Bundle Trust Board Meeting in Public Session 3 August 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 6 July 2021 *Chair* Item 5.1 Public Board Minutes July 2021v1.docx
5.2	Matters arising from the previous meeting/action log *Chair* Item 5.2 Public Action log July 2021.docx
6	Chief Executive Horizon Scan Including STP *Chief Executive* Item 6 Chief Executive's Report 030821.docx
6.1	Covid Wave 3 Update - To Follow *Chief Operating Officer*
7	Patient/Staff Story *Director of Nursing* *Please be aware that sometimes our patient and staff stories can deal with very difficult subjects, which may affect you personally. If you are concerned about this the Trust Secretary can advise you of the subject to be discussed at the start of the meeting.*
7.1	BREAK
8	Strategic Objective 1 To Deliver high quality, safe and responsive patient services, shaped by best practice and our communities
8.1	Assurance and Risk Report from the Quality Governance Committee *Chair of Quality Governance Committee* Item 8.1 QGC Upward report July 2021v1.doc Item 8.1 Quality Governance Committee Terms of Reference January 2021- Final.docx
8.2	CQC Actions Update *Director of Nursing* Item 8.2 CQC Must Do Should Do Progress Report.docx Item 8.2 CQC Must Do Should Do Actions V19 FINAL.pdf
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 *Sarah Dunnett on behalf of Chair of People and OD Committee* Item 9.1 POD - Upward Report - July 2021v1.docx Item 9.1 People and Organisational Development Committee TOR 2021-22.docx
9.2	Equality Diversity and Inclusion Annual Report Item 9.2 Equality_Diversity_Inclusion_Annual_Report_2020_2021_Front_Sheet.docx Item 9.2 Annual_Report_Equality_Diversity_Inclusion_ULHT_2020_2021_FINAL.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

Chris Gibson on behalf of Chair of Finance, Performance and Estates Committee

Item 10.1 FPEC Upward Report July 2021v1.docx

Item 10.1 Finance Performance and Estates Committee TOR 2021-22.docx

10.2 Urology Service Engagement Output

Deputy Chief Executive

Item 10.2 Urology Reconfiguration of services proposal.docx

Item 10.2 Urology consultation report Appendix A.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

Deputy Director of Finance

Item 12 IPR Trust Board -Front page July 2021.docx

Item 12 IPR Trust Board July 2021.pdf

13 Risk and Assurance

13.1 Audit Committee Upward Report including Committee Annual Report

Item 13.1 Audit Committee Annual Report 2020-21.docx

Item 13.1 Audit and Risk Committee TOR 2021-22.docx

Item 13.1 Audit Committee Upward Report.docx

13.2 Strategic Risk Report

Director of Nursing

Item 13.2 Strategic Risk Report - August 2021 v1 (002).docx

13.3 Board Assurance Framework

Trust Secretary

Item 13.3 BAF 2021-22 Front Cover August 2021.docx

Item 13.3 BAF 2021-2022 v27.07.2021.xlsx

14 Any Other Notified Items of Urgent Business

15 The next meeting will be held on Tuesday 7th September 2021

EXCLUSION OF THE PUBLIC
In accordance with Standing Order 3:1 and Section 1(2) of the Public Bodies (Admission to Meetings) Act 1960: To resolve that representatives of the press and other members of the public be excluded from this part of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

Minutes of the Trust Board Meeting

Held on 6 July 2021

Via MS Teams Live Stream

Present

Voting Members:
Mrs Elaine Baylis, Chair
Mr Andrew Morgan, Chief Executive
Mr Mark Brassington, Director of Improvement and Integration/Deputy Chief Executive
Mrs Liz Libiszewski, Non-Executive Director
Mr Paul Matthew, Director of Finance and Digital
Dr Karen Dunderdale, Director of Nursing
Mrs Sarah Dunnett, Non-Executive Director
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)
Dr Maria Prior, Healthwatch Representative
Ms Cathy Geddes, Improvement Director, NHSE/I
Dr Anne-Louise Schokker, Deputy Medical Director
Dr Sakthivel, Consultant Orthopaedics
Ms Jody Blow, Advanced Care Practitioner
Mr Craig Ferris, Deputy Director of Safeguarding
Dr Bethan Stoddart, Consultant Microbiologist
Ms Natalie Vaughan, Deputy Director Infection Prevention and Control

Apologies
Dr Chris Gibson, Non-Executive Director
Mr David Woodward, Non-Executive Director
Dr Neill Hepburn, Medical Director

957/21	**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.
958/21	The Chair moved to questions from members of the public. **Item 2 Public Questions** **Q1 from Jody Clark**

	With the restoration of the daytime A&E at Grantham Hospital, many of our residents are concerned about losing the 24hr access. **The UTC showed that it was well used and although it wasn't overly used at night, many parents could take poorly or injured children there, at any hour and be seen quickly and efficiently.** **This is much easier than getting to Lincoln or Boston during the night - which we are now left with.** **My question is, as the UTC was running 24/7 during the Green site changes, can't an agreement be reached with LCHS, to continue to run the UTC overnight until the ASR consultation? So we continue to have local access and not have to travel during these challenging times?** The Chief Operating Officer responded: The restoration of Grantham meant that the model had been reverted to that in place in May 2020 which did not have an Urgent Treatment Centre and stated. Discussions had been held with Lincolnshire Community Health Services NHS Trust (LCHS) and NHS Lincolnshire to understand if this could be achieved however LCHS needed to restore its own services as part of the restoration and recovery element of Covid-19. LCHS had needed to redeploy staff to cover services. It was important to remember that there was a Clinical Assessment Service (CAS) that closely interacted with NHS 111. If this service was utilised patients were connected to the CAS which was staffed in large proportion by those working in urgent treatment centres. There was also the functionality to have booked appointments overnight so there was an overnight service in place. The Chief Operating Officer encouraged the use of NHS 111 if this was not an emergency to receive advice overnight.
959/21	**Q2 from Vi King** **Can the Trust board confirm they have sufficient competent level 1 trained staff to open level 1 beds for surgery and more importantly level 1 beds for medicine 24 hour 7 days a week.** **Also, can the Trust board confirm that respiratory patients can be accepted at Grantham and what level of respiratory support will they be able to receive.** The Chief Operating Officer responded: Level 1 is the level of care referred to where patients have enhanced support, higher level of nursing contact time. Level 1 care required staff to have competencies with a skill set that required testing and sign off resulting in staff being recognised as a competent level 1 nurse. This has been put in place at Grantham but in a different way to how it was in place prior to Covid-19. The function has been separated out to have a low risk area to protect vulnerable elective patients who were pre-screened and also for level 1 for medical patients who are pre screened. These were patients who did not have such a low level of risk and were in the medium to high risk areas.

	Based on the recommendation from Public Health England when restoring services, these services could not be mixed as there was no evidence to support this being safe. The Chief Operating Officer advised that the Trust did not have sufficient staff to consistently run surgical and medical level 1 beds currently. It was expected that by the end of August all nurses would have been signed off as level 1 but this would be managed in a way where the amount of surgery at Grantham was programmed. If level 1 support could not be offered then those patients would not be operated on at that time. Medical level 1 was challenging for the Trust and at a time where the Trust were trying to allow staff to take annual leave this meant that there was a dependency on agency staff which could be variable. There were sufficient trained level 1 staff at Grantham and other sites to have a continuous rota when required at Grantham. Confidence was offered to the Board but it was noted that this would continue to be a challenge until all staff were trained at the end of August. With regard to respiratory the Chief Operating Officer confirmed that the same model and criteria for East Midlands Ambulance Service NHS Trust to bring patients to Grantham was in place. The Trust would continue to have patients brought to Grantham with respiratory conditions however a 24 hour rota of consultant respiratory physicians was in place. This was a development of the respiratory service and was in line with improvements made with non-invasive procedures and plural service and specialist procedures. This meant that patients presenting to Grantham may be transferred to a specialist unit or a high dependency unit, the Trust believed this was a safe service supported by developments put in place during Covid-19.
960/21	**Q3 from Councillor Ray Wootten** **My question relates to the Grantham Old Hospital.** **Now that the County Council elections are over can you provide me with any information as to your plans for the Old Grantham Hospital. Several years ago former CEO Jane Lewington stated that a new Day Surgery centre might be built in its place utilising part of the old building saving some of its historical past.** **You then stated that it would be demolished and turned into a car park** **I also understand was that it was up for sale, what is the current position now please?** The Director of Finance and Digital responded: It was agreed that the building in the current form did not give the impression wanted for people entering the Trusts' hospital sites. The pandemic had impacted on the Trusts' ability to actively work on any developments on that part of the site. As soon as the pandemic allowed the Trust would refocus capacity and re-open discussions around the intentions and thoughts as to what could be done with that part of the site.
961/21	**Q4 from Cllr Linda Wootten** **This is my question on behalf of one of my residents.**

	My Grandaughter and her partner have just had their first baby which had to be born in Boston, as Grantham has no Maternity or Midwifery service. They are a young couple with limited finances, who then had to return to Boston Pilgrim Hospital to have the babies hearing test done. Unfortunately the baby then became jaundiced and, they had to travel to the QMC Hospital in Nottingham. **Why is this happening? and why isn't there a local facility? that can deal with these situations here in Grantham.** The Director of Nursing responded: Hearing screening would usually be undertaken whilst women and babies were on the ward however discharge would not be delayed for this reason. An out-patient appointment would be offered locally however it was noted that clinics had been suspended due to Covid-19. There had been a recommendation for these to commence again on the Grantham site. Whilst clinics were suspended at Grantham there had been arrangements put in place to undertake these at the Gonerby Road Clinic. The Director of Nursing noted that without further details of the mother and baby it was unclear why this had not been offered. It was also not possible for this reason to advise why the baby had been admitted to Nottingham. Normal pathways would be for a jaundice test to be conducted in the community setting. If this was raised a referral to the hospital of first booking for blood tests and further treatment would be made. The Director of Nursing asked Councillor Wootton to seek permission of the resident to offer details to the Trust Secretary in order to review the detail of this and offer a response to Councillor Wootten and the resident who had raised the question.
962/21	**Item 3 Apologies for Absence** Apologies for absence were received from Dr Chris Gibson, Non-Executive Director, Mr David Woodward, Non-Executive Director and Dr Neill Hepburn, Medical Director
963/21	**Item 4 Declarations of Interest** There were no declarations of interest which had not previously been declared.
964/21	**Item 5.1 Minutes of the meeting held on 1 June 2021 for accuracy** The minutes of the meeting held on 1 June 2021 were agreed as a true and accurate record subject to a number of minor typographical errors being amended.
965/21	**Item 5.2 Matters arising from the previous meeting/action log** The Chair noted that updates had been provided on the action log 579/21 – Staff survey, updated provided on triangulation of data and quality measures. Action date extended to ensure sight not lost on the action. There were no further actions to address during the meeting.

966/21	**Item 6 Chief Executive Horizon Scan including STP** The Chief Executive presented the report to the Board advising that the Integrated Care System (ICS) design framework had now been issued which covered what the system would require to work as an ICS.
967/21	The framework covered matters relating to the proposed partnership and NHS body that would replace the Clinical Commissioning Group.
968/21	The Chief Executive advised that this was subject to legislation with the Health and Care Act bill was being presented in parliament for the first reading. It was understood that the second reading of the bill would be delivered prior to the summer recess of Parliament.
969/21	The Board were advised that the final System Oversight Framework (SOF) details had been received including 10 pages of metrics. The Lincolnshire system would be in SOF level 4 which was in relation to a system with complex issues with intensive support required. This was why the system would be included within the recovery support programme.
970/21	The Chief Executive advised that Keith Spencer had been appointed as the System Improvement Director on a fixed term contract to the Lincolnshire system.
971/21	As part of the Recovery Support Programme there was a need to agree the success and exit criteria which was predicated on the understanding that systems would be in the process for no more than 12 months. The exit criteria were currently being discussed with NHS England but it was anticipated that this would be dependent on the Trust exiting quality special measures, following a further Care Quality Commission inspection for which a date was not yet known. The second criteria was thought to be the system having a 3 year financial plan to March 2024 and delivering the second half of the year financial target.
972/21	The third criteria was likely to be the system having a strategic delivery plan in place until March 2024 however none of the criteria were signed off and would require national sign off. The system were in final discussions with NHS England.
973/21	The Chief Executive noted that the Acute Services Review had now been through the national assurance process and had been returned to the Clinical Commissioning Group. Detail of the public consultation would now be developed with the expectation that this would commence over the coming months, the date was not yet known.
974/21	The Chief Executive advised the Board of the Trust issues including financial performance being in line with the Half 1 (H1) plan. The Care Quality Commissions were currently inspecting the Trust under the Ionising Radiation (Medical Exposure) Regulations for 2 days. The Chief Executive had participated in the initial session.
975/21	The Chair and Chief Executive had signed the Armed Forces covenant and the Board were advised that a new Freedom to Speak Up Guardian was due to commence with the Trust in September.
976/21	The Chief Executive advised that a new Council of Staff Networks had been established to ensure that communications could be maintained with staff networks.
977/21	The Chief Executive was delighted to be able to thank volunteers during national volunteers week and presented long service certificates and badges to 16 volunteers. Thanks were offered to the volunteers who did a fantastic job for the Trust.

978/21	The Chair noted that there was clearly activity happening at national level and was pleased to note that the health and care bill was being debated in parliament. The ICS arrangements in Lincolnshire were well established and work continued to develop the plan which was progressing well.
979/21	The Chair was pleased that the exit criteria for the recovery support programme was being pursued as there needed to be an understanding of how this would be concluded.
980/21	The approval of the ASR was positive given that this had taken some considerable time to be approved, the Chair would welcome the opportunity to support the Clinical Commissioning Group with the consultation exercise. The Trust Board: • **Noted the update and significant assurance provided**
981/21	**Item 7 Patient Story** The Chair welcomed Dr Sakthivel, Consultant Orthopaedics and Jody Blow, Advanced Care Practitioner (ACP) to present the staff story regarding the issue of communication and how the team had approached communication skills.
982/21	Via a pre-recorded video Dr Sakthivel offer detail of a patient complaint that had been received regarding concerns of communication during a consultation. The video demonstrated how Dr Sakthivel and Ms Blow had taken the complaint and reflected on the issues identified in order to provide a learning opportunity.
983/21	Dr Sakthivel and Ms Blow had as a result of the complaint developed a training package for the team in order that this could be completed and learning to be shared across the team. The training would be delivered to all staff within the team and require sign off upon completion.
984/21	Through the Chair the Deputy Director of Safeguarding asked how clients with a learning disability would be embedded within the training.
985/21	Dr Sakthivel advised that this along with other challenges had been considered and there was a need to cater to an individual's needs. Learning disabilities was a wide spectrum but this would be catered for with flexibility within the training.
986/21	The Director of Nursing noted that she was taken aback by the professional ownership of the issue and it was refreshing to see the openness to reflect that this had not been right for the patient and professional practice was considered. There was a whole team approach to curious enquiry and what this meant for the service. The initiative 'hearing it your way' was well liked and chimed with the 'what matters to me' approach across the Trust.
987/21	The Director of Nursing noted the need to consider how this could be brought together due to the powerful nature and how it could be adopted and shared across the Trust.
988/21	There was a complaints theme in relation to communication and this was an improvement initiative that the Director of Nursing would be keen to work on with the team. This would see the evaluation of the initiative and ability to roll out across the Trust.
989/21	The Chief Executive noted the great work that had been undertaken confirming that a number of complaints related to communication. The Chief Executive congratulated the team for progressing this and offered support to this being shared more widely in the Trust.

990/21	The Chair asked Ms Blow is there was enough support in place within trauma and orthopaedics in order to take this forward and be successful in addition to the commitment of support from the Director of Nursing and Chief Executive.
991/21	Ms Blow noted that the team were well supported however would be keen to seek approval for the training to become mandatory for the team and for this to spread across other services. There was a need for all staff to complete this training, not just e-learning in order for the Trust to see a change in professional conduct.
992/21	The Chair noted that this was about behaviour and how patients were put at the heart of care. The Board offered commitment to progress this with a need to focus and support the team to be successful.
993/21	The Chair noted the openness and honesty expressed by Dr Sakthivel with regard to the situation and the reflective practice as a result of the complaint. This demonstrated that the behaviours needed to achieve the aspiration of the Trust becoming a learning organisation.
994/21	Board members supported the learning that had taken place with the Chair thanking Dr Sakthivel and Ms Blow for their attendance at the Board. Both Dr Sakthivel and Ms Blow would be invited back to a future Board meeting in order to feedback how this had developed across the Trust. **Action - Trust Secretary, 7 December 2021** The Trust Board: • **Received the staff story**
	Item 7.1 Break
	Item 8 Objective 1 To Deliver high quality, safe and responsive patient services, shaped by best practice and our communities
995/21	**Item 8.1 Assurance and Risk Report Quality Governance Committee** The Chair of the Quality Governance Committee, Mrs Libiszewski provided the assurances received by the Committee at the 24th June Meeting.
996/21	Mrs Libiszewski noted the length of the agenda advising that a number of items presented to the Committee were commended to the Board and would be presented during the meeting.
997/21	The Committee received the first complaints, legal claims, inquest and patient experience report that pulled together data to triangulate and ensure learning, future reports would develop to offer assurance.
998/21	Mrs Libiszewski advised the Board that the Maternity and Neonatal Oversight Group had taken on significant responsibility for neonatal and maternity care. A number of reports were received and accepted by the Committee including a report from the Maternity and Neonatal Non-Executive Director Safety Champion. Thanks were offered to Mrs Dunnett for the submission and the evidence review of data to support the preparation for the Maternity Clinical Negligence Scheme for Trusts, due to be submitted later in the month.
999/21	The Committee expressed concern regarding the executive scorecard but Mrs Libiszewski was please to advise the Board that a significantly improved version had been presented to the Board that addressed the concerns raised.

1000/21	Mrs Libiszewski advised the Board that a new topical, legal and regulatory report had been received that would identify information for the Committee to be aware of, learning from other organisations and to help frame discussions, actions or other information that may be needed by the Committee.
1001/21	The final version of the Quality Account was agreed on behalf of the Board with the Committee noting that this offered a balanced view and contained all required information. The Board were advised that there was no requirement for the Quality Account to be audited this year due to Covid-19 however stakeholder views were sought. Thanks were offered from Mrs Libiszewski to stakeholders for offering their views within shortened timescales.
1002/21	The Committee received internal audit reports that had provided assurance in respect of serious incidents, complaints and risk.
1003/21	Mrs Libiszewski noted that based on the assurance reports received the Committee had agreed to move strategic objective 1a within the Board Assurance Framework from a red to amber rating.
1004/21	Patient experience and effectiveness had been considered however the Committee determined that these would remain rated red although noted that there had been significant improvements in reporting which were now moving forward. It was hoped that the clinical effectiveness rating could be moved to amber in the near future.
1005/21	Mrs Libiszewski advised the Board that the Committee had noted that the safeguarding and infection prevention and control annual reports had taken a significant step forward despite the difficult year.
1006/21	Dr Prior welcomed that the Trust was not an outlier in regard to clinical harm reviews asking if this would be reported to the Board either via the open or closed session and if the findings would be shared with individuals as part of duty of candour.
1007/21	The Chief Operating Officer advised that a series of criteria was used to select what constituted a harm event, this was taken from national guidance, these were treated as duty of candour and details of which, including flow charts and the decision making tool had been shared with the Quality Governance Committee. It would be possible to provide a summary report to the Board.
1008/21	The Trust were working with NHS England guidance on what indicators were already within the public domain in order to ensure consistency of reporting. There would be consideration to incorporate this in to existing reports to ensure that consistent metrics or details to describe harm were used.
1009/21	The Chief Operating Officer noted that this would be articulated to the Board in a meaningful way to ensure the public were able to see what it would mean to them. A lot of the information was already captured within the Integrated Performance Report and seen through the Quality Governance Committee. The Integrated Performance Report described the vast majority of harm events but did not bring all elements in to a single report
1010/21	The Chair noted the desire of the Board to be open and transparent with regard to the communication of the data.
1011/21	The Chair was pleased to see that a focus remained on non-invasive ventilation and that it was positive to see the establishment of a discharge cell, this added depth to the assurance process.

1012/21	The maternity and neonatal reporting offered strong assurance alongside the clinical negligence scheme for trust compliance and thanks were offered to Mrs Dunnett for the worked undertaken to review the data.
1013/21	The Chair thanked Mrs Libiszewski and the Committee for signing off the Quality Account which was a thorough and well-presented document. Thanks were extended to the Head of Clinical Effectiveness and Complaints for the writing of the document.
1014/21	The move of the patient safety objective from red to amber was credited to the work taking place through the Committee in to the organisation. The Trust Board: • **Received the assurance report**
1015/21	**Item 8.2 Infection Prevention and Control Annual Report** The Chair welcomed Dr Bethan Stoddart, Consultant Microbiologist and Natalie Vaughan, Deputy Director Infection Prevention and Control (IPC) to the Board to present the Infection Prevention and Control Annual report.
1016/21	Dr Stoddart noted the busy year faced by the Trust not only responding to the Covid-19 pandemic but also continuing to manage other infections. Whilst this had been a difficult year there was learning that could be taken from this with new ways of working implemented and the commencement of the reconfiguration of the microbiology team.
1017/21	The overall profile of IPC had changed and there was a determination from the Trust to achieve excellence in IPC.
1018/21	Dr Stoddart noted that the year had also been challenging in respect of staffing whereby the service was operating on the standard level of staff whilst increasing the number of tests processed via the labs. The Board noted the necessity to make changes both clinically and within the laboratory to support the increased level of activity.
1019/21	The Board were advised that the laboratory had conducted over 250k Covid-19 tests whilst continuing to develop new services, deliver routine PCR tests and further develop rapid analysers.
1020/21	It was noted that routine work had been stepped back in line with the Royal College of Pathologists guidance during the response to the pandemic. There had been an opportunity to evaluate some of the tests produced in the laboratory noting that there were some identified that offered a limited output with consideration being given to ceasing some tests.
1021/21	The Board were advised of the increased laboratory safety, ventilation and distancing measures with some elements changing as a result of being accelerated by Covid-19.
1022/21	Despite work focusing on the response to Covid-19 the Trust had achieved the United Kingdom Accreditation Service (UKAS) laboratory standard with Dr Stoddart expressing appreciation of both the IPC and Microbiology teams in this achievement.
1023/21	Dr Stoddart recognised those colleagues who had retired and returned to support the service both in respect of capacity and experience to deal with the pandemic.

1024/21	The Deputy Director Infection Prevention and Control noted achievement of compliance with the hygiene code which had been a focus in addition to Covid-19 and the development of IPC Audit Programmes. It was noted that the specific Covid-19 audit document had also been developed. This offered a clear focus of the standard and where the Trust were performing well and required development.
1025/21	Reporting was offered to the IPC group with site meetings having been established which offered support to divisional colleagues to present progress and seek support for areas of development.
1026/21	Divisional engagement had improved over the past year and there had been a focus of IPC policy development resulting in a suite of IPC policies by which the Trust complied with the hygiene code.
1027/21	The Deputy Director Infection Prevention and Control noted the importance of the robust interface with Estates and Facilities noting that there had been successful recruitment to the role of Estates and Facilities Decontamination Lead.
1028/21	The Board were advised of the work undertaken to develop the IPC service and team which would result in an enhanced service being offered and significant investment being made. This would support both an enhanced service and one that can provide greater leadership across all sites.
1029/21	IPC key objectives had been developed in the past year with the annual report focusing on IPC governance and continual assessment of the national directives, of which the Covid-19 national directives took precedence.
1030/21	The team had also focused on organisms outside of Covid-19 during the year with antimicrobial stewardship being put in place to ensure the appropriate use of antibiotics.
1031/21	The Deputy Director Infection Prevention and Control advised the Board of the focus on compliance with standards of cleanliness with the new national standards having been released and a focus to ensure all hospitals were up to standard.
1032/21	Business as usual within the IPC service continued alongside the management of outbreaks and surveillance of healthcare associated infections. The Trust continued with robust processes for Clostridium Difficile, Methicillin-Resistant Staphylococcus Aureus (MRSA) and other bacteraemia. Root cause analysis had also been undertaken and further streamlining of processes would be undertaken.
1033/21	The Director of Nursing as the Director of Infection Prevention and Control thanked Dr Stoddart and the Deputy Director of Infection Prevention and Control who had supported throughout the pandemic along with those staff who had retired and returned to support the response to the pandemic.
1034/21	The Director of Infection Prevention and Control noted that this was the first full year's report offered since commencing in post and was pleased to present such a high standard of report, commending this to the Board with significant assurance.
1035/21	The Chair noted that this was a strong report and acknowledged that the due diligence had been conducted by the Quality Governance Committee.

	The Trust Board: • **Received the Infection Prevention and Control Annual Report noting the significant assurance**
1036/21	**Item 8.3 Safeguarding Annual Report** The Director of Nursing offered the annual safeguarding report to the Board noting that since appointment to the Trust she had made an appointment to the Deputy Director of Safeguarding role.
1037/21	The report had been received by the Quality Governance Committee where assurance was offered due to the leadership of the Deputy Director of Safeguarding and the significant expertise across adults and children's safeguarding teams.
1038/21	The Deputy Director of Safeguarding noted that whilst the team was small it was impactful. The report presented was different to those previously received by the Board noting the reliance across the system within safeguarding.
1039/21	The safeguarding team had a wide focus including adult, children, learning disabilities, mental health and counter terrorism. The report offered some of the legislative background and over the past 12 months governance processes within the Trust had been strengthened. The Board were advised however that there had been challenges within the governance process.
1040/21	The Deputy Director of Safeguarding noted the involvement of the team in various aspects of the Trusts' work including the development of the digital strategy, training and serious incidents as an example. This involvement of the team had been welcomed across the organisation.
1041/21	The Board were advised that challenges within the service remained noting that safeguarding training requirements were not being however the training pathway had been redeveloped. The safeguarding training had been developed to be challenging to ensure that the Trust could be confident, should the Care Quality Commission visit that all patients were safe.
1042/21	The team had maintained and developed input with partners with the Trust having a strong voice across the system. The data reported identified that there were a number of children and adults in the region that were vulnerable. The other area to be aware of was the invisible child, this is where vulnerable people come in to the areas due to reasons such as affordable housing.
1043/21	The Deputy Director of Safeguarding advised that whilst the Trust were not meeting the training targets there were month on month improvements being seen. It was hoped that the targets would be met by September or October of this year with support in place within the divisions to achieve the target.
1044/21	The Deputy Director of Safeguarding noted that future reports would incorporate learning disabilities, dementia, mental health and autism as these were all within the safeguarding direction of travel.
1045/21	The Board were advised that Liberty Protects would be moving to the Trust which would replace Deprivation of Liberties in April 2022. It was noted that this would add pressure to the Trust due to the timescales for implementation and the financial implications.

1046/21	The Chair noted that the report had been reviewed in detail by the Quality Governance Committee however the Board noted the increasingly complex environment of safeguarding. The Chair was pleased to note the strengthened governance arrangements in place.
1047/21	The Chair noted the training issue and endorsed the approach being taken noting that the professional curiosity element of the training supported the Trust to protect people and that any training developed in line with this would be well supported by the Board. The Trust Board: • **Received the Safeguarding Annual report noting the moderate assurance**
1048/21	**Item 8.4 Complaints Annual Report** The Director of Nursing presented the report to the Board that had been presented to the Quality Governance Committee with moderate assurance.
1049/21	The report demonstrated a reduced number of complaints having been received during 2020/21 which would have been impacted due to the reduced activity within the Trust as a result of Covid-19.
1050/21	The Board were advised that there had been 520 complaints received with 627 closed as the backlog built up over time was addressed. All complaints were acknowledged within 3 working days and whilst the Trust had not responded within the timescales set this had mainly been due to addressing the backlog.
1051/21	The Board were advised that Patient Advice and Liaison contacted had also reduced and again was thought to be due to the impact of the pandemic and the number of patients being seen and treated over the period.
1052/21	Themes had been identified including poor communications with patients and families, lost property and delays in appointment. Actions to address these themes were in place and the patient story presented demonstrated an areas of innovation as to how to respond to poor communications.
1053/21	The Complaints Team were focused on demonstrating actions and read with complainants had been addressed and the report offered confidence in the services and of healthcare professionals. There had been significant work from the central team and divisions in order to provide evidence that demonstrated actions were complete.
1054/21	This effort had led to a reduction in the number of open actions from over 1700 in December 2020 to currently 173 remaining.
1055/21	The Chair noted that the report set out a clear understanding of the position and the actions taken which were having an impact.
1056/21	The Chief Executive noted that as someone who signs off complaint letters and meets with complainants there appeared to be a need for further work to ensure lessons learnt from complaints were fully embedded. Repeated themes were seen in complaints which would suggest, whilst actions had been completed learning was not embedded.
1057/21	The benefit of meeting with complainants was noted as this offered early resolution, with the Chief Executive keen to consider what more could be done to sit with and speak to complainants and offer closure to people who were often distressed.

1058/21	The Director of Nursing agreed with the view of reducing paper and meeting with complainants to address concerns.
1059/21	The Chair encouraged this to be a consideration and a positive step to improving the how services were delivered. The Trust Board: • **Received the Complaints Annual Report noting the moderate assurance** • **Approved the report for publication**
1060/21	**Item 8.5 CQC Actions (must and should do)** The Director of Nursing presented the report to the Board advising that this offered an update in relation to the position of the Care Quality Commission (CQC) recommendations of must and should do actions required by the Trust.
1061/21	The report was offered regularly to the Quality Governance Committee.
1062/21	The Director of Nursing highlighted to the Board that there had been a number of Senior Leadership changes across the divisions and as such staff were being supported with evidence and an understanding of their compliance with the CQC recommendations.
1063/21	The Board were advised that the report not only offered assurance to the CQC but also to the Board on the progress being made.
1064/21	The Director of Nursing advised, as reported by the Chief Executive that the CQC were currently undertaking an Ionising Radiation (Medical Exposure) Regulations visit within the Trust. The Director of Nursing was pleased to be able to support the CQC, virtually through focus groups across a number of ward areas and departments, to allow them to triangulate the written documents and evidence provided during the transitional arrangements.
1065/21	The Chair noted that this had been reviewed in detail by the Quality Governance Committee with the high level summary providing a clear update to the Board. The Trust Board: • **Received the report noting moderate assurance**
1066/21	**Item 8.6 Paediatric Temporary Pathway** The Director of Improvement and Integration/Deputy Chief Executive presented the report to the Board advising of the importance of the paper due to the history of the challenged service within the organisation.
1067/21	The Director of Improvement and Integration reminded the Board that the challenges had begun in 2018 when the clinical teams advised of the significant challenges that they felt meant the inpatient paediatric service could not be sustained due to staffing concerns.
1068/21	It was noted that whilst the concerns had existed for some time these had been mitigated before the clinicians had needed to address the issue.
1069/21	It was unfortunate that there had been a need to suspend the inpatient service for children and young people at Pilgrim however the Trust had worked closely with the local population, patients, families and national bodies in order to design and put in place an interim paediatric assessment unit.

1070/21	This offered 24/7 care to children and young people who needed a length of stay of up to 12 hours, if the stay required was longer then patients would be transferred to another hospital for an inpatient stay.
1071/21	The Health and Overview Scrutiny Committee (HOSC) were updated during this period and the Trust continued to work with families and the local population, notably SOS Pilgrim. The Director of Improvement and Integration thanked SOS Pilgrim for the support to design the new pathway and way forward for the service.
1072/21	The interim model put in place enabled the service to be protected at Pilgrim including maternity services and the special care baby unit which were inextricably linked from a clinical perspective.
1073/21	In 2019 it was clear that the 12 hour length of stay was not meeting the needs of patients or the clinical teams with a small number of transfers taking place and short lengths of stay at other sites inconveniencing families.
1074/21	During 2019 the Trust worked to improve the model and in early 2020 the Trust introduced the short stay paediatric assessment model with the length of stay increased to 24 hours. This enabled the Trust to meet 99.5% of all children and young people demand at Pilgrim and to maintain as much activity as possible on site.
1075/21	This change was agreed through the Covid-19 structure with a paper presented to the Board in June 2021 to outline and provide an update on the fragile services including paediatrics.
1076/21	The paper presented to HOSC in June saw support of the actions taken by the Trust to secure the service at Pilgrim who were also supportive of the revised model and length of stay with some clinical exceptions seeing a length of stay of 48 hours.
1077/21	The Director of Improvement and Integration sought the support of the Board to move to a 12 week engagement exercise to understand if there were any outstanding issues with regard to the current model with a view to accept this as a permanent model based on the outcome of the engagement exercise.
1078/21	The Chair thanked the Director of Improvement and Integration for the context and history presented, this was a positive example of a service moving from being fragile to being able to develop a model that was supported by patients, families and staff.
1079/21	The Board noted the HOSC recommendations and support offered with the report offering significant assurance. The Trust Board: • **Received the report noting the significant assurance** • **Supported the 12 week engagement exercise**
	Item 9 Objective 2 To enable our people to lead, work differently and to feel valued, motivated and proud to work at ULHT
1080/21	**Item 9.1 Assurance and Risk Report People and Organisational Development Committee** The Chair for the People and Organisational Development Committee, Mr Hayward provided the assurances received by the Committee from the 16 June 2021 meeting.

1081/21	Mr Hayward advised the Board that the safer staffing establishment reviews were due to take place during July which would help the Trust to reassess the staffing positon, primarily looking at the agency position and spend in order to rebalance.
1082/21	Work continued with the divisions in respect of workforce planning and the Committee were hopeful this would build a baseline for the future of recruitment and training programmes moving forward.
1083/21	Good progress with the engagement of Junior Doctors was noted through the Guardian of Safe Working report however it was noted that an outstanding area of work remained the rota gaps. The Committee were advised that a Rota Cell Project had been established in order to resolve this issue and further improvement should be seen.
1084/21	Mr Hayward advised the Board of the large number of employee relation cases that were outstanding noting that this had been paused during Covid-19 resulting in a high level of work to recover the position. It was anticipated that this should improve in the next 3 to 5 months.
1085/21	The Board were advised that the Committee had received and reviewed the Disciplinary Policy in light of best practice requesting that clarity be offered to staff on how this would be implemented operationally.
1086/21	The Director of People and Organisational Development advised that the consideration of the policy was a request to all NHS Trusts following the case of the NHS nurse who had committed suicide during the course of being suspended during a disciplinary process.
1087/21	Trusts had been asked to review practice and policy to ensure that the principles of Just Culture were being applied and that the Trust were seeking to learn from errors, be proportionate in response to issues and to ensure appropriate support arrangements were in place for staff.
1088/21	The Director of People and Organisational Development noted that for the Trust this went beyond a new policy but to ensure that the number of people suspended was minimised, additional support was available for staff suspended or going through a process. The Board were advised that a panel chaired by the Chief Operating Officer had been established to ensure cases were progressing as swiftly as possible.
1089/21	The Board were advised that the policy reflected the Just Culture principles and with the agreement of Staff Side a process whereby sanctions could be agreed by all parties, without the need to go through a more significant process had been put in place.
1090/21	The Chair noted the update with regard to the Disciplinary Policy and also noted that active engagement of the Women's Network in the Gender Pay Gap work, thanking the group for taking organisational responsibility to support this. The Trust Board: • **Received the assurance report**
	Item 10 Objective 3 To ensure that service are sustainable, supported by technology and delivered from an improved estate
1091/21	**Item 10.1 Assurance and Risk Report from the Finance, Performance and Estates Committee**

	Mr Hayward, in the absence of the Chair, provided the assurances received by the Finance, Performance and Estates Committee from the 24 June 2021 meeting.
1092/21	Mr Hayward advised the Board of the removal of the fire enforcement notices that had been confirmed by Lincolnshire Fire and Rescue following the fire works that had been completed in the Trust. It was noted that the were further works to be finalised however Lincolnshire Fire and Rescue were content with the progress made to date and that which was ongoing.
1093/21	The Board were advised that July would see the meeting of the Health and Safety Committee with full involvement of Staff Side. This would mean that progress would be made to enforce and strengthen Health and Safety work.
1094/21	Mr Hayward noted the concern of the Committee with regard to the pay bill and delivery of the cost improvement plan which were considered areas of risk going forward. As the Trust moved out of Covid-19 these would have a greater emphasis.
1095/21	Work was now progressing with regard to Patient Level Costings which had paused due to Covid-19 with the Committee expecting to be able to report on this in September.
1096/21	The Committee received and reviewed the report from Nuclear Medicine service which offered information on the next stage and patient perspective. Once this was complete it would be possible to finalise the plan for nuclear medicine and present to the Board.
1097/21	Mr Hayward noted that the performance report was changing in line with national directives which the Committee would monitor as this moved forward to ensure the correct data was in place.
1098/21	The Board were advised that cancer services remained challenged but improvements were being seen and progressed.
1099/21	The Trust Chair noted the removal of the fire enforcement notices, this was a testament to the significant work led by the Chief Operating Officer and colleagues within the Estates and Facilities team to focus on this programme of work.
1100/21	The Board noted the pay and cost improvement plan issues that had been raised which reflected the change in ratings on the Board Assurance Framework. The Chair also noted the missing outcomes which continued to be raised noting that the focus on the Committee on this was right.
1101/21	The performance position was noted along with the restoration of services however this would need to be monitored to ensure anticipated trajectories were followed. The Trust Board: • **Received the assurance report**
	Item 11 Objective 4 To implement integrated models of care with our partners to improve Lincolnshire's health and wellbeing
1102/21	**Item 11.1 Stroke Temporary Pathway** The Director of Improvement and Integration/Deputy Chief Executive presented the report to the Board noting that the paper outline the temporary changes that had been made in order to maintain hyper acute stroke services at the Trust.

1103/21	The normal model was to provider hyper and acute stroke provision at both the Lincoln and Pilgrim sites. At the beginning of the pandemic the service was fragile with this becoming more so due to the challenges of the workforce. A number of locums supporting the service withdrew.
1104/21	As a result the Trust needed to review the service and operation with the clinical model suggesting that hyper acute services were delivered from a single site at Lincoln Hospital with ongoing rehabilitation services offered at both Lincoln and Pilgrim.
1105/21	The Director of Improvement and Integration noted that stroke patients were still able to arrive at Pilgrim through this model and the change only affected the inpatient hyper acute stay which was centralised.
1106/21	A clinically led review was undertaken and updates offered to the Board during the Board sessions held during Covd-19. This was reported to the Health Overview Scrutiny Committee (HOSC) and was taken through the regional NHS England and Improvement major change process agreed through the Covid-19 process.
1107/21	Since Covid-19 had settled in hospitals regular reviews of the pathway were being undertaken to determine if this could return to the pre-Covid-19 model. Unfortunately consultant staffing remained vulnerable and as such this was not possible. The recommendation from the clinical team was to maintain the centralised hyper acute service at Lincoln with inpatient care remaining at Lincoln and Pilgrim following the hyper acute episode.
1108/21	The Board were advised that there had been a degree of patient involvement and engagement which continued and the Trust were committed to returning to the 2 site model as soon as was practicably possible. Regular clinician reviews with the service continue.
1109/21	The Director of Improvement and Integration reiterated the commitment to return to the 2 site model advising the Board that the interim model in place was not the Acute Services Review (ASR) model for stroke services. This formed a separate process and depending on the ASR timescales it may be possible to return to the 2 site model whilst the ASR progressed.
1110/21	The Chair re-emphasised the separate process noting that this should not be confused with the ASR. This had been a specific response to the Trusts' ability to provide a safe service and was a temporary arrangement under regular review.
1111/21	Mrs Dunnett asked in relation to the interim measure, during the time had there been any serious incidents recorded as a result of this and was there support from North West Anglia NHS Foundation Trust (NWAFT) for the temporary arrangements as patients could attend the Trust as a result of the change.
1112/21	The Director of Improvement and Integration noted that there was not an awareness of serious incidents as a result the change and also noted that the Chief Operating Officer had been working closely with NWAFT who were supportive of the change.
1113/21	Initially there had been an increase in the number of stroke patient attending NWAFT however after working with the Trust and the ambulance service to ensure patients were correctly conveyed there was no longer any issues being raised.
1114/21	Mrs Libiszewski confirmed that detail regarding this had been received by the Quality Governance Committee noting that there had been no serious incidents reported to the Committee, there had been a specific ask for this information.

1115/21	Mrs Libiszewski sought assurance that the Trust were working to the national direction for good quality care which sees patients discharged at 7 days which could negate the need for multiple moved.
1116/21	The Director of Improvement and Integration noted that the service, along with the community staff were working hard to reduce the length of stay of patients and pre-Covid-19 significant progress had been made. Length of stay had been affected during Covid-19 due to both the change in the model and the inability to maintain a stroke ward that was dedicated for a certain period of time. The achievement of the 7 day length of stay remained a commitment of the Trust.
1117/21	The Chair noted that the paper detailed a further review in September 2021 and reiterated that this did not form part of the ASR. The Trust Board: • **Received the report noting the moderate assurance** • **Endorsed the temporary pathway changes**
1118/21	**Item 11.2 Trauma and Orthopaedics Project Update** The Director of Improvement and Integration/Deputy Chief Executive presented the report to the Board noting that the paper outlined significant change that was being worked through and trialling across the organisation.
1119/21	This was a positive story about the implementation of large scale change across the organisation, it was noted however that this only reported to the point at which the pandemic affected the organisation and orthopaedic services.
1120/21	The Board were advised that elective care had been more affected more than any other speciality across the hospital and the data presented, to February 2020, demonstrated that the trial had mostly been delivering against the aims and ambitions.
1121/21	There had been a number of things affecting the trial pre-Covid-19 including the request to treat a controlled number of patients during winter 2019/20 and an increase in referrals to the service which had seen the waiting list grow when activity had reduced over the winter period.
1122/21	It was positive that the Trust were attracting more referrals as had been hoped but the inability to treat the volume of patients at the time and the impact of Covid-10 had seen the service significantly affected.
1123/21	The ambition was to reinstate activity which had been done through the recovery of service and to accelerate the recovery of orthopaedics with a significant level of activity being undertaken at Grantham. Theatre capacity at Grantham was being utilised to support the position.
1124/21	The Board were advised that the trial in place was part of the Acute Services Review (ASR) and would be part of this process to understand if this was a model that could be adopted as a permanent change in due course.
1125/21	Mrs Libiszewski noted that Patient Reported Outcome Measures (PROMs) had been used for many years in the NHS and noted that this was not used as a success criteria asking if there was an active decision not to use this.

1126/21	Mrs Libiszewski also noted that the historical data did not appear to demonstrate the impact on the emergency elements of the service as hoped and asked if the relaunch would see an improvement in this.
1127/21	The Director of Improvement and Integration noted that the key performance indicators had been chosen as part of the trial and there had been close working with the Get it Right First Tim team to agree and set these. It was noted that these were sued across a range of hospitals however there was no reason not to use the PROMs data to supplement this. It was agreed that there was more to do in respect of the trauma side of the relaunch.
1128/21	The Chief Operating Officer advised that there was a desire to more widely consider the trauma assessment unit with a view to patients being seen straight from the emergency department without further intervention.
1129/21	The Chair recognised that this was a long running pilot and was a service subject to the ASR process. The paper proposed the continuation of the pilot until the outcome of the ASR was understood.
1130/21	The Board were advised that the assurance of the paper, whilst not included, was moderate due to work that required continued focus. The Trust Board: • **Received the report noting the moderate assurance** • **Approved the extension of the pilot until the outcome of the ASR process was known**
1131/21	**Item 11.3 Urology Pathway Update** The Director of Improvement and Integration/Deputy Chief Executive presented the report to the Board noting that a significant amount of work to review the service had been undertaken due to fragility.
1132/21	The service had worked closely with the Get it Right First Time (GIRFT) Team to consider how the service could be structured to provide this across all sites. There were a number of challenges including staffing and disruption to patients due to emergency cover across Lincoln and Pilgrim, impacting on the ability to deliver elective lists due to busy on call nights for consultants.
1133/21	The service were looking to improve day case, elective and emergency activity with the suggested model developed that was generally supported. The model looked to centralise urology emergency patients to the Lincoln site with more activity being moved from Lincoln to Pilgrim and Grantham. This would offer a redistribution of activity between the sites.
1134/21	The proposal had been presented to the Health Overview Scrutiny Committee (HOSC) in June to request support due to the service undertaking an engagement exercise with the public that would end on 23 July. HOSC had been asked to provide feedback and comments on the proposals.
1135/21	Once the engagement was completed the output would be presented to the Board to consider and provide a final decision with regard to the proposed service model.
1136/21	Mrs Dunnett sought assurance that neighbouring Trusts had been engaged with regard to patient flow, particularly from the south of the county.

1137/21	The Director of Improvement and Integration noted that the service had clear pathways under the model agreed by the Clinical Teams. There was an expectation that people with urology issues could attend Pilgrim emergency department to be assessed, treated and discharged if possible. If an admission was required they would be transferred to Lincoln.
1138/21	It was expected that the vast majority of patients would remain within Trust beds with inpatient stays for emergency cases being on the Lincoln site. Some patients predominant issues was not urology focused and as such they would remain on the Pilgrim site with the urology medical team offering care and intervention.
1139/21	Mrs Libiszewski noted that there was a need to describe the future vision for all of the hospital sites. Covid-19 had brought this in to sharp focus and it would be useful to articulate the view of the future of how all sites would be positioned.
1140/21	The Director of Improvement and Integration noted that the Trust had hospital site visions and strategies for each site that had been in place for some time. There would require better articulation through Board papers to outline where service changes supported or went against the visions. Considering services in isolation appeared to give a disjointed view.
1141/21	The Chair noted that it would be useful for the Board to have sight of and revisit the strategies to ensure they were correct and to clearly articulate how the relevant service changes presented to the Board supported this. This would form part of the Lincolnshire Long Term Plan that would be refreshed in the near future. **Action – Director of Improvement and Integration, 5 October 2021**
1142/21	The Board supported the continuation of the proposed reconfiguration and the continued engagement noting that this had been to HOSC and there had been an agreement to extend the engagement to ensure the population had an opportunity to comment and offer feedback.
1143/21	It was noted that the final paper would be received by the Board in the coming months.
1144/21	The Chair noted that previously presented papers had been in regard to the fragility of services, the papers advised of the status of services and the actions being taken to improve service delivery in interest of patients.
1145/21	The Chair was pleased to note that these were being driven by clinicians and staff within the services which was a step change for the organisation and how the business of the organisation was undertaken, alongside involvement with patients and the public. The Trust Board: • **Received the report noting the moderate assurance** • **Accepted the recommendations to continue with the proposed reconfiguration and continued engagement**
1146/21	**Item 12 Integrated Performance Report** The Director of Finance and Digital presented the report to the Board noting that there was nothing further to raise from the executive summary that had not been addressed through the upward reports from the Committees.
1147/21	Moving forward the Director of Finance and Digital noted that alignment work was required between the executive scorecard within the Integrated Performance Report (IPR), divisional

	scorecard and performance review meeting structure, how the Trust operated business on a monthly basis.
1148/21	Aligned to this would also be the reporting of other key performance indicators that were either statutory or core business as usual operation of the organisation. Discussions would be held at the next Board Development Session to understand how this would come together and from the September Board there would be full alignment of the information presented.
1149/21	From next month it was expected that an updated IPR would be presented to the Board following work that was being completed with Kettering General Hospital that had an exemplar IPR that extended what the Trust had in place.
1150/21	This would bring clarity on actions, issues and mitigating actions to be taken and should offer better clarity to the Board on failing metrics.
1151/21	The Board support the direction of travel for and the need for the IPR and data to support the quality of services being delivered. The Chair noted the need for a single source of information to the Trust in order to be able to discuss the relevant performance position and make improvements where necessary.
1152/21	It was noted that there had been some issues with clarity during the transition period however it was positive to note the forward plan in place that would be discussed in due course.
1153/21	Mrs Dunnett asked what actions were being taken to address breast symptomatic performance.
1154/21	The Chief Operating Officer noted that within the April reporting period presented there were significant concerns over the recruitment of radiologists to support the service. The Trust had worked collaboratively with NHS England/Improvement to review the interaction of breast surgery and radiology teams which had been completed. The review was expected to have a number of efficiency and effectiveness improvement outcomes that would maximise capacity.
1155/21	The forecast trajectory and recovery period was substantial in July moving the Trust back in to the standard post July and in to August. This should see recovery of the 14 day standard and pressure eased on the 62 day treatment standard. There was an expectation that actions would be complete and the Trust back on track in July. The Trust Board: • **Received the report noting the limited assurance**
	Item 13 Risk and Assurance
	Item 13.1 Audit Committee Upward Report
1156/21	The Chair of the Audit Committee, Mrs Dunnett provided the assurances from the meeting held on 17 June with thanks being given to Dr Gibson, Non-Executive Director who had supported the meeting.
1157/21	Mrs Dunnett noted that this was an extraordinary meeting which focused on received the outstanding internal audit reports and the Head of Internal Audit Opinion for 2020/21.

1158/21	It was noted that a number of reports had been delayed due to the Covid-19 pandemic meaning that the audit team had been unable to access some areas to conduct reviews in line with the plan. The programme however was completed and final reports received.
1159/21	Mrs Dunnett noted that the Committee formally received the Head of Internal Audit Opinion that had reached a partial assurance opinions and had been included within the Annual Governance Statement and Annual Accounts. The partial opinion was a reflections of some of the areas Internal Audit had focused on and were known areas of challenge for the Trust.
1160/21	The Committee received the Estates Management report noting that this offered no assurance with the Chief Operating Officer and Estates Team due to attend the next Audit Committee meeting in order to discuss the actions taken since the report was issued.
1161/21	The Audit Committee were keen to ensure a Trust wide focus on recommendations, actions and implementation of actions.
1162/21	The Chair noted that the Audit Committee were considering reports in detail asking the Board to reflect on the issues raised to determine if these should have been alerted at an earlier stage. The Chair noted the need for the Committee to take a view on this and upwardly report to the Board prior to this action being discharged by the Board. The Trust Board: • **Received the report noting the moderate assurance**
1163/21	**Item 13.2 Risk Management Report** The Director of Nursing presented the report to the Board noting that this was the monthly report received by the Board with each Committee having received the relevant sections.
1164/21	The report highlighted the highest priority risks and the Trust continued to see the pandemic and potential impact on patients, staff, visitors and provision of a full range of clinical services as the highest risk.
1165/21	The Director of Nursing noted there was considerable uncertainty with regard to the pandemic and the risk pose to the Trust alongside the effect of the delta variant. The Trust therefore continued to see capacity to manage emergency demand as a very high risk along with workforce engagement, morale and productivity as a high risk.
1166/21	The Chair noted the risks presented with the Board noting the mitigations were relevant and appropriate. The Committees and the Board would continue to focus on the management and mitigation of risk. The Trust Board: • **Accepted the top risks within the risk register** • **Received the report and noted the moderate assurance**
1167/21	**Item 13.3 Board Assurance Framework** The Trust Secretary presented the report to the Board noting that this had been considered by each of the Committees in month.
1168/21	As alluded to through the upward reports from the Committees objective 1a had moved from red to amber and 3b moved from green to amber to reflect concern about the delivery of cost improvement plans.

1169/21	The Chair noted that the Quality Governance Committee had considered a number of papers received by the Board and the move from red to amber was noted and supported.
1170/21	The move from green to amber of objective 3b was supported due to the cost improvement plan delivery and pay expenditure as described.
1171/21	The Chair noted that the papers received in the latter section of the agenda, objective 4 for pathway improvement, whilst offering moderate assurance it was not felt that this would alter the rating on the Board Assurance Framework.
1172/21	The Board confirmed the assurance ratings presented and looked forward to further ratings improving in the future. The Trust Board: • **Received the report and noted the limited assurance**
1173/21	**Item 13.4 Learning from Judicial Review** The Chief Executive presented the report to the Board advising that this had set out the background of the temporary arrangement put in place at Grantham in June 2020 that had been subject to legal challenge via a Judicial Review.
1174/21	Initially this had been based on 4 grounds involving both the Trust and Clinical Commissioning Group however following various process this had resulted in 2 grounds being taken forward involving only the Trust.
1175/21	The Chief Executive noted that the hearing was held online on the 4 March 2021 with the judgement being made on 16 April. Ahead of the decision of the judicial review the Board took the decision to restore services.
1176/21	The judicial review went ahead on the grounds of an allegation of inadequate involvement in the development and decision of the proposals. The review found against the Trust.
1177/21	The second ground had been that the decision was taken on irrational grounds and improper purposes, this was found in favour of the Trust.
1178/21	The Chief Executive advised that the Trust had publicly apologised for not involving people appropriately in the changes that had been made. Particularly with regard to the pace at which these had been made. The Trust were pleased that the Judge found the decision to be rational, taken in good faith and for the proper purpose.
1179/21	It was noted that the judge made a number of favourable comments but it was clear that the Trust did not have the correct process.
1180/21	In the desire and hast to make changes to benefit people's health and wellbeing the process was not sufficient to meet the legal requirements, it was noted however that these did not take in to account a pandemic with this being misjudged by the Trust.
1181/21	The Chief Executive advised that the Trust had been making refreshments to standard operating procedures and whilst the legal duties were known there had been an error on this occasion.

1182/21	Improvement processes were being developed and it was hoped that this had been seen by the Board through the Paediatric and Urology papers presented during the meeting that had an improved set of engagement processes.
1183/21	Additional support was being offered to Divisional colleagues to ensure that they were clear of the requirements on them should there be changes made. There was also work to ensure a more systematic approach as the Integrated Care System to ensure the same level of engagement and involvement was had when developing proposals and taking decisions.
1184/21	The Chief Executive noted that there was a link to the full judicial review within the paper should people wish to review this.
1185/21	The Chair noted that Mrs Libiszewski was seeking clarification on the Committee that would have oversight of engagement processes. The Chair noted that this would require discussions once work to develop engagement and involvement was complete.
1186/21	The Chair noted that this had been an extremely difficult environment in the context in which the decision was made and the Board felt as though they had acted in good faith. This had however been the wrong process which was recognised and apologies given.
1187/21	The learning from the judicial review had already been actioned and taken forward. As an organisation greater involvement, engagement and communication would continue with the public as a consequence of this particular case. The Trust Board: • **Received the report noting the significant assurance**
1188/21	**Item 14 Any Other Notified Items of Urgent Business** The Chair noted that this was the last meeting for Mr Geoff Hayward who had been with the Trust Board in a Non-Executive Director capacity for the last 8 years and had now come to the end of his term.
1189/21	The Chair offered thanks on behalf of the Board for his work over this period of time and for the personal resilience in working in a different range of roles and Committees within the Trust. The Chair noted that Mr Hayward had been a great advocate for patients and quality of services during this time.
1190/21	The Chair noted that this would have been the final meeting for Dr Hepburn, Medical Director, had he been in attendance and extended thanks to him noting that he would remain at the Trust in a clinical role. The Chair commended Dr Hepburn's contribution to the Board noting the sterling leadership offered in relation to the Paediatric Service Model discussed earlier on the agenda.
1191/21	The Chair reflected that this was the last meeting for Mr Rayson, Director of People and Organisational Development before moving on. The Chair expressed both personal appreciation, and as Chair of the Board, for Mr Rayson's contribution to the Trust.
1192/21	The Chair recognised that this had not been an easy role thanking Mr Rayson for his personal resilience, wisdom and stewardship through some difficult circumstances. The Chair celebrated the leadership that had been given to the vaccination programme for which the calm approach had been hugely valued by colleagues. The Chair wished Mr Rayson well for the future.

1193/21	The Chair noted that Dr Prior had asked if there would be consideration to move back to face to face meetings.
1194/21	The Chair advised that this was under consideration however national guidance was awaited. It was noted however that feedback from those who were observing the meetings would be welcomed in order to understand their views. From a Trust perspective utilising the live stream platform had made the meetings more accessible both to those in the community and to staff. This access would not want to be lost if there was a move back to face to face meetings.
1195/21	The next scheduled meeting will be held on Tuesday 3 August 2021, arrangements to be confirmed taking account of national guidance

Voting Members	**7 July 2020**	**4 Aug 2020**	**1 Sept 2020**	**6 Oct 2020**	**3 Nov 2020**	**1 Dec 2020**	**2 Feb 2021**	**2 Mar 2021**	**16 Mar 2021**	**6 Apr 2021**	**4 May 2021**	**1 June 2021**	**6 July 2021**
Elaine Baylis	X	X	X	X	X	X	X	X	X	X	X	X	X
Chris Gibson	X	X	A	X	X	X	X	A	X	X	X	X	A
Geoff Hayward	A	A	A	A	A	X	X	X	X	X	A	A	X
Gill Ponder	X	X	X	X	X	X	X	X	X	X	A		
Neill Hepburn	A	X	X	X	X	X	X	X	X	X	X	X	A
Sarah Dunnett	X	X	X	X	X	X	X	X	X	A	X	X	X
Elizabeth Libiszewski	X	X	X	X	X	X	X	X	X	X	X	X	X
Paul Matthew	X	A	X	X	X	X	X	X	X	X	X	X	X
Andrew Morgan	X	X	X	X	X	X	X	X	X	X	X	X	X
Mark Brassington	X	X	X	X	X	X	X	X	X	X	X	X	X
Karen Dunderdale	X	X	X	X	X	X	X	X	X	A	X	X	X
David Woodward												X	A

PUBLIC TRUST BOARD ACTION LOG

Agenda item: 5.2

Trust Board date	Minute ref	Subject	Explanation	Assigned to	Action due at Board	Completed
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	02/11/2021	Further work commissioned. Report now expected at October Audit Committee
2 March 2021	259/21	Staff Covid-19 Story	To develop a regular plan of activities, such as back to the ward, through staff engagement and organisational development activity	Dir of P&OD	04/05/2021	Annual engagement plan being developed by the OD Team including plans for regular opportunities for staff in support teams to visit and support clinical areas. To be considered by Trust Leadership Team
6 April 2021	579/21	Staff survey	Consideration to be given to triangulation of data between staff survey results and quality measures	Dir of P&OD	01/06/2021	Work being undertaken with Information Services to determine how information can be triangulated
6 April 2021	596/21	Smoke Free Policy	Post implementation review following relaunch to be presented to the Board	Dir of P&OD	02/11/2021	
6 July 2021	994/21	Patient Story	Invitation to Dr Sakthivel and Jody Blow to present and update on the progress of communication training following story at the Board	Warner, Jayne	07/12/2021	

PUBLIC TRUST BOARD ACTION LOG

Agenda item: 5.2

6 July 2021	1141/21	Urology Pathway Update	Refreshed site strategies to be presented to the Board	Brassington, Mark	05/10/2021	

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Public Trust Board*
Date of Meeting	*3 August 2021*
Item Number	*Item number 6*
Chief Executive's Report	
Accountable Director	*Andrew Morgan, Chief Executive*
Presented by	*Andrew Morgan, Chief Executive*
Author(s)	*Andrew Morgan, Chief Executive*
Report previously considered at	*N/A*

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

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

Recommendations/ Decision Required	• *To note*

Executive Summary

System Overview

a) The Health and Care Bill has now received its second reading in the House of Commons and will now proceed to its Committee stage after the summer recess. Amongst other things, the Bill establishes Integrated Care Systems on a statutory footing. It is still anticipated that ICS will become statutory with effect from 1st April 2022. Additional guidance will be issued on a range of topics over the coming months, subject to the Bill passing through Parliament.

b) Many COVID restrictions ended in England on 19th July. However, the NHS in Lincolnshire is continuing to operate in accordance with the Infection Prevention and Control (IPC) procedures that were in place before the 19th July. This means that staff, patients and visitors are expected to continue to follow social distancing rules, to wear a surgical mask (unless medically exempt) and to practice good hand hygiene. This approach has been adopted across the county's health organisations. This is to recognise the ongoing pandemic and that the NHS continues to care for some of the most vulnerable people in our communities. The NHS needs to protect such individuals and provide others with the confidence that they can continue to access services safely. This approach in Lincolnshire is consistent with the IPC advice given by NHS England's Chief Nurse, Ruth May.

c) Revised arrangements have been agreed nationally to allow NHS front line staff to attend work rather than self-isolate if they are contacted by NHS Test and Trace and/or the NHS App. This is to ensure that the safety of services is not compromised as a result of staff absences. There are strict eligibility criteria relating to these new arrangements and cases are dealt with on an individual basis following a risk assessment.

d) These self-isolation changes are partly an acknowledgement of the significant pressure that the NHS is under at the moment. This is a national issue that is replicated in Lincolnshire. All parts of the system are experiencing significant levels of demand, as the NHS focuses on COVID, urgent and emergency care, the restoration and recovery of planned care services, whilst at the same time as dealing with staffing pressures. One aspect of the staffing pressures is the desire to allow staff to take annual leave over the summer, particularly following a period in which many staff have had restricted annual leave opportunities.

e) The COVID vaccination programme continues to run well. The millionth jab in Lincolnshire was given recently. The programme is continuing its efforts to give all over 18's two COVID jabs. Planning is now underway for the commencement of Phase 3 of the COVID vaccination programme, involving booster jabs during autumn/winter. This will be between 6 September and 17th December. There will also be the usual seasonal flu vaccination programme.

Trust Overview

a) At Month 3, the Trust reported an in-month surplus of £0.7m with a year-to-date position of a deficit of £1.1m. Both of these are in line with the H1 2021/22 financial plan.

b) The Trust has received verbal confirmation that its Outline Business Case (OBC) relating to the new A&E Department at Pilgrim Hospital in Boston has received national approval. Written confirmation is awaited. The written confirmation will also contain any specific requirements related to the approval.
c) The public involvement process relating to proposed changes to Urology services across the Trust closed on 23rd July. The responses received will now be considered and an outcome of consultation paper will be presented to a future Board meeting in public.
d) Work is continuing in relation to the NHSE/I Culture and Leadership Programme that the Trust has signed up to. Surveys are about to be conducted with Trust staff and Stakeholders about leadership within the Trust.
e) The final interviews for the Director of People and OD post take place on 4th August 2021. Martin Rayson leaves the Trust on 31st July 2021. An Interim Director is due to join the Trust in early August, pending the arrival of the substantive post holder.
f) Mark Brassington, the Trust's Director of Improvement and Integration/Deputy CEO, is leaving the Trust in early September to take up a secondment opportunity with NHSE/I in the Midlands as their Director of Performance and Improvement. It is expected that this secondment will be for at least 12 months. An Interim Director of Improvement and Integration will be recruited during Mark's absence. The Deputy CEO role will be moved to one of the existing Directors.

Report to:	Trust Board
Title of report:	Quality Governance Committee Assurance Report to Board
Date of meeting:	20th July 2021
Chairperson:	Liz Libiszewski, Non-Executive Director
Author:	Karen Willey, Deputy Trust Secretary

Purpose	This report summarises the assurances received and key decisions made by the Quality Governance Assurance Committee (QGC). The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board's response. This assurance committee meets monthly and takes scheduled reports from all Trust operational groups according to an established work programme. The Committee worked to the 2021/22 objectives.
	Assurance in respect of SO 1a Issue: Deliver harm free care **Patient Safety Group Upward Report** The Committee welcomed the Chair of the Patient Safety Group to the Committee who presented the upward report from the group. The Committee noted the detailed discussions held by the group, in particular Non-Invasive Ventilation, mortality and medical devices. The Committee were advised of the lack of representation from the Medical Division which had been reported by a number of groups however were aware that this was being addressed. The Committee were pleased that the group had highlighted areas of excellent practice including the 3D printing of a piece of equipment to support a patient and the involvement of patient representative to ensure communications regarding a medical device alert was appropriate. **Non-Invasive Ventilation (NIV) Report** The Committee received the report noting that this offered reassurance of activity and process of the impact and implementation. Significant work had been undertaken with the development of Trust wider NIV pathways which joined the emergency department and respiratory pathways. The Committee noted the opening of the respiratory support unit due to take place on 27 July on the Lincoln site which would see the opening of negative pressure rooms. The Committee noted that it would be possible to complete a full audit of

	NIV during August with the output of this anticipated for September. The Committee noted the developments including the 24/7 respiratory consultant rota however noted this now needed to be delivered to ensure improved patient care and experience. The Committee were pleased to note that action had been taken on the long standing issue and the shift forward that was being seen. The Committee supported the diversion of the Project Management Office support to ensure the correct focus on required elements for improvement. The Patient Safety Group would then be in a position to consider the risk related to the issue. **Serious Incident Summary Report** The Committee noted the position with serious incidents and the number declared in month. The Committee were pleased to note the number of reports in month awaiting sign off from the Clinical Commissioning Group (CCG) had reduced with a commitment from the CCG to endeavour to sign the reports of as promptly as possible. **Clinical Harm Review Upward Report** The Committee received the report noting that this continued to be a manual process conducted by clinicians that was time consuming. The Trust were looking to develop an electronic system in order to support the work being conducted. A request had also been made by the Trust to take part in a pilot for a proactive scheme that would consider patients on waiting lists to determine which were likely to come to harm. This would enable patients to be prioritised according to clinical need rather than waiting time. This would enable the Trust to treat patients proactively to ensure they did not come to harm. It was not yet known if the Trust had been successful in the bid to be a pilot site. The Committee were keen that the process developed in order to ensure that clinical time was spent primarily seeing patients rather than reviewing the risk of harm. This would remain under close scrutiny of the Committee. **Significant Patient Safety Related Cases Summary Report** The Committee received the report noting those cases that had been opened and those resolved in month. Work was underway to collate cases so that a review could be undertaken in order to ensure additional learning could be identified through any themes that emerged. **Bard to Ward Assurance – Quality and Safety**

	The Committee were updated that the final element of this was due to start shortly with the monthly matron audits used as part of the quality metric reviews undertaken by the Director of Nursing. The Committee noted that the Ward reviews had commenced at the end of May with groups visiting wards and running mock style Care Quality Commission inspections looking at the key lines of enquiry and gathering evidence. Weekly spot checks were also conducted. The Committee noted that the first quarterly report would be received in October with some teams having 6 months of achievements which would mean they would be eligible to apply for ward accreditation in November. **Visits** The Committee noted that a group had been established in respect of visits across all areas of the Trust. The group would meet quarterly to discuss and consider themes and trend issues. An overview of these meetings would be offered to the Committee with the first due in October which would demonstrate the output of the first visits. The Committee noted the update and were pleased to note that Non-Executive Directors were delighted to be able to be involved in visits again. **Infection Prevention and Control (IPC) Group Upward Report** The Committee received the report noting that the group continued to monitor relevant policies with 4 requiring update and approval. Work continued on the national standards for healthcare cleanliness with an action plan being developed along with an IPC Board Assurance Framework. The Committee noted the invited IPC inspection due to take place by NHS England/Improvement which would take place over 2 days at Lincoln, Grantham and Pilgrim sites at the end of July. It was hoped that this would see the removal of the red rating previously given to the Trust. **Safeguarding Group Upward Report** The Committee noted that training compliance was not being met with issues relating to the current contract for restraint training. This issue had been received and recommendations submitted to the Director of Nursing to conduct restraint training. The Committee noted that Liberty Protect Safeguards would replace Deprivation of Liberty, guidance was awaited with an indication that whilst this had been delayed it would likely be available in Spring 2022. This would see responsibility move from Local Authorities to Acute Trusts and work was underway to understand the impact for the Trust. **NMAAF Upward Report** The Committee received the report noting that this offered triangulated

	assurance across improvement initiatives. It was noted that a number of wards were undertaking Care Watch where a member of the nursing team was present in the bay for the majority of the shift. This had seen an early improvement in the reduction of falls and pressure ulcers. The Committee were pleased to note the development of Boards for Wards which would support the profile of improvement by offering information in an accessible manner on wards. The Committee noted the escalation of nursing documentation resulting in a lack of consistency and adequate documentation. A working group had been established to rectify the issue identified. The Committee noted that care planning had been added to the risk register and explored the level of risk that had been identified to understand if regular reporting would be required to the Committee.
	Lack of Assurance in respect of SO 1b Issue: Improve Patient Experience **Maternity and Neonatal Oversight Group Upward Report** The Committee received the reporting noting the revised work programme and the changes made including the risk register and six month review of the Maternity Clinical Negligence Scheme for Trust (CNST). The Committee noted that the Trust had made the Ockenden submission with a request for funds which had been successful. The amount was not yet known however this was permanent funding to the Trust. The Committee were advised that a formal thematic review was being commissioned to review serious incidents following the identification of themes in serious incidents. The Committee received the Non-Executive Director Maternity Safety Champions written report and verbal update that was offered to highlight staff experiences following a recent visit to the Lincoln site. It was noted that the concerns raised were being addressed through focus groups with the output being upwardly report to the Committee from the group. **Patient Experience Group Upward Report** The Committee received the report noting that the Medicine Division had not been represented at the group. There had been an ongoing lack of representation which would be addressed. The Committee noted that the group were reporting that cancellation of the National Cancer Patient Experience Survey however the Trust would participate in the next available survey.

	The Committee were pleased to note that a number of working groups had been established to support the group including a sensory loss group and the reinstatement of volunteers within the Trust. **Patient Story** The Committee received the maternity patient story which focused on induction of labour and the negative experience of a mother. The Committee were advised of a national rise in induction of labour rates which was reflected within the Trust which reported a rate of 38-40%. Due to the feedback of the mother and social media posts, the Willow Team had been established to ensure that there was clear communication to women about the induction of labour process. The introduction of the team supported women from the point at which they were identified as requiring induction of labour and offered a point of contact for women to speak to a trained professional about their care and any concerns they may have. The Committee were pleased to note the level of positive feedback that had been received since the introduction of the team. This had demonstrated evidence of learning which had been embedded within the clinical team. **PLACE Lite Report** The Committee received the report noting that whilst ward refurbishments were being completed it would be useful to understand how long this would take to be completed across the Trust. The Committee were keen to understand the reporting route for this element of work noting it would feed from the Estates Infection, Prevention and Control (IPC) group to the IPC Group and upwardly to the Committee. **Equality, Diversity and Inclusion Annual Report** The Committee received the annual report in relation to the patient element of equality work. The Committee noted the suspension of special duties due to Covid-19 however were advised of the continuation of general duties. The report offered a view of the work carried out during the response to Covid-19 and the alignment of equality, diversity and inclusion. The Committee noted the continued engagement with the public on pathway changes however explored equality and health inequalities to understand if there were considered during engagement. The Committee noted that there had been work completed in relation to equality impact assessments which would be linked to the quality impact assessment process.

	The Committee received the report and approved for submission to the Trust Board.
	Lack of Assurance in respect of SO 1c Issue: Improve Clinical Outcomes **Clinical Effectiveness Group Upward report** The Committee received the report noting the improvement in reporting and attendance at the group. The group had received the organ donation annual report which had been submitted to the Committee for information. The Committee received the annual organ donation report noting that the work programme of the group would be amended to ensure that reports were received from the Organ Donation Group. The Committee were pleased to note the discussions that had been held in relation to record keeping and consent noting that the group would receive an action plan at the next meeting in order to ensure continued improvement. The Committee noted the establishment of the Sedation Group which would meet and report to the Clinical Effectiveness Group on a quarterly basis. The Committee noted that the group had received and considered a number of national audits.
	Assurance in respect of other areas: **Committee Performance Dashboard** The Committee received the report noting the development of this which was underway. The Committee noted the review process relating to medicines management was still to take place with the timescale to proceed to be confirmed as the team capacity was increased. Patterns of positive performance were noted by the Committee. **Performance Review Meeting Upward Report** The Committee received the report raising question as to the value the report added as this did not offer assurance to the Committee. The Committee noted the report continued to be developed alongside the performance regime within the Trust. It was hoped that as the Divisions commenced reporting to the Board that further assurances could be provided. **Integrated Improvement Plan** The Committee received the report for information noting that this was

	also seen at the Board. The Committee noted the need to see the elements of the report feeding through to the Committee in the upward reports of the groups to demonstrate delivery. **Quality Impact Assessments** The Committee received the report noting the increased level of assurance that continued to be offered to the Committee. As the Committee were assured that processes were in place and embedded it was agreed that reporting would be stepped back to quarterly. **Internal Audit Reports** The Committee received and noted the Public and Patient Experience Internal Audit Report. The Committee noted that the Care Quality Commission had recently undertaken the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) inspection for which the formal report was awaited. **CQC Must and Should Do Actions** The Committee received the report noting that this offered additional assurance and demonstrated a positive movement in the rating of the actions. It was noted however that one rating had been downgraded due to additional assurance being required.
Issues where assurance remains outstanding for escalation to the Board	None
Items referred to other Committees for Assurance	None
Committee Review of corporate risk register	The Committee reviewed the risk register accepting the risks noting that discussions would be held by the Finance, Performance and Estates Committee in relation to the increase of the Emergency Care risk due to increased demand. The Committee discussed the impact on patients and the quality of services in relation to capacity of emergency care.
Matters identified which Committee recommend are escalated to SRR/BAF	None
Committee position on assurance of strategic risk areas that align to committee	The Committee considered the reports which it had received which provided assurances against the strategic risks to strategic objectives.
Areas identified to visit in dept walk rounds	None

Attendance Summary for rolling 12 month period

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

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

United Lincolnshire Hospitals NHS Trust

Quality Governance Committee
Terms of Reference

1. Authority

The Quality Governance Committee is established by the Trust Board in line with the powers set out in the Trust Standing Orders.

The Quality Governance Committee holds only those powers as delegated in these Terms of Reference as determined by the Trust Board.

The Standing Orders and Standing Financial Instructions of the Trust, as far as they are applicable, shall apply to the Committee and any of its established groups.

2. Purpose of the Committee

The Quality Governance Committee exists to scrutinise the robustness of and provide assurance to the Trust Board that there is an effective system of quality governance and internal control across the clinical activities of the organisation that supports United Lincolnshire Hospitals NHS Trust to deliver its strategic objectives and provide high quality care.

The relevant strategic objectives assigned to the Quality Governance Committee for 2020/21 are:

- Deliver Harm Free Care
- Improve patient experience
- Improve clinical outcomes

3. Membership

The members of the Committee are:

- Non-Executive Director (Chair)
- Non-Executive Director (Deputy Chair)
- Non-Executive Director (Maternity Safety Champion)
- Director of Nursing (DIPC, Lead Director for Safeguarding)
- Medical Director (Accountable Officer for Controlled Drugs)
- Chief Operating Officer

The Committee will routinely be attended by:

- Trust Secretary/ Deputy Trust Secretary
- Deputy Director of Clinical Governance

An invitation to attend will be offered by the Committee Chair to:

- CCG Representative

- Divisional representatives to attend as required

4. Attendance and Quorum

The Committee will be quorate when four members are present if this includes at least one Non-Executive Director and one Executive Director.

Where members are unable to attend, they should ensure that a deputy is in attendance who is able to participate on their behalf. A deputy in attendance for a committee member will contribute to the quoracy but does not negate the need for the attendance of one Non-Executive and One Executive Director.

5. Frequency

The Committee will meet monthly.

6. Specific Duties

The Quality Governance Committee will:

- Agree a set of Key Performance Indicators to be presented in the Committee Performance Dashboard monthly
- Consider the control and mitigation of quality related risks and provide assurance to the Board that such risks are being effectively controlled and managed. Whilst the committee's remit covers all of the Trust's services, the committee has a specific oversight role in relation to the quality & safety of the Trust's maternity services (reference: Ockendon)
- Provide assurance to the Board that all legal and regulatory requirements relating to quality are met, including directives, regulations, national standards, policies, reports, reviews and best practice
- Review and provide assurance on those strategic objectives within the Board Assurance Framework, identified as the responsibility of the committee seeking where necessary further action as outlined below:

Deliver Harm Free Care:

- Developing a safety culture
- Improving the safety of medicines management
- Ensuring early detection and treatment of deteriorating patients
- Ensuring safe surgical procedures
- Ensuring a robust safeguarding framework is in place to protect vulnerable patients and staff
- Maintaining HSMR and improving SHMI
- Delivering on all CQC Must Do actions and regulatory notices
- Ensure continued delivery of the hygiene code

Improve patient experience:

- Greater involvement in the co-design of services working closely with Healthwatch and patient groups
- Greater involvement in decisions about care
- Deliver year three objectives of our Inclusion Strategy
- Redesign our communication and engagement approaches to broaden and maximise involvement with patients and carers

Improve clinical outcomes:

- Ensuring our respiratory patients receive timely care from appropriately trained staff in the correct location
- Ensuring recommendations from Get it Right First Time (GIRFT) reviews are implemented
- Ensuring compliance with local and national clinical audit reports
- Reviewing of pharmacy model and service

7. Administrative support

The Committee will operate using a work plan to inform its core agenda. The agenda will be agreed with the Chair and the Director of Nursing (the Executive Director lead for the committee) prior to the meeting.

Agendas and supporting papers will be circulated no later than 7 days in advance of meetings. Any items to be placed on the agenda are to be submitted no later than 8 working days in advance of the meeting. Items which miss the deadline for inclusion on the agenda may be added with permission from the Chair.

Minutes will be taken at all meetings, presented according to the corporate style, circulated to members within 7 days along with the action log and ratified by agreement of members at the following meeting.

8. Accountability and Reporting Arrangements

The Chair of the Committee shall report to the Board after each meeting and provide a report on assurances received, escalating any concerns where necessary.

The Committee will advise the Audit Committee of the adequacy of assurances available and contribute to the Annual Governance Statement.

9. Monitoring effectiveness and Compliance with Terms of Reference

The Committee will complete an annual review of its effectiveness and provide an annual report to the Board on its work in discharging its responsibilities, delivering its specific duties and complying with its terms of reference, specifically commenting on relevant aspects of the Board Assurance Framework and relevant regulatory frameworks.

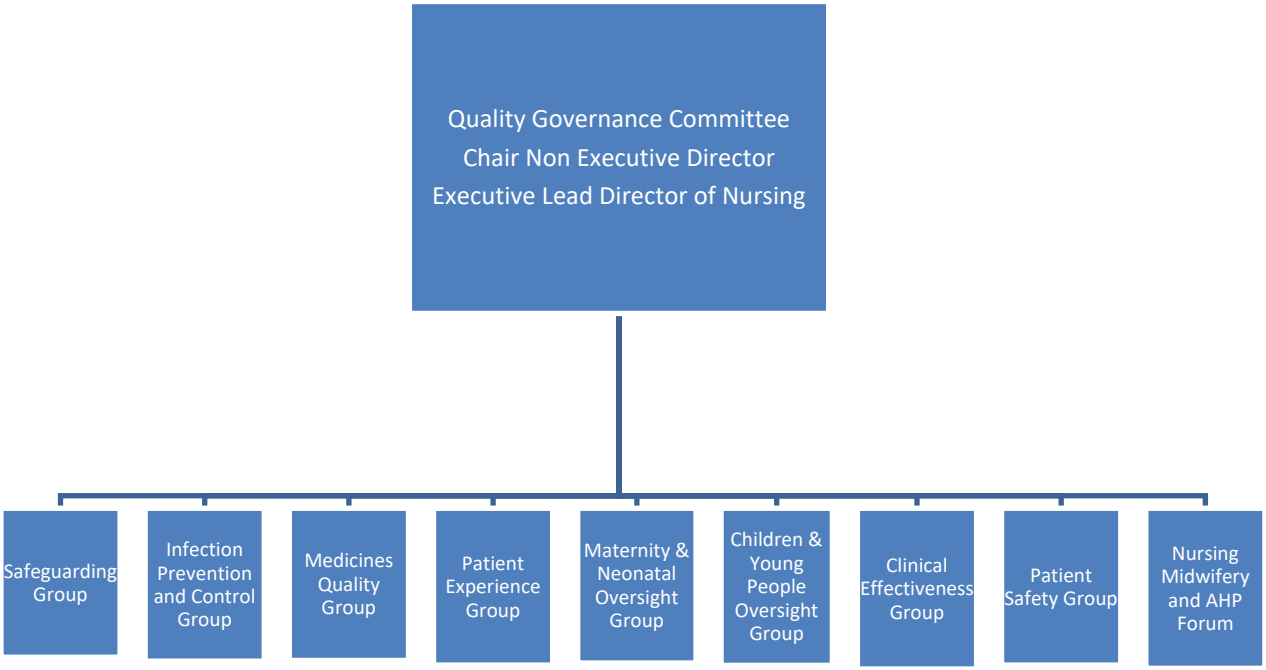
10. Review of Terms of Reference

The Terms of Reference for the Committee will be reviewed annually by the Committee and submitted to the Trust board for approval.

The Committee will on an annual basis review and approve the terms of reference and work programmes of all of its reporting groups.

Approved:
Approved by:
Next Review Date:

Committee reporting group structure:



Meeting	*Trust Board*
Date of Meeting	*3 August 2021*
Item Number	*Item number allocated by admin*
CQC Must Do and Should Do Actions and Regulatory Notices	
Accountable Director	*Karen Dunderdale, Director of Nursing*
Presented by	*Karen Dunderdale, Director of Nursing*
Author(s)	*Kathryn Helley, Deputy Director of Clinical Governance* *Louise Hobson, Head of PMO*
Report previously considered at	*CQC Steering Group – 14/07/2021* *Quality Governance Committee – 20/07/2021*

How the report supports the delivery of the priorities within the Board Assurance Framework	
1a Deliver harm free care	*X*
1b Improve patient experience	*X*
1c Improve clinical outcomes	*X*
2a A modern and progressive workforce	
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	*Link to strategic risks:-* *4405; 4083; 4175; 3688; 3951; 4156; 3503; 4041; 4081; 4145; 4300; 4476*
Financial Impact Assessment	*N/A*
Quality Impact Assessment	*Through governance process of IIP.*
Equality Impact Assessment	*Through governance process of IIP.*
Assurance Level Assessment	*Moderate*

Recommendations/ Decision Required	• *The Trust Board is asked to note the activity that has occurred since the last report.*
	• *The Trust Board is asked to note the progress of delivery of improvements against the CQC 'Must Do' and 'Should Do' actions.*

Executive Summary

To provide the Trust Board with an update on all CQC activity.

The report and Executive Summary of the action plan (Appendix A) provide an update against the CQC 'Must Do' and 'Should Do' actions. This includes the current month's performance.

The report also provides details of other CQC activity taking place within the Trust.

1. Introduction

The CQC published its inspection report in October 2019 following the July 2019 Core Inspection. The Trust has been taking action to address these areas for improvement. This paper and attached appendix provides the Trust Board with an update on that progress and includes more recent requirements identified following the Winter Assurance Visits, to the Lincoln and Pilgrim Hospitals' Emergency Departments. It also includes information related to other activities undertaken with and related to the CQC since the Core Inspection referred to above.

2. Progress to Date

2.1 Monitoring Process

Appendix A attached provides an executive summary outlining the position of the must and should do actions and any risks to delivery. This activity is monitored through the weekly CQC Steering Group.

2.2 Progress Against Must Do and Should Do Areas for Improvement

Progress against all the areas for improvement has been documented and an Executive Summary has now been embedded within the CQC Action Plan to support in pointing out key points, high risks and issues and progress against actions (Appendix A). Also within the report is an overarching view of all the risks and issues (Appendix B). Full details of the risks and issues can be found in the Executive Summary in Appendix A.

Since the last reporting period, there has been a continuation of supporting and helping clinical Divisions to prepare for their forthcoming CQC Evidence Review Panel. With the exception of Surgery, all clinical Divisions have attended a CQC Evidence Review Panel with Dr Karen Dunderdale, Director of Nursing and Dr Neill Hepburn, Medical Director as chairs. Due to unforeseen circumstances Surgery's is to be rearranged.

During these panels, actions are recorded within an Action Log and distributed following the meeting. The Deputy Director of Clinical Governance, supported by the

NHSEI Improvement Director and Head of PMO, continue to support Divisions in the collation of their evidence and to update their Action Log.

All clinical Divisions who have undertaken their preparatory and CQC Evidence Review Panel, have found the session very useful and helpful in preparing for the impending CQC inspection and ensuring that all 'Must Do' and 'Should Do' actions are well evidenced and if not what mitigation is in place to address the action.

To note, from the prep sessions and panels, there has been some movement of the BRAG status of the 'Must Do' and 'Should Do' actions with some improving where the evidence supports this and one reducing from green to amber.

The Executive Summary within Appendix 1 demonstrates that there continues to be steady progress in actions progressing through the BRAG matrix. There has been a positive in that there are no reported red actions as following a recent CQC Evidence Review Panel, it was felt that the below action could be moved to an amber status:-

CQC2019-045: The Trust should ensure patients are appropriately assessed for self-administration of medicines and that their own medicines are in date.

There has also been slippage of one action where it has shifted from green to amber. This action is:-

CQC2019-029: The Trust must ensure there are appropriate systems in place to monitor the condition and risk of deterioration for all patients awaiting admission (eg, on ambulances or in corridor areas awaiting triage) to the Emergency Department at Pilgrim Hospital, Boston.

The CQC Evidence Review Panel felt that further testing is required of the management process implemented and to include as part of this testing a review of the past three AAA incidents to ensure our processes are now embedded.

Any CCQ 'Must Do' and 'Should Do' actions requiring escalation, continue to be fed into the weekly CQC Steering Group and escalated appropriately to the Executive Team Leadership (ELT) forum through the regular Highlight Report.

Currently a date is being arranged for a CQC Evidence Review Panel for all corporate elements of the 'Must Do' and 'Should Do' actions.

2.3 Other Regulatory Activity

Area	Lead	Current Position
Section 31 – Urgent and Emergency Care	Tracey Wall, Head of Nursing	Continue to report fortnightly to the CQC on progress against the issues identified in the Section 31 notice. Currently collating the evidence to support completion of the actions prior to submitting a formal request to remove the conditions on the registration.
Section 29a – Children and Young People / Children and Young People KLOEs	Simon Hallion, Managing Director	Update on progress towards meeting the issues identified in the Section 29a submitted to the CQC on 8 March 2021 with meeting to discuss held on 16 March 2021. Correspondence received from CQC on 6 April 2021 indicating that evidence had been provided to demonstrate achievement of action identified within the Section 29a. Focus group with Childrens Services took place on 14 June 2021.
IPC Assurance Framework	Karen Dunderdale, Director of Nursing	Call undertaken with CQC early 2020/21 regarding the Emergency Support Framework. This led to the development of the IPC BAF which is monitored through the Infection Control Committee.
Patient First – Pressure Resilience in Emergency Medicine	Tracey Wall, Head of Nursing	Patient First Self-assessment shared with the CQC. Awaiting feedback.
Medicines Management	Colin Costello, Chief Pharmacist	Previous call with the Pharmacy team due to concerns. Follow up call held with ELT and Triumvirate on 8 February 2021.
Diabetes Management	Dr Neill Hepburn, Medical Director	Call undertaken on 22 February 2020 following CQC's receipt of the thematic review of diabetes serious incidents. Evidence presented prior to the call.
Well Led TMA	Andrew Morgan, CEO	Evidence against the KLOEs submitted on 29 April 2021 with meeting taking place on 6 May 2021.
Medical Care TMA	Carl Ratcliff, Interim Managing Director	TMA call undertaken on 25 March 2021 with evidence submission occurring on 19 March 2021. Verbal feedback was positive. Subsequent request from the CQC for focus groups to be undertaken with staff from medicine wards. Four focus groups have been arrange during June 2021.
IRMER Visit (Radiotherapy and Interventional Radiology)	Simon Evans, Chief Operating Officer	Virtual visit took place for Radiotherapy (6 July 2021) and Interventional Radiology (7 July 2021). The formal outcome of the visit is awaited.

2.4 Preparation for Impending CQC Inspection

A number of activities are currently taking place in order to prepare for our impending CQC inspection. These include

- *Staff Briefing Sessions* – these sessions have commenced and aim to share with staff what happens on a visit and how they can prepare themselves. A number of meetings are taking place during July and August 2021 with teams at their request.
- *Lunch and Learn* – these sessions, although not specifically for the CQC, will support staff in understanding more about a range of topics such as safeguarding, risk, management of the deteriorating patients, etc.
- *Ward Boards* – the quality governance and safety boards have been approved and these will be piloted in 10 wards over the coming weeks before being rolled out across the Trust.
- *Clear the Clutter* –the Estates and Facilities have reported a good response to the 'Clear the Clutter' campaign. This initiative is now part of the regular workof the team.

In addition, and as mentioned above, at the request of the CQC, a number of focus groups have been undertaken. Initially these have been focussed on children & young people and medicine, however plans are in place for general focus groups in the run up to a visit. Early feedback from the CQC is that staff have shared with them the improvement work that they are undertaking.

3. Conclusion/Recommendations

In conclusion, actions have been and are being taken to close existing conditions and warning notices with the CQC and progress improvements against 'Must Do' and 'Should Do' actions.

Progress and risk continue to be monitored through the fortnightly CQC Steering Group and issues escalated through to ELT and to the Quality Governance Committee and Trust Board as required. Support will continue to be provided by the corporate teams including the collation of the supporting evidence.

The Trust Board is asked to note CQC associated activity, the progress against the delivery of improvements mapped to the CQC 'Must Do' and 'Should Do' actions and the risk to delivery of the remaining actions.

Appendix B – Overview of Number of Issues and Risks

Monthly Issue Summary							
Date	Number of Issues	Very High	High	Moderate	Low	Very Low	Closed
Jul 2021	2	1	0	0	1	0	1
Jun 2021	2	1	0	0	1	0	1
May 2021	2	1	0	0	1	0	1
Apr 2021	2	1	0	0	1	0	1
Mar 2021	2	1	0	0	1	0	1
Feb 2021	1	0	0	0	1	0	1

Monthly Risk Summary							
Date	Number of risks	Very High	High	Moderate	Low	Very Low	Closed
Jul 2021	5	0	0	2	3	0	3
Jun 2021	5	0	0	2	3	0	3
May 2021	5	0	0	2	3	0	3
Apr 2021	5	0	0	2	3	0	3
Mar 2021	5	0	0	2	3	0	3
Feb 2021	3	0	0	1	1	1	1

CQC Must Do / Should Do Actions

Executive Lead: Karen Dunderdale, Director of Nursing
Senior Responsible Officer: Kathryn Helley, Deputy Director of Clinical Governance
Progress Review Date As At: 05/07/2021

Background

In preparation for the Trust's CQC Well-Led Announced Inspection, during June 2019 the Trust underwent a series of unannounced CQC inspections for five of our core services. The core services were:-

> Maternity
> Children & Young People
> Urgent & Emergency Care
> Critical Care
> Medicine

Following the unannounced visits the Trust's Well-Led Inspection took place in July 2019 and the CQC published its inspection report in October 2019. Within the CQC's published report there are a number of Must Do and Should Do actions to be undertaken for each of the core services. In addition the Trust underwent their Winter Pressure Assessment in January 2020 of their Emergency Departments at both Lincoln and Pilgrim Hospitals. The CQC sent its inspection report to the Trust in February 2020.

The purpose of this document is to provide the governance and assurance on the progress being made to date around these actions.

Summary / Key Points

> The focus since the last reporting period has been to help and support clinical Divisions prepare for their forthcoming CQC Evidence Review Panels which have been jointly chaired by Dr Karen Dunderdale, Director of Nursing and Dr Neill Hepburn, Medical Director. All Divisions have received their initial panel meeting at the time of writing this report.

> From the graph opposite there continues to be steady progress in actions progressing through the BRAG matrix. There has been a positive in that there are no reported red actions as following a recent CQC Evidence Review Panel, it was felt that the below action could be moved to an amber status:-

CQC2019-045: The Trust should ensure patients are appropriately assessed for self-administration of medicines and that their own medicines are in date.

There has also been slippage of one action where it has shifted from green to amber. This action is:-

CQC2019-029: The Trust must ensure there are appropriate systems in place to monitor the condition and risk of deterioration for all patients awaiting admission (eg, on ambulances or in corridor areas awaiting triage) to the Emergency Department at Pilgrim Hospital, Boston.

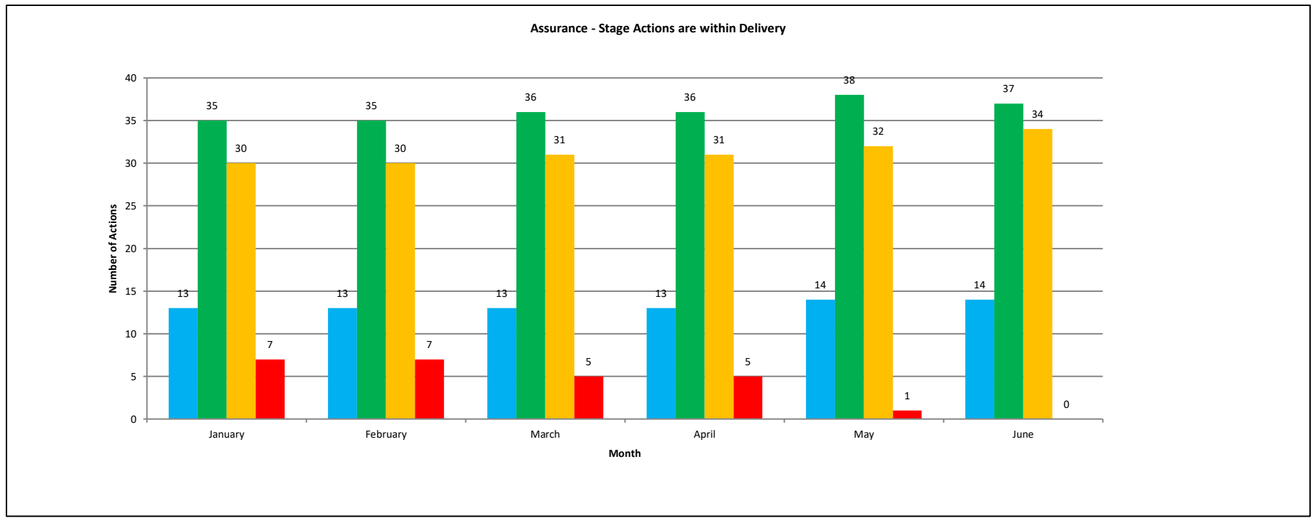
The CQC Evidence Review Panel felt that further testing is required of the management process implemented and to include as part of this testing a review of the past three AAA incidents to ensure our processes are now embedded.

Issues

> (High) There is slow pace in the delivery and receiving demonstrable progress updates of the Pharmacy CQC expectations for Must Do and Should Do actions. **Mitigation:** Escalated to ELT. Post mitigation to be monitored through the CQC Evidence Review Panels.

Risks

> (Medium) Pharmacy Services: There is potential if the Pharmacy issue (see above) does not have adequate mitigation strategy in place, this is open for further new risks to be raised for the Trust. **Mitigation:** To be monitored through the CQC Evidence Review Panels.



Report to:	Trust Board
Title of report:	People and OD Committee Assurance Report to Board
Date of meeting:	14th July 2021
Chairperson:	Geoff Hayward, 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 2021/22 objectives following approval of the BAF by the Board.
Assurances received by the Committee	**Assurance is respect of SO 2a** **Issue: A modern and progressive workforce** **Safer Staffing** The Committee received the regular report noting the need to remain sighted on the care hours per patient day which continued to fall short on registrants. It was noted however that this did not impact on care delivery as this was fulfilled by other staff within the workforce. The Committee were advised that the 95% fill rate continued to fluctuate due to service demand and the increase in activity through the front door resulting in escalation beds being opened. The Committee were pleased to note that the establishment reviews were being completed which would further strengthen the understanding of staffing requirements within the Trust. Work continued to address vacancies and to build the future pipeline for recruitment with projections being developed which would impact agency use. The Committee noted the report and reflected on the benefit of this being replicated for medical staff in order to understand the wider workforce position. **Flexible Working Update** The Committee received the report which had been considered by the Trust Leadership Team and as a result a task and finish group had been

	established to consider the process for how flexible working requests were made and how appeals would be managed. The Committee noted the support from the Divisions and that this only applied to staff on agenda for change contracts. The change would mean that flexible working requests could be made for any reason and no longer governed in relation to childcare. There was confidence in the ability of the Trust to support flexible working but this would not be in place for the whole of the workforce affected at the time of commencement. A plan would be in place to present to NHS England to demonstrate what action the Trust would take. The Committee were pleased to note that conversations had commenced through the establishment reviews regarding the introduction of flexible shifts and combination rotas. **Education Funding** The Committee received the report noting that the plan devised was developed from the input of the education leads within the Trust and funding streams covering the workforce development fund and continuing professional development. The Committee noted the use of the funding for education would support the Trusts desire to become a learning organisation with the intention to ensure these budgets were in place from the start of each financial year to support staff to access training. The Committee noted the link with finance colleagues to ensure the utilisation of the budgets, ensuring this was spent correctly and there was equality of access. The Committee noted the need to be able to allocate the budgets based on the priorities within the Trust, this was being worked towards to move away from being reactive to the budgets available to support staff. The Committee supported the spending plan presented.
	Assurance in respect of SO 2b **Issue: Making ULHT the best place to work** **Freedom to Speak Up Guardian Quarterly Report**

	The Committee received and noted the quarterly report. The Committee noted that this had been received and discussed in detail by the Audit Committee. **Estates and Facilities Response to OD Review** The Committee were pleased to receive the response from the Organisational Development (OD) review undertaken within Estates and Facilities noting that the team had undergone a significant changes over the past 12 months. The Committee noted that as a result of the feedback to the OD Team a number of interim and temporary actions had been put in place to try and understand the concerns of the team. An action plan was being developed in order to embed a change in behaviours within the Team which was hoped to become normal day to day activity. The Committee noted the large size of the staff group and the engagement from them, there had been significant focus on the team. The Committee noted the need to ensure feedback was offered to the Team to ensure that there was a clear demonstration that they had been listened to. Further OD input and support was discussed in respect of the development of the action plan in order to ensure that this would address the underlying behaviour issues that were present. The Committee noted the organisational wider piece of work required to address behaviours within the Trust noting that this was at the heart of the Culture and Leadership Programme in place across the Trust. **GMC Junior Doctor Survey Update** The Committee received the report noting that themes were being seen which were of concern to the Committee. The Committee noted that the themes were in relation to the ability to attend mandatory teaching, supervision and mentorship, bullying and rota concerns. The Committee were advised of the Junior Doctor forum that was well attended and of the clear processes in place the ensure Junior Doctors were aware of how to raise concerns. The Committee noted that whilst these themes were emerging from the response being received there had also been a significant improvement in engagement with Junior Doctors.

	Equality, Diversity and Inclusion Annual Report The Committee received the annual report noting that there had been a suspension of reporting by the Equality and Human Right Committee due to Covid-19, general duties however were not suspended. The report focused on the key activities undertaken to support the workforce during the Covid-19 pandemic and the vaccination programme to ensure staff were significantly protected. The Committee noted that the statutory requirement of the Trust had been met and were pleased to note the establishment of a council of staff networks for the Chairs and Vice-Chairs to come together and share learning. The Committee approved the annual report. **Culture and Leadership Project Upward Report** The Committee received the first upward report from the group noting that the Trust were in the early stages of the work with scoping. There was a desire to ensure the scoping and discovery phases were completed fully before the programme was put in place. The Committee noted the implementation of the Leading Together forum which would result in the culture change team being put in place. The Committee were pleased to note that the programme would not result in a suite of interventions but would identify the totality of issues for the Trust and design solutions, with staff, to address the identified issues once properly understood. The Committee raised concern regarding the resourcing of the project however were advised that progress could be made whilst the appointment of the project manager was finalised.
	Assurance in respect of SO 4b **Issue: To become a University Hospitals Teaching Trust** **Research and Innovation Governance Group Upward Report** The Committee received the report taking it as read noting that there was a need for a more in-depth discussion at a future meeting. **University Teaching Hospital Upward Report** The Committee noted the report covered the 4 risks identified at the commencement of the programme.

	The Committee noted concern that the programme had not progressed since presentation to the Board in June and supported regular reporting to the Committee in order to see progress was being made. Reassurance was offered to advise the Committee that there had been progress with meetings held with the University of Lincoln in the past week which enabled progress to be made with rigour. **Medical Revalidation** The Committee noted the positive progress with Medical Revalidation noting that the Trust had performed well being one of the highest Trusts in the country. The Trust had not stopped medical revalidation during Covid-19 however it was noted there were some postponements. There had been a suspension of the revalidation by the GMC during Covid-19 however the Committee noted that the Trust continued to be at target with no concerns present.
	Assurance in respect of other areas: **Draft Terms of Reference and Work Programme** The Committee received the draft Terms of Reference and Work Programme noting the updates that had been made to the work programme following the previous meeting. The Committee requested inclusion of System People Programme within the work programme to ensure regular reporting was received. The Committee, based on the inclusion of system reporting approved the terms of reference and work programme. **Committee Performance Dashboard** The Committee received the report noting that there had been an increase in absence due to Covid-19, with the Trust undertaking a review the guidance in relation to isolation when staff were alerted to contact with the NHS app. Absence remained a concern for the Trust and as such there would be a re-instatement of calling staff to clarify details of isolation. The Committee were advised of the change to accessing lateral flow tests, reflecting national guidance staff would now be required to obtain these from other sources. The expectation for these to be completed twice

	weekly had been reinforced with staff. Work was underway to determine if there was a digital solution to follow up with those staff who had not completed tests. The Committee noted the position with regarding to vacancies and the increase that had been seen during June. This related to changes in establishment figures and adjustments. There had been a sharp rise in turnover noted during May and June which was believed to be in part due to post-Covid-19 reflections of staff. The Committee raised concern in relation to the increase in establishment that was being seen requesting that the Board had clear sight of the total establishment and the grip and control of the management of the position. **Executive Scorecard** The Committee received the scorecard noting that this would develop overtime and was offered to support the suite of assurance to the Committee. **PRM Upward Report** The Committee received the report noting the positive element of wellbeing and appraisal however this offered reassurance to the Committee, not assurance. The Committee reflected that the report would continue to develop in order to ensure assurances could be provided on the discussion held with the divisions. **Integrated Improvement Plan** The Committee received the report noting the progress against the workforce major projects within the Integrated Improvement Plan. The Committee noted that all major projects were rated as green. The Committee noted concern on the ability to progress the projects at pace due to the pressures on the organisation and within the Organisational Development Team.
Issues where assurance remains outstanding for escalation to the Board	The Committee wished to escalate to the Board the concern in the increase of the establishment noting that there needed to be clear sight of the total establishment and the grip and control of the management of the position.

	The Committee would like to advise the Board of the concerns raised in relation to the progress and achievement of the medical school within timescales noting that this was connected to the achievement of the University Hospitals Teaching Status.
Items referred to other Committees for Assurance	No items referred
Committee Review of corporate risk register	The committee received the risk register noting the current risks presented.
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	**A**	**S**	**O**	**N**	**D**	**J**	**F**	**M**	**A**	**M**	**J**	**J**
Geoff Hayward (Chair)	X	X	X	X	X	X	A	X	A	X	X	X
Sarah Dunnett	X	X	X	X	X	A	X	X	X	X	X	X
Non-Voting Members												
Martin Rayson	X	X	X	X	X	X	X	X	X	X	X	X
Simon Evans	D	D	D	C	C	C	C	C	C	D	A	D
Karen Dunderdale	X	X	X	C	C	C	C	C	X	A	X	D

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

United Lincolnshire Hospitals NHS Trust

People and Organisational Development Committee
Terms of Reference

1. Authority

The People and Organisational Development Committee is established by the Trust Board in line with the powers set out in the Trust Standing Orders.

The People and Organisational Development Committee holds only those powers as delegated in these Terms of Reference as determined by the Trust Board.

The Standing Orders and Standing Financial Instructions of the Trust, as far as they are applicable, shall apply to the Committee and any of its established groups.

2. Purpose of the Committee

The People and Organisational Development Committee exists to scrutinise the robustness of and provide assurance to the Trust Board that there is an effective system of governance and internal control across workforce and organisational development that supports United Lincolnshire Hospitals NHS Trust to deliver its strategic objectives and provide high quality care.

The relevant strategic objectives assigned to the People and Organisational Development Committee for 2021/22 are:

- A modern and progressive workforce
- Making ULHT the best place to work
- To Become a University Hospitals Teaching Trust

3. Membership

The members of the Committee are:

- Non-Executive Director (Chair)
- Non-Executive Director (Deputy Chair)
- Director of People and Organisational Development
- Director of Nursing
- Medical Director

The following roles will be routine attendees at the Committee:

- Trust Secretary/Deputy Trust Secretary
- Deputy Director of Human Resources and Organisational Development
- Head of Organisational Development
- Finance representative – as required
- Operations/Estates and Facilities representative – as required

4. Attendance and Quorum

The Committee will be quorate when four of the membership are present if this includes one Non-Executive Director and one Executive Director.

Where members are unable to attend, they should ensure that a deputy is in attendance who is able to participate on their behalf. A deputy in attendance for a committee member will contribute to the quoracy but does not negate the need for the attendance of one Non-Executive and One Executive Director.

5. Frequency

The Committee will meet monthly.

6. Specific Duties

The People and Organisational Development Committee will:

- Agree a set of Key Performance Indicators to be presented in the Committee Performance Dashboard monthly
- Consider the control and mitigation of workforce related risks and provide assurance to the Board that such risks are being effectively controlled and managed
- Provide assurance to the Board that all legal and regulatory requirements relating to the workforce are met, including directives, regulations, national standards, policies, reports, reviews and best practice
- Review and provide assurance through the Integrated Improvement Plan and Performance Review Meeting reporting, on those strategic objectives within the Board Assurance Framework, identified as the responsibility of the committee seeking where necessary further action as outlined below:

A modern and progressive workforce:

- Embedding robust workforce planning and development of new roles
- Delivery of annual appraisals and mandatory training
- Talent Management - Creating a framework for people to achieve their full potential
- Ensuring access to the personal and professional development that enables people to deliver outstanding care and ensures ULHT becomes known as a learning organisation

Making ULHT the best place to work

- Address the concerns around equity of treatment and opportunity within ULHT, so that the Trust is seen to be an inclusive and fair organisation
- Improving the consistency and quality of leadership and line management across ULHT

- Resetting the ULHT Culture and Leadership Programme – Trust Values and Staff Charter
- Reviewing the way in which we communicate with staff and involve them in shaping our plans
- Agreeing and promoting the core offer of ULHT, so our staff feel valued, supported and cared for
- Focus on junior doctor experience key roles: Freedom to Speak Up, Guardian of Safe Working and Wellbeing Guardian
- Embed a programme focused on staff wellbeing
- Develop staff networks
- Implementing Schwartz Rounds

To Become a University Teaching Hospital

- Developing a business case to support the case for change
- Increasing the number of Clinical Academic posts
- Improve the training environment for students
- Develop a portfolio of evidence to apply for membership to the University Hospitals Association
- Developing a memorandum of understanding with the University of Lincoln

7. Administrative support

The Committee will operate using a work plan to inform its core agenda. The agenda will be agreed with the Chair prior to the meeting.

Agendas and supporting papers will be circulated no later than 7 days in advance of meetings. Any items to be placed on the agenda are to be submitted no later than 8 working days in advance of the meeting. Items which miss the deadline for inclusion on the agenda may be added with permission from the Chair.

Minutes will be taken at all meetings, presented according to the corporate style, circulated to members within 7 days along with the action log and ratified by agreement of members at the following meeting.

8. Accountability and Reporting Arrangements

The Chair of the Committee shall report to the Board after each meeting and provide a report on assurances received, escalating any concerns where necessary.

The Committee will advise the Audit Committee of the adequacy of assurances available and contribute to the Annual Governance Statement.

9. Monitoring effectiveness and Compliance with Terms of Reference

The Committee will complete an annual review of its effectiveness and provide an annual report to the Board on its work in discharging its responsibilities, delivering its specific duties and complying with its terms of reference, specifically commenting on relevant aspects of the Board Assurance Framework and relevant regulatory frameworks.

10. Review of Terms of Reference

The Terms of Reference for the Committee will be reviewed annually by the Committee and submitted to the Trust board for approval.

The Committee will on an annual basis review and approve the terms of reference and work programmes of all of its reporting groups.

Approved:
Approved by:
Next Review Date:

United Lincolnshire Hospitals NHS Trust

Committee reporting group structure:

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	Trust Board
Date of Meeting	3rd August 2021
Item Number	*Item 9.2*
Equality, Diversity and Inclusion Annual Report, 2020-2021	
Accountable Director	Martin Rayson, Director of People & OD
Presented by	Tim Couchman, Equality, Diversity and Inclusion Lead
Author(s)	Tim Couchman, Equality, Diversity and Inclusion Lead
Report previously considered at	People & OD Committee (14/07/21) Quality Governance Committee (20/07/21)

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	
2a A modern and progressive workforce	*X*
2b Making ULHT the best place to work	*X*
2c Well Led Services	*X*
3a A modern, clean and fit for purpose environment	
3b Efficient use of resources	
3c Enhanced data and digital capability	
4a Establish new evidence based models of care	
4b Advancing professional practice with partners	
4c To become a university hospitals teaching trust	

Risk Assessment	4351
Financial Impact Assessment	n/a
Quality Impact Assessment	*n/a*
Equality Impact Assessment	The attached report details the Trust's performance in relation to its equality duties.
Assurance Level Assessment	*Insert assurance level* • *Moderate*

Recommendations/ Decision Required	• The Trust Board is requested to accept and approve the report for publication on the Trust's website (Equality, Diversity and Inclusion section) to ensure compliance with the Public Sector Equality Duty reporting requirements.

The publication of compliance with the Equality Act 2010, alongside the setting and publication of equality objectives, are specific duties of the Public Sector Equality Duty (PSED). The attached annual report details the Trust's compliance and performance in relation to these duties.

Although the Equality and Human Rights Commission suspended the specific duties of the PSED at the start of the COVID-19 pandemic and no reporting was required in relation to the financial year 2019-2020, the general duties remained throughout the pandemic. The general duties of the PSED are:

• **eliminate unlawful discrimination**, harassment and victimisation and any other conduct prohibited by the Act;
• **advance equality of opportunity** between people who share a protected characteristic and people who do not share it; and
• **foster good relations** between people who share a protected characteristic and people who do not share it.

The attached report details the Trust's compliance and performance in relation to its equality duties and the wider delivery of its important equality, diversity and inclusion work during the financial year 2020-2021. Further, although the Trust was not required to report on the 2019-2020 financial year, a highlight report of the significant progress made in relation to the work is attached as an appendix to this report.

United Lincolnshire Hospitals NHS Trust

Equality, Diversity and Inclusion

Annual Report, 2020-2021 (incl. highlights from 2019-2020)

OUTSTANDING CARE personally DELIVERED

Approval tbc

Opening statement regarding equality, diversity and inclusion reporting during the first year of the COVID-19 pandemic:

United Lincolnshire Hospitals NHS Trust, as a public sector body, is governed by the Equality Act 2010 and the Public Sector Equality Duty (section 149 of the Equality Act 2010) in relation to its equality duties. At the start of the COVID-19 pandemic, the Equality and Human Rights Commission, the regulatory body in England for equality, confirmed that due to the pandemic the specific reporting duties of the Public Sector Equality Duty would be suspended for the financial year 2020-2021.

It is important to note, however, that the general duties of the Public Sector Equality Duty remained in place throughout the pandemic, as the importance of paying due regard to the general duties throughout the pandemic was recognised. The general duties are:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

As the financial year 2021-2022 commenced, the specific duty reporting requirements were reinstated, and this annual report reflects this.

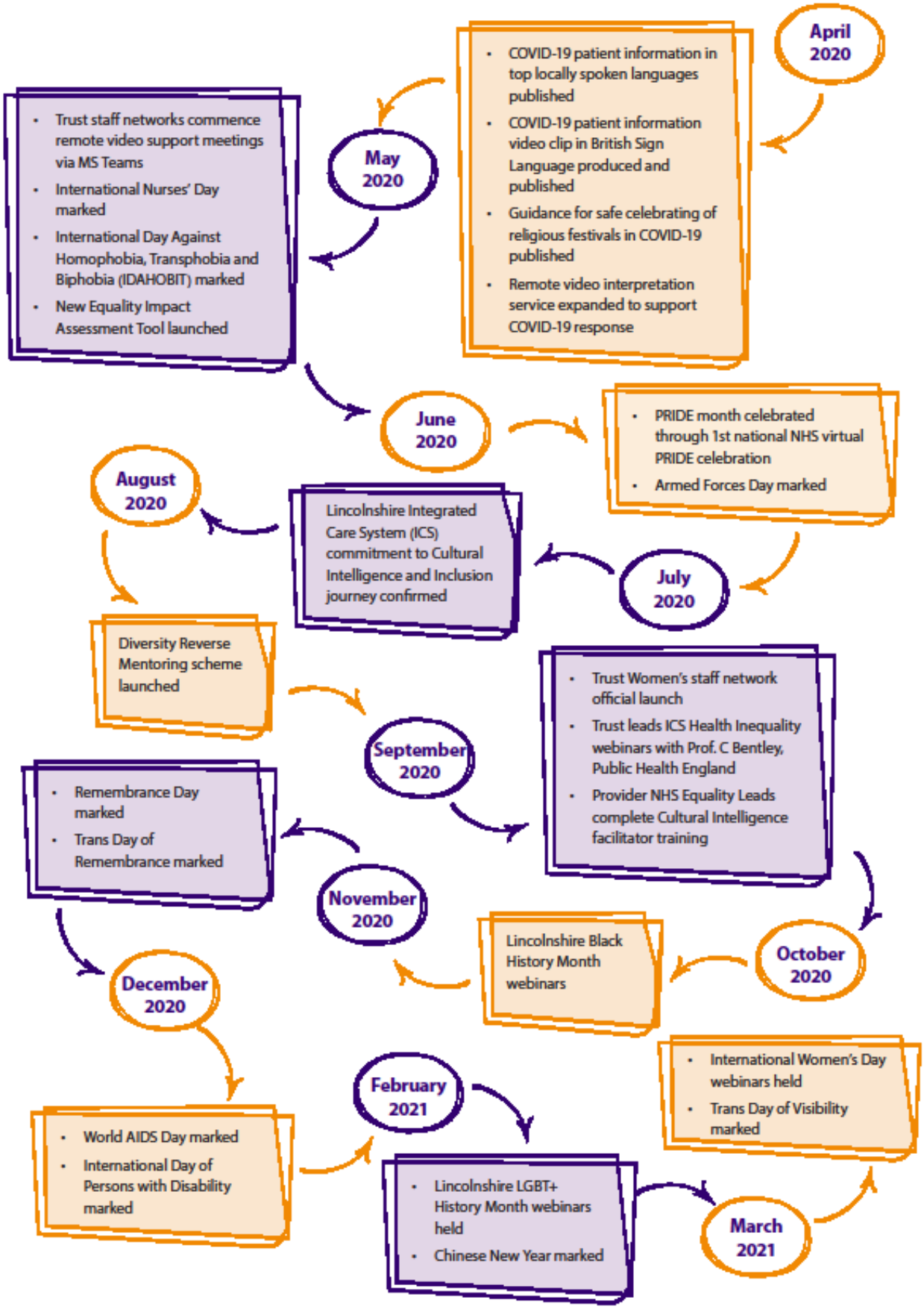
Although the Trust did not produce an equality, diversity and inclusion annual report for 2019-2020, we believe it is important that the great work undertaken in that year is not overlooked. To this end, we have included a highlight infographic of important milestones and achievements in the 2019-2020 financial year and this is included as appendix one at the end of this report.

Through the experience of the pandemic, the Trust, in partnership with its health and social care partners delivered a range of important workstreams at pace to ensure patients, service users and staff were actively support. These were predominantly grouped around the following areas and the work formalised from September 2020:

- Delivering the NHS COVID vaccination programme and continuing to meet the needs of patients with COVID-19.
- Building on what we have learned during the pandemic to transform the delivery of services, accelerate the restoration of elective and cancer care and manage the increasing demand on mental health services.
- Expanding primary care capacity to improve access, local health outcomes and address health inequalities.
- Transforming community and urgent and emergency care to prevent inappropriate attendance at emergency departments (ED), improve timely admission to hospital for ED patients and reduce length of stay.
- Supporting the health and wellbeing of staff and taking action on recruitment and retention.
- Working collaboratively across systems to deliver on these priorities.

As we move into 2021-2022 the Trust, and the key stakeholder in the Integrated Care System, will continue to prioritise and delivery these key national priorities, with a clear focus on ensuring the equality and health inequalities highlighted by the pandemic are addressed in a structured and robust manner.

Key equality milestones for patients, service users and staff in 2020-2021:



Summary of key equality milestones for patients, service users and staff in 2020-2021:

April 2020:
COVID-19 patient information in top locally spoken languages published
COVID-19 patient information video clip in British Sign Language produced and published
Guidance for safe celebrating of religious festivals in COVID-19 published
Remote video interpretation service expanded to support COVID-19 response

May 2020:
Trust staff networks commence remote video support meetings via MS Teams
International Nurses' Day marked
International Day Against Homophobia, Transphobia and Biphobia (IDAHOBIT) marked
New Equality Impact Assessment Tool launched

June 2020:
PRIDE month celebrated through 1st national NHS virtual PRIDE celebration
Armed Forces Day marked

July 2020:
Lincolnshire Integrated Care System (ICS) commitment to Cultural Intelligence and Inclusion journey confirmed

August 2020:
Diversity Reverse Mentoring scheme launched

September 2020:
Trust Women's staff network official launch
Trust leads ICS Health Inequality webinars with Prof. C Bentley, Public Health England
Provider NHS Equality Leads complete Cultural Intelligence facilitator training

October 2020:
Lincolnshire Black History Month webinars

November 2020:
Remembrance Day marked
Trans Day of Remembrance marked

December 2020:
Words AIDS Day marked
International Day of Persons with Disability marked

February 2021:
Lincolnshire LGBT+ History Month webinars held
Chinese New Year marked

March 2021:
International Women's Day webinars held
Trans Day of Visibility marked

Initial responses to the COVID-19 pandemic 2020 from an equality perspective:

The arrival of the COVID-19 pandemic in Lincolnshire in March 2020, required the NHS and other key stakeholders to respond quickly in order to care for and protect the local population, as the emerging impacts of the new virus became evident. Although responses to COVID-19 were fast moving and changing, the potential equality impacts started to become evident at an early juncture. Listed below, are some of the important equality related impacts identified and the actions the Trust and its partners took to protect and care for patients, service users and staff during these challenging times:

Issue identified:	**How we responded:**
Our patients and service users	
In the initial stages of the pandemic, the need for high quality information about COVID-19 in languages spoken in Lincolnshire.	We sourced high quality information from Doctors of the World (www.doctorsoftheworld.org.uk) and published on the Trust website (https://www.ulh.nhs.uk/news/important-information-about-the-coronavirus-covid-19/). This information was also shared with our NHS system partners. Please note this information is now archived as current information is accessed via hyperlink to the NHS Lincolnshire website.
In the initial stages of the pandemic, the need for high quality information about COVID-19 for people from the Deaf Community.	The Trust commissioned a video clip in British Sign Language (BSL) produced by Topp Language Solutions, our contracted provider of BSL interpretation services. The video clip was shared through our NHS and other healthcare partners and placed on our website (https://www.ulh.nhs.uk/news/important-information-about-the-coronavirus-covid-19/). Please note this information is now archived as current information is accessed via hyperlink to the NHS Lincolnshire website.
In the initial stages of the pandemic, the need for high quality information about COVID-19 in Easy Read.	The Trust sourced information about COVID-19 in Easy Read and published on our website (Information-about-Coronavirus-ER-SS2.pdf (ulh.nhs.uk). Please note this information is now archived as current information is accessed via hyperlink to the NHS Lincolnshire website.

After the initial stages of the pandemic, the NHS system in Lincolnshire identified the need for a system approach to sharing important COVID-19 information and resources, including information about the vaccination programme.	The Trust signposts to the NHS Lincolnshire website, via hyperlinks, on the Trust homepage: United Lincolnshire Hospitals NHS Trust (ulh.nhs.uk) and https://www.lincolnshire.nhs.uk/covid/COVID-19-Vaccination-Resources
The need for a more rapid Equality Impact Assessment tool identified, to support the responses to the COVID-19 pandemic and to ensure equality impacts are identified and responded to appropriately.	The Lincolnshire Provider NHS Trust Equality, Diversity and Inclusion Leads drafted, tested and implemented a new Rapid Equality Impact Assessment Tool and associated resources: Template_Rapid_Service_Change_Equality_I
Our staff	
Initial evidence indicated that people from Black, Asian and Minority Ethnic backgrounds are more vulnerable and at risk from COVID-19.	Trust Chief Executive wrote individual letters of support to all Black, Asian and Minority Ethnic staff members outlining the support available to all staff. Staff network meetings moved to online via MS Teams and meeting frequency was increased to support staff.
Further research highlighted a range of factors, incl. race, ethnicity, comorbidities, age, sex, pregnancy etc., which increased likelihood of poorer outcomes related to COVID-19.	Trust requested all staff complete an individual risk assessment and agree adjustments to working arrangements, where required, with their line managers and / or Occupational Health. From November 2020 the individual risk assessment was revised to include the research based COVID-age tool.
Local and national concerns regarding the availability of appropriate Personal Protective Equipment (PPE), particularly for frontline staff, raised in the media.	Trust provided reassurance to staff regarding the availability and stock levels of PPE via weekly updates in the Trust internal communications. Trust provided frontline staff with assurance that PPE was being utilised in line with Public Health England guidance.

	Trust required frontline staff to undertake PPE FIT testing. Staff networks offered as a forum for staff to raise and discuss concerns.
Need for diversity of thought in important decision making in the COVID-19 gold command structure.	Confirmed that COVID-19 gold command structure included senior staff members from a diverse range of backgrounds. Further, BAME staff network chair and vice-chair invited to attend COVID-19 gold command meetings.
COVID-19 vaccine roll-out to all eligible and vulnerable staff members.	From December 2020 COVID-19 vaccination programme for staff implemented in designated on-site vaccination hubs. By the end of March 2020 all vulnerable staff offered at least their first vaccine, with many staff also in receipt of the second vaccine. By 23rd May 2021, 98.1% of vulnerable / at risk staff had received their 1st dose of the vaccine and 92.9% of vulnerable / at risk staff had received their 2nd dose of the vaccine.
Our organisation	
The COVID-19 pandemic shone a bright light on the importance of addressing issues relating to equality and health inequalities and the resulting increased work schedule for the equality, diversity and inclusion function in the Trust.	The Trust committed resources to enable the employment of administration and practitioner roles within the equality, diversity and inclusion function of the organisation.

Delivery of our Equality Objectives 2020-2021:

The setting and delivery of equality objectives is one of the specific duties of the Public Sector Equality Duty (PSED). The Trust published a suite of equality objectives and these are embedded in 'Our Inclusion Strategy' (https://www.ulh.nhs.uk/about/equality-diversity/equality-objectives/).

Through the majority of 2019-2020 the Trust remained on target with the delivery of its equality objectives and significant progress has been made in all equality objectives identified. With reporting of PSED specific duty requirements being suspended in 2020-2021 and the primary focus of the Trust's worked being aligned to the response and management of the COVID-19 pandemic, the focus around equality objectives has been paused to ensure the more pressing areas of pandemic response received the appropriate attention.

During the pandemic responses throughout 2020-2021 attention to equality has been a 'golden thread'. As we enter 2021-2022, the Trust remains committed to delivery of its equality objectives in the current year, which is also the final year of 'Our Inclusion Strategy'. It is envisaged that 'Our Inclusion Strategy' will be refreshed and aligned to the Trust's Integrated Improvement Plan and new equality objectives will be identified and embedded within the new strategy.

INTRODUCTION

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

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

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

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

As outlined earlier, the financial year 2020-2021 has been a time in which the Trust has had a major focus on the COVID-19 pandemic. Nevertheless, during this challenging time it has been important to build on the significant progress made in relation to demonstrating the Trust's commitment to improving equality, diversity and inclusion for our patients and service users, our communities and our staff.

The Trust has developed a revised vision which truly places patients at the heart of what we do. It is to deliver “Outstanding Care, Personally Delivered”. Alongside this vision we have a set of values which are shown in the diagram below:

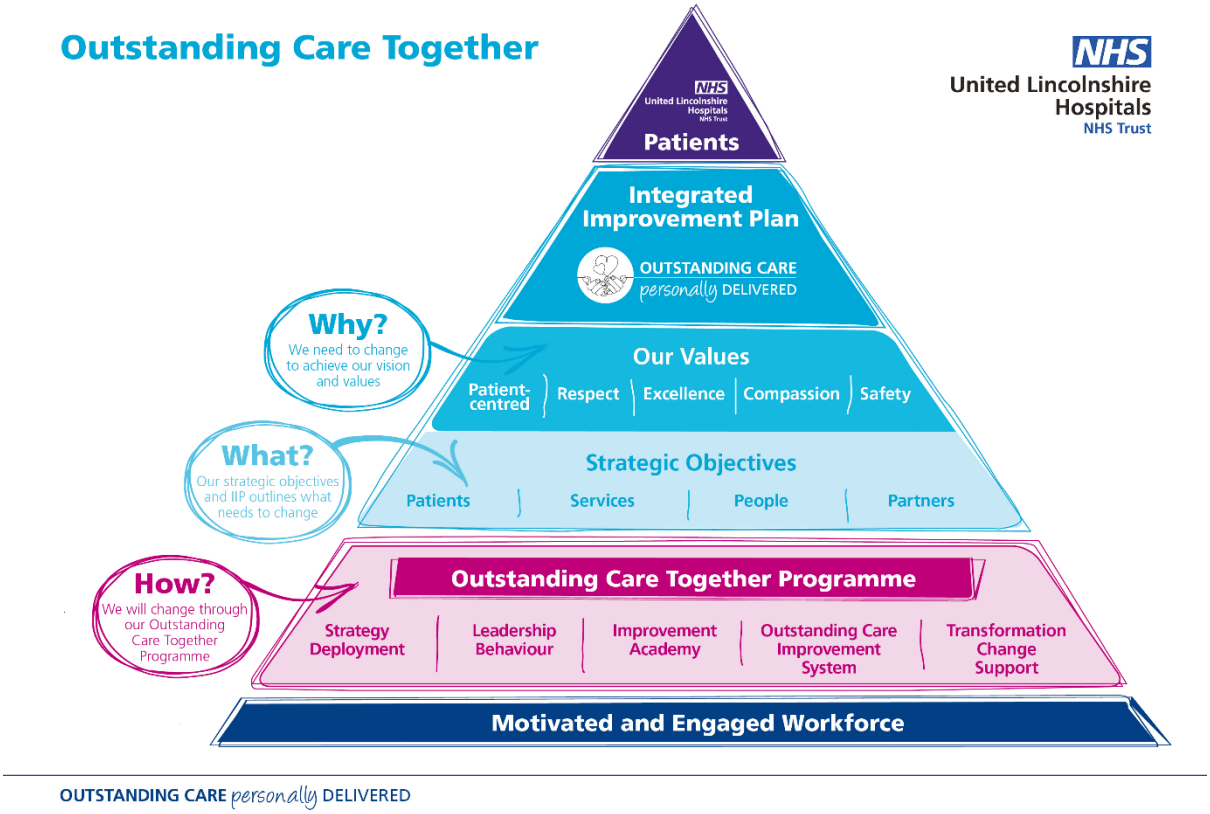
Equality, diversity and inclusion flows through all our values, but is particularly embodied within “respect”.

The Trust recognises that it needs to improve significantly if it is to achieve its vision and consistently deliver its values. It has defined what it wants to achieve in objectives for our Patients, People, Services and Partnerships, as follows:

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

These drive the equality, diversity and inclusion agenda at the Trust.

The way in which we will deliver our vision and values through our Outstanding Care Together Framework is shown in the diagram below:



The key delivery tools are the Integrated Improvement Plan and the Outstanding Care Together Programme. The latter provides a set of tools that we will use to deliver change. The focus of our change programme is set out in the integrated improvement plan. As 2021-2022 starts, commence the second year of the integrated improvement plan.

Within it are a four strategic initiatives, which are multi-year programmes focused on the key issues for the Trust. They include a culture and leadership programme, through which we will seek to tackle the issues in terms of workforce engagement and morale, including the identified issues around bullying, harassment and discrimination.

There are also a significant number of major projects. These are the priorities for each financial year. In the 2020/21 integrated improvement plan there was a project focused specifically on equality, diversity and inclusion called “deliver year three objectives of our Inclusion Strategy”. This demonstrates the commitment of the Trust to equality, diversity and inclusion as a core part of our improvement plan. The impact of COVID has meant that many projects have rolled forward into the 2021/22. The project has been re-scoped and is called “address the concerns around equity of treatment and opportunity within United Lincolnshire Hospitals NHS Trust”

The “people” elements of the Trust’s integrated improvement plan link closely into the National NHS People Plan and our Lincolnshire System People Plan. The diagram below summarises the priorities within the Lincolnshire System Plan. The commitment to openness and inclusivity is made within the section on “belonging”.

In 'Our Inclusion Strategy' we set out our strategic vision for all our work around the equality, diversity, inclusion and human rights agenda. A copy of our inclusion strategy can be located on the Trust's website: https://www.ulh.nhs.uk/about/equality-diversity/equality-objectives/.

As part of the Public Sector Equality Duty 2011, we have developed a suite of equality objectives for the duration of 'Our Inclusion Strategy'. Our equality objectives are grouped around; (i) our patients and service users, (ii) our local communities, (iii) our staff and (iv) our Trust. Some of our equality objectives are 'stand-alone' and will be delivered within a financial year, but many of our equality objectives are designed to grow and develop throughout the course of our inclusion strategy. We are confident that delivery of our inclusion strategy and the equality objectives will enable us as a Trust to realise our vision for equality, diversity and inclusion to be a 'golden thread' running through, and central to, how we work together to provide sustainable high quality patient-centred care for all people living in Lincolnshire. The detail of our vision for equality, diversity and inclusion can be located on the Trust's website: https://www.ulh.nhs.uk/about/equality-diversity/equality-diversity-inclusion-2021-vision/

As we enter 2021-2022 we are in the final year of our Inclusion Strategy and work will be completed to refresh and renew our Inclusion Strategy, develop new equality objectives and review our wider inclusion vision in line with the Trust's Integrated Improvement Plan.

In this annual report we highlight our inclusion related successes and challenges during 2020-2021, our performance in relation to our statutory, mandatory and regulatory requirements, and our commitment to continue the journey of improvement in relation to equality, diversity and inclusion for all patients, service users and staff in the future.

1. GOVERNANCE AND REGULATION OF EQUALITY, DIVERSITY AND INCLUSION (INCL. HUMAN RIGHTS) AT THE TRUST

The Trust has governance and regulatory frameworks and mechanisms in place to ensure that transparent assurance is provided in relation to the discharging of equality duties.

1.1 Equality, Diversity and Inclusion Operational Group and Equality, Diversity and Inclusion Engagement Network

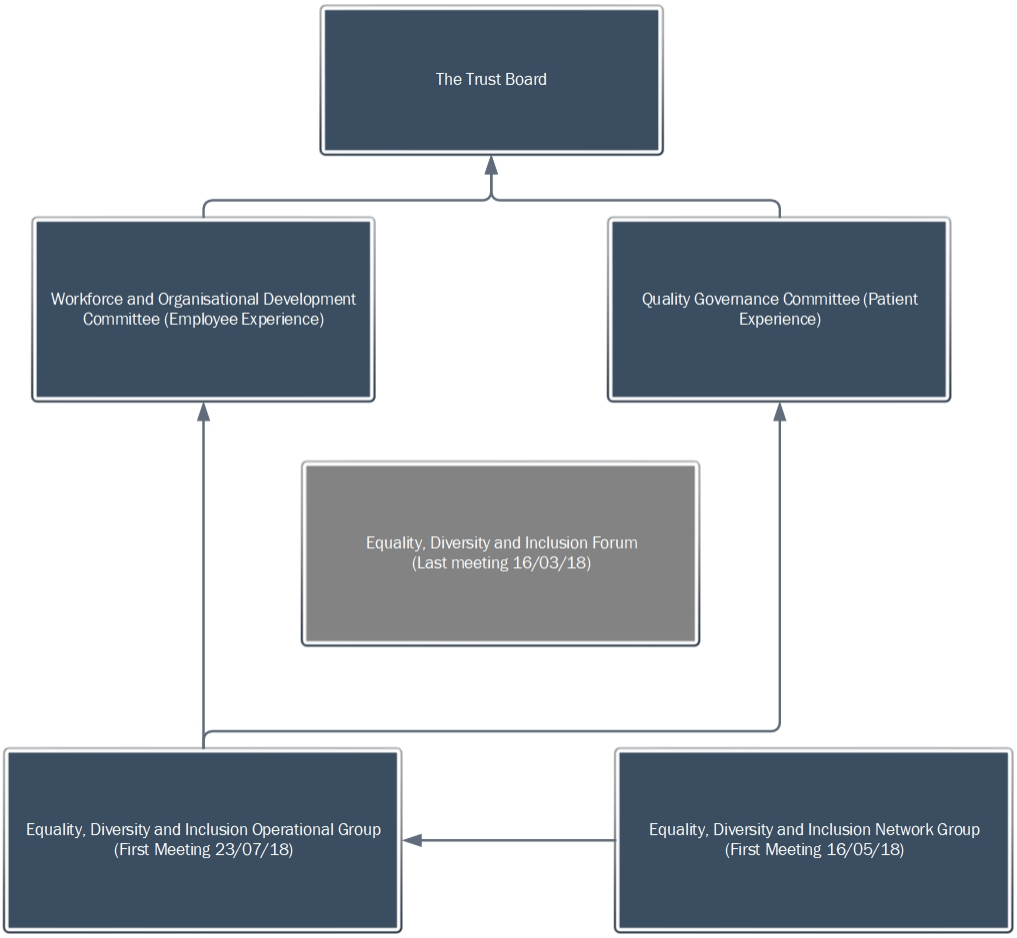
The Equality, Diversity and Inclusion Operational Group brings together key stakeholders in the Trust to ensure the equality, diversity and inclusion work is driven forward in a structured and coherent manner, in line with the Trust's integrated improvement plan. The Operational Group leads and drives the change required in relation to the inclusion agenda in active support of the Trust's Integrated Improvement Plan vision for 'outstanding care, personally delivered'.

Through the COVID-19 pandemic responses in 2020-2021 the group has paused physical meetings and as we enter 2021-2022 the Trust will review its meeting and governance arrangements for the important equality, diversity and inclusion work.

The Equality, Diversity and Inclusion Engagement Network focuses primarily on the engagement with patients, service users and staff across the inclusion agenda and reports into the Operational Group. Outwardly facing the Engagement Network has branded its activity under the banner of 'Hearing Lincolnshire's Hidden Voices'.

Through the COVID-19 pandemic responses in 2020-2021 the physical meetings of the engagement network were placed on hold. As we enter 2021-2022 the Trust is working with its Integrated Care System (ICS) partners to agree appropriate levels and methods of engagement with patient, service user, community and staff groups to ensure people's voices are heard and acted upon in a safe and appropriate manner.

As we move into 2021-2022, the current governance arrangements for equality, diversity and inclusion are shown in the infographic below. These arrangements will be reviewed in 2021-2022 to ensure they reflect the wider Trust and Integrated Care System governance arrangements.



1.2 Assurance reporting to the NHS Clinical Commissioning Group (CCG)

The Lincolnshire Clinical Commissioning Group was formed on 1 April 2020.

The Trust has continued to nurture and develop an excellent working relationship with the NHS Lincolnshire CCG. Through the COVID-19 pandemic response, the Lincolnshire CCG paused the assurance reporting requirements for the Trust, in line with the Equality and Human Rights Commission's suspending of PSED specific reporting duties.

The Trust looks forward to restarting the assurance reporting to the NHS Lincolnshire CCG in the 2021-2022 financial year.

1.3 Care Quality Commission (CQC)

The latest CQC inspection report was published in October 2019. Overall the Trust was rated as 'Requires Improvement'.

During the inspection the Trust's performance in relation to equality, diversity and inclusion was reviewed, by clinical division. In summary the positive comments received in relation to equality, diversity and inclusion focussed on:

- ✓ Services promoting equality and diversity in their daily work.
- ✓ Leaders and staff actively engaging with equality groups.

- ✓ Services demonstrating an open culture.
- ✓ Services being inclusive and taking account of patients' individual needs and preferences.
- ✓ Services making reasonable adjustments.

In summary the negative comments received in relation to equality, diversity and inclusion focussed on:

- The trust should ensure the causes of workforce inequality are sufficiently addressed to ensure staff from a Black, Asian and minority ethnic background are supported through their career development.
- Some services were not fully inclusive and not taking into account the patients' individual needs.

The full CQC report can be accessed via a hyperlink in the bottom right hand corner of the Trust website homepage: https://www.ulh.nhs.uk/

Issues identified by the CQC in relation to clinical services are being addressed through the clinical divisional management teams. The issue relating to the workforce inequalities identified, particularly for staff members from Black, Asian and Minority Ethnic backgrounds being supported through their career development, is being addressed through the Trust's Talent Management Strategy and wider race equality work and is supported by engagement with our staff networks.

It is encouraging that the CQC inspectors were able to see evidence of the progress the Trust is making in relation to the equality, diversity and inclusion work. The need to continue on this journey of improvement is acknowledged by the Trust and the next stages of our work are focussed around evidencing meaningful engagement and ensuring the equality work is mainstreamed throughout the organisation.

2. STATUTORY DUTIES – EQUALITY ACT 2010 AND PUBLIC SECTOR EQUALITY DUTY (PSED)

When the Equality Act 2010 came into statute, it brought together and harmonised all previous equalities legislation. The Equality Act 2010 is the primary piece of legislation around equalities. The Public Sector Equality Duty (PSED) forms part of the Equality Act 2010 (section 149) and is applicable to NHS, and other public sector bodies. The PSED came into force in 2011.

The Trust is fully committed to caring for all patients, service users, their families and carers, and staff in a manner which embraces, respects, promotes and celebrates inclusion and cultural diversity.

The Equality Act 2010 requires specific provision is made to consider the impact of services and activity for people who identify with one or more of the nine protected characteristics, and for public sector bodies to take proactive steps to:

- Eliminate unlawful discrimination, harassment and victimisation and any other conduct prohibited by the Act
- Advance equality of opportunity between people who share a protected characteristic and people who do not share it and
- Foster good relations between people who share a protected characteristic and people who do not share it

These are referred to as the three aims of the General Equality Duty.

The protected characteristics and other groups at risk of health inequality

The Equality Act 2010 brought together previous gender, race and disability duties and extended the protection from discrimination to nine protected characteristics.

Over and above the nine equality groups protected from discrimination under the Equality Act 2010, we also have a duty of care to all our service users and staff, who may be vulnerable to potential risk of experiencing health inequality.

One area highlighted through the experience of the COVID-19 pandemic is the intersectionality in relation to the protected characteristics and other areas of potential health inequality. In essence, intersectionality acknowledges that no one human being is defined by only one protected characteristic, but that we are all defined by a range of characteristics and other factors, which together might place the individual at an increased risk of discrimination and a poorer health outcome. So for example, an older person living with a number of disabilities, living in a situation of social isolation and deprivation is potentially at higher risk of discrimination and poorer health outcomes, than, for example, a younger non-disabled person living in a socially connected and more affluent situation.

Protected characteristic groups	Other people groups at potential risk of health inequality
Age	Carer responsibilities
Disability	Military service
Gender reassignment	Homelessness
Marriage and civil partnership	Poverty / deprivation
Pregnancy and maternity	Geographical / rural isolation
Race	Long-term unemployment
Religion or belief	Stigmatised occupations (for example men and women involved in prostitution)
Sex	Drug / alcohol use
Sexual orientation	Limited family or social network

The Trust has a duty to engage with the communities it serves and to work with partner organisations to understand, mitigate and remove any potential discrimination and demonstrate its commitment to addressing and removing health inequalities, as articulated in the Health and Social Care Act 2012.

The experience of COVID-19 has highlighted again the importance of ensuring equality is delivered and health inequalities are addressed.

In September 2020 the Trust's Equality, Diversity and Inclusion Lead, together with the Equality, Diversity and Inclusion Leads from the other NHS Provider Trusts, launched Lincolnshire Integrated Care System seminars with Professor Chris Bentley from Public Health England, to look at a Place Based Approach to addressing health inequalities in Lincolnshire. This work was unfortunately paused to the second wave of COVID-19.

In early 2021 the Lincolnshire Integrated Care System appointed a system lead for health inequalities and a system board was established. The Director of People and Organisational Development at United Lincolnshire Hospitals NHS Trust represents the organisation on this board and a programme of work is in the early stages of development. The Trust looks forward working with key stakeholders to address health inequalities under the leadership and direction of the Lincolnshire Integrated Care System Health Inequalities Board.

2.1 Publication of an equality, diversity and inclusion annual report

As part of the public sector equality duty the Trust publishes this annual report in relation to equality, diversity and inclusion. The equality, diversity and inclusion annual report includes a wide range of information, including some higher level patient / population data (appendix two), workforce equality monitoring data (appendix three) and Trust volunteer equality monitoring data (appendix four).

Although the Trust records equality monitoring data for patients and service users for most of the protected characteristics of the Equality Act 2010, the data is currently not in a format which would be appropriate or meaningful for publication. However, in 2020-2021 the Trust commenced work on establishing an equality dashboard for patient and service user equality monitoring data, which will enable our clinical divisions and directorates to review their service delivery in an intelligent manner and ensure our local population groups are accessing clinical services. A regular review of this data, will also enable clinical divisions and directorates to identify population groups which might not be accessing services as we would expect and ensure measures are taken to ensure potential health inequalities are addressed. Further, the equality dashboard will also assist clinical divisions and directorates in the planning of future service delivery. At the end of 2020-2021 the first draft of the dashboard was completed, with testing planned for early 2021-2022. Once tested and finalised the equality dashboard will be rolled out across all clinical divisions and directorates.

In early 2021-2022 work will commence on a workforce equality dashboard for clinical divisions and directorates, as well as all other corporate directorates in the Trust. The workforce equality dashboard will enable Trust divisions and directorates to review the equality monitoring information of their staff and ensure they are able to develop a fair and representative workforce.

Once approved by the Trust Board the annual report is published on the Trust's website (https://www.ulh.nhs.uk/about/equality-diversity/equality-diversity-and-inclusion-annual-report/)

2.2 Publication of an Inclusion Strategy, including equality objectives

In 2017-2018 the equality, diversity and inclusion forum led on the production of 'our inclusion strategy'. A range of stakeholders, including patient and service user groups and staff groups, were given the opportunity to contribute to the strategy.

Setting and delivering equality objectives is a further statutory requirement on the Trust as a public sector organisation. Equality objectives for the duration of our inclusion strategy are contained within the document.

Our inclusion strategy was published at the beginning of July 2018 and is available on the Trust's website (https://www.ulh.nhs.uk/about/equality-diversity/equality-objectives/)

The Trust is in the final year of 'Our Inclusion Strategy' and the strategy will be refreshed and aligned to the Trust's Integrated Improvement Plan in the current year.

2.3 Equality Analysis

Equality analysis is the mechanism through which the Trust is able to demonstrate 'due regard' to the Equality Act 2010 and the meeting of its equality duties in relation to all Trust business and activity. Equality analysis ensures that all protected characteristics and other groups at potential risk of health inequality are proactively considered in the Trust's services and business.

The Trust has a system of equality analysis in place and from 2017-2018 significant papers and documents going to the Trust Board should be supported by an equality analysis, through which the potential equality related impacts are identified, mitigated and removed.

During 2019-2020 the Equality, Diversity and Inclusion Leads for the three Lincolnshire Provider NHS organisations commenced work on a potential unified equality analysis / equality impact assessment tool for the NHS Provider organisations in the county.

With the arrival of the pandemic, the need for a more rapid Equality Impact Assessment tool was identified, to support the responses to the COVID-19 pandemic and to ensure equality impacts are identified and responded to appropriately. The Lincolnshire Provider NHS Trust Equality, Diversity and Inclusion Leads drafted, tested and implemented a new Rapid Equality Impact Assessment Tool and associated resources.

As the feedback from staff using the new equality impact assessment tool in all three Trusts was thoroughly positive, towards the end of 2020-2021, the three Equality, Diversity and Inclusion Leads further developed the tool to include health inequalities and had started the process of adopting a new Equality and Health Inequalities Impact Assessment Tool in their respective organisations. Approval for this new impact assessment tool is expected in early 2021-2022.

2.4 Gender Pay Gap Reporting

From March 2018 a new statutory requirement in relation to gender pay gap reporting was introduced. Although Gender Pay Gap reporting was suspended due to the pandemic, the Trust had already posted its gender pay gap data and report in March 2020, both on the government and Trust websites. Although Gender Pay Gap reporting will be reinstated for 2021-2022 the submission deadline has been pushed back to early October 2021. The Trust will ensure its Gender Pay Gap reporting is completed and submitted in a timely manner.

The Trust publishes information about the gender pay gap, which can be found on the government website at United Lincolnshire Hospitals Nhs Trust gender pay gap data for 2019-20 reporting year - GOV.UK - GOV.UK (gender-pay-gap.service.gov.uk)

The associated report and proposed actions can be located on the Trust's website at https://www.ulh.nhs.uk/about/equality-diversity/gender-pay-gap-reporting/

2.5 Staff Equality Networks

The general duties of the Equality Act 2010 are to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct that is prohibited by the Act.
- Advance equality of opportunity between people who share a characteristic and those who don't
- Foster good relations between people who share a characteristic and those who don't

It is recognised that staff equality networks are an excellent mechanism through which the general duties of the Act can be supported in relation to staff from the protected groups and other groups at potential risk of inequality.

The Trust is extremely proud of its five staff networks. In 2019-2020 significant progress was made in the establishment of the Mental and Physical Lived Experience (MAPLE) and Women's

staff networks. Although the experience of the COVID-19 pandemic has been a significant challenge to all working in the NHS, our staff networks have risen to the challenges in relation to the cessation of face-to-face meetings and actively embraced the MS Teams virtual meeting platform and effectively utilised the online platform as an important way to connect and support one another.

In spite of the pandemic both the MAPLE and Women's networks were officially launched in 2020-2021.

The Trust currently has five established staff networks:

- LGBT+ (Lesbian, gay, bisexual and transgender) staff network, with Paul Matthew, Director of Finance and Digital, as the executive sponsor.
- Black, Asian and Minority Ethnic staff network, with Mark Brassington, Deputy Chief Executive, as the executive sponsor.
- Armed Forces Staff Network, with Dr Neill Hepburn, Medical Director, as the executive sponsor.
- Mental and Physical Lived Experience (MAPLE) staff network, with Martin Rayson, Director of People and Organisational Development, as the executive sponsor.
- Women's staff network, with Dr Karen Dunderdale, Director of Nursing, as the executive sponsor.

Through the pandemic the importance of staff networks has been formally recognised at a national level and articulated in the NHS People Plan. The Trust has further strengthened its commitment to our staff networks, to ensure the voices of our staff network are further amplified and acted upon. For example, as 2020-2021 drew to a close, the Trust Executive Team were consulting on a fair and equitable remuneration for staff network chairs and vice-chairs. Further, in 2020-2021 the Trust Board strengthened its engagement with the staff networks. Both these initiatives will be formalised early in 2021-2022. Alongside this, during 2021-2022 the Trust will further engage with our workforce to ascertain whether any further staff networks are required to support staff from other protected groups and / or groups requiring further support to ensure their voices are heard and acted upon.

Due to the pandemic staff network-led events like Lincoln PRIDE, Black History Month, LGBT+ History Month and International Women's Day celebrations were not possible in the usual face-to-face / day conference formats. However, starting with the LGBT+ staff network's participation in the national NHS LGBT+ Teams virtual PRIDE celebration in June 2020, the Lincolnshire Equality, Diversity and Inclusion Leads and members of the staff networks, rose to the challenge of hosting online webinars to celebrate these important events. Not only did the online webinar model enable us to attract a range of national, regional and local speakers in a very cost efficient manner, they also evaluated extremely well and enabled us to increase our reach of delegates when compared to face-to-face events of previous years.

The Trust is immensely proud of our staff networks and is committed to support their work and further development in the future.

3. MANDATORY DUTIES - NHS STANDARD CONTRACT

3.1 Implementation of the NHS Equality Delivery System (EDS)

The NHS Equality Delivery System (currently EDS 2) is an integrated improvement tool to support NHS organisations develop and evidence a structured approach to equality improvement. NHS organisations are required to use the EDS and compliance with this is mandated in the NHS Standard Contract.

Since 2018 NHS England has been revising the EDS. The Equality, Diversity and Inclusion Leads from across Lincolnshire have been active participants in the EDS, version 3 engagement. The EDS, version 3, will be a much more streamlined, user friendly and focussed framework.

In early 2020 the Equality, Diversity and Inclusion Leads were asked by NHS England to join the pilot of the EDS, version 3, and to work on the new EDS as a Lincolnshire system. Work on this was commencing just as the COVID-19 pandemic arrived. The EDS, version 3, is currently being finalised and we look forward to picking this work up as a system very soon. In the present time, in order to really be able to produce an effective EDS version 3 system wide strategy and plan, which is looking likely to be published in the late summer 2021, by which time half of the year will have elapsed, the proposal is that for 2020/2021 the 3 provider Trusts will not undertake an EDS and use the time to really focus on a robust system wide approach to the new EDS due and there will then be consistency and a system / ICS focus to the new EDS.

As the financial year 2020-2021 drew to a close, the Equality, Diversity and Inclusion Leads from the three NHS Provider Trusts in Lincolnshire were actively working on the new EDS, version 3, pilot, and the current EDS2 will not be refreshed. It is envisaged that the three Trusts will be able to publish their EDS, version 3 data in 2021-2022.

In May 2019 the Trust completed a full review of its EDS2 work and the full EDS2 report can be located on the Trust's website: https://www.ulh.nhs.uk/about/equality-diversity/nhs-equality-delivery-system-eds2/.

3.2 Implementation of the NHS Workforce Race Equality Standard (WRES)

The WRES is designed to help NHS organisations understand and actively address differences in the experience between Black, Asian and Minority Ethnic (BAME) and white staff. The WRES comprises nine indicators; indicators 1 – 4 are taken from the Trust's HR data systems; indicators 5 – 8 are taken from the national NHS Staff Survey and indicator 9 appertains to the Trust's senior leadership. The WRES provides a robust reporting framework and supports NHS organisations to address and close any gaps through the development and implementation of action plans for improvement.

The WRES was implemented in 2015 and since 2017, through the establishment of the BAME Staff Equality Network, the voices of BAME members of staff have been heard and acted upon in relation to the Trust's commitment to improving race equality. This has been an exciting development and we look forward to building on this important work as we move forward with integrating the staff equality networks in a meaningful manner.

Information about the Trust's WRES work can be located on the Trust website: https://www.ulh.nhs.uk/about/equality-diversity/nhs-workforce-race-equality-standard-wres/

As already noted in this annual report, when the pandemic started, the Equality and Human Rights commission suspended all equality reporting duties for the financial year 2020-2021, this included WRES and WDES reporting. As the disproportionate impact of COVID-19 on people from a range of equality and health inequality groups became evident, the NHS in England reinstated the requirement for WRES and WDES reporting for 2020-2021. The Trust completed and submitted its WRES and WDES to NHS England in a timely manner.

The WRES report covering the period 2019-2020 can be located on the Trust website via the link above. Some highlight points from the report are:

Indicator 1: The percentage of Black, Asian and Minority Ethnic staff employed by the Trust increased to 12.10% (from 11.56% in the previous year). This is significantly higher than the percentage of Black, Asian and Minority Ethnic people who reside in Lincolnshire.

Indicator 2: The gap in the relative likelihood of Black, Asian and Minority Ethnic people being appointed from shortlisting continued to close and was reported at 1.08 (down from 1.15 in the previous year).

Indicator 3: The gap in the relative likelihood of Black, Asian and Minority Ethnic staff entering the formal disciplinary process remained at around the same level and was reported at 1.26 (up very slightly from 1.25 in the previous year).

Indicator 4: The gap in the relative likelihood of Black, Asian and Minority Ethnic staff accessing non-mandatory training and continuing professional development remained the same at 1.27.

Indicator 5: Although the percentages of both Black, Asian and Minority Ethnic and white staff reporting experience of harassment, bullying or abuse from patients, relatives of the public in the last 12 months improved slightly, with both percentages being slightly over 29%. However, they remain unacceptably high and the Trust needs to address this as a matter of urgency and some of the specific actions taken are highlighted below.

Indicator 6: The percentage of Black, Asian and Minority Ethnic staff reporting experience of harassment, bullying or abuse from staff in the last 12 months increased to 37.90%. This is 7% higher than the reported experience of white staff and both figures are of concern and the Trust needs to address this as a matter of urgency and in a structured and robust manner.

Indicator 7: The percentage of Black Asian and Minority Ethnic staff believing that the Trust provides equal opportunities for career progression or promotion reduced to 69.30% (from 72.30% in the previous year). This is a lower percentage when compared to white staff at 84.10%. This matter has been highlighted by the CQC and the Trust is developing robust actions to ensure barriers in relation to career progression are removed and staff from Black, Asian and Minority Ethnic backgrounds are able to confidently report a more equitable experience.

Indicator 8: The percentage of Black, Asian and Minority Ethnic staff who reported a personal experience of discrimination at work from a manager, team leader or other colleague increased to 19.70% (from 19.10% the previous year). This is of concern to the Trust and significantly

poorer experience than that reported for white staff at 6.80%. The Trust must develop robust plans to ensure discrimination at work is addressed.

Indicator 9: The percentage of Board members by ethnicity compared to the Black, Asian and Minority Ethnic workforce remained the same as in the previous year, with all Board members identifying as white. It is recommended that the Board reviews this issue and develops plans to redress this imbalance.

Whilst the WRES data evidences improvements in some areas, there are, unfortunately, other areas where the data is deteriorating.

As a direct result of the initial impact of COVID-19, the Trust's Black Asian and Minority Ethnic staff network developed a detailed action plan, based around the five pillars of the NHS COVID-19 recovery plan:

- Protection and safety
- Engagement
- Media and communication
- Decision making
- Recovery and redesign

A number of the actions delivered have been highlighted earlier in this annual report in the section addressing the Trust's initial response to the COVID-19 pandemic.

During 2020-2021 the Trust also embarked on a number of important strategic initiatives which should have a direct impact on improving the experience of Black, Asian and Minority Ethnic staff and lead to an improvement in the WRES data. In outline these initiatives are:

- Start of the Cultural Intelligence and Inclusion journey as a Lincolnshire Integrated Care System (supporting improvement in indicators 5, 6, 7 and 8).
- Start of the Cultural Leadership programme in the Trust (supporting improvement in indicators 5, 6, 7 and 8).
- Including the WRES, Model Employer and Race Disparity Ratio in the Trust's Talent Management Strategy (supporting indicators 1, 4 and 9).
- Overhaul of Trust recruitment processes (supporting indicators 2 and 7).
- Review of the Trust's Disciplinary policies (supporting indicator 3).
- Review of the Trust's work to address the issues of bullying and harassment at work (supporting indicators 5, 6 and 8).

As these important initiatives continue in 2021-2022, they will all directly influence and inform improvements in the experience of Black, Asian and Minority Ethnic colleagues and will be included in an integrated WRES action plan. Further, the Trust is preparing to implement the new Medical WRES in 2021-2022 and it is expected that NHS England with include the Medical WRES in the NHS Standard Contract.

3.3 Implementation of the NHS England Workforce Disability Equality Standard (WDES)

In 2019 NHS England launched the WDES. Similar to the WRES, the WDES comprises of a set of metrics against which NHS Trusts must report and following analysis of the local data, and in partnership with staff members, develop actions for improvement.

The Trust reports on the WDES annually and posts the WDES reports on its website at: https://www.ulh.nhs.uk/about/equality-diversity/nhs-workforce-disability-equality-standard-wdes/

Similar to the WRES, although reporting of the WDES was initially suspended when the pandemic started, reporting was reinstated by NHS England and the Trust completed and submitted its WDES report in a timely manner. The Trust identified six primary actions for improvement in relation to the WDES and progress was made in relation to each of the actions.

1) Undertake further meaningful steps to improve staff self-disclosure rates around disability.
2) Support the emerging MAPLE staff network and enable MS Teams meetings of the group to recommence from August 2020, until face-to-face meetings can be re-established.
3) Include members of the MAPLE network in the first cohort of Reverse Mentoring, to start with members of the Trust Board in September 2020.
4) Integrate the learning and key actions from the COVID-19 experience into action planning, grouped around the themes of 1) Safety and Protection; 2) Decision Making; 3) Engagement; 4) Media and Communications and 5) Redesign.
5) The WDES action plan will be developed with the support of the emerging MAPLE staff network and will be delivered and monitored within the Trust's Integrated Improvement Plan (Talent Management section).
6) Further develop the network of Freedom to Speak Up champions to embrace members of the MAPLE staff network.

The most significant action in 2020-2021 has been the formal establishment of the Mental and Physical Lived Experience (MAPLE) staff network and the appointment of a network chair, vice-chair and executive sponsor. The Trust looks forward to the MAPLE staff network developing its own plan of work in 2021-2022.

3.4 Implementation of the NHS Accessible Information Standard (AIS)

The AIS came into force for all NHS organisations in July 2016.

The NHS Provider organisations in Lincolnshire have a contract in place to ensure British Sign Language, and other sensory impairment translation services, are available to support patients and services access care services provided by the NHS. When the pandemic started in 2020, Topp Language Solutions, the contracted provider, supported the Trust and our patients and service users, by introducing a remote video platform, through which interpretation services could be delivered.

The Trust continued to make progress in relation to the full implementation of the AIS in 2019-2020, with the introduction of the option for patients and service users to utilise SMART technology assisted methods of communication. In 2020-2021 the Trust invested further into remote video services as an option to support patients and service users in accessing some of their care services.

As we enter 2021-2022, we look forward to continued integration of the AIS in the Trust's IT systems to support patients and service users in accessing care services appropriate to their communication requirements.

3.5 Provision of a system for delivery of interpretation and translation services

Further to point 4.4, alongside interpretation and translation services for people living with sensory impairment, the Lincolnshire-wide approach to interpretation and translation services makes provision for those accessing our NHS services who require foreign language support. This part of the contract is provided by DA Languages.

Through the contracted provider, the Trust is able to offer interpretation and translation services in the following formats:

- Face-to-face interpretation and translation (paused for safety reasons during the pandemic)
- Telephone interpretation and translation
- Remote video interpretation and translation (expanded in response to the pandemic)
- Written

To protect our patients, service users, staff and interpreters, the Trust ceased face-to-face interpretation and translation services due to the pandemic. To compensate for this, the Trust worked with the contracted providers and expanded the use of remote video interpretation and translation services. As the 2020-2021 drew to a close, the Trust started to introduce processes, in line with other clinical services and in partnership with our Infection Prevention and Control Team, to start safely re-introducing a face-to-face interpretation and translation service, where clinical necessity required. The safe re-introduction of face-to-face interpretation and translation services will continue into 2021-2022 and will be directed by national guidelines and Trust policy.

In 2020-2021 the Trust continued to deliver healthcare services to the culturally diverse population of Lincolnshire. In 2020-2021 the primary languages into which communication was interpreted and translated were:

- Polish
- Lithuanian
- Russian
- Romanian
- Bulgarian
- Latvian
- Portuguese
- Bengali
- Cantonese

As well as a wide range of other international languages.
The fulfilment rates for services provided by DA Languages for 2020-2021 are listed in the table below:

Booking Type	Fulfilment %
Face-to-face Interpreting	91.35%
Telephone Interpreting	99.70%
Written Translation	100.00%
Video Remote Interpreting	100.00%

Although the fulfilment rate for face-to-face interpreting is slightly lower than expected, this needs to be understood in the context that through the majority of the pandemic response all but non-essential face-to-face interpreting was ceased and therefore the actual numbers of interpreting episodes are very low. The fulfilment rates for all the other interpretation and translation methods is above the contractual fulfilment rates.

Topp Language Solutions performed over and above their contractual obligations in relation to British Sign Language interpretation services provided for the Trust with a 98.98% fulfilment rate achieved.

3.6 Inclusion of equality monitoring in Trust internal incident reporting

The Trust has a system in place whereby complaints and PALS incidents can be reviewed to establish whether there are trends, from an equality perspective, which need to be addressed.

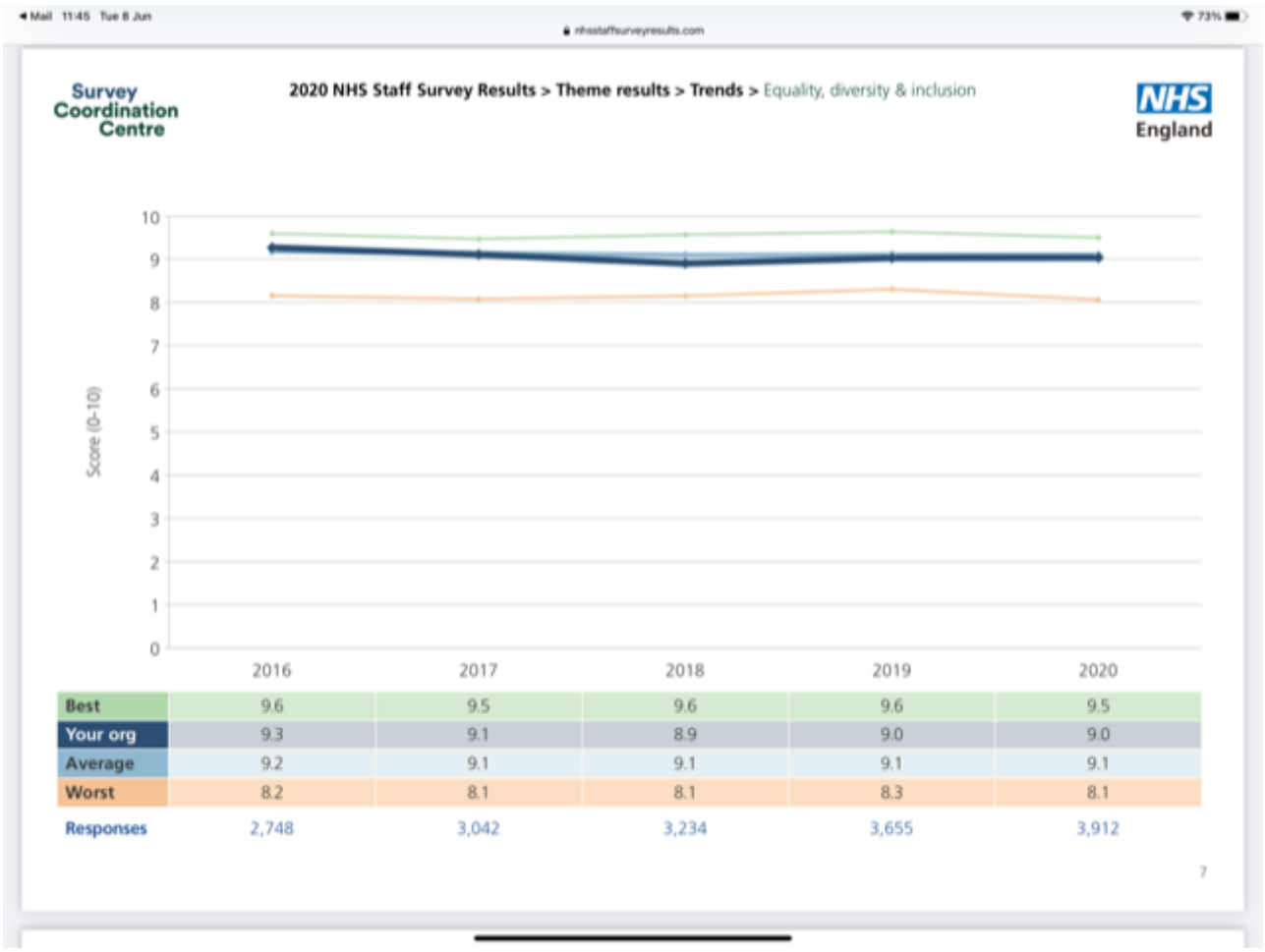
In July 2019 the Trust expanded its internal incident reporting system to include the option for the person reporting to declare whether a particular incident is believed to be equality related. This is for both patient and service user and staff related incidents. Where this has been recorded, a member of the Equality, Diversity and Inclusion Team is able to support the staff member who is investigating the incident. Further, the Equality, Diversity and Inclusion Team is able to pull higher level reports to ascertain whether there are any trends emerging which require further investigation and support at a divisional, clinical business unit or corporate directorate level.

In 2021-2022 this data will be included in the new Equality, Diversity and Inclusion dashboards for our divisional and corporate structures and enable them to deal with reported issues and trends in structured manner.

4. THE NHS STAFF SURVEY 2020

In 2020 the Trust provided all staff members with the opportunity to participate in the nationally led annual NHS Staff Survey. With a response rate of 51.3% (equates to 4039 completed surveys), we are encouraged to note a continued increase in the number of staff completing the staff survey (up from 33% in 2015, to 39% in 2016, to 45% in 2017, to 46% in 2018; to 50% in 2019). This means we have an increasing quality of feedback from our staff in relation to their experience of being employed by the Trust.

A review of the higher level data appertaining to the equality, diversity and inclusion metrics, indicates that the Trust has retained a score of 9.0 on a scale of 1-10. This score is 0.1 point below the national average and demonstrates no significant change. The infographic below illustrates this:



The overall theme of equality, diversity and inclusion in the NHS Staff Survey comprises of the ratings our staff provided in the four areas of experience of:

- Career progression and promotion.
- Discrimination from patients, service users or the public.
- Discrimination from managers, team leaders or colleagues.
- Adequate adjustments being made to support the employee undertake their role.

The equality and diversity theme of the national staff survey, needs to be understood in the context of a sadly deteriorated set of staff survey results in 2020.

As we enter 2021-2022, each of the questions and feedback will be analysed in more detail, shared with the relevant staff networks for consideration and further action for improvement identified and undertaken. This engagement will actively inform the actions each of our networks choose to focus on in their plans of work, as well as inform the higher level plans of action the Trust needs to deliver in the coming year. Further, the Trust has already committed to the commencement of the Cultural Intelligence and Inclusion journey with other stakeholders in the Lincolnshire Integrated Care System in 2021, as well as the commencement of the NHS Leadership Academy Cultural and Leadership programme in the Trust.

5. OUR EQUALITY OBJECTIVES FOR 2021-2022

The setting, monitoring and delivery of equality objectives form part of our Public Sector Equality Duty. Our equality objectives are contained within 'Our Inclusion Strategy' and as we enter 2021-2022, we are in the final year of the strategy. Our Inclusion Strategy and Equality Objectives are published on our website: https://www.ulh.nhs.uk/about/equality-diversity/equality-objectives/. In 2021-2022 we will refresh Our Inclusion Strategy to reflect the Trust's Integrated Improvement Plan and develop a new set of equality objectives. These will be developed in partnership with key stakeholder, consulted on and published ready for implementation at the beginning of April 2022.

In 2021-2022 we will aim to complete delivery of all our current equality objectives, as articulated in Our Inclusion Strategy. This will also include completing the equality objectives from the previous year, which were paused due to the pandemic.

Progress and assurance in relation to the delivery of our equality objectives will be provided to the Trust Board, through the mechanism of our committee structure. Further assurance of delivery of our equality objectives will be provided to the Lincolnshire Clinical Commissioning Group as an integral part of our regular assurance reporting.

6. CONCLUSION

2020-2021 has been a particularly challenging year for the United Lincolnshire Hospitals NHS Trust and the wider NHS, as we have actively responded to the challenges of the COVID-19 pandemic. However, through this the Trust has sought to not only remain resolutely focussed on its equality duties, but also to continue to develop and deliver it important equality, diversity and inclusion work.

The future direction of the Trust has been eloquently articulated in the Integrated Improvement Plan, published in 2020-2021, and equality, diversity and inclusion are at the heart of this plan.

Of all the many achievements in 2020-2021, the primary highlights of the year have been:

- Significant equality, diversity and inclusion focused response to the COVID-19 pandemic for patients, service users, our communities and our staff.

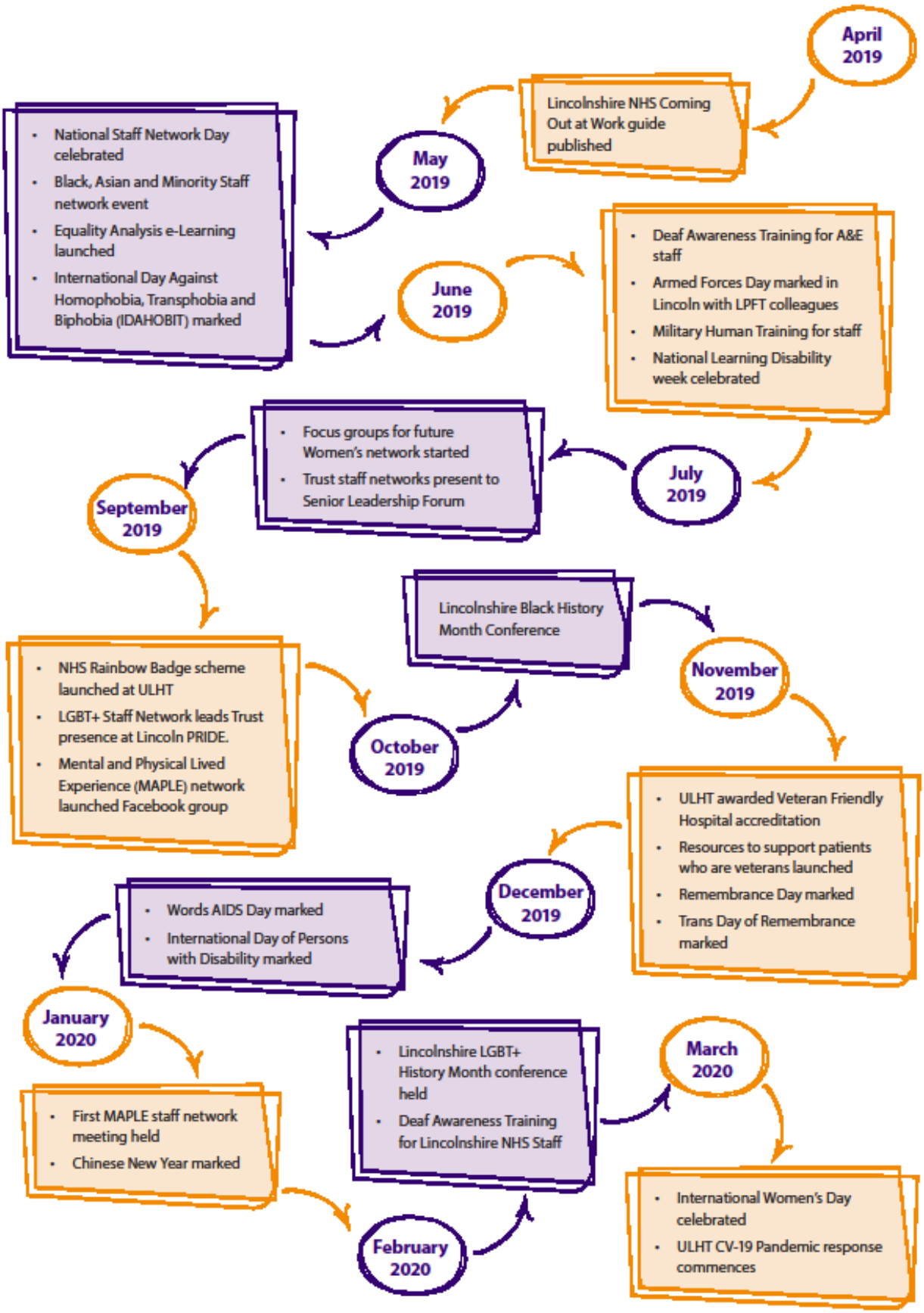
- The strengthening of all our staff networks and the formal establishment of our MAPLE and Women's networks.
- Introduction of a new Equality Impact Assessment framework
- High levels of vaccination uptake from Black Asian and Minority Ethnic staff and other staff group at higher risk from COVID-19
- Significant strengthening of our equality, diversity and inclusion related working across the Lincolnshire System

It has been disappointing that our plans to commence our Cultural Intelligence (CQ) and Inclusion Journey as a Lincolnshire Integrated Care System, led by the NHS Provider organisation's Equality, Diversity and Inclusion Lead, was delayed due to the second wave of COVID-19. However, this important work is helping to address issues of discrimination and harassment is scheduled to commence in early 2021-2022.

As 2021-2022 commences, the Trust's leadership's commitment to equality, diversity and inclusion across all its activity and function and best articulated in the Integrated Improvement Plan, provides assurance that this important work will continue to ensure the United Lincolnshire Hospitals NHS Trust and our key stakeholders in the Lincolnshire Integrated Care System continue to grow as inclusive providers of services and as an inclusive employer.

Tim Couchman, Equality, Diversity and Inclusion Lead
June 2021

Appendix 1. **Key equality milestones for patients, service users and staff in 2019-2020:**



Summary of key equality milestones for patients, service users and staff in 2019-2020:

April 2019
Lincolnshire NHS Coming Out at Work guide published

May 2019
National Staff Network Day celebrated
Black, Asian and Minority Staff network event
Equality Analysis e-Learning launched
International Day Against Homophobia, Transphobia and Biphobia (IDAHOBIT) marked

June 2019
Deaf Awareness Training for A&E staff
Armed Forces Day marked in Lincoln with LPFT colleagues
Military Human Training for staff
National Learning Disability week celebrated

July 2019
Focus groups for future Women's network started
Trust staff networks present to Senior Leadership Forum

September 2019
NHS Rainbow Badge scheme launched at ULHT
LGBT+ Staff Network leads Trust presence at Lincoln PRIDE.
Mental and Physical Lived Experience (MAPLE) network launched Facebook group

October 2019
Lincolnshire Black History Month Conference

November 2019
ULHT awarded Veteran Friendly Hospital accreditation
Resources to support patients who are veterans launched
Remembrance Day marked
Trans Day of Remembrance marked

December 2019
Words AIDS Day marked
International Day of Persons with Disability marked

January 2020
First MAPLE staff network meeting held
Chinese New Year marked

February 2020
Lincolnshire LGBT+ History Month conference held
Deaf Awareness Training for Lincolnshire NHS Staf
March 2020
International Women's Day celebrated
ULHT COVID-19 pandemic response commences

Appendix 2. **Headline Lincolnshire population data**

In the 2011 census the population of Lincolnshire was 713.653 (Source: ONS via Lincolnshire Research Observatory).

2015: Lincolnshire population estimated to be 736.700 (Source: ONS 2015 Mid Year Population Estimates/ GP Registrations April 2015 (NHS-HSCIC)). The rate of Lincolnshire's population growth has increased in recent years but latest figures show that it is below the national rate of growth.

Protected equality characteristic	Lincolnshire population	Population projections and other information
Age	0-15 years of age: 121.878 (17.08%) 16-64 years of age: 443.924 (62.20%) 65+ years of age: 147.851 (20.72%) The average age in Lincolnshire is 43 years. ONS Census 2011	The ONS reports that between 2005 and 2015, the age demographic of Lincolnshire has changed as follows: 0-19 years of age from 23% to 22% 20-64 years of age from 57% to 58% 65+ years of age from 19% to 22%
Disability	43 % rated their health as very good 36% rated their health as good 15.10% rated their health as fair 4.60% rated their health as bad 1.30% rated their health as very bad ONS Census 2011	20.40% stated their health affected their day-to-day activities. 8.70% of people aged 16-64 years (working age) stated their health affected their day-to-day activities ONS Census 2011
Gender reassignment	It is telling that there is a lack of good quality statistical data regarding trans people in the	

	UK. Current estimates indicate that some 650,000 people are "likely to be gender incongruent to some degree". Source: Transgender Equality First Report of Session 2015–16, House of Commons Women and Equalities Committee	
Marriage and civil partnership	27.80% stated they were single (having never been married of in a civil partnership) 51.50% stated they were married 0.20% stated they were in a same sex civil partnership 2.40% stated they were separated 8.10% stated they were widowed / surviving civil partner 10.0% stated they were divorced / civil partnership dissolved ONS Census 2011	Marriage (Same Sex Couples) Act 2013, with the first same sex marriages taking place from March 2014.
Pregnancy and maternity	In 2015 there were 7.773 live births in Lincolnshire.	In 2015 there were 35 still births in Lincolnshire
Race	The largest population in the county is White: British/English/Scottish/Northern Irish/Welsh at 93.0% The largest minority group in the county is White: other at 4.0% The Black, Asian and minority ethnic population in Lincolnshire is 2.4% ONS Census 2011	The potential impact of Brexit on EU nationals (White: other) living and working in Lincolnshire is currently unquantifiable and unknown.

Religion and belief	ONS Census 2011: Buddhist – 0.20% Christian – 68.50% Hindu – 0.20% Jewish – 0.10% Muslim – 0.40% Sikh – 0.10% Other religion – 0.40% No religion – 23.10% Religion not stated – 7.10%	Lincolnshire's data mirrors a national data trend which evidences a reduction in religious affiliation, but an increase in people stating no religion or the religion is not stated.
Sex	51 % female 49 % male Source: LPFT	
Sexual orientation	The ONS stated that in 2015 1.7% of the UK population identified themselves as lesbian, gay or bisexual (LGB)	The ONS figures are challenged by a number of groups, with estimates ranging between 5 – 10 % (for example, Stonewall, Kinsey Report, and the Treasury (Civil Partnership Act).
Carers	11.10% stated they were unpaid care providers. 2.9% reported this activity is more than 50 hours per week. ONS Census 2011	

Appendix 3.

Workforce equality monitoring data as at 31st March 2021

In the data report below, the workforce data of the Trust at the 31st March 2021 is presented.

The following observations are noted:

Age: The Trust acknowledges that in general terms it employs an ageing workforce. The Trust is developing plans and actions, particularly through the Lincolnshire Talent Academy, to attract younger people to work in the organisation.

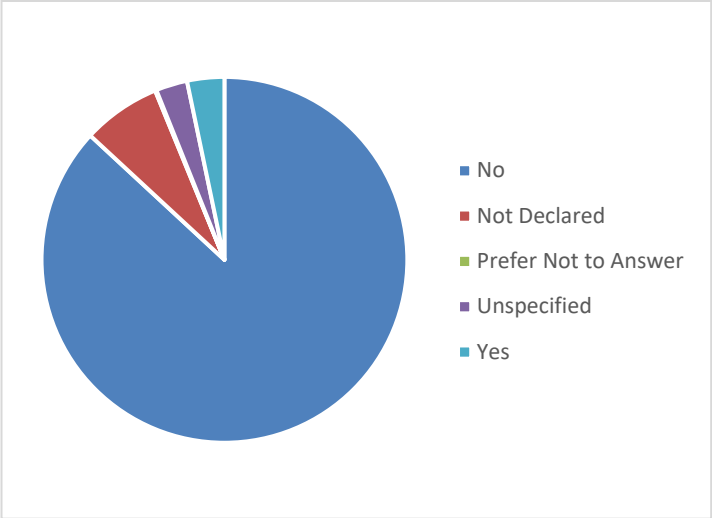
Ethnicity: The Trust is proud to attract employees from a range of ethnic backgrounds and thereby contribute to the cultural diversity of the county. We recognise our employee data for non-white ethnic backgrounds is higher than the local population and that many of these people are members of our clinical workforce. It is also encouraging that our white, other members of the workforce, is broadly representative of the local demography.
Our Black, Asian and minority ethnic staff network reviews and advises the Trust in relation to this report and further positive action required to support a fair and positive employment experience for staff from all ethnic backgrounds.

Gender: Like most, if not all, NHS organisations, the Trust employs a majority female workforce (approx. 79%). Compared to the local population demography, this is by far the largest variance. As an act of positive action, the Trust is advised to consider promoting career opportunities to the local male population.

Disability: The largest disparity in our workforce disability equality monitoring data remains the low percentage of staff who choose to share their disability status. With the launch of the Workforce Disability Equality Standard (WDES) in 2019 and the establishment of the Mental and Physical Lived Experience (MAPLE) staff network in the same year, the Trust has started to develop a positive and supportive narrative and actions to support our disabled staff.

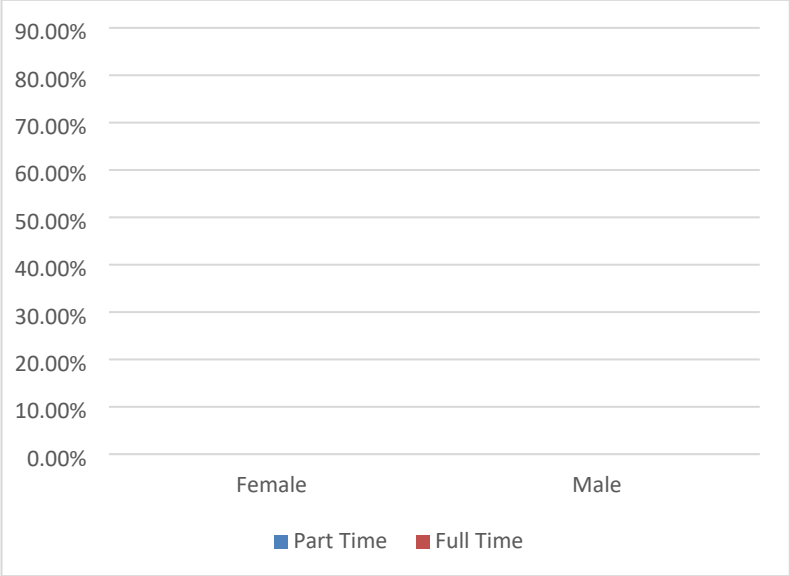
In general terms, the Trust is advised to consider positive actions to encourage staff members to feel comfortable and confident to disclose their equality monitoring information for the categories where relatively high non-disclosure rates exist.

Disability:



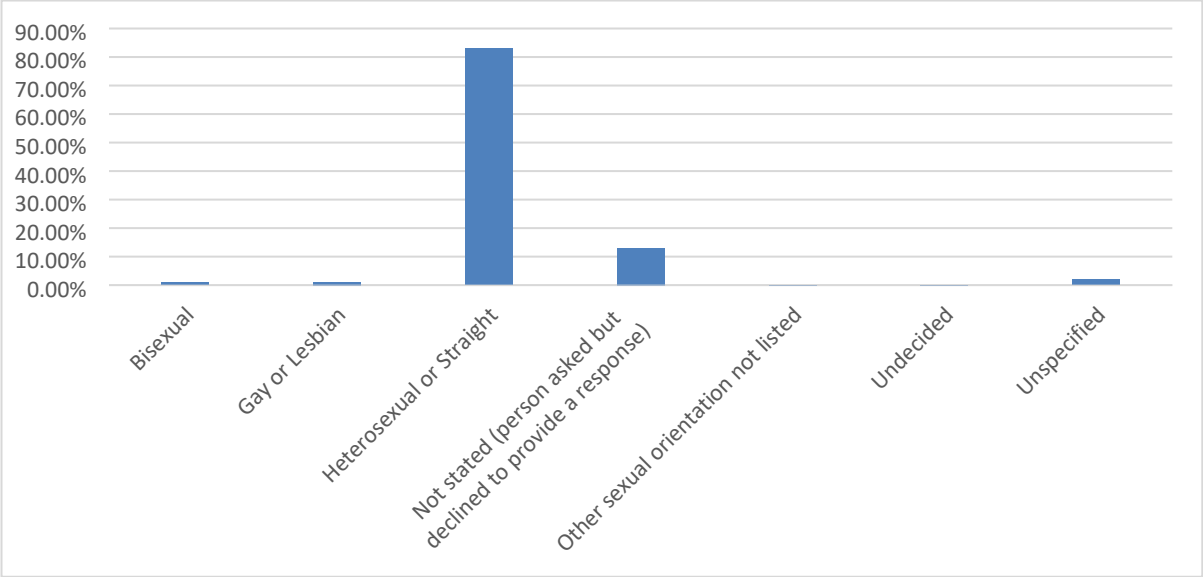
Disability	%age
No	86.89%
Not Declared	6.92%
Prefer Not to Answer	0.12%
Unspecified	2.78%
Yes	3.29%
Total	**100.00%**

Gender:



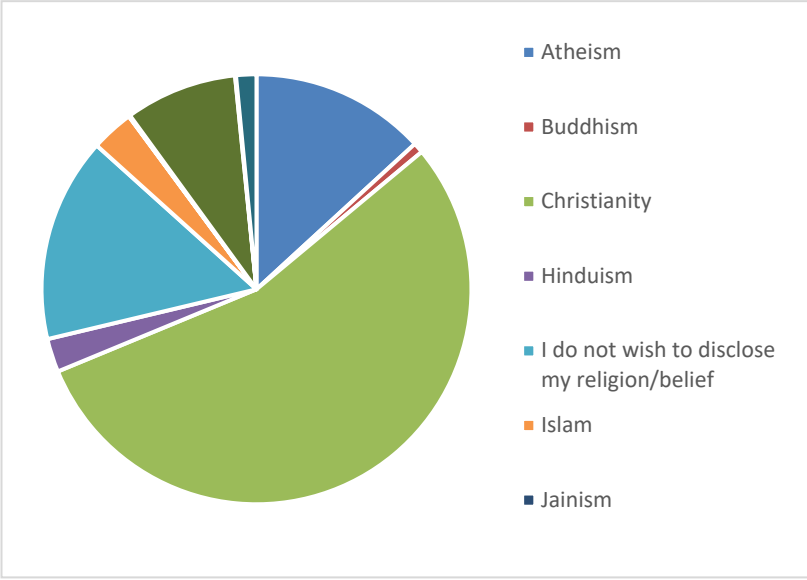
Gender	%age	%age
	Female	Male
Part Time	39.39%	3.20%
Full Time	39.40%	18.01%
Total	**78.78%**	**21.22%**

Sexual Orientation:



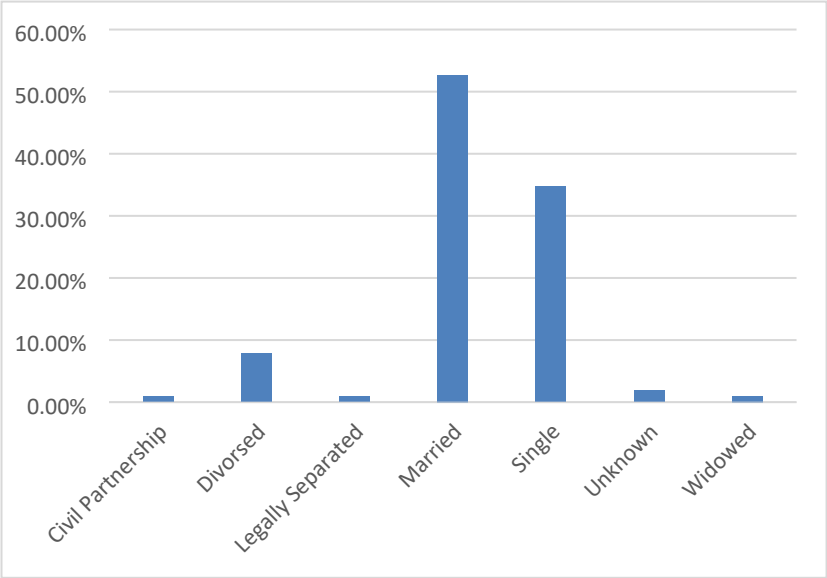
Sexual Orientation	%age
Bisexual	0.84%
Gay or Lesbian	1.06%
Heterosexual or Straight	82.91%
Not stated (person asked but declined to provide a response)	13.06%
Other sexual orientation not listed	0.07%
Undecided	0.07%
Unspecified	1.99%
Total	**100.00%**

Religion:



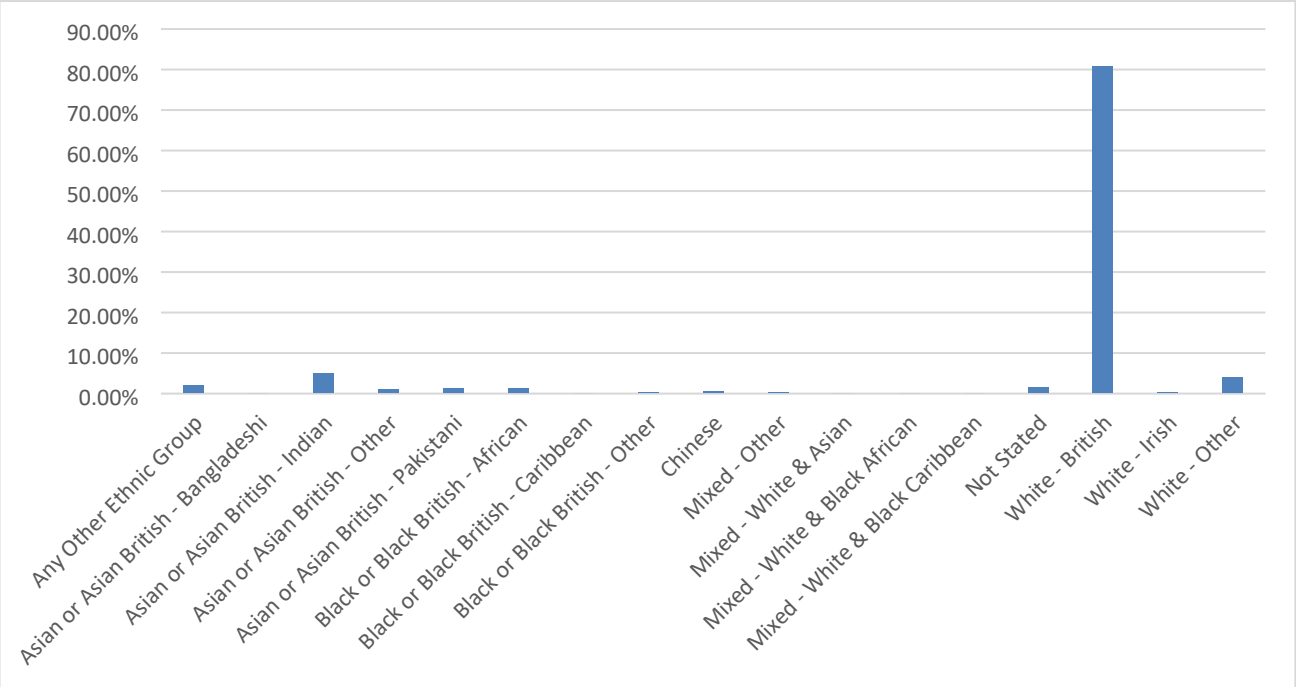
Religious Belief	%age
Atheism	13.18%
Buddhism	0.78%
Christianity	54.80%
Hinduism	2.52%
I do not wish to disclose my religion/belief	15.39%
Islam	3.21%
Jainism	0.02%
Judaism	0.08%
Other	8.42%
Sikhism	0.07%
Unspecified	1.52%
Total	**100.00%**

Marital Status:



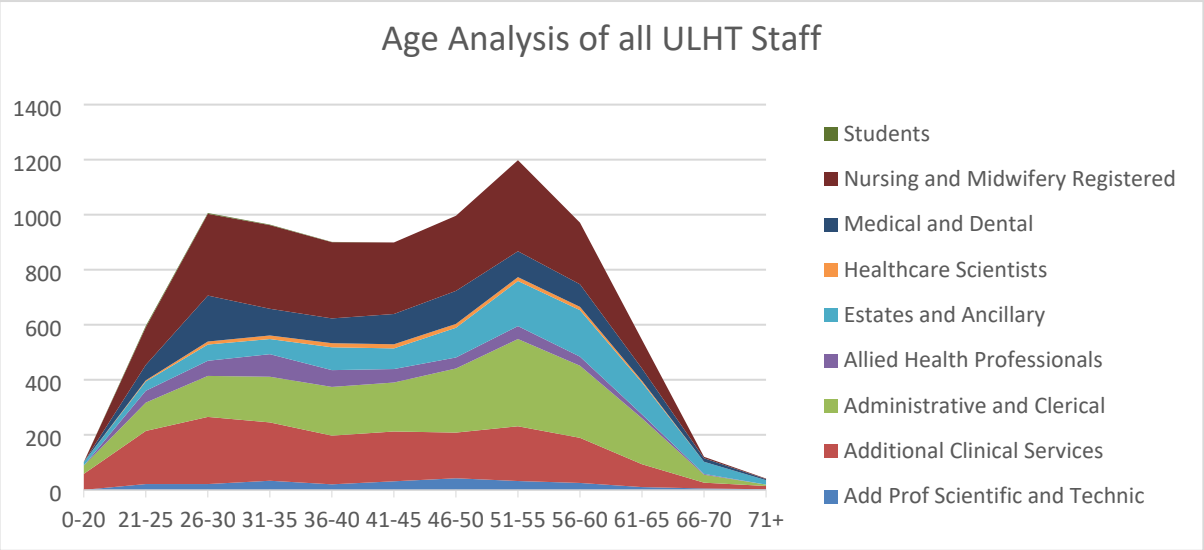
Marital Status	%age
Civil Partnership	0.94%
Divorced	7.82%
Legally Separated	0.96%
Married	52.67%
Single	34.70%
Unknown	1.92%
Widowed	1.00%
Total	**100.00%**

Ethnicity:



Ethnicity	%age
Any Other Ethnic Group	2.05%
Asian or Asian British - Bangladeshi	0.22%
Asian or Asian British - Indian	5.12%
Asian or Asian British - Other	1.15%
Asian or Asian British - Pakistani	1.34%
Black or Black British - African	1.33%
Black or Black British - Caribbean	0.22%
Black or Black British - Other	0.31%
Chinese	0.64%
Mixed - Other	0.34%
Mixed - White & Asian	0.23%
Mixed - White & Black African	0.16%
Mixed - White & Black Caribbean	0.22%
Not Stated	1.56%
White - British	80.74%
White - Irish	0.32%
White - Other	4.07%
Total	**100.00%**

Age Profile by Staff Group (Excludes Bank Staff):



Age Band	0-20	21-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65	66-70	71+	Total
Total	101	596	1006	964	901	899	996	1198	971	545	120	41	8338
Percentage of Workforce	1.21%	7.15%	12.07%	11.56%	10.81%	10.78%	11.95%	14.37%	11.65%	6.54%	1.44%	0.49%	100.00%

Appendix 4.

Equality monitoring data for Trust volunteers to 31 March 2021:

Voluntary Services - Equality and Diversity information as at 31/03/21

Gender

Females	132	68%
Males	63	32%
total	195	100%

Ethnicity

British	73	39%
English	78	42%
Scottish	<11	0%
Welsh	<11	0%
Mauritian	<11	0%
Hungarian	<11	0%
Irish Republic	<11	0%
Danish	<11	0%
Asian	<11	0%
Declined	<11	0%
Not Given	34	18%
total	185	100%

Disability

No	132	70%
Yes	<11	0%
Unspecified	23	12%
Not Declared	32	17%
total	187	100%

Age

0-20	<11	0%
21-25	<11	3%
26-30	0	0%
31-35	<11	0%
36-40	<11	2%
41-45	<11	0%
46-50	<11	2%
51-55	<11	5%
56-60	14	8%
61-65	25	14%
66-70	44	23%
71+	86	44%
not recorded	<11	0%
total	169	100%

Report to:	Trust Board
Title of report:	Finance, Performance and Estates Committee Assurance Report to Board
Date of meeting:	22 July 2021
Chairperson:	David Woodward, Non-Executive Director
Author:	Karen Willey, Deputy Trust Secretary

Purpose	This report summarises the assurances received, and key decisions made by the Finance, Performance and Estates Committee (FPEC). The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board's response. This assurance committee meets monthly and takes scheduled reports from all Trust operational groups according to an established work programme. The Committee worked to the 2021/22 objectives.
Assurances received by the Committee	**Lack of Assurance** in respect of SO 3a A modern, clean and fit for purpose environment **Estates Statutory Compliance Report** The Committee received the report noting that critical infrastructure remained a high risk that continued to be progressed however a number of incidents had occurred during the reporting period. The Committee noted that the Health and Safety Committee had held a meeting which would be upwardly report to the August Committee. It was noted that the Committee had been successful with good representation from Staff Side and the Divisions. The Committee sought assurance on the ability to maintain star ratings that had been introduced for cleanliness of the environment however were advised that over the course of the past year standards had increased with no intention of these reducing. There would however need to be consideration of the investment being made within housekeeping to ensure this did not continue to grow. The Committee noted that discussion was held by the Health and Safety Committee in relation to the British Safety Council visit in to Covid-19 measures and the subsequent action plan that had been developed. The Committee requested further feedback in relation to the actions being undertaken in order to be aware of the scale of issues.
	Assurance in respect of SO 3b Efficient Use of Resources **Finance Report**

	The Committee noted the in-month surplus position of £608k and a year to date deficit of £1.1m noting that this aligned to plan at the end of quarter 1. The Trust had been asked for a resubmission in relation to the elective recovery fund (ERF) which placed £7.6m of income in to the position taking the Trust to a surplus of £1.8m in half 1. Brokerage of income to the Clinical Commissioning Group would be required to support the unmitigated risk that was being held. The Committee however noted the risk of the payment of ERF against the assumption and local calculations that had been put in to the position. The Committee noted the very late change of the Q2 gateway target to 0.95%. The Committee were advised of the 3% pay award to staff which was not included within the position with an expectation that this would be funded separately. The Committee noted the agency pay position which had reduced in totality since March 2021 however was not demonstrating a reduction in line with the cost improvement plan (CIP) ambition of a reduction of 25%. Non-pay was favourable to plan and reflected the planned growth in activity volume linking to the CCG brokerage. This was an offset of the income adjustment. The Committee noted concern on the delivery of CIP with the Trust required to deliver £6.4m of which £2.4m would be offset by the ERF payment. The Trust were working towards a deliverable of £4m in the first half of the year with only £1m currently identified. The committee were concerned that this was unachievable and clarified that while other possible mitigations existed they would not be sufficient for the Trust to deliver the planned H1 surplus. Without mitigating actions being taken to close the CIP gap and make up for the lost ERF the H1 position could be a deficit of c.£6m The Committee noted the work underway with the Divisions through the Financial Review Meetings in order to ensure that there was focus and action on CIP delivery. Focus would also be required in relation to workforce transformation to support the reduction in agency nursing. The Committee noted that whilst the headline agency figures were similar there had been a reduction in the unit cost. The capital position was report as having spent £2.6m year to date which put the Trust behind plan. The Committee recognised that the original capital plan was very unlikely to be delivered but with substitution between national and locally funded projects (and subject to necessary approvals) the capital number was still deliverable. A review of capital was being undertaken to determine where progress could be made.

	The Committee were pleased to be advised that the outline business case had been approved for the Pilgrim Emergency Department which would now be developed in to a full business case before being put to the Board and Joint Investment Committee, respectively in December 2021. The Committee again noted that missing outcomes had not progressed as hoped in month and would make a formal referral to the Audit Committee for this to be reviewed. Discussions would be held with the Trust Leadership Team in order to discuss next steps and actions as a step change was required. **Capital, Revenue and Investment Group Upward report** The Committee received and noted the report from the group.
	Assurance in respect of SO 3c Enhanced data and digital capability **Information Governance Group Upward Report** The Committee received the report noting the achievement of the Data Security Protection Toolkit for which the submission was made on 30th June. This was the second year the Trust had achieved compliance. The Committee noted that work would be undertaken in order to utilise, where possible, the current patient records system to capture the required equality, diversity and inclusion data. **RCA Outcome Pilgrim Power Outage** The Committee received the outcome conducted in relation to the root cause analysis of the power outage noting that work was underway to address the actions identified. Electrical infrastructure work was underway to ensure all areas requiring protected power supply were identified and appropriate action taken.
	Assurance in respect of other areas: **Committee Performance Dashboard** The Committee received the report noting the 15 minute standard had a mean of 7-8 minutes with a standard deviation of just over 1 minute. The Committee were pleased to note there was not an extreme variation being seen. The Committee noted the difficulties of ambulance conveyances at peak periods noting the action being taken to redistribute ambulances to other areas in order to support pressures at Accident and Emergency. The Committee noted that the scorecard had been further updated ahead of the meeting however noted that significant progress was needed to ensure data could clearly be seen through the scorecard. The Committee were advised that theatre capacity had been planned to reach more than 100% of pre-Covid-19 levels by the end of July, at

	Grantham this was at 160%. It was noted however that theatres were not as fully utilised as pre-Covid-19 levels partly due to increased infection, prevention and control measures and reflecting the case mix and prioritisation of patients. This would however support the reduction of backlogs within some specialities. The Committee noted the confirmation of half 2 of the financial year being funded in a similar way to half 1 with block payments and top ups relating to Covid-19 and to support the system breakeven position. Adjustments would however be made including the increase in Cost Improvement Plan requirements between 3-5%. The Committee noted the risk in respect of performance delivery relating to the third wave of Covid-19 and the absence and availability of the workforce due to burnout and Covid-19 related illness or isolation. The Committee would receive revised trajectories to reflect the position and to demonstrate expected delivery over the remainder of the financial year. This would factor in efficiencies and planning assumptions over and above the national planning guidance to restore services. **Integrated Improvement Plan** The Committee received the integrated improvement plan noting that this was in the early stages of the maturity cycle with the Senior Responsible Officers continuing to develop the scoping documents and milestone plans. The Committee noted that dependencies had not yet been included within the report being advised that this continued to develop and would be presented to the Committee in August. The Committee raised concern regarding the length of time between stages 4 and 5 of the projects seeking assurance on how progress would be measured between these stages with significant time between them. **Operational Performance against National Standards** The Committee received three performance reports covering Cancer, Urgent Care and Planned Care. The Committee noted that progress had been made in relation to cancer waits for 62 day and 104 day waiters however this had now plateaued to circa 200 patients on the 62 day wait backlog. It was recognised that the affected specialties across the region were also facing difficulties, in part due to the dependency on intensive care units. Work progressed on the backlog and the pathways would be protected from wave 3 of Covid-19 due to the solutions put in place and the protection offered through the services being offered at Grantham Hospital.

	The Committee noted that the Trust were monitoring shadow standards which would be core standards from September 2021 which had originated from the Professor Flowers review. The Committee noted the debate in relation to 2 week waits held by the Clinical Harm Group noting that harm reviews were most effective when conducted at the 62 day wait stage. The Committee were pleased to note the investment and delivery of new diagnostic equipment noting that the delivery and implementation of equipment was on track and would support the Trust to realise efficiencies over time. The Committee asked for confirmation at its next committee that all the equipment had been delivered as planned by the scheduled August deadline. The Urgent Care report offered to the Committee reflected activity until the July reporting period with some positive activity to note however the Committee were advised of the increase in risk since the production of the report as July had already seen the Trust escalate its emergency status to level 4 the highest level on response on 3 occasions as well as 5 breaches of the 12 hour trolley wait standard. The Committee discussed the level of risk relating to urgent care and the incredibly challenging period with risks to the workforce, urgent care demand increase and the need to maintain the elective programmes. The Committee noted the new indictors being reported particularly the percentage of patients held in the emergency department for 12 hours. Whilst this remained a shadow monitoring standard the Trust had seen a significant improvement in the position resulting in a change to national standing for the Trust. The Committee received the planned care report noting the strong management of 52 week waits with a downward trajectory being reported for a reduction in the longest waits. The Committee were pleased to note within the reporting period that there were no patients who had waited more than 104 weeks. The Committee noted the continued work to categorise patients in to the relevant prioritisation categories based on clinical need. A review had been undertaken by NHS England/Improvement as the Trust had been identified as an outlier for P2 category patients, having more of the higher category than lower. It was noted however that clearance times were not affected by this. **Performance Review Meeting (PRM) Upward report** The Committee received the report noting that this would continue to develop in line with the development of the performance regime within

	the Trust. It was expected that an improved report offering assurance would be available to the Committee in October. **Board Assurance Framework** The Committee received the Board Assurance Framework noting the updates. Following discussion during the meeting the Committee agreed that objective 3b would be rated as red from amber due to the H1 plan not being deliverable currently and uncertainty about the outturn for the year. **Internal Audit – Estates** The Committee received the internal audit report relating to estates management and the action plan developed in response noting the content. The Committee noted that oversight of the delivery of the action plan was the responsibility of the Audit Committee. **Draft Terms of Reference and Work Programme** The Committee approved the draft Terms of Reference and work programme.
Issues where assurance remains outstanding for escalation to the Board	The Committee noted concern with regard to the lack of progress with missing outcomes and wished to alert the Board that this required additional action and would be referred to the Audit Committee.
Items referred to other Committees for Assurance	The Committee wished to refer the issue of missing outcomes to the Audit Committee for review and to alert the Committee to the impact this was having on income for the Trust.
Committee Review of corporate risk register	The Committee received the risk register noting the proposed increase of the risk 'Capacity to manage emergency demand (4175) from 20 to 25 (very high). The Committee noted the key risk indicators described within the paper supporting the increase of the risk to 25.
Matters identified which Committee recommend are escalated to SRR/BAF	No items identified
Committee position on assurance of strategic risk areas that align to committee	As above
Areas identified to visit in dept walk rounds	None

Attendance Summary for rolling 12-month period

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

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

Finance, Performance and Estates Committee
Terms of Reference

1. Authority

The Finance, Performance and Estates Committee is established by the Trust Board in line with the powers set out in the Trust Standing Orders.

The Finance, Performance and Estates Committee holds only those powers as delegated in these Terms of Reference as determined by the Trust Board.

The Standing Orders and Standing Financial Instructions of the Trust, as far as they are applicable, shall apply to the Committee and any of its established groups.

2. Purpose of the Committee

The Finance, Performance and Estates Committee exists to scrutinise the robustness of and provide assurance to the Trust Board that there is an effective system of governance and internal control areas across finance, operational performance, estates and digital services of the organisation that supports United Lincolnshire Hospitals NHS Trust to deliver its strategic objectives and provide high quality care.

The relevant strategic objectives assigned to the Finance, Performance and Estates Committee for 2021/22 are:

- A modern, clean and fit for purpose environment
- Efficient use of resources
- Enhanced data and digital capacity
- Establish new, evidence-based models of care

3. Membership

The members of the Committee are:

- Non-Executive Director (Chair)
- Non-Executive Director (Deputy Chair)
- Non-Executive Director
- Director of Finance and Digital
- Chief Operating Officer
- Director of Improvement and Integration

The following roles will be routine attendees at the Committee:

- Trust Secretary/Deputy Trust Secretary
- Deputy Director of Finance

4. Attendance and Quorum

The Committee will be quorate when four of the membership are present if this includes one Non-Executive Director and one Executive Director.

Where members are unable to attend, they should ensure that a deputy is in attendance who is able to participate on their behalf. A deputy in attendance for a committee member will contribute to the quoracy but does not negate the need for the attendance of one Non-Executive and One Executive Director.

5. Frequency

The Committee will meet monthly.

6. Specific Duties

The Finance, Performance and Estates Committee will:

- Agree a set of Key Performance Indicators to be presented in the Committee Performance Dashboard monthly
- Consider the control and mitigation of finance, operational performance, estates and digital services related risks and provide assurance to the Board that such risks are being effectively controlled and managed
- Provide assurance to the Board that all legal and regulatory requirements relating to finance, operational performance, estates and digital services are met, including directives, regulations, national standards, policies, reports, reviews and best practice
- Review and provide assurance through the Integrated Improvement Plan and Performance Review Meeting reporting, on those strategic objectives within the Board Assurance Framework, identified as the responsibility of the committee seeking where necessary further action as outlined below:

A modern, clean and fit for purpose environment:

- Developing a business case to demonstrate capital requirement
- Delivering environmental improvements in line with Estates Strategy
- Continual improvement towards meeting PLACE assessment outcomes
- Reviewing and improving the quality and value for money of facilities services including catering and housekeeping
- Continued progress on improving infrastructure to meet statutory Health and Safety compliance

Efficient use of resources:

- Delivering cost improvement programme
- Delivering financial plan

- Utilising Model Hospital, Service Line Reporting and Patient Level Costing data to drive focussed improvements
- Implementing the CQC use of resources report recommendations

Enhanced data and digital capability:

- Improving utilisation of the Care Portal with increased availability of information
- Commencing implementation of the electronic health record
- Implement a single new business intelligence platform that supports decision making and drives improvement
- Implementing robotic process automation
- Improving end user utilisation of electronic systems
- Completing roll-out of data quality kite mark

Establish new, evidence-based models of care:

- Supporting the implementation of new models of care across a range of specialties
- Supporting creation of integrated care system
- Support the consultation for Acute Service Review (ASR)
- Improvement programmes for cancer, outpatients, theatres and urgent care
- Development and implementation of new pathways for paediatric services
- Urology transformation change programme
- Pre-Operative assessment Modernisation

7. Administrative support

The Committee will operate using a work plan to inform its core agenda. The agenda will be agreed with the Chair prior to the meeting.

Agendas and supporting papers will be circulated no later than 7 days in advance of meetings. Any items to be placed on the agenda are to be submitted no later than 8 working days in advance of the meeting. Items which miss the deadline for inclusion on the agenda may be added with permission from the Chair.

Minutes will be taken at all meetings, presented according to the corporate style, circulated to members within 7 days along with the action log and ratified by agreement of members at the following meeting.

8. Accountability and Reporting Arrangements

The Chair of the Committee shall report to the Board after each meeting and provide a report on assurances received, escalating any concerns where necessary.

The Committee will advise the Audit Committee of the adequacy of assurances available and contribute to the Annual Governance Statement.

9. Monitoring effectiveness and Compliance with Terms of Reference

The Committee will complete an annual review of its effectiveness and provide an annual report to the Board on its work in discharging its responsibilities, delivering its objectives and complying with its terms of reference, specifically commenting on relevant aspects of the Board Assurance Framework and relevant regulatory frameworks.

10. Review of Terms of Reference

The Terms of Reference for the Committee will be reviewed annually by the Committee and submitted to the Trust board for approval.

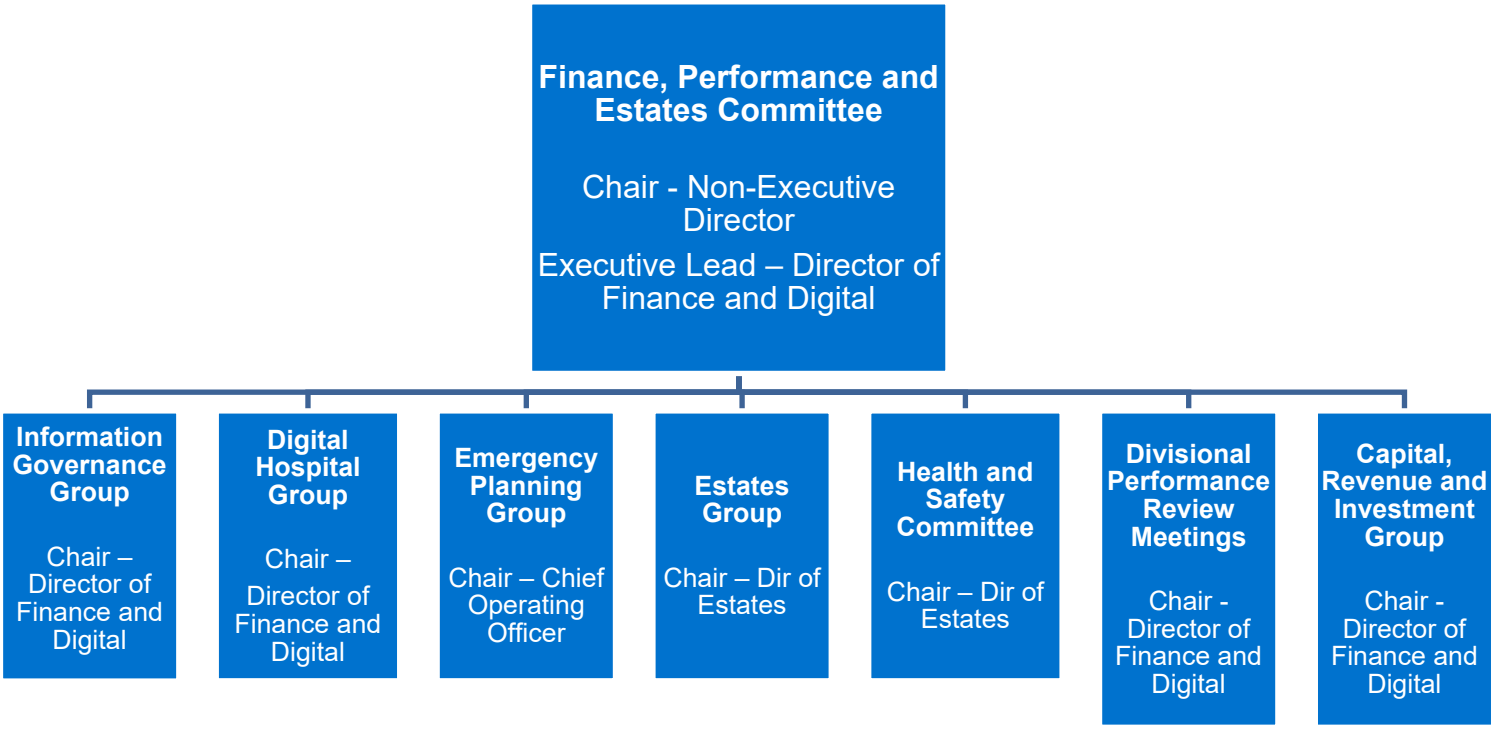
The Committee will on an annual basis review and approve the terms of reference and work programmes of all of its reporting groups.

Approved:
Approved by:
Next Review Date:

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Committee reporting group structure:



Meeting	*ULHT Trust Board*
Date of Meeting	*3rd August 2021*
Item Number	*Item 11.3*
Trustwide Urology Reconfiguration of services proposal	
Accountable Director	*Mark Brassington, Deputy Chief Executive and Paul Matthew, Director of Finance and Digital*
Presented by	*Mark Brassington, Deputy Chief Executive* *Mr Andrew Simpson, Consultant Urologist and Deputy Medical Director, Clinical Effectiveness* *Grainne ODwyer, Divisional Clinical Director, Surgery*
Author(s)	*Chloe Scruton, General Manager*
Report previously considered at	*Lincolnshire Health Scrutiny Committee* *Trust Leadership Team*

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

Risk Assessment	*Clinical Risk Analysis completed to inform QIA, along with Benefits Analysis.*
Financial Impact Assessment	*Financial Impact - £300k savings pa as a result of agency use reduction*
Quality Impact Assessment	*Approved by QIA Panel on 12th July 21. Overall risk score of 12.*
Equality Impact Assessment	*EIA forms part of the new QIA model*
Assurance Level Assessment	*Insert assurance level* • *Significant*

Recommendations	• *Approval for the implementation of the Urology reconfigured service model to go-live on Monday 9th August 2021*

Executive Summary

As part of our ongoing commitment to continually improving hospital services, the urology department have undertaken a full public consultation exercise to contribute to a reconfiguration of both planned and emergency urology services across Lincolnshire's hospitals. The 10-week public consultation ended on 23rd July 21.

At present, emergency urology admissions at the weekends go through one single site - alternating between Lincoln and Pilgrim hospitals - with emergency admissions at both Lincoln and Pilgrim hospitals during the week.

Under the current proposal, Pilgrim hospital would continue to see emergency urology patients, but if the patient needs admission or surgery they would be transferred to Lincoln County Hospital if they are medically stable to do so. Alternatively, they would be admitted to Pilgrim Hospital ICU or the Urology Consultant on-call would travel to Pilgrim Hospital site.

Taking into account patient experience insight, expert clinical advice, discussions with partners and data, we are proposing that in future Lincoln County Hospital in future receives all emergency urology admissions seven days per week.

The service is currently unstable due to the on-call challenges, this change would help us to ensure that we have a stable and sustainable urology service for the future, increase our capacity to perform planned surgery without disruption, better meet the needs of our emergency cases, enable us see and treat more people and avoid on the day cancellations.

An interim GIRFT (Get it Right First Time) review of the service took place on 23rd July 21, attended by three GIRFT clinical leads. The team offered uniform support for the proposed new model; written confirmation of their support for the reconfiguration is anticipated but was not available at the time of writing this paper.

A number of stakeholder experts have been involved throughout the proposal, they are:
GIRFT
Patient Experience panel
KPMG
EMAS – East Midlands Ambulance Service
CCG colleagues
ULHT staff
HSC

1. Purpose

The purpose of this paper is to provide the Trust Board with an overview of the proposed reconfiguration of Trust urology services and seek its support to move forward with the implementation of the model outlined below

Currently, planned urology services are delivered from Lincoln County Hospital; Pilgrim Hospital, Boston; Grantham and District Hospital, and County Hospital, Louth. Emergency urology admissions at the weekends go through one single site - alternating between Lincoln and Pilgrim hospitals - with emergency admissions at both Lincoln and Pilgrim hospitals during the week.

As part of our ongoing commitment to continually improve hospital services, the urology department has undertaken a review of both planned and emergency urology services across Lincolnshire's hospitals. Based on this review, the department proposes a new model for delivery of care to improve patient outcomes and experience, support workforce development and retention, and ensure services are sustainable for the future.

The review has taken into account patient experience insight, expert clinical advice from the Royal College of Surgeons, Getting It Right First Time (GIRFT) national clinical leads, discussions with partners and analysis of available data. At present, urology services across the Trust are characterised as fragile as a result of the current on-call structure so doing nothing is not an option and could compromise patient safety.

It is proposed that Lincoln County Hospital in future receives all emergency urology admissions seven days per week. This would ensure that the other sites are better organised to manage the majority of elective procedures, thereby reducing elective cancellations, increasing capacity and supporting the recovery of services post-COVID 19. Essentially, this approach will level the demand across the sites, creating enhanced patient choice and reducing patient wait times, while better meeting the needs of our emergency cases

The data presented within this paper includes activity from 2019/20; activity post this year has not been included due to the impact of the COVID-19 pandemic on non-elective and elective care.

2. Introduction and Current State

The Urology service at United Lincolnshire Hospitals NHS Trust was defined as a single department when the service was consolidated in 2006, in response to national recommendations for the delivery of major urological cancer surgery. However, in many ways the 2 sites have continued to work independently, with separate staffing, pathways and on-call arrangements (although joint on-call rotas operate at the weekends).

Parallel working at the Lincoln and Pilgrim main sites has caused some difficulties, including;

- Inequity of access to services for Lincolnshire patients
- Onerous on-call rota with frequent gaps, causing safety concerns, financial strain on the service, additional agency spend, duplication of rotas and patient accessibility challenges
- Alternating on-call system at weekends has led to confusion in acute pathways, with many patients being redirected from one site to another. This has been feedback in previous complaints into the Trust.
- Complaints from patients about access to the service including last minute cancellation of procedures

- Staff engagement challenges leading to recruitment and retention issues and teams working in silos
- Lack of whole team identity

The current state service poses a risk to clinical staff and patients. This concern has been echoed by the GIRFT clinical leads too, who recommend that, in line with accepted national practice, on-call consultants are freed from elective activity to ensure the delivery of high-quality emergency care at all times – something which is not possible under the current model. This will also enable compliance with NICE requirements particularly in relation to renal tract stone management (NICE 118). The wellbeing of our staff is really important us and the current model is a cause of concern, owing to the heavy on-call rota commitments, resulting in difficulties in recruiting and retaining consultants and clinical staff. Patient experience is currently impacted on negatively owing to inconsistencies in care and insufficient timely access to non-elective care. Disruption to elective surgery is also a cause for concern owing to the current on-call rota structure, resulting in same day cancellations.

3. Case for Change

Historically ULHT had struggled with delivering the optimal mix of capability, capacity and resources across its hospital sites. Services tended to be delivered across all sites, however the rurality of Lincolnshire means that the distance between the sites and poor transport infrastructure limits opportunities for scale and networked ways of working. Over recent years ULHT has experienced pressure on elective beds due to a high volume of unplanned admissions.

Alongside this, high medical vacancies exist across ULHT in urology (elective and non-elective) service (c.28% of medical posts vacant).

Data analysed from 2017 - 2020 inclusive showed around 1,900 urological patient procedures are cancelled annually. For the procedures that were cancelled by the hospital (i.e. not by the patient), around 25% were cancelled on the day and 10% due to lack of beds. Cancellation of surgery at any time leads to poor patient experience and satisfaction, and additional pressure on the waiting list. Being cancelled on the day of surgery is extremely distressing for patients and their families.

The data below provides an overview of where patients currently have urology procedures based on the GP practice that referred them. The data confirms that many patients attend the hospital based on the shortest lead time and not necessarily the hospital closest to them. This evidence supports the hypothesis that patients are offered a choice of location for their procedure.

Lincoln

72%

patients with a GP postcode prefix of LN1 to LN6 had their procedure at Lincoln County

Pilgrim

76%

patients with a GP postcode prefix of PE had their procedure at Pilgrim

Grantham

37%

patients with a GP postcode prefix of NG had their procedure at Grantham

Louth

32%

patients with a GP postcode prefix of LN11 to LN13 had their procedure at Louth

The new NHS Long Term Plan published on 7 January 2019 fully supports the split of elective and non-elective work onto different sites to drive improvements, and recognises that managing complex, urgent care on a separate dedicated site allows improved emergency assessment and better access to specialist care, so patients have better access to the right expertise at the right time.

On the basis of recommendations arising from the Urology Getting It Right First Time (GIRFT) visit, Urology was selected for a major reconfiguration supported by the Integrated Improvement Directorate (IID) Delivery Team and KPMG, with strong executive backing.

The GIRFT programme's national report into urology services, published in 2018, makes a number of important recommendations around the delivery of emergency urological care. These include providing consultant delivered emergency care by reducing elective commitments when on call, reviewing workloads to ensure on-call arrangements are sustainable, and focusing available resources to ensure high-quality emergency care is available seven days a week. Most NHS organisations ensure that Consultants are not on-call when delivering elective commitments to ensure prompt response to emergency care.

The proposed model for urology services at ULHT was developed following an options appraisal with GIRFT clinical lead, Mr Simon Harrison and supports the delivery of these recommendations. Support has been provided by the regional GIRFT implementation team throughout the project, through weekly meetings with the project team, and the proposed model was presented to the GIRFT clinical leads on 23rd July 2021. The team offered uniform support for the model; written confirmation of their support for the reconfiguration is anticipated but was not available at the time of writing this paper.

The proposed model has been presented to the Surgical Division and they have been consulted throughout. The model receives full divisional support.

The key features of the reconfiguration include:

- Focus for acute urology at a single site emphasising increased same day care, acute lists and clinics
- Maintenance of diagnostic and outpatient activity across sites
- Increased non-complex elective procedures at Grantham and Pilgrim, with a focus on day case and short stay work but including specialist stone procedures.
- Retaining some complex major procedures at LCH
- Single urology team with expanded consultant and SAS (middle tier) colleagues and a new tier of acute care practitioners

North West Anglia NHS Foundation Trust (NWAFT) has implemented a similar model to the one which is proposed herein. A meeting with NWAFT was held on 13th May 2021 to share best practice and to gain knowledge from them in terms of benefits of the model and advice in relation to implementation considerations, primarily around operational practicalities.

Additionally, the project outcomes link directly to the Trust's 5 year Integrated Improvement Plan. At high level, the alignment to each of the strategy themes is as follows:

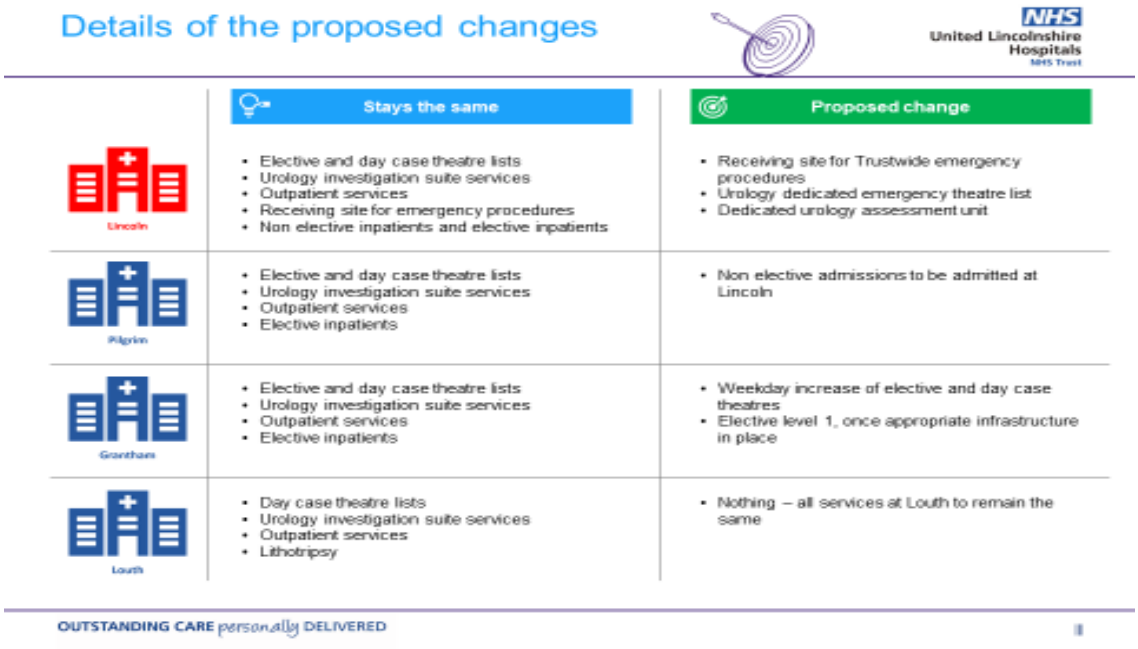
Patients	• Complaints, SI's and DATIX • Average length of stay (emergency) • Cancelled procedures • Cancer Performance (28d) • Variation in cost per patient (PLICS) • Procurement costs
People	• Staff engagement and medical vacancy rates
Service	• Financial performance • Agency costs • Service stability
Partners	• Collaboration with GIRFT – best practice alignment and delivery of GIRFT recommendations.

4. Service Configuration – Location of activity

Our proposal would be to create a separation of duty, so that our consultants would be either on-call or scheduled to perform planned care. Critically, they would not be required to fulfil both duties at the same time, thus eliminating the risk around planned care being cancelled at short notice due to emergency pressures e.g. a consultant currently can be on-call and delivering elective planned commitments at the same time.

In order to successfully implement this rota, we need to look at the location of urology surgery provision across the county. The proposal is for Lincoln to become the primary receiving site for all non-elective activity. All sites will continue to provide elective activity. The rationale behind this configuration is to:

- Stabilise elective activity – reduce disruption and cancelled procedures
- Provide a more robust clinical rota covering both sites, with the on-call consultant focused at Lincoln
- Improve patient access to emergency care and treatment
- Reduce on the day cancellations



Emergency presentation

When designing the new rota, agility and continuity of safe care was the key priority. In the proposed model of service, patients with an urgent urological condition requiring admission to the Emergency Department by ambulance would be taken directly to Lincoln County Hospital. This would be the case seven days a week.

Patients attending the Emergency Department at Pilgrim hospital with a urology condition as a walk-in would be assessed as normal. Patients diagnosed with an urgent urinary condition, providing their condition was stable, would be transferred to Lincoln County Hospital by ambulance or they can choose to transport themselves for treatment and surgical intervention as required. Whilst this transfer is ongoing, the specialist team will be waiting at the receiving site for the patient to arrive.

In this event, treatment would not be delayed. The team at Pilgrim hospital would ensure that any immediate requirements in terms of medication and stabilisation were administered, prior to transfer to Lincoln County Hospital.

In the event a patient's condition could not be stabilised and they were considered not medically fit for transfer, or with a time critical presentation (eg testicular torsion), the patient would be admitted to Pilgrim hospital for treatment and the on-call consultant would be required to attend at that location.

Throughout the development of this proposal, EMAS has been fully consulted to mitigate patient safety risks. EMAS felt that this reconfiguration would provide clarity to their crews as the alternate take at the weekends can often lead to confusion. Additional information on this can be found below.

Planned surgery

At the moment, a choice of location is given for patients to have planned surgery. This can be at Pilgrim Hospital, Boston, Grantham and District Hospital, Lincoln County Hospital or County Hospital, Louth. Patients normally choose to have their surgery at the location with the shortest waiting time. This would not change. Patients would still have a choice as we would continue to provide planned surgery at all of our sites

Follow-up care/outpatient appointments

There are no changes proposed to the location of follow-up appointments, post treatment/surgery. Patients would still be able to attend the hospital of their choice for their follow-up appointments. There would not be any impact on patients in terms of access to services and distance of travel.

5. Activity Modelling

In order to accommodate the non-elective activity at Lincoln, a shift in elective activity is required, as show below:

The table below shows a summary of activity, comparing the current position by site with the proposed future model.

Day case and elective demand			
Location	Current	Proposed	Annual Change
Louth	638	638	No change
Grantham	216	916	700 increase
Lincoln	1,534	710	824 reduction
Pilgrim	988	1,112	124 increase

Non elective demand				
Location	Type	Current	Proposed	Annual Change
Lincoln	Overnight	650	1,034	384 increase
	Same Day	313	313	No change
Pilgrim	Overnight	384	0	384 reduction
	Same Day	233	233	No change

6. Staffing Structure

- Whole time equivalent comparisons: current versus future state.
- Increased WTE supports fragility of workforce issue.

Resource	Current	Future
Consultant	9.00*	10.00
SAS (assoc' spec and spec doctors)	7.80*	8.00
Specialist Trainee	1.00	1.00
Junior Drs (FY1/FY2)	7.00	8.00
ACPs	0.00	6.00
	24.8	**33.0**

**Note: Currently 8x funded consultants and 1x specialty doctors is acting up to consultant grade.*

7. On-call structure

Resource	Current On-call Model	Future On-call Model
Consultant	X2 24 hours	X1 24 hours
SAS (assoc' spec and spec doctors)	X2 12 hours	X1 24 hours
Surgical Junior Drs (FY1/FY2)	X1 24 hours	X1 24 hours

7.1 Recruitment and Retention

The proposed on-call rota would enable the Trust to successfully recruit to clinical posts, hugely reducing the reliance on unplanned agency staff. The current rota is onerous and therefore does not lend itself to successfully recruiting to vacant posts.

When recruiting to posts in the specialty, once staff commence they do not find the current model a workable one and therefore the ability to retain our consultants and clinical staff is of ongoing significant concern. The proposed rota will have regard for ensuring the health, safety, and wellbeing of our clinical staff.

7.2 Staff location and responsibilities

Consultants –

Consultants will retain a base hospital and will operate a timetable of elective activity based at that site and between them supporting other sites including Grantham, Louth and Community Hospitals. During a 10 week cycle they will deliver 1 week of acute activity based at Lincoln hospital, split in to a 4 day weekday and 3 day weekend segments.

SAS/ SPR doctors –

SAS and ST doctors will retain a base hospital with a timetable of elective activity which will support their development needs and with alignment to a named consultant. They will support acute activity on a 1:8 rota based at Lincoln, non-resident on call for night cover.

Nurse Consultant –

The urology nurse consultant provides professional leadership for the urology specialist nurses and ACPs as well as delivering diagnostic and outpatient activity for the department. She will also be in a position to help support the service by offering out of hours cover at the Pilgrim site.

Acute Care Practitioners-

We have invested in the service to on-board 6 ACPs who have been appointed to the urology team; they will support the acute service operating a 24 hour resident on-call rota and acting as the urology single point of contact (USPOC). All of the team will be in a position to respond to referrals from across sites, virtually or in person. In tandem with their acute commitments, the ACPs will support diagnostic and specialist activity, including flexible cystoscopies, transperineal prostate biopsies and stone management.

Urology Specialist Nurses –

The urology specialist nurses support the activity of the department across sites including the provision of:

- Cancer clinical nurse specialist roles
- Continence assessment and urodynamics
- Therapies involving bladder instillations
- Catheter and TWOC (trial without catheter clinics)

8. Key Benefits

	Activity	Expected Benefit Areas
Services	Right sized team to reduce agency burden Procurement review of consumables Financial performance review	Medical agency spend reduction Procurement cost opportunities Reduction in service deficit against budget Sustainable financial service
People	Revised on-call rota to support the change. Staff engagement survey and baselining activity leading to an engagement plan for the service	Improved engagement Training opportunity for SAS & ACP tier Reduced admin burden to manage rota and resource
Patients	Voice of patient exercise to support the reconfiguration Standardised pathways and pathway reconfiguration activities Stepped-up urology assessment unit	Complaints, SIs and DATIX reductions Average length of stay reduction Direct access model for cancer pathway Continuity and consistency of care Increase in proportion of patients discharged from assessment unit Improved flow from ED
Partner	GIRFT supporting project from a best practice perspective GIRFT recommendations from most recent report informing the solution	Alignment of solution with GIRFT recommendations and best practice guidance Increased support of Primary Care Work with system to provide best care for Lincolnshire patients

9. Patient benefits at a glance

- Reduced waiting list and pathway times for cancer to ensure 85% of patients are treated within 62 days.

- Reduced patient waiting times to ensure initial appointment can be offered within 4 weeks and treatment within 18 weeks.
- Reduction in on the day cancelled procedures.
- Reduction in non-elective admission and overall bed usage.
- Continuity and consistency of care.
- Work with system to provide best care for Lincolnshire patients.
- Stepped-up urology assessment unit.
- Improved flow from emergency department.

10. Benefits Matrix

A comprehensive benefits matrix has been captured to support the reconfiguration. The key benefits are highlighted above in section 8 and section 9. Below is a summary of the benefits matrix that will be used to manage and track the benefits of the reconfiguration.

Benefit	Baseline	Opportunity statement	Quality	Operations	Workforce	Finance	GIRFT	Model Hospital
Medical agency spend	£100k / month	• c£300k annually • Reduce to zero by Sept-21		X	X	X		
Average length of stay	3 days	• Root cause understanding of ALoS metrics. Seeking to reduce non-elective admissions and overall bed usage • Increase in proportion of patients discharged from assessment units	X	X			X	X
Cancelled procedures	13% of EL and DC cases cancelled on same day.	• Reduction in cancelled operations. Target to be established • 2019 baseline used – cancelled by the hospital (not patient)	X	X	X		X	
Cancer performance (28d)	64%	• Direct access pathway model to reduce pathway duration • Improvement in 28d national standard performance • Standardise process • Focus on bladder and kidney pathway	X	X				
Indirect and PLICS data variation	Various	• Over the data, the total costs for all codes is £13.98m against an income of £11.10m yielding a delta of £2.88m • 80% of the loss (£2.3m) is attributed to 18 unique HRG codes (this accounts for 51% of the total volume of procedures)	X	X	X	X	X	X
Procurement costs	£843k annual non pay costs.	• Note: £561k of the total non-pay costs relate to clinical supplies & services • At least £93k identify to date (urethroscope)	X			X		

Benefit	Baseline	Opportunity statement	Quality	Operations	Workforce	Finance	GIRFT	Model Hospital
Waiting list	December 2020	• 18 week RTT for ULHT is 60.8% (2,089 patients). • Target to be established.	x	x		x		
Admissions	Pre-COVID	• Reduce unnecessary admissions for urological conditions		x			x	
Staff engagement	Pre-COVID Staff survey and ad-hoc survey April 2021	• Pulse survey issued Jan-21 to establish baseline. • Engagement plan to be developed to support outcomes		x	x		x	
On-call provision	GIRFT	• Reconfiguration will address the key concerns from GIRFT about reducing elective commitments for on-call consultants.	x	x	x	x	x	
Emergency care provision	GIRFT	• Ensure high-quality emergency care is available 7-days a week • Explore options as part of a Urology Area Network (UAN)	x	x			x	
Data integrity	GIRFT	• Review data collection • Improve coding accuracy • Increase income through accurate coding • Staffing costs per WAU	x	x	x	x	x	x

11. Patient Pathways

It is recognised that the new service model involves a change in the structure of the acute service, with the main focus for emergency care being the Lincoln site. Whilst new pathways will direct emergency admissions to the Lincoln site, clearly support from urology will be required for self-presenting patients and inpatient specialties at other sites. Clarity is therefore provided within this section in relation to access to specialist urologist opinion.

To support the transfer of patients from other sites into Lincoln hospital, and to reduce pressure on the Emergency Department, a Urology Assessment Unit will be developed to allow rapid specialist decision making and intervention, supporting timely management and discharge where appropriate.

The patient pathway model for patients presenting at A&E's other than Lincoln is embedded below.

Urology Reconfiguration - Cur

Initial assessment of patients self-presenting to Pilgrim hospital with potential urological pathology will be undertaken by the A&E team in line with existing guidelines embedded below. Where a urology opinion/request for admission is deemed necessary, contact will be made through the urology single point of contact (USPOC). They will advise on the basis of telephone/virtual assessment whether:

- Patient can be discharged with appropriate urology follow up (USPOC to arrange through specialty coordinator)
- Patient requires further investigation (e.g. CT scan) and re-discussion with USPOC in the light of results
- Patient requires transfer to LCH Urology (USPOC to notify TAU, A&E to arrange urgent transfer through EMAS). Patient transfers will occur in line with the ULHT Transfer Policy.

Patient requires attendance by urology at referring site. USPOC to contact on call urology consultant to confirm attendee.


Guideline for Management of Acut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Guideline for the management of renal

Whist in the A&E department, the patient remains under the care of the A&E team and will be subject to observations according to the ULHT Observation Policy available on the Trust intranet.

Patients with NEWS score 5 and over should be escalated to the A&E medical team and the USPOC. A sepsis screen must be performed in accordance with the ULHT Sepsis Protocol available on the Trust intranet.

Patients with NEWS score 7 and over should be escalated as above and CCOT informed. CCOT will liaise with ICU as required re admission for stabilisation. In all cases where ICU admission is considered, the on call urology consultant will be contacted regarding onward urological management and provide support to ICU as detailed below.

11.1 Inpatients under other specialities requiring urological opinion/intervention

Urology will continue to offer support to patients admitted under other specialities in whom urological pathology is diagnosed. The pathway for obtaining advice and review depends on the urgency of the condition. Access to specialist urological advice will be enhanced by timetabling a site based urologist (the duty urologist) on a daily basis to support inpatient urology services.

11.2 Urgent referrals

Urgent and out of hours referrals should be directed to the USPOC. The USPOC, with support as required by the on call urology middle grade/consultant, will provide advice on immediate management and any further investigations required. These should be requested by the parent team. The USPOC will record all urgent referrals and their outcome and notify the DU of patients requiring review.

11.3 Referral Outcome – The outcome of the referrals may include:

- Patient to remain under the care of the parent team for further urological follow up as an outpatient.
- Patient to remain under the care of the parent team with further review through the Duty Urologist ward round
- Patient transferred to LCH for Urology care. Ward team to arrange transfer and USPOC to inform receiving ward. Patient remains under the care of the parent team until admitted to Lincoln Urology, supported by further advice from the Urology team as required.

- Patient requires urgent attendance by Urology at referring site. USPOC to contact on call Urology Consultant to confirm attendee.

11.4 Ward round by Duty Urologist

The duty urologist for the site will undertake a ward round 7 days a week commencing at 2pm to review non-urgent referrals for the day, review progress of previous referrals and liaise with the on call LCH team as necessary to plan further intervention or transfer.

11.5 Patients on the Critical Care Unit requiring Urological opinion/intervention

The urology service is committed to supporting the critical care unit at Pilgrim Hospital by the provision of timely specialist advice. Requests for advice should normally be made directly to the on call urology consultant, who will advise on further management and investigation. The on call consultant will attend the site as required and on the request of the ICU consultant. Further daily review of ICU patients with urology problems may be delegated to the DU.

11.6 Deterioration in Post-Operative Urology Inpatients at Pilgrim Hospital

Elective urology services will continue to be provided at Pilgrim Hospital with 3 full day urological surgical lists per week. Inpatients will be accommodated as at present on Ward 5A. The operating surgeon will be responsible for post-operative review of patients following the list and urology inpatients will be reviewed by on site consultant scheduled to undertake a morning ward round. Out of hours the routine care of inpatients will be the responsibility of the cover foundation doctor for surgery. In case of deterioration, escalation to CCOT will occur in line with the Observation policy (see 10.2.3 above) and the initial point of contact for specialist urology advice will be the USPOC, who will liaise with the urology middle grade on call as required. Where further urological intervention is required, the urology middle grade will discuss with the consultant on call regarding transfer of the patient or attendance at the Pilgrim site.

11.7 Urological Support Required in Other Speciality Theatres – Planned

The urology service is happy to provide support for other surgical specialties through assistance in operative procedures which will or may impact on the urinary tract based on preoperative assessment. The responsible specialty consultant will liaise with the consultant scheduled to be on site at the time of planned surgery. The urology specialty coordinator can help identify the appropriate consultant and ensure they are free of other commitments. Ideally 6 weeks' notice should be provided although it is appreciated for cancer surgery this period may be shorter. Where there is extensive pelvic disease involving the bladder, where a cystectomy may be required, a cross specialty discussion involving the Urology Specialist MDT should occur to determine the optimum location for management.

11.8 Urological Support Required in Other Specialty Theatres – Unplanned

It is recognised that unplanned disruption of the urinary tract may occur during both elective and emergency surgery. In this instance, the appropriate contact will be the on call urology consultant who will provide advice and attend the site to provide assistance on request. During working hours the on call consultant may liaise with consultants on site to establish if more expeditious assistance is available.

11.9 GP Referrals

Patients with a clear urological diagnosis will be referred into LCH by their GP. This pathway has been clarified through communication with Primary Care and supported by EMAS and TASL

11.10 EMAS Direct Conveyance to Lincoln

EMAS have been provided with a list of conditions meriting conveyance to LCH for assessment/admission, as detailed below (definitive list to be finalised in liaison with EMAS):

- *Urinary retention*
- *Gross haematuria including retention in association with haematuria and blood clots*
- *Acute scrotal pain*
- *Severe loin to groin pain - Strong suspicion of Renal / ureteric colic*
- *Penile/scrotal trauma*
- *Paraphimosis*
- *Prolonged painful erection (Priapism)*
- *Displaced/blocked nephrostomy*
- *Sepsis associated with nephrostomy / urethral catheter blockage*
- *Infection and haemorrhage following recent urological surgery or investigation*

12 Clinical Risk Analysis

A task & finish group was established by the Urology Project Team to undertake a specific piece of work look at potential failure points within the non-elective pathway and conducting a walk-through of patient scenarios. This group comprised Kevin Bland (KPMG), Dawn Malloney (Project Manager), Mr Andrew Simpson (Consultant Urologist & Deputy Medical Director, Mr Aris (Consultant Urologist), Jacqui Roberts (ACP), Chelsea Brown (ACP) and Angela Stockwood (Clinical Services Manager).

13 Quality Impact Assessment

The clinical risk analysis has directly fed into the Quality Impact Assessment. The QIA was signed off by the Trust's QIA Panel on 12th July 2021.

QIA2021-080
Urology Surgery Recc

14 Public/Patient engagement

To support the reconfiguration activity, a formal patient consultation exercise was conducted for 10 weeks which ended on the 23rd July 2021. This includes five open public meetings were provided that included attendance from both operations and clinical specialist.

The document below was provided to the public to provide clarity on the proposed changes.

16 210317 Urology services engagement

Additionally, a web survey was provided so the voice of the patient was captured. Overall, 175 individual responses were captured from the patient consultation exercise (153 from the public web survey, 22 from a ULHT Patient Panel Meeting and 1 from the public meetings.) A summary of the feedback is presented below.

Positive Feedback	Concerns	Mitigation
Staff: complementary about current staff, see the change as a vehicle to improved recruitment and specialists. Resource usage: general feeling that reconfiguration will positively improve access to resources / service. Patient experience: support for the separation of elective and planned activity. Feel this would result in a reduction in cancellations of elective activity. Support a reduction in elective waiting times. Patients happy to travel for expert care. Activity: welcome increased elective activity at Pilgrim, Grantham and Louth hospitals	Travel & transport: concern about delays in treatment due to emergency transport to another hospital site. concerns about how Boston-area patients would get back home after discharge from Lincoln hospital. Impact on other providers: EMAS ability to cope with demand. Patient safety: concern about risks connected with not receiving emergency care as quickly. Concerns about services being moved away from Pilgrim- disadvantaging population of Boston and the East Coast	Hospital transport on discharge will be provided for qualifying patients; for other patients, solutions including taxi provision will be explored on an ad hoc basis. EMAS are in full support of the proposal; modelling suggests the impact will be one additional transfer for admission per day The additional tier of on call provides enhanced access to specialist opinion through the SPOC. The provision of elective, diagnostic and specialist services at PHB will increase.

Appendix A provides a full breakdown of the overall results of the consultation.

15 Stakeholder Engagement

The following stakeholders have been involved throughout the design of this proposal:

ULHT Staff
EMAS
CCG
Patient panel
GIRFT
ULHT transport providers
HSC

16 Finance

In the current model there is a high reliance on agency medics. The investment into this service and improvements to the model of working is expected to improve recruitment and retention of staff. This includes:

• Investment of 6.00 WTE Advanced Clinical Practitioners (ACP), who would form part of the first on-call and reduce reliance on agency locums.

• Drive on substantive recruitment of Medical staff, including an investment of budget from within the CBU to fund a 10th consultant post.

• Introduction of Core Trainees working across Urology and Orthopaedics at Grantham site, funded from within the CBU.

The total investment into the service is £700k pa. Spend on medical agency was £780k in 19/20 and £1,153k in 20/21.

	Current Establishment			Future Establishment	
Cost Category	WTE	Cost 19/20 £k	Cost 20/21 £k	WTE	Cost £k
Consultants	8.00	2,143	2,313	10.00	1,682
SAS	8.80	948	992	8.00	878
Specialist Trainee	1.00	119	99	1.00	81
Junior Drs	7.00	325	358	8.00	373
ACPs	-	-	-	6.00	470
Total	24.80	3,535	3,762	33.00	3,484

Table showing current vs future costs of the medical workforce plus the ACPs. The future cost represents the model fully established with post-holders at 'top of scale' and without any premium costs from agency or extra duties.

As a result of these investments and the subsequent elimination of agency the specialty is expected to achieve a cost improvement of c£300k (FYE).

The overall capacity and activity will stay the same. However, there is a potential income opportunity for reduced cancellations. Of approximately 500 cancelled operations per year, 17% were due to bed availability or unplanned surgeon absence. The reconfiguration could mitigate cancellations for these reasons and therefore there is an opportunity worth around £120k, using an average elective tariff.

17 Key risks

There are a number of potential risks to the continued success of the programme identified. The top three are listed below:

- Public Consultation – potential aversion to changes resulting in reconfiguration not being feasible
- Recruitment of Middle Grade and ACP posts
- Patient safety and management of clinical risk

18 Recommendations –

In order to deliver a long term future Urology sustainable service which provides the best care for our patients, it is recommended that approval is granted to make the service changes described above.

We would respectfully ask Trust Board supports the proposed reconfiguration of urology services, with an implementation of the new model within August 2021. A detailed data dashboard has been developed to monitor the impact of the service change and this will be reported to Trust Board on a regular basis. The department will also use GIRFT gateway metrics, which are refreshed quarterly and benchmarked against top decile performance, to review the service on an ongoing basis.

19 Abbreviations -

GIRFT - (Get it Right First Time)

TWOC - Trial without catheter

NEWS – National early warning scores

CCOT – Critical Care Outreach Team

MDT – Multi-disciplinary Team

TASL – Thames Ambulance Service Liaison

EMAS – East Midlands Ambulance Service

A&E – Accident and Emergency

USPOC – Urology single point of contact

Public consultation on the future of urology services in ULHT hospitals

1. Introduction

This consultation exercise was launched on Monday 17 May and ran for eight weeks until Friday 23 July 2021.

The intention was to share our proposals with staff, stakeholders, patients and public of Lincolnshire and hear their feedback on the proposals, including potential risks, issues and concerns.

All feedback received will be considered as part of decision-making on future service models.

We have used a number of different approaches to gather patient, public and staff views on the proposals for change, which has elicited feedback from over 175 individuals.

2. Consultation activities and response rates

Activity	Date	Participation
Staff and public survey	Run 17/05/21- 23/07/21	153
Public engagement event (virtual) 2pm	21/05/21	0
Public engagement event (virtual) 6.30pm	09/06/21	0
ULHT Patient Panel meeting	14/06/21	22
Presentation at Lincolnshire Health Scrutiny Committee	23/06/21	Committee members
Public engagement event (virtual) 10am	24/06/21	1
Public engagement event (virtual) 10am	13/07/21	0
Public engagement event (virtual) 6.30pm	20/07/21	0

In total, this means our consultation exercise has listened to over 175 people.

3. Promotion

The consultation exercise, including the survey and public engagement events, have been promoted widely across Lincolnshire, using the following methods:

- Social media promotion- multiple posts across all ULHT social media channels throughout consultation duration (2-3 posts per week).
- Website pages and promotion.
- Emailed directly to all ULHT Membership and stakeholders (over 2,000 individuals).
- Shared with partner NHS organisations for wider dissemination to membership, colleagues and stakeholder database.
- Shared with media and promoted in local media.
- Poster displayed in NHS premises.

4. Findings

Survey-

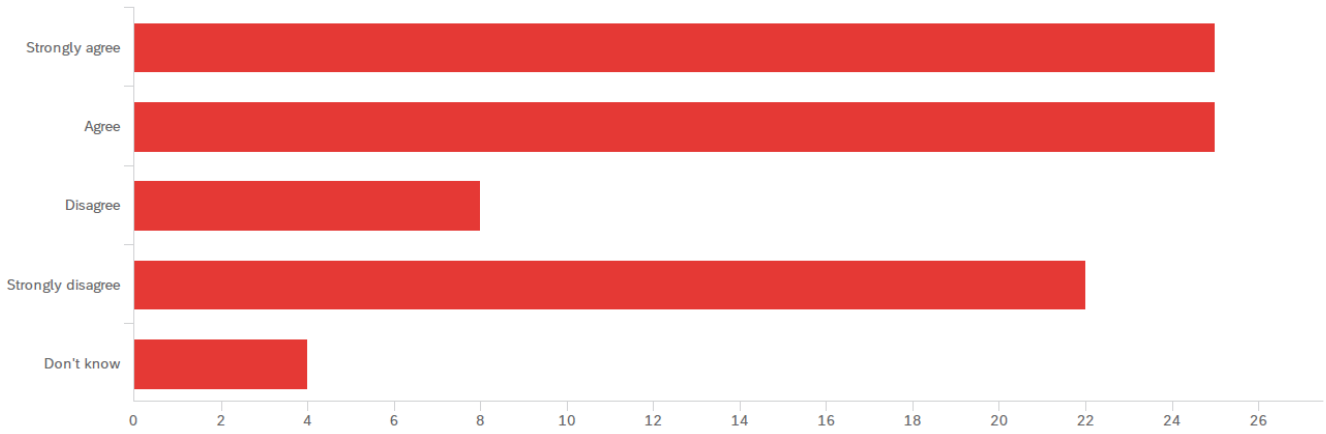
The survey was circulated using all of the above methods and attracted 153 responses from public, patients, stakeholders and staff.

Overall, the sentiment of survey results were split between those who felt that the proposed service model was a good idea for a range of reasons and those who felt that the service change should not be done.

The full results of the survey can be found on our website.

A summary of the key questions asked which will assist in decision-making is described below:

All emergency admissions to be seen at Lincoln hospital 7 days-a-week, an increase in dedicated planned surgery at Pilgrim Hospital, Boston and Grantham hospitals. Planned surgery will continue at Lincoln and Louth Hospitals and outpatients will remain at all sites. To what extent do you agree with this proposal?

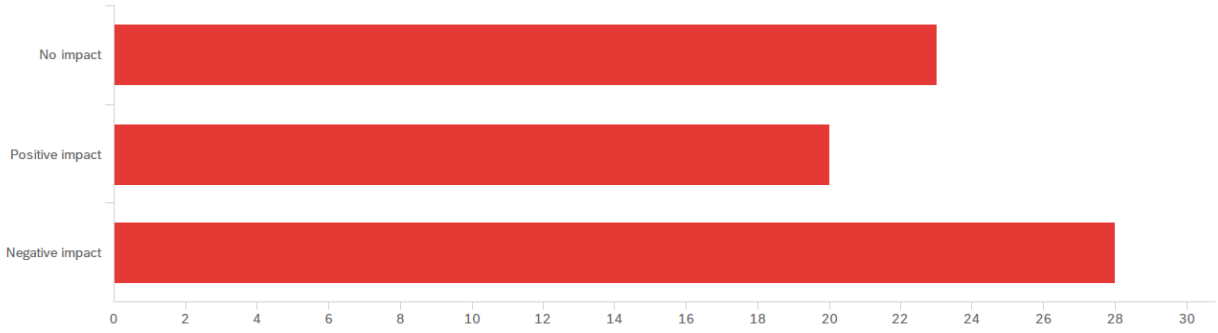


Overall, the majority of respondents (60%) agree or strongly agree with the proposed change to the urology service. There are a significant number, however, who do not agree (36%) and a small percentage who are not sure either way (4%).

Please tell us why you agreed or disagreed with this proposal and if you have any other suggested proposals
Key points included:

- Seems like a better use of resources
- Excellent idea/ support for principle- multiple comments
- Support separation of elective and planned activity
- Lack of confidence in Pilgrim for planned care- therefore positive that emergencies may not be treated there
- Concern around lack of transport infrastructure
- Concern about increased travelling times and possible safety risks for those in Boston and the East coast- multiple comments
- Concern about 'big picture' of this being one of a number of services proposed to move away from Pilgrim
- Concern about capacity at Lincoln to cope with increased activity
- Concern about impact on ambulance service/ambulance availability to transport emergencies
- Questions around impact on other services- maternity and gynaecology
- Belief that this is a financially-motivated proposal

Please tell us about the impact this proposal might have on you:



There were fairly evenly split responses between the three options, but slightly more respondents said it would have a negative impact on them (39%), than said it would have a positive or no impact.

Please tell us the reason for you answer above
Key points included:

- Concern that the proposal would put lives at risk due to travelling times and difficulties with access to ambulances
- Concern over increased travel times- specifically the impact on Boston area residents and a resulting inequality of service across the county
- Concerns of lack of access to public transport
- Happy to see less risk of planned procedures being cancelled
- Not a current service user, so no impact anticipated
- Patents not in Boston area believe they will see no impact
- Happy to travel for expert care
- Worried about impact on other services at Pilgrim

Please tell us any other suggestions you have for improving our urology services or what could be considered to mitigate any concerns you might have:

Key points included:

- Individual patient stories
- Need local services to remain and be funded to do so
- Don’t want the change to happen/ keep the service as it is
- Believe it is a service improvement which will improve recruitment
- Need dedicated urology beds at Pilgrim
- Suggestion to have dedicated on-call surgeons
- Would like to see continuity of consultant throughout an individual’s care
- Would like more regular outpatient appointments
- Direct admission to Pilgrim should be considered- instead of A&E
- Communication with patients needs to improve
- Listen to patients
- More staff needed
- Centralise to Pilgrim rather than Lincoln
- Consider introduction of more services at Grantham and Louth

Consultation meetings-

Only one attendee came to our engagement events. Feedback was that they now have a better understanding of the service.

Lincolnshire Health Scrutiny Committee-

Comprehensive response, summarised as:

- Committee does not feel it can support the proposals.
- Welcome a reduction in cancellations and improvements to elective activity.
- Concern about removal of services from Pilgrim hospital.
- Keen to see the views of the local community taken into account.
- Concern around impact on patients who would need to travel a greater distance for emergency urology care by ambulance.
- Concern around risks associated with 'walk in' patients and increased risk during transfer.
- Concerns around impact on travel arrangements and access to transport for patients upon discharge from Lincoln hospital, who may need to get home to the Boston area.
- Questions over possible impact on East Midlands Ambulance Service (EMAS).
- Noted suggested positive impact on staff recruitment and training, and a request to see evidence of this being the case if the change is implemented.

ULHT Patient Panel-

The proposals were taken to our ULHT Patient Panel who provided the following feedback:

- Possible to see the benefits of making the system more efficient- fewer cancellations are better.
- Concern about impact upon EMAS.
- Understand it is not ideal to have people on call as well as doing day job.
- Question about understanding and evaluating the impact on patients of any change.
- Question on financial implication of proposed change.
- Concern about why Lincoln chosen as main site and impact on Pilgrim.
- Concern about impact on patents who live on the orders of Lincolnshire.

5. Themes

Collating all of the evidence from the above described consultation exercise, the below themes have emerged:

Positive feedback for the proposed service model:

- **Staff:**
  - Praise for staff currently working in the service.
  - Support for the model that protects staff time and improves staff recruitment

- **Use of resources:** Feeling that the proposed service model would be a better use of resources
- **Patient experience:**
    - Support for the separation of elective and planned activity
    - Feel this would result in a reduction in cancellations of elective activity
    - Support a reduction in elective waiting times
    - Feel more confident being cared for at a 'specialist' centre
- **Making the most of expertise:** Patients happy to travel for expert care
- **Activity:**
    - Welcome increased elective activity at Pilgrim, Grantham and Louth hospitals
    - Keen to see a retention of patient choice for elective procedures

Concerns raised about the proposed service model:

- **Travel and transport:**
    - Concern about delays in treatment due to emergency transport to another hospital site
    - Risks associated with walk-in emergency patients to Pilgrim and their care
    - Concerns about how Boston-area patients would get back home after discharge from Lincoln hospital- including eligibility and availability of patient transport service
    - Concerns about Lincolnshire's transport infrastructure, and the impact that will have on travel times
    - Worries about impact on ability for family to visit those in hospital
    - Concerns about increased impact on those within certain Protected Characteristic groups due to limited access to transport- particular concerns for those who are older, those on low incomes and families with young children
- **Concern about impact on other providers:**
    - Questions about East Midlands Ambulance Service (EMAS) ability and resources to cope with increased number of transfers
    - Concern about Lincoln hospital capacity to cope with increased emergency patient numbers
- **Patient safety:** Concern about risks connected with not receiving emergency care as quickly- worse outcomes
- **Concerns about more and more services being moved away from Pilgrim- disadvantaging population of Boston and the East Coast**

Neutral feedback included:

- **Questions about impact on other services in the hospitals:** Including gynaecology and maternity services
- **Keen to see evaluation of patient experience data and impact upon staff recruitment if the change is made**

Mitigation measures consultees felt could be put in place to help address concerns included:

- Provision of dedicated urology beds at Pilgrim
- Suggestion to have dedicated on-call surgeons

- Improved continuity of consultant throughout an individual's care
- More regular outpatient appointments available
- Direct admission to Pilgrim should be considered- instead of A&E
- Communication with patients needs to improve
- Centralise to Pilgrim rather than Lincoln
- Consider introduction of more services at Grantham and Louth.

Meeting	Trust Board
Date of Meeting	3rd August 2021
Item Number	
Integrated Performance Report for June 2021	
Accountable Director	Paul Matthew, Director of Finance & Digital
Presented by	Paul Matthew, Director of Finance & Digital
Author(s)	Sharon Parker, Performance Manager
Report previously considered at	N/A

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

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

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

Executive Summary

Quality

Pressure Ulcers Unstageable

There have been 37 hospital acquired Category 2 and 7 Unstageable pressure ulcers reported for the month of June against a trajectory of 28.3. This is an increase of 1 since the last reporting period. Actions to recover can be seen below but to note the implementation of an e-learning package commenced in April 2021 and Trust compliance is currently sitting at 81% at the end of June.

Medication Incidents reported as causing harm

June has seen an increase in medication incidents with harm at 22.9% against a trajectory of 10.7%. The number of incidents causing some level of harm (low /moderate /severe / death) has remained consistent with the last 12 months, however is higher than the national median. A large proportion of incidents are occurring at the point of administration of medication and the main error is omitting medicines. Actions to recover can be seen below in the exception report.

Patient Safety Alerts responded to by agreed deadline

The following NatPSA was issued on the 13th August 2020 – Steroid Emergency Card to support early recognition and treatment of adrenal crisis in adults with a completion date of the 13th May 2021. The alert came with 4 specific actions which have only been partly completed. Joint leads in place from Pharmacy and the Medical Directors office. NatPSA has been escalated through the appropriate sub-groups. The central Clinical Governance team are in the process of reviewing policy and procedures, including upward reporting, for all NatPSA.

Mortality

HSMR

ULHT's HSMR for the 12-month rolling period is unknown, due to an issue with NHS Digital submissions to Dr Foster.

SHMI

ULHT SHMI score is 112.5 an increase from the last reporting period and places the Trust in Band 1 with a "Higher than expected SHMI". SHMI includes both deaths in-hospital and within 30-days of discharge and is reflective up to January 2021.

The Trust participates in all relevant National Clinical Audit

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

eDD

The Trust achieved 92.3% compliance with sending eDDs within 24 hours for June 2021. 96% were sent anytime during the month of May 2021. Paediatrics remain an outlier and actions in place to recover can be seen below.

Sepsis based on May 2021 Data

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

Screening compliance for child inpatients has remained the same at 84% for the month of May against a trajectory of 90%.

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

Screening compliance for ED children has decreased slightly to 87% for the month of May against a trajectory of 90%.

Duty of Candour – May 2021 Compliance

The Trust achieved 50% compliance with the Duty of Candour in May 2021, for in person notification (verbal) and 38% compliance for written follow-up. Actions to recover can be seen below.

Operational Performance

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

Operational performance for the periods from August 2020 where data is available reflects the Recovery Phase where services are being reinstated as part of this Phase 3 Recovery programme. From August 1st this recovery commenced with ambitions to returning to pre-Covid-19 levels of waiting lists, response times and constitutional standards, in line with expectations as set out in Sir Simon Stevens' letter of 31st July 2020.
The Covid-19 2nd wave impacted significantly against the Trusts plans, posing challenges across both non-elective and elective pathways, including cancer, and resulting in the intermittent pausing of the green pathways at both Lincoln and Pilgrim hospitals. Grantham has now been restored to its original function and purpose.

This report covers May and June performance, and it should be noted that as the demands of Wave 2 diminished, the Trust has now moved into a phase of restoration of services and is now guided by national requirements as set out in NHS England's 2021/22 Priorities and Operational Planning Guidance. This guidance which moves away from a focus on statutory access standards will have direct impact on performance, specifically RTT. Additionally, new Emergency and Planned Care Standards are now being implemented, monitored, and reported going forwards.

A & E and Ambulance Performance

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

4-hour performance for June deteriorated against May's performance of 72.56% being reported at 70.74%. This is the eighth time in eleven months the Trust's performance has been below the agreed trajectory.

There was one 12 hr trolley wait, reported via the agreed process. This breach was considered avoidable.

Performance against the 15 min triage target demonstrated a 2.18% improvement in June, up from 86.05% in May to 88.23%. The recording of triage improved marginally by 0.17% in June when compared with May's performance.

Ambulance conveyances for June were, 4685, down by 3.27% against May. There were 349 >59minute handover delays recorded in June, a deterioration of 64 from May. Delays experienced at LCH and PHB are attributed to volume and conveyance pattern.

Length of Stay

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

Referral to Treatment

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

May demonstrated some improvement in performance. May demonstrated an increased performance of 5.8% to 61.62%. The Trust reported 1032 incomplete 52-week breaches for May end of month, (an improvement of 317) down from 1349 in April. The Trust remains in a relatively strong position when compared to other regional providers.

The Cancer/Elective Cell continued to meet three times weekly throughout the month of May and June with a weekly confirm and challenge meeting with surgical specialities led by senior clinical review and prioritisation to ensure capacity across all sites are maximised for the most critical patients. Cancer patients and clinically urgent remain a priority with a continued focus on 62+ day, 104+ days cancer patients and 40+, 52+ and 78+ week patients on the 18-week RTT PTL.

Waiting Lists

Overall waiting list size has increased in May by 5,356, to 48,475. The number of incomplete pathways is now approx. 14,087 more than in March 2018, however there remains a cohort of patients remaining on the Trust's ASI list that are not accounted for in this figure. Work continues between OPD and the CBUs regarding the returning to a standard 'polling' approach as part of our post wave 2 restoration plans.

A recovery plan for ASIs has been developed and including a recovery trajectory. As of week commencing 7th July ASI numbers have reduced from circa 10,300 to only 839 and remains ahead of trajectory.

The Trust reported 3,299 over 40week waits; an increase of 121 from April. The numbers of patients waiting over 26 weeks increased by 706 from April. The longest waiting patients continue to be tracked and discussed weekly with escalation as appropriate and reported bi-weekly to NHSE/I.

Diagnostics

CT
Decrease in breaches within CT May 120 compared to 153 in April. This will be due to patient's choice and cardiologists' capacity. CT activity has increased from 6,232 to 6,557, this is over a 1,000 increase from May 19.

MRI
42 breaches in March compared to 46 last month, majority of these are cardiac and general anaesthetic patients.

Physiological Sciences.
Neurophysiology - peripheral neurophysiology LCH is reporting 65 for May compared to 19 last month. Waiting lists are monitored weekly

Endoscopy
Cystoscopy carried out within endoscopy had 46 breaches in May, compared to 65 breaches last month.
Colonoscopy had 307 breaches in May compared to 392 last month. These are the planned patients all live patients are being carried out within 41 days.

Cardiology
Echocardiography had 2,848 breaches for June, compared to 2,804 last month.
Echocardiography Stress /TOES had 31 breaches in June, compared to 39 last month

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

Cancer

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

79% of the 14 day breach performance was attributed to the Breast Service in respect of the One-stop appointments. A demand verses capacity gap exists and has been previously articulated. This also applies to the Symptomatic Breast service.

The impact of COVID-19 on the delivery of the cancer pathways remains evident for 31 day and 62 day standards.

62 Day pathway backlogs are not reducing – 218 as of 8th July 2021 verses 188 on 10th June 2021.

May 62 day performance: Head & Neck 16.7%, Breast = 31.8%, Colorectal = 37.5%, Upper GI = 40.5%, Gynaecology = 4

Workforce

Mandatory Training - The trend for completion of mandatory training remains strongly upwards over the last few months. A review of core learning is underway to ensure the training that staff are being asked to complete is appropriate and should be mandatory.

Sickness Absence – Sickness has risen rapidly during July. This is the impact of Wave 3 of COVID, both in terms of staff being absent because of COVID and staff isolating. We are reviewing the rules for isolating (within the terms of national rules) and reintroducing more intensive oversight of sickness. Compliance with expectations of the use of the Attendance Management System is patchy and this is inhibiting our ability to manage sickness effectively.

Staff Appraisals - The AfC appraisal rate continues to disappoint. There has not been the expected improvement as a consequence of the implementation of the WorkPal system. This is a focus of Divisions in their work to improve staff morale and engagement. The fundamental issues remains the extent to which managers feel they have time to spend on appraisal. This will be a focus of Divisions and Directorates.

Agency Spend – The trend on agency spend is downwards, but there will need to be a step change in spend levels, particularly in nursing agency spend, if the targets are to be achieved. The two workforce transformation groups, for nursing and medical staff, have been refocused on the short-term measures that can lead to that reduction in spend. This will be a mixture of greater grip and control and the identification and management of the factors that are driving agency spend e.g. effective rota management of medical staff.

Finance

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

The Lincolnshire system resubmitted its financial plan for H1 of 2021/22 to take account of Elective Recovery Funding (ERF). The revised H1 financial plan for the Trust is inclusive of a £1.8m surplus position, £7.6m ERF, costs of restoration of £5.8m and a requirement for the Trust to deliver cost improvement (CIP) savings of £6.4m.

The Trust has delivered a £0.7m surplus for the month of June (in line with plan) and a £1.1m deficit year to date (in line with plan).

Capital expenditure as at Month 3 of the financial year equated to £2.6m against a submitted plan of £6.0m.

The capital programme for 2021/22 currently stands at £33.7m for the full-year, with c£23m agreed at Trust Board in May and subsequently the remaining c£10m agreed at FPEC (May meeting) thereby completing the agreed capital programme that has been shared with all key stakeholders.

The month end cash balance is £44.0m which is a decrease of £10.0m against cash at 31 March 2021.

Paul Matthew
Director of Finance & Digital
July 2021

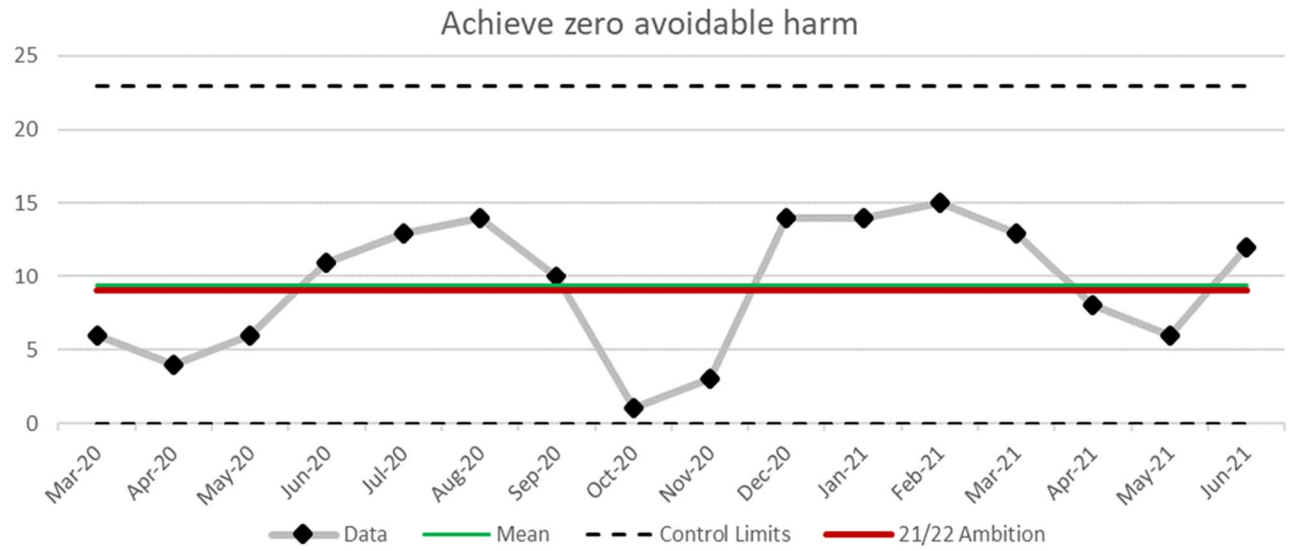
Statistical Process Control Charts

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

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

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

An example chart is below:



Statistical Process Control Charts

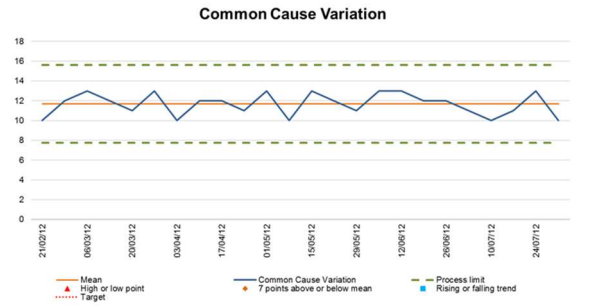
Normal variations in performance across time can occur randomly- without a direct cause, and should not be treated as a concern, or a sign of improvement, and is unlikely to require investigation unless one of the patterns defined below applies.

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

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

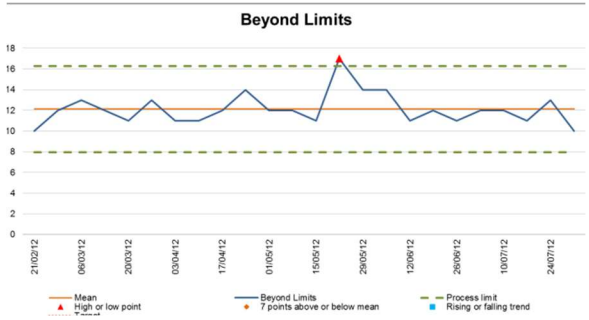
Icons are used throughout this report either complementing or as a substitute for SPC charts. The guidance below describes each icon:

Normal Variation



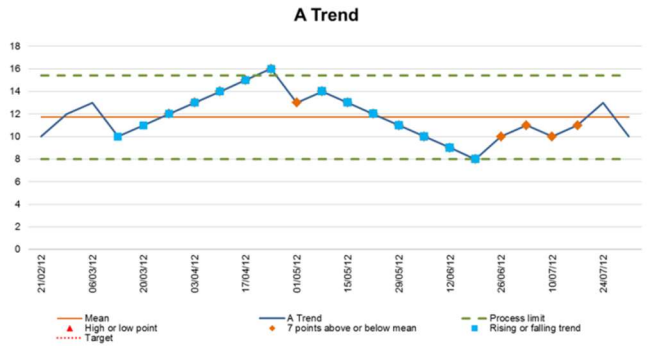
Extreme Values

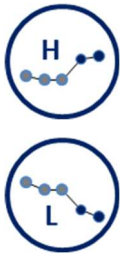
There is no Icon for this scenario.



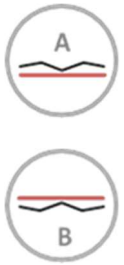
Statistical Process Control Charts

A Trend (upward or downward)





A Trend (a run above or below the mean)



Where a target has been met consistently

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

Where a target has been misse consistentl

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

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Strategic Goal	Domain	Measure ID	Measure	Measure Definition	Baseline	21/22 Ambition	Apr	May	Jun	Latest month pass/fail to ambition	Trend variation
Strategic Metrics	Patients	1	Top 25% for acute Trusts for 'Overall' Inpatient experience	Results in recommending our services to friends and family	4th quartile	3rd quartile	89.95%	91.17%	91.16%		
	Patients	2	Achieve zero avoidable harm	Serious incidents (including Never Events) of harm - Moderate, severe and death.	15	9	8	6	12		
	Patients	3	Top 25% for SHMI	Summary Hospital-level Mortality Indicator	4th quartile	4th quartile	Q4 (110.57)	Q4 (110.64)	Q4 (112.05)		
	People	4	Top 25% for acute Trusts across all 10 themes in the staff survey	In year monitoring via staff survey on staff morale and leadership.		+10% improvement					
	Partners	26	Deliver 62 day combined cancer standard (77%)	Patients that start a first treatment for cancer within two months (62 days) of an urgent GP referral, including NHS cancer screening services.	69.20%	77%	61.60%	61.30%			
	Partners	27	Total wait in Emergency Department over 12 hours (<1% of patients)	Number of Patient ED attendances waiting more than 12 hours from arrival to transfer, admission or discharge as a percentage of ED attendances.	3.60%	<1%	4.55%	4.71%	5.80%		
	Partners	28	Urgent Treatment (P2) treatment turnaround time is less than 4 weeks	Waiting time from receiving patient referral until treatment is given.	6.7	<4 weeks					
	Partners	29	Deliver Outpatient activity through non-face to face	Increase volume of Outpatients activity for pre-booked telephone and web-based sessions, between consultant and patient		25%	37.42%	35.80%	33.70%		
	Services	9	Deliver a breakeven revenue position	Financial status		Breakeven					
	Services	10	Deliver £200m capital plan	Financial status	£15m	£39m					
Local Projects	Patients	11	No. of medication errors causing harm is <10%	Medication incidents reported as causing harm (low /moderate /severe / death), as a percentage of total medication incidents.	20%	13%	24.64%	20.30%	22.92%		
	Patients	12	Reduce no. of patient fall incidents	Number of Falls reported (including no harm)	200	159 (-20.5%)	120	124	131		
	People	13	% of staff saying proud to work for ULHT	Staff survey on morale and leadership		+10% improvement					
	Partners	14	First non elective admission by 10am	Daily situation reporting before 10am, on unplanned admissions of patients for specific General and Acute wards.	48%	60%	59.76%	60.23%	57.45%		
	Services	15	Reduce agency spend by 25%	Reduction in hospital recruiting to posts as temporary cover (non permanent salaried positions).	£44m	£33m (-25%)	£3,848,000	£3,718,000	£3,417,000		
Watch Metrics	Patients	16	Reduce complaints around discharge by 50%	Where patient has been discharged from hospital but is unsatisfied in the way the discharge was handled	n/a						
	Patients	17	Reduce complaints about the experience in A&E by 50%	Patient experience complaints about treatment of A&E	n/a						
	Patients	18	Time to screening and treatment for sepsis (1 hour)	Number of sepsis incidents reported	37.5% (3/8)	62.5% (5/8)	62.50%	75.00%			
	Patients	19	Reduce incidence of pressure ulcers	Number of Pressure Ulcers reported on ward- Category 2, 3, 4 & Unstageable	58	45	33	40	44		
	People	20	% of staff that feel trusted and valued	Staff survey on morale and leadership							
	People	21	No. of managers trained in coaching skills	Staff survey on morale and leadership							
	Partners	22	Increase the proportion of patients seen by a decision maker within one hour	Patient arrival to the time seeing a A&E doctor, within 1 hour.	50%		57.32%	56.48%	57.87%		
	Partners	23	Reduction in the new to follow up ratio	Reduction in the number of follow up outpatient activities undertaken.	1:2.28		1:1.48	1:1.49	1:1.35		
	Partners	24	First OPA within 4 weeks	Number of outpatients seen within 4 weeks of their referral to hospital. Includes external referrals only (from GP, Dentist, Optician) for all urgency types (2WW, Urgent, Routine) to consultant led services (non-telephone).	51%		37.73%	52.07%	55.88%		
	Services	25	Improve CIP performance to a minimum of 4% by 2021/22	Improving the financial performance through proactive monitoring of Cost Improvement Plan (CIP)	1.7%						

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

Quality | Operational Performance | Workforce | Finance

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PERFORMANCE OVERVIEW - QUALITY

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target per month	Apr-21	May-21	Jun-21	YTD	Pass/Fail	Trend Variation
Deliver Harm Free Care	Clostridioides difficile position	Safe	Patients	Director of Nursing	9	4	2	5	11	P	
	MRSA bacteraemia	Safe	Patients	Director of Nursing	0	0	0	0	0	P	
	MSSA bacteraemia cases counts and 12-month rolling rates of hospital-onset, by reporting acute trust and month using trust per 1000 bed days formula	Safe	Patients	Director of Nursing	TBC	0.11	0.07	0.04	0.07		
	E. coli bacteraemia cases counts and 12-month rolling rates, by reporting acute trust and month using trust per 1000 bed days formula	Safe	Patients	Director of Nursing	TBC	0.08	0.14	0.14	0.12		
	Catheter Associated Urinary Tract Infection	Safe	Patients	Director of Nursing	1	0	0	Data not available yet	0	P	
	Falls per 1000 bed days resulting in moderate, severe harm & death	Safe	Patients	Director of Nursing	0.19	0.02	0.00	0.04	0.02	P	
	Pressure Ulcers category 3	Safe	Patients	Director of Nursing	4.3	1	1	0	2	P	B
	Pressure Ulcers category 4	Safe	Patients	Director of Nursing	1.3	1	0	0	1	P	
	Pressure Ulcers - unstageable	Safe	Patients	Director of Nursing	4.4	5	3	7	15	F	
	Venous Thromboembolism (VTE) Risk Assessment	Safe	Patients	Medical Director	95%	97.57%	97.80%	96.08%	97.15%	P	
	Never Events	Safe	Patients	Director of Nursing	0	0	0	0	0	P	
	Reported medication incidents per 1000 occupied bed days	Safe	Patients	Medical Director	4.3	5.25	4.8	5.13	5.06	P	
	Medication incidents reported as causing harm (low /moderate /severe / death)	Safe	Patients	Medical Director	10.7%	24.6%	20.3%	22.9%	22.60%	F	A

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PERFORMANCE OVERVIEW - QUALITY

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Apr-21	May-21	Jun-21	YTD	Pass/Fail	Trend Variation
Deliver Harm Free Care	Patient Safety Alerts responded to by agreed deadline	Safe	Patients	Medical Director	100%	none due	0%	67.0%	33.50%	F	
	Hospital Standardised Mortality Ratio - HSMR (basket of 56 diagnosis groups) (rolling year data 3 month time lag)	Effective	Patients	Medical Director	100	115.45	117.08	No Data	116.27	F	H
	Summary Hospital Mortality Indicator (SHMI) (rolling year data 6 month time lag)	Effective	Patients	Medical Director	100	110.57	110.64	112.05	111.09	F	H
	The Trust participates in all relevant National clinical audits	Effective	Patients	Medical Director	100%	95.00%	95.00%	95.00%	95.00%	F	A
	eDD issued within 24 hours	Effective	Patients	Medical Director	95%	93.40%	92.10%	92.30%	92.60%	F	
	Sepsis screening (bundle) compliance for inpatients (adult)	Safe	Patients	Director of Nursing	90%	86.0%	92.0%	Data not available yet	89.00%	P	
	Sepsis screening (bundle) compliance for inpatients (child)	Safe	Patients	Director of Nursing	90%	84.0%	84.0%	Data not available yet	84.00%	F	
	IVAB within 1 hour for sepsis for inpatients (adult)	Safe	Patients	Director of Nursing	90%	93.0%	93.0%	Data not available yet	93.00%	P	
	IVAB within 1 hour for sepsis for inpatients (child)	Safe	Patients	Director of Nursing	90%	100.0%	100.0%	Data not available yet	100.00%	P	
	Sepsis screening (bundle) compliance in A&E (adult)	Safe	Patients	Director of Nursing	90%	94.0%	94.0%	Data not available yet	94.00%	P	A
	Sepsis screening (bundle) compliance in A&E (child)	Safe	Patients	Director of Nursing	90%	90.0%	87.0%	Data not available yet	88.50%	F	
	IVAB within 1 hour for sepsis in A&E (adult)	Safe	Patients	Director of Nursing	90%	95.0%	95.0%	Data not available yet	95.00%	P	
	IVAB within 1 hour for sepsis in A&E (child)	Safe	Patients	Director of Nursing	90%	50.0%	100.0%	Data not available yet	75.00%	P	
	Rate of stillbirth per 1000 births	Safe	Patients	Director of Nursing	4.20	2.89	3.12	3.34	3.12	P	B
Improve Patient Experience	Mixed Sex Accommodation breaches	Caring	Patients	Director of Nursing	0	1	0	Data not available yet	1	P	
	Duty of Candour compliance - Verbal	Safe	Patients	Medical Director	100%	79.00%	50.00%	Data not available yet	64.50%	F	L
	Duty of Candour compliance - Written	Responsive	Patients	Medical Director	100%	53.00%	38.00%	Data not available yet	45.50%	F	L

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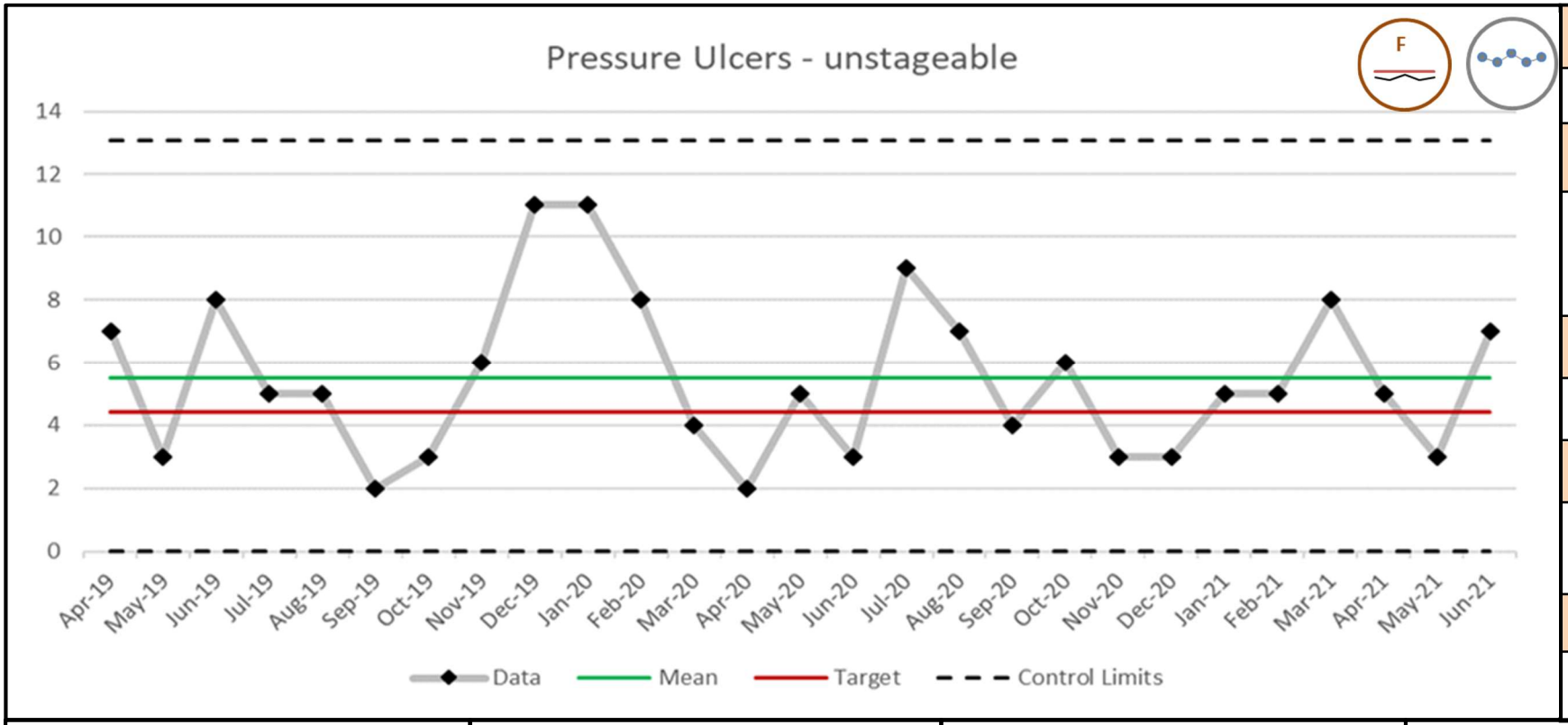

Jun-21
7
Variance Type
Metric is currently experiencing Common Cause Variation
Target
4.4
Target Achievement
Metric is failing the target
Executive Lead
Director of Nursing

Background:
Total number of patients with an unstageable pressure ulcer.

What the chart tells us:
We are currently at 7 against a target of 4.4 per month.

Issues:
The total number of reported hospital acquired reported pressure ulcers for category 2, 3, 4 and Unstageables is 44 an increase of 4 from May 2021 although this remains within normal variation.
Patients who have existing pressure damage are not consistently receiving early assessment and identification on admission to hospital. Work being completed by the Divisional team, Quality Matron and Tissue Viability team has highlighted some differences in skin integrity care provided across the emergency care pathways between hospital sites.

Actions:
Targeted support and bespoke training is being provided to emergency care pathway areas from the Quality Matron and Tissue Viability teams. Working in partnership with the clinical teams to develop local actions plans to drive improvements in early skin assessment, intervention and documentation which would be expected to impact on reducing the number of hospital attributable pressure damage incidents being reported.

Mitigations:
Following the introduction of Pressure ulcer prevention and management eLearning at the end of April it has been reported to have been positively received and rates of compliance are at 81% at the end of June.
Skin Integrity Group (SIG) are sighted on areas with increased incidences where deep dives are to be undertaken.

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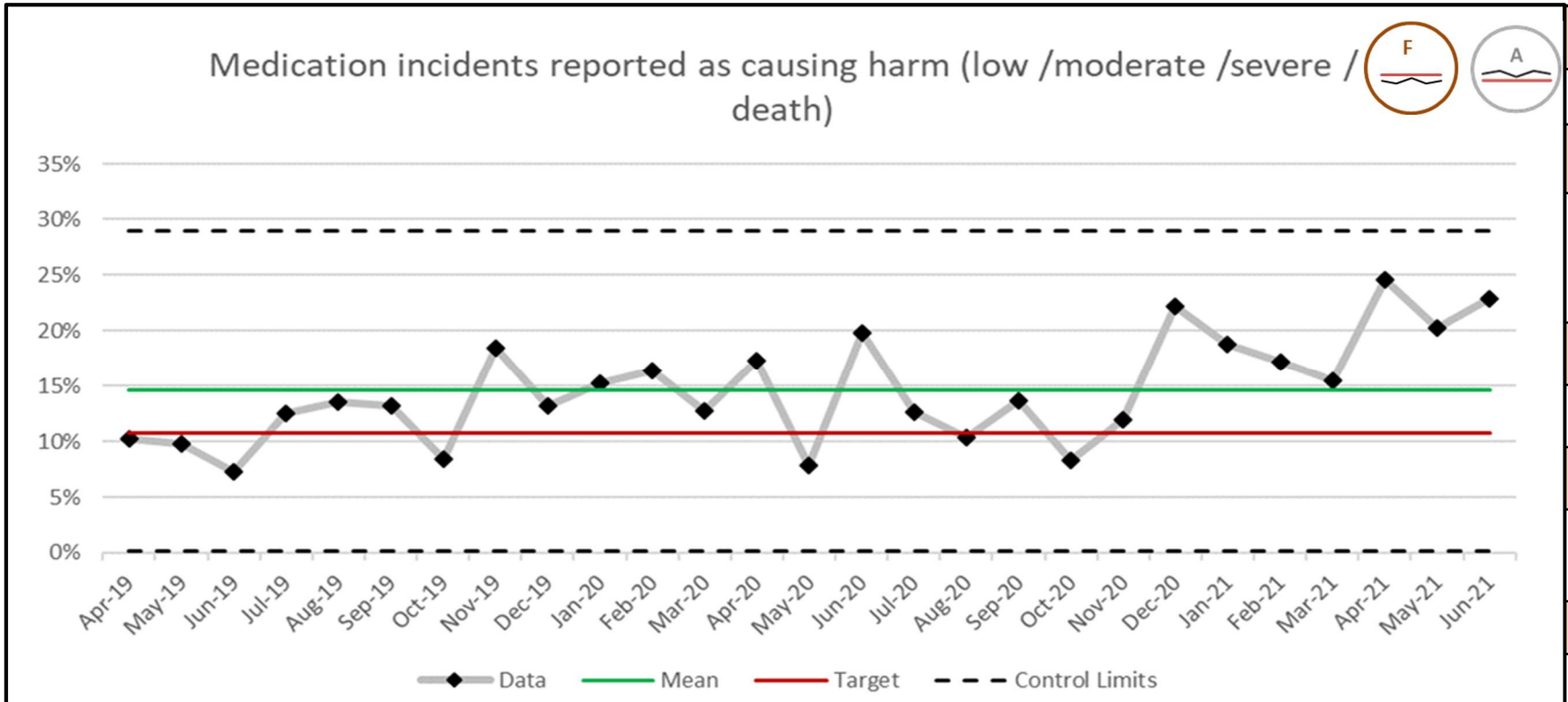

Jun-21
22.9%
Variance Type
Metric is currently experiencing Special Cause Variation – above the mean
Target
10.7%
Target Achievement
Metric is consistently failing the target
Executive Lead
Medical Director

Background:
Medication Incidents reported as causing harm (low/moderate/severe or death)

What the chart tells us:
In the month of June the number of incidents reported was 144. The number of incidents causing some level of harm (low /moderate /severe / death) is 22.9% more than double the national average of 10.8.

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

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

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

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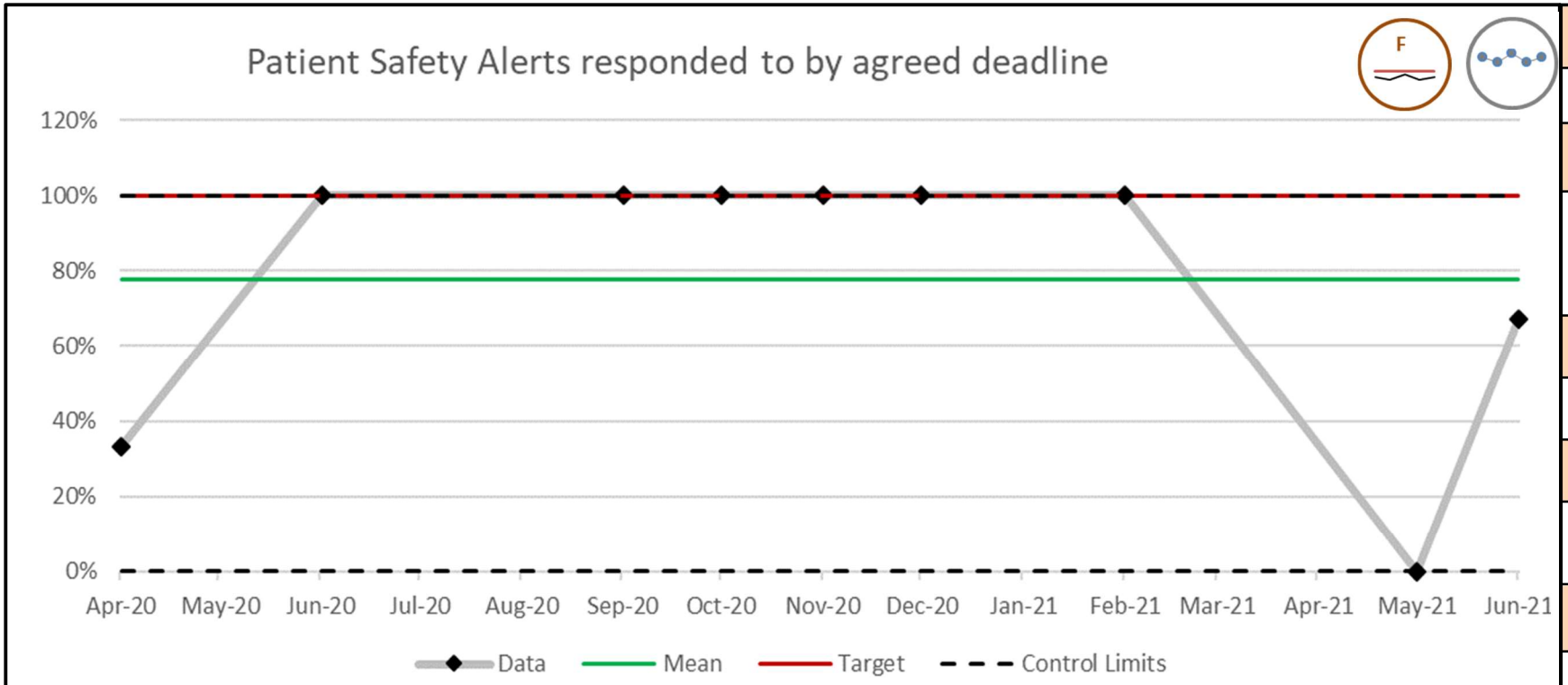


June-21
67%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
100%
Target Achievement
Metric is failing to target
Executive Lead
Medical Director

Background:
Percentage of patient safety alerts responded to by an agreed deadline.

What the chart tells us:
We are currently at 67% against a 100% target.

Issues:
The following NatPSA was issued on the 13th August 2020 – Steroid Emergency Card to support early recognition and treatment of adrenal crisis in adults with a completion date of the 13th May 2021. The alert came with 4 specific actions which have only been partly completed.

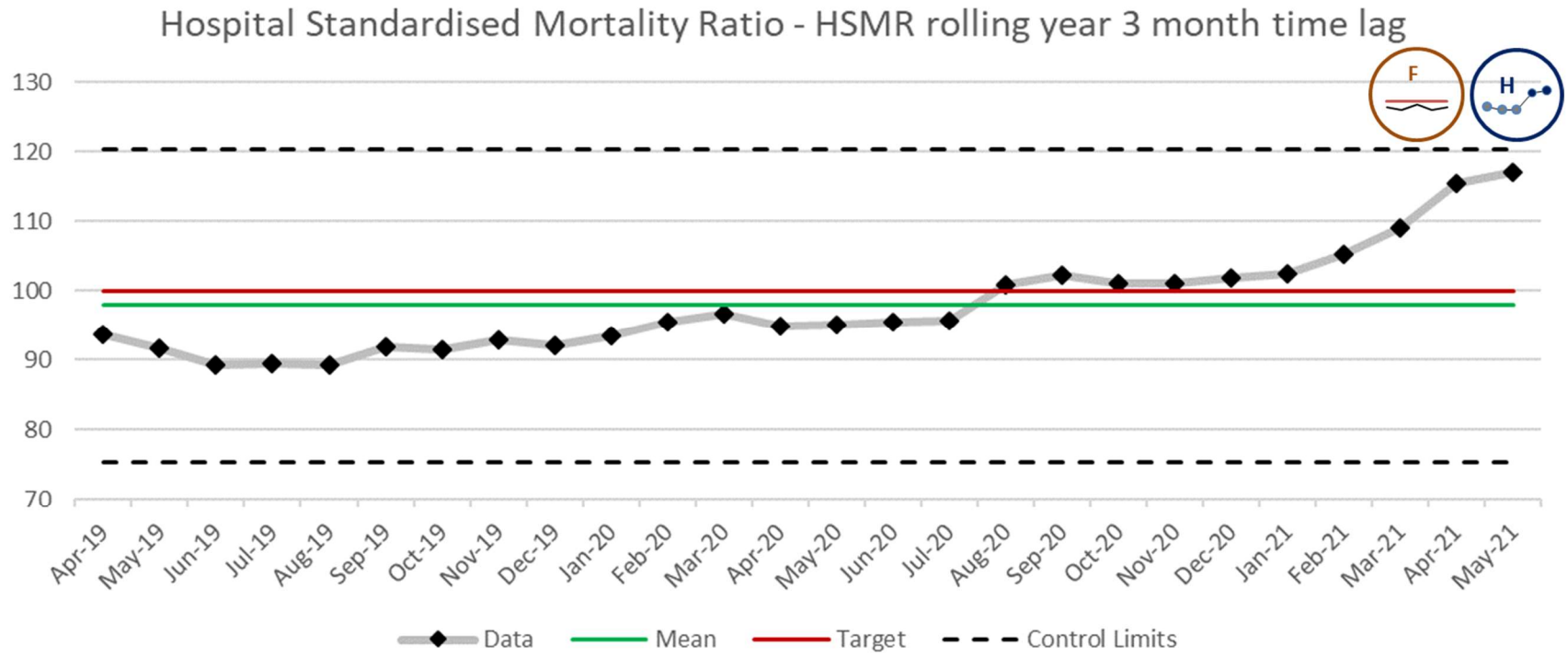
Actions:
Joint leads in place from Pharmacy and the Medical Directors office. NatPSA has been escalated through the appropriate sub-groups.

Mitigations:
The central Clinical Governance team are in the process of reviewing policy and procedures, including upward reporting, for all NatPSA.

Quality | Operational Performance | Workforce | Finance

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



May-21
117.08
Variance Type
Metric is currently experiencing Special Cause Variation – high trend
Target
100
Target Achievement
Metric is consistently failing the target
Executive Lead
Medical Director

Background:
Hospital Standardised Mortality Ratio (HSMR) (basket of 56 diagnosis groups) (rolling year data 3 month time lag)

What the chart tells us:
We are currently at 117.08 against a 100 target.

Issues:
ULHT's HSMR for the 12-month rolling period is unknown, due to an issue with NHS Digital submissions to Dr Foster.

The previous Trust HSMR for Mar-20 to Feb-21 was 117.08, which is within the 'High' banding.

Actions:

Mitigations:

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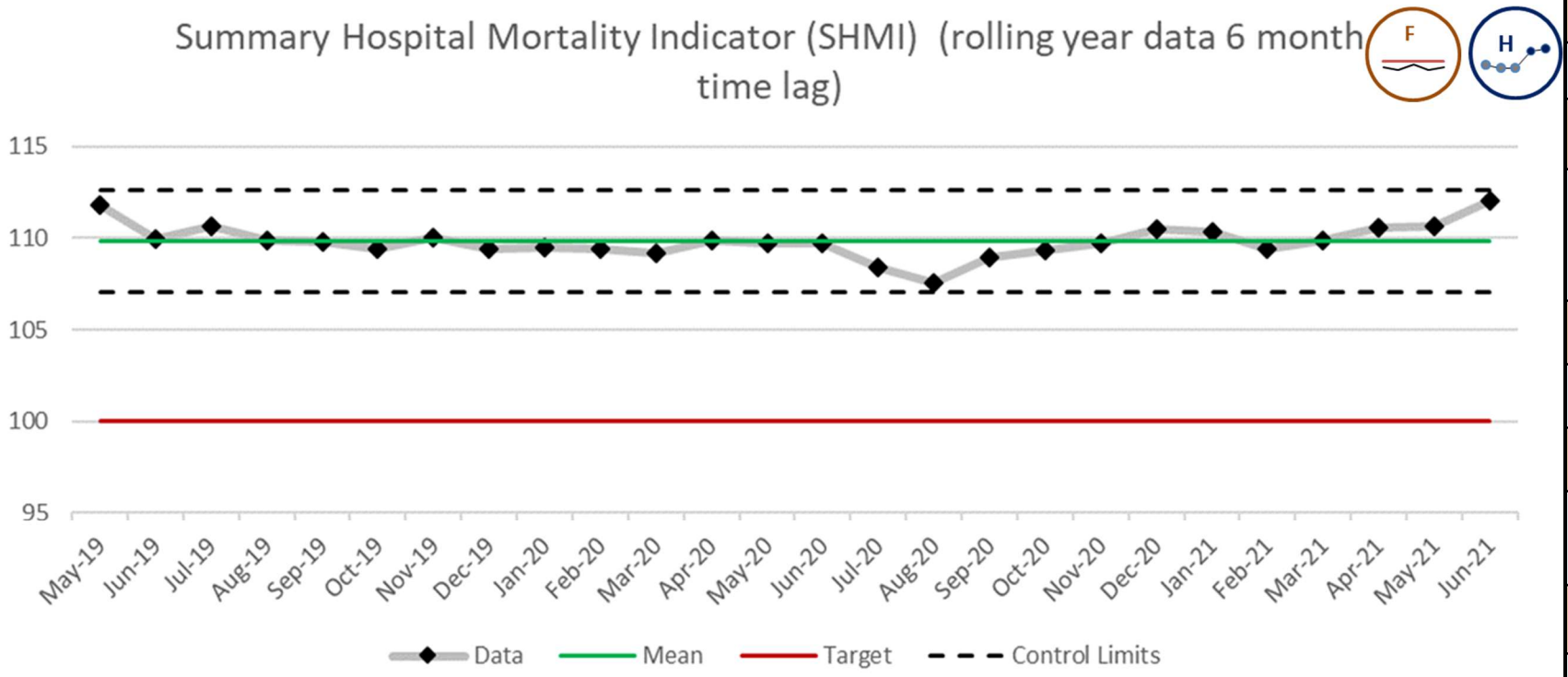

Jun-21
112.05
Variance Type
Metric is currently experiencing Special Cause Variation – high trend
Target
100
Target Achievement
Metric is consistently failing the target
Executive Lead
Medical Director

Background:
Summary Hospital Mortality Indicator (SHMI) (rolling year data 6 month time lag)

What the chart tells us:
ULHT SHMI is 112.05; an increase from the last reporting period against a target of 100.

Issues:
This places the Trust in Band 1 with a 'Higher than expected SHMI'. SHMI includes both deaths in-hospital and within 30 days of discharge. The data is reflective up to January 2021.
NHS Digital are excluding all data in regard to COVID-19. An extract from NHS Digital shows that 4.1% of spells (2755 spells), have been excluded due to COVID-19 coding. The national average is 4.5%.

Actions:

Mitigations:

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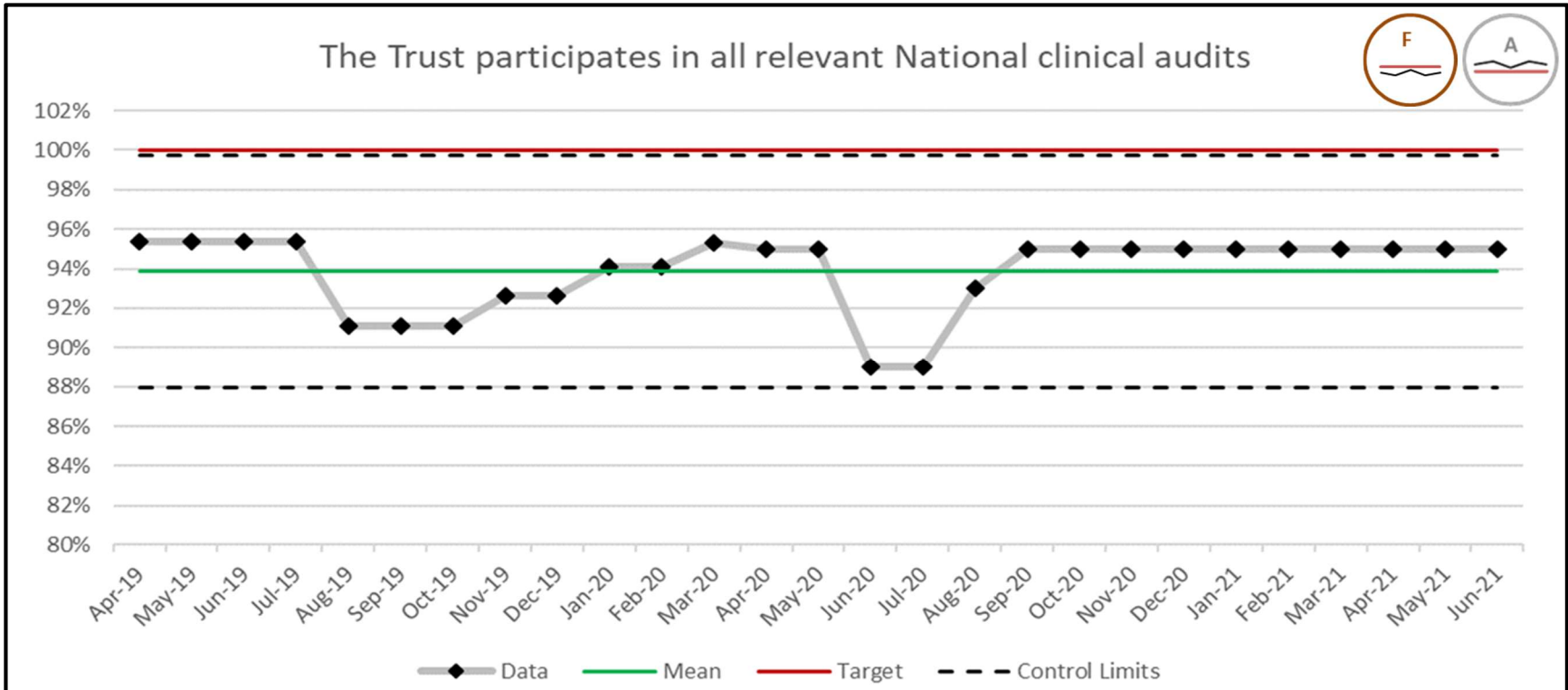

Jun-21
95%
Variance Type
Metric is currently experiencing Special Cause Variation – above the mean
Target
100%
Target Achievement
Metric is consistently failing the target
Executive Lead
Medical Director

Background:
The Trusts National clinical audits participation rate.

What the chart tells us:
The % participation National Clinical Audit rate has remained at 95% for the month of June 2021 compared to a target of 98%.

Issues:
The following is not compliant with data submissions;
None Participation in the National IBD audit has been clarified with the Clinical Director for Medicine.

Actions:
The IBD specialist nurses will be collecting the biologics data.
Data sharing agreement, registration forms and NHS digital access Caldicott Guardian submitting on behalf of the Trust.
Participation fee Division of Medicine funding – finance information circulated IBD will invoice the Trust.

Mitigations:
Elective procedures cancelled in line with NHS England Guidance. Procedures that are now taking place, this should improve participation as the Trust returns to normal working.

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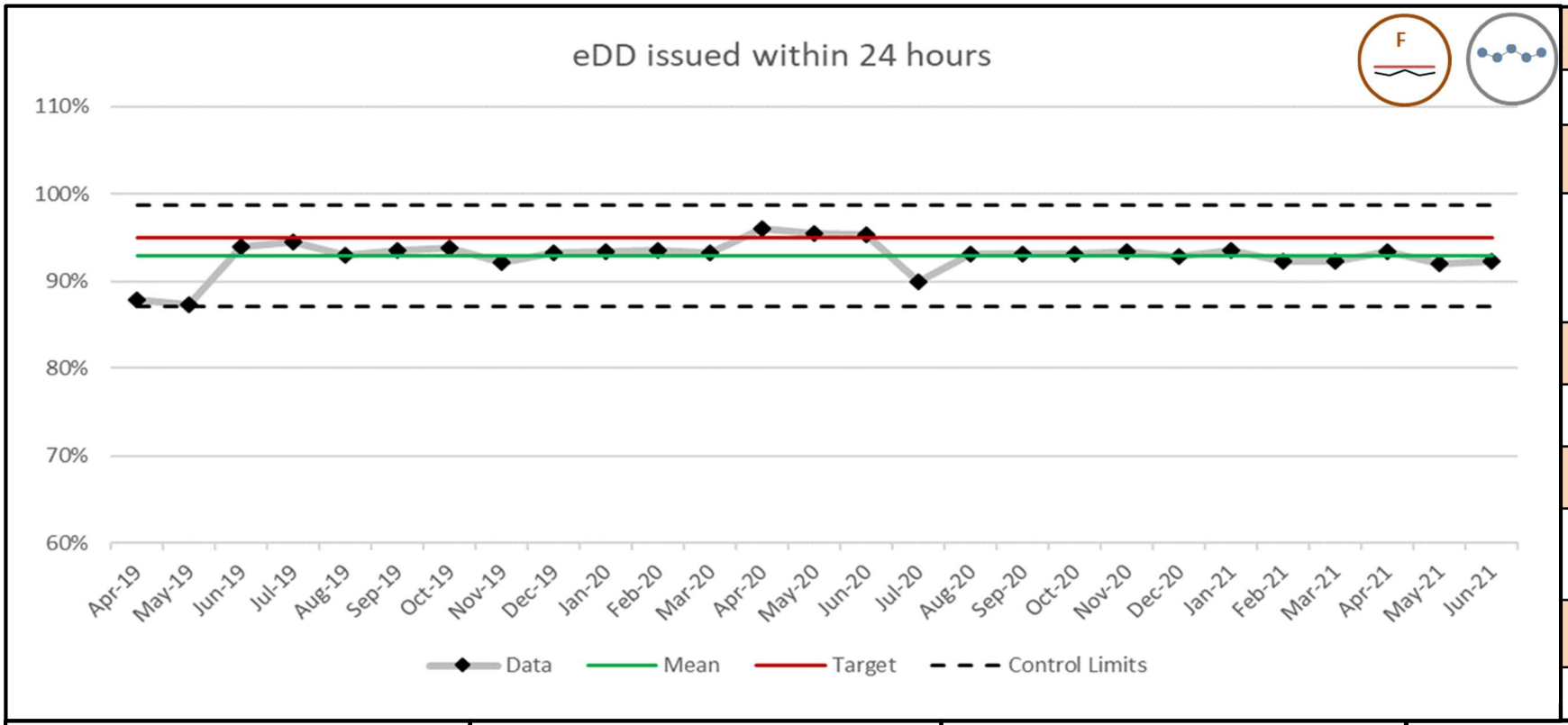

Jun-21
92.30%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
95%
Target Achievement
Metric is consistently failing the target
Executive Lead
Medical Director

Background:
Percentage of expected date of discharge issued within 24 hours.

What the chart tells us:
The Trust achieved 92.3% compliance with sending eDDs within 24 hours for June 2021 against a target of 95%, however 96% were sent anytime during the month of June 2021.

Issues:

Actions:

- Paediatric eDD template being streamlined
- Actions implemented within paediatrics to help improve compliance.
- When the backlog has been sent to the GPs and the paediatric template streamlined the eDD group will disestablish and each Division will be accountable for their eDD performance.

Mitigations:

Quality | Operational Performance | Workforce | Finance

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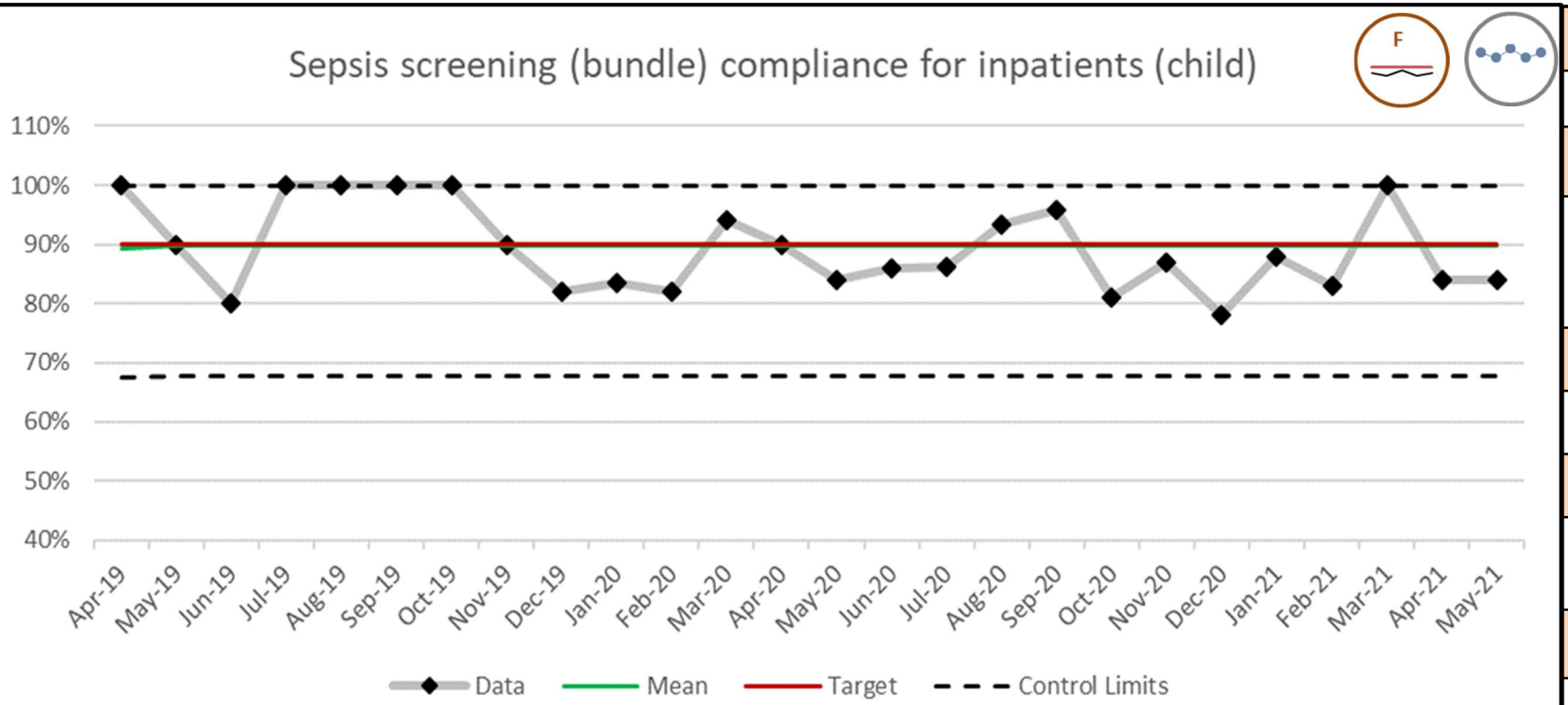

May-21
84%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
Metric is consistently failing the target
Executive Lead
Director of Nursing

Background:
Sepsis screening (bundle) compliance for Inpatients (Child).

What the chart tells us:
Sepsis screening compliance for inpatients (children) is 84% which is currently below the 90% target.

Issues:
The ward is seeing an increasing number and dependency of Paediatric patients. Lincoln does not currently have a Sepsis Link Nurse for inpatient Paediatrics.

Actions:
Scenario and Sepsis training for new / temporary staff is being carried out. Sepsis Practitioner is visiting the wards regularly to offer assistance. The Clinical Educators on both sites and the Sepsis Link Nurse at Pilgrim are also offering assistance were needed. All staff that have missed or had a delayed screen are involved in carrying out the Harm reviews for these patients. The ward Managers in both areas also speak to staff involved on a 1:1 basis.

Mitigations:
Sepsis compliance and issues are all discussed at speciality governance meetings.

Quality | Operational Performance | Workforce | Finance

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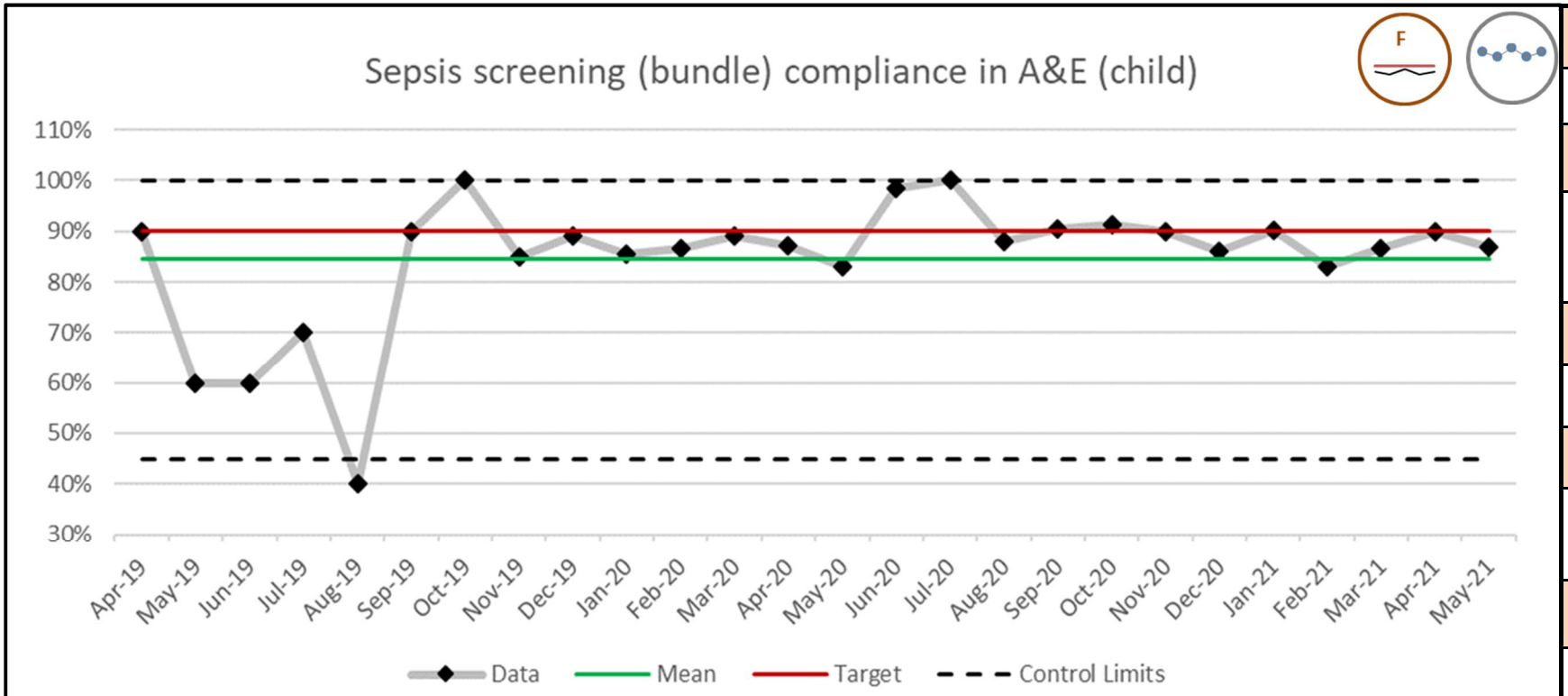

May-21
87%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
Metric is consistently failing the target
Executive Lead
Director of Nursing

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

What the chart tells us:
Screening compliance in ED is 87% which is below the 90% target.

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

Actions:
Sepsis Practitioners are currently doing regular walk rounds in the department and offering any assistance if needed. Scenario training is taking place on both sites and has had a good attendance. Harm reviews are being carried out for all delayed / missed screens and ED staff are involved in carrying these out.

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

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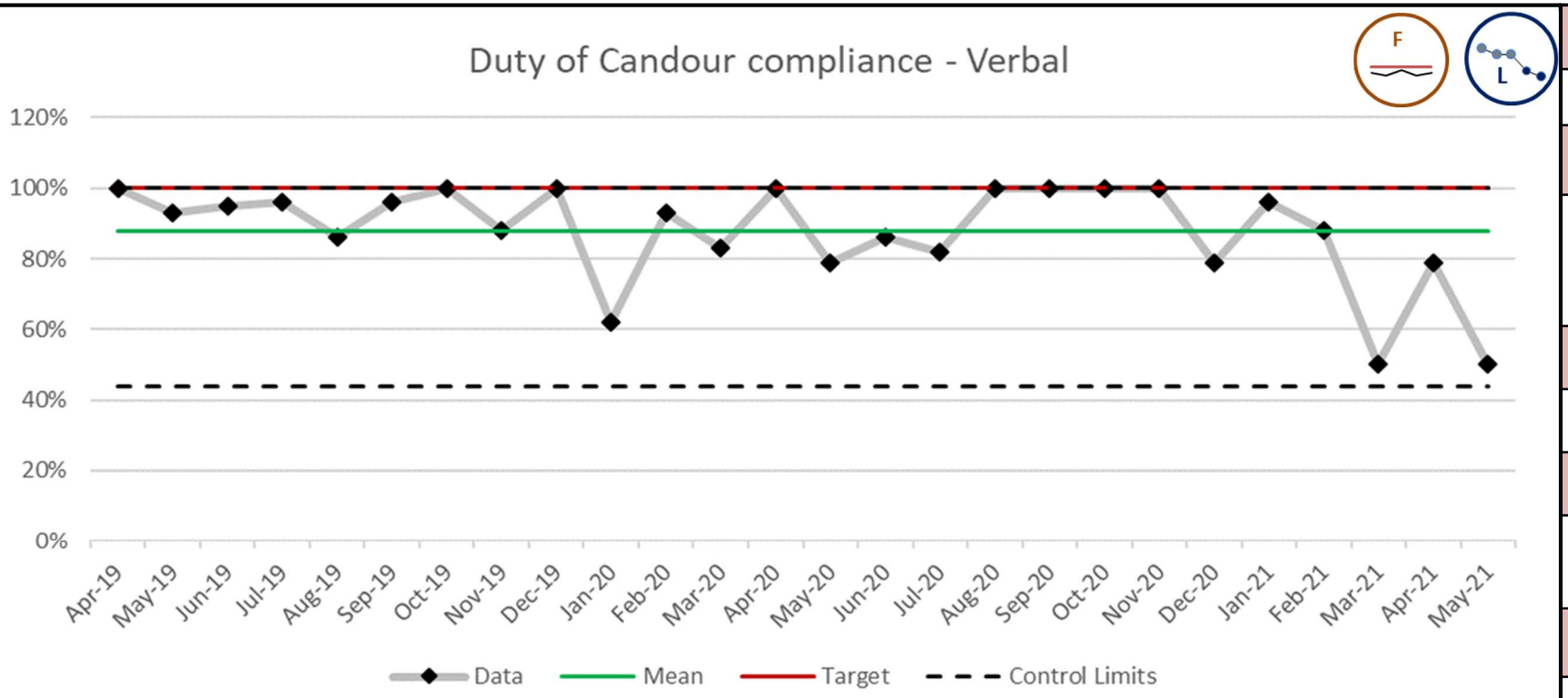

May-21
50%
Variance Type
Metric is currently experiencing Special Cause Variation – low trend
Target
100%
Target Achievement
Metric is consistently failing the target
Executive Lead
Medical Director

Background:
Percentage of verbal duty of candour compliance

What the chart tells us:
The Trust achieved 50% compliance with the Duty of Candour in May 2021, for in person notification (verbal)

Issues:

Actions:
All handlers of moderate and above harm incidents will be contacted through Datix by the Risk and Incident Administrator to initiate verbal DoC and an offer of written DoC letter – this will be carried out daily.

Mitigations:
Each Friday a report of all outstanding DoC (verbal and written) containing the incident location and incident handler sent to each clinical lead of the Divisions for action and also the Assistant Director of Clinical Governance for ongoing monitoring.
DoC will be added to the monthly Integrated Governance Reports from August 2021.
External training is currently being sourced.

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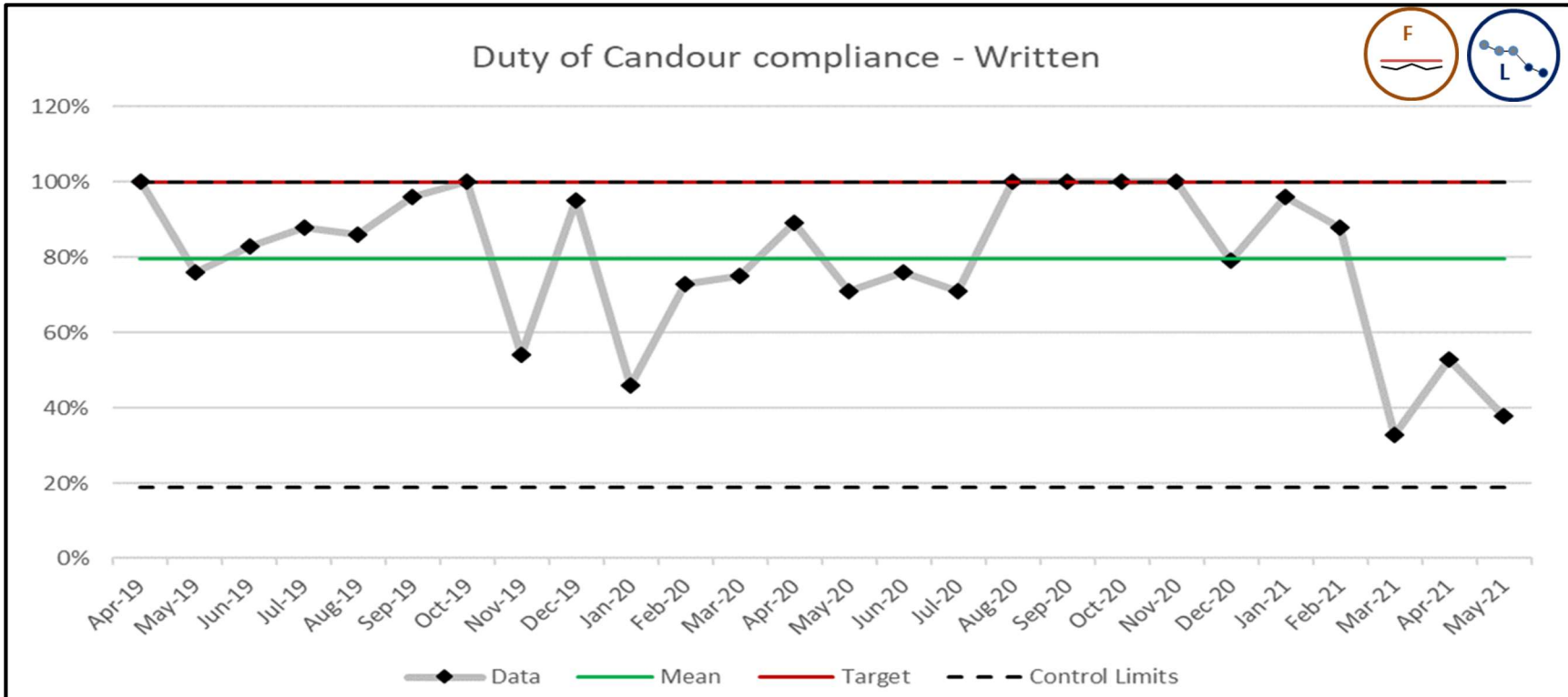

May-21
38%
Variance Type
Metric is currently experiencing Special Cause Variation – low trend
Target
100%
Target Achievement
Metric is consistently failing the target
Executive Lead
Medical Director

Background:
Percentage of written duty of candour compliance

What the chart tells us:
The Trust achieved 38% compliance with the Duty of Candour in May 2021, for written follow-up.

Issues:

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

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

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

PERFORMANCE OVERVIEW – OPERATIONAL PERFORMANCE

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	Apr-21	May-21	Jun-21	YTD	YTD Trajectory	Latest Month Pass/Fail	Trend Variation	Kitemark
Improve Patient Experience	% Triage Data Not Recorded	Effective	Patients	Chief Operating Officer	0%	0.28%	0.48%	0.31%	0.36%				
Improve Clinical Outcomes	4hrs or less in A&E Dept	Responsive	Services	Chief Operating Officer	83.12%	74.23%	72.56%	70.74%	72.51%	83.12%			
	12+ Trolley waits	Responsive	Services	Chief Operating Officer	0	2	1	1	4	0			
	%Triage Achieved under 15 mins	Responsive	Services	Chief Operating Officer	88.5%	91.15%	86.05%	88.23%	88.48%	88.50%			
	52 Week Waiters	Responsive	Services	Chief Operating Officer	0	1349	1032		2381	0			
	18 week incompletes	Responsive	Services	Chief Operating Officer	84.1%	55.82%	61.62%		58.72%	84.10%			
	Waiting List Size	Responsive	Services	Chief Operating Officer	37,762	43,119	48,475		n/a	n/a			
	62 day classic	Responsive	Services	Chief Operating Officer	85.4%	60.76%	60.94%		60.85%	85.39%			
	2 week wait suspect	Responsive	Services	Chief Operating Officer	93.0%	76.09%	80.15%		78.12%	93.00%			
	2 week wait breast symptomatic	Responsive	Services	Chief Operating Officer	93.0%	2.30%	6.50%		4.40%	93.00%			
	31 day first treatment	Responsive	Services	Chief Operating Officer	96.0%	92.98%	93.83%		93.41%	96.00%			
	31 day subsequent drug treatments	Responsive	Services	Chief Operating Officer	98.0%	99.13%	99.15%		99.14%	98.00%			
	31 day subsequent surgery treatments	Responsive	Services	Chief Operating Officer	94.0%	85.42%	76.74%		81.08%	94.00%			
	31 day subsequent radiotherapy treatments	Responsive	Services	Chief Operating Officer	94.0%	98.95%	98.91%		98.93%	94.00%			
	62 day screening	Responsive	Services	Chief Operating Officer	90.0%	80.00%	81.48%		80.74%	90.00%			

PERFORMANCE OVERVIEW – OPERATIONAL PERFORMANCE

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	Apr-21	May-21	Jun-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%	81.21%	75.00%		78.11%	85.00%	F		
	Diagnostics achieved	Responsive	Services	Chief Operating Officer	99.0%	71.00%	70.85%		70.93%	99.00%	F		
	Cancelled Operations on the day (non clinical)	Responsive	Services	Chief Operating Officer	0.8%					0.80%			
	Not treated within 28 days. (Breach)	Responsive	Services	Chief Operating Officer	0				0	0			
	#NOF 48 hrs	Responsive	Services	Chief Operating Officer	90%	90.14%	92.42%	89.89%	90.82%	90%	F		
	#NOF 36 hrs	Responsive	Services	Chief Operating Officer	TBC	78.87%	81.82%	77.53%	79.41%				
	EMAS Conveyances to ULHT	Responsive	Services	Chief Operating Officer	4,657	4,481	4,843	4,685	4,670	4,657	F		
	EMAS Conveyances Delayed >59 mins	Responsive	Services	Chief Operating Officer	0	207	285	349	280	0	F	A	
	104+ Day Waiters	Responsive	Services	Chief Operating Officer	10	47	42	49	138	30	F		
	Average LoS - Elective (not including Daycase)	Effective	Services	Chief Operating Officer	2.80	2.55	3.21	2.49	2.75	2.80	P		
	Average LoS - Non Elective	Effective	Services	Chief Operating Officer	4.50	4.58	3.97	4.23	4.26	4.5	P		
	Delayed Transfers of Care	Effective	Services	Chief Operating Officer	3.5%	Submission suspended				3.5%			
	Partial Booking Waiting List	Effective	Services	Chief Operating Officer	4,524	16,046	14,830	15,001	15,292	4,524	F	L	
	Outpatients seen within 15 minutes of appointment	Effective	Services	Chief Operating Officer	70.0%	44.4%	41.7%	40.0%	42.11%	70.00%	F		
	% discharged within 24hrs of PDD	Effective	Services	Chief Operating Officer	45.0%	42.8%	43.9%	42.2%	43.01%	45.00%	F		

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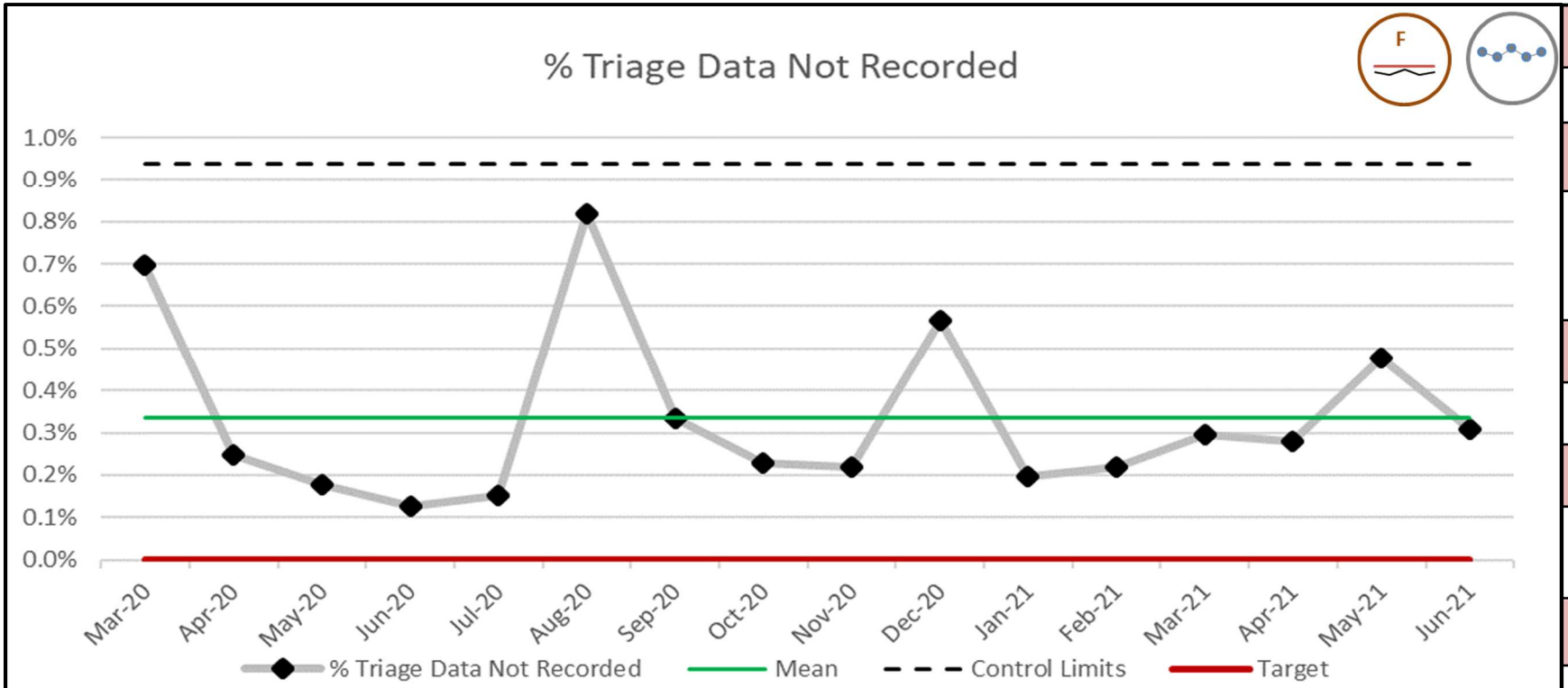
NHS United Lincolnshire Hospitals NHS Trust



Jun-21
0.31%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
0%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

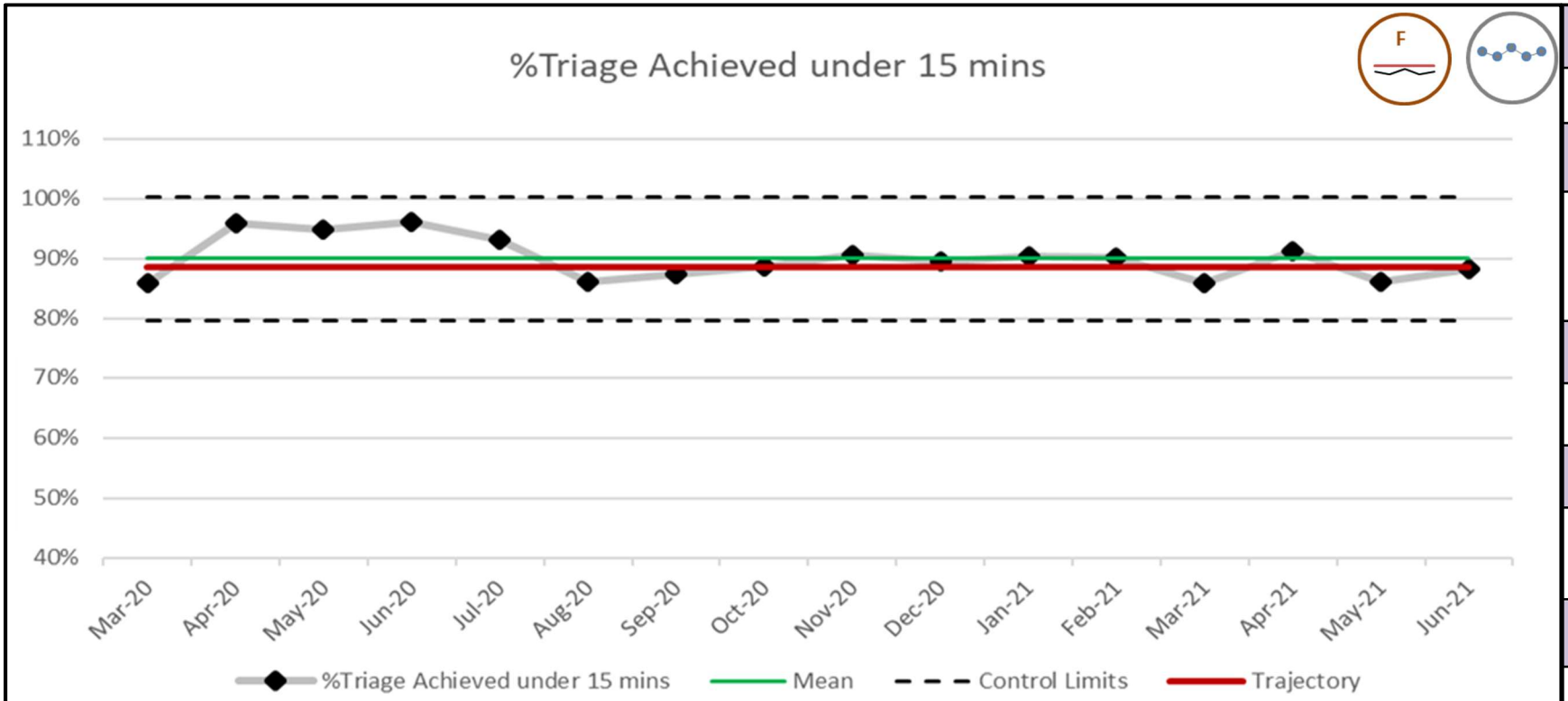
Background:
Percentage of triage data not recorded.

What the chart tells us:
3.1% of emergency attendance triages not recorded at PHB and LCH.
June demonstrated a 0.17% positive variation compared with May but remains below the target of 95%.

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

Actions:
- Increased access to MTS training and time to input data.
- Increased registrant workforce to support 2 triage streams to be in place
- To move to a workforce model with Triage dedicated registrants and remove the dual role component.

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



Jun-21
88.23%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
88.5%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:

Percentage of triage achieved under 15 minutes.

What the chart tells us:

0.27% of emergency attendances were not triaged with 15 minutes of arrival. The compliance against this target is 88.50%. June demonstrated an improvement of 2.18% compared with May but remains below the target by 0.27%.

Issues:

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

Actions:

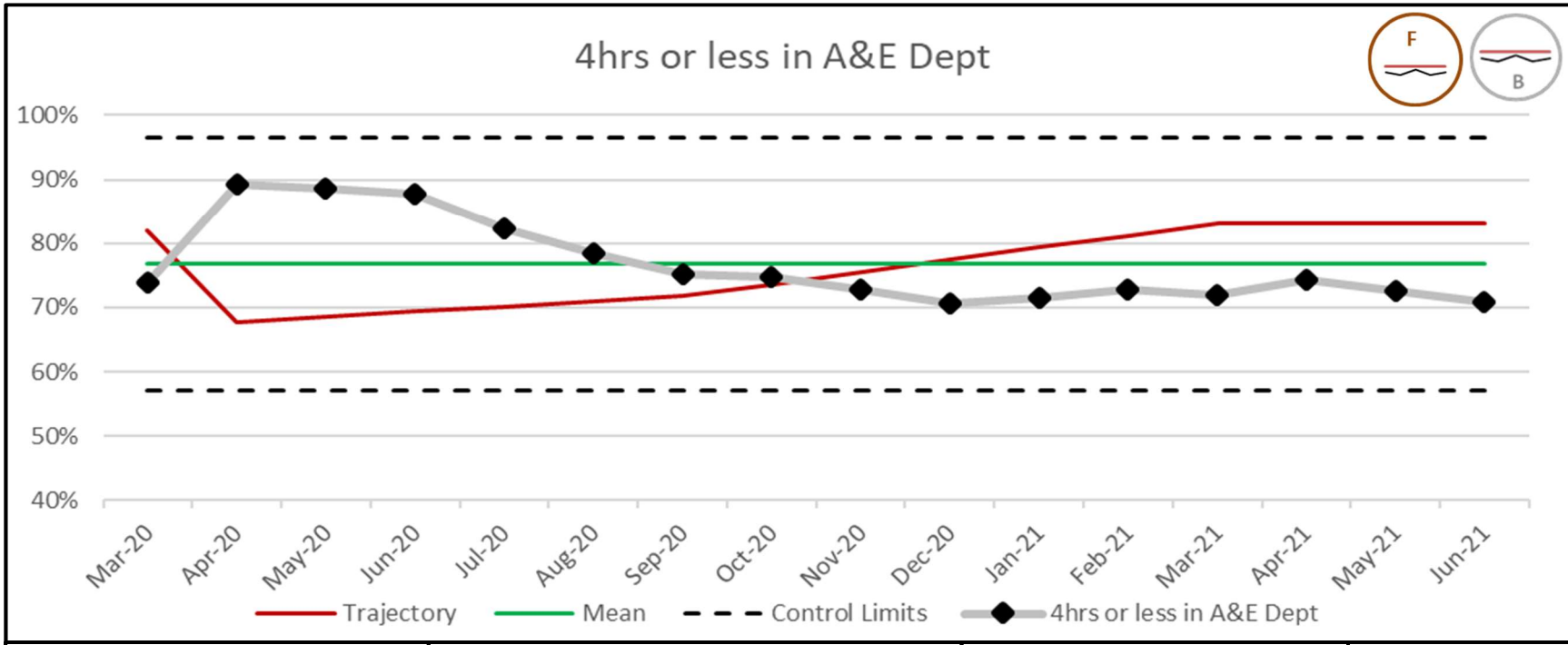
Increased access to MTS training.
Increased registrant workforce to support 2 triage streams to be in place via Emergency Department recruitment campaign.
To move to a workforce model with Triage dedicated registrants and remove the dual role component.
This metric forms part of the Emergency Department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

Mitigations:

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

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Jun-21
70.74%
Variance Type
Metric is currently experiencing Special Cause Variation – below the mean
Target
83.12%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
The current 4-hour transit target performance for June. The agreed compliance trajectory for June is 83.12%. June experienced a further deterioration in performance against the agreed trajectory. June out turned at 70.74% compared to 72.56% in May. A 1.82% negative variance compared to May and a 12.38% negative variance to the agreed performance trajectory.

Issues:
A 32.38% increase in attendances in June 2021 compare to June 2020 and a further comparison to June 2019 denotes an increase of 25.90%. A total of 19,330 Emergency Department/UTC attendances in June 2021 compared to 13,075 in June 2020 and 14,325 in June 2019. Inadequate discharges to meet the admission demand. Ongoing medical and nursing gaps that were not Emergency Department specific Increased Urgent Care Centre demand. Of the 19,330 recorded attendances for type 1 and type 3 across the Trust, type 1 attendances accounted for 9,407 and type 3 accounted for 9,923 attendances. A total of 403 type 3 attendances required transfer to the Emergency Department for ongoing treatment.

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

Mitigations:
Additional weekend support at Bronze level to promote increases discharges. EMAS have enacted a targeted admission avoidance process. The Discharge Lounge at LCH is now operating a 24/7 service provision to release the burden placed on the Emergency Department at LCH in terms of patients awaiting AIR/CIR and also transport home. This will go live at PHB week commencing 19th July. Increased CAS and 111 support especially out of hours. EPIC to Specialty Consultant reviews to ensure DTA applied appropriately. Implementation of STRAP (Short Term Rescue A&E Protocol) on both the LCH and PHB sites to de-escalate. Clinical Operational Flow Policy adherence and compliance and Full Capacity Protocol activation when OPEL 3 reached.

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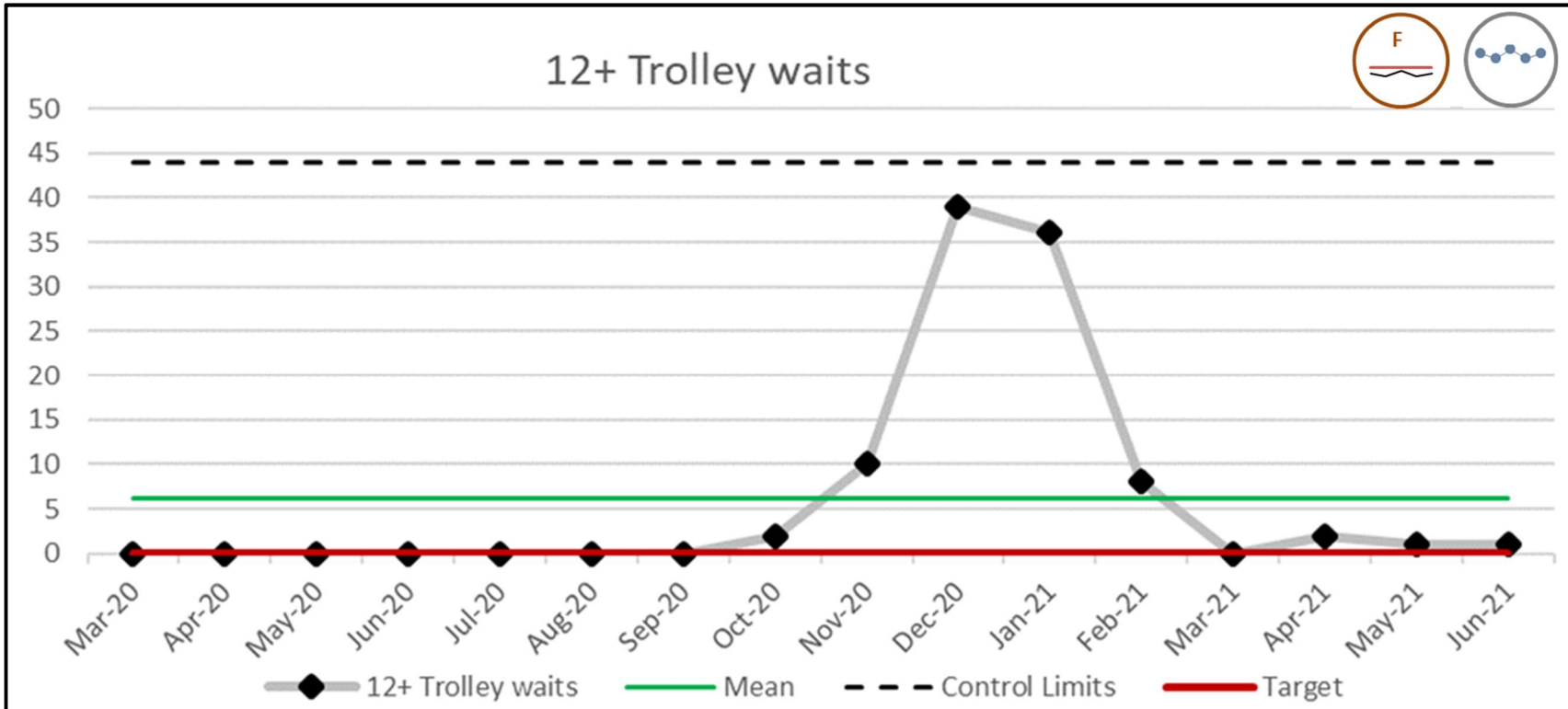
NHS United Lincolnshire Hospitals NHS Trust



Jun-21
1
Variance Type
Metric is currently experiencing Common Cause Variation
Target
0
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
June experienced 1 x 12hr trolley wait.

Issues:
This patient was deemed a 'Clinical exception'. There are no exceptions based on clinical need unless a clinical change was noted in the patient pathway and recorded.
This breach was considered avoidable.
There remains some complacency in terms of 12hr trolley waits.

Actions:
Every reported 12hr trolley wait is subject to an immediate clinical review to ascertain whether it is deemed a 'true' 12hr trolley wait breach and is signed off by the Clinical Lead for ED. The Trust continues to work closely with national regulators in reviewing and reporting these breaches. A timeline for the 12 trolley waits with the greatest total time in ED is submitted to NHSe/i at 11am the next day by the Deputy Chief Operating Officer. A daily review of all potential 12hr trolley waits is in place should this be required. This is led by the Chief Operating Officer. All involved specialities are expected to attend. System Partners and Regulators remain actively engaged and offer practical support in situational escalations.

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

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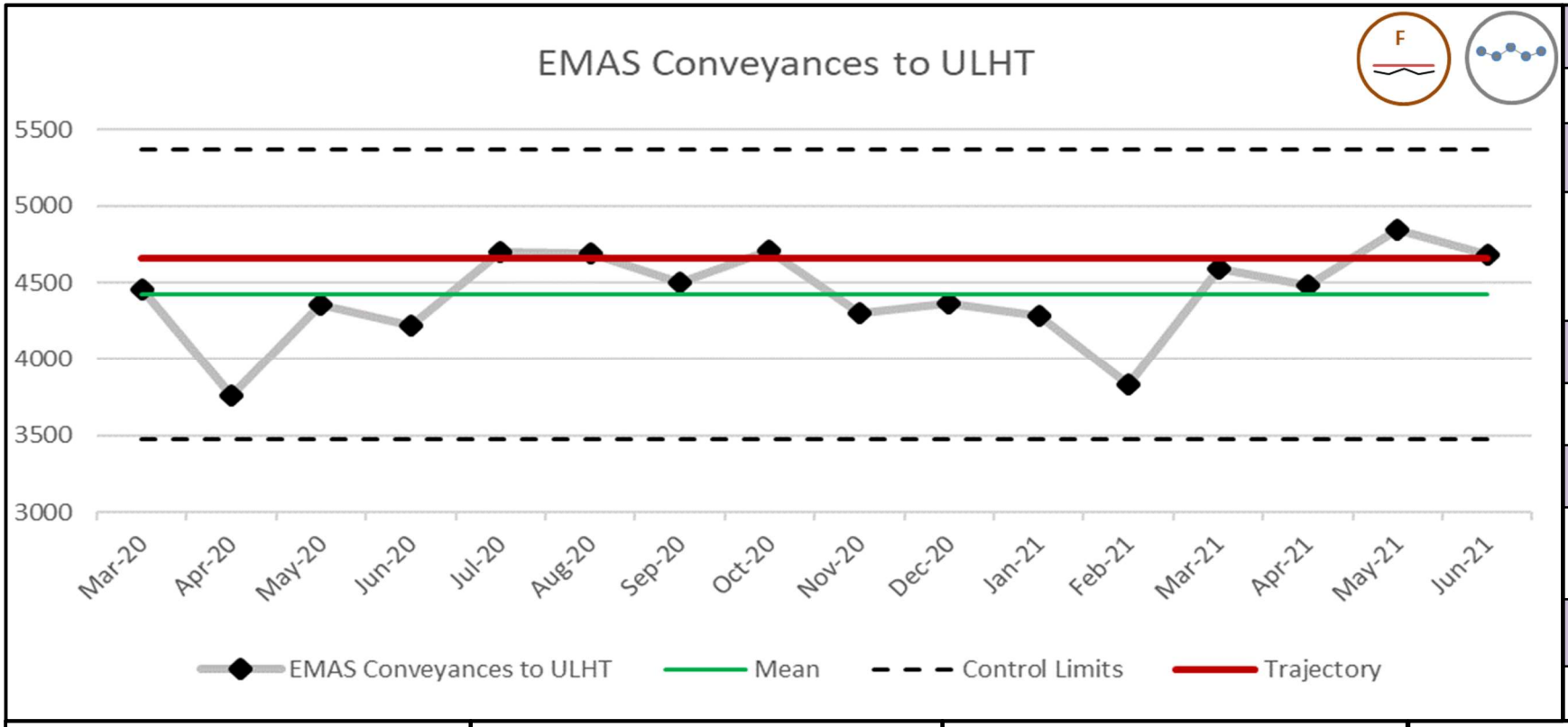
NHS United Lincolnshire Hospitals NHS Trust



Jun-21
4685
Variance Type
Metric is currently experiencing Common Cause Variation
Target
4657
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:

Overall demand for conveyance to the emergency departments and assessment units continues to increase across EMAS with peak demand in the late afternoon and evening.

What the chart tells us:

The total number of conveyances to ULHT demonstrates a slight reduction for June, 4,685 compared to 4,843. A reduction of 158 conveyances. This is a reduction of 3.27%.

Issues:

The pattern of conveyance is such that arrivals are loaded to the late afternoon and into the evening.

The use of alternative pathways to avoid conveyance to the Trust are still not fully adhered to but progress is being made.

Actions:

Work continues across the system to ensure conveyances are reduced further by accessing the support of CAS and other alternative pathways

Increased use of the UTC's through a revision of the access criteria is beginning to yield some benefits.

Increased resourcing of 111 and CAS for advice and admission avoidance options are in place.

The use of LIVES for on scene treatment and optimisation to avoid onward conveyance to the emergency department.

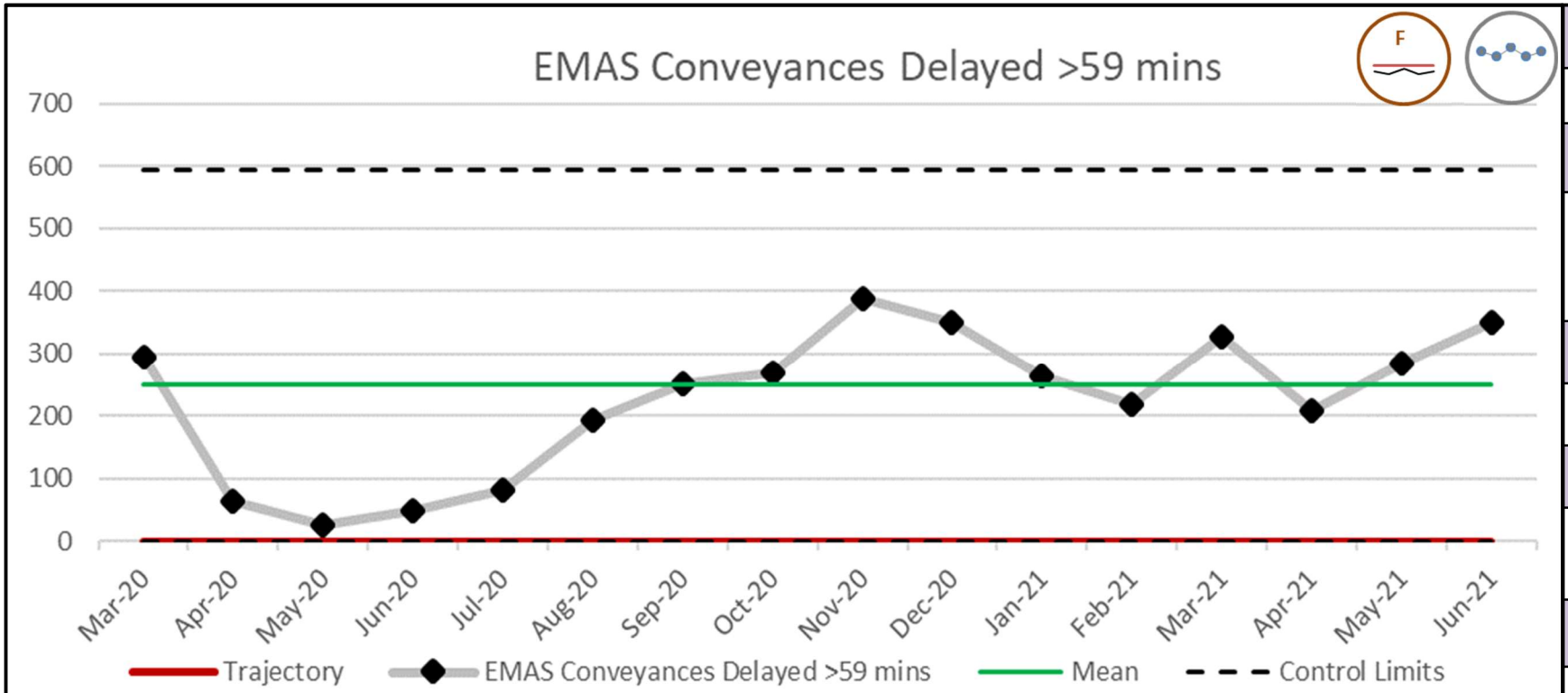
Mitigations:

The increase to the overall footprint of our emergency department will assist in responding to ambulance arrivals.

Internal conveyance deflects are enacted to manage the arrivals when any of the sites are under increased pressure. This proves more beneficial when the deflect is from LCH to PHB.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Jun-21
349
Variance Type
Metric is currently experiencing Common Cause Variation
Target
0
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:

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

What the chart tells us:

June experienced an increase in greater than 59 minutes handover delays. 349 in June compare to 285 in May. This represents an 18.34% increase.

Issues:

The pattern of conveyance and prioritisation of clinical need attributes to the delays.
Increased conveyances in the late afternoon and evening coincides with increased 'walk in' attendances causing a reduce footprint to respond to timely handover.
Poor flow and discharges result in the emergency departments being unable to de-escalate due to an increase number of patients waiting for admission.

Actions:

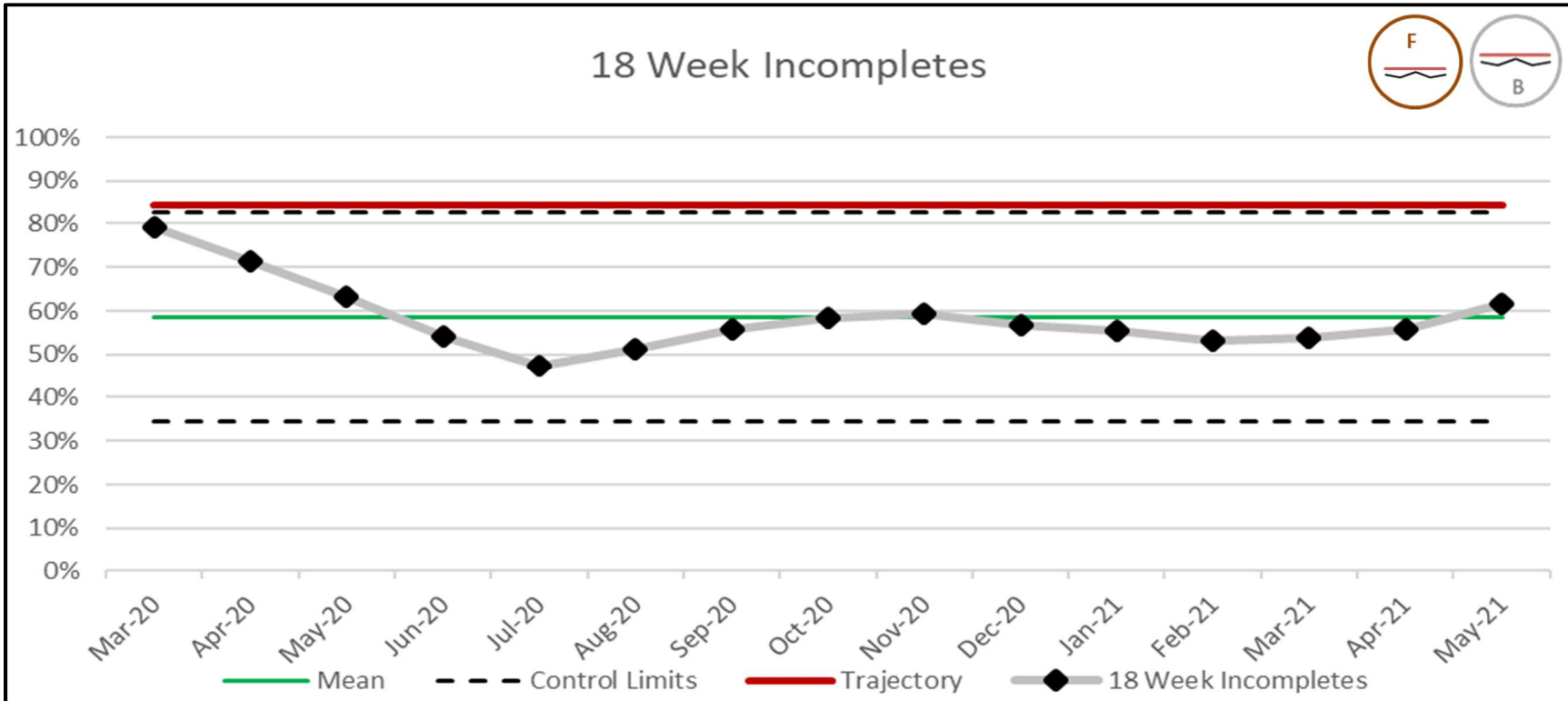
All ambulances approaching 30 minutes without a plan to off load are escalated to the Clinical Site Manager and the in hours Operational Silver Commander to secure a resolution.
Daily messages to EMAS crews to sign post to alternative pathways and reduce conveyances to the acute setting.
Active monitoring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

Mitigations:

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

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



May-21
61.62%
Variance Type
Metric is currently experiencing Special Cause Variation – below the mean
Target
84.1%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
There is significant backlog of patients on incomplete pathways. May saw RTT performance of 61.62% against a 92% target, which is 5.8% up on April.

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

- Ophthalmology – 2914 (reduced by 179)
- Trauma and Orthopaedics – 2217 (reduced by 39)
- ENT – 2059 (Increased by 241)
- Maxillo-Facial Surgery and Orthodontics and Oral Surgery – 1486 (increased by 45)
- Dermatology – 1425 (increased by 56)

Actions:
Planned routine elective work remains challenging, with available capacity being focussed on cancer.

Mitigations:
Trauma and Orthopaedics was the lowest performing specialty, however performance increased from 46.87% last month to 51.33% (increase of 4.46%).
Patient pathways are discussed at the weekly PTL meeting.

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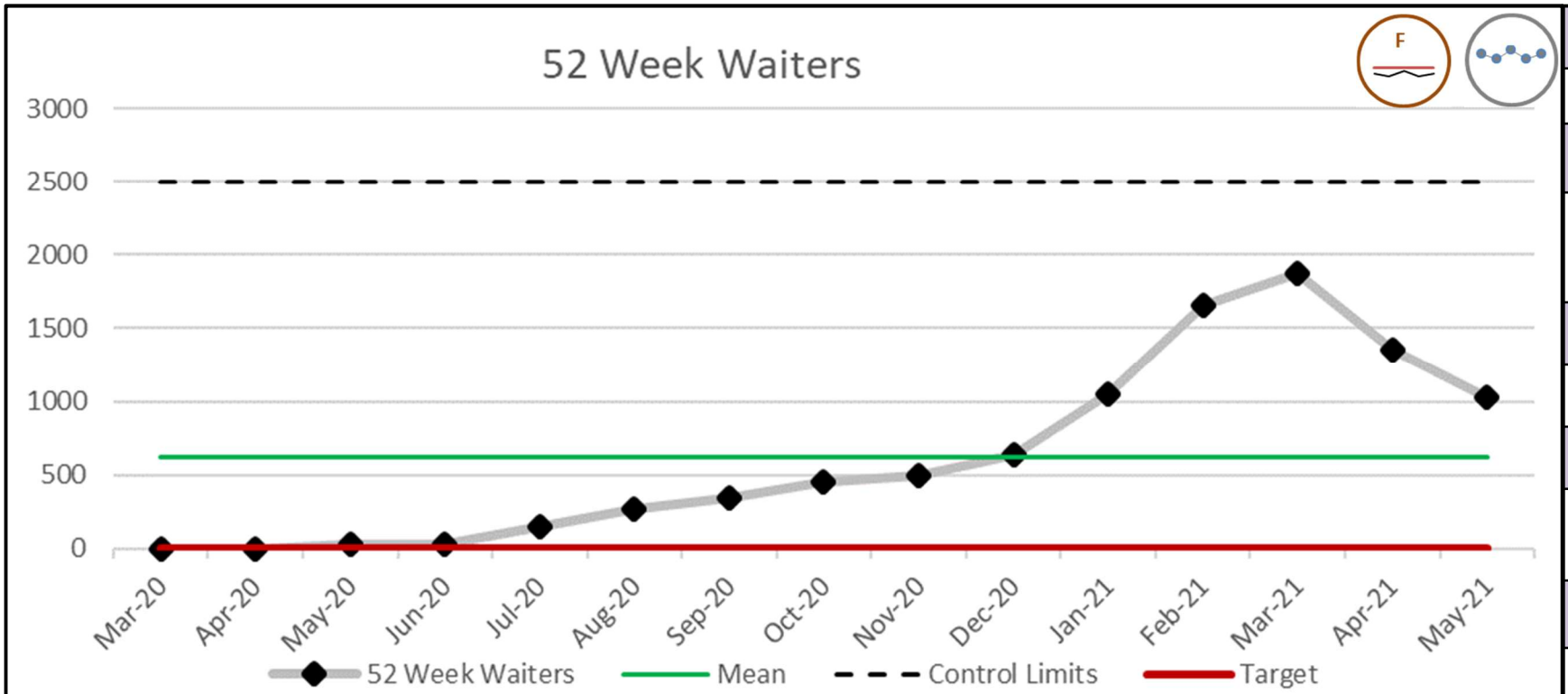

May-21
1032
Variance Type
Metric is currently experiencing Common Cause Variation
Target
0
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
The Trust reported 1,032 incomplete 52 week breaches. A decrease of 317 from April.
The number of 52 week breaches has been steadily reducing since March 2021.

Issues:
Due to capacity challenges, together with issues regarding lack of pre-assessment appointments the admitted position remains challenging.

Actions:
Pre op assessment service is being reviewed to provide more capacity.
All patients waiting more than 52 weeks are required to have an RCA and harm review completed.

Mitigations:
Non admitted patients continue to be reviewed, utilising all available media.
Long waiting patients are reviewed at the weekly PTL meeting.

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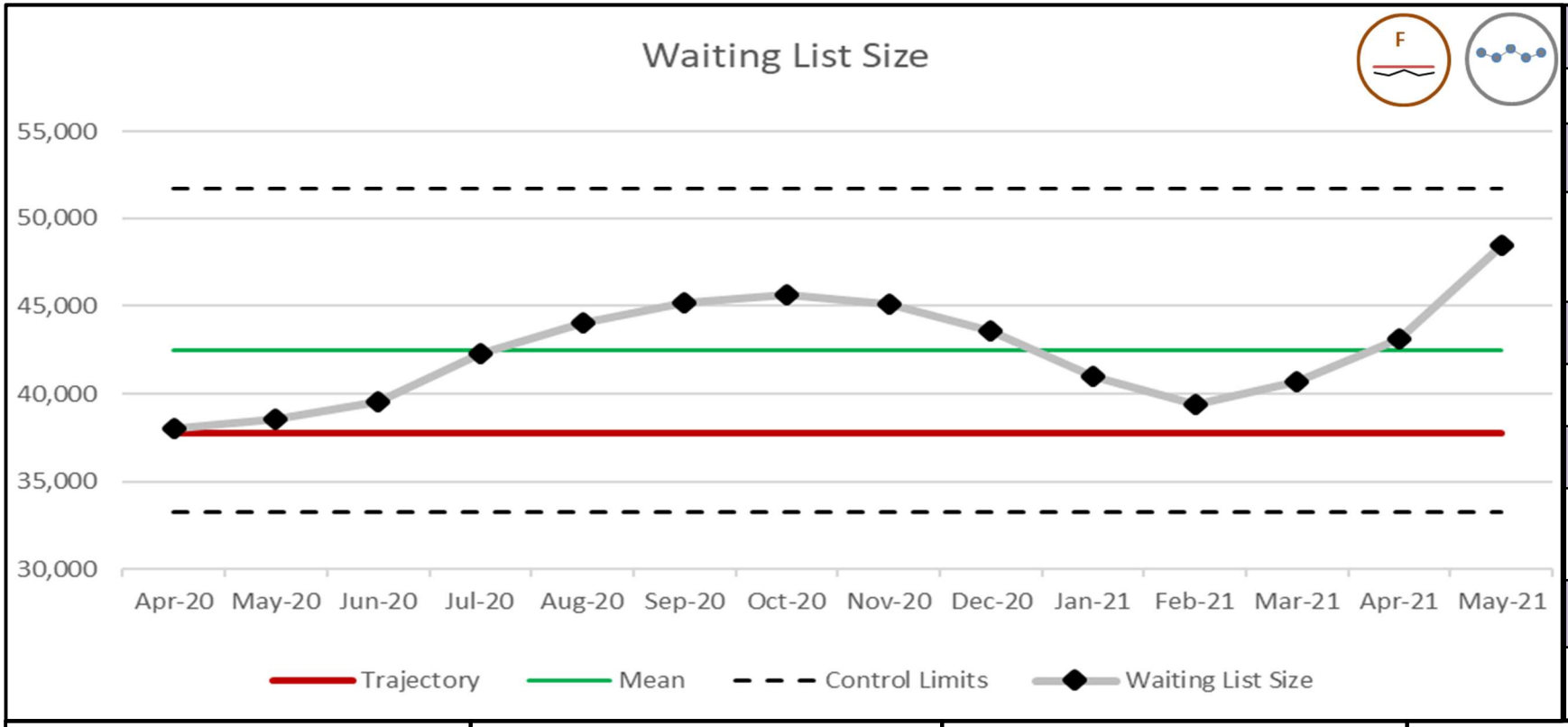

May-21
48,475
Variance Type
Metric is currently experiencing Common Cause Variation
Target
37,762
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
Overall waiting list size has increased from April, with May showing an increase of 5,356 to 48,475.
The incomplete position for May 2021 is now approximately 9,443 more than the March 2018 39,032) target.

Issues:
Patients on the ASI list are being added to the open referrals list; therefore causing a rise in the overall waiting list size.
The top five specialties showing an increase in total incomplete waiting list size from April are:

- ENT +1,353
- Ophthalmology +882
- Gynaecology +632
- Dermatology +605
- General Surgery +312

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

- Trauma and Orthopaedics -316
- Breast Surgery -65
- Rehabilitation Service -53
- Clinical Oncology -51
- Colorectal Surgery -31

The Trust reported 3,299 over 40 week waits; an increase of 121 from April.
The numbers of patients waiting over 26 weeks increased by 706 from April.

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

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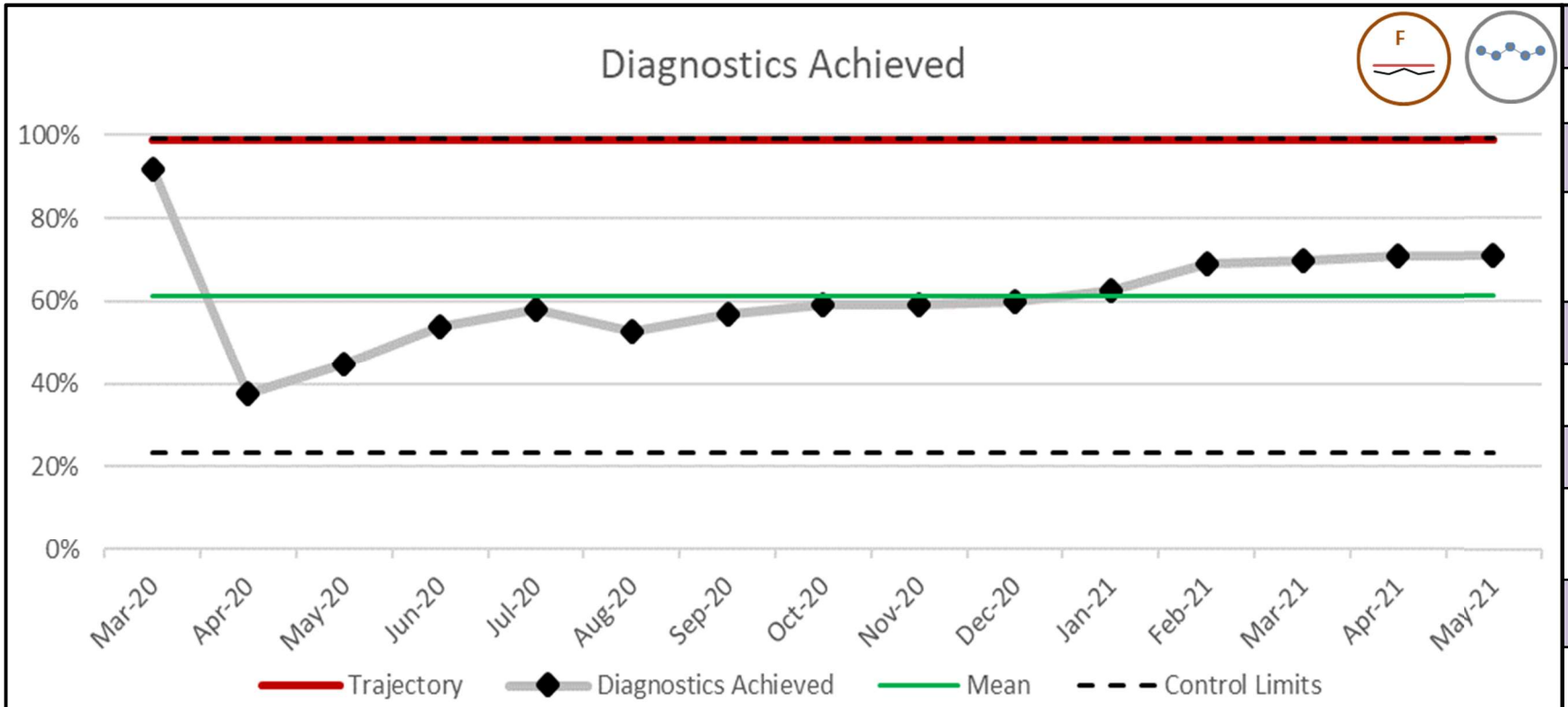


May-21
70.85%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
99%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

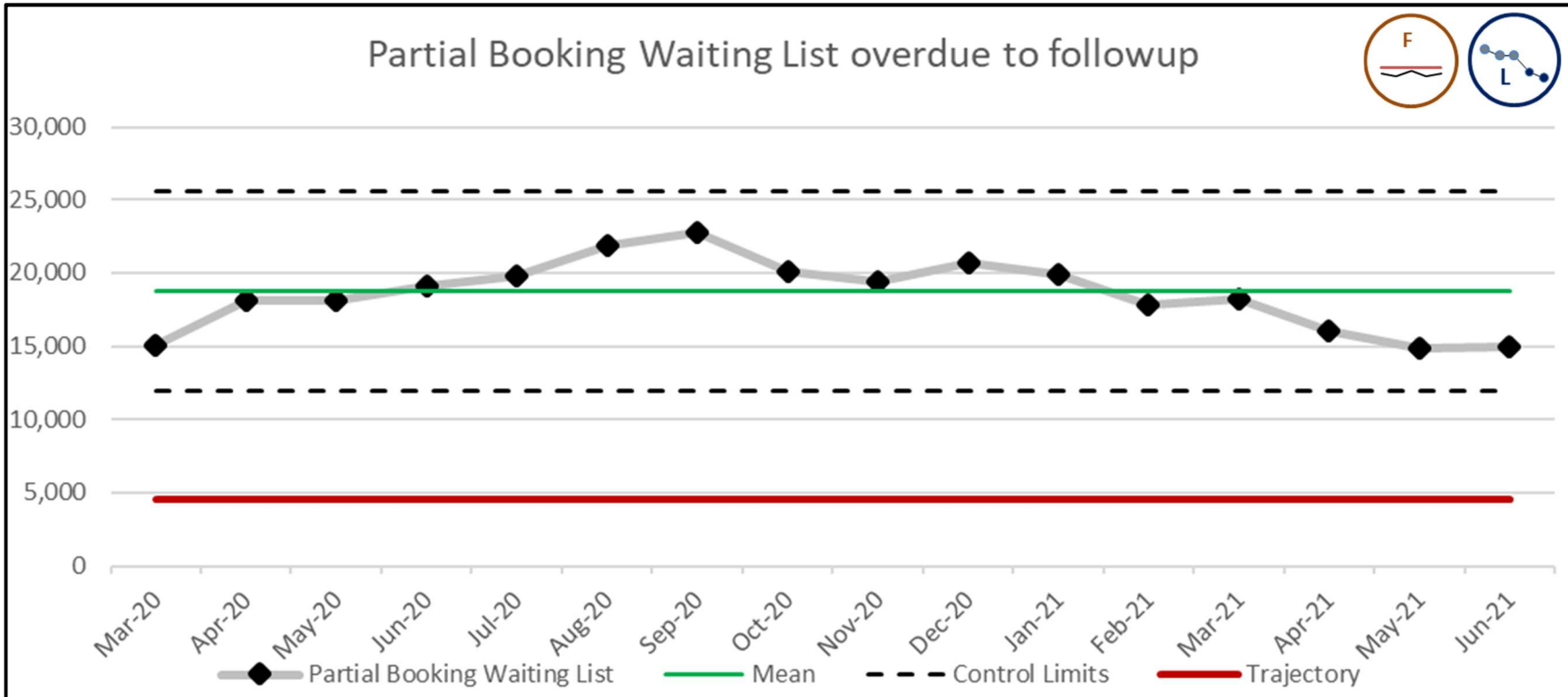
Background:
Diagnostics achieved in under 6 weeks.

What the chart tells us:
We are currently at 70.85% for May 2021 against the 99.00% target.

Issues:
All areas have lost capacity due to social distancing, demand is still higher than capacity for some procedures so causing increased backlogs for some specialities and increasing the number of breaches declared each month for those specialities. CT - Decrease in breaches within CT May 120 compared to 153 in April. This will be due to patient's choice and cardiologists' capacity. CT activity has increased from 6,232 to 6,557, this is over a 1,000 increase from May 19. MRI - 42 breaches in March compared to 46 last month, majority of these are cardiac and general anaesthetic patients. Physiological Sciences. Neurophysiology - peripheral neurophysiology LCH is reporting 65 for May compared to 19 last month. Waiting lists are monitored weekly. Endoscopy - Cystoscopy carried out within endoscopy had 46 breaches in May, compared to 65 breaches last month. Colonoscopy had 307 breaches in May compared to 392 last month. These are the planned patients all live patients are being carried out within 41 days. Cardiology - Echocardiography had 2,848 breaches for June, compared to 2,804 last month. Echocardiography Stress /TOES had 31 breaches in June, compared to 39 last month. The main concern for the DM01 for the trust is the cardiac position as this is pulling the overall performance down.

Actions:
Where demand out strips capacity additional resource is being sort, but this is proving difficult to obtain in cardiology echoes.

Mitigations:
All waiting lists are being monitored and where 50% of the waiting list is over 6 weeks we are being asked to complete a clinical validation for each patient and assign a D code to that patient. Going forward every new referral will have a D code assigned to that patient. This will make sure all patients are seen in clinical urgency.



Jun-21
15,001
Variance Type
Metric is currently experiencing Special Cause Variation – low trend
Target
4,524
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 15,001 against a target of 4,657.
Due to Covid the number of patients overdue a follow up appointment significantly increased. Since outpatient appointments reintroduced reduced to similar pre Covid levels. Work required to continue to reduce.

Issues:
Conflicting priorities, resources, space, aligning requirements

Actions:
Service recovery plans produced and updated, Meeting to monitor progress, challenge and support against plan, Specialities to continue validation, clinical triage and exploring technological solutions.
642 meeting in place to challenge short notice clinic cancellations.

Mitigations:
Supporting site priorities taking outpatient clinics down, due to clinical urgency (site/patient flow and theatres)

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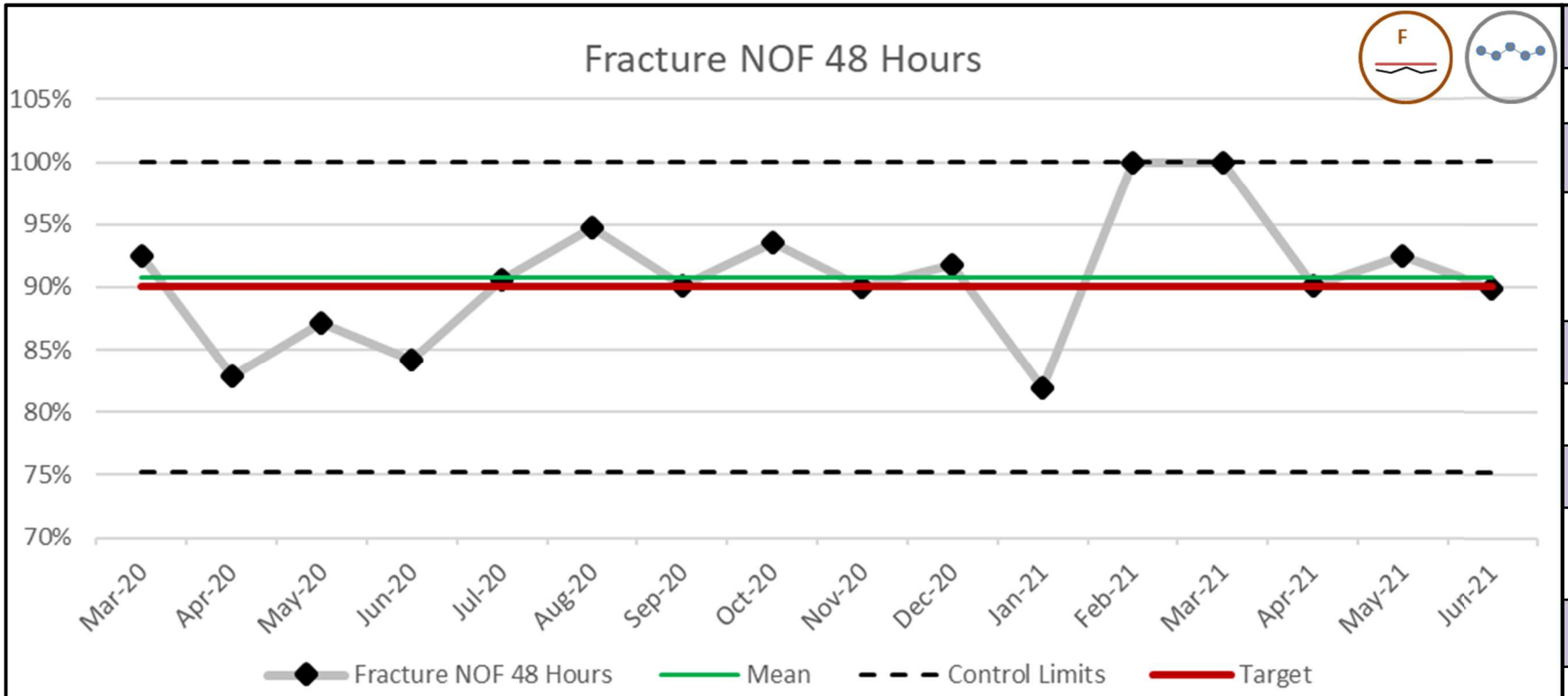

Jun-21
89.89%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
Metric is failing the target
Executive Lead
Chief Operating Officer

Background:
Percentage of fracture neck of femur patients time to theatre within 48 hours.

What the chart tells us:
In June 21 performance was 89.89% against a target of 90%.

A marginal reduction in NOF time to theatre performance has been seen. The performance of this metric is variable due to trauma demand and the health of patients which can cause delays in surgery.

Issues:
- Increase in trauma demand.
- High vacancy rate in theatres which limits capacity for additional theatres.
- Due to increase in trauma demand and the types of injuries seen, certain procedures have been clinically prioritised ahead of NOF patients.

Actions:
NOF pathway project ongoing to ensure pathway from EMAS response through to patient discharge post-surgery being fully optimised and responsibilities/protocols are clear.
Forward planning of theatre lists required based on historical peaks in activity seen.
'Golden patient' initiative to be fully implemented.
Ensure robust processes in place to utilise Trust wide trauma capacity and beds.

Mitigations:
- Ensure trauma lists are fully optimised.
- Reduce 'on the day' change in order of the trauma list where clinically appropriate.

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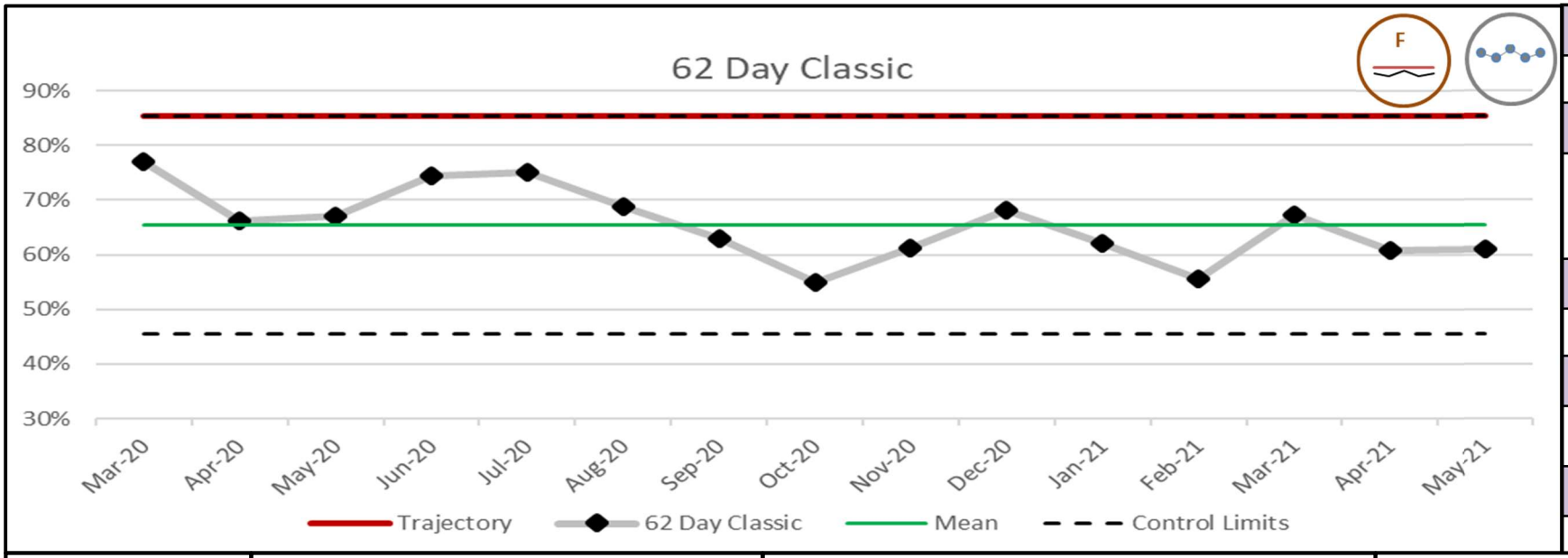


May-21
60.94%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
85.4%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

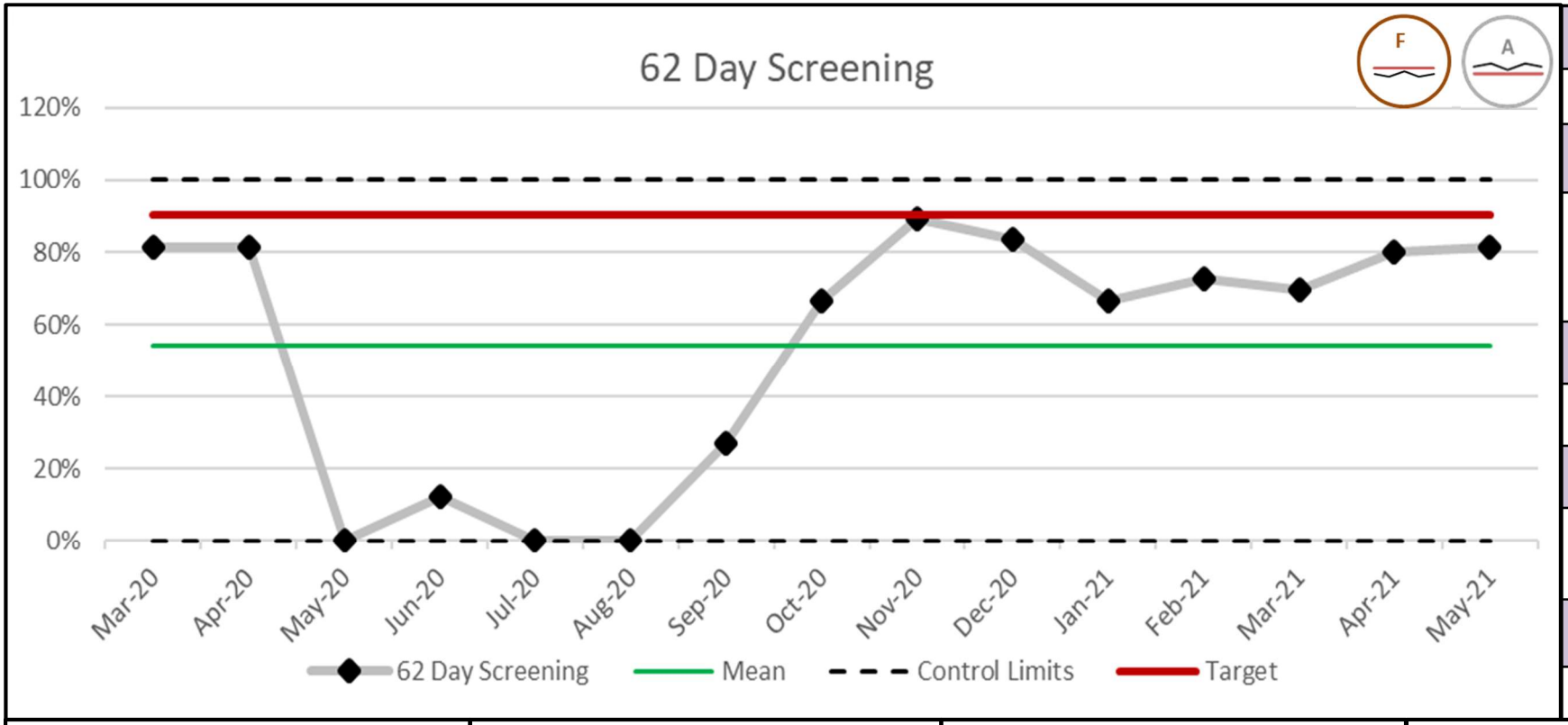
Background:
Percentage of patients to start a first treatment within 62 days of an urgent GP referral.

What the chart tells us:
We are currently at 60.94% against an 85% target.

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

Actions:
28 Day standard identified as Trust's cancer performance work stream in the Integrated Improvement Program for 2021-22. 2 H&N consultant posts have been recruited, 1 started in April 2021, and another is due to start in July 2021. Two substantive Medical Oncologists have been recruited, both due to start in November 2021, pushed back from July and October, (one covering Breast, Renal and Urology and another covering Gynae and Breast). Funding from EMCA is in place for full-time Cancer Navigator posts to support Surgery, Medicine and Family Health. Recruitment processes are underway. Endoscopy booking team recruited 3 fixed term WTE – now in post and training completed. A Case of Need is being written to request funding for these posts to become substantive because the additional workload will become business as usual. 2 fixed term WTE Endoscopist posts have gone through the interview and selection process twice with only 1 applicant, so a Case of Need is being written for permanent funding. This will support the Bowel Cancer Screening age reduction.

Mitigations:
Pre-covid level theatre capacity is expected to be achieved by circa end July 2021. Successful bid for Radiology equipment: 5 low dose CT scanners (2 x PH, 2 x LC, 1 x GK), 2 digital X-ray rooms, 4 Ultrasounds (3 x general, 1 x Breast), 38 PACS reporting stations, replacement of Fluoro room, 3 DR Mammography rooms (1 each PH, LC and GK). Delivery is in stages between April and August. Increase in internal radiology reporting capacity. Increase in CTC capacity whilst we have the relocatable and modular staffing from 336 slots pcm to 530 slots pcm. A Nurse endoscopist has been appointed on Bank and is supporting weekend lists and BSCP. Review of Colorectal theatre list scheduling to better align with clinician availability and consideration of moving level 1 patients to Grantham.



May-21
81.48%
Variance Type
Metric is currently experiencing Special Cause Variation – above the mean
Target
90%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

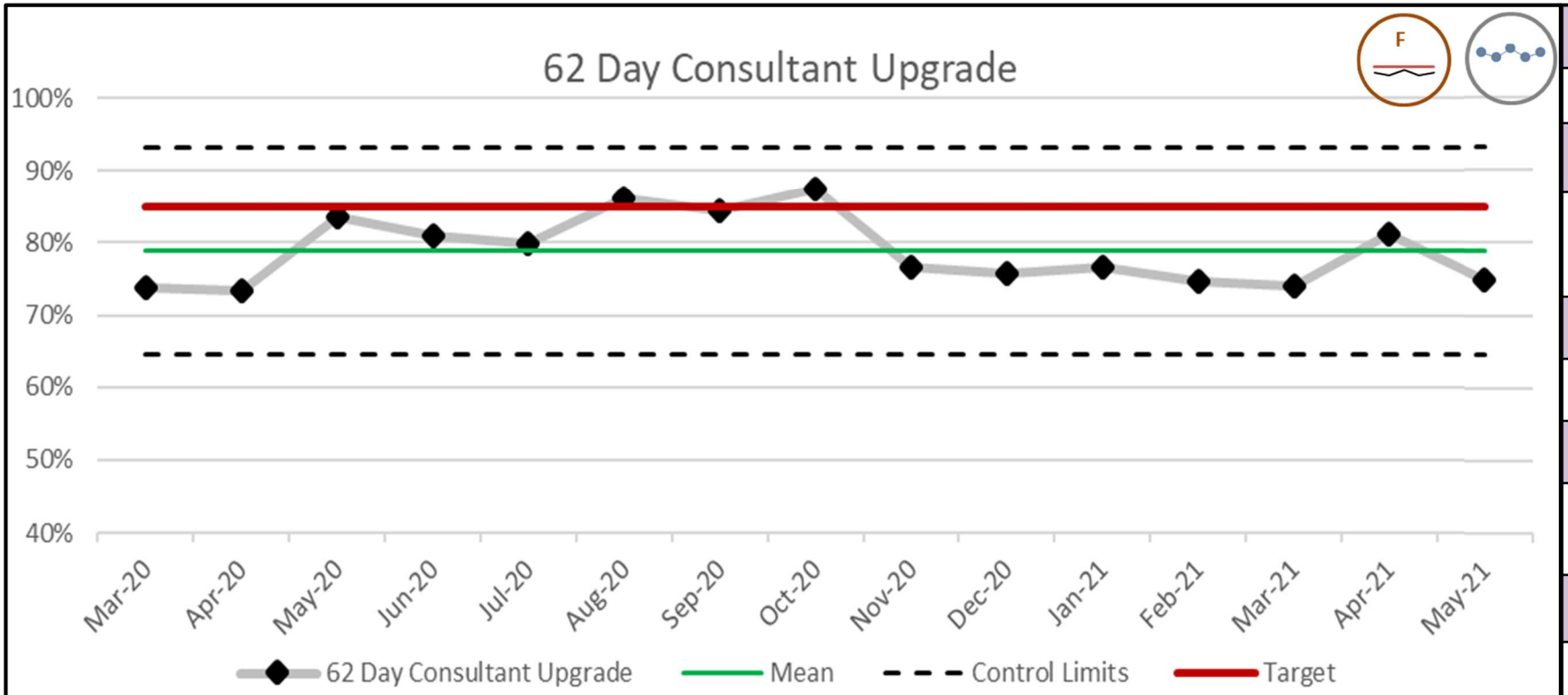
Background:
Percentage of patients to start a first treatment within 62 days of referral from an NHS cancer screening service.

What the chart tells us:
We are currently at 81.5% against a 90% target

Issues:
See issues on previous page – 62 day classic

Actions:
See actions on previous page – 62 day classic

Mitigations:
See mitigations on previous page – 62 day classic



May-21
75%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
85%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 75% against an 85% target

Issues:
See issues on previous page – 62 day classic

Actions:
See actions on previous page – 62 day classic

Mitigations:
See mitigations on previous page – 62 day classic

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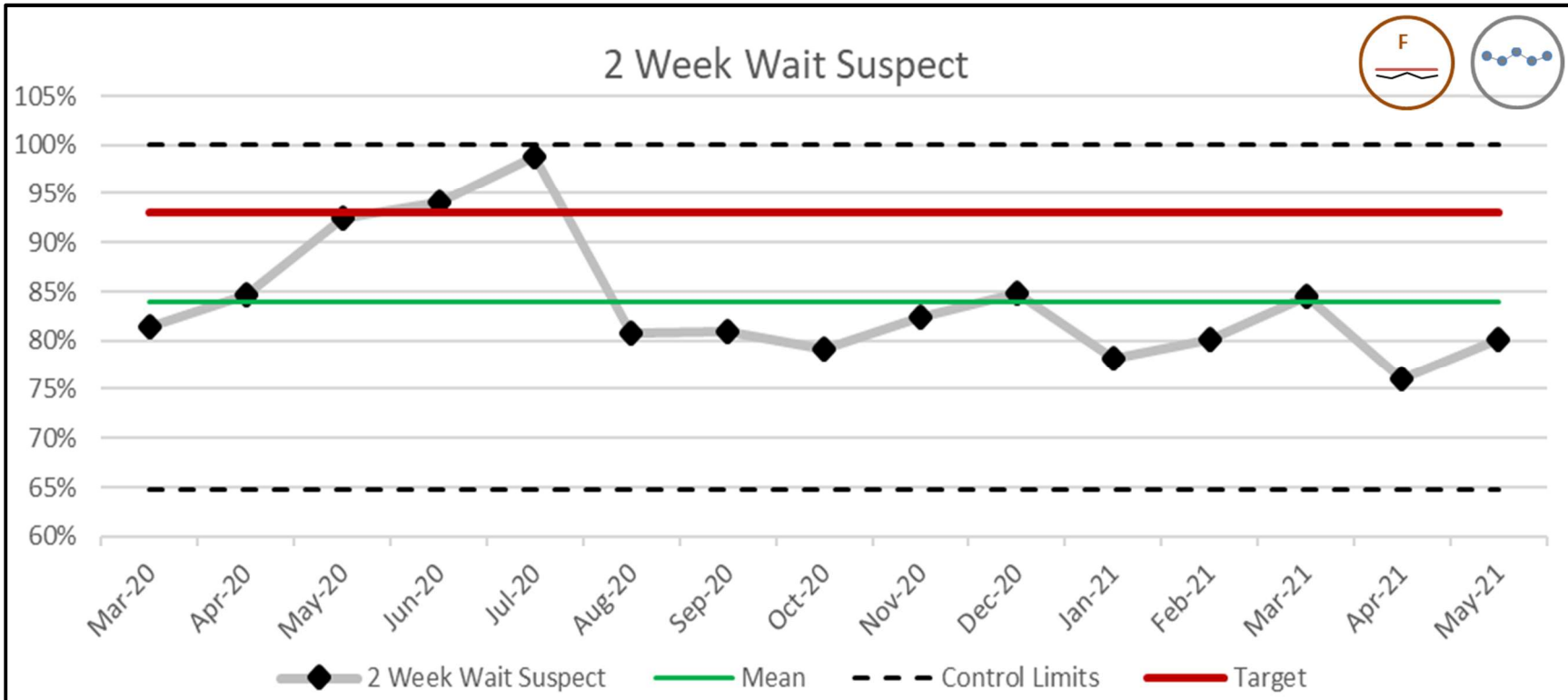


May-21
80.15%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
93%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

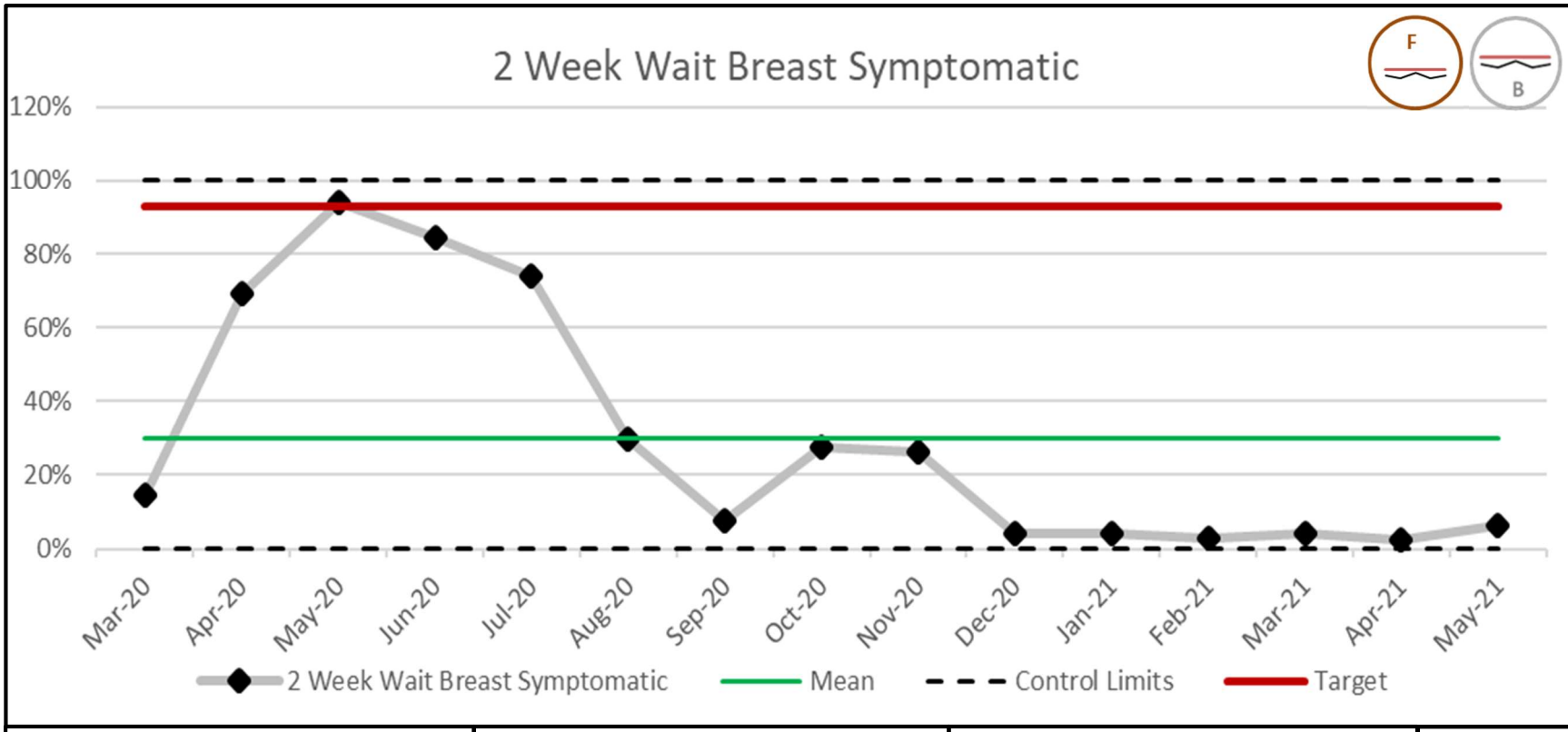
Background:
Percentage of patients seen by a specialist within two weeks of an urgent referral for suspected cancer.

What the chart tells us:
We are currently at 80.2% against a 93% target.

Issues:
The Trust's 14 Day performance continues to be significantly impacted by the current Breast Service One-Stop appointment alignment issues - 79% of the Trust's 14 Day breaches were within that tumour site. The other tumour sites that considerably under-performed include Gynaecology (69.5%), Haematology (81.3%), and Upper GI narrowly missed (90.5%). All other tumour sites achieved the standard. The 14 Day Breast Symptomatic has been affected by the same impact of the Breast Service One-Stop appointment alignment issues. For STT, patient engagement in diagnostic process (reluctance to visit hospitals due to perceived COVID-19 risk, including those waiting for vaccines or the 3 week 'effectiveness' period). Reduced clinic throughput due to social distancing / IPC requirements, especially in waiting areas. Patient acceptance & compliance with swabbing and self-isolating requirements. Patients not willing to travel to where our service and / or capacity is.

Actions:
Breast Services review and "deep dive" (following final report from NHSI support).
Gynaecology Direct Access ultrasound pathway – awaiting date for commencement.
Pilot of triaging all Skin 2ww referrals due to commence in July.
Upper GI Direct Access pathway – Looking to implement in July / August.
Bladder and testicular pathway – scoping to revert to direct access pathway and Haematuria to one stop clinics. Clinical sign off took place on 09/06/2021.

Mitigations:
Lung Direct Access pathway now Trustwide.



May-21
6.5%
Variance Type
Metric is currently experiencing Special Cause Variation – below the mean
Target
93%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 6.5% against a 93% target.

Issues:
See issues on previous page – 2 week wait suspect

Actions:
See actions on previous page – 2 week wait suspect

Mitigations:
See mitigations on previous page – 2 week wait suspect

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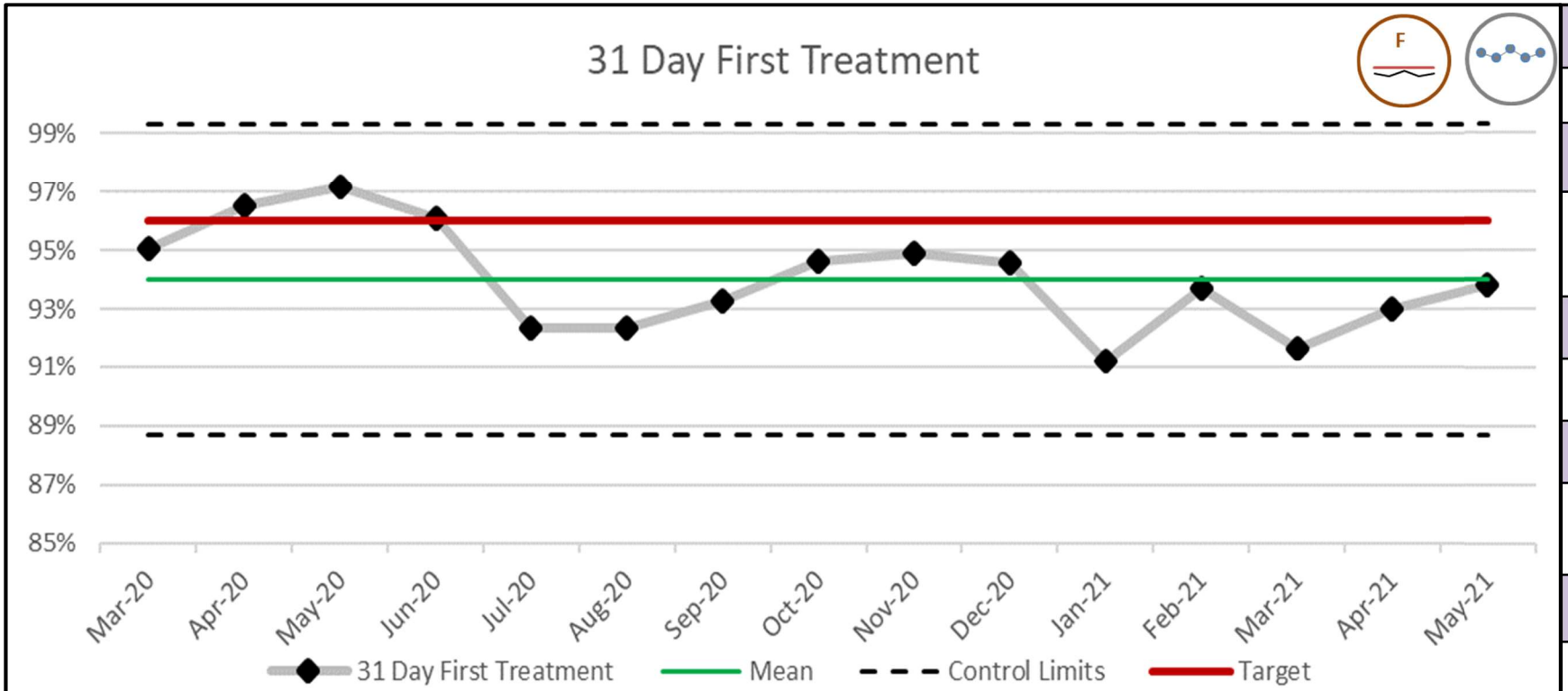

May-21
93.83%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
96%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:
Percentage of patients treated who began first definitive treatment within 31 days of receiving their diagnosis.

What the chart tells us:
We are currently at 93.8% against a 96% target.

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

Actions:
Two substantive Medical Oncologists have been recruited, both due to start in November 2021, pushed back from July and October, (one covering Breast, Renal and Urology and another covering Gynae and Breast). Review of Colorectal theatre list scheduling to better align with clinician availability and consideration of moving level 1 patients to Grantham.

Mitigations:
Pre-covid level theatre capacity is expected to be achieved by circa end July 2021.

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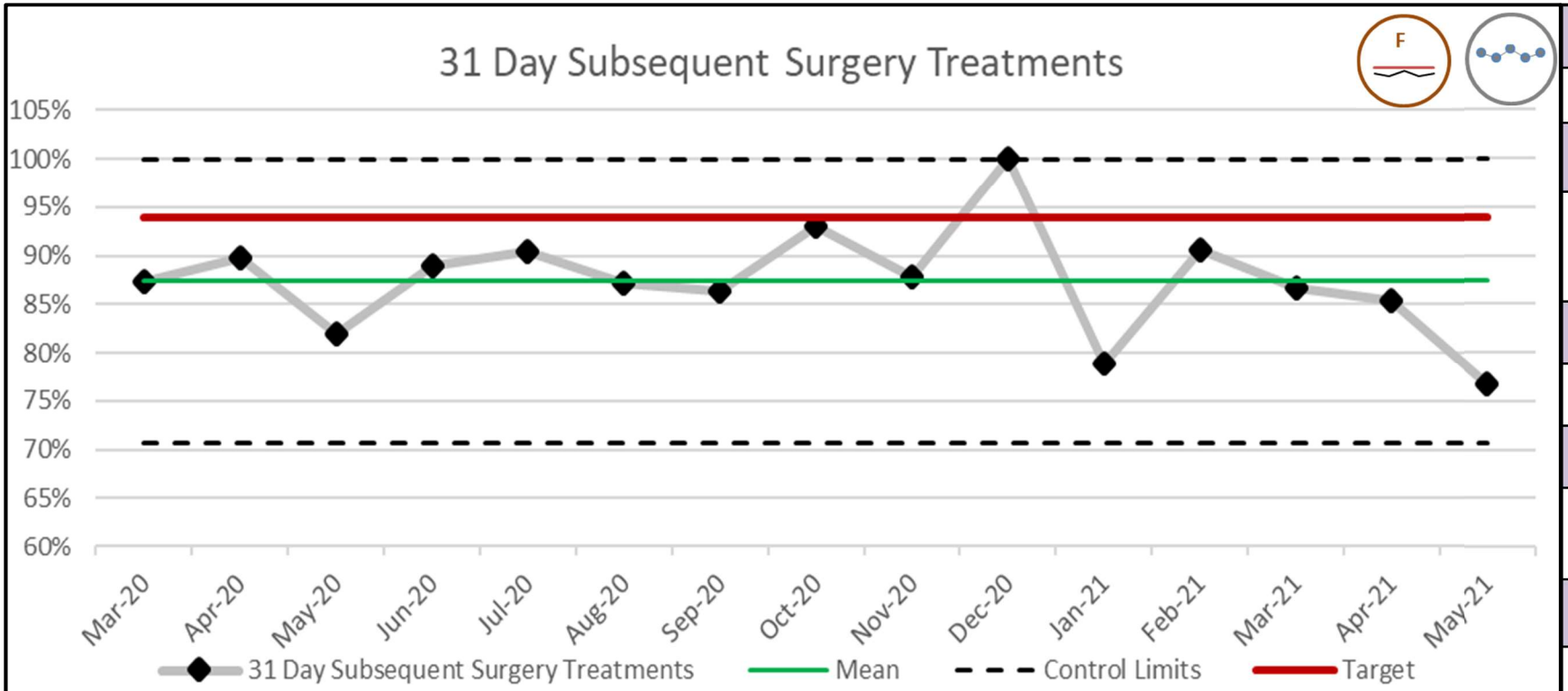

May-21
76.74%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
94%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 76.7% against a 94% target.

Issues:
See issues on previous page – 31 day first treatment

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

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

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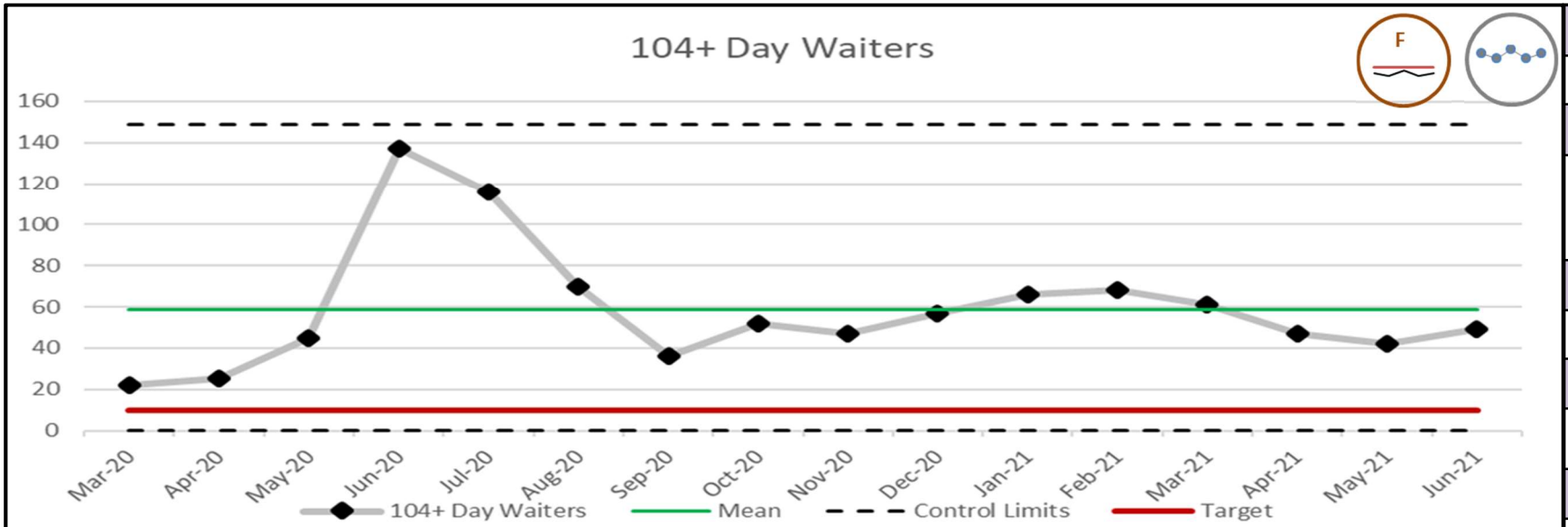

Jun-21
49
Variance Type
Metric is currently experiencing Common Cause Variation
Target
10
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:
Number of cancer patients waiting over 104 days.

What the chart tells us:
At the beginning of July 104 Day Backlog was 49 against the target <10. As of 8th of July the 104 Day backlog is at 55 patients. The current position by tumour site is as follows: 30 Colorectal, 8 Head & Neck, 7 Upper GI, 6 Urology, 3 Lung, 1 Skin

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

Actions:
28 Day standard identified as Trust's cancer performance work stream in the Integrated Improvement Program for 2021-22. 2 H&N consultant posts have been recruited, 1 started in April 2021, and another is due to start in July 2021. Two substantive Medical Oncologists have been recruited, both due to start in November 2021 (one covering Breast, Renal and Urology and another covering Gynae and Breast). One agency Medical Oncologist will also be in post for 6 months, commenced 24th May (covering UGI / LGI and CUP). Funding from EMCA is in place for full-time Cancer Navigator posts to support Surgery, Medicine and Family Health. Recruitment processes are underway. Endoscopy booking team recruited 3 fixed term WTE – now in post and training completed. A Case of Need is being written to request funding for these posts to become substantive because the additional workload will become business as usual. 2 fixed term WTE Endoscopist posts have gone through the interview and selection process twice with only 1 applicant, so a Case of Need is being written for permanent funding. This will support the Bowel Cancer Screening age reduction.

Mitigations:
Pre-covid level theatre capacity is expected to be achieved by circa end July 2021.
Successful bid for Radiology equipment: 5 low dose CT scanners (2 x PH, 2 x LC, 1 x GK), 2 digital X-ray rooms, 4 Ultrasounds (3 x general, 1 x Breast), 38 PACS reporting stations, replacement of Fluoro room, 3 DR Mammography rooms (1 each PH, LC and GK). Delivery is in stages between April and August. Increase in internal radiology reporting capacity. Increase in CTC capacity whilst we have the relocatable and modular staffing from 336 slots pcm to 530 slots pcm. A Nurse endoscopist has been appointed on Bank and is supporting weekend lists and BSCP. Review of Colorectal theatre list scheduling to better align with clinician availability and consideration of moving level 1 patients to Grantham. Work to enhance the early identification of patients requiring Pre-Diagnosis CNS support is ongoing.

PERFORMANCE OVERVIEW - WORKFORCE

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	Apr-21	May-21	Jun-21	YTD	YTD Trajectory	Latest Month Pass/Fail	Trend Variation	Kitemark
A Modern and Progressive Workforce	Overall percentage of completed mandatory training	Safe	People	Director of HR & OD	95%	87.90%	89.64%	91.26%	89.60%		F		
	Number of Vacancies	Well-Led	People	Director of HR & OD	12%	9.60%	8.50%	11.31%	9.80%		P		
	Sickness Absence	Well-Led	People	Director of HR & OD	4.5%	5.01%	4.96%	4.97%	4.98%		F		
	Staff Turnover	Well-Led	People	Director of HR & OD	12%	10.78%	11.31%	11.69%	11.26%		P		
	Staff Appraisals	Well-Led	People	Director of HR & OD	90%	76.42%	74.92%	72.19%	74.51%		F	A	
					£'000	£'000	£'000	£'000	£'000				
	Agency Spend	Well-Led	People	Director of HR & OD	-£1,801	-£3,848	-£3,718	-£3,417	-£10,983		F		

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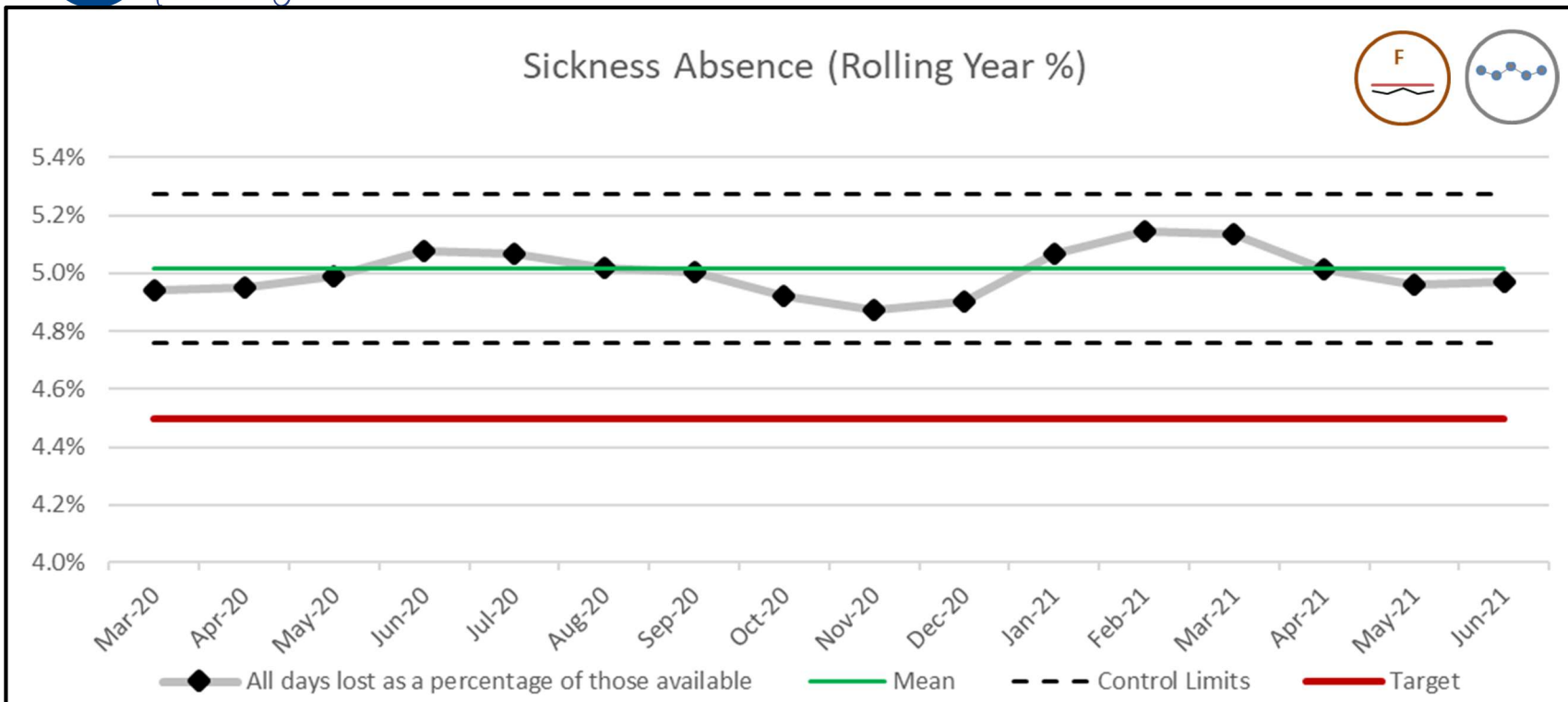

Jun-21
4.97%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
4.5%
Target Achievement
Metric is consistently failing to target
Executive Lead
Director of HR & OD

Background:
% of sickness absence rolling year.

What the chart tells us:
The chart shows us that sickness has been reducing since Wave 2 of COVID. However, there has been a small increase in June, which has picked up pace in July as Wave 3 impacts.

Issues:
- Wave 3 COVID in the community.
- Increasing number of staff being asked to isolate through NHS App or as a consequence of school age children being sent home.
- Patchy use of AMS which makes systematic management of sickness more difficult.

Actions:
- Reviewing requirement to isolate if contacted through NHS App (within national rules).
- Reinstatement of Wave 2 actions to manage sickness.
- Focus through the management chain of effective use of AMS by staff and managers.

Mitigations:
See Actions.

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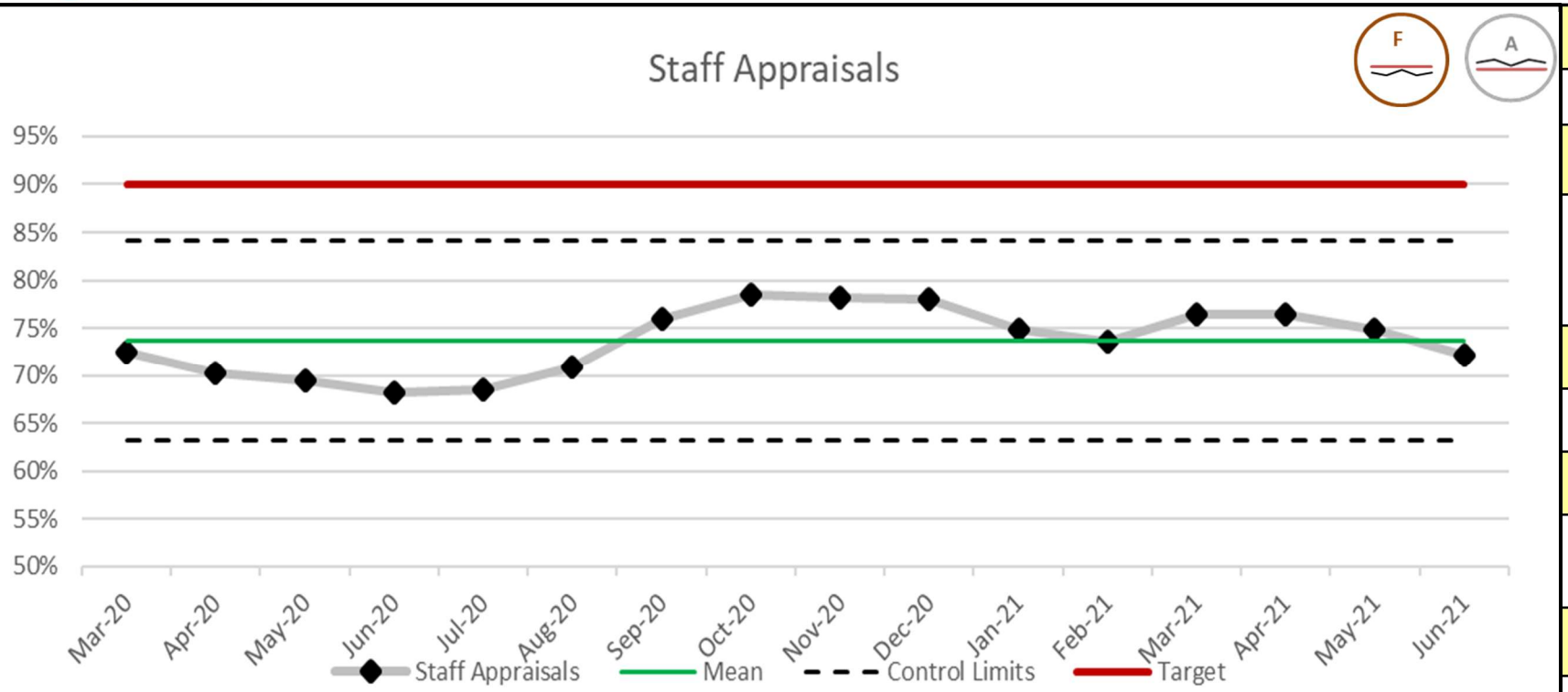

Jun-21
72.19%
Variance Type
Metric is currently experiencing Special Cause Variation – above the mean
Target
90%
Target Achievement
Metric is consistently failing to target
Executive Lead
Director of HR & OD

Background:
% of staff appraisals completed.

What the chart tells us:
We continue to struggle to achieve the target completion rate for appraisal. There has been an impact from COVID, but the challenge is broader to achieve the systematic completion of appraisals.

Issues:
- Impact of Covid.
- Appraisal completion not business as usual for managers.
- WorkPal system yet to be embedded.

Actions:
- Focus on the reasons why appraisal not completed through Workforce Strategy Group.
- Continue to embed the new Workpal system to underpin appraisal.
- Ensure link between appraisal and pay progression is enforced.

Mitigations:
- The Divisions have included completion of appraisal in their IIP major projects.
- Link to Culture and Leadership Programme – appraisal to be the norm as part of leader/staff member relationship.

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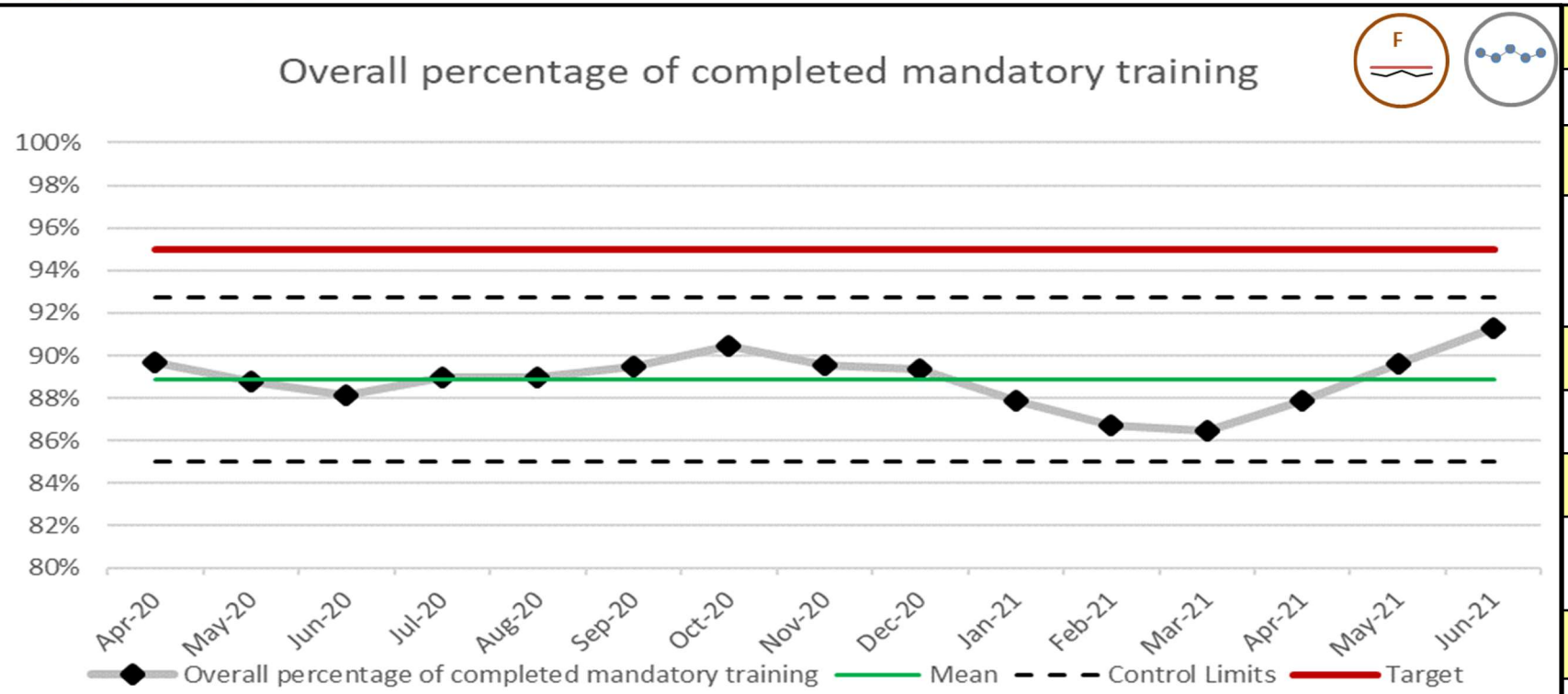
NHS United Lincolnshire Hospitals NHS Trust



Jun-21
91.26%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
95%
Target Achievement
Metric is consistently failing to target
Executive Lead
Director of HR & OD

Background:
Overall percentage of completed mandatory training.

What the chart tells us:
Compliance with mandatory training continues to increase, after dipping during COVID.

Issues:
- Are our targets too rigorous because we are not properly profiling who needs to complete what training?
- Are we protecting training time for our staff?
- Capacity issues amongst those responsible for core learning.

Actions:
- Review of core learning underway - looking at who is required to do what core learning + protected training time.
- Addressing capacity issues through additional temporary staff.

Mitigations:
See actions

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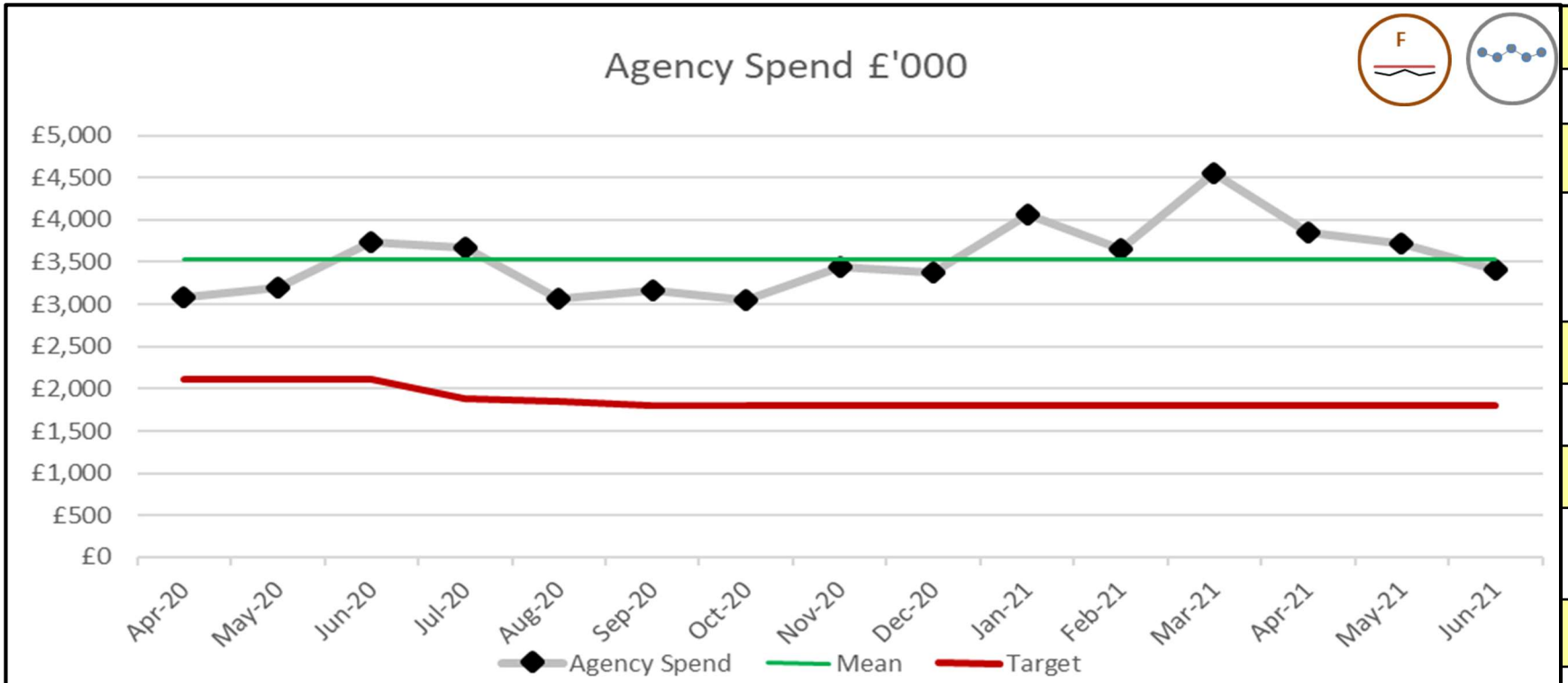
NHS United Lincolnshire Hospitals NHS Trust



Jun-21
£3,417,000
Variance Type
Metric is currently experiencing Common Cause Variation
Target
£1,801,000
Target Achievement
Metric is consistently failing to target
Executive Lead
Director of HR & OD

Background:
Agency spend £'000

What the chart tells us:
Agency spend is on a downward trajectory. There are adjustments to be made in June which will reduce the reduction. However the trajectory at present would not lead to the delivery of the 25% reduction target

Issues:
- Staff absences are high at present due to sickness and annual leave.
- Issues around full grip and control in all areas.
- Issues around good rota design for medical staff.
- Management of junior doctor gaps.

Actions:
- Focus of workforce groups on grip and control.
- Support to rota co-ordinators.
- Potential cohort recruitment of trust grade doctors.

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

OUTSTANDING CARE
personally DELIVERED

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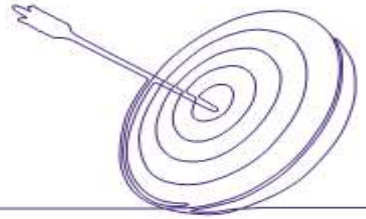
Financial Position Month 3 (2021/22)
Finance Report
5 Year Priority – Efficient Use of Resources

Quality | Operational Performance | Workforce | Finance

Finance Spotlight Report



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	Current Month			Year To Date		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
Operating income from patient care activities	54,248	50,809	-3,439	153,242	149,919	-3,323
Other operating income	2,519	2,649	130	7,824	8,055	231
Employee expenses	-34,831	-34,196	635	-105,388	-104,472	916
Operating expenses excluding employee expenses	-20,614	-18,049	2,565	-54,907	-52,947	1,960
Net Finance Costs	-639	-639	0	-1,889	-1,890	-1
Other gains/(losses) including disposal of assets	0	59	59	0	66	66
Surplus/(Deficit) For The Period/Year	**682**	**633**	**-49**	**-1,118**	**-1,269**	**-151**
Remove capital donations/grants I&E impact	6	55	49	18	169	151
Adjusted financial performance surplus/(deficit)	**688**	**688**	**0**	**-1,100**	**-1,100**	**0**

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

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

- The Lincolnshire system resubmitted its financial plan for H1 of 2021/22 to take account of Elective Recovery Funding (ERF). The revised H1 financial plan for the Trust is inclusive of a £1.8m surplus position, £7.6m ERF, costs of restoration of £5.8m and a requirement for the Trust to deliver cost improvement (CIP) savings of £6.4m.

- The above table shows that the Trust has delivered a £0.7m surplus for the month of June (in line with plan) and that the Trust has delivered a £1.1m deficit year to date (in line with plan).

Finance Spotlight Report (continued)

United Lincolnshire Hospitals NHS Trust

- The current month and YTD Income positions are both £3.3m and £3.1m adverse to plan respectively; the adverse variance includes an accrual for ERF risk of £1.1m, and the agreed brokerage back to the CCG to support delivery of the overall system financial position. The brokerage will be monitored monthly and will vary depending on the timing of the ERF, CIP and overall phasing and alignment of the plans at a Trust and System level.

- Shadow monitoring of activity on a Tariff basis determined that actual activity of £35.8m was delivered in the current month, such that actual activity delivered is £13.3m lower than the income the Trust received. However, the income is inclusive of COVID, Top Up, Restore and BAU allocations.

- The current month and YTD Pay positions are £0.6m and £0.9m favourable to plan respectively; the favourable Pay position includes slower than planned growth in activity volumes and investment.

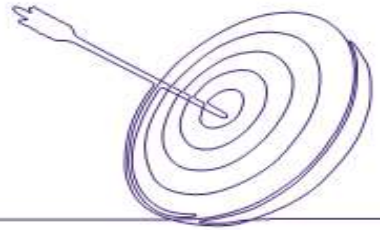
- The YTD Pay position does not include an accrual for the A4C pay award as this has not been agreed nationally; pay award costs are anticipated to be offset by an income stream.

- The June Pay position includes an accrual of £60k per month as an estimate of the YTD impact of the Flowers Case, and £0.2m in relation to the cost of the Covid Vaccination Programme in April.

- The June Pay position includes expenditure of £3.4m on Agency staff and £3.1m on Bank staff; this represents a reduction of £1.4m compared to March (if we remove the impact of technical items at year end); this is £0.3m better than plan, but reductions are required in Q2 to deliver the CIP target.

- The current month and YTD Non Pay positions are £2.6m and £2.0m favourable to plan respectively; the favourable Non Pay position reflects slower than planned growth in activity volumes and reflects the revised plan and links with the CCG income brokerage.

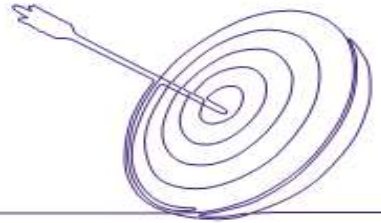
Finance Spotlight Report (continued)



United Lincolnshire Hospitals NHS Trust

- Non Pay expenditure of £52.9m YTD is a monthly average of £17.6m per month and allowing for inflation this is broadly aligned to spend of £17.4m in March (if we remove the impact of technical items).
- The increase of £0.8m in the Non Pay position from May to June includes £0.7m in relation to Pass-through Drugs and Devices.
- In 2021/22, efficiency savings will be referred to as CRES (Cost Reduction Expenditure Savings) rather than as CIP.
- As at Month 3, CRES of £3.0m has been delivered in total: £0.8m in relation to 2021/22 schemes, £2.1m in relation to the FYE of 2020/21 schemes & £0.1m in relation to approved Investment.
- Capital expenditure as at Month 3 of the financial year equated to c£2.6m against a submitted plan of c£6.0m.
- The capital programme for 2021/22 currently stands at £33.7m for the full-year, with c£23m agreed at Trust Board in May and subsequently the remaining c£10m agreed at FPEC (May meeting) thereby completing the agreed capital programme that has been shared with all key stakeholders.
- The month end cash balance is £44.0m which is a reduction of £10.0m against cash at 31 March 2021.

Finance Dashboard



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

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

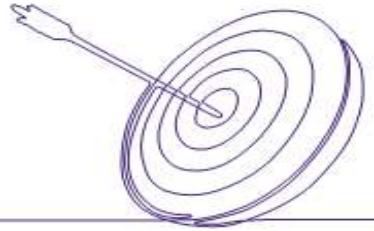
Metric	Rating Boundary			
	1	2	3	4
Capital servicing capacity	2.5	1.75	1.25	<1.25
Liquidity ratio (days)	0	-7	-14	<-14
I&E Margin	1%	0%	-1%	<=-1
I&E margin distance from plan	0%	-1%	-2%	<=-2%
Agency	0%	25%	50%	>=50%

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

Finance and use of resources rating	Full Year	Full Year	Full Year	Actual	Forecast
	31/03/2019	31/03/2020	31/03/2021	YTD JUN 2021	31/03/2022
Capital service cover metric	(10.40)	(1.73)	0.06	2.29	3.19
Capital service cover rating	4	4	4	2	1
Liquidity metric	(98.73)	(128.28)	3.71	3.30	2.82
Liquidity rating	4	4	1	1	1
I&E margin metric	(19.71%)	(7.62%)	0.38%	(0.70%)	0.28%
I&E margin rating	4	4	2	3	2
Agency metric	77.00%	110.00%	113.00%	109.00%	109.00%
Agency rating	4	4	4	4	4
I&E margin: distance from financial plan - metric	(2.80%)	0.70%	n/a	0.70%	0.00%
I&E margin: distance from financial plan - rating	4	1	n/a	1	1

The calculation and constituent elements of each metric is set out further at appendix 7 for information

Capital Spend



NHS
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NHS Trust

Scheme Summary	YTD Plan £000	YTD Actual £000	YTD Variance £000
Fire	900.0	675.4	224.6
Estates - General	490.0	184.2	305.8
Estates - Ward Refurbishments	0.0	45.2	-45.2
Estates - Medical School	100.0	184.1	-84.1
Estates - Lincoln & Pilgrim ED - Stage 1	355.0	252.3	102.7
Estates - Lincoln ED - Resus - Stage 2	700.0	95.2	604.8
Estates - EPC	0.0	11.3	-11.3
Estates - CIR	1,718.0	714.1	1,003.9
Medical Equipment	400.0	87.9	312.1
Digital	809.0	334.6	474.4
Service Developments	300.0	0.0	300.0
Pilgrim A&E / UTC	234.0	41.5	192.5
Funding yet to be allocated	0.0	0.0	0.0
Total	6,006.0	2,625.8	3,380.2

Scheme Summary	Full Year Plan £000	Forecast Actual £000	Forecast variance £000
Fire	2,251.0	2,251.0	0.0
Estates - General	1,919.6	1,919.6	0.0
Estates - Ward Refurbishments	1,500.0	1,500.0	0.0
Estates - Medical School	2,400.0	2,400.0	0.0
Estates - Lincoln & Pilgrim ED - Stage 1	712.0	712.0	0.0
Estates - Lincoln ED - Resus - Stage 2	8,000.0	8,000.0	0.0
Estates - EPC	500.0	500.0	0.0
Estates - CIR	4,033.5	4,033.5	0.0
Medical Equipment	1,781.3	1,781.3	0.0
Digital	4,258.4	4,258.4	0.0
Service Developments	2,369.8	2,369.8	0.0
Pilgrim A&E / UTC	3,981.0	3,981.0	0.0
Funding yet to be allocated	0.0	0.0	0.0
Total	33,706.6	33,706.6	0.0

All key stakeholders are involved in ensuring schemes are monitored and managed. Exception reporting on issues shared with CDG fortnightly.

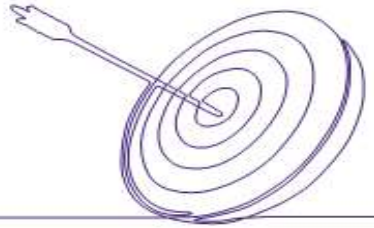
Capital funding levels for 2021/22 agreed, with a plan of c£33.7m. Trust Board, in May, agreed the initial allocation of c£23m and FPEC subsequently agreed the allocation of the remaining c£10m. All key stakeholders have been informed of the finalised capital programme.

The capital plan submitted to NHSE/I has a year-to-date plan at M3 of £6.0m. Spend incurred at M3 equated to c£2.6m, therefore schemes are behind plan by c£3.4m.

Key areas of variance are:

- CIR scheme installation, electrical/water/LST radiators, progressing but remains behind submitted plan by c£1m. Re-assessing specifications to ensure correct tenders are shared causing temporary delays in spend being incurred alongside shortage of materials.
- Lincoln ED Resus scheme behind submitted plan by £0.6m.
- Digital Schemes £0.5m behind plan.
- Fire schemes delayed due to assessment of works required, causing £0.2m variance
- Medical Devices behind plan by £0.3m due to late allocation of funds. Orders being raised and purchases made so purely a timing issue.

Balance Sheet



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	31 March 2021	30 June 2021	
		Plan	Actual
	£000	£000	£000
Intangible assets	4,600	4,142	4,127
Property, plant and equipment	247,119	249,859	246,467
Receivables	2,790	2,781	2,774
Total non-current assets	254,509	256,782	253,368
Inventories	6,510	6,728	6,741
Receivables	25,935	16,975	23,988
Cash and cash equivalents	54,042	49,044	43,997
Total current assets	86,487	72,747	74,726
Trade and other payables	(69,643)	(59,023)	(57,679)
Borrowings	(402)	(555)	(555)
Provisions	(2,056)	(2,178)	(2,243)
Other liabilities	(1,587)	(2,943)	(1,942)
Total current liabilities	(73,688)	(64,699)	(62,419)
Total assets less current liabilities	267,308	264,831	265,675
Borrowings	(3,624)	(3,471)	(3,471)
Provisions	(4,069)	(4,040)	(3,983)
Other liabilities	(12,075)	(11,949)	(11,949)
Total non-current liabilities	(19,768)	(19,460)	(19,403)
Total assets employed	247,540	245,371	246,272
Financed by			
Public dividend capital	677,570	677,570	677,570
Revaluation reserve	27,522	27,348	27,348
Other reserves	190	190	190
Income and expenditure reserve	(457,742)	(459,737)	(458,836)
Total taxpayers' equity	247,540	245,371	246,272

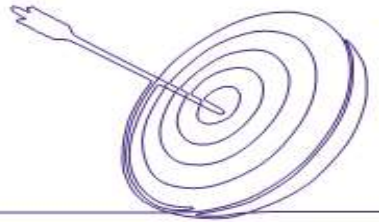
Note 1: The revised H1 financial plan submitted in May did not include a full monthly balance sheet and cashflow. The plan presented here, whilst not submitted, underpinned the actual submission.

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

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

Note 4: Trade Payables remain below pre-pandemic levels with the Trust continuing to pay suppliers well within the 30 day target. Staff related creditors are however at higher levels than historically seen, with increases due to annual leave (£8.1m) and 'Flowers' accruals (£1.4m).
Capital creditors have dropped from March and are now at £3.9m.
BPPC for June was 90% / 89% as measured by value / volume of invoices paid.

Cashflow – April – September 2021 (H1)



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	Apr-21 £m	May-21 £m	Jun-21 £m	Jul-21 £m	Aug-21 £m	Sep-21 £m
Cash at Bank b'f	**54.0**	**50.5**	**53.0**	**43.9**	**45.6**	**47.3**
NHS England	6.4	6.5	6.5	6.5	7.8	5.7
Clinical commissioning groups	42.0	43.6	42.6	46.2	46.2	46.2
Other Patient related income	0.2	0.3	0.7	0.4	0.4	0.4
Patient related Income	**48.6**	**50.5**	**49.9**	**53.1**	**54.4**	**52.3**
Non-pat care services to other Govt bodies	1.1	0.8	1.2	1.0	1.0	1.0
Education & Training	8.4	-	0.1	2.8	2.8	2.8
Research & Development	0.0	0.0	0.2	0.1	0.1	0.1
Pay Recharges	0.4	0.1	0.3	0.3	0.4	0.5
Leasing Income	0.0	0.2	0.3	0.2	0.2	0.3
Other Income	0.4	0.6	0.6	0.5	0.6	0.8
Other Operating Income	**10.4**	**1.7**	**2.7**	**4.9**	**5.2**	**5.6**
Income Total	**59.0**	**52.2**	**52.5**	**58.0**	**59.6**	**57.8**
Payroll: Weekly / Monthly	(18.1)	(17.5)	(17.7)	(17.7)	(17.7)	(19.0)
Payroll: Tax / NI	(8.2)	(8.2)	(8.1)	(8.1)	(8.1)	(8.1)
Payroll: Pensions	(4.6)	(4.7)	(4.7)	(4.7)	(4.7)	(4.7)
Agency	(7.2)	(2.7)	(5.3)	(5.4)	(5.4)	(5.4)
Non Pay: NHSLA	(2.4)	(2.4)	(2.4)	(2.4)	(2.4)	(2.4)
Non Pay Other	(17.5)	(11.0)	(21.6)	(16.7)	(16.7)	(16.7)
Non Pay - VAT Reclaim	1.3	-	0.8	0.7	0.7	0.7
Operating Expenses Total	**(56.7)**	**(46.4)**	**(59.0)**	**(54.2)**	**(54.2)**	**(55.5)**
PDC dividends payable/refundable	-	-	-	-	-	(3.1)
Finance Costs Total	**-**	**-**	**-**	**-**	**-**	**(3.1)**
Revenue Cash movement in Month	**2.3**	**5.7**	**(6.4)**	**3.8**	**5.4**	**(0.8)**
Capital cash spent: Internally Funded	(5.8)	(3.1)	(2.6)	(1.3)	(2.7)	(1.7)
Capital cash spent: PDC Funded	(0.0)	(0.0)	(0.1)	(0.8)	(1.0)	(1.1)
Capital PDC received	-	-	-	-	-	-
Total External Financing & Capital	**(5.8)**	**(3.1)**	**(2.7)**	**(2.1)**	**(3.6)**	**(2.8)**
TOTAL CASH AT BANK c'f	**50.5**	**53.0**	**43.9**	**45.6**	**47.3**	**43.8**

Note 1: Cash balances remain significantly increased on 2019/20 levels. Whilst Trusts are no longer paid one month in advance, the continued block payment regime means cash balances remain high. Coupled with this the Trust received payments in March to cover future outgoings associated with accrued annual leave and the Flowers liability due to be paid out in September.

Note 2: The cash position has remained relatively steady since March, the only notable movement being a reduction in capital creditors from £13.1m to £3.9m. The level of trade creditors has also reduced from £16.5m in March to £9.4m.

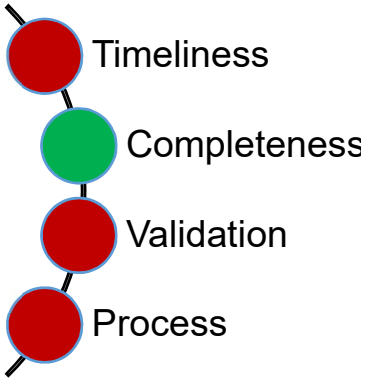
Note 3: ERF income of £7.6m for H1 is profiled to be received from CCGs between July – September.

Note 4: As at the end of June, taking into account the capital cash underspend from 2020/21, capital creditors and internally generated resource (depreciation) £9.5m of the cash held relates to capital.

Note 5: The cashflow presentation is aligned to pre-COVID and 20/21 reporting and is underpinned by a daily cashflow.

APPENDIX A - KITEMARK

Reviewed: 1st April 2018
Data available at: Specialty



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

United Lincolnshire Hospitals NHS Trust

Annual Report to the Trust Board from the Audit and Risk Committee 2020/21

ROLE OF THE COMMITTEE

In accordance with its agreed terms of reference the Audit and Risk Committee's main purpose is to advise the Board on the adequacy and effectiveness of the Trust's systems of internal control and its arrangements for risk management, control and governance processes. In order to discharge this function it is best practise for the Trust Board to receive a formal annual report from the Trust's Audit and Risk Committee (the Committee). This report summaries the work of the Committee for the financial year 2020/21. This report includes information provided by both Internal and External Audit.

TERMS OF REFERENCE

During 2020/21, in line with all other Committees of the Board, the Committee's Terms of Reference were reviewed. The terms of reference and membership of the Committee reflect the governance arrangements and the guidance requirements set out in the NHS Audit Committee Handbook (HFMA 2018). Under the agreed terms of reference the Committee was to support the Board by scrutinising the robustness of and providing assurance that there is an effective system of governance and control for risk, the accounting policies and the accounts of the organisation, the planned activity and results of both internal and external audit and assurances relating to the corporate governance requirements for the organisation.

MEETINGS

Due to the Trust responding to the Covid-19 pandemic and the national steer to reduce the burden on Trusts the Committee met and operated during 2020/21 working to a reduced agenda and length of meeting.

The Committee whilst reducing its agenda still considered all items necessary to fulfil its role of supporting the Trust Board by critically reviewing and reporting on the relevance and robustness of governance structures and assurance processes on which the Trust board places reliance. Following each meeting, an assurance report was provided to the Trust Board.

MEMBERSHIP AND ATTENDANCE

The Committee is appointed by the Board from amongst the Non-Executive Directors of the Trust. During 2020/21 the Committee was chaired by Mrs Sarah Dunnett.

Details of the Committee's membership and attendance during 2020/21 is set out below meetings have been conducted virtually in response to the pandemic:

Non-Executive Director (Chair)
Non-Executive Director - Finance, Performance and Estates Committee Chair
Non-Executive Director – People and OD Committee Chair
Non-Executive Director – Quality Governance Committee Chair

In attendance:
Director of Finance and Digital (Executive Lead)
Trust Secretary and FTSU Guardian
Internal Audit Representative
External Audit Represnetative
LCFS

Members	**2 Apr 2020**	**16 Jun 2020**	**27 Jul 2020**	**12 Oct 2020**	**15 Jan 2020**
Non-Executive Director (Mrs Dunnett, Chair)	X	X	X	X	X
Non-Executive Director (Mrs Ponder)	X	X	X	X	X
Non-Executive Director (Mr Hayward)	X	X	X	X	X
Non-Executive Director (Mrs Libiszewski)	X	X	A	X	A

A denotes Apologies given

REVIEW OF BUSINESS

The Audit and Risk Committee's work programme for 2020/21 is set out as an appendix to this report.

The Audit and Risk Committee has been responsible for the oversight of the following strategic objectives of the Trust in 2020/21:

- Objective 2c Well Led Services

During 2020/21 the Committee has utilised the Board Assurance Framework to provide focus to the meetings and ensure alignment of the agenda to the elements of the BAF. At the end of the year the strategic objective was rated as follows:

Objective 2c – **AMBER**

OVERVIEW

The Audit and Risk Committee has continued to, over the last twelve months, improve the assurance it can give to the Board on the adequacy and effectiveness of the Trust's systems of internal control and it's arrangements for risk management, control and governance processes. The Committee has reported its progress to the Board through upward reports, reporting progress against the delivery of the work plan, as defined by the terms of reference and through this annual report.

The work programme for the Committee in 2020/21 has focused on meeting the organisation's requirements to produce and publish a set of audited accounts and annual report during Covid-19. The Committee has, whilst working to a reduced agenda provided focus to Internal Audit, Counter Fraud and External Audit during the Covid-19 pandemic.

The Committee has been well attended by members. The Chair has been actively involved in the agenda setting alongside the Director of Finance and Digital.

Other key areas of focus of the Committee have included:

- Board Assurance Framework
- Risk Management
- Compliance with Governance Arrangements

INTERNAL CONTROLS AND RISK MANAGEMENT

Assurance Framework

The Board Assurance Framework (BAF) is the key assurance document for the Trust. The Audit Committee has scrutinised the BAF at each of its meetings in 2020/21 and has considered the adequacy of the mechanisms and processes surrounding the BAF in place to support the Trust Board in seeking assurance in respect of the strategic objectives. The Committee received the Head of Internal Audit Opinion and acknowledged the opinion given in relation to the BAF. The Committee also received updates from each committee chair aligned to their committees.

Care Quality Commission Regulation

There were no CQC visits during 2020/21 as a result of the pandemic.

The Trust continues to have CQC conditions in place in respect of its licence. These were reported in the Annual Governance Statement.

Self-Declaration / Self-Assessment Processes

The Trust is required to make a self-declaration of compliance against the Single Over-sight Framework (SOF) at the year end. A quarterly report of compliance against the themes set out in the SOF has been prepared and considered by the Audit Committee each quarter. The Committee continue to develop this report.

Governance Arrangements

The Committee received quarterly reports on compliance with the Trust's governance arrangements. The Committee has continued to monitor closely the level of waivers performed and through the Director of Finance and Digital worked to see these reduce, this has been a particular challenge due to the pandemic. In addition there has been a review of overpayment of salaries, pharmacy stock and progress housing improved controls have now been put in place but this has yet to demonstrate all of the required improvements.

The Committee has received specific updates in respect of policy management and sought assurance on controls over Trust documentation.

Annual Review of Governance Arrangements

The Committee reviewed as part of the annual update and in light of best practice, changes to the key corporate governance documents of the Trust:

- Standing Financial Instructions
- Scheme of Delegation
- Standing Orders

The Committee recommended amendments to these for approval at Trust Board.

Quality Account

There was no requirement for the Trust Quality Report for 2020/21 to be subject to audit. This report was produced and considered by the Quality Governance Committee and published in line with the required timeframe.

Counter Fraud Service

The Trust is required to monitor and ensure compliance with NHS Provider Standards for Fraud, Bribery and Corruption regarding its arrangements for counter fraud and corruption work. A key role for the Committee is to provide assurance to the Trust Board that these arrangements are robust.

During the year, the Committee:

- received and recommended to the Trust Board the LCFS Annual report
- approved the Annual Counter Fraud Plan
- reviewed and approved the Trust's annual LCFS submission to NHSCFA
- monitored progress against the plan
- monitored reactive and proactive fraud work provided by the LCFS, and received reports on the volume of cases under investigation and subsequent actions taken by management to strengthen control, an area of additional reporting requested but the Committee

- received strategic updates

Internal Audit

Grant Thornton have been the Internal Audit service provider. During the year the Committee:

- Approved the Internal Audit Plan for 2020/21 to address areas of internal control where assurance was sought, to cover mandatory areas as required by NHS Internal Audit Standards and to meet the statutory responsibility to provide a Head of Internal Audit Opinion. The internal audits in the 2020/21 plan were impacted by the pandemic
- monitored progress against plan, including consideration of issues arising and high priority recommendations through receipt of regular progress reports
- received and considered the Head of Internal Audit's opinion for 2020/21
- focussed on overdue audit recommendations

The overall Head of Internal Audit opinion was Partial Assurance with Improvements Required which is consistent with last year and committee expectations based on risk based audit planning and reports received throughout the year.

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EXTERNAL AUDIT AND FINANCIAL REPORTING

The Trust's external auditor for 2020/21 was Mazars this was the first year of their contract with the Trust.

The Audit Plan set out the work to be undertaken in relation to the 2020/21 accounts and was developed on the basis of a risk-based approach to audit planning. This was received and considered by the Committee.

The external auditors presented their Annual Opinion to committee members prior to the Trust Board's review of the Annual Accounts in June 2021. The Committee considered and recommended the 2020/21 Annual Accounts and report to the Board.

RISKS

The BAF and Corporate risk register have been reviewed at the committee at each meeting identifying where updates have been required based on assurances received at the Committee. The Committee have reviewed the format of the assurance framework and confirmed that it is fit for purpose.

The Audit Committee is an essential element of the Trust's corporate governance structure. It works closely with the Assurance Committees and the Chair of each of these committees is also a member of the Audit Committee, which helps provide additional assurance on the adequacy of the Trust's systems and controls.

2020/21 was a particularly challenging year but against this backdrop this report demonstrates that the Committee has fulfilled its terms of reference and contributed to strengthening internal control within the Trust.

The Committee can provide the Board with assurance that, by addressing its terms of reference, it has scrutinised the levels of controls in place and as necessary applied

additional control measures in order to maintain, strengthen and develop systems of control that enable the Trust to be compliant with its legislative and statutory duties.

The Committee will review its priorities for 2020/21 and the focus for the new financial year 2021/22 will be on continuing to support and assure the Trust Board on reviewing and strengthening financial reporting, internal control, risk assurance and governance and achieving well led. The Committee will continue to ensure that it is itself improving with an increased focus on strengthening and reviewing new arrangements as they develop within the Lincolnshire ICS.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Audit and Risk Committee
Terms of Reference

1. Authority

The Audit and Risk Committee is appointed by the Trust Board in line with the powers set out in the Trust Standing Orders.

The Audit and Risk Committee holds only those powers as delegated in these Terms of Reference as determined by the Trust Board.

The Standing Orders and Standing Financial Instructions of the Trust, as far as they are applicable, shall apply to the Committee and any of its established groups.

The Committee is authorised by the Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the committee. The Committee is authorised by the governing body to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

2. Purpose of the Committee

The Audit and Risk Committee exists to scrutinise the robustness of and provide assurance to the Trust Board that there is an effective system of governance and control for risk, the accounting policies and the accounts of the organisation, the planned activity and results of both internal and external audit and assurances relating to the corporate governance requirements for the organisation.

The relevant strategic objectives assigned to the Audit and Risk Committee for 2020/21 are:

- Well Led Services

3. Membership

The members of the Committee are:

- Non-Executive Director (Chair)
- Non-Executive Director (Quality Governance Committee Chair)
- Non-Executive Director (Finance, Performance and Estates Committee Chair)
- Non-Executive Director (People and OD Committee Chair)

The following roles will be routine attendees at the Committee:

- Director of Finance and Digital
- Trust Secretary/Deputy Trust Secretary
- Representative from Internal Audit
- Representative from External Audit
- Counter Fraud Representative (at least twice annually)
- Deputy Director of Finance

The Accountable Officer should discuss at least annually with the committee the process for assurance that supports the governance statement and should attend the committee when it considers the draft annual governance statement and the annual report and accounts.

Executive Directors/ Senior Managers may be invited to attend when the committee is discussing areas of risk or operation that are the responsibility of that director/manager.

4. Attendance and Quorum

The Committee will be quorate when three of the four Non-Executive Director members are present.

5. Frequency

The committee will not meet less than five times per year. At least once a year the committee will meet privately with the internal and external auditors.

6. Specific Duties

The Audit and Risk Committee will:

Integrated governance, risk management and internal control:

- Review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisations activities (clinical and non-clinical), that supports the achievement of the organisations objectives
- Review the adequacy and effectiveness of all risk related disclosure statements (in particular the annual governance statement) together with any accompanying head of internal audit opinion, external audit opinion or other appropriate independent assurances, prior to submission to the Trust Board
- Review the adequacy and effectiveness of the underlying assurance processes that indicate the degree of achievement of the organisation's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements
- Review the adequacy and effectiveness of the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications
- Review the adequacy and effectiveness of the policies and procedures for all work related to counter fraud, bribery and corruption as required by NHSCFA

Internal Audit:

- Consider the provision of the internal audit service and the costs involved.
- Review and approve the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework.
- Consider the major findings of internal audit work (and management response) and ensuring coordination between the internal and external auditors to optimise the use of audit resources.
- Ensure that the internal audit function is adequately resourced and has appropriate standing within the organisation.
- Monitor the effectiveness of internal audit and carry out an annual review.

External Audit:

- The Committee shall review and monitor the external auditors independence and objectivity and the effectiveness of the audit process. In particular the Committee will review the work and findings of the external auditors and consider the implications and management's responses to their work
- Consider the appointment and performance of external auditors, as far as the rules governing the appointment permit (and make recommendations to the Trust Board when appropriate).
- Discuss and agree with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan.
- Discuss with the external auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee.
- Review all external audit reports, including the report to those charged with governance (before its submission to the Trust Board) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

Other Assurance Functions:

- The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation. Including but not limited to any reviews by DHSC arm's length bodies or regulators/inspectors for example, the CQC, NHS Resolution, Royal Colleges, accreditation bodies etc.
- The Committee will review the work of other committees within the organisation whose work can provide relevant assurance to the audit committee's own areas of responsibility.
- The Committee will satisfy itself on the assurance that can be gained from the clinical audit function through its review of the work of the Quality Governance Committee.

Counter Fraud:

- The Committee shall satisfy itself that the organisation has adequate arrangements in place for counter fraud, bribery and corruption that meet NHSCFA's standards and shall review the outcomes of work in these areas.
- The Committee will refer any suspicions of fraud, bribery and corruption to the NHSCFA.

Management:

- The Committee shall request and review reports, evidence and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.
- The Committee may request specific reports from individual functions within the organisation

Financial Reporting:

- The Committee shall monitor the integrity of the financial statements of the organisation and any formal announcements relating to its financial performance.
- The Committee will ensure that the systems for financial reporting to the governing body, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided.
- The Committee shall review the annual report and financial statements before submission to the Trust Board focussing particularly on
    - The wording in the annual governance statement and other disclosures relevant to the terms of reference of the committee.
    - Changes in and compliance with, accounting policies, practices and estimation techniques
    - Unadjusted misstatements in the financial statements
    - Significant judgements in preparation of the financial statements
    - Significant adjustments resulting from the audit
    - Letters of representation
    - Explanations for significant variances

Whistleblowing:

- The Committee shall review the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial, clinical or safety matters and ensure that any concerns are investigated proportionately and independently.

7. Administrative support

The Committee will operate using a work plan to inform its core agenda. The agenda will be agreed with the Chair prior to the meeting.

Agendas and supporting papers will be circulated no later than 7 days in advance of meetings. Any items to be placed on the agenda are to be submitted no later than 8 working days in advance of the meeting. Items which miss the deadline for inclusion on the agenda may be added with permission from the Chair.

Minutes will be taken at all meetings, presented according to the corporate style, circulated to members within 7 days along with the action log and ratified by agreement of members at the following meeting.

8. Accountability and Reporting Arrangements

The Chair of the Committee shall report to the Board after each meeting and provide a report on assurances received, escalating any concerns where necessary.

The Committee shall report at least annually to the Trust Board on its work in support of the annual governance statement, specifically commenting on:

- The fitness for purpose of the Board Assurance Framework
- The completeness and embeddedness of risk management in the organisation
- The integration of governance arrangements
- The appropriateness of the evidence that shows the organisation is fulfilling regulatory requirements relating to its existence as a functioning business
- The robustness of the processes behind the quality accounts

The annual report should also describe how the committee has fulfilled its terms of reference and give details of any significant issues that the committee has considered in relation to the financial statements and how they were addressed.

9. Monitoring effectiveness and Compliance with Terms of Reference

The Committee will complete an annual review of its effectiveness and provide an annual report to the Board on its work in discharging its responsibilities, delivering its objectives and complying with its terms of reference, specifically commenting on relevant aspects of the Board Assurance Framework and relevant regulatory frameworks.

10. Review of Terms of Reference

The Terms of Reference for the Committee will be reviewed annually by the Committee and submitted to the Trust board for approval.

The Committee will on an annual basis review and approve the terms of reference and work programmes of all of its reporting groups.

Approved:
Approved by:
Next Review Date:

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*3 August 2021*
Item Number	*Item 13.1*
Audit Committee Upward Report	
Accountable Director	*Sarah Dunnett, Audit Committee Chair*
Presented by	*Sarah Dunnett, Audit Committee Chair*
Author(s)	*Jayne Warner, Trust Secretary*
Report previously considered at	*N/A*

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

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

Recommendations/ Decision Required	• *Ask the Board to note the upward report and the actions being taken by the Committee to provide assurance to the Board on strategic objective 2c*

Executive Summary

The Audit Committee met via MS Teams on the 12th July 2021, the Committee considered the following items:

External Audit

The Committee received a verbal update from the External Audit provider. It was noted that the audit closure certificate had to be issued by the 20th September. It was noted and agreed that the Committee would need to meet ahead of this date to receive the certificate. This would be arranged as an extraordinary meeting of the Committee. This position had been created by delays in the issue fo national guidance in relation to the VFM work and changes to the reporting timetables.

Internal Audit

The Committee were advised of good progress against the Internal Audit Plan 2021/22 and specifically sought assurances in relation to the ability of Internal Audit to complete the necessary elements of the plan which would allow the production of the Head of Internal Audit Opinion for the Trust.

The Trust Internal Audit providers were able to confirm that a further three final reports had been issued.

- Patient Experience
- Research and Development Follow Up
- Educational Funding Follow Up

The Committee remain concerned about implementation of recommendations made and asked that an Executive attend a future meeting to feedback progress on Research and Development and Educational Funding.

A further report the IIP CQC Outcomes report was with the Trust in draft. All reports are being considered by relevant assurance committees of the Board with a focus on implementation of recommendations.

The Committee noted that the General Ledger review had been rescheduled for later in the year.

The Committee received a comprehensive update on the Trust's response to the recommendations contained in the Internal Audit Estates Report and the plans to strengthen controls. The Director of Estates and Facilities and the Chief Operating Officer joined the meeting for this item. The Committee would receive a further update on implementation of actions taken at its meeting in October 2021. The Committee agreed that an escalation to Board was required to allow Board to consider the wider issues highlighted in relation to ownership and responsibility and the culture and leadership work programme. The Audit Committee would seek assurance that the output of the programme would address the issues which had been highlighted as part of this review.

The Committee noted that there were 50 outstanding audit actions, which was an increase from the last meeting seven high risk, 24 medium risks and 19 low risks.

The Committee were advised that Internal Audit felt that the emphasis on clearing actions had slipped. The Committee would continue to seek assurance that there was an appropriate level of grip and control over agreed actions.

Counter Fraud

The Committee reviewed and approved the Local Counter Fraud Specialist Progress Report and Counter Fraud Annual Report 2020/21.

The Committee noted that the 961 responses had been received to the Annual Staff Fraud Awareness Survey a 10% increase on the last time the survey had been completed. Results will be considered at a future meeting. Training rates had fallen slightly below target but were recovering.

The Committee agreed that the annual report was reflective of the reporting which it had received throughout the year. Noting particularly the areas of the Counter Fraud Functional Standard Return which were rated Amber and Red which will be monitored through the Counter Fraud Service quarterly progress report.

The Committee approved minor changes to the Local Counter Fraud Bribery and Corruption Policy and Response Plan.

Compliance Report

The Committee received the regular report on compliance noting that this covered the period from April 2021 to June 2021. The Committee noted the level of waivers of standing orders remained high. The Committee noted that in response to the Estates Internal Audit Report the waivers for 2020/21 had been revisited and all gaps in reporting identified and clarified.

The Committee noted the lifting of the fire notices since the last reporting period.

The Committee noted that the report had been developed to include a report from procurement where breaches of standing financial instructions had been identified. This was in direct response to recommendations for improvement made by Internal Audit

Board Assurance Framework

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

Policies Update

One element of objective 2c was the implementation of a robust policy management system. The Committee received a report and noted the continued limited assurance provided. The Committee noted the actions in place to improve processes and ensure policies were adequately maintained and used. The Committee remained concerned about capacity and noted that additional resource had been identified and was in place.

The Committee were advised that the first stage of the cleansing exercise had taken place with each document in the document management system being realigned to the current corporate structure. This process would then allow a review with each Division and Corporate Directorate of all documents held for each area.

Corporate Governance Manual

An update to the Corporate Governance Manual to align this with the updated terms of reference and duties of the Board Committees was received and agreed. These were the only updates to the manual and were approved for recommendation to Trust Board.

Risk management and revision of risk register

The Committee had previously requested assurance on the actions being taken to strengthen controls over risks. The Committee received a report on the progress of the review of the risk register to support improvement. The Committee were advised that whilst the timeline had slipped the work was progressing. The reporting of risk into each Committee was also under review to ensure that the risks were fit for purpose to give a true reflection of greatest risks to organisation.

Meeting	*Trust Board*
Date of Meeting	*3rd August 2021*
Item Number	*Item 13.2*
Strategic Risk Report	
Accountable Director	*Dr Karen Dunderdale, Director of Nursing*
Presented by	*Dr Karen Dunderdale, Director of Nursing*
Author(s)	*Matt Hulley, Risk & Incident Manager*
Report previously considered at	*N/A*

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

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

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

Executive Summary

- This Strategic Risk Report focuses on the highest priority risks currently being managed within the Trust.
- Key risk indicators for all Very high risks (those rated 20-25) have been updated with available data, as evidence of the current extent of risk exposure
- The effect of the 'Delta Variant' on ULH services requires careful monitoring
- 87% of all strategic risks are now overdue their review date. This will be addressed as part of the ongoing roll out and review of the Risk Register reconfiguration.
- Capacity to manage emergency demand (4175) has been recently reviewed at FPEC and increased its score to 25 based on experiences in July 2021. This will be comprehensively reported in Augusts FPEC risk report and overseen at QGC for any quality impacts.

Purpose

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

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

1. Introduction

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

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

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

2. Strategic Risk Profile

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

Risk title (ID)	Local impact of the global coronavirus (Covid-19) pandemic (4558)

Current risk rating	Very high (25)	**Risk lead**	Natalie Vaughan
Lead group	Infection Prevention & Control Group		

Key Risk Indicators (KRIs):

- Total number of Covid-19 inpatient admissions – as of 23 July 2021 there had been 3,138 Covid-19 inpatient cases within ULHT; this is an increase of 64 since 25 June, indicating an increase in inpatient admission rates
- Number of current inpatient admissions due to Covid-19 – 16 at Lincoln and 7 at Pilgrim as of 23 July 2021; previous months' figures indicated 2 across the entire trust
- Patient deaths due to Covid-19 – total of 841 as of 23 July 2021, compared with 837 at the 23 July 2021
- Serious Incidents where the pandemic response is a contributory factor – to the end of June 2021 there were 30 completed SI investigations that cited the pandemic response; an average of 3.5 incidents per month between March and July 2020; an average of 1 per month between August and December 2020 with a declining average of 0.5 incidents per month within 2021. No further SIs relating to Covid have been declared since April 2021

Gaps in control & mitigating actions:

- England Covid alert level is at Level 3 (epidemic is in general circulation)
- Cases of the Delta variant of COVID-19 are increasing across the country and the situation is being monitored closely.
- Intensive care capacity to be increased to 200% if required
- 3 vaccines have now been approved by the MHRA and are being rolled out across the country; there are several approved treatments for Covid-19 symptoms that are now in use.
- Operational Gold Command in place to manage the ULHT response – control protocols are used for site access; PPE use; social distancing; patient admissions & discharges; staff rapid testing; use of essential equipment & oxygen
- Essential information to all staff is now being provided to staff through the weekly ULHT Bulletin which has replaced the SBAR

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

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

Key Risk Indicators (KRIs):

- The A&E 12hour Trolley wait standard has been breached 5 times since July 7th 2021. This standard often does not fully describe the overall levels of overcrowding in Emergency Departments that occurs when this standard is breached.
- Over the same period July 7th to date the Trust has escalated its emergency status to Level 4 the highest level of response on 3 occasions. This also includes enacting the Critical Incident STANDBY emergency preparedness response as a result of loss of safe access to emergency department services through overcrowding.
- A&E waiting times against the constitutional standard – 4-hour performance for May was 72.56% a deterioration against April's performance of 74.23% This is the seventh time in ten months the Trust's performance has been below the agreed trajectory
- Ambulance conveyances for May were 4843, up 7.48% against April. The Trust saw an increase in >59-minute ambulance handover delays, with 285 in May a deterioration of 78 from April.

Gaps in control & mitigating actions:

- The trust has met with NHSEi regional executive team to review gaps and mitigations on two occasions the latest 19th July 2021.
- It is recognised that across the region the combination of pressure to recover backlogs, increased urgent care admissions above expected levels, increased Covid presentations (although below Wave 1 and 2) coupled with workforce availability issues have created a particularly challenging environment for acute trusts to operate safely in.
- Improvement measures and the U&EC improvement plan whilst will help alleviate some pressures currently do not fully address the combined issues of demand vs capacity and workforce availability.
- In Wave 1 and Wave 2 of the Covid-19 response the Trust identified a Risk Score of 25 for Covid-19 pandemic impact. Although many of the elements of this risk are the same as those described in the Covid-19 score 25 risk, this risk Capacity to manage emergency demand (4175) more accurately describes the main risk the Trust is experiencing.
- Specific concerns relate to ambulance handover delays, increased non-elective admissions, stranded and super-stranded patients
- Lincoln site reconfiguration plans & business case for investment on Pilgrim site (with government funding)
- The U&EC improvement programme has undertaken an internal review of process, key stakeholders and original milestones where off track clear rectification plans are now in place
- Partnership working within the system will support a more proactive response and delivery to system need. U&EC Partnership Board currently leads the system response to the risk described.

- Harm reviews are being carried out for all patients affected by waiting more than 12 hours in A&E following a decision to admit and ambulance handover delays of more than 2 hours

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

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

Key Risk Indicators (KRIs):

- Staff appraisal rates – was 74.92% in May and 76.42% in April and 75.67% YTD against a target of 90%
- People Pulse survey results – almost 900 staff completed the first survey (in July 2020), a response rate of around 12%; 85% of staff felt informed (+0.6 vs NHS overall); 63% felt confident in local leaders (equal to NHS overall); 61% felt supported (-5.7 vs NHS overall); 59% felt they had a good work-life balance (-2.5 vs NHS overall).
- NHS National Staff Survey (NSS) results – some improvement in results of 2019 staff survey across two thirds of the questions, still below average for acute trusts; less than 50% of staff would recommend ULHT as a place to work; the Trust's score for the bullying & harassment theme in the NSS stayed relatively unchanged in 2019 at 7.6 against a national average of 7.9.

Gaps in control and mitigating actions:

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

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

3. Conclusions & recommendations

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

posed to the Trust. The effect of the 'Delta Variant' on ULH services requires careful monitoring

3.2 This incorporates a very high risk recently reviewed at FPEC and increased its score to 25 based on experiences in July 2021. This will be comprehensively reported in Augusts FPEC risk report.

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	Risk Type	Rating (current)	Risk level (current)	Review date
4175	Capacity to manage emergency demand	Service disruption	25	Very high risk	01/10/2021
4558	Local impact of the global coronavirus (Covid-19) pandemic	Harm (physical or psychological)	25	Very high risk	31/03/2021
4083	Workforce engagement, morale & productivity	Reputation / compliance	20	Very high risk	30/06/2021
4556	Safe management of demand for outpatient appointments	Harm (physical or psychological)	12	High risk	30/06/2021
4481	Availability & integrity of patient information	Service disruption	12	High risk	31/12/2020
4581	Heating (Trust Wide)	Harm (physical or psychological)	12	High risk	31/03/2021
3520	Compliance with fire safety regulations & standards	Reputation / compliance	12	High risk	30/09/2021
4081	Quality of patient experience	Patient experience	12	High risk	31/12/2020
4082	Workforce planning process	Service disruption	12	High risk	31/03/2021
3689	Compliance with asbestos management regulations & standards	Reputation / compliance	12	High risk	31/03/2021
4043	Compliance with patient safety regulations & standards	Regulatory compliance & standards (including performance targets)	12	High risk	31/03/2021
4145	Compliance with safeguarding regulations & standards	Regulatory compliance & standards (including performance targets)	12	High risk	31/03/2021
4146	Effectiveness of safeguarding practice	Patient safety (physical or psychological harm)	12	High risk	31/03/2021
4157	Compliance with medicines management regulations & standards	Reputation / compliance	12	High risk	30/06/2021
4181	Significant breach of confidentiality	Reputation / compliance	12	High risk	31/12/2020
4179	Major cyber security attack	Service disruption	12	High risk	31/12/2020
4176	Management of demand for planned care	Service disruption	12	High risk	31/12/2020
4362	Workforce capacity & capability (recruitment, retention & skills)	Service disruption	12	High risk	30/06/2021
4437	Critical failure of the water supply	Service disruption	12	High risk	31/03/2021
4405	Critical infrastructure failure disrupting aseptic pharmacy services	Service disruption	12	High risk	30/06/2021
4406	Critical failure of the medicines supply chain	Service disruption	12	High risk	30/06/2021
4423	Working in partnership with the wider healthcare system	Service disruption	12	High risk	31/12/2020
4401	Safety of the hospital environment	Harm (physical or psychological)	12	High risk	31/03/2021

4402	Compliance with regulations and standards for mechanical infrastructure	Reputation / compliance	12	High risk	31/03/2021
4403	Compliance with electrical safety regulations & standards	Reputation / compliance	16	High risk	31/03/2021
4404	Major fire safety incident	Harm (physical or psychological)	16	High risk	30/09/2021
4480	Safe management of emergency demand	Harm (physical or psychological)	16	High risk	31/12/2020
4383	Substantial unplanned expenditure or financial penalties	Finance	16	High risk	30/09/2021
4300	Availability of medical devices & equipment	Medical equipment	16	High risk	31/12/2020
4156	Safe management of medicines	Harm (physical or psychological)	16	High risk	30/06/2021
4142	Safe delivery of patient care	Patient safety (physical or psychological harm)	16	High risk	31/03/2021
4144	Uncontrolled outbreak of serious infectious disease	Patient safety (physical or psychological harm)	16	High risk	31/12/2020
4044	Compliance with information governance regulations & standards	Reputation / compliance	16	High risk	30/06/2021
3690	Compliance with water safety regulations & standards	Reputation / compliance	16	High risk	31/03/2021
3720	Critical failure of the electrical infrastructure	Service disruption	16	High risk	31/03/2021
3688	Quality of the hospital environment	Reputation / compliance	16	High risk	31/03/2021
4003	Major security incident	Harm (physical or psychological)	16	High risk	31/03/2021
4424	Delivery of planned improvements to quality & safety of patient care	Regulatory compliance & standards (including performance targets)	8	Moderate risk	31/12/2020
4476	Compliance with clinical effectiveness regulations & standards	Reputation / compliance	8	Moderate risk	31/12/2020
4441	Compliance with radiation protection regulations & standards	Reputation / compliance	8	Moderate risk	30/06/2022
4389	Compliance with corporate governance regulations & standards	Reputation / compliance	8	Moderate risk	31/12/2020
4397	Exposure to asbestos	Harm (physical or psychological)	8	Moderate risk	31/03/2021
4398	Compliance with environmental and energy management regulations & standards	Reputation / compliance	8	Moderate risk	31/03/2021
4399	Compliance with health & safety regulations & standards	Reputation / compliance	8	Moderate risk	30/09/2021
4351	Compliance with equalities and human rights regulations, standards & contractual requirements	Reputation / compliance	8	Moderate risk	31/03/2021
4352	Public consultation & engagement	Reputation / compliance	8	Moderate risk	31/12/2020
4353	Safe use of medical devices & equipment	Patient safety (physical or psychological harm)	8	Moderate risk	31/12/2020
4363	Compliance with HR regulations & standards	Reputation / compliance	8	Moderate risk	31/03/2021

4368	Efficient and effective management of demand for outpatient appointments	Reputation / compliance	8	Moderate risk	30/06/2021
4382	Delivery of the Financial Recovery Programme	Finance	8	Moderate risk	31/03/2021
4182	Compliance with ICT regulations & standards	Reputation / compliance	8	Moderate risk	31/12/2020
4177	Critical ICT infrastructure failure	Service disruption	8	Moderate risk	31/12/2020
4180	Reduction in data quality	Reputation / compliance	8	Moderate risk	31/12/2020
4138	Patient mortality rates	Reputation / compliance	8	Moderate risk	31/03/2021
4141	Compliance with infection prevention & control regulations & standards	Regulatory compliance & standards (including performance targets)	8	Moderate risk	31/12/2020
3503	Sustainable paediatric services at Pilgrim Hospital, Boston	Service disruption	8	Moderate risk	01/09/2021
3687	Implementation of an Estates Strategy aligned to clinical services	Service disruption	8	Moderate risk	31/03/2021
3721	Critical failure of the mechanical infrastructure	Service disruption	8	Moderate risk	31/03/2021
3722	Energy performance and sustainability	Finance	8	Moderate risk	31/03/2021
3951	Compliance with regulations & standards for aseptic pharmacy services	Reputation / compliance	8	Moderate risk	30/06/2021
4579	Delivery of the new Medical Education Centre	Reputation / compliance	8	Moderate risk	31/12/2020
4384	Substantial unplanned income reduction or missed opportunities	Finance	8	Moderate risk	30/09/2021
4502	Compliance with regulations & standards for medical device management	Regulatory compliance & standards (including performance targets)	8	Moderate risk	31/12/2020
4526	Internal corporate communications	Reputation / compliance	8	Moderate risk	31/12/2020
4528	Minor fire safety incident	Harm (physical or psychological)	8	Moderate risk	30/09/2021
4553	Failure to appropriately manage land and property	Finance	8	Moderate risk	31/03/2021
4486	Clinical outcomes for patients	Harm (physical or psychological)	8	Moderate risk	31/12/2020
4497	Contamination of aseptic products	Harm (physical or psychological)	10	Moderate risk	30/06/2021
4061	Financial loss due to fraud	Finance	4	Low risk	31/12/2020
4277	Adverse media or social media coverage	Reputation / compliance	4	Low risk	31/12/2020
4385	Compliance with financial regulations, standards & contractual obligations	Reputation / compliance	4	Low risk	30/09/2021

4386	Critical failure of a contracted service	Service disruption	4	Low risk	31/12/2020
4387	Critical supply chain failure	Service disruption	4	Low risk	31/12/2020
4388	Compliance with procurement regulations & standards	Reputation / compliance	4	Low risk	31/12/2020
4438	Severe weather or climatic event	Service disruption	4	Low risk	31/12/2020
4439	Industrial action	Service disruption	4	Low risk	31/12/2020
4440	Compliance with emergency planning regulations & standards	Reputation / compliance	4	Low risk	31/12/2020
4467	Impact of a 'no deal' EU exit scenario	Service disruption	4	Low risk	30/06/2021
4469	Compliance with blood safety & quality regulations & standards	Regulatory compliance & standards (including performance targets)	4	Low risk	31/12/2020
4482	Safe use of blood and blood products	Patient safety (physical or psychological harm)	4	Low risk	31/12/2020
4483	Safe use of radiation (Trust-wide)	Harm (physical or psychological)	4	Low risk	30/06/2022
4514	Hospital @ Night management	Service disruption	4	Low risk	31/12/2020
4567	Working Safely during the COVID - 19 pandemic (HM Government Guidance)	Reputation / compliance	4	Low risk	30/06/2021
4400	Safety of working practices	Harm (physical or psychological)	6	Low risk	30/09/2021

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*3 August 2021*
Item Number	*Item 13.3*
Board Assurance Framework (BAF) 2021/22	
Accountable Director	*Andrew Morgan Chief Executive*
Presented by	*Jayne Warner, Trust Secretary*
Author(s)	*Karen Willey, Deputy Trust Secretary*
Report previously considered at	*N/A*

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

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

Recommendations/ Decision Required	• *Board to consider assurances provided in respect of Trust objectives noting that framework has been reviewed through committee structure*
	• *Board to accept the change to the ratings for objectives 1a and 3b*

Executive Summary

The relevant objectives of the 2021/22 BAF were presented to all Committees during June and the Board are asked to note the updates provided within the BAF.

Assurance ratings have been provided for all objectives and have been confirmed by the Committees. The rating for objective 3b has been amended by the relevant Committee following review and discussion as a result of the papers presented.

The Finance, Performance and Estates Committee rated objective 3b as red from amber to reflect that the Half 1 financial plan currently being undeliverable and the uncertainty of the outturn for the year.

The Board are asked to consider the BAF and the RAG ratings presented and confirm the acceptance of the change of ratings.

The following assurance ratings have been identified:

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

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

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

Ref	Objective	Exec Lead	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Control Gaps	How identified control gaps are being managed	Source of assurance	Assurance Gaps - where are we not getting effective evidence	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating
SO1	**To deliver high quality, safe and responsive patient services, shaped by best practice and our communities**												
						Group, lead & plan in place to support the delivery of an improved patient safety culture (Developing a Safety Culture) (PSG)	Patient Safety Walk Rounds and Human Factors training delayed due to second wave of Covid-19 Definition of Safety Culture Ambition	Human factors training is now rescheduled for June 2021 2nd Wave of Pascal Survey to commence in ED External Safety Culture company engaged to deliver focus groups at all levels through the organisation and support development and strategy	Trust Wide Accreditation Programme Reports Safety Culture Surveys Action plans from focus groups and survey findings Update reports to the Patient Safety Group	Organisational understanding of Safety Culture			
						Robust Quality Governance Committee, which is a sub-group of the Trust Board, in operation with appropriate reporting from sub-groups. (CG)	Revised governance and reporting arrangements currently being embedded with some groups reporting into the sub-groups still in their infancy.	Review of Quality Governance Committee and Sub-group structures undertaken. Review to be undertaken once revised mechanisms have been in place for 6 months.	Upward reports from QGC sub-groups	Upward reports from groups reporting into sub-groups require some strengthening.	Template for groups reporting to sub-groups to be designed.		
						Patient Safety Group which is a sub group of the Quality Governance Committee in place meeting monthly. (PSG)	Disruption to existing governance arrangements during the pandemic Divisional representation at PSG especially Medical input Maturity of PSG subgroups and effectiveness	Patient Safety Group & sub-group meetings have continued to take place throughout the pandemic Review of information being fed into the sub groups Divisional triumvirates currently reviewing meeting attendance	Quality and Safety Risk Report Patient Safety Group (incorporating sub-groups) and the Clinical Effectiveness Group Patient safety indicators in the IPR				
						Infection Prevention and Control Committee in place and meeting monthly (IPCG)	Disruption to development of IPCG due to COVID-19 pandemic. Requirement to progress Divisional IPC assurance and monitoring processes. Requirement to develop the IPC service and Team via a consultation process. Need to develop Estates related sub groups (decontamination, water safety and ventilation).	2022/21 IPC Key Objectives in line with the requirements of the Hygiene Code. Divisional roles and responsibilities framework. Progressing with an IPC service and Team consultation and funding secured to significantly expand and strengthen IPC Team. Redefined IPC audit and incident analysis processes. Strengthening of Estates progress reporting and recruitment of Estates and Facilities and Decontamination Lead.	IPCG agenda in line with IPC Key Objectives and Hygiene Code. IPC service and Team consultation is progressing. Divisional and Estates progress and exception reporting. Recruitment of Estates and Facilities and Decontamination Lead.	Some aspects of Divisional and Estates reporting require further development. Insufficient IPC Team resource to currently provide the appropriate support to the Divisions and develop the IPC service. Awaiting the Estates and Facilities and Decontamination Lead to commence in post.	IPC identified gaps are being managed and monitored by reporting and gap analysis to the IPCG. Development progression via consultation and recruitment processes.		

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						IPC policies and procedures are in place in line with the requirements of The Health and Social Care Act (2008). Code of Practice on the prevention and control of infections and related guidance "Hygiene Code" (IPCG)	Policies not in line with the requirements of the Hygiene Code and some have not been reviewed and updated.	Planned programme of IPC policy development and update in line with Hygiene Code requirements.	IPC programmes of surveillance and audit are in place to monitor policy requirements. Divisional audit processes with progress and exception reporting to IPCG, IPC Site meetings and IPC related Divisional forums. Associated action and development plan documentation	Not all policies have been produced or updated. Some aspects of reporting require further development.	Reporting to and monitoring by IPCG and other related forums, e.g. Site meetings.		
						Process in place to monitor delivery of and compliance with The Health and Social Care Act (2008). Code of Practice on the prevention and control of infections and related guidance (IPCG).	Non-compliance with some aspects of the Hygiene Code.	Premises and facilities Premises Assurance Model (PAM) - 21/22 - take forward as a sub project led by (E&F). Gap Analysis to be compiled and presented quarterly to the IPCG and QGC. IPC policies to be updated / developed / written in line with the timetable. •Recruited into Estates and Facilities/Decontamination Lead post with a start date of June/July 2021. • Good progress with achieving and sustaining standards of environmental cleanliness. Potential to remain at amber due to infrastructure concerns & requirement to achieve compliance with new National Standards of Cleanliness directive • Provision of suitable hand hygiene facilities work under the remit of ward enhancement, capital and tap replacement programmes.	IPC programmes of surveillance and audit are in place to monitor policy requirements. Divisional audit processes with progress and exception reporting to IPCG, IPC Site meetings and IPC related Divisional forums. Associated action and development plan documentation	Not all policies have been produced or updated. Some aspects of reporting require further development.	Reporting to and monitoring by IPCG and other related forums, e.g. Site meetings.		
						Infection Prevention and Control BAF in place and reviewed monthly (IPCG)	Non-compliance with some aspects of the Hygiene Code as above	Restoration and Project Salus. Gap analysis with development plan is produced as detailed above	Progress and gap analysis reports to IPCG, QGC, PMO, E&F/IPC and Site groups and other forums	Work is progressing with regards to environmental infrastructure, water safety and ventilation. Decontamination work will progress when the Lead commences in post. IPC audit and RCA investigations require some further development at Divisional level	Reporting to and monitoring by IPCG and other related forums.		
						Defined and separate care pathways in place for urgent and planned care to aim to prevent and reduce the risk of nosocomial infection (IPCG)	The required care pathways are in place or under development	Identified via the implementation of Project Salus in line with PHE COVID-19: Guidance for maintaining services within health and care settings. Infection prevention and control recommendations.	Operations and Divisional data and reporting.	Some embedding of the implementation of Project Salus requirements as services come back on line	Reporting to and monitoring by IPCG and other related forums, e.g. Operations and Divisional		

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1a	Deliver Harm Free Care	Director of Nursing/Medical Director	Failure to manage demand safely Failure to provide safe care Failure to provide timely care Failure to use medical devices and equipment safely Failure to use medicines safely Failure to control the spread of infections Failure to safeguard vulnerable adults and children Failure to manage blood and blood products safely Failure to manage radiation safely Failure to deliver planned improvements to quality and safety of care Failure to provide a safe hospital environment Failure to maintain the integrity and availability of patient information Failure to prevent Nosocomial spread of Covid-19	4558 4480 4142 4353 4146 4556 4481	CQC Safe	Elective care patients assessed by test and symptoms to be Covid-19 risk minimised (IPCG)	Elective care patients are assessed as per the low risk category requirements documented in the PHE COVID-19: Guidance for maintaining services within health and care settings. Infection prevention and control recommendations.	Identified via the implementation of Project Salus in line with PHE COVID-19: Guidance for maintaining services within health and care settings. Infection prevention and control recommendations.	Operations and Divisional data and reporting.	Some embedding of the implementation of Project Salus requirements as services come back on line	Reporting to and monitoring by IPCG and other related forums, e.g. Operations and Divisional	Quality Governance Committee	A
						Mortality group in place which meets monthly (PSG)	Disruption to existing governance arrangements during the pandemic Embedding Structured Judgement Process consistently across the Divisions	Mortality Group meetings have continued throughout the pandemic; MorALS Group is now in place & reporting to Patient Safety Group SJR Training has been provided Divisions are being supported to provide learning to MoRals	Mortality Report Datix module to complete SJR's Lincs Collaborative meeting minutes Divisional engagement at the monthly MoRals meeting				
						Monthly mortality report in place to track achievement of SHMI/Mortality targets (Maintaining our HSMR and improving our SHMI) (PSG)	Gaps in the number of structured judgement reviews undertaken Impact of Covid-19 on coding triangles	Funding available to train an additional 40 members of staff to undertake structured judgement reviews by the end of March 2021	National Clinical Audits Dr Foster alerts HSMR and SHMI data				
						Robust policies and procedures for incident investigations, harm reviews and assurance of learning (PSG)	Clinical harm review processes not all documented & aligned with incident reporting	Task and finish group in place to agree required changes to harm review processes and documentation Appointment of a Clinical Harm and Mortality Manager	Incident Management Report Quarterly harm report to PSG Bi-weekly executive level Serious Incident meeting Learning to Improve Newsletters Patient Safety Briefings Divisional Integrated Governance reports				
						Theatre Safety Group developed (Ensuring safe surgical procedures) (PSG)			Upward report from Theatre Safety Group to PSG with onward escalation to QGC as necessary.				
						Process in place to ensure safe use of surgical procedures (NatSIPs/LocSIPs) (PSG)	Lack of assurance regarding progress of implementing NatSIPs/LocSIPs within the Trust	Working Group set up and meeting as per the ToR, divisional representation; quarterly reporting to PSG		Audit of compliance not currently in place	Review will occur through the Task & Finish group and reported upwards to PSG		
						Medication safety Group in operation (Reduce medication errors) (Improving the safety of medicines management) (Review of Pharmacy model and service) (PSG)	Lack of e-prescribing leading to increase in patient safety incidents	Replacement of manual prescribing processes with an electronic prescribing system; improvements to medication storage facilities; strengthening of Pharmacy involvement in discharge processes	Upward Report of the: Medicines Quality Group				
						Medical devices safety group in place which received relevant reports (PSG)			Upward report from Medical Devices Safety Group to PSG with onward escalation to QGC as necessary.				

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						Appropriate policies and procedures in place to ensure medical device safety (PSG)	Lack of assurance regarding staff training on the medical devices	Implementation of a central database of medical device user training records					
						Appropriate policies and procedures in place to recognise and treat the deteriorating patient. (Ensuring early detection and treatment of deteriorating patients) (PSG)	Number of incidents occurring regarding lack of recognition of the deteriorating patient - monthly update to the DPG required Maturity of some of the sub-groups	Deteriorating Patient Group set up as a sub group of the Patient Safety Group to identify actions taken to improve; has its own sub-groups covering NIV; AKI; sepsis; VTE;DKA	Audit of response to triage, NEWS, MEWS and PEWS Sepsis Six compliance data Audit of compliance for all cardiac arrests Upward reports into DPG from all areas Observation policy	Observation policy overdue review	Observation policy under review with expected update to the next DPG in July		
						Ensuring a robust safeguarding framework is in place to protect vulnerable patients and staff (Ensuring a robust safeguarding framework is in a place to protect vulnerable patients and staff) (SVOG)	Sedation group New funding needed to continue restraint training delivery. Business case being developed in conjunction with conflict resolution team and will be presented to QGC within next 2 months	Updated policy & training in use of chemical restraint / sedation; strengthening of pathways & training to support patients with mental health issues					
						Dementia steering group relaunched April 2021 to provide oversight and direction in relation to Dementia and Delirium pathway. (SVOG)	Dementia pathway not in place. Dementia training Level 2 and level 3 currently in development - training strategy being written	Dementia Level 1 training available and achieving 90%+. Joint work ongoing between ULHT and partners.					
						Safeguarding and Vulnerability Oversight Group (SVOG) established and meet Bi-monthly (reporting to QGC) with divisional Safeguarding. (SVOG)	Safeguarding training remains below expected level.	Training plans developed and in place for Safeguarding Children and Safeguarding Adults. Training redeveloped to mitigate for Covid and data monitored by Deputy Director Safeguarding and SVOG with appropriate escalation taken to divisional leads.	Upward Report of the: Safeguarding Group Safeguarding, DoLS and MCA training and monitored monthly with appropriate escalation system issues continue to be a problem with e-learning which require manual updating of each staff record - additional staff member agreed to assist with completion however unable to give a completion date at this present time				
						Appropriate policies in place to ensure CAS alerts and Field Safety Notices are implemented as appropriate.	Gap in current policy identified meaning that not all responses from divisions are received / recorded.	Task and Finish Group set up to review processes and improve compliance.	Quarterly report to PSG with escalation to QGC as necessary. Compliance included in the integrated governance report for Divisions.				

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
						Appropriate policies and procedures in place to reduce the prevalence of pressure ulcers, including a Skin Integrity Group (NMAAF)							

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						Formal governance processes in place within divisions, including regular meetings and reporting, supported by a central governance team (CG)	Training provision for Divisional Clinical Governance Leads No formal job description of roles and responsibilities for Clinical Governance Leads	Role based TNA being devised for Clinical Governance leads Roles and responsibilities being addressed through the Medical Director's office	Minutes of Divisional Clinical Governance meetings with upward reporting within the Division Divisional Integrated Governance Report Support Offer in place from the central CG team for the Divisions				
						Robust process in place to monitor delivery against the CQC Must Do and Should Do actions and regulatory notices (Delivering on all CQC Must Do actions and regulatory notices) (CG)	Second round of CQC Confirm and Challenge sessions were cancelled due to second wave of Covid-19, however these have now recommenced.	Confirm and challenge meetings have now re-commenced. Robust process for assessing evidence to demonstrate achievement has been developed.	Monthly report to QGC on Must and Should dos	Further work required to strengthen the reporting.			
						Appropriate medical records management systems and processes in place (? Move to 3c - enhanced digital capability)	Current issues identified in relation to management of paper medical records	Implementation of an Electronic Patient Record (EPR) system; Group involving Dep DoN has met to begin to work on management of paper medical records					
						Maternity Transformation (MNOG)	New control - to be discussed at next MNOG meeting.						
						Development and implementation of new pathways for Paediatric services (CYPOG)	New control - to be discussed at next CYPOG meeting.						
						Trust wide Children's standards (CYPOG)	New control - to be discussed at next CYPOG meeting.						
						Patient Experience Group, which is a sub-group of the Quality Governance Committee, in place meeting monthly Robust Complaints and PALS process in place (PEG)	Patient Experience Group reinstated in its new format and ToR, the group needs to develop its maturity	The group meets monthly, has developed a work reporting plan	Upward reports to QGC monthly and responds to feedback Review of ToR in July 2021 Quarterly Complaints reports identifying themes and trends presented at the Patient Experience Group Patient Experience Group upward report	Complaints & PALs Policy under review and will come to April meeting			
						Patient Experience & Carer plan 2019-2023	Number of objectives in the plan paused due to Covid	Objectives being reviewed with updated timeframes going forward for inclusion in the IIP and other improvement plans at Directorate level	Patient Experience & Carer Plan progress report to Patient Experience Group and IIP Support and Challenge meetings with monthly highlight reports.				
						Patient Experience Intranet page	Intranet page requires updating; number of areas out of date and new information needs adding	Patient Information remains on the issues log for the Patient Experience Group until completed					

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						Ward and dept review visits as part of Quality Accreditation and assurance programme			New process commenced end April 2021. Patient Experience Reports to be generated ahead of visit and patient experience team and patient representatives included within visit teams Each visit includes elements of patient experience. A report will go to Patient Experience Group, NMAAF and QGC as per committee frequency for oversight and assurance				
						Patient Panel meeting monthly and reporting into the Patient Experience Group. (Redesign our communication and engagement approaches to broaden and maximise involvement with patients and carers) (PEG)	Patient Panel is a new group and not yet reached maturity in its business Staff training in relation to communication and engagement	Panel is chaired by Head of Patient Experience, has an agenda and representatives that attend Patient Experience group to feedback and ensure continuity of messaging IIP projects specifically: co-design; Schwartz Rounds; engaging with patients and families; real time surveying, involving in decisions about care.	Upward reports and minutes to the Patient Experience Group Real time patient and carer feedback User involvement numbers National patient surveys Number of locally implemented changes as a result of patient feedback	IIP projects update			
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	Care of the dying patient guidelines and procedures (PEG) Visiting Procedure Post Pandemic with associated booking script, booking templates, information leaflet, posters and internal and external communications	Guidelines updated to consider COVID precautions. Swan Scheme resources lost during ward moves. Experience of death and dying study showed staff distress and anxiety is significant.	Swan resource boxes being developed for distribution to all areas during May. Wedding boxes created for a number of key wards and within Chaplaincy services. Experience of death and dying recommendations being taken forward through wellbeing initiatives and a focus during Dying Matters week 10-16 May	Special Palliative Care Team and Lead Nurse for End of Life Care are developing an outline business case for the CCG to strengthen the resource available in the Trust to increase capacity in the team in order to provide training and education to ward staff. The Deputy Director of Nursing is linked into this work for oversight SUPERB Patient Experience Dashboard Patient Experience indicators in the IPR Care Opinion			Quality Governance Committee	R

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						Inclusion Strategy in place and in date (PEG)	Lack of diversity in patient feedback and engagement	Equality, Diversity and Inclusion Lead is member of Patient Experience Group. Engagement events scheduled with Sensory Impairment Group (27.04.21), Traveller Community and BAME community groups (24.05.21). Reaching out to Eastern European community groups. Review of all relevant policies relating to Patient Experience underway	Patient Experience report; ED&I Lead reports				
						Robust process in place for annual PLACE inspection accompanied by PLACE LITE (PEG)	PLACE Lite Process needs to be embedded as Business as Usual	PLACE Lite visits are being scheduled for the year across the organisation. Each visit includes a patient representative on the team. This will result in a visit report which goes to the newly established PLACE Group. Monthly review meetings of the Matrons Quality Metrics with the DoN and DDoN 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.	Patient Experience Team are members of PLACE Group. PLACE report to go to Patient Experience Group quarterly Matron Quality Metrics Estates attendance and updates at the fortnightly CQC meetings	Patient Experience Plan 2020 – 2023 in date. Intranet updated. Plan to be added to April agenda and upwardly reported to QGC. Multi-agency working group scheduled 09.03.21 for review of Carers Policy. PLACE Lite report to April meeting.			
						Getting it Right First Time Reviews are undertaken (CEG)	Due to Covid there is a delay in implementing GIRFT recommendations	Quarterly reports to Clinical Effectiveness Group GIRFT project Manager in post	Upward reports to QGC and its sub-groups KPIs in the integrated governance report	Divisions not having oversight of their workstreams	Workstreams to be presented at PRMs		
						Clinical Effectiveness Group in place and meets monthly (CEG)	The function of Clinical Effectiveness Group is evolving	Agenda reviewed on a meeting by meeting basis to ensure that all priority items are covered 2020/21 work plan developed with Terms of Reference	National audit status Compliance with local and national audits	Divisions to commence reporting from July 2021			
						Clinical Audit Group in place and meets monthly (CEG)	There are outstanding actions from local audits	Audit Leads present compliance with their local audit plan and actions	Reports generated detailing status of local audits and number of open actions	Clinical Audit Leads may not attend to present their updates	Rolling attendance in progress and names of Clinical Audit Leads not attending will be escalated to the Triumvirate		

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1c	Improve clinical outcomes	Medical Director	Failure to provide effective and timely diagnosis and treatment that deliver positive patient outcomes	4558	CQC Responsive CQC Effective	National and Local Audit programme in place and agreed (CEG)	Audit findings do not always demonstrate the necessary improvements	Increased focus on reporting outcomes from audit Revision of Clinical Audit Policy to strengthen Introduction of the Clinical Audit Group attended by Clinical Audit Leads	Reports from the National Audit Programmes Relevant internal audit reports Relevant internal audit reports	The Trust has been notified of outlier status due to data quality	Clinical Audit Team is expanding and they will ensure there are robust processes for data collection and validation of data prior to national submission	Quality Governance Committee	R
						Process for monitoring the implementation of NICE guidance and national publications in place (CEG)	There are a number of pieces of guidance for which the baseline assessments are still required	Increased resources to help clear backlog of NICE guidelines and technical appraisal assessments	Reports on compliance with NICE / Tas	There remains a number of completed baseline assessments with outstanding actions	Dedicated staff within Clinical Governance until June 2021 to help close outstanding actions		
						Process in place for taking part in the Patient Related Outcome Measures (PROMs) project (CEG)	Due to Covid elective surgery was cancelled, number of submissions lower than expected (expected number based on previous years hips & Knee replacement)	The Trust has implemented project Salus and the restoration of services will be increase number of elective surgery cases which in turn will increase number of PROMS.	Quarterly reports to CEG and upwardly reported to QGC	Business Units not sighted on their performance due to no reporting during COVID-19	National reports to be presented at Governance Meetings once produced		
						Divisional governance meetings in place (NICE) (CEG)	Triumvirate not fully appraised of their compliance with audit and NICE	Within the Integrated Governance Report compliance with NICE and audit is included	Quarterly Divisional Reports from Divisions to be presented at CEG	Divisions to commence reporting to CEG from July 2021			
						Quarterly Learning Lessons Newsletter in place at both Division and Trust wide level (CEG)	Staff may not access emails to review newsletters						
SO2	**To enable our people to lead, work differently and to feel valued, motivated and proud to work at ULHT**												
2a	A modern and progressive workforce	Director of People and Organisational Development	Vacancy rates rises Turnover increases Sickness absence rises Under-investment in education & learning Failure to engage organisation in continuous improvement Failure to transform the medical & nursing workforce	4362	CQC Safe CQC Responsive CQC Effective	NHS people plan & system people plan & four themes:- - Looking after our people - Belonging in the NHS - New ways of working & delivering care - Growing for the future	Awaiting sign off of system people plan		Reported progress on the implementation of the NHS People Plan and the Lincolnshire System Workforce Plan NB New indicators being developed for the 21/22 financial year			People and Organisational Development Committee	A
						Workforce planning and workforce plans	Overall vacancy rate declining but increasing for clinical roles.	IIP Project - Embed robust workforce planning and development of new roles					
						Recruitment to agreed roles - plan for every post		Pipeline report shows future vacancy position International nurse recruitment & cohort recruitment	Internal Audit - Recruitment follow up				
						Focus on retention of staff - creating positive working environments		IIP Projects - appraisal, mandatory training, talent management	Modern Employer targets Rates of appraisal/mandatory training compliance				
						Embed continuous improvement methodology across the Trust		Training in continuous improvement for staff	Staff survey feedback				
						Reducing sickness absence	Sickness absence rate higher than average	Embedding of AMS	Sickness/absence data Turnover rates Vacancy rates				

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						Ensuring access to the personal and professional development that enables people to deliver outstanding care and ensures ULHT becomes known as a learning organisation	IIP projects in early stage of delivery	IIP projects - education and learning	Reported progress on the implementation of the NHS People Plan and the Lincolnshire System Workforce Plan NB New indicators being developed for the 21/22 financial year				
2b	Making ULHT the best place to work	Director of People and Organisational Development	Further decline in demand Failure to address examples bullying & poor behaviour Lack of investment or engagement in leadership & management training Perceived lack of listening to staff voice Under-investing in staff engagement with wellbeing programme Failure to respond to GMC survey Ineffectiveness of key roles Staff networks not strong	4083	CQC Well Led	NHS People Plan & System People Plan & four themes:- - Looking after our people - Belonging in the NHS - New ways of working & delivering care Growing for the future	Awaiting sign off of system people plan Delivery of IIP projects in early stage of delivery	Delivery of IIP projects as set out in controls				People and Organisational Development Committee	R
						Trust values & staff charter - Resetting our Culture & Leadership programme	Poor staff survey results in 2020 (although in pulse survey more positive)	Creation of Learning Together Forum					
						Effective communication mechanisms with our staff - ELT Live, managers cascade, intranet etc.		Reviewing the way in which we communicate with staff and involve them in shaping our plans	Staff survey feedback - engagement score, recommend as place to work				
						Leadership & Management training. (Improving the consistency and quality of leadership and line management across ULHT)		Continue to implement new leadership programme e.g training on well-being conversations	Pulse surveys - " Have your say" Number of staff attending leadership courses				
						Perception of fairness and equity in the way staff are treated		IIP Project - Address the concerns around equity of treatment and opportunity within ULHT so that the Trust is seen to be an inclusive and fair organisation	WRES/ WDES Data Internal Audit - Equality, Diversity and Inclusion				
						Staff networks	Some staff networks stronger than others	Continued work to embed the networks and provide them with effective support	Protect our staff from bullying, violence and harassment - measure through National Staff Survey				
						Demonstrate that we care and are concerned about staff health and wellbeing		Embed programme focused on staff wellbeing	Reports on progress in implementing the NHS People Plan and the Lincolnshire System Workforce Plan Number of Schwartz rounds completed (once implemented)				
						Focus on junior doctor experience key roles:- - Freedom to speak up Guardian - Guardian of safe working - Well-being Guardian	Identified FTSU capacity in Trust as insufficient	Budget identified for post and recruitment exercise commenced for full time FTSU Guardian Junior doctor forum	GMC junior doctor survey				

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2c	Well led services	Chief Executive	Current risk register configuration not fully reflective of organisations risk profile Current systems and processes for policy management are inadequate resulting in failure to review out of date or policies which are not fit for purpose	4277 4389	CQC Well Lead	Delivery of risk management training programmes	Training delayed due to Covid-19	Corporate support offer made to divisions	Third party assessment of well led domains Internal Audit assessments Risk Management HOIA Opinion received and Audit Committee considered in June noting 'partial assurance with improvement required can be given on the overall adequacy and effectiveness of the Trust's framework of governance, risk management and control. Completeness of risk registers Annual Governance Statement			Audit Committee	A
						Shared Decision making framework	Councils suspended due to Covid-19		Number of Shared decision making councils in place	8 councils established. Target for 2021 was 6	Feedback tools to review progress/success		
						Implementing a robust policy management system		Review of document management processes New document management system - SharePoint Single process for polices	Numbers of in date policies	Movement on policies still not fast enough	Clinical and Corporate Policies and Guidelines now managed through single process by Trust Secretary Report to Audit Committee quarterly Report to ELT fortnightly		
						Ensure system alignment with improvement activity							
SO3	**To ensure that services are sustainable, supported by technology and delivered from an improved estate**												
						Develop business case to demonstrate capital requirement	Business Case is not fully signed off and articulates a level of capital development that cannot be rectified in any single year.	Interim case for £9.6M of CIR has been reviewed and approved by NHSE with the majority of schemes due to deliver in 2020/21 Capital Delivery Group has oversight of the delivery of key capital schemes.	Capital Delivery Group Highlight Reports	Infrastructure case has tackled £9.6M of the overall £100m+ backlog.	Estates improvement and Estates Group review compliance and key statutory areas. Development of 2021/22 Capital Programme will continue to ensure progress against remaining backlog of critical infrastructure. Capital Delivery Group will monitor the delivery of key capital programmes and ensure robust programme governance.		

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						Delivering environmental improvements in line with Estates Strategy		Estates improvement forum and improvement team monitor progress through and has restarted now Wave 2 Covid has passed.		Collation of Audits across all areas during Covid are partial due to availability of high viral load areas.			

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3a	A modern, clean and fit for purpose environment	Chief Operating Officer	Longer term impact on supplier services (including raw materials) who are supporting the improvement, development, and maintenance of our environments. Availability of funding to support the necessary improvement of environments (capital and revenue)	3720 3520 3688 4403 3690	CQC Safe	Continual improvement towards meeting PLACE assessment outcomes	PLACE assessments have been suspended and delayed for a period during COVID		PLACE assessments	PLACE Assessments have been reduced to PLACE/light in lieu of access and staffing restrictions during Covid.		Finance, Performance and Estates Committee	R
						Review and improve the quality and value for money of Facility services including catering and housekeeping	Value for Money schemes have been delayed during COVID		MiC4C cleaning inspections Staff and user surveys 6 Facet Surveys	6 Facet Survey are not recent and require updating.	IPC Cell/Group and upward reporting of cleanliness is reported through to QGC. Water Safety and Fire Safety Groups will report through alongside Health and Safety Groups to relevant sub-committees and provide a more comprehensive view offering assurance were it is possible and describing improvement where it is not. The appointment of Authorised engineers in key statutory areas will give responsible person/Executive arms length oversight of assurance gaps to fill.		
						Continued progress on improving infrastructure to meet statutory Health and Safety compliance		Water/Fire safety meetings are in place and review of controls are part of external validation from authorised engineers.	Reports from authorised engineers Response times to urgent estates requests Estates led condition inspections of the environment Response times for reactive estates repair requests Progress towards removal of enforcement				
						Delivering £6.4m CIP programme in H1 21/22 and estimated full Year 21/22 CIP value of £15.4m.	Operational ownership and delivery of efficiency schemes	Divisional Financial Review Meetings - paused due to COVID - reinstated from May 21. Request to all Divisions to provide detailed CIP recovery plans.	Delivery of revised CIP Achievement of both ULHT and STP financial Plan	Model Hospital Benchmarking/Reporting - paused due to COVID - reinstated from May 21 (update brought to FPEC in May)	Gaps are being reviewed monthly with Divisions through FRMs		

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3b	Efficient use of our resources	Director of Finance and Digital	Efficiency schemes do not cover extent of savings required. Continued reliance on agency and locum staff and use of enhanced bank rates to maintain services at substantially increased cost Failure to achieve recruitment targets increases workforce costs Unplanned expenditure (as a result of unforeseen events) National requirements and Trust response to Restoration and Recovery and third COVID wave.	4382 4383 4384	CQC Well Led CQC Use of Resources	Delivering financial plan aligned to the Trust and Lincolnshire STP financial plan / forecast for 2021/22	Urgent and unplanned Restore and Covid related costs	Lincolnshire STP financial plan Lincolnshire STP collective management of financial risk Savings plan, monitoring and reporting.	Delivery of the Trust and System financial plans for H1	Granular detailed CIP implementation plans.	Internally through FRMs and upwards into FPEC, externally through the STP reporting structure including Finance Leadership Group upwards to the Executive Leadership Group.	Finance, Performance and Estates Committee	R
						Reduce agency spend by 25% from the 19/20 baseline as per IIP priority	Reliance on temporary staff to maintain services, at increased cost	Centralised agency & bank team	Delivery of the IIP 25% agency reduction target.	Granular detailed plan for every post plans.	Through the Medical and Nursing Workforce Transformation Groups and through FRMs upward into FPEC		
						Utilising Model Hospital, Service Line Reporting and Patient Level Costing data to drive focussed improvements to be restarted from Q2	Lack of up-to-date and robust benchmarking information due to the usefulness of the 20/21 cost collection exercise being reduced related to COVID.	Refresh of internal costing and SLR information for roll out in the Trust in Q2 21/22.	SLR and PLICs information	CQC Use of Resources - paused due to COVID	Improvement in the CQC Use of Resources is part of the Trust 21/22 IIP		
						Implementing the CQC Use of Resources Report recommendations	Lack of up-to-date and robust benchmarking information due to the usefulness of the 20/21 cost collection exercise being reduced related to COVID.	Refresh of internal costing and SLR information for roll out in the Trust in Q2 21/22.	SLR and PLICs information	CQC Use of Resources - paused due to COVID	Improvement in the CQC Use of Resources Trust scoring is part of the Trust 21/22 IIP and performance is reported through PMO upward reports.		
						Working with system partners to deliver the Lincolnshire Plan.	Urgent and unplanned Restore and Covid related costs	Lincolnshire STP financial plan Lincolnshire STP collective management of financial risk Savings plan, monitoring and reporting.	Delivery of the Trust and System financial plans for H1	Granular detailed CIP implementation plans.	Internally through FRMs and upwards into FPEC, externally through the STP reporting structure including Finance Leadership Group upwards to the Executive Leadership Group.		
						Detailed activity modelling aligned to resource requirements to support Trust and System Restoration.	Impact of Wave 3 and increasing acuity of NEL patients creating bed and staffing resource pressures to deliver restoration plan.	Trust Restoration plan and through Restoration and Recovery daily Trust meetings. Lincolnshire STP activity plan Lincolnshire STP collective management of restoration of planned care activity	Reporting against the Trust and System Restoration plan and national Trajectories.				
						Improve utilisation of the Care Portal with increased availability of information -	Cyber Security and enhancing core infrastructure to ensure network resilience. .	Digital Services Steering Group Digital Hospital Group Operational Excellence Programme Outpatient Redesign Group	Number of staff using care portal	Schemes paused to enable tactical response to Covid-19. Limited progress being made where possible. .	Management of control gaps being reintroduced in a phased way as impact of Wave 2 reduces. Nationally mandated ICS Minimum Viable Product shared record must be in place by September 2021. Hence, work ongoing with partner organisations to ensure their data is within the Care Portal.		

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3c	Enhanced data and digital capability	Director of Finance and Digital	Tender for Electronic Health Record is delayed or unsuccessful Major Cyber Security Attack Critical Infrastructure failure	4177 4179 4180 4182 4481	CQC Responsive	Commence implementation of the electronic health record	Roll-out IT equipment to enable agile user base Redeployment of staff as a result of Trust response to Covid-19.	Digital Services Steering Group Digital Hospital Group e-HR Programme Steering Group	Delivery of 20/21 e HR plan		EPR OBC to be approved by NHSE/I	Finance, Performance and Estates Committee	A
						Undertake review of business intelligence platform to better support decision making			Delivering improved information and reports Implement a refreshed IPR	IPR refresh being completed in July 2021 for June 2021 reporting.	Steady implementation of PowerBI through specific bespoke dashboards and requests.		
						Implement robotic process automation	Lack of expert knowledge available within and to the Trust (experts in short supply nationally) Business case under development						
						Improve end user utilisation of electronic systems	Business case for additional staff under development						
						Complete roll out of Data Quality kite mark			Ensuring every IPR metric has an associated Data Quality Kite Mark	Information improvements aligned to reporting needs of Covid-19.	A number of metrics have had a review and these are awaiting formal sign off. They will then appear in the IPR. Remaining metrics have a work plan and deadlines associated with completion.		
SO4	**To implement integrated models of care with our partners to improve Lincolnshire's health and well-being**												
			Failure of specialty teams to design and adopt new pathways of care Failure to support system working			Supporting the implementation of new models of care across a range of specialties	Specialty strategies not in place	Requirement for specialty strategies now part of strategy deployment and will commence August 2021	Reports -ELT / TLT -Committees -Board -System -Region	Impact of specialty changes	New performance framework will address and the upward report regarding IIP		
						Improvement programmes for cancer, outpatients and urgent care in progress	Recovery post COVID and risk of further waves Urgent Care Transformation team not yet established	Outpatient Improvement Group Cancer Improvement Board Urgent and Emergency Care Board.	Improvement against strategic metrics % of patients in Emergency Department >12 hrs (Total Time) Delivery against 62 day combined standard Urgent Treatment (P2) turnaround time Deliver outpatient activity non face to face		Reporting via FPEC		

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4a	Establish new evidence based models of care	Director of Improvement and Integration	Failure to design and implement improvement methodology		CQC Caring CQC Responsive CQC Well Led	Development and Implementation of new pathways for paediatric services - in progress, included in 21/22 plans.	Engagement exercise required to seek further views regarding the proposed revised model	CYP Group re-established	Board report July 2021			Finance, Performance and Estates Committee	A
						Urology Transformational change programme	Engagement exercise required to seek further views regarding the proposed revised model	Urology steering group in place reporting through IIP	Board report July 2021				
						Pre op Assessment Modernisation							
						Support Creation of ICS - Lincolnshire designation 1st April 2021	Delay to review and adoption of legislation	Weekly ICS meetings Provider Collaborative Steering Group	SLB reports and upward reports by CEO / Chair				
						Support the consultation for Acute Service Review (ASR) Phase 1 - PCBC with national team	Awaiting CCG to review and sign off approach to consultation	Weekly ASR meetings	SLB reports and upward reports by CEO / Chair				
						Implementing the Outstanding Care Together Programme to support the Organisation to focus on high priority improvements - in progress	Disruption due to COVID has resulted in a less mature approach to strategy deployment, broad understanding across the organisation, progress on building capacity and capability.	OCTP Exec led pillar meetings continue ELT/TLT oversight Board / system reporting	Weekly ELT updates Monthly TLT updates Quarterly board reports Quarterly board development sessions				
4b	To become a University Hospitals Teaching Trust	Director of Improvement and Integration	Failure to develop research and innovation programme Failure to develop relationship with university of Lincoln and University of Nottingham Failure to become member of university hospital association		CQC Caring CQC Responsive CQC Well Led	University Hospital Teaching Trust Status Developing a business case to support the case for change			Progress with application for University Hospital Trust status			People and Organisational Development Committee	R
						Increasing the number of Clinical Academic posts			Numbers of Clinical Academic posts RD&I Strategy and implementation plan agreed by Trust Board				
						Improve the training environment for students			GMC training survey Stock check against checklist Internal Audit - Education Funding				
						Developing an MOU with the University of Lincoln			RD&I Strategy and implementation plan agreed by Trust Board				
						Develop a portfolio of evidence to apply for membership to the University Hospitals Association							

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The BAF management process

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

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

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

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

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

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

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

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