be sourced from the System for the following 2 years.
	Assurance in respect of SO 3c Enhanced data and digital capability **Issues: Assurance Report Digital Hospital Group** The Committee received the report noting that this provided clear assurances to the Committee.
	Assurance in respect of SO 4a Establish new evidence based models of care **Issue: Outpatient Programme update** The Committee received the report for information and noted the content.
	Assurance in respect of other areas: **Committee Performance Dashboard** The Committee received the dashboard noting a concern regarding targets that had not been set for the year. It was noted that some trajectories weren't set due to the impact of Covid-19 and the Committee were assured that work was underway, in line with recovery and restoration plans, to determine targets from 2021/22. The Committee noted the improvement with 12-hour trolley waits and ambulance conveyances, however, noted that there appeared to be slow recovery of diagnostic services. It was noted that there was a lower level of risk associated with diagnostic services and to support recovery across all services some elements of diagnostics were being recovered at a slower pace. The Committee reflected on the 104-day waiters and 52-week waiters which continued to decline but recognised this was due to the impact of Covid-19 and would form part of recovery plans.

	Integrated Performance Report The Committee received the report noting that there was now a move from pandemic to endemic in respect of Covid-19 resulting in this being managed alongside other infectious diseases. Project Salus would provide flexibility to manage capacity of infectious diseases in an improved manner. The Committee noted the delivery of cancer services and were advised that patients were reviewed on a daily basis and prioritised on individual need over thematic or tumour site pathways. This was offering a greater level of mitigation to the risk of harm to patients. The Committee were advised that critical care had been expanded to 200% capacity as per national direction, with current capacity running at 170%. As a result, the requirement for additional staff had resulted in a reduced level of staff availability for services such as theatres. **PRM Upward report** The Committee received the report noting the introduction of a 90-minute cancer standard and congratulated the Surgery division for being the first in the country to introduce such a standard. The Committee noted that concerns raised within the Family Health Division regarding system use were being escalated and engagement with the provider was underway. The Committee noted that this was an ongoing national issue and the Director of Finance and Digital was engaged in discussions with the provider to seek a resolution. The report referenced potential patient harm however the Committee were assured that there was oversight of this through the Quality Governance Committee. The Committee discussed the recovery of services in relation to staff well-being noting that that this would form a fundamental part of the restoration of services and focus would be provided through the People and Organisational Development Committee. **Integrated Improvement Plan update** The Committee noted the difficult position with the delivery of the Integrated Improvement Programme due to Covid-19. The Committee requested an update in relation to Model Hospital at an appropriate time noting that due to the impact of Covid-19 there had been limited to no progress currently.
Issues where assurance remains outstanding for	No additional items to raise.

escalation to the Board	
Items referred to other Committees for Assurance	None
Committee Review of corporate risk register	Due to the reduced agenda, the Committee did not review the risk register during the meeting, but Committee members had reviewed the risk report and risk register prior to the meeting.
Matters identified which Committee recommend are escalated to SRR/BAF	The Committee was assured that the BAF was reflective of the key risks in respect of the strategic objectives of the organisation.
Committee position on assurance of strategic risk areas that align to committee	As above
Areas identified to visit in dept walk rounds	Department walk around currently suspended

Attendance Summary for rolling 12-month period

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

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

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

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

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

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

Executive Summary

Quality

Infection Prevention and Control

The Trust has declared an MRSA Bacteraemia that occurred on the Lincoln Site. The DIPC has already undertaken an RCA with the clinical team and it has been declared as a Serious Incident. A number of immediate actions have already been undertaken by the clinical team following the identification of the care delivery issues. This case was hospital acquired, avoidable and antibiotics were used inappropriately. This is the second case within the financial year of 2020-2021.

Incidents Investigation and Closure

Never Events

The Trust declared a Never Event in January relating to a mis-placed nasogastric tube. The incident was responded to promptly by the clinical team to prevent serious harm to the patient. This is the second declared Never Event for the financial year of 2020-2021. Immediate actions to be taken have already been identified and the incident has been reported in accordance with the Serious Incident Framework.

Number of Serious Incidents Declared

23 Serious Incidents were declared for January, these are split between a wide range of specialties across all 4 divisions at both Lincoln and Pilgrim hospitals. A review has identified that 4 relate to the declaration of a number of ED 12 hour breaches. Clinical harm reviews are underway for all affected patients with support from the CCG to downgrade these incidents if no harm established.

Medication Incidents reported as causing harm

January has seen a slight reduction in medication incidents with harm to 18.8% against a trajectory of 10.7%. All pharmacists aligned to each Divisional CBU are currently working with the wards and departments to identify issues contributing to this higher level of reporting.

Mortality

HSMR

HSMR for the rolling year (November 19 – October 2020) is showing at 102.53 for the Trust which is an increase from the previous month but is still within expected limits. Lincoln site is outside the expected limits at 109.31 for the rolling year. COVID-19 deaths are being attributed to a diagnosis group (Viral infection), which is not included within the HSMR 56 Basket Diagnosis Groups. However, should a patient have COVID-19 included as a secondary diagnosis, these will pull thorough into the datasets.

Septicaemia (except in labour): alerting for the eighth month at Lincoln and third month at Trust level – Case note review undertaken and presented at the February Patient Safety Group.

Other liver diseases: Fourth month alerting at Trust Level – Case note review now in progress.

SHMI

ULHT are in Band 2 within expected limits with a score of 110.35 a slight decrease from the last reporting period. SHMI includes both deaths in-hospital and within 30-days of discharge and is reflective up to August 2020. ULHT's current in-hospital SHMI is 100.23 but is still within confidence levels.

Clinical Audit and Effectiveness

National Clinical Audit Participation Rate

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

Sepsis based on December Data

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

Screening compliance for adult inpatients has shown a decline for the second month at 82% against a trajectory of 90%.

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

Sepsis screening compliance for inpatient (child) has decreased to 78% for December against a trajectory of 90%.

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

Sepsis screening compliance for ED (child) has decreased to 86% for December against a trajectory of 90%.

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

Compliance for Children's antibiotics within an hour in ED has fallen to 50% against a trajectory of 90%.

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

Compliance for adult's antibiotics within an hour as am inpatient has fallen to 80% against a trajectory of 90%.

Due to redeployment of the Sepsis Practitioners through the second wave of the Covid-19 pandemic, actions taken and plans to recover have not been identified. However, assurance has been provided by the ED team that harm reviews for all delays in screening and antibiotic administration are continuing.

Mixed Sex Accommodation Breach

The single sex breach occurred in January and has been validated. This was a conscious decision to support ED and reduce patient safety concerns. The CQC are fully supportive of the decision making in this circumstance.

Duty of Candour

The Trust achieved 79% compliance with the Duty of Candour, both in person notification (verbal) and written follow-up for January. This equated to 3 non-compliant incidents out of the 14 that were notifiable. This is the first month since July 2020 that 100% compliance has

not been achieved. All three incidents have been declared as serious incidents and all required notifications have now been provided. Early notification to the Divisional Triumvirate will monitored to help improve compliance.

Operational Performance

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

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

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

A & E and Ambulance Performance

4-hour performance for January was 71.41% an improvement against December's performance of 70.54% however, remains below the planned trajectory of 79.32%, this is against a decrease in activity of 5.06% from December. This is now the third time in 6 months the Trust's performance has been below the agreed trajectory, but is the first time in 9 months that performance has improved. Both recording and achievement of the 15 min triage targets improved with % not recorded improving by 0.37% and a corresponding slight improvement in achievement at 90.42% compared to 89.48% in December. It continues to be above the mean performance, slightly above trajectory and well within control limits.

Ambulance conveyances for January were 4279 compared to 4365 in December, a reduction of slight rise of 1.98%. However, the Trust saw a drop in >59-minute ambulance handover delays, with 263 reported in January when compared to 350 in December.

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

An internal discharge cell is now in place to support pathway zero patient discharges.

The newly appointed General Manager for UEC commenced in post in January.

Length of Stay

LoS for non-elective admissions improved slightly in January at 4.76 compared to 4.81 in December, but remains above the Trust target of 4.5 days. Non elective discharges deteriorated slightly however in January 3,033 compared with 3,064 in December.

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

Referral to Treatment

RTT performance for December dropped by 2.62% compared to November reflecting the ongoing impact upon the green pathways available at Lincoln and Pilgrim throughout December, and remains below trajectory. The Trust reported 642 incomplete 52 week breaches for December end of month. Whilst in response to the ongoing pressures relating to Covid-19 Wave 2, the weekly PTL meeting have been temporarily stood down to free up key operational staff to support operational flow, a weekly review is maintained by the Dep COO – Planned Care and the Operations Manager-18 Week/RTT Trust Lead. All long waiters are reviewed and escalation is made to the individual CBU as required to ensure clinical review and prioritisation occurs.

With the ongoing pausing of the green pathways at both Lincoln and Pilgrim hospitals the daily Cancer/Elective Cancellation Cell continues to meet daily in response to the Covid 2nd Wave with senior clinical review and prioritisation daily of all cancellations, and to ensure capacity across all sites are maximised for the most critical patients. Cancer patients and clinically urgent remain a priority with a continued focus on 62+ day, 104+ days cancer patients and 40+, 52+ and 78+ week patients on the 18 week RTT PTL.

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

Waiting Lists

Overall waiting list size has decreased from November decreased by 1551 to 43,562. The number of incomplete pathways is now approx. 4530 more than in March 2018.

November to December saw an increase of patients waiting over 40 weeks of +1672 with Ophthalmology showing the greatest increase (+324). Month end position was 6637 patients reflecting the pressures on these pathways.

However, the numbers of patients waiting over 26 weeks again reduced, decreasing by 276 from November reflecting the work undertaken to clinically prioritise and treat the most clinically urgent patients first. The longest waiting patients are tracked and discussed weekly with escalation as appropriate and reported bi-weekly to NHSE/I.

Cancelled Operations

'On the Day' Cancelled Operations saw a significant drop in December, this reflects the planned cessation of a significant proportion of the green lists across LCH and PHB.

However, against those patients cancelled on the day, there was no reduction in performance in the 28 day target with breaches totalling 10 in December as in November and reflects the challenge in being able to re-date patients into a significantly reduced theatre base.

Diagnostics

(Diagnostics January Data Not Yet Available) Diagnostics access performance continues to improve with December's performance standing at 60.1% compared with achievement in November of 59.24%. Endoscopy, continues to book cancer patients within 7-10 days and is now also booking routines.

Radiology is currently achieving 91.5% against a target of 99% with activity currently standing at over 110% of last year's activity. There are however growing pressures in Respiratory Physiology and Cardiac CT's.

CT performance is much improved with 319 breaches in December compared to 595 in November.

Cardiac Physiology had 2019 breaches in December a slight increase of 19 from November reflecting the regional challenges with this service. The Division of Medicine continue to work with regional partners to identify potential solutions.

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

Cancer

Backlog number of patients waiting more than 62 and 104 days remains an absolute priority. Performance for December for the 62 Day Classic Cancer Target increased by 7.8% compared to November, achieving 68% placing us both below the national average (75.55%), but represents a second month of significant improvement.

As of 5th February there remained 66 patients over 104 days down from 163 in mid-July (60% reduction). Colorectal cancer capacity remains the most challenged specialty accounts for 39 of these 70. A large proportion of these patients have significant complex/mental health needs. The temporary pausing of green pathways owing to Covid-9 related pressures has impacted upon activity and the 62 day recovery. However, there is ongoing work across the system to identify the most appropriate capacity for the most urgent and longest waiting cancer patients, with daily senior clinical review and prioritisation of any cancellations. ULHT patients are being reviewed at partner organisations MDTs as well as escalation to EMCA.

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

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

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

Paul Matthew
Director of Finance & Digital
February 2021

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

PERFORMANCE OVERVIEW

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	Nov-20	Dec-20	Jan-21	YTD	YTD Trajectory	Latest Month Pass/Fail	Trend Variation	Kitemark
Deliver Harm Free Care	Clostridioides difficile position	Safe	Patients	Director of Nursing	9	4	3	5	56		P		
	MRSA bacteraemia	Safe	Patients	Director of Nursing	0	0	0	1	2		F		
	MSSA bacteraemia cases counts and 12-month rolling rates of hospital-onset, using trust per 1000 bed days formula	Safe	Patients	Director of Nursing	TBC	0.00	0.01	0.08	0.05				
	E. coli bacteraemia cases counts and 12-month rolling rates, per 1000 bed days formula	Safe	Patients	Director of Nursing	TBC	0.01	0.01	0.11	0.06				
	Never Events	Safe	Patients	Director of Nursing	0	0	0	1	2		F		Timeliness, Completeness, Validation, Process
	New Harm Free Care	Safe	Patients	Director of Nursing	99%	Data suspended							Timeliness, Completeness, Validation, Process
	Pressure Ulcers category 3	Safe	Patients	Director of Nursing	4.3	1	1	0	13		P		
	Pressure Ulcers category 4	Safe	Patients	Director of Nursing	1.3	0	0	0	1		P		Timeliness, Completeness, Validation, Process
	Pressure Ulcers - unstageable	Safe	Patients	Director of Nursing	19/20 will be used as a benchmark	3	3	5	47				
	Summary Hospital Mortality Indicator (SHMI) (rolling year data 6 month time lag)	Effective	Patients	Medical Director	100	109.75	110.53	110.35	109.42		F		
	Hospital Standardised Mortality Ratio - HSMR (rolling year data 3 month time lag)	Effective	Patients	Medical Director	100	101.04	101.85	102.53	99.06		F	A	
	Sepsis screening (bundle) compliance for inpatients (adult)	Safe	Patients	Director of Nursing	90%	85.00%	82.00%		86.43%		F		
	Sepsis screening (bundle) compliance for inpatients (child)	Safe	Patients	Director of Nursing	90%	87.00%	78.00%		86.84%		F		
	IVAB within 1 hour for sepsis for inpatients (adult)	Safe	Patients	Director of Nursing	90%	90.00%	80.00%		90.83%		F		
	IVAB within 1 hour for sepsis for inpatients (child)	Safe	Patients	Director of Nursing	90%	86.00%	100.00%		90.44%		P		

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

PERFORMANCE OVERVIEW

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	Nov-20	Dec-20	Jan-21	YTD		Latest Month Pass/Fail	Trend Variation	Kitemark
Deliver Harm Free Care	Sepsis screening (bundle) compliance in A&E (adult)	Safe	Patients	Director of Nursing	90%	93.00%	91.00%		92.86%		P	A	
	Sepsis screening (bundle) compliance in A&E (child)	Safe	Patients	Director of Nursing	90%	90.00%	86.00%		90.51%		F	A	
	IVAB within 1 hour for sepsis in A&E (adult)	Safe	Patients	Director of Nursing	90%	96.00%	92.00%		95.74%		P		
	IVAB within 1 hour for sepsis in A&E (child)	Safe	Patients	Director of Nursing	90%	86.00%	50.00%		86.53%		F		
	Rate of stillbirth per 1000 births	Safe	Patients	Director of Nursing	4.20	2.40	2.39	2.64	2.28		P	B	
	Number of Serious Incidents (including never events) reported on StEIS	Safe	Patients	Director of Nursing	14	4	25	23	129		F	?	Timeliness, Completeness, Validation, Process
	Catheter Associated Urinary Tract Infection	Safe	Patients	Director of Nursing	1				0				
	Falls per 1000 bed days resulting in moderate, severe harm & death	Safe	Patients	Director of Nursing	0.19	0.00	0.04	0.19	0.11		P		Timeliness, Completeness, Validation, Process
	Reported medication incidents per 1000 occupied bed days	Safe	Patients	Medical Director	4.3	4.91	4.18	4.42	4.95		P		
	Medication incidents reported as causing harm (low /moderate /severe / death)	Safe	Patients	Medical Director	10.7%	12.00%	22.20%	18.80%	14.28%		F		
	Potential under reporting of patient safety incidents / Reported incidents (all harms) per 1,000 bed days	Safe	Patients	Medical Director	30	33.24	31.02	33.58	35.07		P		
	Patient Safety Alert compliance (number open beyond deadline)	Safe	Patients	Medical Director	0	0	0	0	2		P		
	National Clinical audit participation rate	Effective	Patients	Medical Director	98%	95.00%	95.00%	95.00%	93.60%		F		
	7 day Services Clinical Standard 2 (all patients have a Consultant review within 14 hours of admission)	Effective	Patients	Medical Director	90%	Not Collected audit done twice a year							
	7 day Services Clinical Standard 8 (ongoing review)	Effective	Patients	Medical Director	90%	Not Collected audit done twice a year							
	Venous Thromboembolism (VTE) Risk Assessment	Safe	Patients	Medical Director	95%	96.65%	96.95%	97.00%	97.08%		P		
	eDD issued within 24 hours	Effective	Patients	Medical Director	95%	93.36%	92.90%	93.50%	93.61%		F		

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

PERFORMANCE OVERVIEW

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-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%	89.69%	88.80%	88.16%	88.95%	88.96%	89.49%	90.47%	89.56%	89.33%	87.85%	89.12%		F	B	
	Number of Vacancies	Well-Led	People	Director of HR & OD	12%	13.28%	12.52%	12.20%	11.88%	12.74%	12.43%	12.29%	12.15%	12.36%	12.25%	12.41%		F	B	
	Sickness Absence	Well-Led	People	Director of HR & OD	4.5%	4.95%	4.99%	5.08%	5.07%	5.02%	5.00%	4.92%	4.87%	4.90%	5.07%	4.99%		F		
	Staff Turnover	Well-Led	People	Director of HR & OD	12%	11.45%	11.00%	10.62%	10.80%	10.73%	10.76%	10.92%	11.01%	11.28%	11.76%	11.03%		P		
	Staff Appraisals	Well-Led	People	Director of HR & OD	90%	70.30%	69.48%	68.27%	68.52%	70.86%	75.91%	78.51%	78.20%	78.04%	74.80%	73.29%		F		
					£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000				
	Agency Spend	Well-Led	People	Director of HR & OD	TBC	-£3,078	-£3,200	-£3,743	-£3,674	-£3,060	-£3,163	-£3,047	-£3,450	-£3,382	-£4,058	-£33,855				
5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	YTD		Latest Month Pass/Fail	Trend Variation	Kitemark
Improve Patient Experience	Mixed Sex Accommodation breaches	Caring	Patients	Director of Nursing	0	0	0	0	0	0	0	1	1	1	1	4		F		Timeliness, Completeness, Validation, Process
	% Triage Data Not Recorded	Effective	Patients	Chief Operating Officer	0%	0.25%	0.18%	0.13%	0.15%	0.82%	0.40%	0.23%	0.22%	0.57%	0.20%	0.31%		F		
	Duty of Candour compliance - Verbal	Safe	Patients	Medical Director	100%	100.00%	79.00%	86.00%	82.00%	100.00%	100.00%	100.00%	100.00%	79.00%		91.78%		F		
	Duty of Candour compliance - Written	Responsive	Patients	Medical Director	100%	89.00%	71.00%	76.00%	71.00%	100.00%	100.00%	100.00%	100.00%	79.00%		87.33%		F		

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NHS United Lincolnshire Hospitals NHS Trust

PERFORMANCE OVERVIEW

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	Nov-20	Dec-20	Jan-21	YTD	YTD Trajectory	Latest Month Pass/Fail	Trend Variation	Kitemark
Improve Clinical Outcomes	4hrs or less in A&E Dept	Responsive	Services	Chief Operating Officer	79.32%	72.78%	70.54%	71.41%	79.17%	72.42%	F	L	
	12+ Trolley waits	Responsive	Services	Chief Operating Officer	0	10	39	36	87	0	F	?	
	%Triage Achieved under 15 mins	Responsive	Services	Chief Operating Officer	88.5%	90.65%	89.48%	90.42%	91.22%	88.50%	P		
	52 Week Waiters	Responsive	Services	Chief Operating Officer	0	498	642		2428	0	F	H	
	18 week incompletes	Responsive	Services	Chief Operating Officer	84.1%	59.33%	56.72%		57.50%	84.10%	F	B	
	Waiting List Size	Responsive	Services	Chief Operating Officer	37,762	45,113	43,562		n/a	n/a	F	H	
	62 day classic	Responsive	Services	Chief Operating Officer	85.4%	61.20%	68.20%		66.52%	85.39%	F		
	2 week wait suspect	Responsive	Services	Chief Operating Officer	93.0%	82.40%	84.90%		86.47%	93.00%	F		
	2 week wait breast symptomatic	Responsive	Services	Chief Operating Officer	93.0%	26.40%	4.00%		46.33%	93.00%	F	L	
	31 day first treatment	Responsive	Services	Chief Operating Officer	96.0%	94.90%	94.60%		94.66%	96.00%	F		
	31 day subsequent drug treatments	Responsive	Services	Chief Operating Officer	98.0%	100.00%	100.00%		98.74%	98.00%	P		
	31 day subsequent surgery treatments	Responsive	Services	Chief Operating Officer	94.0%	87.90%	100.00%		89.51%	94.00%	P		
	31 day subsequent radiotherapy treatments	Responsive	Services	Chief Operating Officer	94.0%	91.30%	90.10%		92.86%	94.00%	F		
	62 day screening	Responsive	Services	Chief Operating Officer	90.0%	88.90%	83.30%		39.99%	90.00%	F	H	

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

PERFORMANCE OVERVIEW

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	Nov-20	Dec-20	Jan-21	YTD	YTD Trajectory	Latest Month Pass/Fail	Trend Variation	Kitemark
Improve Clinical Outcomes	62 day consultant upgrade	Responsive	Services	Chief Operating Officer	85.0%	76.60%	75.80%		80.92%	85.00%	F		
	Diagnostics achieved	Responsive	Services	Chief Operating Officer	99.0%	59.24%	60.08%		53.63%	99.00%	F	A	
	Cancelled Operations on the day (non clinical)	Responsive	Services	Chief Operating Officer	0.8%	3.01%	1.42%		1.60%	0.80%	F		
	Not treated within 28 days. (Breach)	Responsive	Services	Chief Operating Officer	0	10	10		97	0	F		
	#NOF 48 hrs	Responsive	Services	Chief Operating Officer	90%	Awaiting validation			89.03%	90%			
	#NOF 36 hrs	Responsive	Services	Chief Operating Officer	TBC	Awaiting validation			77.66%				
	EMAS Conveyances to ULHT	Responsive	Services	Chief Operating Officer	4,657	4,304	4,365	4,279	4,388	4,657	P		
	EMAS Conveyances Delayed >59 mins	Responsive	Services	Chief Operating Officer	0	388	350	263	194	0	F	H	
	104+ Day Waiters	Responsive	Services	Chief Operating Officer	5	47	57	66	651	50	F		
	Average LoS - Elective (not including Daycase)	Effective	Services	Chief Operating Officer	2.80	2.38	3.90	2.31	2.86	2.80	P		
	Average LoS - Non Elective	Effective	Services	Chief Operating Officer	4.50	4.67	4.81	4.76	4.30	4.5	F		
	Delayed Transfers of Care	Effective	Services	Chief Operating Officer	3.5%	Submission suspended			3.13%	3.5%			
	Partial Booking Waiting List	Effective	Services	Chief Operating Officer	4,524	19,385	20,675	19,883	19,973	4,524	F	A	
	Outpatients seen within 15 minutes of appointment	Effective	Services	Chief Operating Officer	70.0%	46.8%	47.9%	56.9%	43.57%	70.00%	F		
	% discharged within 24hrs of PDD	Effective	Services	Chief Operating Officer	45.0%	31.6%	34.0%	36.2%	35.46%	45.00%	F		

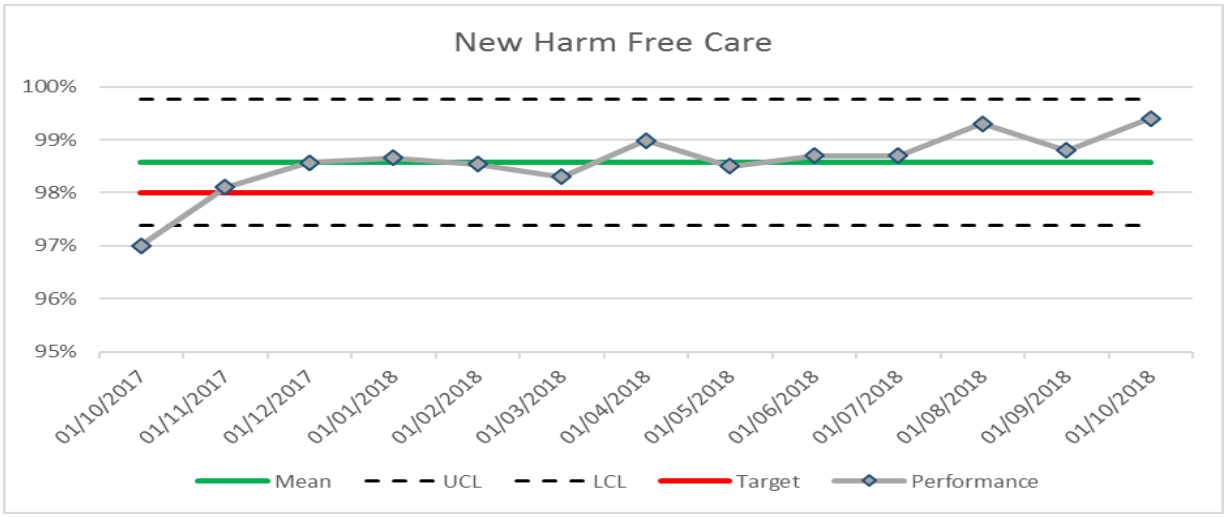
STATISTICAL PROCESS CONTROL CHARTS

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

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

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

An example chart is below:



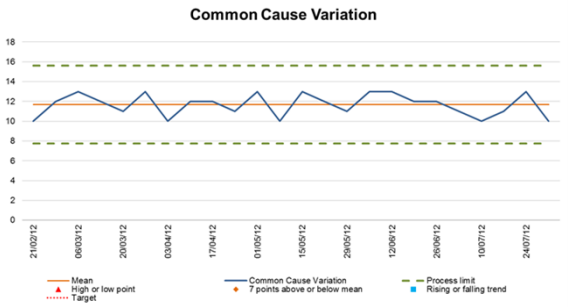
Normal variations in performance across time can occur randomly- without a direct cause, and should not be treated as a concern, or a sign of improvement, and is unlikely to require investigation unless one of the patterns defined below applies.

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

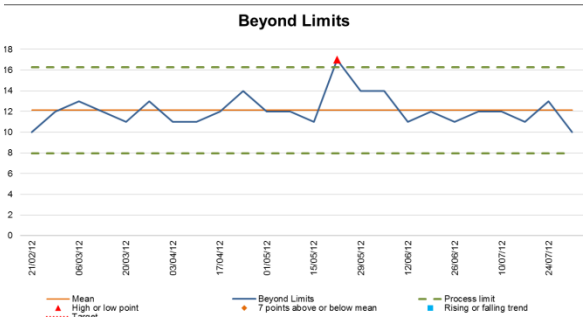
- Normal variation – (common cause) fluctuations in data points that sit between the upper and lower control limits
- Extreme values – (special cause) any value on the line graph that falls outside of the control limits. These are very unlikely to occur and where they do, it is likely a reason or handful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

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

Normal Variation

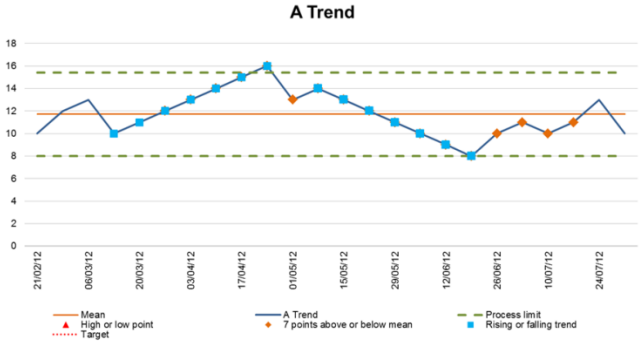


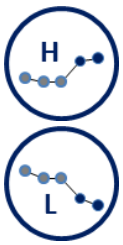
Extreme Values



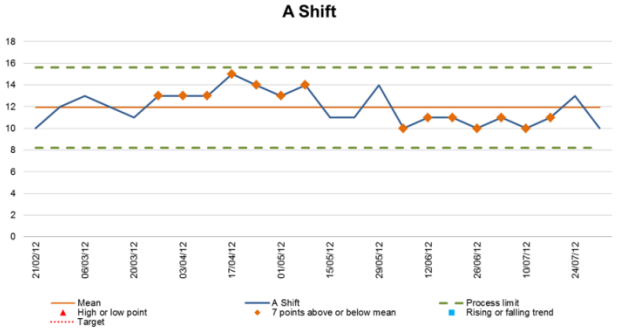
There is no Icon for this scenario.

A Trend (upward or downward)





A Trend (a run above or below the mean)



Where a target has been met consistently

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

Where a target has been missed consistently

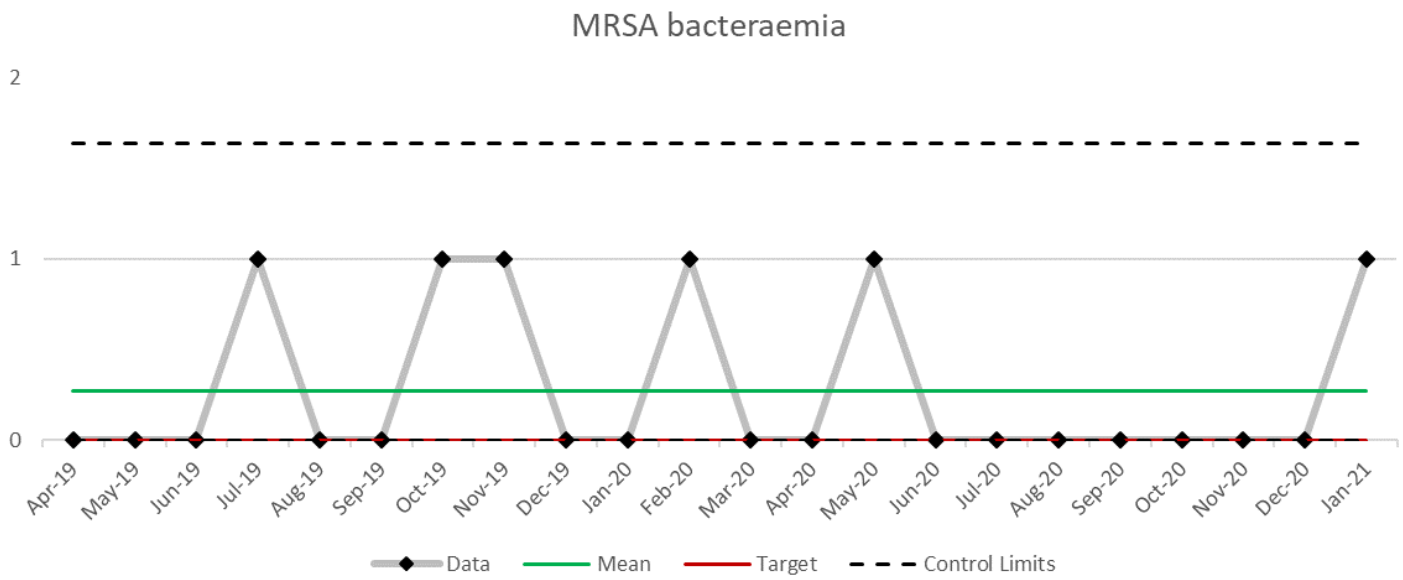
Where the target has been missed for at least 3 of the most recent data points in a row, or in a string of 7 of the most recent data points, at least 5 out of the 7 data points have missed.

DELIVER HARM FREE CARE – MRSA BACTERAEMIA

Executive Lead: Director of Nursing

CQC Domain: Safe

Strategic Objective: Patients



Challenges/ Successes

A DIPC review has been undertaken for this patient.

The Trust screening policy and the Trust MRSA policy were not followed. The patient had multiple ward moves which does not allow continuity of care.
There was a failure to contact staff effectively at the point of confirming MRSA, no record of conversation between microbiologist and nurse on ward, handover issue between staff.
Triangulation of the result for treatment did not happen.
MRSA treatment was not commenced or followed in a timely manner as per policy.

The patient is improving on treatment.

Actions to Recover

The Clinical team are reviewing the patients journey and developing an action plan as there were several areas for improvement- patient not isolated on admission, patient not screened for MRSA/CPE, delay in starting treatment for MRSA, poor documentation for peripheral cannula.

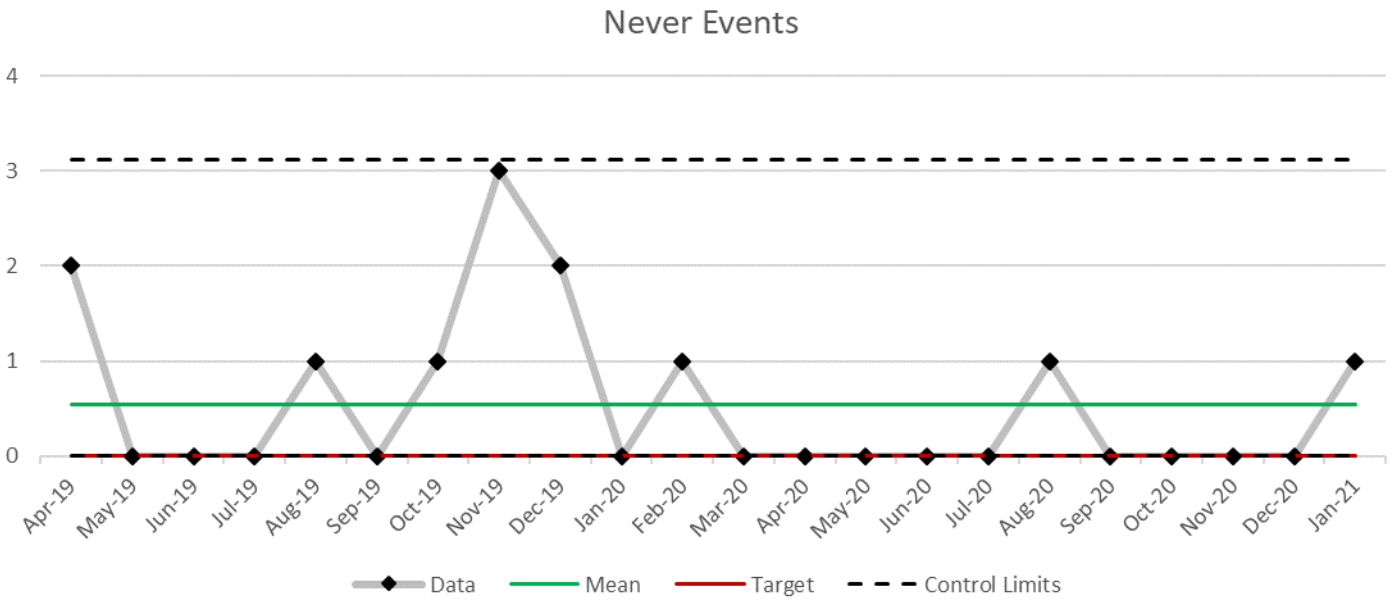
A Trust Vascular Access Group is being convened to pull a number of strands of work together by various teams to ensure the DIPC has oversight of the invasive devices

DELIVER HARM FREE CARE – NEVER EVENTS

Executive Lead: Director of Nursing

CQC Domain: Safe

Strategic Objective: Patients



Challenges/ Successes

- The Trust declared one Never Event Serious Incident in January 2021; this incident involved a mis-placed nasogastric tube; the incident was responded to promptly to prevent serious harm to the patient.
- This is the second Never Event to be declared in the 2020/21 year to date.

Actions to Recover

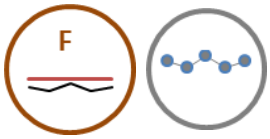
- An investigation into the incident has begun, supported by the central Serious Incident Team.
- Urgent action taken within the division to clarify responsibilities under Trust policy for confirming placement of NG tubes.

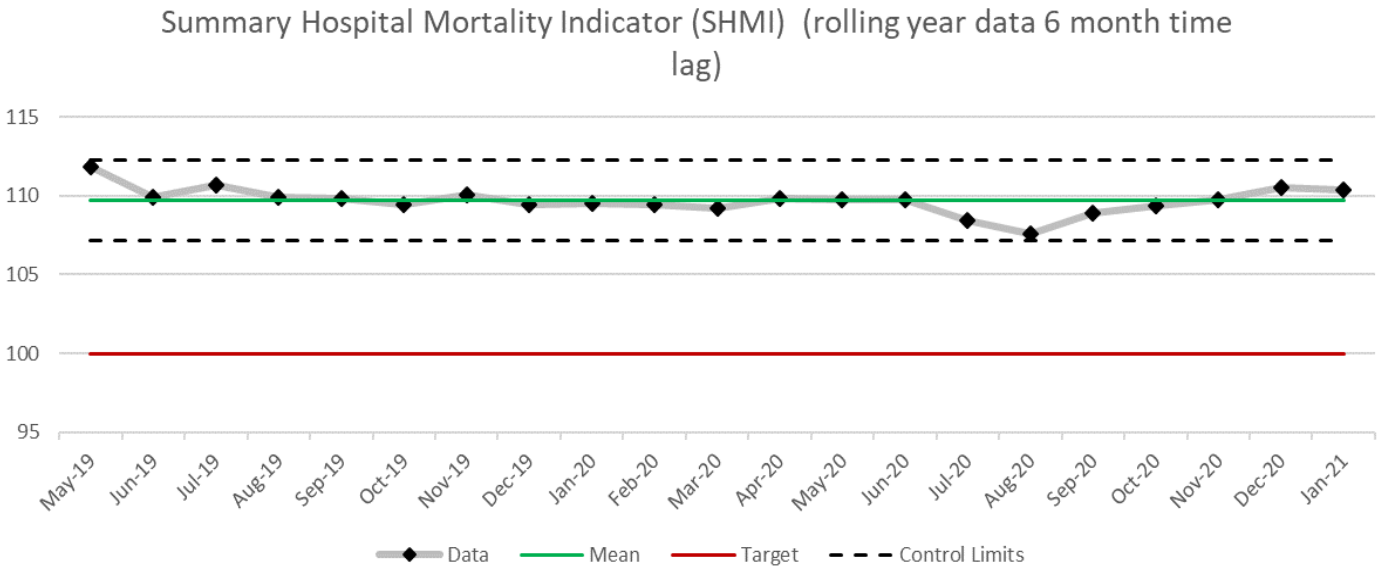
DELIVER HARM FREE CARE – MORTALITY SHMI

Executive Lead: Medical Director

CQC Domain: Effective

Strategic Objective: Patients





Challenges / Successes:

ULHT are in Band 2 within expected limits with a SHMI of 110.35, a slight decrease from the last reporting period.
SHMI includes both deaths in-hospital and within 30 days of discharge.
The data is reflective up to August 2020.

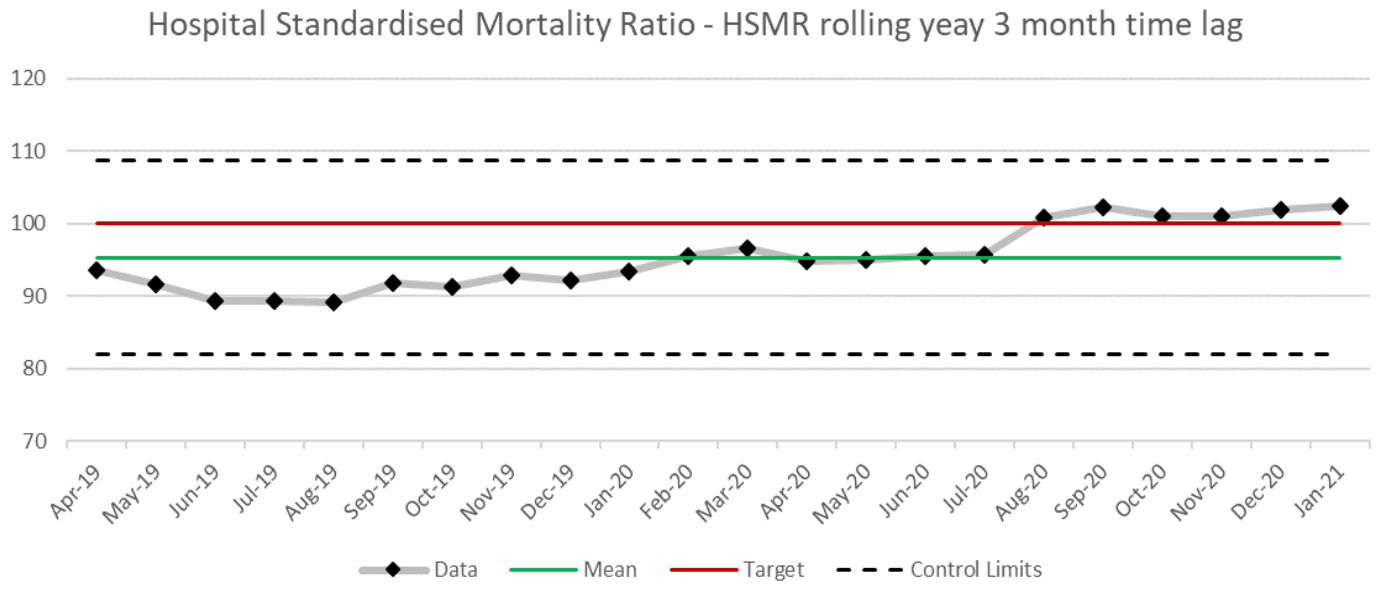
- Current in-hospital SHMI is 100.23, this is still within confidence levels.

DELIVER HARM FREE CARE – MORTALITY HSMR

Executive Lead: Medical Director

CQC Domain: Effective

Strategic Objective: Patients



Challenges/Successes

- ULHT's HSMR is at 102.53, which is within expected limits.
- Lincoln site is outside the expected limits at 109.31 for the rolling year.
- Pilgrim and Grantham are achieving better than the expected threshold limits for the rolling year.
- HSMR for the financial year is showing above expected for the Trust and Lincoln sites, however, due to the COVID-19 pandemic this was to be expected. Pilgrim is above the threshold but within the confidence intervals.

Alerts:

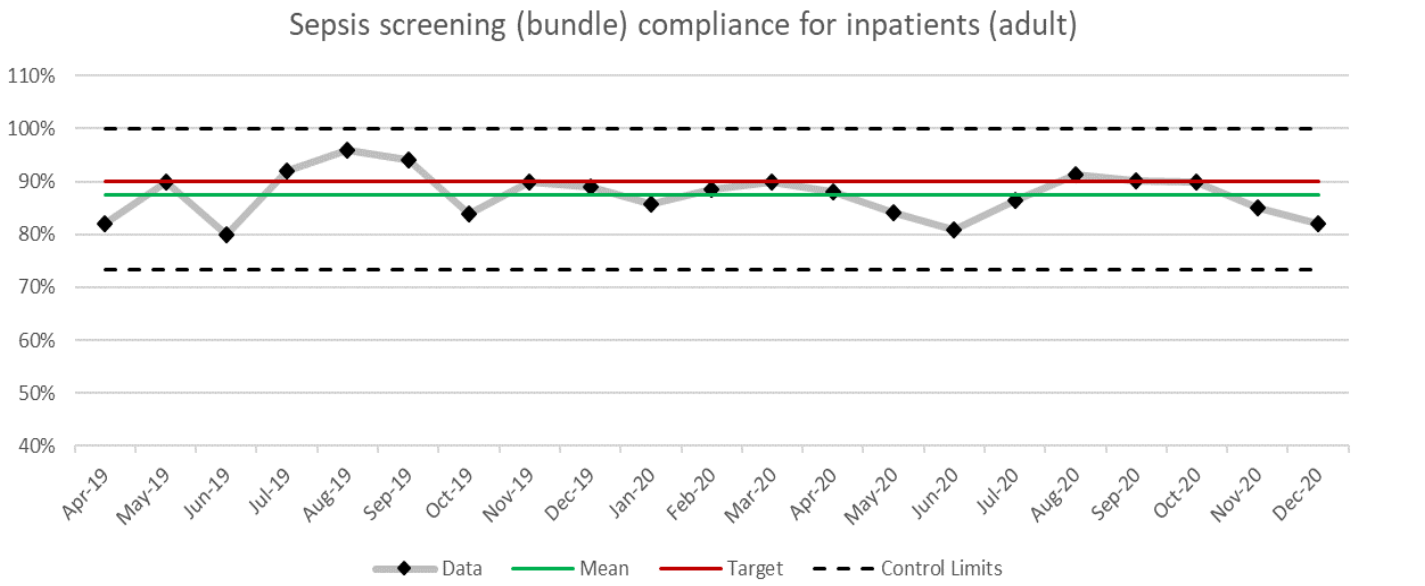
- Intestinal obstruction without hernia – first month alerting
- Other liver diseases - Fourth month alerting Trust level. Case note review in progress.
- Pleurisy pneumothorax pulmonary collapse - Second month alert. This will be discussed at MorALS
- Septicaemia (except in labour) - Eighth month alerting at Lincoln & third month at Trust. Case note has been completed and is to be presented at PSG.
- Skin and subcutaneous tissue infections - Second month alerting at Grantham. Notes to be reviewed to assess coding.

DELIVER HARM FREE CARE – SEPSIS SCREENING (BUNDLE) COMPLIANCE

Executive Lead: Director of Nursing

CQC Domain: Safe

Strategic Objective: Patients



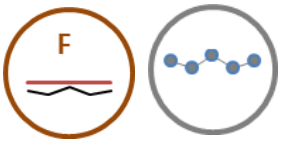
Sepsis leads have been re deployed to A & E causing delays in data.

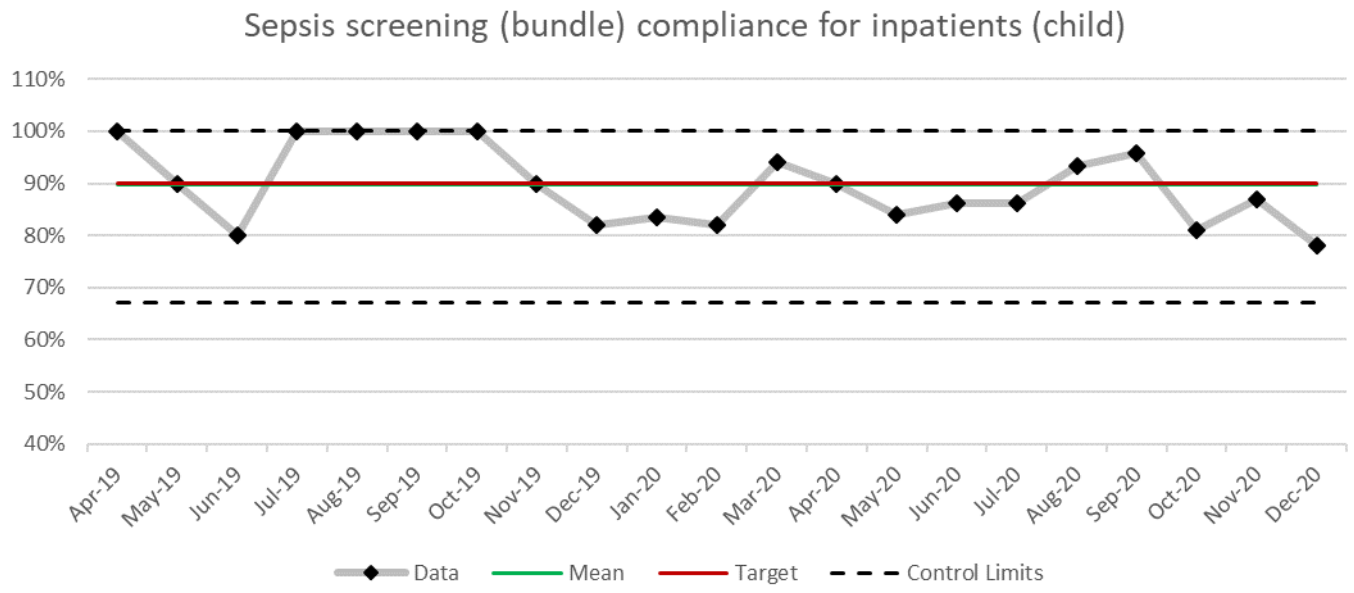
DELIVER HARM FREE CARE – SEPSIS SCREENING (BUNDLE) COMPLIANCE

Executive Lead: Director of Nursing

CQC Domain: Safe

Strategic Objective: Patients



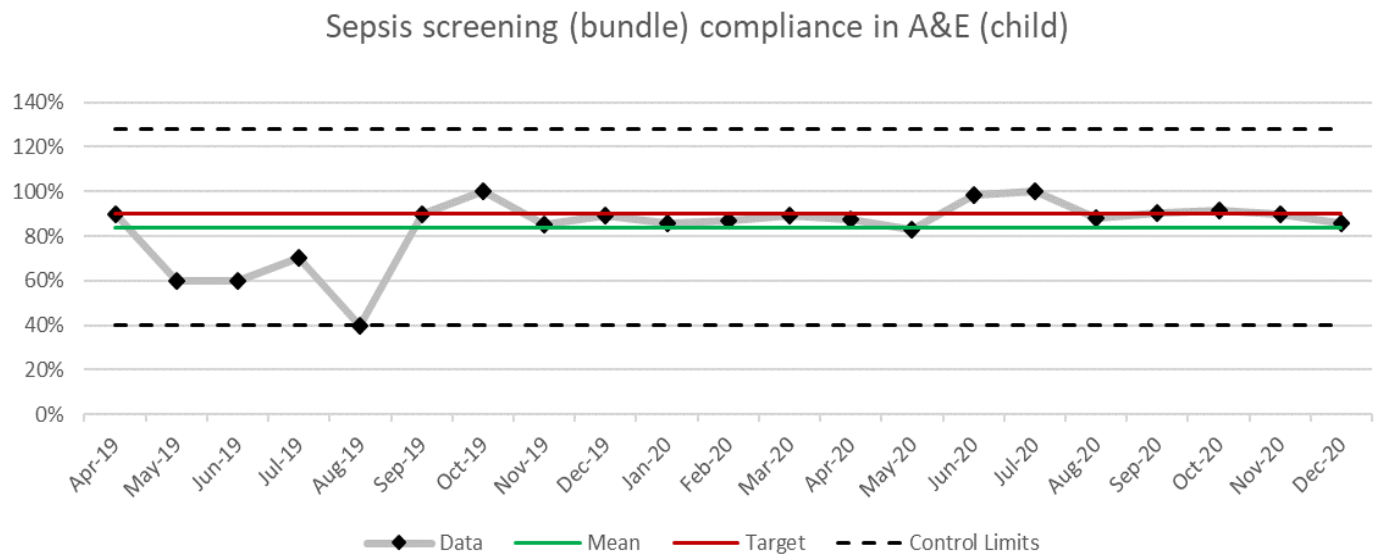


DELIVER HARM FREE CARE – SEPSIS SCREENING (BUNDLE) COMPLIANCE

Executive Lead: Director of Nursing

CQC Domain: Safe

Strategic Objective: Patients

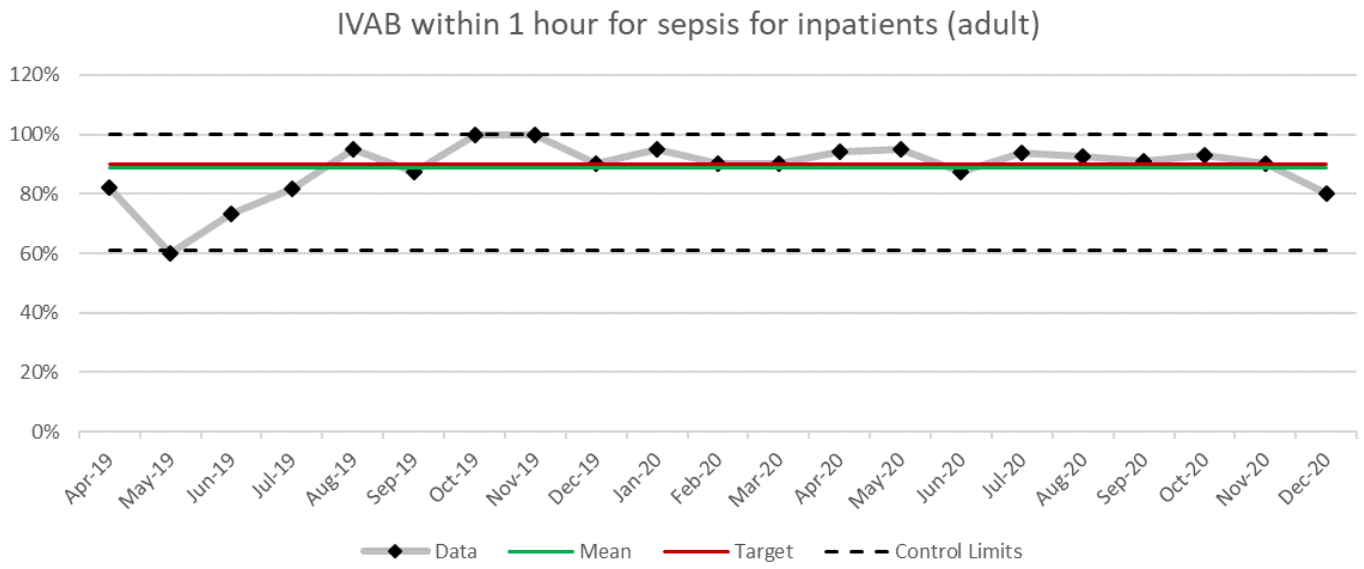


DELIVER HARM FREE CARE – IVAB WITHIN 1 HOUR FOR INPATIENTS

Executive Lead: Director of Nursing

CQC Domain: Safe

Strategic Objective: Patients

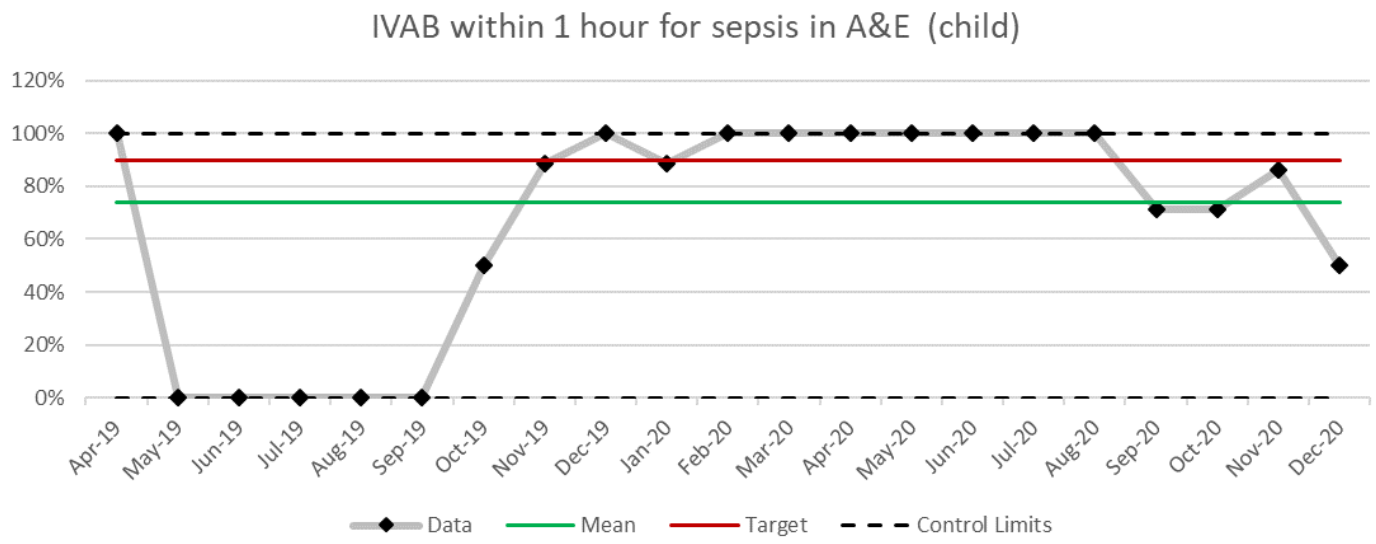


DELIVER HARM FREE CARE – IVAB WITHIN 1 HOUR FOR INPATIENTS

Executive Lead: Director of Nursing

CQC Domain: Safe

Strategic Objective: Patients

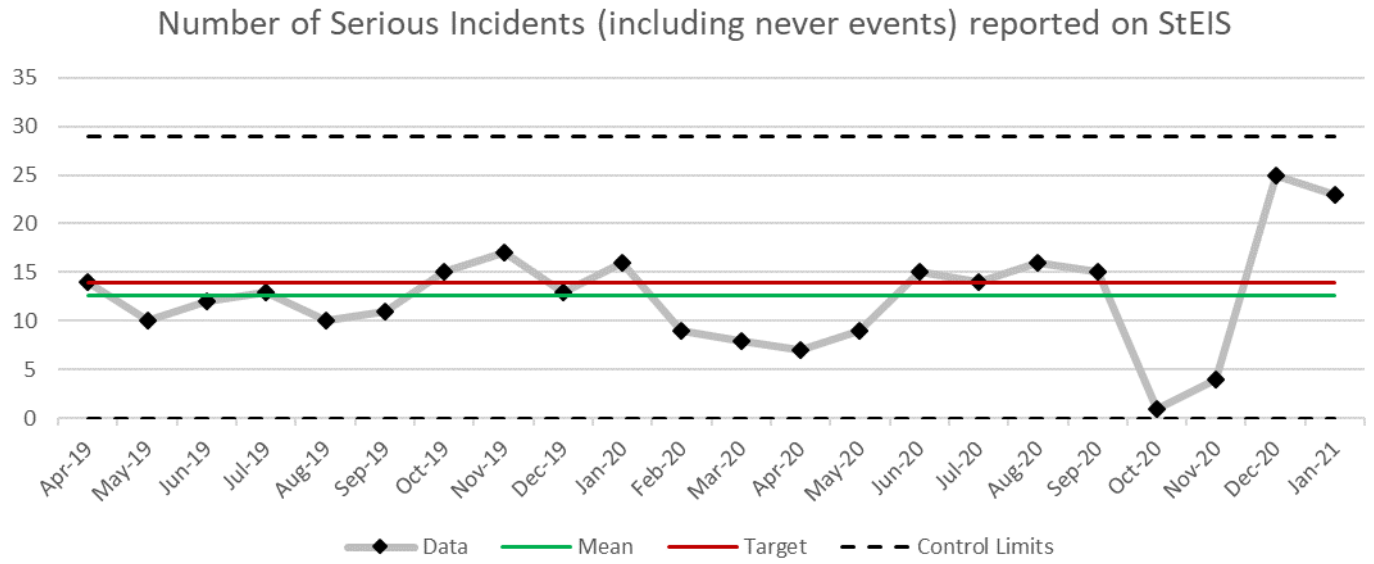


DELIVER HARM FREE CARE – SERIOUS INCIDENTS ON StEIS

Executive Lead: Director of Nursing

CQC Domain: Safe

Strategic Objective: Patients



Challenges / Successes:

- The Trust declared 23 Serious Incidents in January 2021, following on from 25 declared in December 2020.
- This is significantly about the previous monthly average of 9 in the year to date.
- Of those 23 incidents, there were 12 that actually occurred in January 2021; 8 occurred in December 2020; 1 in November; 1 in September; and 1 in August 2016 that has only recently been reported via a CNST claim.
- Those 23 incidents are split between a wide range of specialties across all 4 divisions and at both Lincoln and Pilgrim hospitals.

Actions in place to recover:

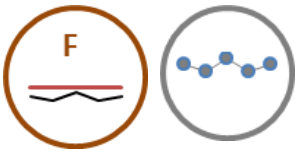
- 4 of the Serious Incidents declared in January concerned breaches in A&E of 12 hours from decision to admit (DTA), affecting a total of 33 patients; Medicine Division are currently completing harm reviews to determine the impact of these incidents and those declared in December.
- Investigations are currently underway for all Serious Incidents declared in January 2021.

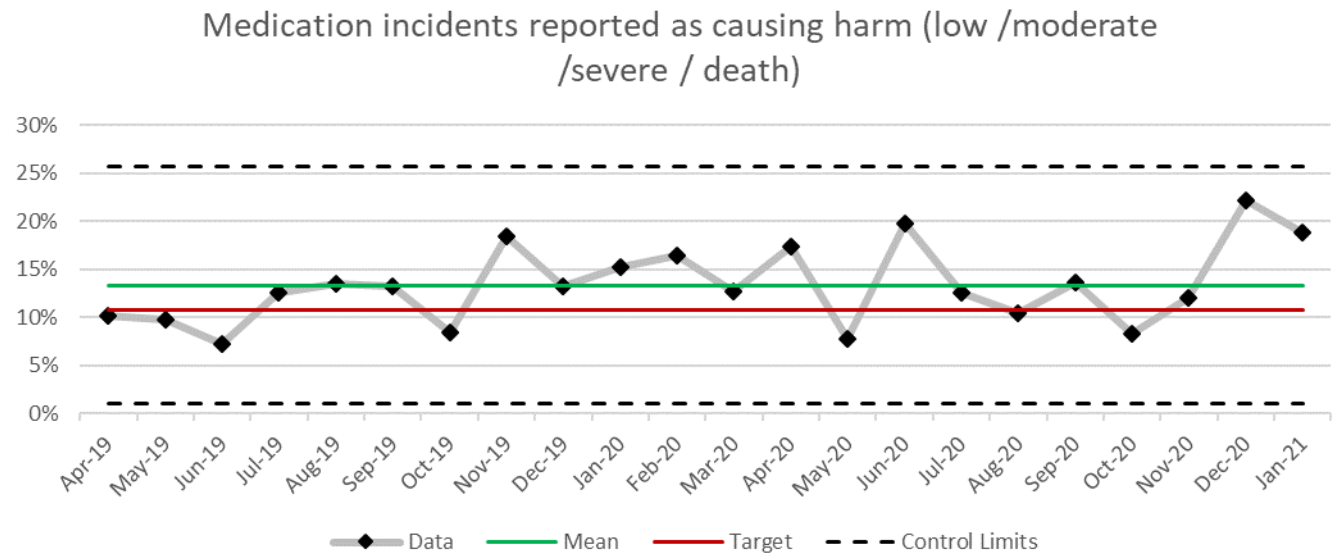
DELIVER HARM FREE CARE – MEDICATION INCIDENTS CAUSING HARM

Executive Lead: Medical Director

CQC Domain: Safe

Strategic Objective: Patients





Challenges / Successes:

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

Actions in place to recover:

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

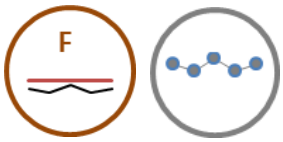
The Medicines Quality Group have been asked to consider a new approach to how pharmacy work with the ward teams to address the fundamental blocks to improving this issue.

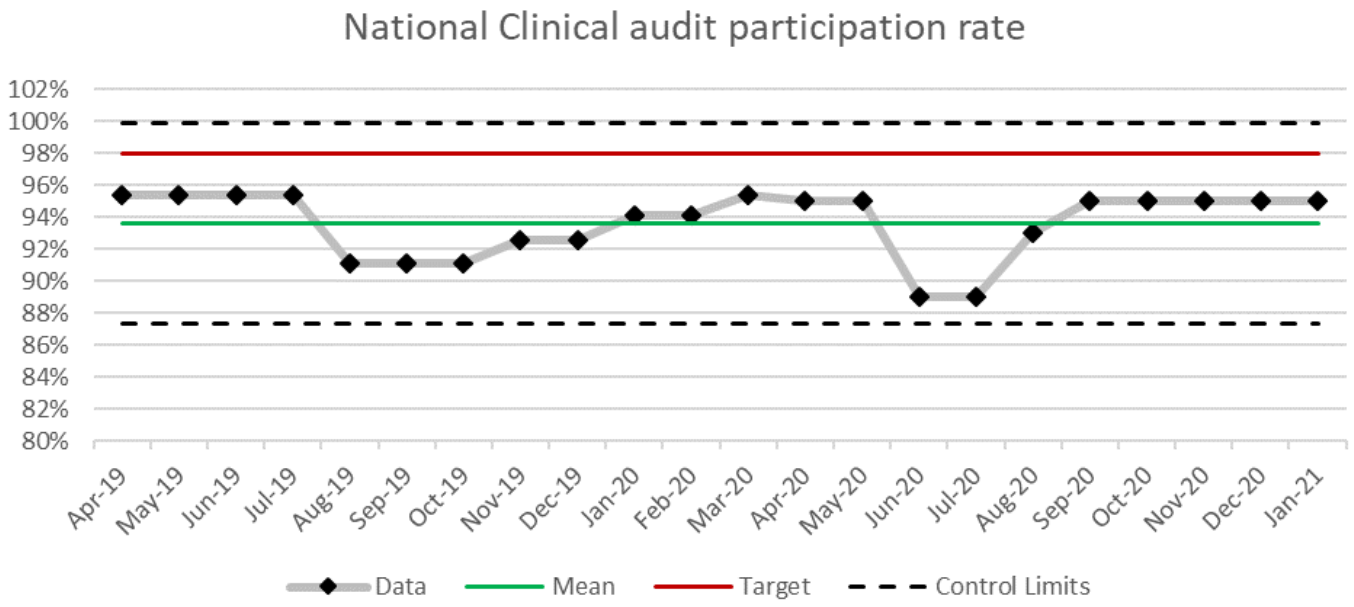
DELIVER HARM FREE CARE – NATIONAL CLINICAL AUDIT RATE

Executive Lead: Medical Director

CQC Domain: Effective

Strategic Objective: Patients





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

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

Elective procedures cancelled in line with NHS England Guidance

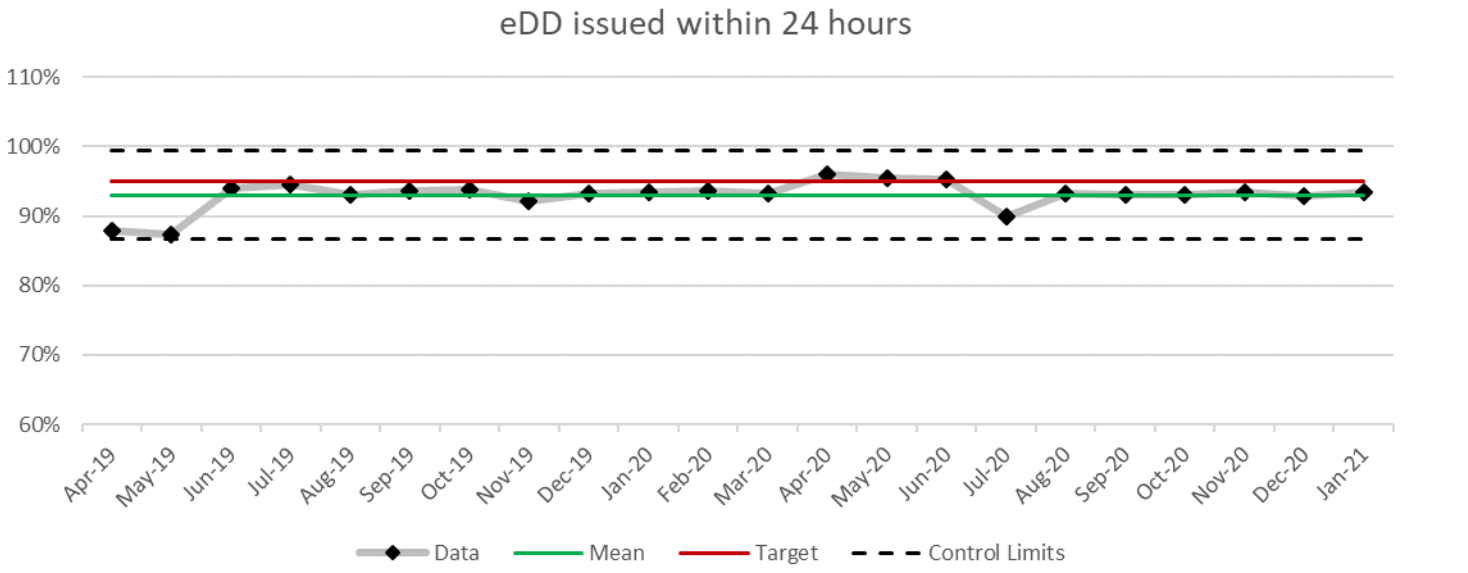
- Procedures that are now taking place this should improve participation submissions with the Green site restoration phase
- Bowel cancer data submissions are lower than expected for Lincoln and Grantham escalated to clinical leads and the cancer team manager to improve data submission
- Oesophageal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

DELIVER HARM FREE CARE – eDD ISSUED WITHIN 24 HOURS

Executive Lead: Medical Director

CQC Domain: Effective

Strategic Objective: Patients



Challenges/Successes

The Trust achieved 93.5% compliance with sending eDDs within 24 hours for January 2021. 96% were sent anytime during the month of January 2021.

Actions in place to recover:

Due to COVID-19 the changes required from IT have been put on hold.

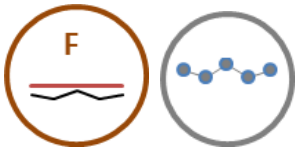
eDD will feed into the Clinical Effectiveness Group and the Deputy Medical Director for Clinical Effectiveness will chair the meetings going forward.

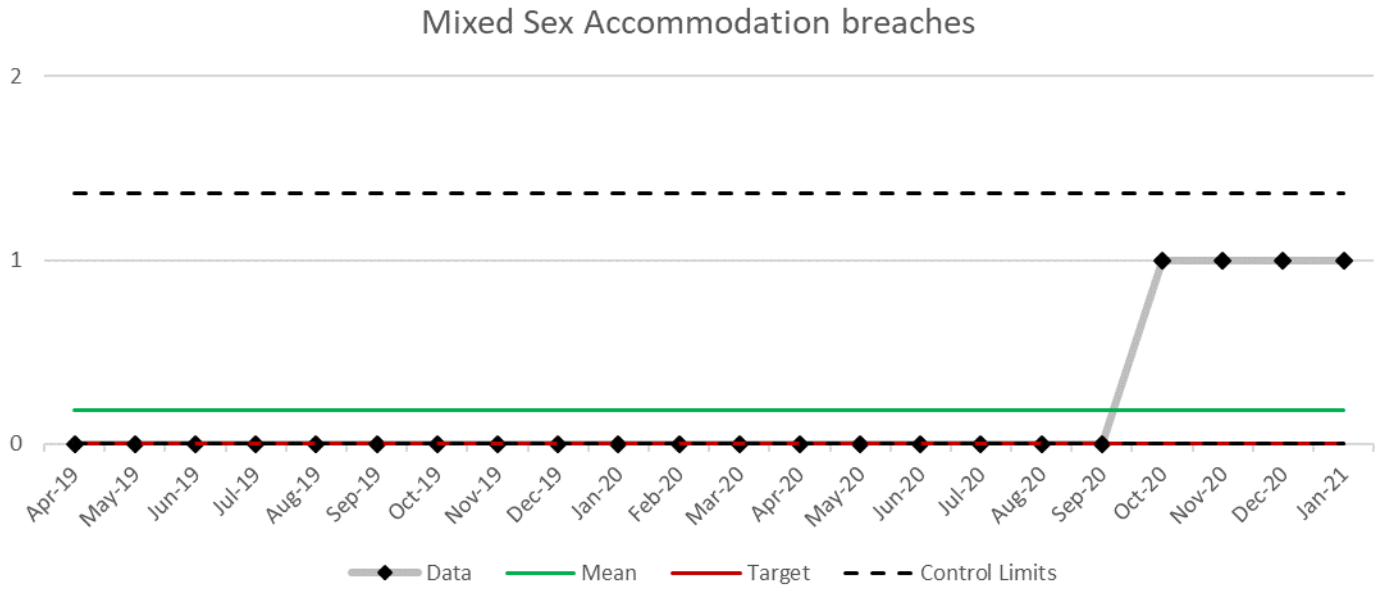
IMPROVE PATIENT EXPERIENCE – MIXED SEX ACCOMMODATION

Executive Lead: Director of Nursing

CQC Domain: Caring

Strategic Objective: Patients





Actions in place to recover:

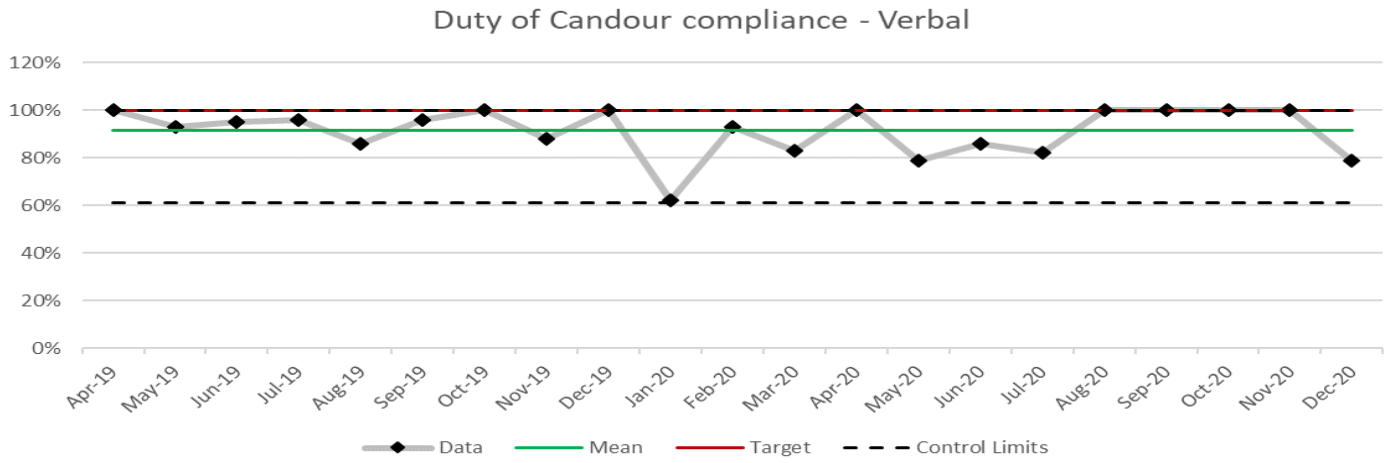
Further investigation of the incident is required to identify any actions to be taken to prevent reoccurrence.

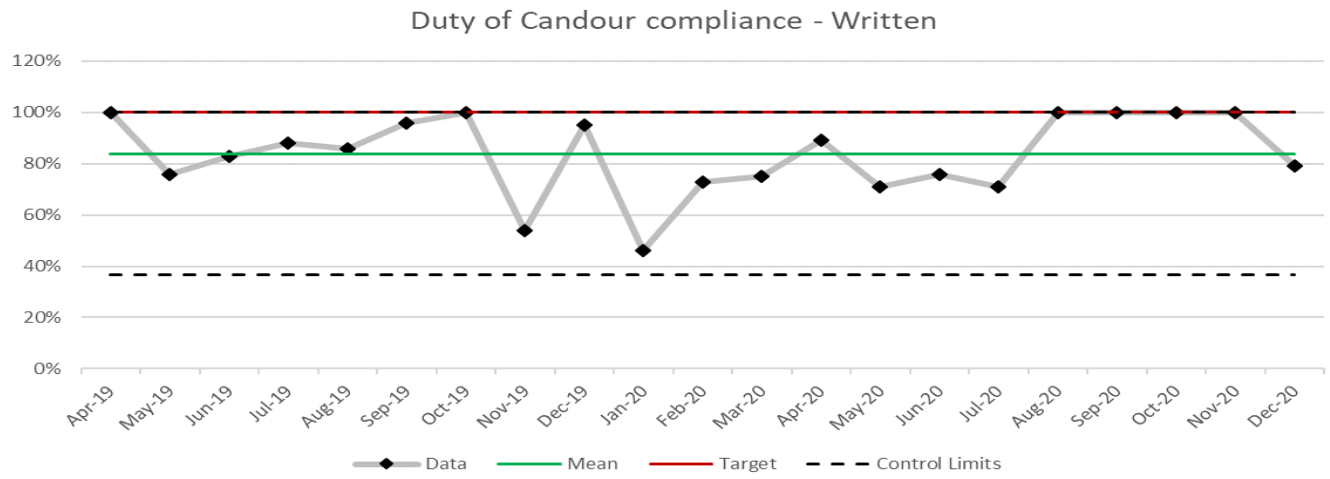
IMPROVE PATIENT EXPERIENCE – DUTY OF CANDOUR

Executive Lead: Director of Nursing

CQC Domain: Caring

Strategic Objective: Patients





Challenges / Successes:

- The Trust achieved 79% compliance with the Duty of Candour, both in person notification (verbal) and written follow-up.
- There were 3 non-compliant incidents out of 14 that were notifiable under the Duty of Candour regulation.
- This is the first month since July 2020 that 100% compliance has not been achieved.

Actions in place to recover:

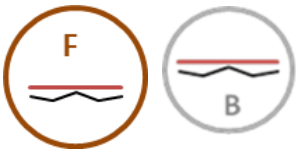
- Each of the non-compliant incidents have now been declared as Serious Incidents; all required notifications have now been provided.
- The central Clinical Governance Team continue to monitor Duty of Candour compliance throughout the month and provide support with written follow-up letters where the initial notification has been provided by the clinical team.

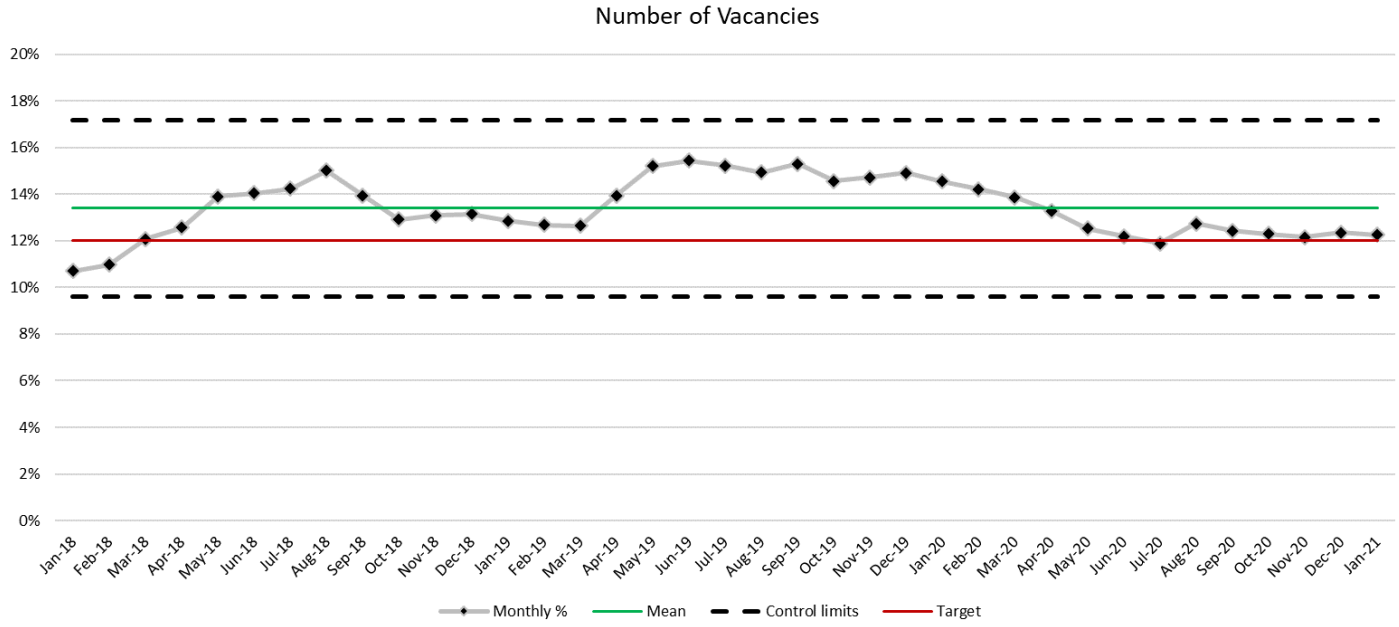
A MODERN AND PROGRESSIVE WORKFORCE – VACANCY RATES

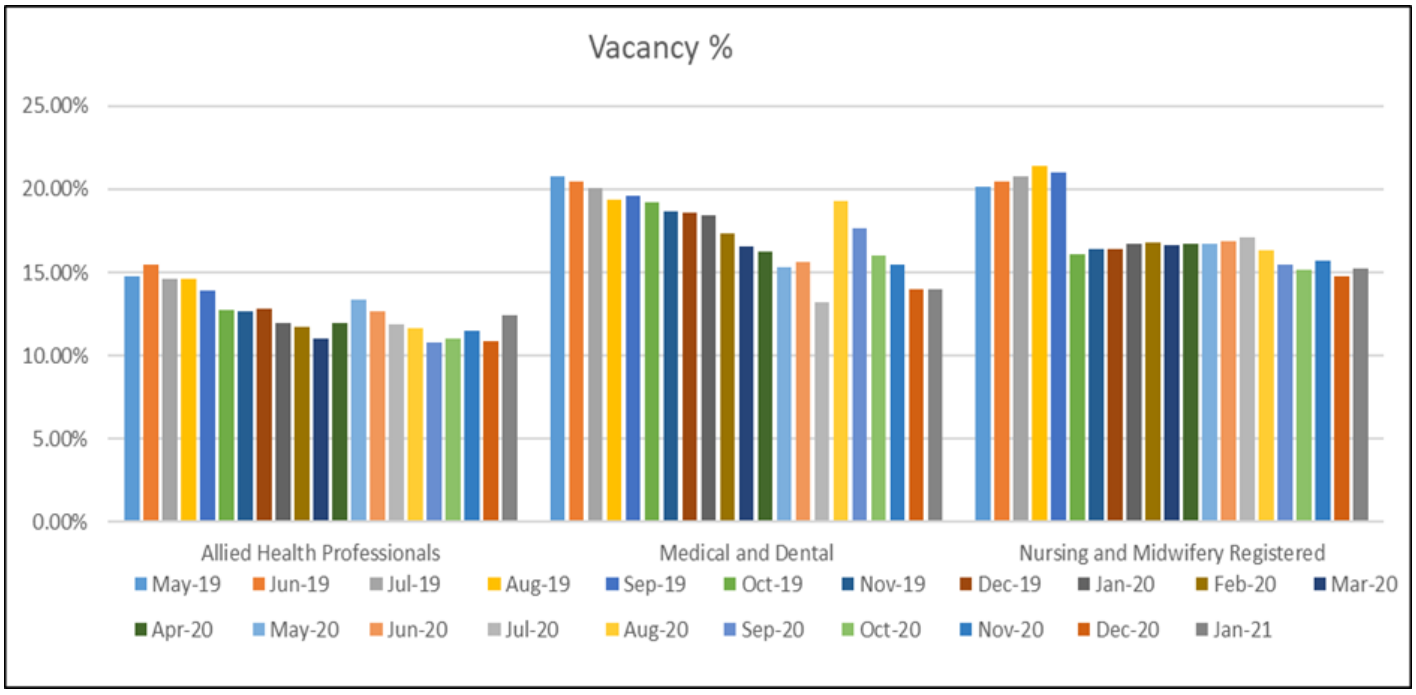
Executive Lead: Director of HR & OD

CQC Domain: Well-Led

Strategic Objective: People







Staff Group	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21
Allied Health Professionals	11.71%	11.02%	11.93%	13.33%	12.66%	11.90%	11.66%	10.81%	11.06%	11.47%	10.89%	12.44%
Medical and Dental	17.31%	16.58%	16.27%	15.31%	15.66%	13.21%	19.28%	17.65%	16.00%	15.50%	14.01%	14.03%
Nursing and Midwifery Registered	16.82%	16.67%	16.75%	16.69%	16.87%	17.08%	16.36%	15.50%	15.16%	15.72%	14.78%	15.22%

Whilst the overall vacancy rate remains fairly static at just over 12%, the increase in turnover suggests that vacancy rates could well increase in the next few months.

Our new pipeline report shows that there is a significant amount of recruitment activity, although this has been impacted by COVID. There has been good progress in delivering the plan for every medical post, with explicit activity against the majority of vacant medical posts (and clarity where and why there is no current activity).

The NHSE/I supported nursing recruitment programme is progressing well. To date we have made 126 job offers to international nurse recruits, to start by the end of April 2021. There will be further work on the international recruitment pipeline, to achieve the target of 200 new appointments by October 2021. The support from NHSE/I enable us to better support those candidates to pass their OSCE exams and enhance the pastoral care we are able to give to ensure those candidates have a good experience when they start with us and wish to remain.

We have offered to 196 HCSW applicants, with the intent that they should start by end-March 2021. There is a fast-track training programme for that group, working in partnership with the University of Lincoln.

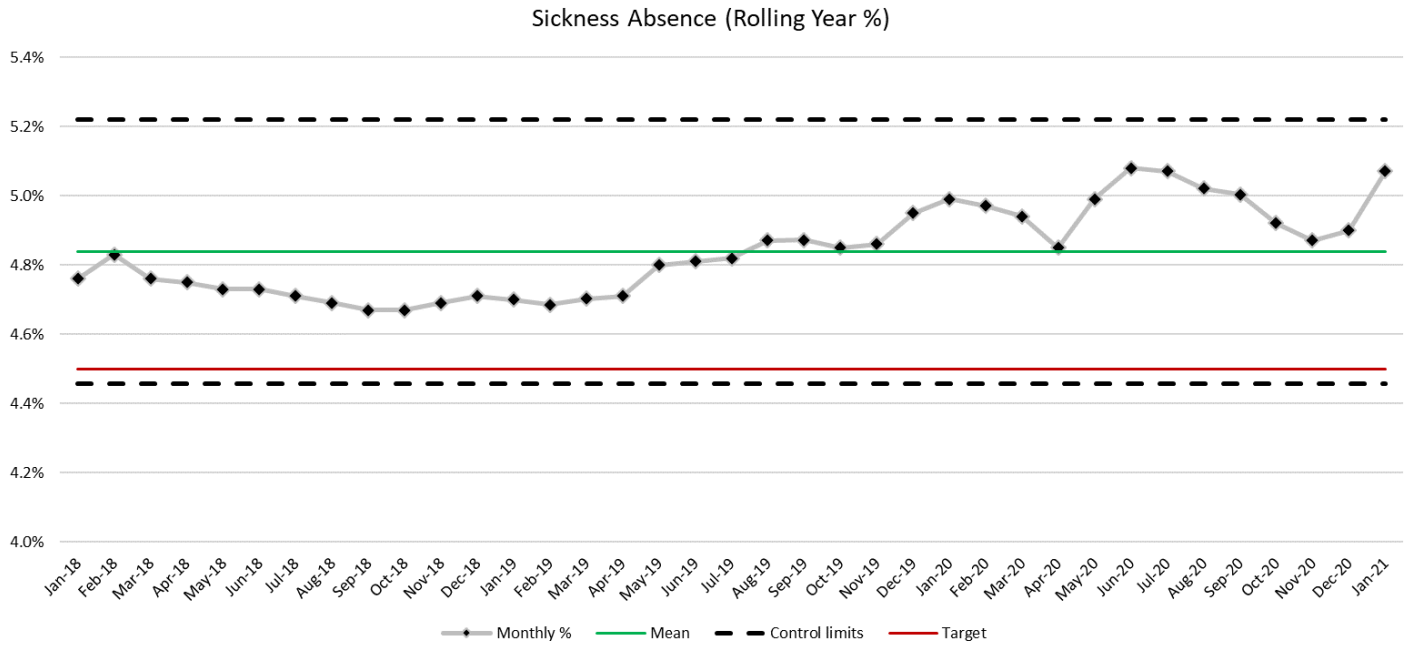
Going forward, we want to learn from the experience of this project work and ensure we can sustain the pace of recruitment, not only into nursing, but also other clinical roles.

A MODERN AND PROGRESSIVE WORKFORCE – SICKNESS

Executive Lead: Director of HR & OD

CQC Domain: Well-Led

Strategic Objective: People



The 12 month rolling absence figure for January 2021 is 5.07 %, compared to 4.90% in November 2020

The current sickness absence figure is 7.97% (as at 22nd February). This is a significant reduction on the December figure. However the 12 month rolling average is likely to continue to rise to reflect the impact of COVID over the last 12 months. COVID absence is now at just over 2%.

What is evident is that non-COVID sickness is higher than at the same time last year. The increase is in short-term sickness, as long-term sickness has essentially been unchanged.

There is no evident change to the type of sickness. 27.3% of sickness in February 2020 was a consequence of stress and anxiety and 26.1% in February 2021. Unfortunately the recorded increase is in the “other sickness” category, which has gone up from 16.8% to 28% in the same period, which is not helpful in helping understanding the causes of sickness and the actions we can take.

The ER Team have continued to support staff with daily well-being calls who are absent due to Stress and Anxiety, Shielding and Isolating. Whilst we have seen an increase in Stress and anxiety, evidence from the daily well-being calls supported cases were not related to COVID solely and were mainly personal reasons. Only in some cases was COVID a contributing factor.

They ER Team have also supported the Vaccine Hub to ensure patients eligible to receive the vaccine had the opportunity to have an appointment as soon as possible.

The Employee Relations Team continue to support and embed the new Absence Management System. During the pandemic the new system has been gradually rolled out to all divisions in the Trust with last cohort of Medical Staff and ICUs going live on 1st Feb 2021. The next phase of the project is the implementation of the Case Management module from 1st March 2021 which will proactively support managers with active management of absence cases within their divisions. The ER Team are liaising with Managers to ensure all relevant information is recorded accurately to enable effective management of the system. We will work proactively to embed use of the system and the good practice around absence management that it supports, through to the end of June 2021.

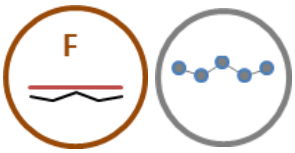
The ER Team will continue to focus on arranging formal hearings for all ER activity including Absence Capability. The ER team will continue to support managers to ensure contact is maintained with employees throughout the processes.

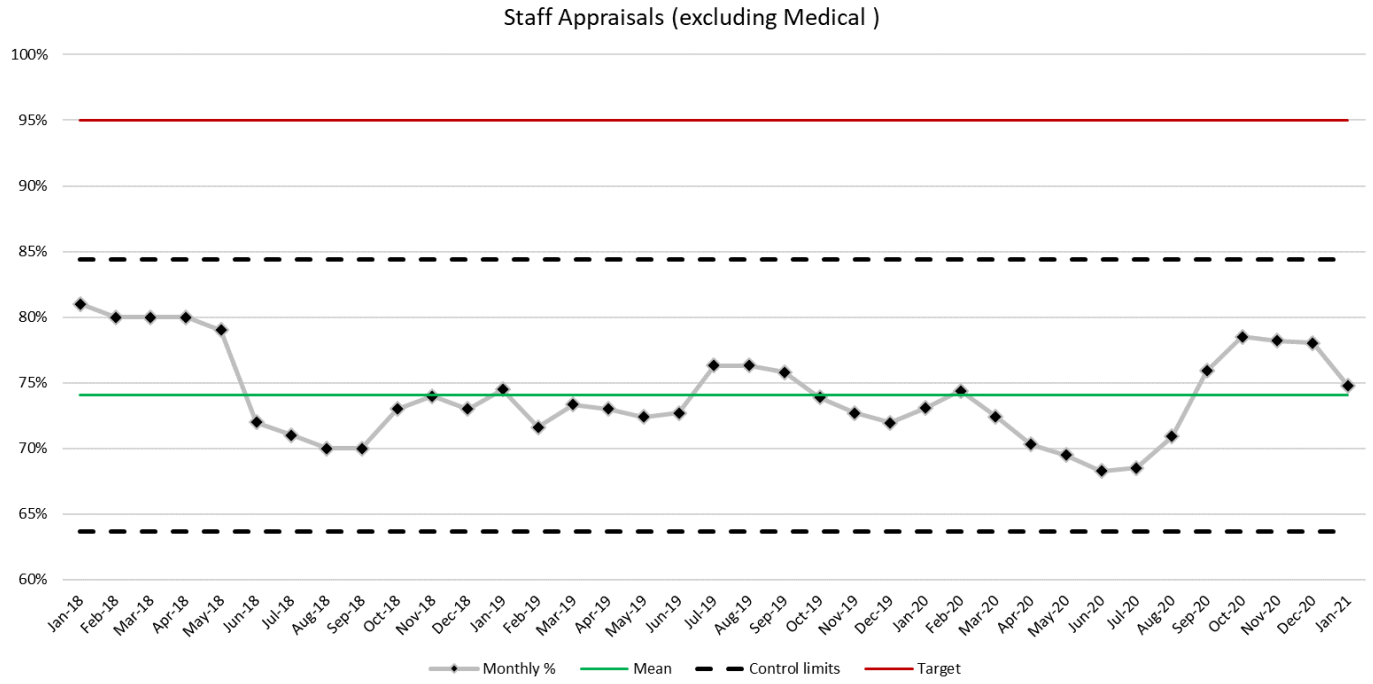
A MODERN AND PROGRESSIVE WORKFORCE – APPRAISALS

Executive Lead: Director of HR & OD

CQC Domain: Well-Led

Strategic Objective: People





Appraisal rates are clearly impacted by COVID. A decline in appraisal completion rates during Wave 1 was followed by a significant increase between July and October, where there was a big focus on ensuring appraisals were undertaken. Wave 2 of COVID has caused a decline since October and a fairly large drop in February. There are variations between Divisions. Medicine and Estates & Facilities have the lowest appraisal completion rates.

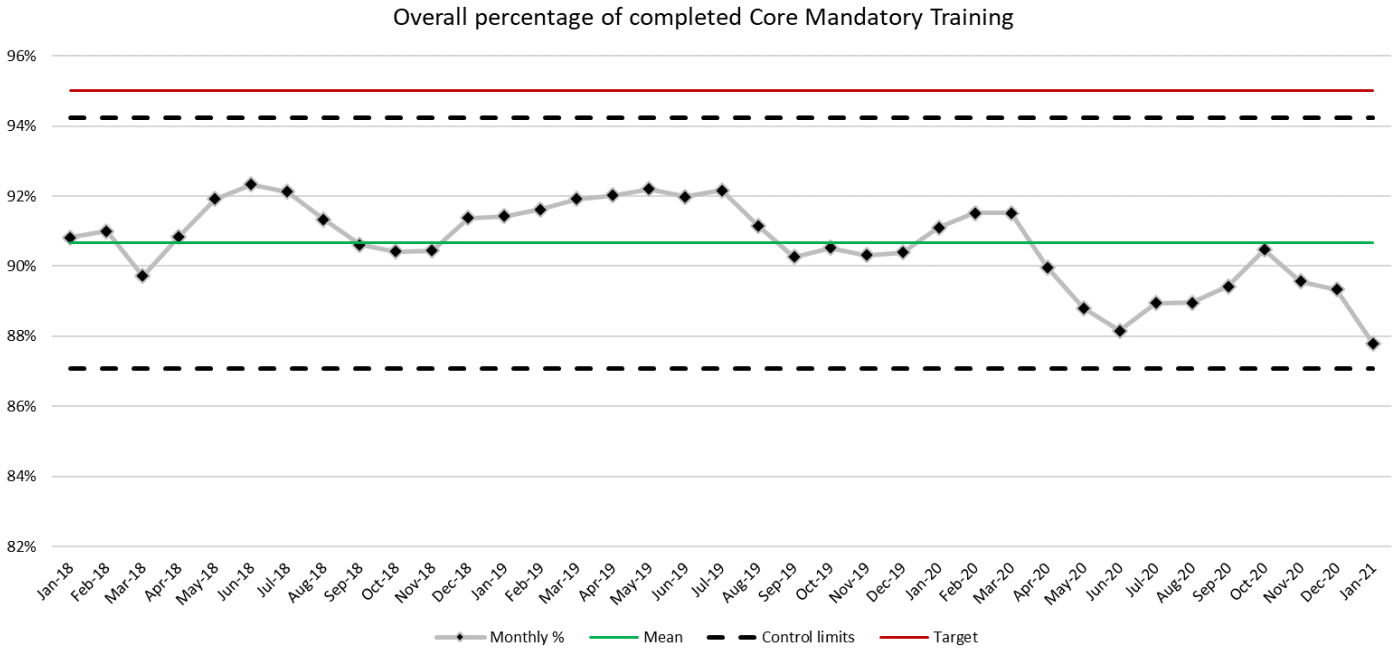
The HR Business Partners have a focus on appraisal rates and are working with management teams to ensure there is recovery through to the end of the financial year. We are now planning to introduce the new WorkPal system in the new financial year, which will assist in improving the quality of individual performance management discussions, although in itself it will not ensure they are completed.

A MODERN AND PROGRESSIVE WORKFORCE – CORE LEARNING

Executive Lead: Director of HR & OD

CQC Domain: Well-Led

Strategic Objective: People



The completion rates for core learning are following a similar pattern to appraisal. The impact of COVID is obvious, but we must arrest the decline in completion rates since October 2020 as we move into the "Recovery" phase.

The rates by Division are shown below:

Division	Overall Compliance %
Clinical Support Services	89.41%
Corporate	90.32%
Director of Estates & Facil	86.02%
Family Health	88.51%
Medicine	83.71%
Surgery	89.70%

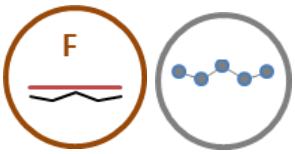
We have added to the core-learning portfolio through COVID as face-to-face delivery reverted to on-line. This will have impacted on completion rates to a degree. We will look to HR Business Partners to work with management teams to ensure completion rates improve over the next few months.

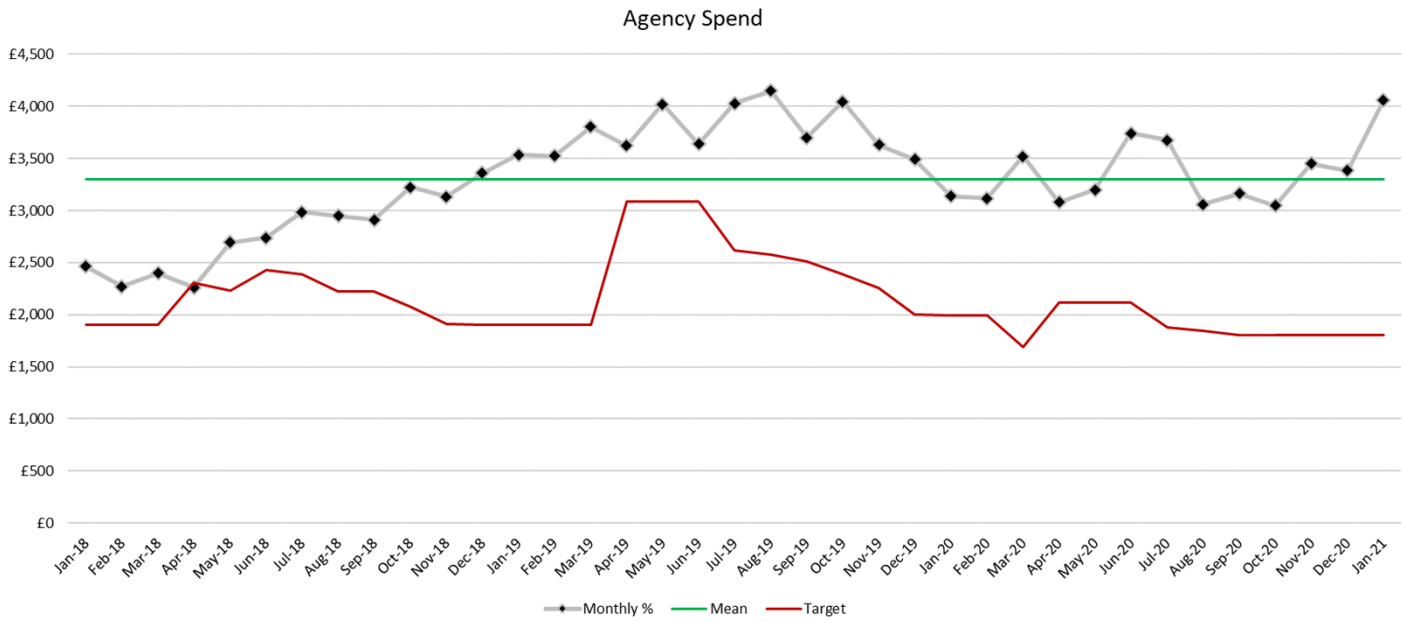
EFFICIENT USE OF OUR RESOURCES – AGENCY SPEND

Executive Lead: Director of HR & OD

CQC Domain: Well-Led

Strategic Objective: People





Agency spend did increase significantly in January. The pressures of COVID and the need to maintain safe staffing levels are having an impact. In Nursing for example the underlying nurse expenditure position in January was c£230k higher than the average of the previous 3 months and equated to an additional 2,200 of hours worked.

We continue to see benefit on medical agency spend from the increase in the use of bank (up from 20% to 50% of temp medical staff usage) and control over rates. However if we are to achieve the 25% reduction in agency staff cost planned for in 21/22, we will need to take significant additional action. This will include:

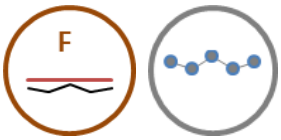
- Continued focus on recruitment to medical, nursing and other clinical roles (and the narrative around vacancies outlines the plans to do so
- Deep dive into specialty medical agency spend, to understand why vacancy reductions are not translating into equivalent reductions in agency spend
- Review the construct of the medical workforce
- Review of all non-clinical agency posts on an individual basis
- Continued push to drive down sickness absence rates.

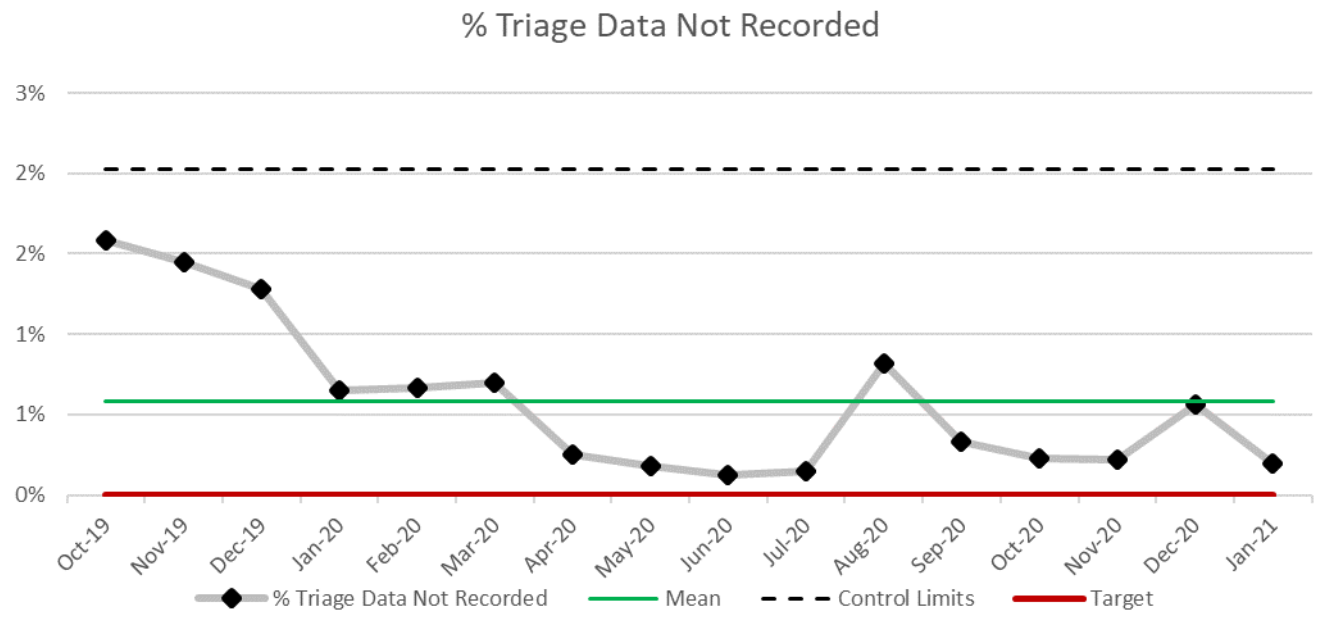
IMPROVE PATIENT EXPERIENCE – % TRIAGE DATA NOT RECORDED

Executive Lead: Chief Operating Officer

CQC Domain: Effective

Strategic Objective: Patients





Challenges/Successes

- January demonstrated a 0.37% positive variation in performance compared with December and
- Improvement has been seen on both sites. This may coincide with a further decrease in attendance.
- The ability to provide two triage streams improved in January to a slight improvement in staff absence through sickness and reduced bank and agency fill. Higher tier agencies requests increased in January to attempt to mitigate the gaps.
- Achievement against this metric is co-dependent upon having a fully trained and compliant staffing rota as well as the individual compliance of staff.
- The UEC Operational Leads continue to be proactive in addressing recording compliance in real time in hours but the main contributory factor is out of hours.

Actions in place to recover:

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

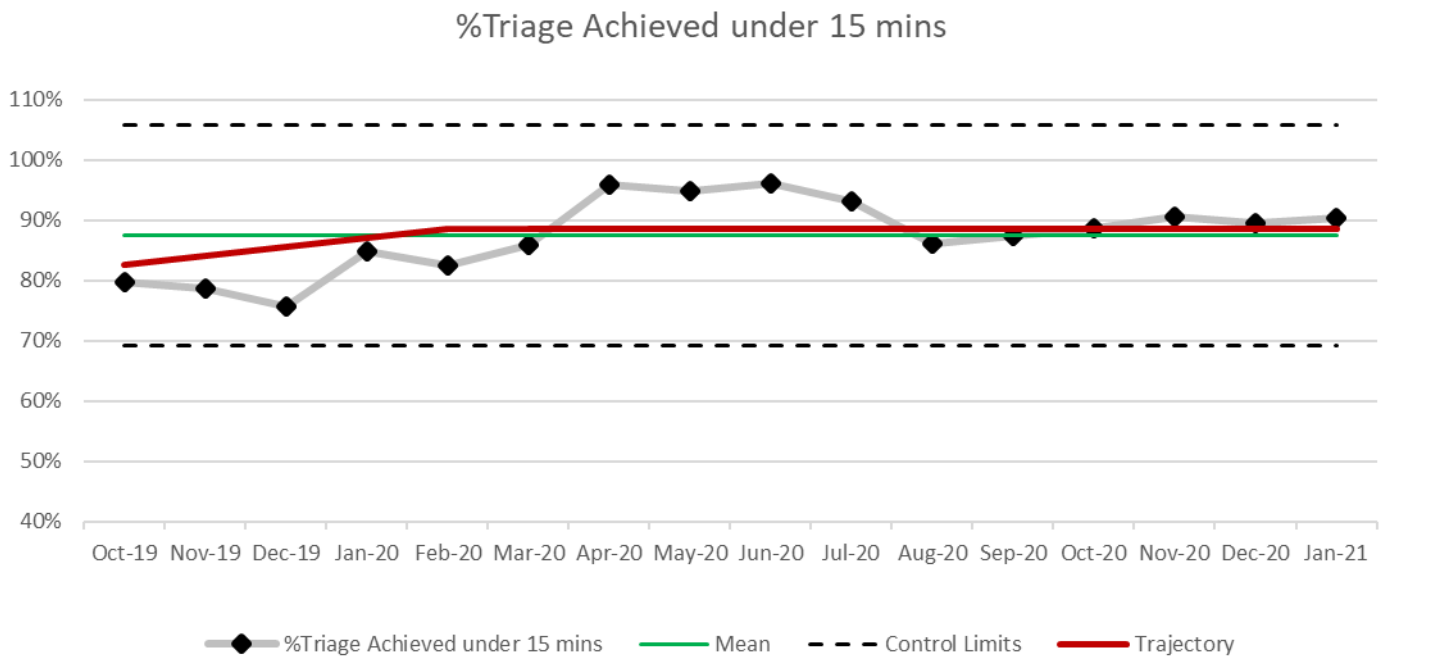
Triage time is a key patient safety performance indicator and forms an essential part of the department huddles. Performance against this safety indicator is scrutinised at the 4 x daily Capacity and Performance meetings.

IMPROVE CLINICAL OUTCOMES – %TRIAGE ACHIEVED UNDER 15

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services



Challenges/Successes

- Triage under 15 minutes improved in January by 0.94%%. 90.42%% in January versus 89.48% in December. The balance between managing the blue pathway and green pathway in both our Emergency Departments and our Assessment Units continues to be problematic, but with the Capacity Cell intervention, this is improving.
- The ability to provide two triage streams has improved.
- Measures are in place to assure the delivery of this key metric improvement trajectory toward 100%.
- This metric continues to be captured as part of the daily and weekly CQC assurance reporting and performance is discussed daily by clinicians as part of the ED safety huddles led by the Deputy Divisional Nurse for Urgent an Emergency Care and now the newly appointed General Manager for Urgent and Emergency Care.

Actions in place to recover:

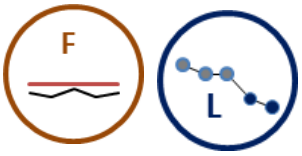
- The focus must remain on achievement of this safety metric.
- All key operational posts have now been appointed to within Urgent and Emergency Care and the expectation of action and remedy has been made explicit.
- Clear action and recovery plans are scrutinised at the four times daily Performance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

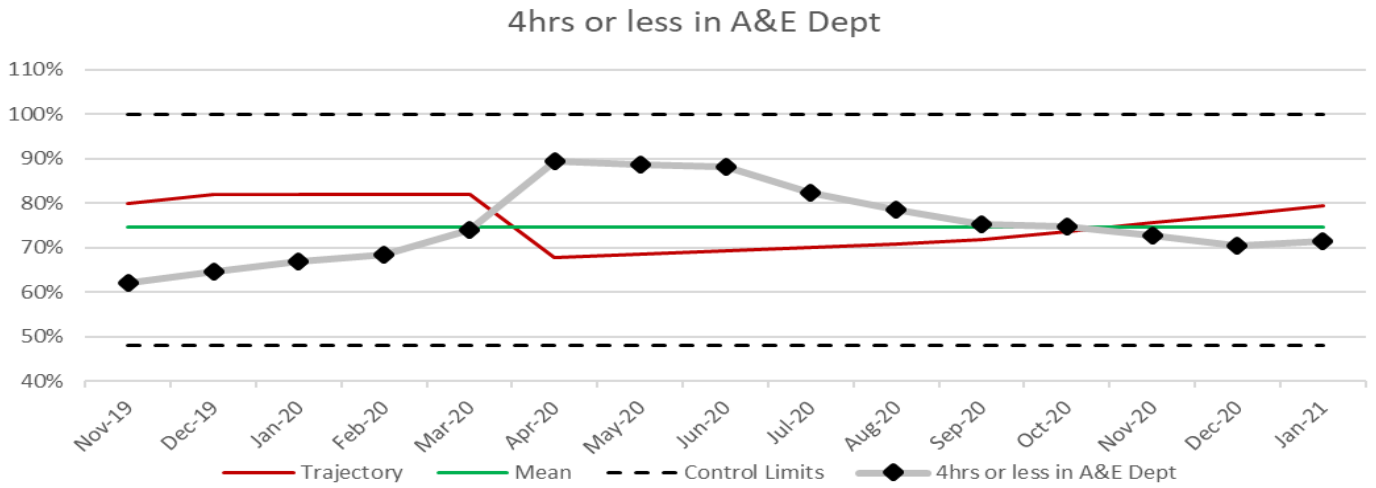
IMPROVE CLINICAL OUTCOMES – A&E 4 HOUR WAIT

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services





Challenges/Successes

- January ED type 1 and streaming was 12,935 attendances verses 13,624 in December (-689 attendances). This represents a 5.06% decrease. By site LCH experienced a 5.91% decrease in attendances, PHB saw a decrease of 3.75%. Grantham also experienced a decrease in UTC attendances of 5.47%.
- January overall outturn for A&E type 1 and primary care streaming delivered 71.41% against an agreed trajectory of 79.32%.
- This demonstrates an improvement in performance of 0.87% compared with December outturn. This is the first sign of improvement in performance in the last 8 months.
- Performance continues below the agreed trajectory by 7.91%. Trajectory is 79.32% vs achievement of 71.41%. Daily reporting to National Regulators is in place via the Chief Operating Officer and the Deputy Chief Operating Officer.
- By site, for December, LCH delivered 69.91%, a 2.88% improvement on December's performance, PHB delivered 68.02%, an improvement of 7.34%. GDH achieved 98.55% which was a slight improvement of 0.42% compared to December. This includes type 1 and type 3 activity.
- The highest days of delivery by the Emergency Departments only was on 2nd January when LCH achieved 72.78% and 16th January when PHB delivered 72.94%. The performance uplift from the UTCs was 9.67% at LCH (82.45%) and 9.9% at PHB (82.84%). Conversely, the lowest days of delivery by the Emergency Departments was 9th January when PHB only achieved 40.54% and 20th January, when LCH only achieved 41.76%. The performance uplift from the UTCs activity was 20.76% (61.30%) and 16.75% (58.51%) respectively.
- Streaming at GDH, LCH and PHB experienced 61 >4hr transit time breaches in December compared with 90 in December a reduction of 27 and a decrease of 32.3%. The highest number proportionate to attendances was GDH.

Actions in place to recover:

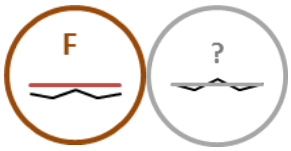
- The Recovery phase of COVID management reflects those process improvements, not affected by volume, in a revised Urgent and Emergency Care Delivery Programme led by a recently appointed General Manager and dedicated Improvement Lead. These appointments, working in Partnership with the Clinical and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

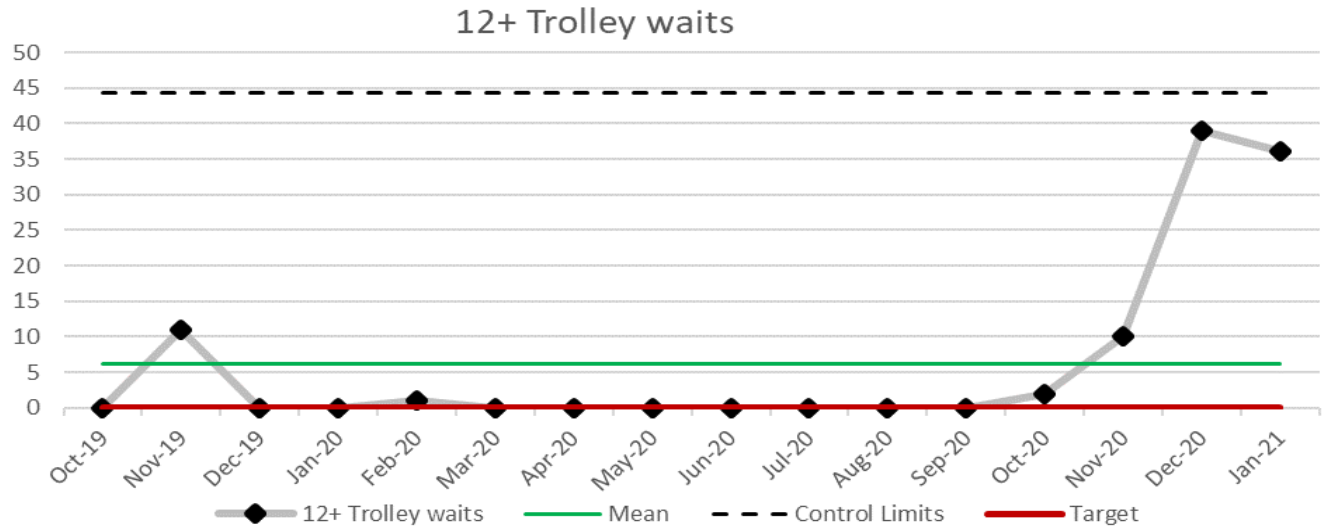
IMPROVE CLINICAL OUTCOMES – 12 HR + TROLLEY WAITS

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services





Challenges/Successes

- The Trust experienced and recorded 36 x 12+ hour trolleys waits in January, all at Lincoln County Hospital.
- December 2020 +12hr trolleys waits revalidated position reduced from 41 to 39.
- The Trust is working closely with national regulators in reviewing and reporting these breaches. A timeline for the +12 trolley wait with the greatest total time in ED is submitted to NHSe/i at 11am the next day.
- Poor flow and an inability to respond to blue and green pathway demand continues to be problematic and plans are in place to re-balance blue and green segregation as COVID-19 begin to reduce.
- The impact of continued shortfalls in available workforce has contributed to delays in timely planning and completion of treatments and interventions.
- January continued to experience both Ward and Staff outbreaks resulting in 'closed' or 'restricted' G&A core beds and a suspension of the 'Green Pathways' at both Pilgrim and Lincoln.
- Availability and access to the correct bed type at PHB has continued to prove successful but the implementation of critical discharge events at Lincoln County have not yielded the benefits expected. LCH remains our most vulnerable site both from a flow and IPC perspective.
- System Partners and Regulators remain actively engaged and offer practical support in situational escalations and declared critical incidents at ULHT

Actions in place to recover:

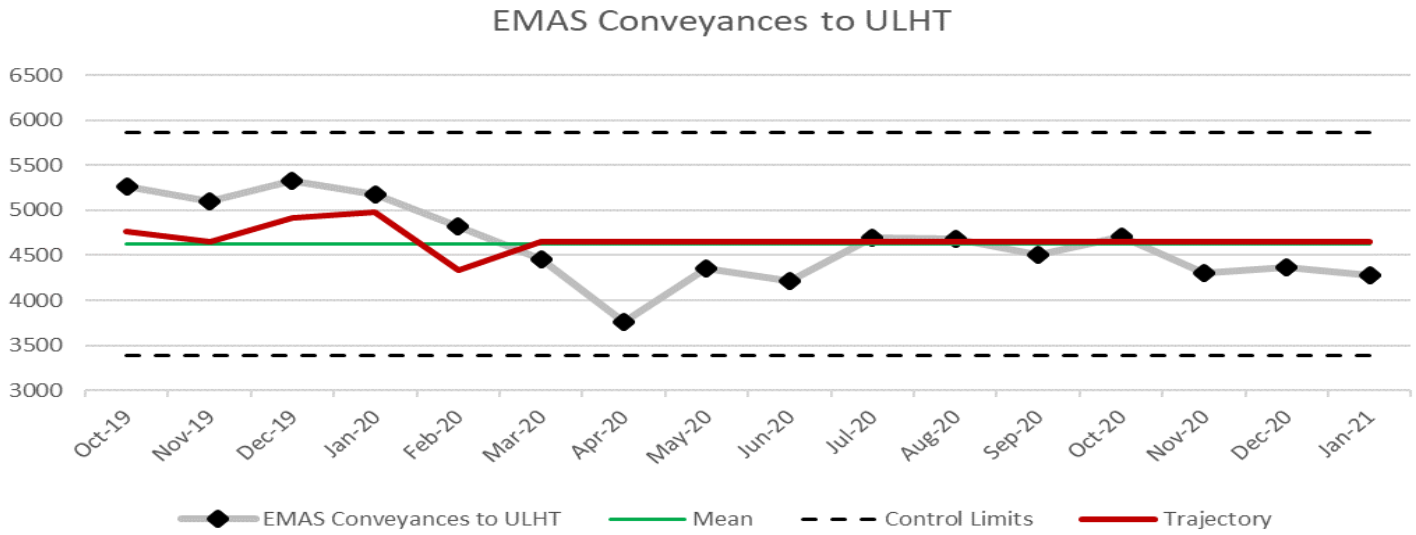
- Daily Capacity Planning Cell meetings are in place and include key stakeholders to assess, plan and agree the flow interventions required and escalate to Gold Command any obstacles for resolution.
- A multi-disciplinary approach to unblock discharge delays across all sites on pathways 0, 1, 2 & 3 is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

IMPROVE CLINICAL OUTCOMES – AMBULANCE CONVEYANCES

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services



Challenges/Successes

- Ambulance conveyances for January were 4279 compared to 4365 in December. This represents a 1.98% decrease in conveyances across all sites.
- By site, LCH conveyances were 2446 in January compared with 2543 in December, a 3.82% decrease, PHB was 1793 in January compared with 1777 in December, a slight of increase of 0.9%. Multiple conveyance deflects were put in place from LCH to PHB during January including bespoke deflects from GDH to PHB. GDH experienced a decrease in conveyance in January, 40 compared to 45 in December, a decrease of 11.12 %.
- Load share for conveyances from GDH to PHB and LCH is more balanced but requires constant monitoring by both the Trust Operational Teams, the UEC CBU and EMAS.
- We continue to work with the System to reduce our overall attendances and conveyances by ensuring all admission avoidance pathways are robust and communicated daily.
- The use of CAS for advice and admission avoidance options appears to have increased and subsequent benefits are being realised but not to the extent expected.
- The anticipated creation of the Priority Admission Response Units (PARU) to support the Emergency Departments experienced further delays and are now expected to be in place by the end of March.

Actions in place to recover

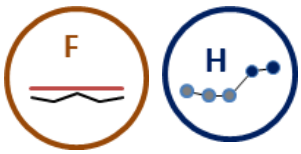
- Recovery plans are in place by the Trust for urgent and emergency care (UEC) which include patients being appropriately clinically managed through alternative streams to avoid large numbers of patients in the emergency department leading to possible delays in Ambulance handover. The benefit of these alternative streams have yet to be realised fully.
- Increased resourcing of CAS by LCHS which includes an extended criterion.
- Increased use of and streaming to the UTCs is now in place and some benefits are being seen although the pathways and extended criterion needs to be more robust.
- An increase to the overall footprint of our Emergency Departments is currently underway with secured funding.
- System Partners are committed to delivering a reduction on the overall burden on the Acute Trust. The Systems UEC Recovery plans give transparency and assurance of the Recovery plans developed and agreed to support this. Regional and National support continues to be made available.

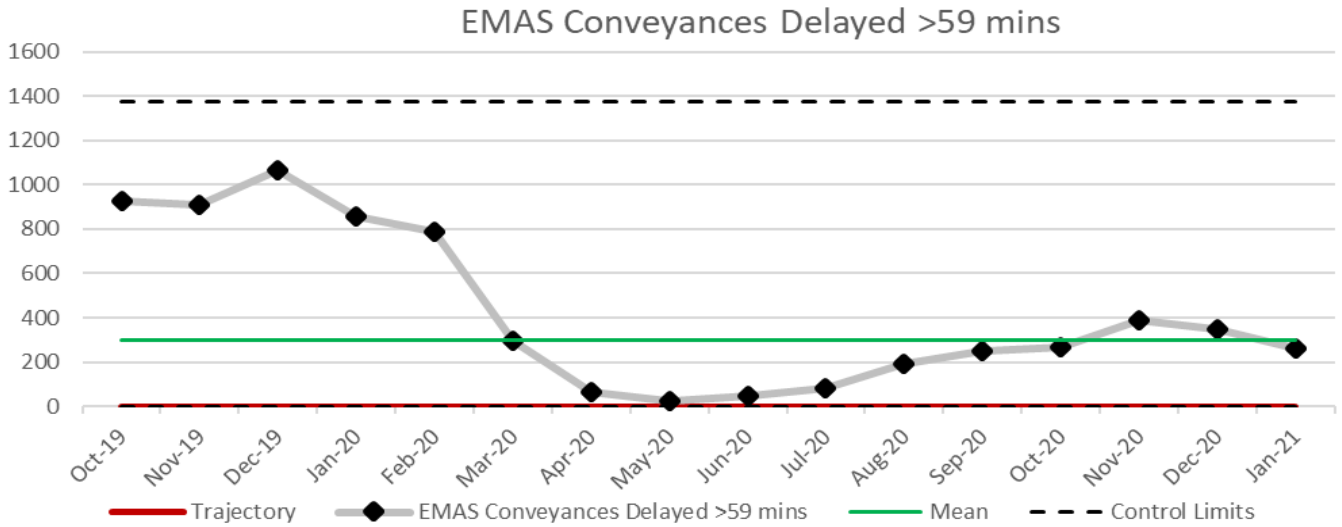
IMPROVE CLINICAL OUTCOMES – AMBULANCE HANDOVER >59

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services





Challenges/Successes

- January reported 263>59-minute hand over delays. This is a decrease of 87 on the December figure of 350. This represents a 24.86%% decrease in >59-minute ambulance handover delays. LCH had 180 >59-minute ambulance conveyances in January compared with 204 in December. This represents an 11.77% decrease in January compared with December. PHB had 83 > 59-minute ambulance handover delays in January compared to 146 in December. This represents a 43.16% decrease.
- Delays experienced at LCH and PHB remain attributed to a continued inability to 'flex' the segregated pathways more responsively against the presenting demand particularly in the evening when conveyances demand is increased.
- There continues to be a challenge regarding the pattern of conveyance and poor flow, especially at LCH.
- Robust relationships exist with the Lincolnshire EMAS Divisional Operations Manager, Clinical Site Manager, ULHT Operational Silver Commander and Operational CCG Silver to ensure any concerns are raised.
- Daily System Calls are in place at 10.30am where number of conveyances, conveyance avoidance and handover delays are discussed.
- All handover delays >59 mins are now reported to the CCG by EMAS.

Actions in place to recover

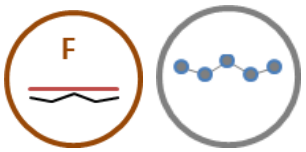
- As part of recovery and following confirmation of additional monies to enhance our urgent care facilities, work continues to bring these plans to fruition. This will include a larger footprint for RAT. This measure seeks to significantly reduce >59mins handover delays.
- Dedicated UEC Project Management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

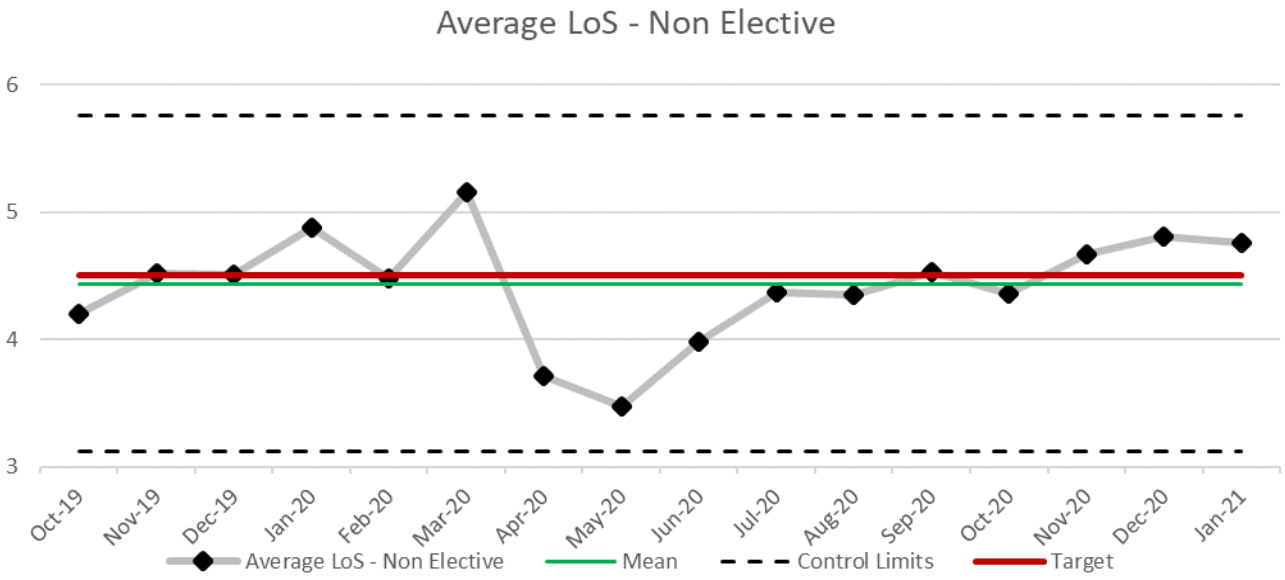
IMPROVE CLINICAL OUTCOMES – AVERAGE LOS NON-ELECTIVE

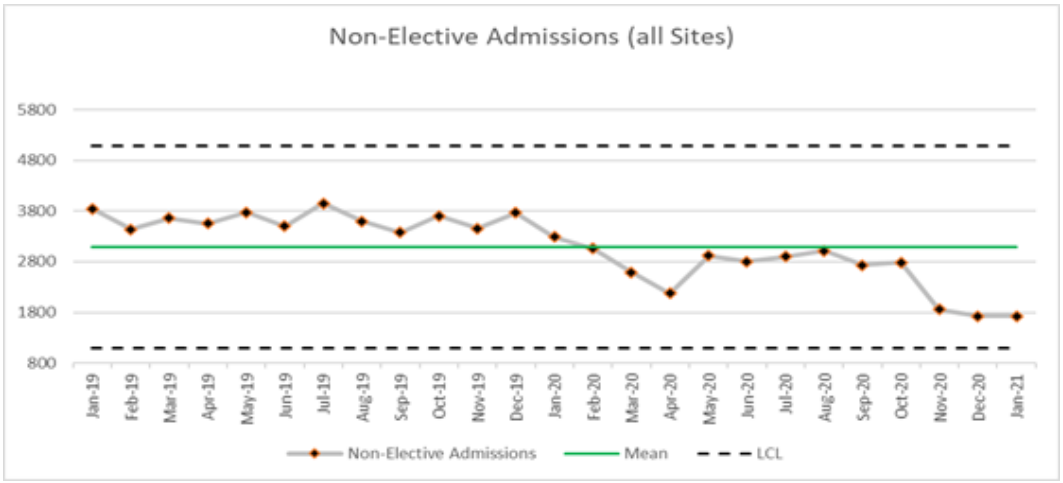
Executive Lead: Chief Operating Officer

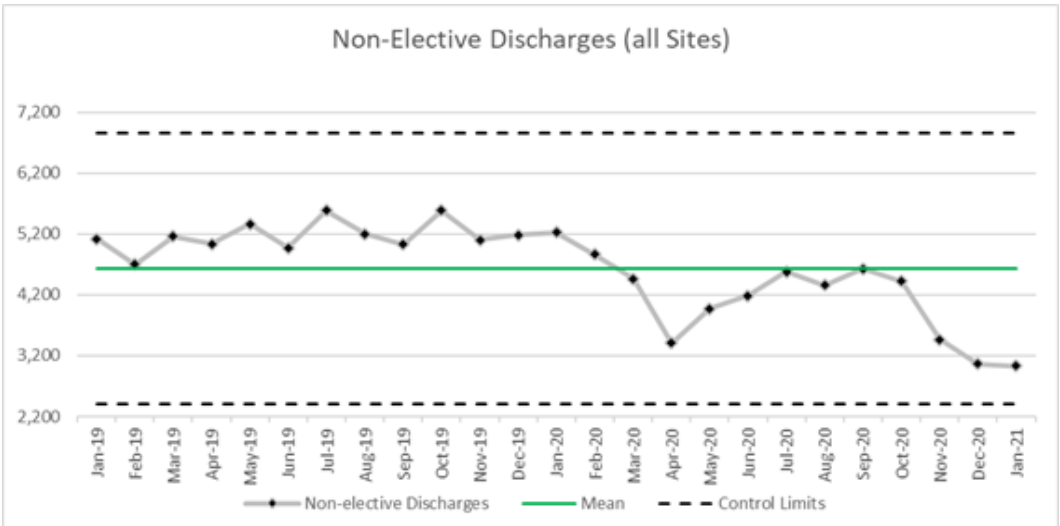
CQC Domain: Effective

Strategic Objective: Services









Challenges/Successes

- Average LOS for non-elective admissions (NELA) saw a slight improvement during January, delivering 4.76 ALOS compared to 4.81 ALOS in December. This represents a positive variation of 0.05 days and is above the trust target of 4.50 days.
- LCH ALOS increased from 5.01 days in December to 5.15 days. PHB decreased from 4.74 days in December to 4.47 in January.
- Non elective admissions decreased in January to 1728 verses 1729 in December. A January 2020 admission comparison to January 2021 shows a 47.45% decrease in non-elective admissions. 3288 NELA in January 2020 verses 1728 in January 2021.
- Non elective discharges decreased from 3,064 in December to 3,033 in January, a reduction of 31. This represents a 1.02% reduction.
- A number of critical discharge events occurred during January with mixed results.
- G&A core bed availability within ULHT has reached its tolerance at PHB and LCH. This continues to be compounded by Coronavirus outbreaks on several wards, patients and staff. This has rendered a number of beds unusable across our acute sites.
- The ward refurbishment and cleaning programmes have continued during January but with some disruption.
- The C-19 third wave modelling (prevalence and bed requirement) has proven accurate to +/- 5 days but increased pressure on our ICU beds is palpable. Fourth wave impact and modelling has been announced
- During January the numbers of patients with a LLOS decreased slightly. 79 in January compared to 92 in January. A decrease of 13 patients.
- The work of the system wide discharge cell continues to address inequalities in access for both Community care and adult social care and remains in operation 7 days a week with twice daily calls.
- Extensive work has been undertaken with system partners to acquire and agree funding and access to designated beds for our positive COVID19 patients on pathways 1, 2 & 3.
- LCHS have redesigned their bed capacity to support positive COVID19 patients transfers from Acute Beds.

Actions in place to recover

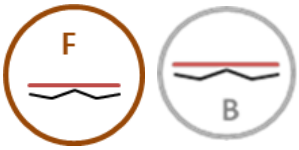
- Multi-agency discharge meetings continue to take place daily, seven days a week. Line by line reviews take place against each patient on pathway 1, 2 and 3. This process is now robust and an increase the discharge of medically optimised patients across the entire week (7days) is being realised.
- Long length of stay meetings for each hospital site remain in place to support more complex patients through their discharge pathway.
- More work is required in respect of the discharge pathways, in particular pathway zero and especially at LCH. A newly established internal discharge cell chaired by the Deputy Chief Operating Officer and Deputy Medical Director aligned to Patient Safety will support the delivery of this.
- The System secured and commissioned care homes who will support patients with positive swabs, especially pathway 1 and 2 where the demand is the greatest. We are seeing the benefit of this intervention/action. ULHT, LCHS and LCC are managing these pathways with LCHS re-designing their current bed reconfiguration now due to reducing number of COVID-19 positive patients requiring this interim support.

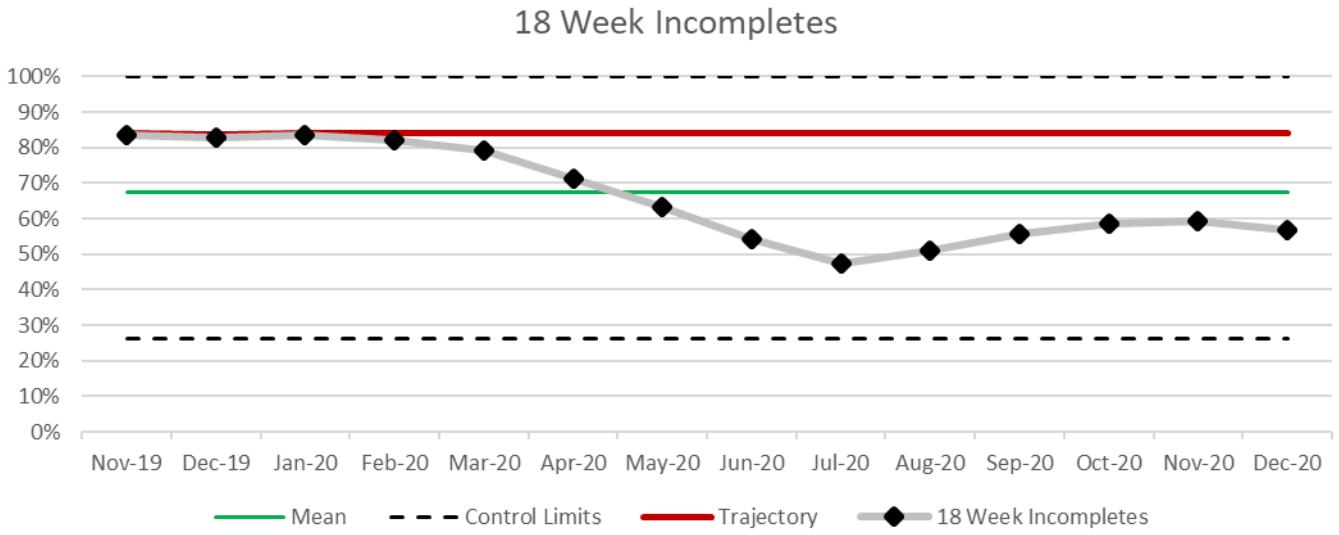
IMPROVE CLINICAL OUTCOMES - RTT 18 WEEKS INCOMPLETES

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services





Challenges/Successes

RTT performance is currently below trajectory and standard.

December saw RTT performance of 56.72% which is -2.62 % worse than November.

Paediatric Surgery was the lowest performing specialty, with performance decreasing from 42.55% last month to 30.18% (-12.32%). Neurology is slightly worse this month with a 0.25% decrease from 54.49% last month to 54.24% in December.

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

- Ophthalmology - 2914 (Reduced by 179)
- Trauma & Orthopaedics - 2217 (Reduced by 39)
- Ent - 2059 (Increased by 241)
- Maxillo-Facial Surgery + Orthodontics + Oral Surgery - 1486 (Increased by 45)
- Dermatology - 1425 (Increased by 56)

Actions in place to recover:

Performance across most specialties continues to increase albeit slowly.

As the figures above show, ENT's performance continues to decline together with Maxillo-Facial surgery and Dermatology. Due to the focussed efforts of Ophthalmology utilising the facilities at Louth County hospital, their performance has positively increased.

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

Specialties achieving the 18 week standard for December were:

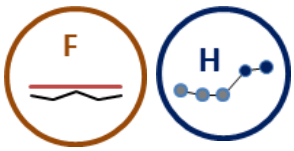
- Clinical Oncology 95.05%
- Breast Surgery 92.23%
- Paediatric Urology 92.11%
- Medical Oncology 100% (one patient)
- Acute Internal Medicine 100% (one patient)
- Paediatric Cystic Fibrosis 100% (one patient)

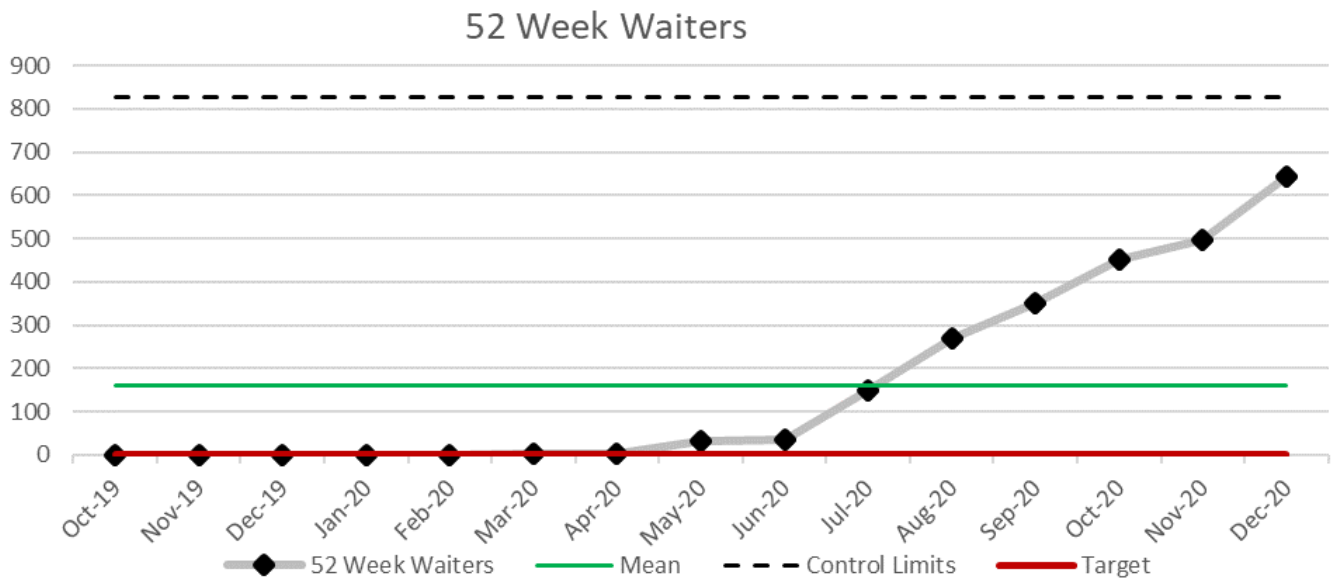
IMPROVE CLINICAL OUTCOMES – 52 WEEK WAITERS

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services





Challenges/Successes

The Trust reported six hundred and forty-two incomplete 52 week breaches for December end of month. As anticipated there are an increased number of breaches declared each month. However, full focus is on these patients at the weekly PTL meeting to ensure that there is a plan for every patient. Due to pressures of the second wave of the pandemic, this meeting was temporarily stood down. However, at the beginning of February it was re-instated. Due to the high volume of long waiting patients, validation of these is very challenging.

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

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

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

Actions in place to recover

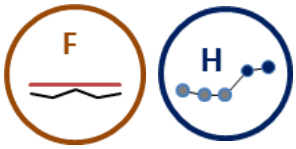
Recovery plans continue to be implemented; accounting for a changing environment.
Across the Trust outpatient services continue to use all available media to consult with patients.

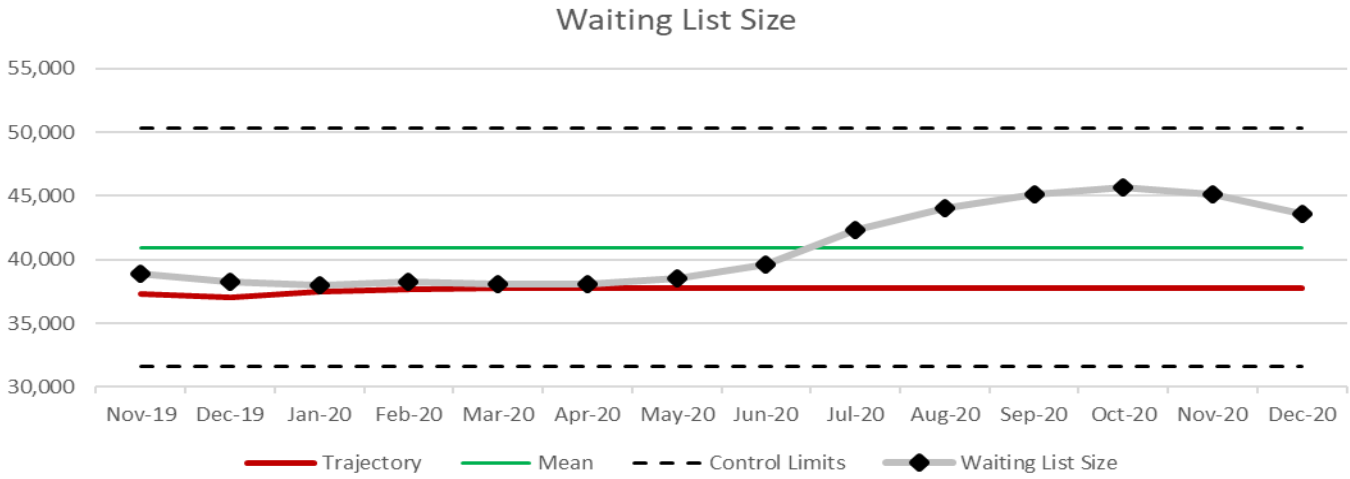
IMPROVE CLINICAL OUTCOMES – WAITING LIST SIZE

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services





Challenges/Successes

Overall waiting list size has decreased from November, with December total waiting list decreasing by 1,551 to 43,562. The incompletes position for December is now approx. 4,530 more than the March 2018 (39,032) target.

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

- Breast Surgery + 146
- Nursing Episode + 63
- Paediatrics + 39
- Diabetic Medicine + 31
- Gastroenterology + 18

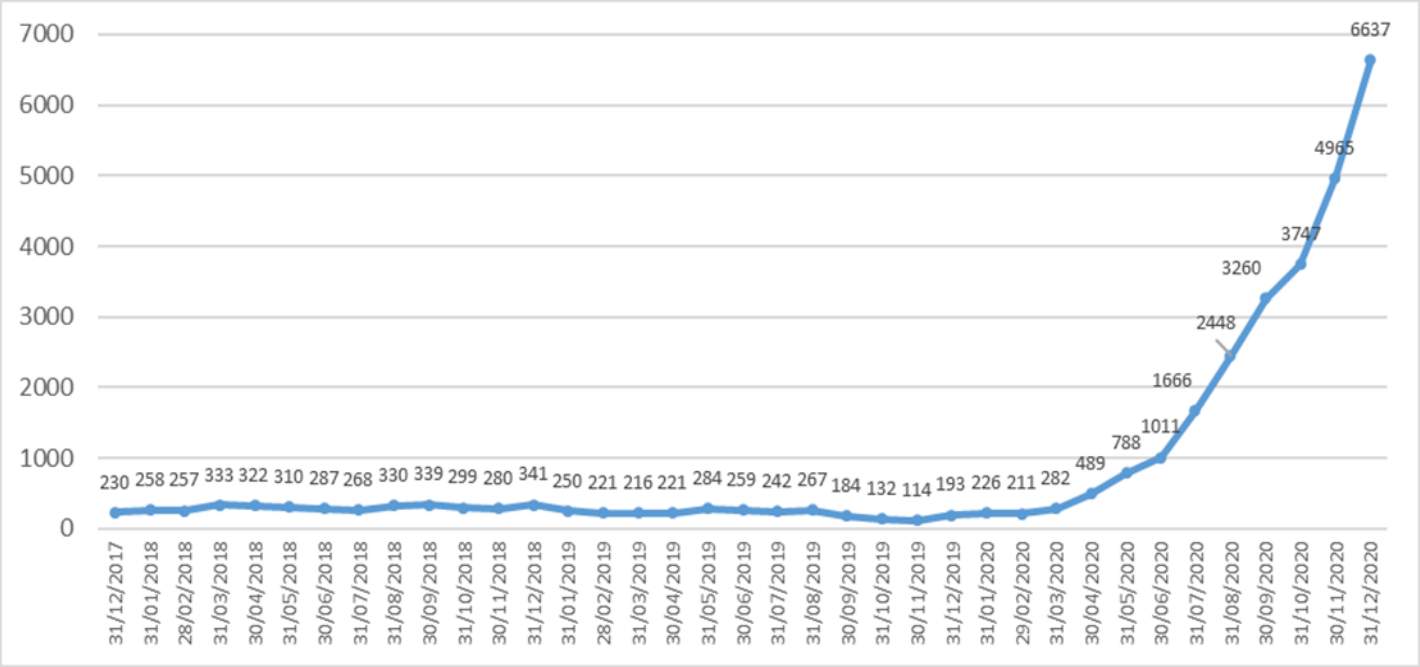
The five specialties showing the biggest decrease in total incomplete waiting list size from November are:

- Ophthalmology - 484
- Dermatology - 199
- Cardiology - 198
- Trauma & Orthopaedics - 194
- General Surgery – 176

Actions in place to recover

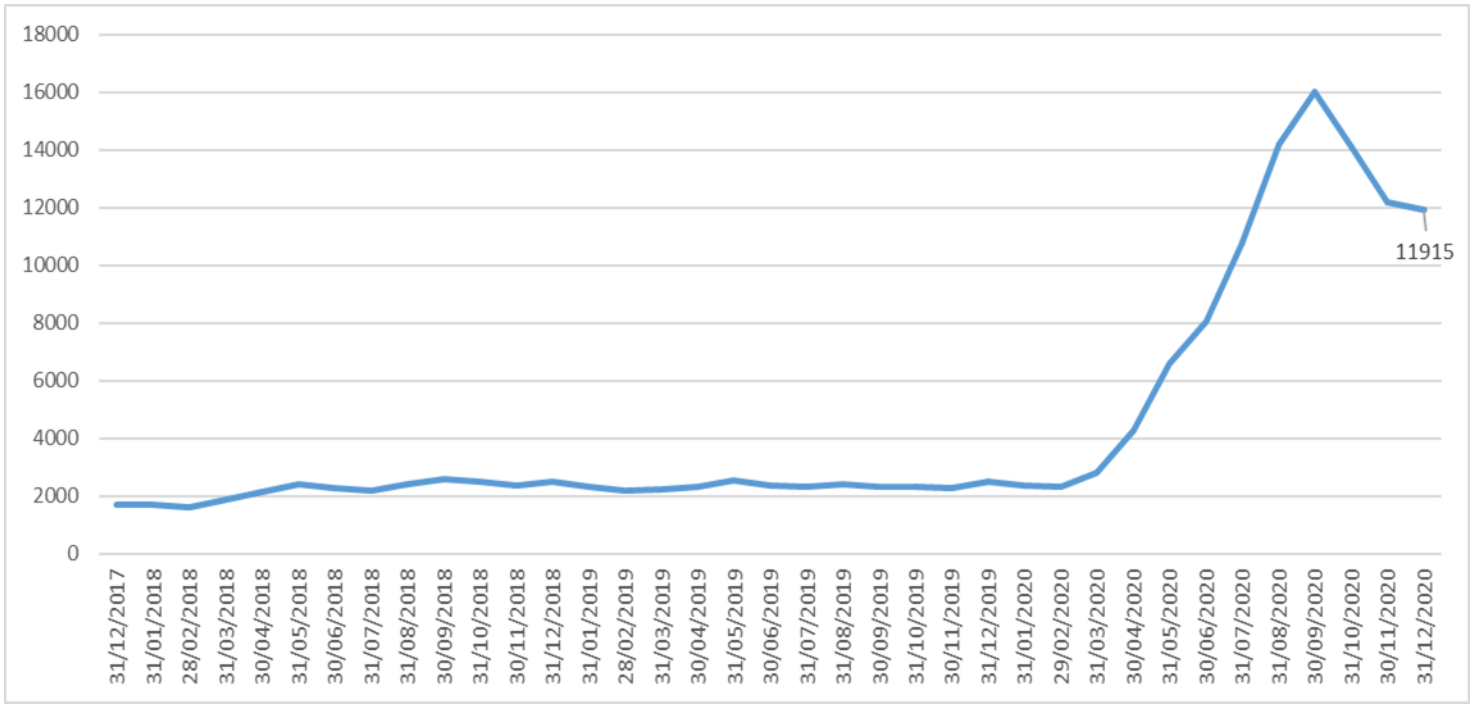
The longest waiting patients are tracked and discussed at the weekly PTL meeting. December showed 6637 patients waiting 40 weeks and above as the chart below shows. November to December saw an increase of patients waiting over 40 weeks, +1672, with Ophthalmology (+324) showing the largest increase. Seven specialties reduced their position compared to last month, with Neurology showing the best improvement of -4 patients from last month.

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



The chart below illustrates incomplete patient pathways waiting 26 weeks and above. Progress up to 31st December, shows a decrease of 276 patients from November. Nineteen specialties decreased their position with the largest decrease being seen in Ophthalmology, - 274. The largest increase was seen in Gynaecology, +105.

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



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

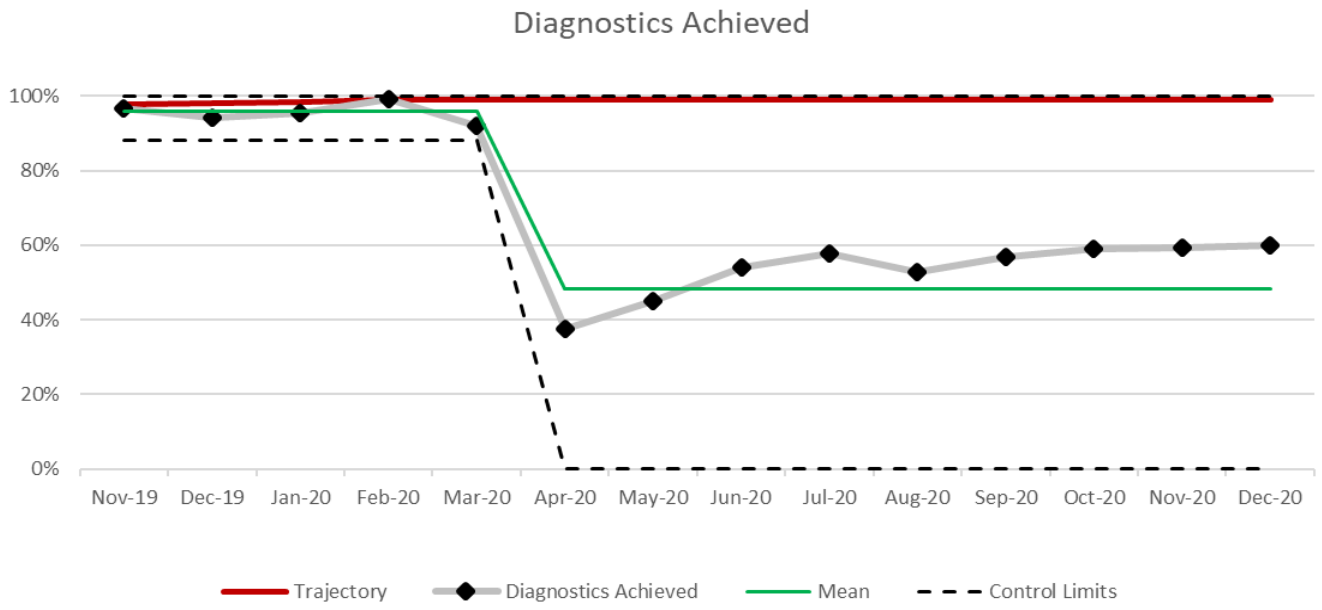
At the end of December, ULHT reported 3 pathways as waiting over 80 weeks for first definitive treatment. All 3 were in specialty General Surgery.

IMPROVE CLINICAL OUTCOMES – DIAGNOSTICS

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services



DM01 return for Dec Was 60.1% and in November was 59.24%, which is an improvement from October 59.11%.

Radiology

Radiology is currently achieving 91.5% against a target of 99% this is one of the best in the region at present. We have recovered to between 110% and 130% of previous years activity which is very encouraging. Our main issues are that A&E, inpatient demand and activity has returned to pre Covid levels and in some weeks surpassed pre Covid levels. Due to social distancing CT this massively impacts on our outpatient and GP capacity. We have the added reduction in capacity due to our Green site and patients unwillingness to travel or attend appointments due to Covid fears.

Due to Covid pathways there is an increased demand of lengthy CT procedures such as CT Colonoscopy again impacting on normal capacity. Our main struggle/back log at the moment is the demand for Cardiac CT and capacity for Cardiac CT. We are dependent on a cardiologist for each list and demand has far outreached the funded cardiac CT capacity.

CT is a much improved position of 319 breaches for December compared to 595 in November.

- Cardiac CT's will need additional capacity from cardiology consultants list have now been booked.
- Sourcing and retaining agency staff to man the additional CTs is difficult.

Physiological Sciences.

- Neurophysiology - peripheral neurophysiology LCH has improved reporting 371 for December compared to 536 for November.
- Audiology - Audiology Assessments have improved, only there were only 67 breaches for December.
- Waiting lists are monitored weekly.

- Additional capacity is being sort via outsourcing, additional lists and over time.

Endoscopy

- Still awaiting the 300 plus OGD to be removed from the waiting list, performance is very much the same as November.

Cardiology

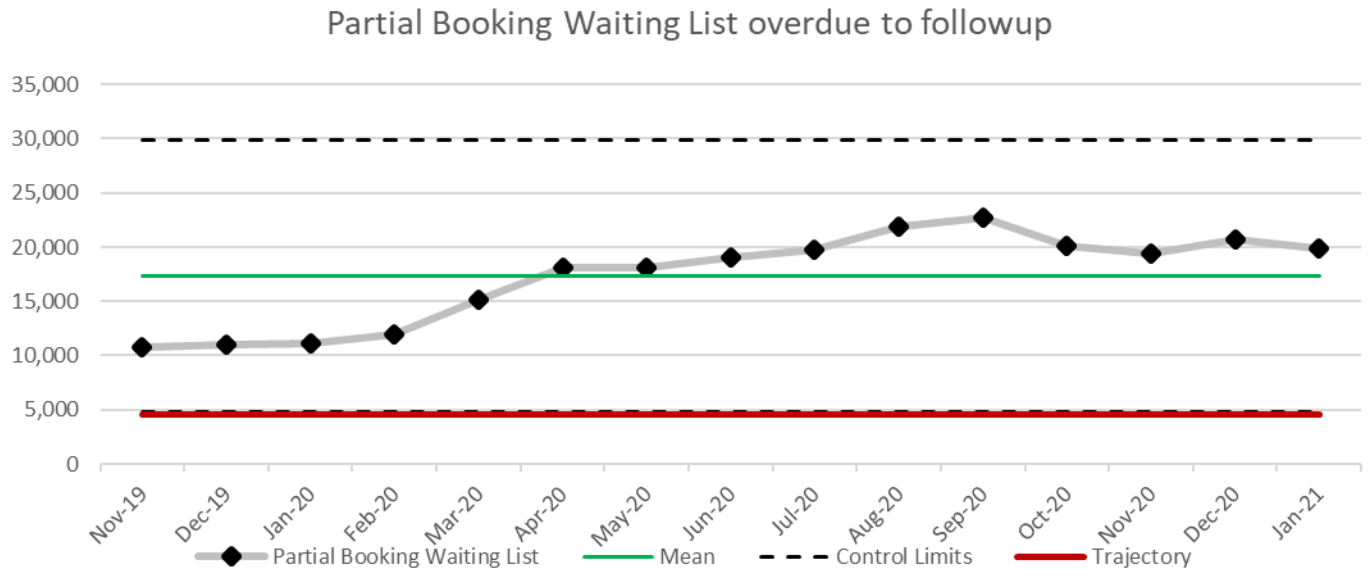
- Cardiology – echocardiography had 2019 breaches in December and 2000 breaches in November.
- Cardiology - echocardiography Stress /TOES had 99 breaches in December.
- Cardiac physiology have been asked to support ICU, (Rebecca Johnson is compiling a service impact and recovery plan).

IMPROVE CLINICAL OUTCOMES – PARTIAL BOOKING WAITING

Executive Lead: Chief Operating Officer

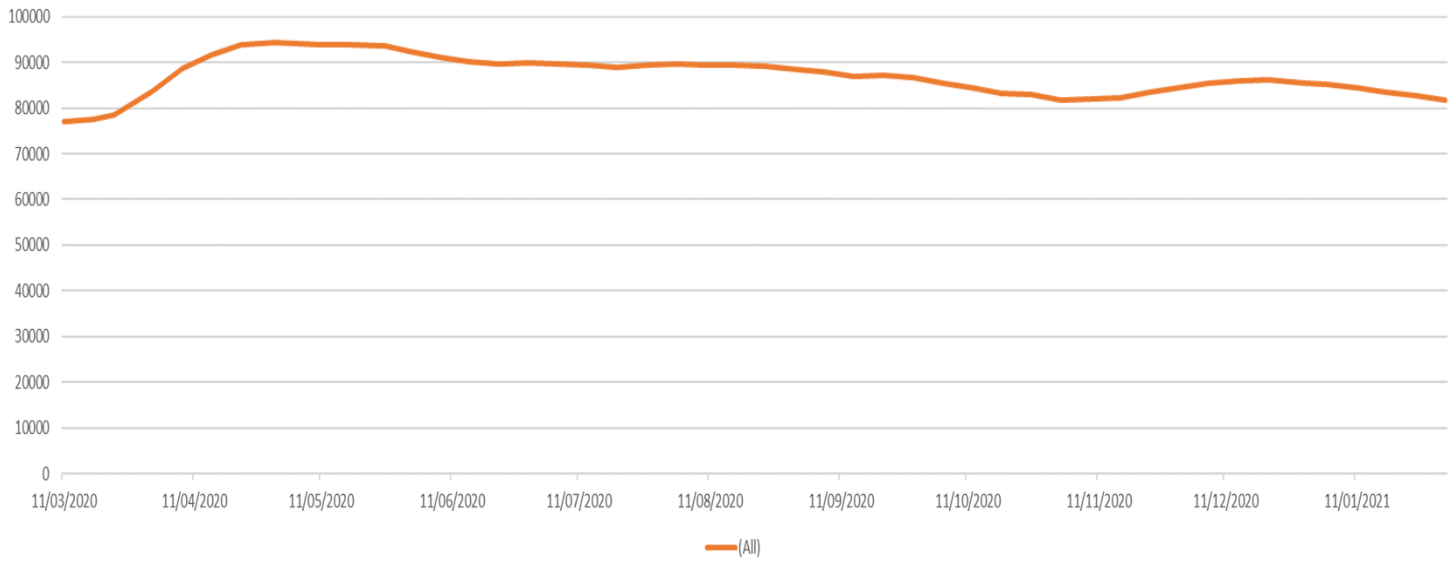
CQC Domain: Responsive

Strategic Objective: Services



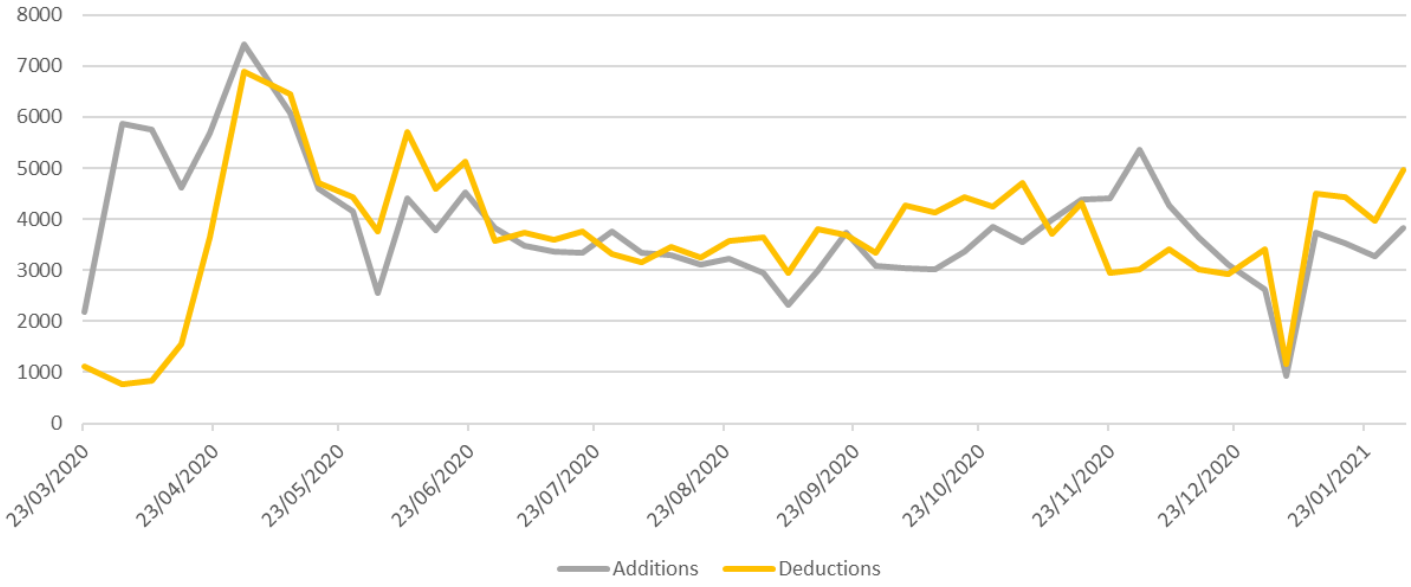
Challenges/Successes:

Following a period of growth through March to May due to a significant reduction in routine outpatient activity because of the Trust's response to COVID-19 first wave. The Trust started to reduce the PBWL in line with its recovery plan to reduce to pre Covid levels. The increase in Covid patients within the Trust in November and December has meant a reduction in activity, although not to the same low levels as wave 1. This has impacted on the recovery plan and has meant only a small reduction on the PBWL since December.



Actions in place to recover:

With the workforce pressures in place we have continued where possible with the administrative validation, clinical triage, and the scaling up of technology enabled care. The plan for the introduction of PIFU (patient Initiated Follow Ups) has been scaled back dependent on the speciality involved. We are continuing with our PBWL meetings to offer support and an opportunity to review recovery plans.

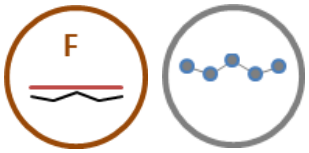


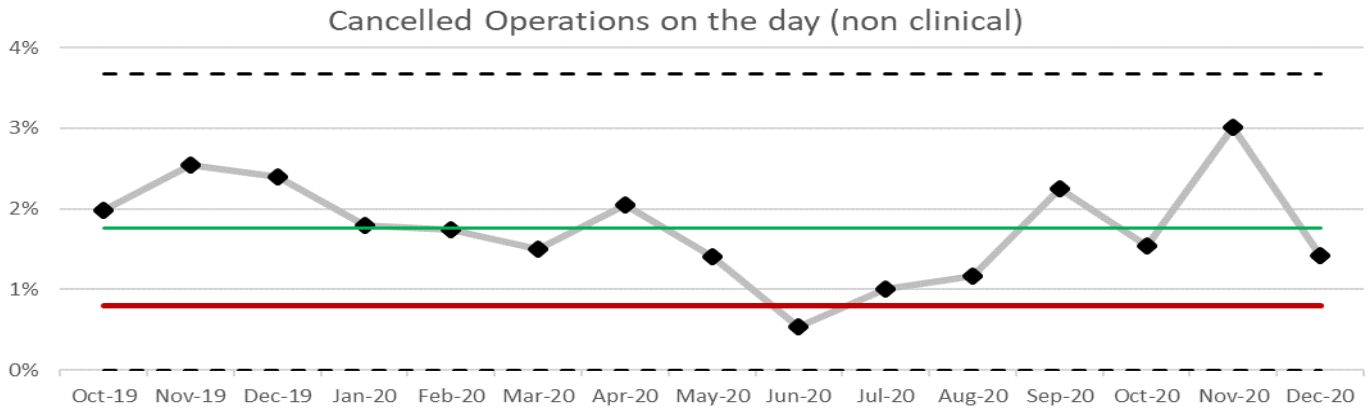
IMPROVE CLINICAL OUTCOMES – CANCELLED OPS

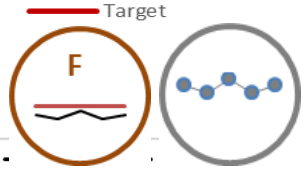
Executive Lead: Chief Operating Officer

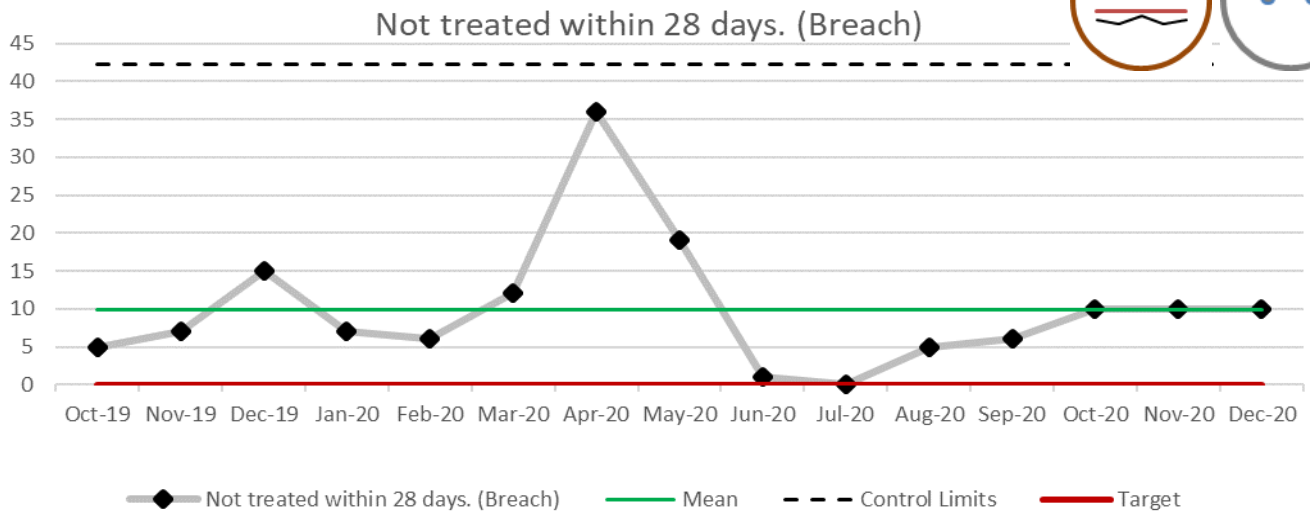
CQC Domain: Responsive

Strategic Objective: Services









Challenges/Successes:

Primary reasons for on the day cancellations include; patients being medically unfit/ unwell, patients no longer requiring the surgery, lack of theatre time, and lack of HDU/ITU beds and a list cancellation due to surgeon absence.

Actions in place to recover:

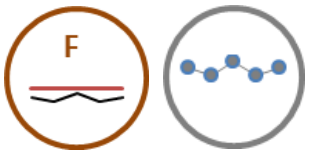
List allocations are regularly reviewed to identify potential for reduction in cancellations.

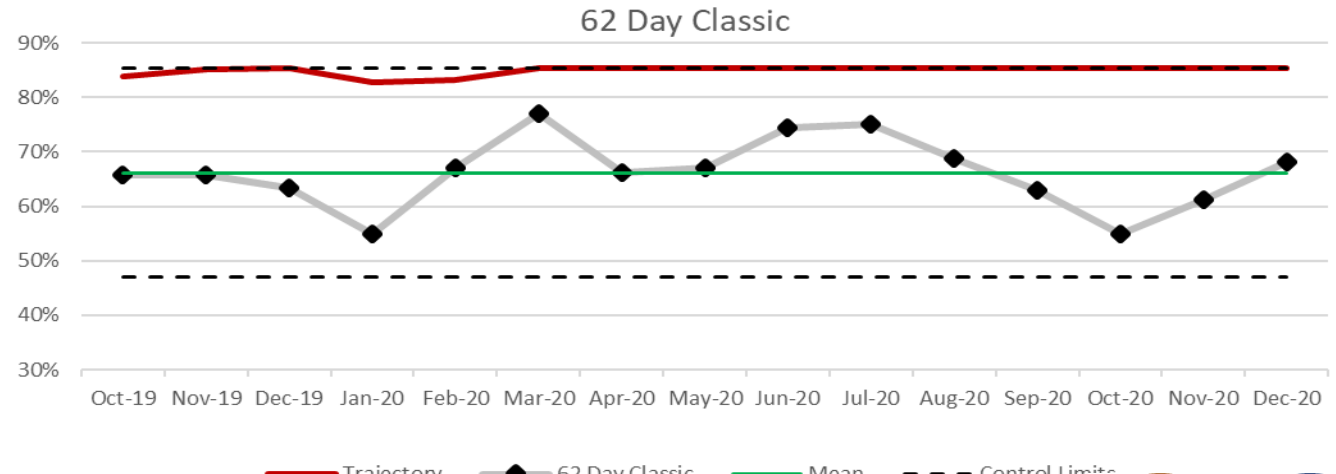
IMPROVE CLINICAL OUTCOMES – CANCER 62 DAY

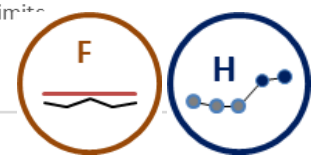
Executive Lead: Chief Operating Officer

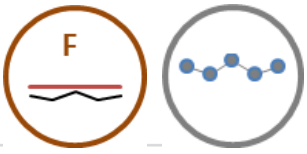
CQC Domain: Responsive

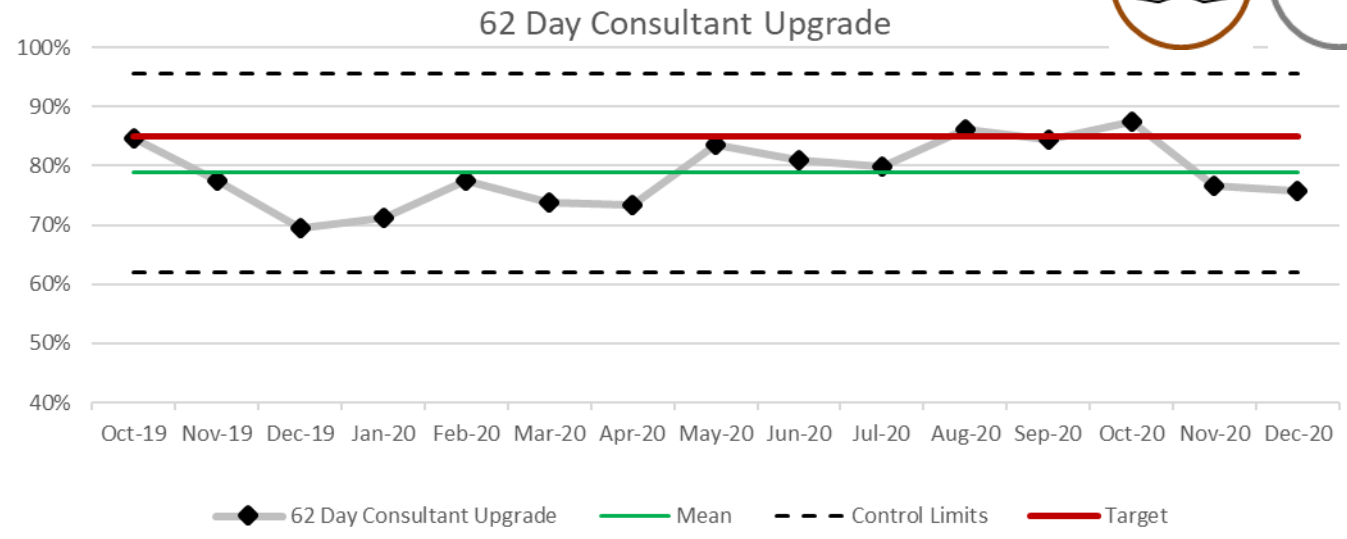
Strategic Objective: Services





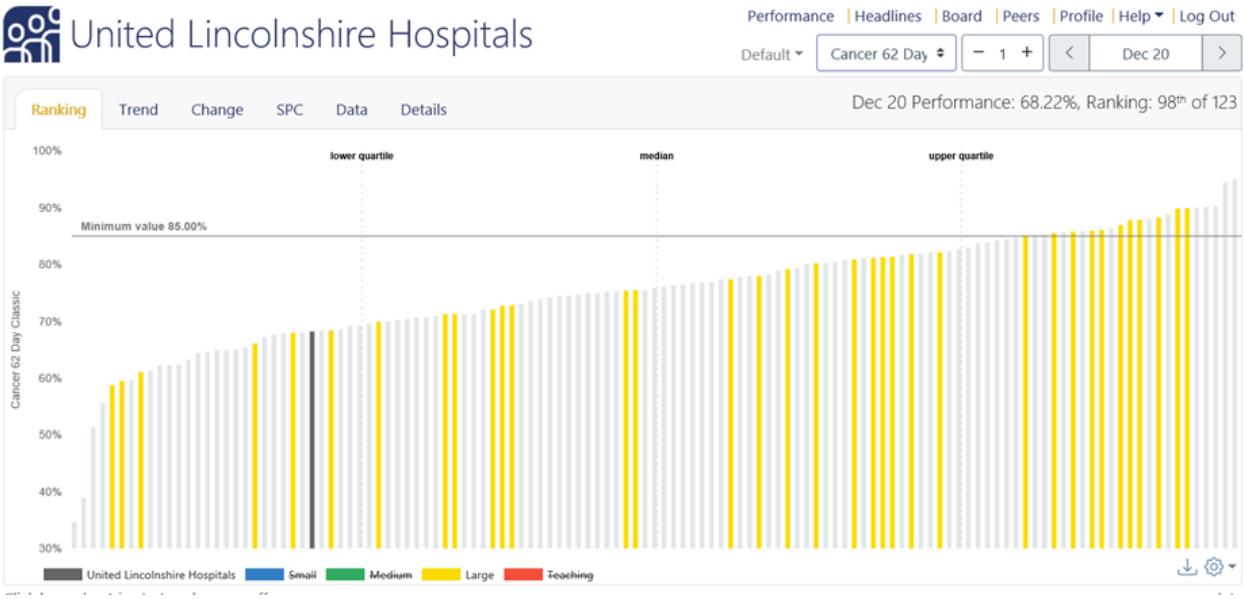


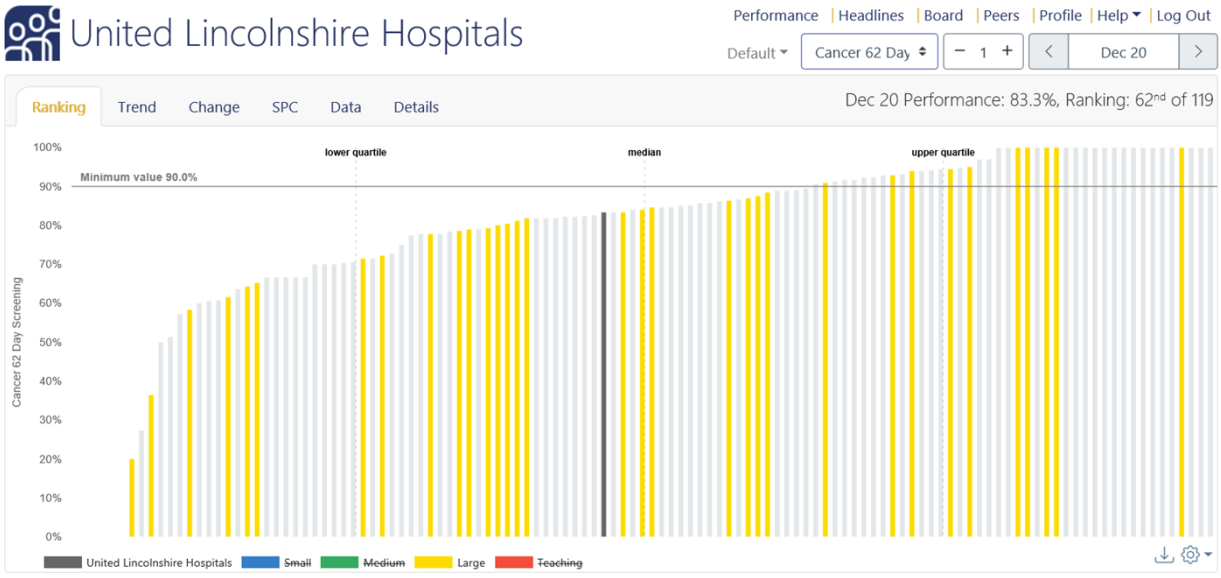


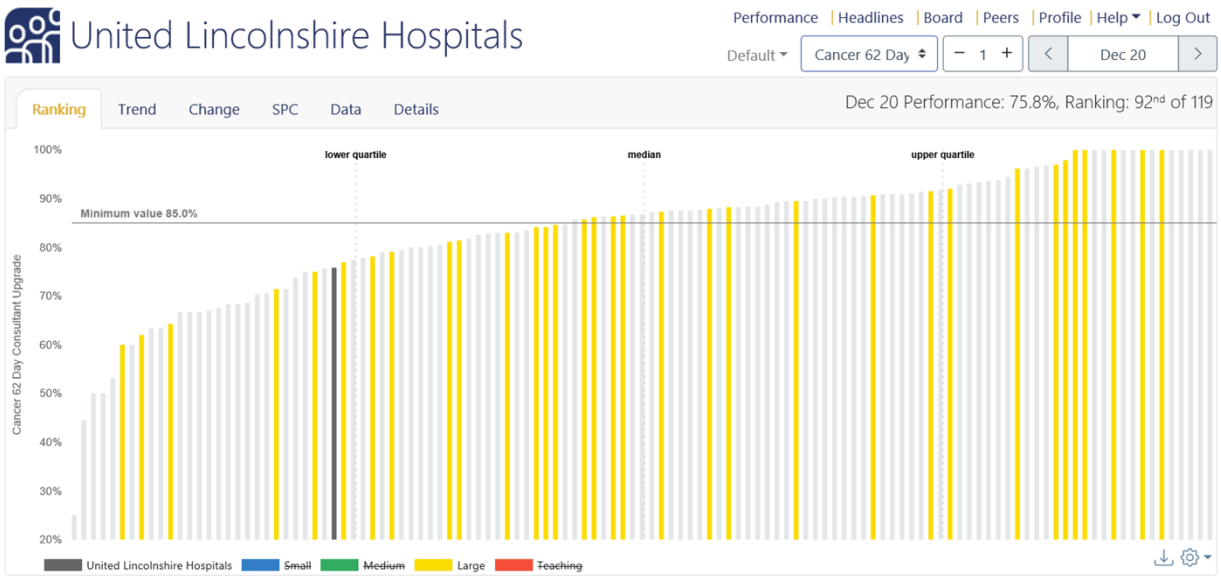


Challenges/Successes

In December our 62 Day Classic performance increased by 7.8% compared to November, at 68% placing us both below the national average (75.2%) and in the lower quartile.







Early indications are that our December 62 Day Classic performance will be circa 68%

Challenges to our performance include:

- Inappropriate referrals from GPs (e.g. not having face-to-face appointment prior to referral).
- Patient engagement in diagnostic process (reluctance to visit hospitals during COVID-19 with the second surge threat, and now reality, amplifying this effect).
- Increased time to book diagnostics with patients due to COVID requirements (for Endoscopy it has increased from 6 mins to 16 mins per patient) can add to patient anxiety and reluctance to attend.
- Capacity not always where patient is willing to travel.
- Patient acceptance & compliance with swabbing and self-isolating requirements.
- Limited outpatient capacity due to social distancing requirements.
- Reduced theatre capacity across the Trust, all Specialties vying for additional sessions.
- Severely restricted access to Independent Sector capacity relative to regional colleagues.
- Recognition that backlogs will be created during COIVD-19 wave 2, due to stopped/reduced clinical services.
- 62 Day backlogs significantly in excess of pre-COVID levels for Colorectal, Head & Neck, Upper GI and Urology.
- Capacity within Divisions to give necessary attention to Cancer.
- Lost treatment capacity due to short notice cancellation of patients (unwell on the day of treatment or day before), not allowing time to swab replacement patients.

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

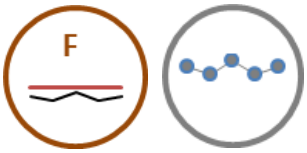
- 28 Day FDS identified as Trust's single cancer performance work stream in the Integrated Improvement Program for 2021-22.
- Additional theatres installed at Grantham for Breast & Gynaecology.
- Breast Services review (awaiting review of final report from NHSI support).
- Review of Colorectal theatre list scheduling to better align with clinician availability and consideration of moving level 1 patients to Grantham.
- Case of Need in progress for CT and MRI extensions.
- Bid for 'blue' CT at Grantham – currently with ET.
- Endoscopy booking team recruited 3 WTE – now in post and completing training.
- 2 WTE Endoscopist posts going through the interview and selection process. So far a Nurse Endoscopist has been appointed on Bank who will support weekend lists.
- £1.26m NHSE funding awarded for replacement of Pilgrim decontamination unit as well as new stacks and scopes (scope guide for Grantham, stacks and scopes for Lincoln and Boston). Work began w/c 01/02/21 and will take approx. 6 weeks – aim to be finished mid-March.
- Dedicated admin resource within Colorectal CBU to support clinical engagement.
- Full time Navigator posts EMCA funding from April to support Medicine and Family Health.
- Return of H&N consultant (from sabbatical) and third post to be re-advertised. Further interviews due 12/02/21 pending Royal College approval.
- Oncology Fragile Service under review with new locum consultant started 14th December (urology, breast and non-melanoma skin). Two Medical Oncologists are due to start in April 21 (Urology, Renal, Lung, Skin and Breast.

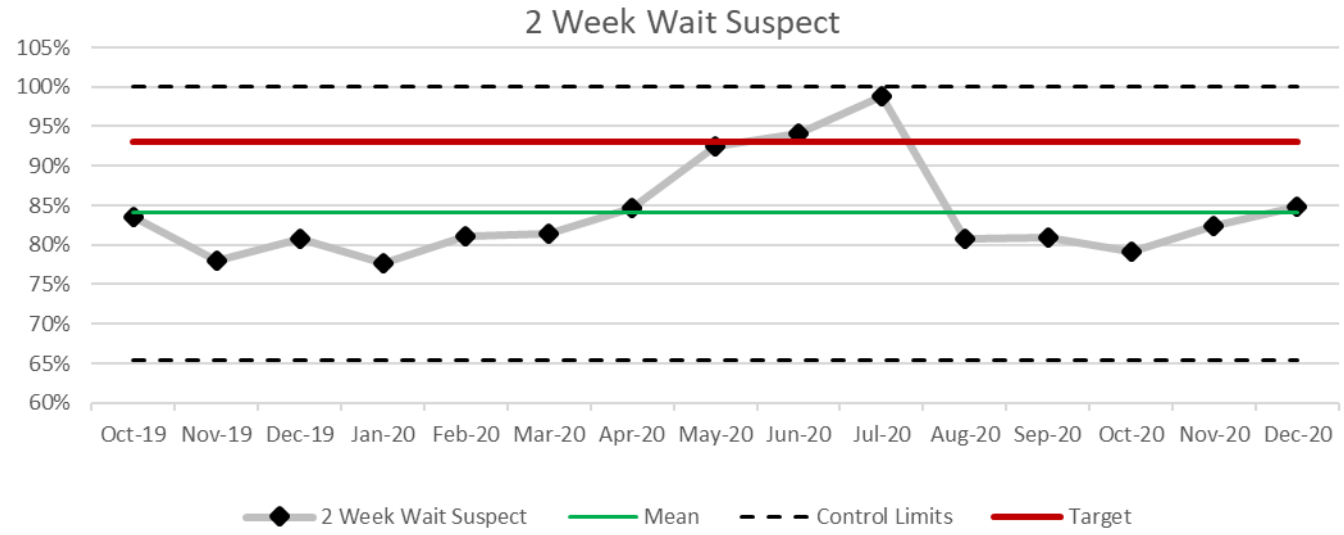
IMPROVE CLINICAL OUTCOMES – CANCER 2 WEEK WAIT

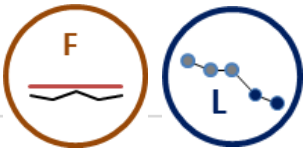
Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services

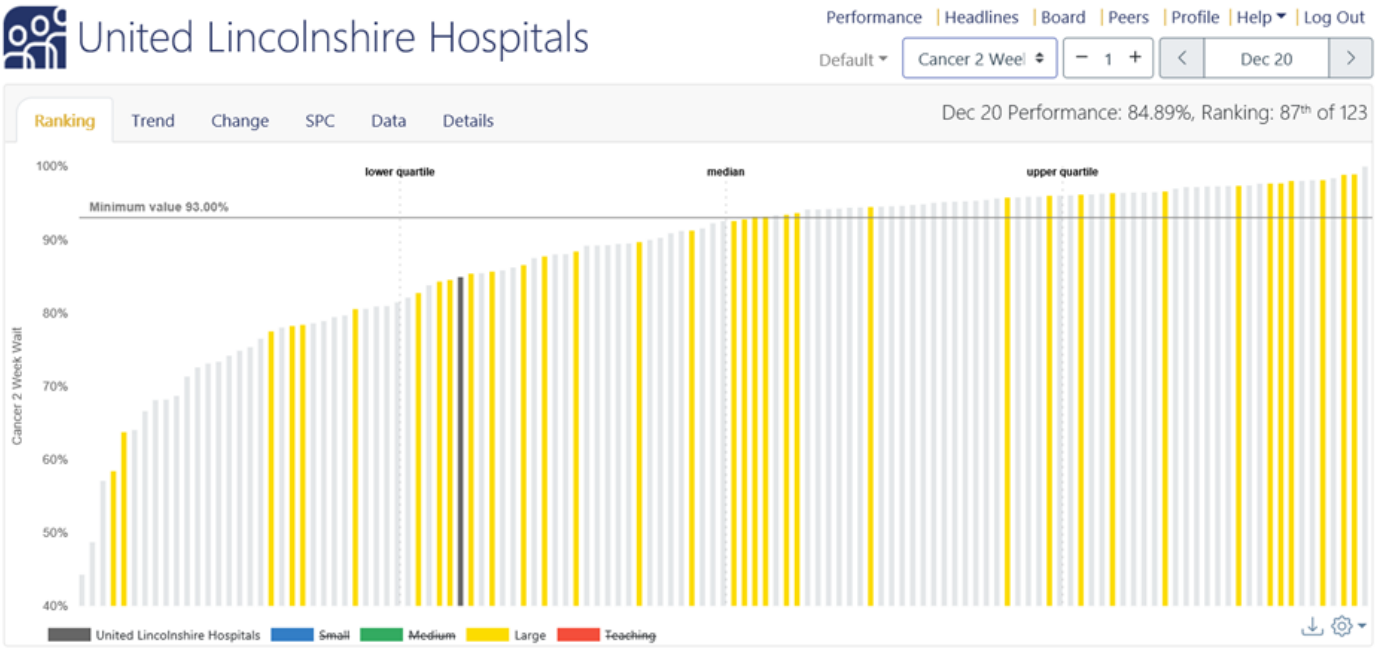


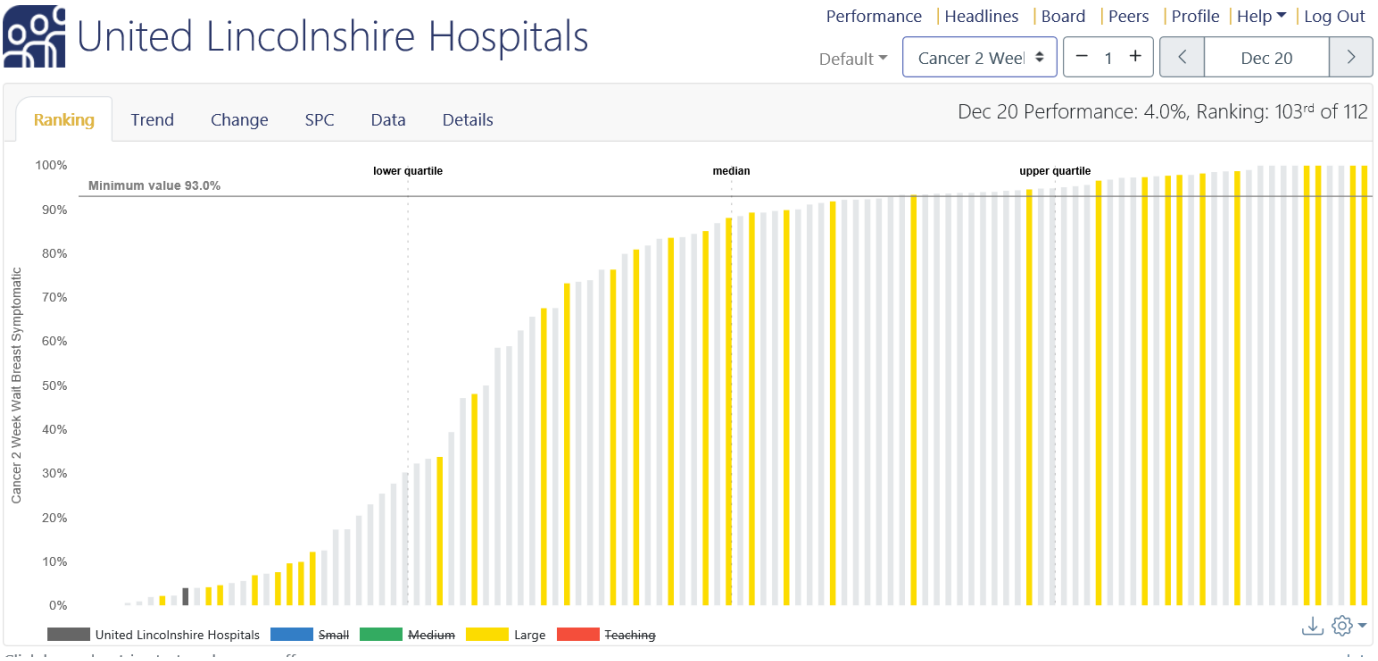




Challenges/Successes

The Trust's 14 Day performance continues to be significantly impacted by the current Breast Service One-Stop appointment alignment issues - 71% of the Trust's 14 Day breaches were within that tumour site. The other tumour site that considerably under-performed include Gynaecology (11%). The 14 Day Breast Symptomatic has been affected by the same impact of the Breast Service One-Stop appointment alignment issues.





Actions in place to recover:

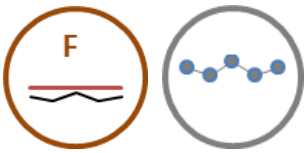
- Work continues to align all the 2ww Referral forms to NG12.
- Breast Services review (awaiting feedback on final report from NHSI support).
- New Gynae ultrasound Direct Access pathway due to commence w/c 9th November but delayed due to COVID surge.
- Lung Direct Access pathway to commence Trust wide.
- Lung – Pilot to appoint patients within 48 hours being trialled for 1 month (Jan/Feb).
- Pilot of triaging all Skin 2ww referrals – early stage of development at present, no start date identified.
- Project to establish Upper GI Direct Access pathway – no start date identified.
- Urology continued review of cystoscopy provision (on hold during COVID wave 2)
- Bladder and testicular pathway – scoping to revert to direct access pathway and Haematuria to one stop clinics.

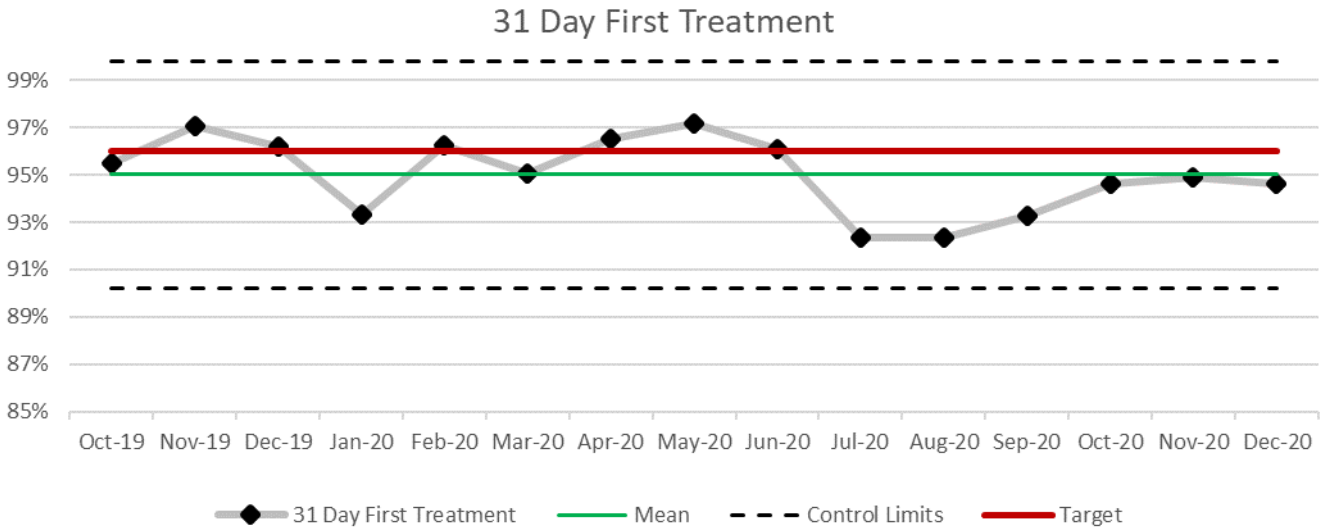
IMPROVE CLINICAL OUTCOMES – CANCER 31 DAY

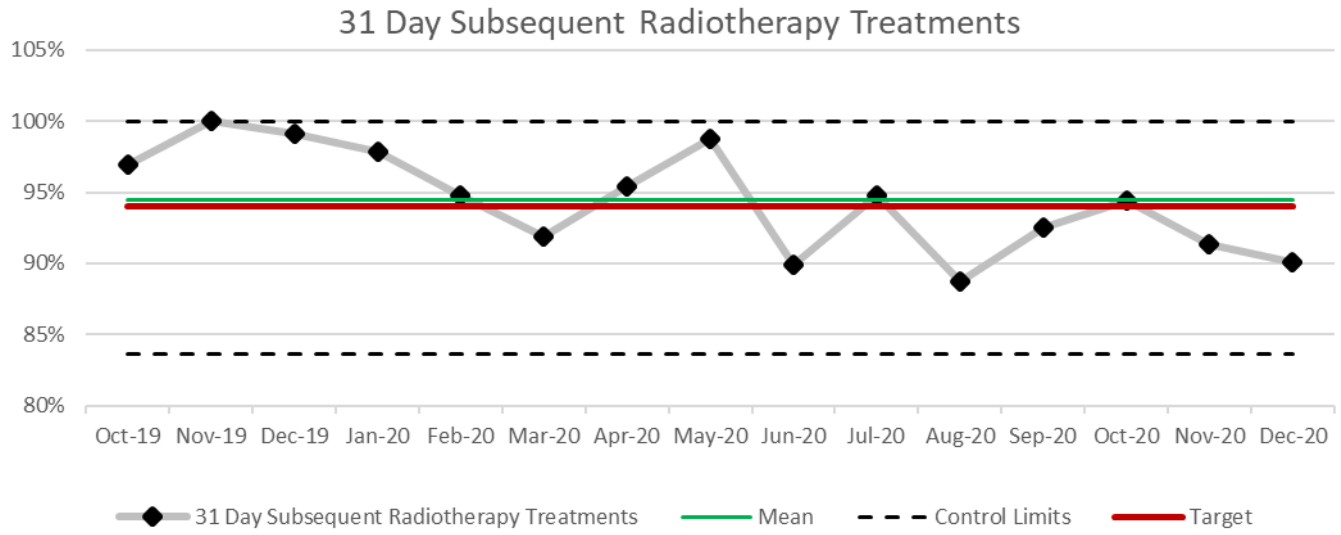
Executive Lead: Chief Operating Officer

CQC Domain: Responsive

Strategic Objective: Services

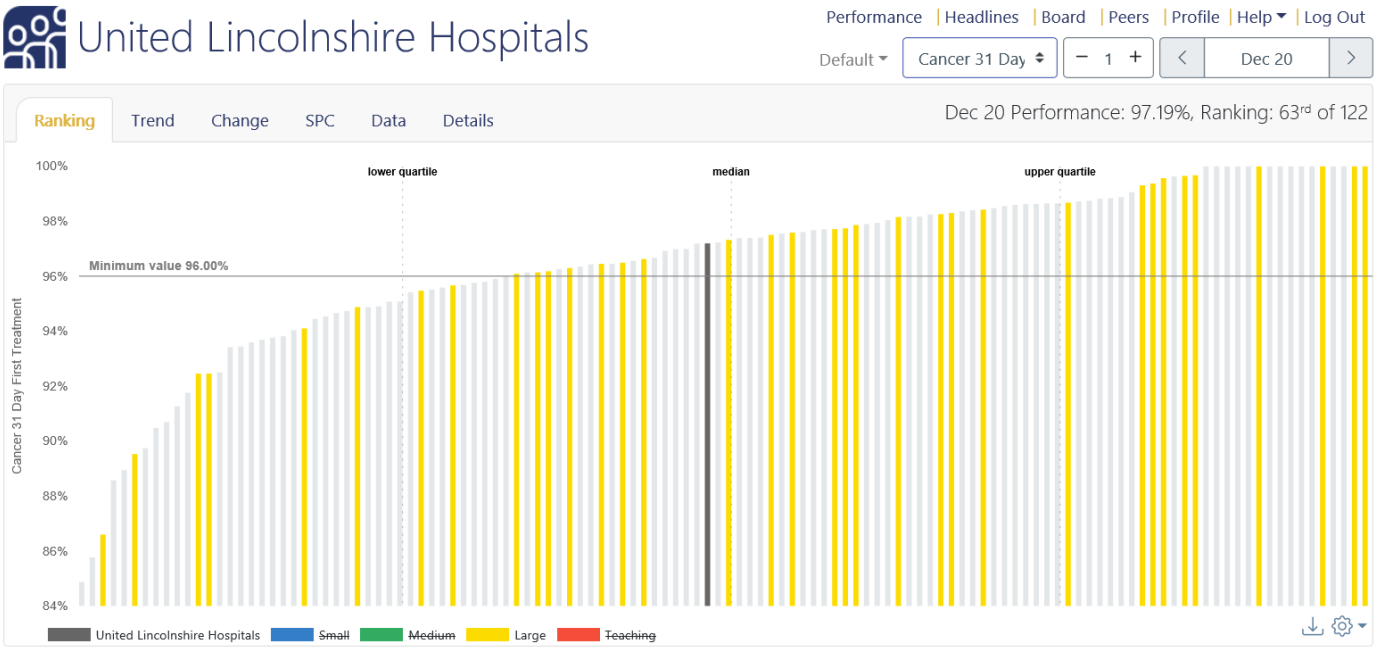


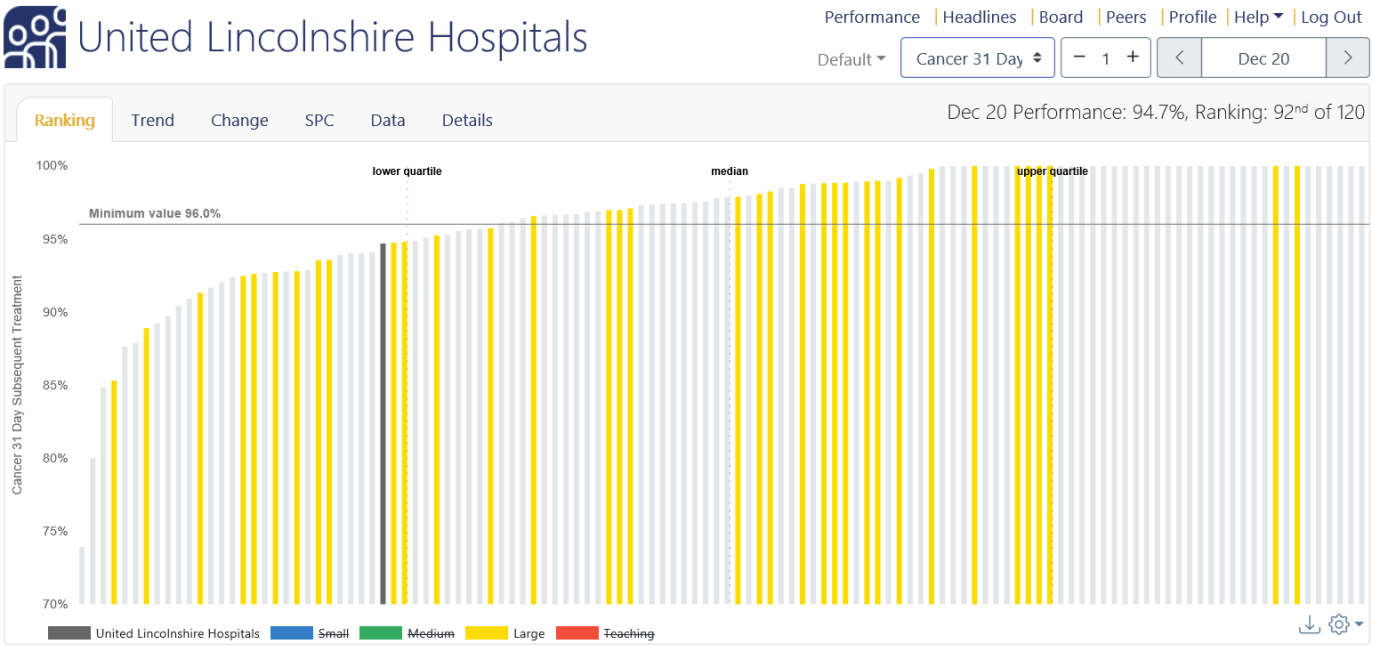




Challenges/Successes

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





Actions in place to recover:

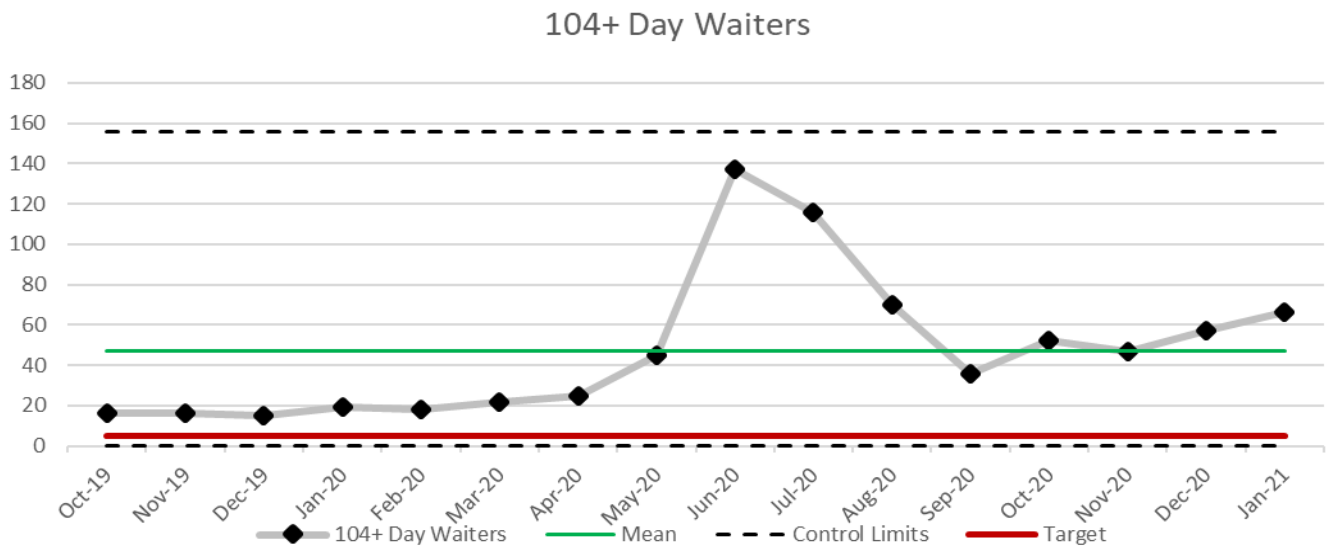
- Additional theatres installed at Grantham for Breast & Gynaecology.
- Review of Colorectal theatre list scheduling to better align with clinician availability and consideration of moving level 1 patients to Grantham.
- P2 patients referred to EMCA sub hub for potential treatment within other Trusts.
- Return of H&N consultant. Unfortunately the 3rd post appointed to and due to start in December had to withdraw. Further interviews due 12/02/21 pending Royal College approval.
- Oncology Fragile Service under review. New locum consultant started 14th December (urology, breast and non-melanoma skin). Two Medical Oncologists are due to start in April 21 (Urology, Renal, Lung, Skin and Breast.

IMPROVE CLINICAL OUTCOMES – CANCER 104+ DAY WAITERS

Executive Lead: Chief Operating Officer

CQC Domain: Responsive

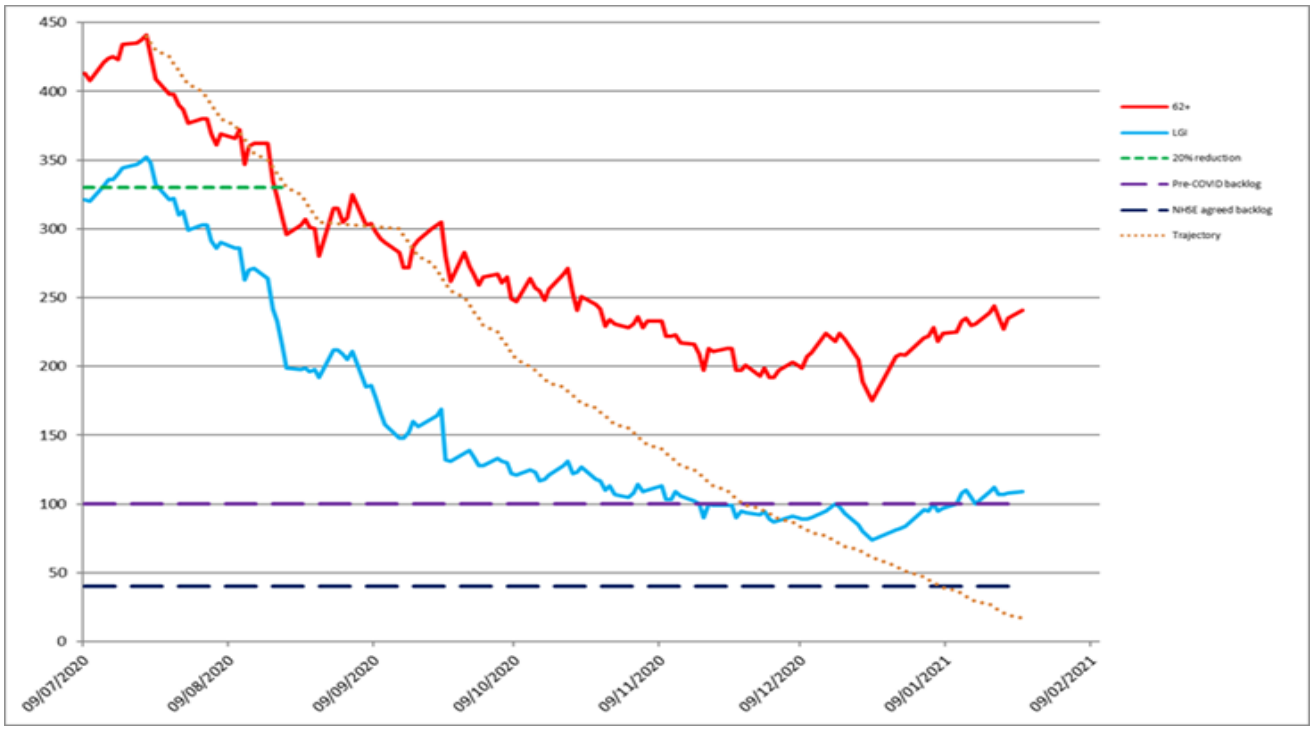
Strategic Objective: Services



Challenges/Successes

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

- As of 5th of February the 62 Day backlog is at 243 patients (from 441, target – below 40) **45% Reduction.**
- In August Colorectal patients accounted for c.70% of backlog and is now c.48%.
- Of the other tumour sites, Head & Neck, Gynae, Breast, and Urology remain outliers compared to pre-COVID levels.



104 + Waiters as of 5th of February is at 66 (from 163, target – below 10) **60% Reduction**

- 39 Colorectal
- 9 Urology
- 5 Head and Neck
- 3 Gynaecology, Lung and Upper GI
- 1 each Skin, Sarcoma, Haematology and Breast

Over 19% of the 104 Day Waiters have complex social or mental health needs requiring significant specialist nurse involvement (Pre-Diagnosis CNS).

Challenges to reducing the backlogs:

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

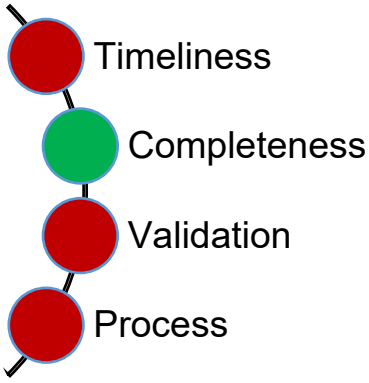
<u>Actions in place to recover:</u>

As for the 62 Day Performance actions:

- 28 Day FDS identified as Trust's single cancer performance work stream in the Integrated Improvement Program for 2021-22.
- Additional theatres being installed at Grantham for Breast & Gynaecology, with first due 14th January 2021 (coming from Italy but delayed as factory closed due to COVID).
- Breast Services review (awaiting final report from NHSI support).
- Review of Colorectal theatre list scheduling to better align with clinician availability
- Additional relocatable CT at Boston.
- Bid for 'blue' CT at Grantham.
- Endoscopy booking team recruited 3 WTE – currently undertaking training.
- 2 WTE Endoscopist posts going through the interview and selection process.
- New Endoscopy decontamination facility at Louth on line since September, giving improved turn-around times.
- £1.26m NHSE funding awarded for replacement of Pilgrim decontamination unit as well as new stacks and scopes. Decontamination unit at Boston now signed off with orders placed for stacks and scopes (scope guide for Grantham, stacks and scopes for Lincoln and Boston) – delivery time approx. 4 weeks.
- Dedicated admin resource within Colorectal CBU to support clinical engagement.
- Return of H&N consultant (from sabbatical) and third post to be re-advertised.
- Oncology Fragile Service under review with new locum consultant started 14th December (urology, breast and non-melanoma skin). Two Medical Oncologists are due to start in April 21 (Urology, Renal, Lung, Skin and Breast).

APPENDIX A – KITEMARK

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



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

Meeting	*Trust Board*
Date of Meeting	*Tuesday 2 March 2021*
Item Number	*Item 13.1*
Strategic Risk Report	
Accountable Director	*Dr Karen Dunderdale, Director of Nursing*
Presented by	*Dr Karen Dunderdale, Director of Nursing*
Author(s)	*Paul White, Risk & Incident Lead*
Report previously considered at	*N/A*

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

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

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

Executive Summary

- This Strategic Risk Report focuses on the highest priority risks currently being managed within the Trust.
- Key risk indicators for all very high risks (those rated 20-25) have been updated with data available at the time of reporting, to evidence the current extent of risk exposure.
- There are currently 4 strategic risks that are rated Very high:
  - Local impact of the global coronavirus pandemic (25)
  - Capacity to manage emergency demand (20)
  - Workforce capacity & capability (20)
  - Workforce engagement, morale & productivity (20)
- 3 strategic finance risks have been reviewed and reduced in rating so far this quarter:
  - Substantial unplanned expenditure or financial penalty has reduced from Very high risk (20) to High risk (16)
  - Delivery of the financial recovery programme has reduced from Very high risk (20) to Moderate risk (8)
  - Compliance with financial regulations, standards & contractual obligations has reduced from High risk (12) to Low risk (4)

Purpose

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

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

1. Introduction

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

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

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

1.3 All entries on strategic or operational risk registers should be formally reviewed and updated on a quarterly basis as a minimum requirement, although they can be updated in the interim if there is evidence that the level

of risk has changed. The next round of quarterly reviews are due for completion by the end of March 2021.

1.4 Following an independent review of some of the Trust's governance arrangements commissioned by the Director of Nursing and carried out in 2020, recommendations were made to review the risk register structure and strengthen links with the Board Assurance Framework (BAF). Proposals for addressing these recommendations are being developed for consideration by the Executive Leadership Team (ELT).

2. Strategic Risk Profile

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

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

Key Risk Indicators (KRIs):

- Total number of confirmed Covid-19 inpatient cases – as of 22 February 2021 there had been 2,800 Covid-19 inpatient cases within ULHT (an increase of 277 in the previous 10 days).
- Number of current in-patient admissions due to Covid-19 – 46 at Lincoln and 23 at Pilgrim on 22 February 2021 (compared with 67 and 29 respectively on 12 February).
- Patient deaths due to Covid-19 – total of 761 as of 22 February 2021; compared with 733 as of 12 February and 568 as of 11 January.
- Number and severity of incidents linked to Covid-19 – monthly average between April and June 2020 was 85; reduced to 63 in August / September; 109 between November and January
- Covid-related incidents by severity – between March 2020 and January 2021 there were 15 Moderate harm incidents linked to the pandemic response (not necessarily due to Covid-19 infection); 12 Severe harm; and 2 Deaths

Gaps in control & mitigating actions:

- Lincolnshire is currently in national Lockdown; critical incidents and standby critical incidents have been declared on several occasions due to staffing capacity and demand issues; the staged relaxation of national lockdown controls is planned to commence from 8 March
- Several vaccines have now been approved by the MHRA and are being rolled out across the country; there are also approved treatments for Covid-19 symptoms that are now in use.
- ULHT continues to manage demand and resources in line with the national pandemic strategy.

- Essential information to all staff continues to be provided through daily SBAR briefings and the Trust also continues to brief relevant external stakeholders
- Work is currently taking place to identify hospital onset Covid-19 cases, so that an appropriate review can take place to identify learning and areas for improvement

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

Risk title (ID)	Capacity to manage emergency demand (4175)		
Current risk rating	Very high (20)	**Risk lead**	Simon Evans
Lead group	Divisional Performance Review Meetings (PRMs)		

Key Risk Indicators (KRIs):

- A&E waiting times against the constitutional standard – 4-hour performance was 74.76%, for October 2020; 72.78% for November; 70.54% for December
- 12hour+ A&E waits – there were 2 in October 2020; 10 in November; and 41 in December
- Ambulance handover times >59 minutes – in October 2020 there were 270 ambulance handover delays; in November there were 388; in December there were 350

Gaps in control & mitigating actions:

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

2.3 There are 3 strategic finance risks that have a reduced rating following review this quarter:

- Substantial unplanned expenditure or financial penalties has reduced from **Very high risk** (20) to **High risk** (16); agency staff spend remains the biggest cause of increased expenditure risk, although it is reducing
- Delivery of the Financial Recovery Programme has reduced from **Very high risk** (20) to **Moderate risk** (8)
- Compliance with financial regulations, standards & contractual obligations has reduced from **High risk** (12) to **Low risk** (4)

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

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

Key Risk Indicators (KRIs):

- Staff vacancy rates – overall vacancy rate reduced to 12.4% in September, to 12.3% in October and 12.2% in November, against a target of 12%
- Staff turnover rate overall is around 10% (as of September 2020)
- Sickness absence rates – the 12 month rolling absence rate to September 2020 was 5%; to October and November it was 4.9%, against a target of 4.5%; rolling year average does mask a significant increase due to Wave 2 COVID, peaking at above 10% pre-Christmas
- Bank & agency usage (medical and nursing) - Total agency spend increased in November, largely as a consequence of an increase in medical agency spend / increase in COVID related shifts covered by agency; Nursing agency expenditure also increased again in November as a consequence of the impact of COVID.
- Core Learning compliance rates – increased to 89.5% in September and to 90.5% in October and were 89.6% in November; the Trust achieved the 95% compliance rate for IG training during September

Gaps in control and mitigating actions:

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

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

Key Risk Indicators (KRIs):

- Staff appraisal rates - appraisal rates (excluding medical staff) across the Trust increased in September 2020 to 75.9% and to 78.5% in October (having fallen to below 70% between May and July) against a target of 90%; Medical staff appraisal rates remain in the high 90%.
- People Pulse survey results – almost 900 staff completed the first survey (in July 2020), a response rate of around 12%; 85% of staff felt informed (+0.6 vs NHS overall); 63% felt confident in local leaders (equal to NHS overall); 61% felt supported (-5.7 vs NHS overall); 59% felt they had a good work-life balance (-2.5 vs NHS overall).
- NHS National Staff Survey (NSS) results – 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 the full strategic risk register is included as **Appendix 1**.

3. Conclusions & recommendations

3.1 The highest priority risk at present continues to be the risk of harm due to the impact of the Covid-19 pandemic. There remains considerable uncertainty as to the future course of the pandemic, however there are signs in the last month that the roll-out of the vaccination programme is having a positive on reducing the risk.

3.2 Workforce risks, including capacity and capability along with morale and productivity, also remain significant risks and are closely linked with the risks associated with high levels of emergency demand.

3.3 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)
4558	Local impact of the global coronavirus (Covid-19) pandemic	Operations	Harm (physical or psychological)	25	Very high risk
4362	Workforce capacity & capability (recruitment, retention & skills)	Human Resources & Organisation Development	Service disruption	20	Very high risk
4083	Workforce engagement, morale & productivity	Human Resources & Organisation Development	Reputation / compliance	20	Very high risk
4175	Capacity to manage emergency demand	Urgent & Emergency Care CBU	Service disruption	20	Very high risk
4300	Availability of medical devices & equipment	Nursing Directorate	Service disruption	16	High risk
4156	Safe management of medicines	Pharmacy CBU	Harm (physical or psychological)	16	High risk
4142	Safe delivery of patient care	Nursing Directorate	Harm (physical or psychological)	16	High risk
4144	Uncontrolled outbreak of serious infectious disease	Nursing Directorate	Service disruption	16	High risk
4044	Compliance with information governance regulations & standards	Corporate Services	Reputation / compliance	16	High risk
3690	Compliance with water safety regulations & standards	Estates & Facilities	Reputation / compliance	16	High risk
3720	Critical failure of the electrical infrastructure	Estates & Facilities	Service disruption	16	High risk
3688	Quality of the hospital environment	Estates & Facilities	Reputation / compliance	16	High risk
4003	Major security incident	Estates & Facilities	Harm (physical or psychological)	16	High risk
4403	Compliance with electrical safety regulations & standards	Estates & Facilities	Reputation / compliance	16	High risk
4383	Substantial unplanned expenditure or financial penalties	Finance & Digital	Finances	16	High risk
4480	Safe management of emergency demand	Urgent & Emergency Care CBU	Harm (physical or psychological)	16	High risk
4437	Critical failure of the water supply	Estates & Facilities	Service disruption	12	High risk
4405	Critical infrastructure failure disrupting aseptic pharmacy services	Pharmacy CBU	Service disruption	12	High risk
4406	Critical failure of the medicines supply chain	Pharmacy CBU	Service disruption	12	High risk
4423	Working in partnership with the wider healthcare system	Improvement & Integration Directorate	Service disruption	12	High risk

ID	Title	Clinical Business Unit	Risk Type	Rating (current)	Risk level (current)
4401	Safety of the hospital environment	Estates & Facilities	Harm (physical or psychological)	12	High risk
4402	Compliance with regulations and standards for mechanical infrastructure	Estates & Facilities	Reputation / compliance	12	High risk
3503	Sustainable paediatric services at Pilgrim Hospital, Boston	Children & Young Persons CBU	Service disruption	12	High risk
3520	Compliance with fire safety regulations & standards	Estates & Facilities	Reputation / compliance	12	High risk
4081	Quality of patient experience	Nursing Directorate	Reputation / compliance	12	High risk
4082	Workforce planning process	Human Resources & Organisation Development	Service disruption	12	High risk
3689	Compliance with asbestos management regulations & standards	Estates & Facilities	Reputation / compliance	12	High risk
4043	Compliance with patient safety regulations & standards	Nursing Directorate	Reputation / compliance	12	High risk
4145	Compliance with safeguarding regulations & standards	Nursing Directorate	Reputation / compliance	12	High risk
4146	Effectiveness of safeguarding practice	Nursing Directorate	Harm (physical or psychological)	12	High risk
4157	Compliance with medicines management regulations & standards	Pharmacy CBU	Reputation / compliance	12	High risk
4181	Significant breach of confidentiality	Corporate Services	Reputation / compliance	12	High risk
4179	Major cyber security attack	Finance & Digital	Service disruption	12	High risk
4176	Management of demand for planned care		Service disruption	12	High risk
4481	Availability & integrity of patient information	Finance & Digital	Service disruption	12	High risk
4556	Safe management of demand for outpatient appointments	Outpatients CBU	Harm (physical or psychological)	12	High risk
4581	Heating (Trust Wide)	Estates & Facilities	Harm (physical or psychological)	12	High risk
4497	Contamination of aseptic products	Pharmacy CBU	Harm (physical or psychological)	10	Moderate risk
4567	Working Safely during the COVID -19 pandemic (HM Government Guidance)	Estates & Facilities	Reputation / compliance	9	Moderate risk
4526	Internal corporate communications	Chief Executive	Reputation / compliance	8	Moderate risk
4528	Minor fire safety incident	Estates & Facilities	Harm (physical or psychological)	8	Moderate risk
4553	Failure to appropriately manage land and property	Estates & Facilities	Finances	8	Moderate risk

ID	Title	Clinical Business Unit	Risk Type	Rating (current)	Risk level (current)
4384	Substantial unplanned income reduction or missed opportunities	Finance & Digital	Finances	8	Moderate risk
4502	Compliance with regulations & standards for medical device management	Nursing Directorate	Reputation / compliance	8	Moderate risk
4579	Delivery of the new Medical Education Centre	Improvement & Integration Directorate	Reputation / compliance	8	Moderate risk
4486	Clinical outcomes for patients	Medical Directorate	Harm (physical or psychological)	8	Moderate risk
4476	Compliance with clinical effectiveness regulations & standards	Medical Directorate	Reputation / compliance	8	Moderate risk
4424	Delivery of planned improvements to quality & safety of patient care	Nursing Directorate	Reputation / compliance	8	Moderate risk
4467	Impact of a 'no deal' EU Exit scenario	Corporate Services	Service disruption	8	Moderate risk
4404	Major fire safety incident	Estates & Facilities	Harm (physical or psychological)	8	Moderate risk
4389	Compliance with corporate governance regulations & standards	Chief Executive	Reputation / compliance	8	Moderate risk
4397	Exposure to asbestos	Estates & Facilities	Harm (physical or psychological)	8	Moderate risk
4398	Compliance with environmental and energy management regulations & standards	Estates & Facilities	Reputation / compliance	8	Moderate risk
4399	Compliance with health & safety regulations & standards	Estates & Facilities	Reputation / compliance	8	Moderate risk
4400	Safety of working practices	Estates & Facilities	Harm (physical or psychological)	8	Moderate risk
4351	Compliance with equalities and human rights regulations, standards & contractual requirements	Human Resources & Organisation Development	Reputation / compliance	8	Moderate risk
4352	Public consultation & engagement	Chief Executive	Reputation / compliance	8	Moderate risk
4353	Safe use of medical devices & equipment	Nursing Directorate	Harm (physical or psychological)	8	Moderate risk
4363	Compliance with HR regulations & standards	Human Resources & Organisation Development	Reputation / compliance	8	Moderate risk
4368	Efficient and effective management of demand for outpatient appointments	Outpatients CBU	Reputation / compliance	8	Moderate risk
4382	Delivery of the Financial Recovery Programme	Finance & Digital	Finances	8	Moderate risk
4182	Compliance with ICT regulations & standards	Finance & Digital	Reputation / compliance	8	Moderate risk

ID	Title	Clinical Business Unit	Risk Type	Rating (current)	Risk level (current)
4177	Critical ICT infrastructure failure	Finance & Digital	Service disruption	8	Moderate risk
4180	Reduction in data quality	Finance & Digital	Reputation / compliance	8	Moderate risk
4138	Patient mortality rates	Medical Directorate	Reputation / compliance	8	Moderate risk
4141	Compliance with infection prevention & control regulations & standards	Nursing Directorate	Reputation / compliance	8	Moderate risk
3687	Implementation of an Estates Strategy aligned to clinical services	Estates & Facilities	Service disruption	8	Moderate risk
3721	Critical failure of the mechanical infrastructure	Estates & Facilities	Service disruption	8	Moderate risk
3722	Energy performance and sustainability	Estates & Facilities	Finances	8	Moderate risk
3951	Compliance with regulations & standards for aseptic pharmacy services		Reputation / compliance	8	Moderate risk
4061	Financial loss due to fraud	Finance & Digital	Finances	4	Low risk
4277	Adverse media or social media coverage	Chief Executive	Reputation / compliance	4	Low risk
4385	Compliance with financial regulations, standards & contractual obligations	Finance & Digital	Reputation / compliance	4	Low risk
4386	Critical failure of a contracted service	Finance & Digital	Service disruption	4	Low risk
4387	Critical supply chain failure	Finance & Digital	Service disruption	4	Low risk
4388	Compliance with procurement regulations & standards	Finance & Digital	Reputation / compliance	4	Low risk
4438	Severe weather or climatic event	Corporate Services	Service disruption	4	Low risk
4439	Industrial action	Corporate Services	Service disruption	4	Low risk
4440	Compliance with emergency planning regulations & standards	Corporate Services	Reputation / compliance	4	Low risk
4441	Compliance with radiation protection regulations & standards		Reputation / compliance	4	Low risk
4469	Compliance with blood safety & quality regulations & standards	Nursing Directorate	Reputation / compliance	4	Low risk
4482	Safe use of blood and blood products	Nursing Directorate	Harm (physical or psychological)	4	Low risk
4483	Safe use of radiation (Trust-wide)	Diagnostics CBU	Harm (physical or psychological)	4	Low risk
4514	Hospital @ Night management	Operations	Service disruption	4	Low risk

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*2 March 2021*
Item Number	*Item 13.2*
Board Assurance Framework (BAF) 2020/21	
Accountable Director	*Andrew Morgan Chief Executive*
Presented by	*Jayne Warner, Trust Secretary*
Author(s)	*Karen Willey, Deputy Trust Secretary*
Report previously considered at	*N/A*

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

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

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

Executive Summary

The relevant objectives of the 2020/21 BAF were presented to all Committees during February.

The Board are asked to note particularly the updates provided for objectives 1a, b and c as a result of consideration at the Quality Governance Committee. The BAF has been updated to show controls and assurances in place in respect of the response to Covid-19 along with those objective areas which had been able to continue with elements of business as usual.

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

The following assurance ratings have been identified:

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

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

Board Assurance Framework (BAF) 2020/21 - February 2021

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

Ref	Objective	Exec Lead	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Control Gaps	How identified control gaps are being managed	Source of assurance	Assurance Gaps - where are we not getting effective evidence	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating
SO1	**To deliver high quality, safe and responsive patient services, shaped by best practice and our communities**												
			Failure to manage demand safely Failure to provide safe care			Plan in place to support the delivery of a safety culture	Patient Safety Walk Rounds and Human Factors training delayed due to second wave of Covid-19		Trust Wide Accreditation Programme Reports National and Local Harm Free Care indicators Safeguarding, DoLS and MCA training Safety Culture Surveys Sepsis Six compliance data HSMR and SHMI data Flu vaccination rates Audit of response to triage, NEWS, MEWS and PEWS IPC Assurance Framework FLOW audits CQC Ratings and progress on delivery of Must Do and Should Do actions and regulatory notices Monitoring nosocomial infection rates National Clinical Audits Dr Foster alerts Patient safety indicators in the IPR		Assurance gaps to be identified through Trust Board streamlined governance process and Quality Governance Committee		
						Robust Quality Governance Committee, which is a sub-group of the Trust Board, in operation with appropriate reporting from sub-groups		Review of Quality Governance Committee and Sub-group structures					
						Patient Safety Group which is a sub group of the Quality Governance Committee in place meeting monthly.	Meetings have reduced due to Covid	Agenda reviewed on a month by month basis to ensure that urgent issues are picked up.					
						Infection Prevention and Control Committee in place and meeting monthly	Meetings have reduced due to Covid	Agenda reviewed on a month by month basis to ensure that urgent issues are picked up.					
						Relevant IPC policies and procedures in place and in date							
						Process in place to monitor delivery of the Hygiene Code							
						Infection Prevention and Control BAF in place and reviewed monthly		National guidance followed on PPE / infection prevention & control; Pandemic Flu Plan initiated; separate care pathways for urgent & planned care;					
						Separate care pathways in place for urgent and planned care to aim to eliminate risk of nosocomial infection							
						Elective care patients assessed by test and symptoms to be Covid-19 risk minimised							
						Establishment of Grantham 'Green Site' and temporary repurposing of A&E to an Urgent Treatment Centre under LCHS management.							

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 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	Mortality group in place which meets monthly	Meetings have reduced due to Covid	Agenda reviewed on a month by month basis to ensure that urgent issues are picked up.	Quality and Safety Risk Report Incident Management Report Mortality Report Upward Reports of the: Safeguarding Group Medicines Optimisation and Safety Group Patient Safety Group (incorporating sub-groups) and the Clinical Effectiveness Group			Quality Governance Committee	R
						Monthly mortality report in place to track achievement of SHMI/Mortality targets	Gaps in the number of structured judgement reviews undertaken Impact of Covid-19 on coding triangles	Funding available to train an additional 40 members of staff to undertake structured judgement reviews by the end of March 2021					
						Robust policies and procedures for incident investigations, harm reviews and assurance of learning	Clinical harm review process in its infancy.	Task and finish group set up to agree areas requiring a harm review, design process and quantify numbers.					
						Theatre Safety Group developed	Theatre Safety Group has struggled to meet due to Covid and progress is slow						
						Process in place to ensure safe use of surgical procedures (NatSIPs/LocSIPs)	Lack of assurance regarding the progress of implementing NatSIPs/LocSIPs within the Trust	Review of progress being undertaken with a view to relaunching the programme					
						Medication safety Group in operation	Lack of e-prescribing leading to increase in patient safety incidents	Replacement of manual prescribing processes with an electronic prescribing system; improvements to medication storage facilities; strengthening of Pharmacy involvement in discharge processes					
						Medical devices safety group in place which received relevant reports							
						Appropriate policies and procedures in place to ensure medical device safety	Lack of assurance regarding staff training on the medical devices	Implementation of a central database of medical device user training records					
						Appropriate policies and procedures in place to recognise and treat the deteriorating patient,	Number of incidents occurring regarding lack of recognition of the deteriorating patient	Deteriorating Patient Group set up as a sub group of the Patient Safety Group to identify actions taken to improve					
						Ensuring a robust safeguarding framework is in place to protect vulnerable patients and staff	?? Sedation group	Updated policy & training in use of chemical restraint / sedation; strengthening of pathways & training to support patients with mental health issues					
						Appropriate policies and procedures in place to reduce the prevalence of pressure ulcers, including a Skin Integrity Group							
						Formal governance processes in place within divisions, including regular meetings and reporting, supported by a central governance team							

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
						Robust process in place to monitor delivery against the CQC Must Do and Should Do actions and regulatory notices	Second round of CQC Confirm and Challenge sessions cancelled due to second wave of Covid-19						
						Appropriate medical records management systems and processes in place		Implementation of an Electronic Patient Record (EPR) system					
1b	Improve patient experience	Director of Nursing	Failure to provide a caring, compassionate service to patients and their families Failure to provide a suitable quality of hospital environment	3688 4081	CQC Caring	Patient Experience Group, which is a sub-group of the Quality Governance Committee, in place meeting monthly Robust Complaints and PALS process in place	Significant delay in co-design of services due to impact of Covid Complaints policy out of date	Amalgamation of the Complaints and PALS policy underway and due for completion end of February 2021	Quarterly Complaints reports identifying themes and trends presented at the Patient Experience Group Patient Experience Group upward report		Assurance gaps to be identified through Trust Board streamlined governance process and Quality Governance Committee	Quality Governance Committee	R
						Patient Panel meeting monthly and reporting into the Patient Experience Group.	Staff training in relation to communication and engagement	IIP projects specifically: co-design; Schwartz Rounds; engaging with patients and families; real time surveying, involving in decisions about care.	Real time patient and carer feedback User involvement numbers National patient surveys Number of locally implemented changes as a result of patient feedback				
						Care of the dying patient guidelines and procedures	QSIR virtual cohort paused due to Covid - plans to reset for March	Supporting visiting arrangements for EOL patients including virtual options as required	SUPERB Patient Experience Dashboard Patient Experience indicators in the IPR Care Opinion				
						Inclusion Strategy in place and in date	Delivery of Year 3 objectives of the Inclusion Strategy due to impact of Covid Patient Experience Strategy now out of date	Review of all relevant policies relating to Patient Experience underway					
						Robust process in place for annual PLACE inspection accompanied by PLACE LITE	Inability to undertake Quality ward/department review visits due to Covid	Monthly review meetings of the Matrons Quality Metrics with the DoN and DDoN Review of process for ward / department visits underway with plans to recommence April Estates works planned across Lincoln, Pilgrim and Grantham hospitals to address identified through the PLACE survey (Patient-Led Assessment of the Clinical Environment) - including decoration of walls, windows & fascias; flooring; and bed space curtains / track systems.	Matron Quality Metrics PLACE Inspection reports Estates attendance and updates at the fortnightly CQC meetings				

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
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 Reviews are undertaken	Process for reviewing GIRFT postponed due to Covid		Upward reports to QGC and its sub-groups KPIs in the integrated governance report Relevant internal audit reports Reports from the National Audit Programmes		Assurance gaps to be identified through Trust Board streamlined governance process and Quality Governance Committee	Quality Governance Committee	R
						Clinical Effectiveness Group in place and meets monthly	Meetings reduced due to Covid	Agenda reviewed on a meeting by meeting basis to ensure that all priority items are covered					
						Clinical Audit Group in place and meets monthly							
						National and Local Audit programme in place and agreed	Audit findings do not always demonstrate the necessary improvements	Increased focus on reporting outcomes from audit Revision of Clinical Audit Policy to strengthen Introduction of the Clinical Audit Group attended by Clinical Audit Leads					
						Process for monitoring the implementation of NICE guidance and national publications in place	There are a number of pieces of guidance for which the baseline assessments are still required	Clearance of backlog of NICE guidelines and technical appraisal assessments					
						Document control process in place for clinical guidelines and SOPs	Issues identified with the current document control process	Task and finish group set up to identify action required to address					
						Process in place for taking part in the Patient Related Outcome Measures (PROMs) project							
						Divisional governance meetings in place							
						Enhanced governance support in place from the central team							
						Clinical Service Review Programme in place	The process does not include system partners leading to potential fragmentation in clinical pathways						
						Quarterly Learning Lessons Newsletter in place at both Division and Trust wide level							

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
SO2	**To enable out people to lead, work differently and to feel valued, motivated and proud to work at ULHT**												
2a	A modern and progressive workforce	Director of People and Organisational Development	The second wave of COVID and the potential for a third, is having a very significant impact on the ability to progress the programmes that will enable us to fundamentally improve the indicators against this objective. We have been able to access additional resources to increase capacity to support programmes around recruitment and sickness management. This will have limited impact in this financial year, but will put us in a better position in 2021/22.	4362	CQC Safe CQC Responsive CQC Effective	Embed Robust workforce planning and development of new roles Targeted recruitment campaigns to include overseas recruitment - NHSE/I supported project to recruit 100 international recruits by April and another 100 by October Delivery of annual appraisals and mandatory training Creating a framework for people to achieve their full potential Embed continuous improvement methodology across the Trust Reducing absence management Deliver Personal and Professional development	Many Integrated Improvement Plan activity slowed down or paused due to Covid-19 in 20/21 financial year Implementation of Workpal paused due to Covid-19 wave 2 Cancellation/pause of key programmes due to Covid-19 wave 2 Limited capacity within team to deliver, start delayed until OD Lead in place	Covid Command and decision making structure alongside Board agreed lean governance arrangements have been in place during the COVID incident. We have re-established the Workforce Strategy Group, who are overseeing delivery of the People workstreams of the IIP and have designed a report to give assurance to the People and OD Committee, highlighting actions to manage control gaps. The Operational Equality and Diversity Group will undertake a similar role for workforce equality and diversity issues.	Vacancy rates Turnover rates Rates of appraisal/mandatory training compliance Learning days per staff member Staff survey feedback Sickness/absence data Reported progress on the implementation of the NHS People Plan and the Lincolnshire System Workforce Plan NB New indicators being developed for the 21/22 financial year	Implementation of Workpal paused due to Covid-19 Learning and development activity paused during Covid-19 National Staff Survey results received and analysis being completed	Assurance gaps to be identified through Trust Board streamlined governance process and People and Organisational Development Committee	People and Organisational Development Committee	**R**
2b	Making ULHT the best place to work	Director of People and Organisational Development	The second wave of COVID and the potential for a third, is having a very significant impact on the ability to progress the programmes that will enable us to fundamentally improve the indicators against this objective. We have been able to access additional resources to increase capacity to support programmes around recruitment and sickness management. This will have limited impact in this financial year, but will put us in a better position in 2021/22.	4083	CQC Well Led	Embedding our values and behaviours Reviewing the way in which we communicate with staff and involve them in shaping our plans Adapting our responsibility framework and leadership programmes in line with the NHS Leadership Compact Revise our diversity action plan for 2021/22 to ensure concerns around equity of treatment and opportunity are tackled Agree and promote the core offer of ULHT, so our staff feel valued, supported and cared for Implementing Schwartz Rounds Embed Freedom to Speak Up	Many Integrated Improvement Plan activity slowed down or paused due to Covid-19 in 20/21 financial year, including leadership development Schwartz rounds deferred due to Covid-19	Covid Command and decision making structure alongside Board agreed lean governance arrangements have been in place during the COVID incident. We have re-established the Workforce Strategy Group, who are overseeing delivery of the People workstreams of the IIP and have designed a report to give assurance to the People and OD Committee, highlighting actions to manage control gaps. The Operational Equality and Diversity Group will undertake a similar role for workforce equality and diversity issues.	WRES/ WDES Data Staff survey feedback - engagement score, recommend as place to work Number of staff attending leadership courses Number of Schwartz rounds completed (once implemented) Protect our staff from bullying, violence and harassment - measure through National Staff Survey Reports on progress in implementing the NHS People Plan and the Lincolnshire System Workforce Plan	National Staff Survey results received and analysis being completed Leadership development activity paused/slowed due to Covid-19 Schwartz rounds paused due to Covid-19	Staff survey results to be presented in detail once analysed Leadership development activity to recommence post Covid-19 Recommencement of Schwartz rounds to be considered in June 2021, where appropriate	People and Organisational Development Committee	**R**

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
						and Guardian of safe Working Celebrate year of the Nurse/Midwife			Use of NHSI Covid pulse survey NB New measures being developed for 21/22 year				
2c	Well led services	Chief Executive	Current systems and processes for policy management are inadequate resulting in failure to review out of date or policies which are not fit for purpose	4277 4389	CQC Well Led	Review of executive portfolios - Complete Simplify Trust strategic framework - Complete Embedding Divisional Governance structures to operate as one team Delivery of risk management training programmes Review and strengthening of the performance management & accountability framework - Complete Development and delivery of Board development programme - Complete Shared Decision making framework Implemented a robust policy management system Ensure system alignment with improvement activity Operate as an ethical organisation	None None Training delayed due to Covid-19 None Councils suspended due to Covid-19	Corporate support offer made to divisions Review of document management processes New document management system - SharePoint Single process for polices	Third party assessment of well led domains Internal Audit assessments Completeness of risk registers Annual Governance Statement Number of Shared decision making councils in place Numbers of in date policies	HOIA Opinion will be received in April 2021 8 councils established. Target for 2021 was 6 Movement on policies still not fast enough	Feedback tools to review progress/success Additional resource support from ICT/Libraries Report to Audit Committee quarterly Report to ELT fortnightly	Audit Committee	A

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

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

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SO4	**To implement integrated models of care with our partners to improve Lincolnshire's health and well-being**												
4a	Establish new evidence based models of care	Director of Improvement and Integration	Specific projects paused during the Covid 19 manage phase, specific projects are now progressing with delivery throughout the Covid Recovery Phase		CQC Caring CQC Responsive CQC Well Led	Supporting the implementation of new models of care across a range of specialties - in progress Support Creation of ICS - commencing Support the development of an Integrated Community Care programme - on hold Support the consultation for Acute Service Review (ASR) Phase 1. Assurance panel held with NHSE/I on 12/12/20to review the Pre-Consultation Business Case. Requests for further information from that session have been prepared and it is hoped the consultation process can begin during 2021. Improvement programmes for cancer, outpatients and urgent care in progress, programme for theatres is on hold Development and Implementation of new pathways for paediatric services - in progress Implementing the Outstanding Care Together Programme to support the Organisation to focus on high priority improvements.	Support required from the Trust to the System not yet identified Data reporting	Control gaps identified and reported through to Gold Command Structure Delivery of service transformation aligned to the IIP overseen by the Trust Leadership Team.	Numbers of new models of care established Delivery of ASR Year 1 objectives Improvement in health and wellbeing metrics		Steady implementation of the Outstanding Care Together Programme to identify Strategic priorities for the remainder of 2020/21 and for 2021/22 aligned to the IIP. Roll out of Outstanding Care Improvement System has started with Wave 1 in Medicine Outpatient Transformation work has been escalated from the perspective of moving to virtual and telephone consultations which has also enabled outpatient activity to continue safely during the Covid Pandemic. The Lincolnshire system has agreed a new system architecture to support the implementation of an Integrated Care System. In the new architecture, ULHT has been allocated the system lead role for cancer and access. Simon Evans is the SRO for access and Dr Neill Hepburn the SRO for cancer. The SRO's has been asked to scope out their programmes for 2021/22.	Finance, Performance and Estates Committee	**A**
4b	Advancing professional practice with partners	Director of Nursing	Specific projects paused during Covid 19 response		CQC Caring CQC Responsive CQC Well Led	Supporting the expansion of medical training posts Support widening access to Nursing and Midwifery and AHP Support expansion of Paediatric nursing programme Developing System wide rotational posts Scope framework to support staff to work to the full potential of their licence Ensure best use of extended clinical roles and our future requirement		Students who are on placement have been allowed to choose where they wish to work and have been supported in their request. There is a formal route of raising any concern via HEE, HEIs and locally. Any issues have been managed in a timely manner	Increase in training post numbers Numbers on Apprenticeship pathways Numbers of dual registrants Numbers of joint posts and non medical Consultant posts Numbers of pre-reg and RN child		The Medical Director would be required to add information around medical staffing		**A**

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

The BAF management process

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

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

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

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

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

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

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

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

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*2 March 2021*
Item Number	*Item 14*
Trust Board Membership	
Accountable Director	*Elaine Baylis, Trust Chair*
Presented by	*Elaine Baylis, Trust 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	*Insert risk register reference*
Financial Impact Assessment	*Insert detail*
Quality Impact Assessment	*Insert detail*
Equality Impact Assessment	*Insert detail*
Assurance Level Assessment	*Insert assurance level* • *Significant*

Recommendations/ Decision Required	• *The Board are asked to note the forthcoming changes in Board membership*

Executive Summary

The Board are asked to note the following forthcoming changes to Board membership.

Mrs Gill Ponder and Mr Geoff Hayward both reach the end of their terms as non-executive directors during 2021.

Reflecting best practice the Chair has taken the opportunity to review the skill set of the non- executive directors against the current operating environment of the Board and also wishes to take steps to try to improve the diversity of the Board so that it better represent our local population. As a consequence the Trust will commence a recruitment exercise in March 2021 for two non-executive posts.

The Trust is conducting a joint recruitment campaign with Lincolnshire Community Health Services NHS Trust who also have non executive director vacancies with the intention of maximising interest and attracting a wide and diverse pool of applicants to separate roles in the two Trusts. For ULHT we will be seeking a Chair for the Finance, Estates and Performance Committee and a Chair for the People and Organisational Development Committee.

In the interim period following the end of Mrs Ponder and Mr Hayward's terms and to allow for an appropriate induction period for the two newly appointed directors the Chair has asked Mr Gibson to chair the Finance, Performance and Estates Committee and Mrs Dunnett to Chair the People and Organisational Development Committee.

In addition to this and in response to the Ockenden Review, Mrs Dunnett will join the Quality Governance Committee in her role as Maternity Non Executive Safety Champion.