Bundle Trust Board Meeting in Public Session 7 September 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 3 August 2021
Chair
Item 5.1 Public Board Minutes August 2021 v2.docx

5.2 Matters arising from the previous meeting/action log
Chair
Item 5.2 Public Action log August 2021 v1.docx

6 Chief Executive Horizon Scan
Chief Executive
Item 6 Chief Executive's Report, 070921.docx

6.1 Covid - Wave 3
Chief Operating Officer
Item 6.1 COVID Wave 3 Update Trust Board Sept v2.docx

7 Patient/Staff Story
Director of Nursing

Please be aware that sometimes our patient and staff stories can deal with very difficult subjects, which may affect you personally. If you are concerned about this the Trust Secretary can advise you of the subject to be discussed at the start of the meeting.

8 Strategic Objective 1 To Deliver high quality, safe and responsive patient services, shaped by best practice and our communities

8.1 Assurance and Risk Report from the Quality Governance Committee
Chair of QGC
Item 8.1 QGC Upward report August 2021.doc

8.1.2 NHSE/I IPC Visit Feedback - for information
Director of Nursing/DIPC
Item 8.1.2 20210812 ULHT NHSEI Visit letter FINAL V2.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 Interim Director of People and Organisational Development
Interim Director of People and OD
Item 9.1 People & OD update - September 2021.docx

10 Strategic Objective 3 To ensure that services are sustainable, supported by technology and delivered from an improved estate

10.1 Assurance and Risk Report from the Finance, Performance and Estates Committee
Chair of FPEC
Item 10.1 FPEC Upward Report August 2021.docx

10.2 Nuclear Medicine
Chief Operating Officer
Item 10.2 Nuclear medicine September 2021.docx
Item 10.2 Nuclear medicine paper Sept 2021.docx

11	Strategic Objective 4 To implement integrated models of care with our partners to improve Lincolnshire's health and wellbeing
12	Integrated Performance Report
	Director of Finance & Digital
	Item 12 IPR Front page August 2021.docx
	Item 12 IPR Trust Board August 2021 v2.docx
13	Risk, Governance and Assurance
13.1	Risk Management Report
	Director of Nursing
	Item 13.1 Strategic Risk Report - August 2021 v1 (002).pdf
13.2	Board Assurance Framework
	Trust Secretary
	Item 13.2 BAF 2021-22 Front Cover September 2021.docx
	Item 13.2 BAF 2021-2022 v26.08.2021.pdf
13.3	Trust Board Voting Rights
	Chair
	Item 13.3 Trust Board Voting Rights.docx
14	Any Other Notified Items of Urgent Business
15	The next meeting will be held on Tuesday

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 3 August 2021

Via M Teams Live Stream

Present

Voting Members:
Mrs Elaine Baylis, Chair
Mr Andrew Morgan Chief Executive

Mrs Liz Libiszewski, Non-Executive Director
Dr Karen Dunderdale, Director of Nursing
Mrs Sarah Dunnett, Non-Executive Director
Dr Chris Gibson, Non-Executive Director
Professor Philip Baker, Non-Executive Director
Dr Colin Farquharson, Medical Director
Mr Mark Brassington, Director of Improvement and Integration/Deputy Chief Executive

Non-Voting Members:
Mr Simon Evans, Chief Operating Officer
Mrs Alison Dickinson, Associate Non-Executive Director

In attendance:
Mrs Jayne Warner, Trust Secretary
Mrs Karen Willey, Deputy Trust Secretary (minutes)
Dr Maria Prior, Healthwatch
Mr Jonathan Young, Deputy Director of Finance
Mr Andrew Simpson, Consultant Urologist/Deputy Medical Director
Mrs Sharon Kidd, Patient Experience and Engagement Manager (Item 7 only)
Dr Catherine O'Dwyer, Divisional Clinical Director (Item 10.2)
Mr Tim Couchman, Equality, Diversity and Inclusion Lead (Item 9.2)

Apologies:
Ms Cathy Geddes, Improvement Director, NHSE/I
Mr David Woodward, Non-Executive Director
Mr Paul Matthew, Director of Finance and Digital

1196/21	**Item 1 Introduction** The Chair welcomed Board members and members of the public who had joined the live stream to the meeting.
1197/21	In line with guidance on Covid-19 the Board continue to hold meetings open to the public through the use of technology. 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.
1198/21	The Chair highlighted that although national Covid-19 restrictions were lifted on the 19 July 2021 the NHS continued to operate under the advice of NHS England in regard to Infection Prevention Control measures including the requirement to follow social distancing rules, impacting on the ability to revert to Board meetings in the pre pandemic format. The Trust Board would continue to follow national advice and operate in accordance with procedures that had been implemented during the pandemic.

1199/21	The Chair moved to questions from members of the public. **Item 2 Public Questions** **Q1 from Jody Clark** **As we approach the 5 year anniversary of, what was originally, a temporary overnight closure of our A&E, which is still ongoing.** **I was surprised to see the latest investment going towards green energy?** **"United Lincolnshire Hospitals NHS Trust has been awarded £1,554,170 to replace gas fired boilers with air source heat pumps at Grantham Hospital. These measures will help the Trust to achieve the NHS's plan to reach net zero by 2040."** **Because of this from 2016 "Grantham and District Hospital will play host to the Lord Lieutenant of Lincolnshire,Toby Dennis as he opens the hospital's new energy centre. The hyper-efficient energy centre will provide the hospital with improved heating and hot water facilities following works that involved the replacement of temporary boilers with three new condensing boilers and the laying of new pipework around the hospital.** **This £650,000 investment coincides with the launch of United Lincolnshire Hospitals NHS Trust's Sustainable Development Management Plan (SDMP) which outlines how the Trust is working towards being even more sustainable and energy efficient.** **The Trust is already one of the best performers in the country for reducing its carbon footprint, with a reduction of 13% from 2010 to 2015, compared to the national target of 10% for NHS organisations.** **The new energy centre will help support the hospital in meeting energy targets and reducing running costs, as well as providing an improved and efficient heating and hot water service to the hospital and service users."** **So my question is, why is investment being requested for issues that are surplus to requirements, when we don't have our full services back - only 3 days fracture clinic and still no overnight walk in access at Grantham Hospital?** The Chief Operating Officer responded: The Trust were pleased to have received the grant of £1,554,170 to replace gas fired boilers with air source heat pumps at Grantham Hospital and highlighted that it continued to demonstrate the Trusts' commitment to Grantham Hospital and the future of services that were provided at the site. The Chief Operating Officer highlighted that the investment would reduce the carbon footprint and improve the reliability and resilience of some services whilst future proofing the site in relation to the green footprint. The Trust also saw benefit from not only the reliability but running costs of the site which were equally as important. The Chief Operating Officer confirmed that the A&E service had been restored to the previous model prior to the changes that were implemented in response to Covid-19 however the changes were not financially motivated. The Chief Operating Officer stressed that the changes were not influenced financially and that the grant would therefore have no impact. The Chief Operating Officer highlighted that the fracture clinic was open four days per week and that the Trust also ran a virtual fracture clinic which was implemented during Covid-19. The fracture clinic had reduced the amount of time that patients had to physically visit the Grantham site and where possible telephone consultations would be used to manage fractures going forward.

1200/21	**Q2 from Vi King** **Please can I ask due to people from Grantham and surrounding areas being admitted to Lincoln hospital, why the visiting slots cannot be shared. E.g. The hour slot one person goesin for half an hour and another person could go in for half an hour.** **What is the Trust criteria if a member of staff has a family member who lives in the same household, who has tested positive, but the member of staff is negative can they go to work?** The Director of Nursing responded: The Trust had recently considered a review around the current restrictions on visiting noting that a decision was made based on the prevalence of the virus currently being high in the community alongside the Trust seeing an increase in the number of patients admitted to hospital. The Trust wanted to continue to minimise the risk of transmission and therefore keep the number of people accessing the hospital wards to a reduced number and restrict visiting to a one hour slot. The Director of Nursing noted that the visiting restrictions would be reviewed again in late August 2021 to include options such as those suggestions put forward. The Director of Nursing highlighted that the national guidance remained clear with regard to staff isolation and that individual members of staff must self-isolate for ten days in line with guidance. The Trust did not intend to change the stance on staff isolation where there had been direct contact with a positive individual.
1201/21	**Item 3 Apologies for Absence** Apologies for absence were received from Mr Paul Matthew, Director of Finance and Digital, Mr David Woodward, Non-Executive Director and Ms Cathy Geddes, Improvement Director, NHSE/I.
1202/21	The Chair extended a warm welcome to the new members of the Board including Dr Colin Farquharson, Medical Director, Professor Philip Baker, Non-Executive Director and Mrs Alison Dickinson, Associate Non-Executive Director.
1203/21	**Item 4 Declarations of Interest** The Chair noted that the Declarations of Interest would be updated to include new members of the Board. There were no declarations of interest which had not previously been declared.
1204/21	**Item 5.1 Minutes of the meeting held on 6 July 2021 for accuracy** The minutes of the meeting held on 6 July 2021 were agreed as a true and accurate record.
1205/21	**Item 5.2 Matters arising from the previous meeting/action log** The Chair noted that updates had been provided on the action log:
1206/21	007/21 – Review of TOM and governance to be presented to the Board – The Chair highlighted that the action was not due until November 2021 however confirmed that internal audit were actively engaged in reviewing the Trust operating model.
1207/21	259/21 – To develop a regular plan of activities, such as back to the ward, through staff engagement and organisation development activity – The Trust Secretary noted that the

	annual engagement plan had been developed by the Organisational Development Team and was being considered by the Workforce Strategy Group which would be presented to the Trust Leadership Team in August for sign off. Action closed.
1208/21	579/21 – Consideration to be given to the triangulation of data between staff survey results and quality measures – The Chief Executive assured the Board that item 579/21 would be picked up by the Interim Director of People and Organisational Development.
1209/21	**Item 6 Chief Executive Horizon Scan** The Chief Executive presented the report to the Board advising that with regard to the Integrated Care System (ICS) the second reading of the Health and Care Bill had taken place through the House of Commons and would move to the Committee stage following summer recess. It was understood that the anticipated date for the ICS to become a statutory body would be 1st April 2022.
1210/21	The Chief Executive highlighted that the NHS had both a new Secretary of State and Chief Executive with Amanda Prichard appointed as the Chief Executive for the NHS on the 1 August 2021.
1211/21	The Board were reminded that there was two components to the ICS, the Integrated Care Board, which replaced the CCG and had an expanded role as a statutory body and the Integrated Care Partnership, which was the relationship between the NHS and stakeholders, including local authorities.
1212/21	The Chief Executive highlighted that the NHS continued to follow Infection Prevention and Control (IPC) requirements and confirmed that risk assessments were in place for staff including clear rules regarding eligibility criteria on decisions for staff to return to work, which would need to be signed off by Gold Command.
1213/21	It was noted that the vaccination roll out continued to go well and the number of vaccinations had exceeded 1 million across the Lincolnshire System. There was a continued drive to vaccinate all over 18 year olds and it was noted that the vaccination of pregnant women remained a government focus.
1214/21	The Chief Executive highlighted that the Trust remained busy and was anticipating seeing winter pressures and increased Covid-19 cases, noting that A&E admissions had risen to pre Covid-19 levels. The Trust were looking to recover some of the elective care work that had been delayed during the Covid-19 pandemic alongside ensuring that staffing levels were such that staff would be able to take their annual leave.
1215/21	The Chief Executive noted that the Trust's finances were in line with the plan and that the Trust were pleased that the outline business case for the new A&E department at Pilgrim Hospital, had been approved at national level. This would allow the Trust to proceed with the next step to a full business case which would include procurement and the instruction to build.
1216/21	The Chief Executive welcomed the arrival of the new Medical Director and noted that the Interim Director of People and Organisational Development was due to join the Trust in August.
1217/21	The Chief Executive highlighted that the recruitment process for the substantive Director of People and Organisational and Development would take place in September 2021.
1218/21	The Chief Executive noted that the Director of Improvement and Integration/ Deputy Chief Executive had been offered a secondment with NHS England Improvement (NHSE/I) East Midlands as the Director of Performance and Improvement. The Trust were looking to fill the vacancy as a secondment through the NHS talent pool. The Chief Executive noted that the Deputy Chief Executive portfolio would move to another Executive Director for the period of

	the secondment.
1219/21	Dr Gibson acknowledged the hard work and contribution of The Director of Improvement and Integration/ Deputy Chief Executive noting that the improvement part of that the role was crucial in particular to Finance Performance and Estates Committee.
1220/21	The Director of Nursing advised in relation to expectant parents there was clear guidance on vaccination until delivery of babies. There were clear processes and controls in place to ensure appropriate guidance was offered by midwives to ensure women were able to make an informed choice.
1221/21	It was noted that a randomised control trial was due to be recruited to as previous research did not include expectant women and there was some anxiety from expectant mothers.
1222/21	The Chair was reassured in relation to the level of support being offered and noted that there would be a need for the Board to receive more detailed reports in relation to the ICS as this progressed. The Trust Board: • **Noted the update and significant assurance provided**
1223/21	**Item 6.1 Covid Wave 3 Update** The Chief Operating Officer presented the report and highlighted that the Trust were in third wave of the Covid-19 pandemic and noted that the paper articulated differences between waves 1 and 2 including the lessons learned and the significant differences between each wave.
1224/21	The Chief Operating Officer noted that during wave 1 and 2 of Covid-19 reduced levels of urgent care demand and patients being admitted was experienced and during the peak of wave 2 the Trust did not see pre-Covid-19 levels of emergency demand.
1225/21	The Chief Operating Officer noted that wave 3 had seen increased pre-Covid-19 levels of urgent care admissions. The risk register entry around demand and capacity of urgent care, had been revised to a higher level risk of a score of 25. The risk had been presented to the Finance, Performance and Estates and the Quality Governance Committees for consideration.
1226/21	The Chief Operating Officer noted challenges around the need to maintain critical planned care services in particular cancer treatments and care throughout wave 3 in a way which had not been done in wave 1 and 2 due to the suspension of the services. There was an importance to maintain rapid access to time critical services throughout the Covid-19 wave 3.
1227/21	The Chief Operating Officer noted the challenges regarding workforce and that the Trust must ensure that the workforce continued to be allowed to take appropriate leave and manage the taking of annual leave which had been affected during wave 2 due to the need to respond to the level of the surge.
1228/21	The Chief Operating Officer advised that the Trust was following the national trajectory which indicated that the level of hospitalised patients with Covid-19 or the level of patients in critical care may not be seen. This provided assurance that the critical care teams would not be at the same capacity as had been seen during wave 2.
1229/21	It was noted that the Trust continued to see high levels of sickness across staff and that a series of mitigations had been put in place to mobilise the Trust and respond rapidly.
1230/21	The Chair sought assurance that in the absence of the Director of People and Organisational Development the correct level of leadership was in place across the Trust.

1231/21	The Chief Operating Officer assured the Board that measures were in place and the response to re-deployment was being managed by a very experienced Managing Director leading the Workforce Cell.
1232/21	In addition to the measures, Lincolnshire Partnership NHS Foundation Trust (LPFT) and Lincolnshire Community Health Services NHS Trust (LCHS) were supporting the Trust to work through the other elements of the workforce cell, to respond quickly and provide the Interim Director of People and Organisational Development a robust handover.
1233/21	Mrs Dickinson asked for the percentage of vaccination uptake amongst staff within the Trust. The Chief Operating Officer confirmed that the uptake was circa 90% for clinical staff. It was noted that the uptake for Black, Asian and Minority Ethnic colleagues at the Trust was one of the highest in the region.
1234/21	The Chair noted that the Board anticipated the predicted increase and inpatient demand which was likely to last until November/December 2021, which would impact on services and result in prolonged challenge. The Trust Board: • **Received the reporting noting the limited assurance**
1235/21	**Item 7 Patient/Staff Story** The Director of Nursing welcomed the Patient Experience and Engagement Manager to present the staff story regarding how the Trust supported patients with life threating illnesses and experiencing end of life care and gave the opportunity to renew vows with the support of the Chaplaincy Team and the Swan Scheme.
1236/21	Via a pre-recorded video the Board were offered details of the wedding box scheme that enabled wards to arrange weddings and vow renewals for patients. The Board also heard from Reverend Alison Amelia, Chaplain through the video about a vow renewal that had taken place using the Swan Scheme wedding box.
1237/21	The Chair thanked the Patient Experience and Engagement Manager for the presentation and noted its emotive content.
1238/21	The Chief Executive echoed the Chairs comments and informed the Board that he had attended one of the ceremonies and personally witnessed the efforts of staff and demonstration of the Trust's values.
1239/21	The Director of Nursing commented that it was a fantastic story and positive that patients could be supported in this way by the Trust, and that the Trust charitable fund could be used to facilitate it. The Director of Nursing queried if colleagues were aware of the boxes and that the service was available.
1240/21	The Patient Experience and Engagement Manager confirmed teams had been made aware that the chaplaincy team could provide a service however hoped that the boxes would further promote the service.
1241/21	The Chair extended a special thanks to the Chaplaincy Team, acknowledging their hard work and efforts. The Trust Board: • **Received the staff story**
	Item 8 Objective 1 To Deliver high quality, safe and responsive patient services, shapedby best practice and our communities

1242/21	**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 20 July 2021 Meeting.
1243/21	Mrs Libiszewski made reference to Objective 1a of the Board Assurance Framework (BAF) which was rated amber with the Committee receiving an update on non-invasive ventilation from the Chair of the Patient Safety Group. It was highlighted that significant work had taken place and the Committee was assured that progress had been made.
1244/21	Mrs Libiszewski noted that the harm review process was reviewed with a recognition of the time taken away from clinical activity to undertake the reviews.
1245/21	Mrs Libiszewski highlighted that the Quality Governance Committee received an update on visits across the Trust that would be reported into the Committee and the Trust Board including 15 steps visits and the ward accreditation process.
1246/21	An update was received in respect of Infection Prevention Control and an invited review had taken place with an anticipated update expected at the August 2021 Committee.
1247/21	Mrs Libiszewski noted the Safeguarding Group upward report which had indicated a heightened awareness of the compliance rate of clinical restraint training with recommendations submitted to the Director of Nursing to conduct restraint training.
1248/21	Mrs Libiszewski noted that the patient experience objective continued to be rated as red within the BAF however noted that significant improvements had been made. It was noted that an update regarding maternity and neonatal had been received, and that a thematic review was being commissioned serious incidents and those incidents being appropriately referred to the Healthcare Safety Investigation Branch where applicable.
1249/21	The Committee received a written report from Non-Executive Maternity Safety Champion who continued to meet with staff. Staff experience had been highlighted through a visit to Lincoln Hospital and focus groups were now taking place to consider the concerns that staff had highlighted.
1250/21	The Committee received the Equality, Diversity and Inclusion Annual Report which had been approved for submission to the Board and would be discussed during the meeting.
1251/21	Mrs Libiszewski noted that the Committee had reviewed strategic objective 1c, improve clinical outcomes which remained red however, further work was taking place and it was noted that there had been an improvement in reporting to the committee. The Committee commended the annual Organ Donation Report which had been presented to the Clinical Effectiveness Group and upwardly to the Committee.
1252/21	The Committee continued to receive monthly Quality Impact Assessment reports due to the concerns regarding the approach, however the Committee were assured that systems and processes were embedded in the Trust. The Committee requested that the frequency of reporting be reduced to quarterly as a result of the assurances received.
1253/21	The Committee were advised of the increase in the emergency care risk to a rating of 25 and updates would continue to be received with regard to patient experience and care. This was also being considered at the Finance, Performance and Estates Committee.
1254/21	Mrs Libiszewski noted that the Committee terms of reference were included within the papers noting the significant number of supporting groups that reported to the Committee which offered a strengthened approach to reporting.
1255/21	The Chair was pleased to see progress with regard to non-invasive ventilation noting that this had been a challenge for the Trust also noting that the respiratory support units were in

	operation.
1256/21	The Chair noted that the clinical harm reviews were ongoing and ensuring that patients can get rapid access to planned care and that the outcome of the NHSE/I Inspection would be received in due course which was understood to be a much improved position.
1257/21	The Chair sought clarity regarding care planning being added to the risk register.
1258/21	The Director of Nursing confirmed that an upward report had been received through the Nursing & Midwifery AHP Advisory Forum (NMAAF) around inconsistency of nursing admission documentation and therefore planning of care from a nursing perspective.
1259/21	It was noted that the totality of nursing documentation would need to be reviewed as there were a number of associated risks with the inconsistency of documentation however the electronic patient record would resolve some of these issues. Whilst the electronic patient record was being implemented a model was being developed with the Senior Nursing Team with regard to a framework to build assessment of care planning.
1260/21	A working group had been commissioned to look at a specific range of expertise of colleagues across various disciplines across the workforce to resolve the issue. The Trust Board: • **Received the Assurance Report**
1261/21	**Item 8.2 CQC Actions Update** The Director of Nursing presented the report noting this offered a monthly overview for the Board which was considered in detail through the Quality Governance Committee.
1262/21	The Director of Nursing noted that the divisions had undertaken a substantial amount of work which had been reported to the Board in July 2021 and had been supported by the Director of Improvement and Integration.
1263/21	The Director of Nursing noted that this had enabled the improvements seen to be evidenced and had led to an improved and updated action plan with no red rated actions. It was noted that a weekly meeting to oversee the work had been established and since the report was written, a sizeable amount of evidence had been submitted to the Care Quality Commission (CQC).
1264/21	Mrs Dunnett queried if as a Trust, horizon scanning of other CQC reports for good practice or lessons to learn, had taken place over the last 6 months. Mrs Dunnett also asked how the Trust assured that green rated actions were embedded in the organisation with a sustainable improvement.
1265/21	The Director of Nursing noted that the Trust did horizon scan and had examples from two Trusts who had had recent inspections that perhaps did not go as well as anticipated. The Trust reviewed the reports and performed a gap analysis to look at the Trusts' position, obvious examples were around maternity care which featured on the Quality Governance Committee agenda and work plan.
1266/21	Regarding the embedding of actions, the Trust had a number of ways to review this through ward reviews, 15 steps and inspections of areas with multi professional teams through observational visits. In addition to this external peer reviews were requested by the Trust.
1267/21	The Chair made reference to the CQC action which referenced deteriorating patients and noted that one action had been moved from green to amber and sought assurance that there was some focus on this in relation to the difficult operational pressures that the Trust were facing

1268/21	The Director of Nursing highlighted that the work which had been undertaken provided evidence that the actions were being addressed and noted that the report into the patient safety group had reviewed evidence. The fact that this had moved to amber was testament that there had been identification of a lack of evidence that supported the position and demonstrated the strengthening of the governance arrangements offering a true understanding of the position.
1269/21	The Director of Nursing noted clear plans were in place in respect of the deteriorating patient group with strong governance wrapped around this which reported to the Deputy Medical Director, who chaired the Patient Safety Group.
1270/21	The Chief Operating Officer noted that as part of Covid-19 wave 3 planning regionally the Trust had received a number of request to review how organisations were managing deteriorating patients and the increased pressures on A&E departments. The Trust were extremely well placed in a number of the processes and in the must and should do actions and already had the procedures in place and evidence to support this. The Trust Board: • **Received the report noting the moderate assurance**
	Item 9 Objective 2 To enable our people to lead, work differently and to feel valued, motivated and proud to work at ULHT
1271/21	**Item 9.1 Assurance and Risk Report People and Organisational Development Committee** On behalf of the Chair for the People and Organisational Development Committee, Mrs Dunnett provided the assurances received by the Committee from the 14 July 2021 meeting.
1272/21	Mrs Dunnett highlighted that objective 2a was amber rated on the Board Assurance Framework (BAF) and confirmed that the Committee had received assurance on the staffing report which reflected nursing staff levels across the Trust. The Committee were assured on the progress being made in terms of managing the levels on a daily basis as well as the transformation work that was taking place across the Trust.
1273/21	Mrs Dunnett noted that a report had been received from a newly established task and finish group to increase flexible working across the Trust for Agenda for Change staff. Mrs Dunnett then noted that assurance that work was occurring in non-medical education and the funding that was available had been received.
1274/21	Mrs Dunnett noted that in respect of objective 2b, which was rated red, the committee noted that there was a lot of work ongoing in the area however it was still work in progress which was reflected by the red rating on the BAF. The report presented to the Committee was comprehensive and included plans on how to deal with issues in the estates department. The organisational development element of the work was being closely monitored by the Committee.
1275/21	The Committee had received assurance on the Trust wide culture and leadership project however the Committee were keen to ensure that the project was appropriately resourced to deliver.
1276/21	Mrs Dunnett highlighted that the Junior Doctors Survey results were not where the Trust expected them to be and that the culture programme was able to identify some of the concerns raised via the survey.
1277/21	Mrs Dunnett noted that the Committee were assured on the progress that was being made regarding the annual medical re-validation report.
1278/21	The Committee received an update in relation to becoming a teaching hospital noting that whilst progress had been made the report did not offer evidence of this since the last report

	was received. As such the Committee were unable to make further assessment in regards to the rating on the BAF.
1279/21	Mrs Dunnett noted that the Committee agreed the Terms of Reference noting that a new Chair would be appointed and that personnel changes were taking place within the People and Organisational Development Directorate.
1280/21	Mrs Dunnett noted that the Committee reviewed the dashboard and highlighted areas that had already been discussed.
1281/21	The Committee noted the high levels of vacancies and the significant increase in establishments levels across the Trust in excess of 300 posts, some of which had been temporary posts in response to Covid-19 and some had been to reflect how services where being strengthened.
1282/21	The Committee expressed concern that the Board did not have a holistic view of recruitment and where new posts had been established and were keen for the Board to hold discussions to understand the totality of the situation.
1283/21	The Chair noted the escalations and expressed the disappointed on the lack of assurance provided for objective 4b and encouraged that the correct level of assurance and reports were provided.
1284/21	Concern was also expressed with regard to the increase in establishment across the organisation.
1285/21	The Chief Executive noted that establishment increase had been added to the new Interim Director of People and Organisational Development tasks and would be prioritised once commenced into the role.
1286/21	The Board noted the need for a review of the establishment to be received by the Committee with a clear understanding of how this was positioned across the organisation and the narrative around vacancies within the Trust. **Action – Interim Director of People and OD, 7 September 2021** The Trust Board: • **Received the assurance report**
1287/21	**Item 9.2 Equality Diversity and Inclusion Annual Report** The Equality, Diversity & Inclusion Lead presented the report to the Board noting that this had been presented to both the People and Organisational Development Committee and the Quality Governance Committee therefore due diligence on the detail had been done.
1288/21	The Equality, Diversity & Inclusion Lead noted that the report included a highlight report in appendix 1 for 2019 /2020 and explained that the rationale to include the report was that during the Covid-19 pandemic the equality and human rights commission suspended reporting requirements which included some of the specialist duties of the public sector equality duties.
1289/21	The Equality, Diversity & Inclusion Lead noted that the Trust continued to foster good relationships with equality groups that clearly remained through the pandemic, seeking endorsement from the Board for the report to be published on the Trust website.
1290/21	The Equality, Diversity & Inclusion Lead noted that the report continued to demonstrate that the Trust were compliant with statutory and contractual duties and that there had been a significant growth in the equality and diversity work across the Trust.

1291/21	The Board noted that the Covid-19 pandemic highlighted a number of health inequality issues and that early in the pandemic there was a disproportionate impact on the BAME community including employees and patients. Issues regarding co-morbidities, impact on age and sex and from a health inequalities view and the impacts regarding social isolation, rural isolation and social deprivation were also significant challenges for the county.
1292/21	The Equality, Diversity & Inclusion Lead highlighted that a milestone infographic had been produced which provided an overview of the highlights of the last reporting year. It was highlighted some of the key Covid-19 responses linked to important piece of work, initially in response and then ensuring that the responses were aligned to the integration of care plan.
1293/21	The Equality, Diversity & Inclusion Lead highlighted the new inequality impact assessment tool, was one of the key things across the provider Trusts, that had been implemented and tested through the pandemic responses and had led to a template being implemented across the Trust which had been officially signed off for use.
1294/21	System working had been strengthened and was a key area of growth and highlighted the cultural intelligence and inclusion work that the Trust and system had secured funding for in July 2020. There had been a number of plans in place for further developments that had been paused due to wave 2 of Covid-19 but had not recommenced.
1295/21	New models for staff engagement had been developed as a result of challenges faced from the pandemic with the growth of staff networks and amplifying the voice of staff networks. Events that would ordinarily have been held face to face were now being conducted as online webinar events.
1296/21	The Equality, Diversity & Inclusion Lead mentioned the Trust reversed mentor scheme, noting that the Trust had had two cohorts attended with members of the Board on the first cohort, the second cohort was coming to an end and current recruitment to the third cohort for the autumn was underway.
1297/21	Dr Gibson expressed his frustration in recent years that the Trust were unable to provide detailed analysis of data and strongly supported the development of the dashboard however noted that this may require some investment in IT and analysis.
1298/21	The Chair endorsed Dr Gibson's comments and agreed that the Board would require sight of the dashboard.
1299/21	The Chief Executive further endorsed the comments noting there remained work to be done regarding the relative impact of the Equality and Diversity Team, the staff networks, other leaders within the organisation and the need to ensure the right balance of who held responsibility and accountability to make a difference.
1300/21	Mrs Dickson asked if there had been an impact on the Trusts' workforce as a result of the EU Exit.
1301/21	The Equality, Diversity & Inclusion Lead noted that this had not been a significant focus in the last two years however it was initially considered and a decline in workforce numbers had been noted. It was agreed that the Equality, Diversity & Inclusion Lead would engage with the People and Organisation and Developmental Team and HR colleagues to provide further detail on the matter to the Committee. **Action – Equality, Diversity and Inclusion Lead, 2 November 2021**
1302/21	The Equality, Diversity & Inclusion Lead noted that the dashboard was in draft format, the patient dashboard would be developed in the first instance and support was in place from the Director of Finance and Digital to start with the building and structure. A first draft of the dashboard was being tested by one of the Trust Divisions and feedback would be received.
1303/21	The Equality, Diversity & Inclusion Lead noted the comments regarding strengthening the

	impact of work on patients noting that the workforce database was currently being developed by the workforce intelligence and IT teams. It was noted that the Equality, Diversity and Inclusion Group had been paused during Covid-19 however this was stepping back up as the Trust recognised that this offered assurance to the Board.
1304/21	The Board note that the workforce race equality standard, workforce disability equality standard and staff workforce data all indicated that more work was needed to address inequality and become a more inclusive organisation, as aspired to within the integrated improvement plan.
1305/21	The Chair noted that there was a great opportunity to integrate the 2020/21 plan into the Integrated Improvement Plan and to bring all the actions into the work stream. The Trust Board: • **Received the annual report** • **Approved the report for publication**
	BREAK
	Item 10 Objective 3 To ensure that service are sustainable, supported by technology and delivered from an improved estate
1306/21	**Item 10.1 Assurance and Risk Report from the Finance, Performance and Estates Committee action** Dr Gibson, on behalf of the Chair, provided the assurances received by the Finance, Performance and Estates Committee from the 22 July 2021 meeting.
1307/21	Dr Gibson acknowledged the length of the agenda advising the Committee had continued to receive improved quality of reports from the Estates group. Detail had been offered to the Committee through the estates statutory compliance report however it was noted that there remained a number of critical infrastructure issues to be addressed by the Trust over the coming years.
1308/21	Dr Gibson noted that the Health and Safety Committee was fully functioning with representation from staff side and divisions however concern had been raised by the Committee regarding a lack of full information received from the British Safety Council visit on Covid-19 measures.
1309/21	Dr Gibson noted that in relation to objective 3b, efficient use of resources, that at the end of quarter 1, the Trust were aligned to the financial plan however there were a number of challenges that would be seen in the remaining half of the year.
1310/21	The Committee noted the elective recovery fund which had gone through a late change of target and noted a grammatical error in the second paragraph on page 2, the gateway target was not 0.95% but 95% and would be difficult to achieve.
1311/21	Dr Gibson advised that the agency pay position was not where hoped and the cost improvement programmes (CIP) were also proving challenging and noted that for those reasons the Committee recommended that the assurance rating for objective 3b in the BAF was reduced from amber to red.
1312/21	Dr Gibson highlighted objective 3c and the Information Governance Group upward report which detailed full achievement of the data security protection standard which had been fully achieved for the second year by the Trust.
1313/21	Dr Gibson highlighted the reference to the 15 minutes standard noting that this was confirmed as triage of within 15 minutes of care and although the Trust were not achieving the target the Committee were pleased to note the mean was 7 to 8 minutes.
1314/21	The Committee, under its responsibility had reviewed the Integrated Improvement Plan and

	although it was still in the early stages the Committee were satisfied that it was almost entirely green in terms of the RAG ratings.
1315/21	Dr Gibson noted that the Trusts operational performance was reported against internal benchmark and national standards and received three performance reports including, cancer, planned care and urgent care.
1316/21	The Board were advised of the 62 day wait for confirmed cancer cases noting that considerable progress had been made initially to reduce and maintain the backlog however it was noted that this had plateaued at around 200 patients. It was acknowledged that this would be increasingly difficult to address during wave 3 of Covid-19.
1317/21	Dr Gibson noted that due to the backlog, harm reviews had grown in importance and the Committee had debated the appropriate point to conduct a harm review. It was noted that clinical colleagues would prefer to wait for a later stage for the patient pathway to assess a harm review.
1318/21	Dr Gibson noted that the challenges as wave 3 of the Covid-19 pandemic progressed would impact on urgent care, there had not been a reduction in the number of patients accessing urgent care as had been seen in the previous waves.
1319/21	Dr Gibson further noted that the current data on urgent care would indicate significant pressure on the urgent care cases and for that reason the risk rating would be raised to 25.
1320/21	Dr Gibson highlighted concern regarding a recently received internal audit report on the overall function of the estates department and were pleased to see that the audit committee were following up on the recommendations.
1321/21	The Committee approved the terms of reference which were submitted to the Board for approval.
1322/21	The Chair shared concern regarding the CIP position. The position in relation to missing outcomes were noted and the desire to further understand the situation.
1323/21	This was important for patients alongside the financial implication for the Trust. The Chair requested that the Audit Committee considered the position and ascertain action to be taken. **Action – Director of Finance and Digital, 11 October 2021**
1324/21	The Chair noted the increase of the risk in the capacity to manage the urgent care demand, risk 1475, from 20 to 25 and noted that the Finance, Performance and Estates and Quality Governance Committee had conducted significant due diligence and supported the increase in the rating on the risk register. The Trust Board: • **Received the assurance Report**
1325/21	**Item 10.2 Urology Service Engagement Output** The Chair noted that the Board had previously been alerted to a change in the Trusts Urology Service and invited the Director of Improvement and Integration to present the report alongside the Consultant Urologist and the Divisional Clinical Director.
1326/21	The Director of Improvement and Integration offered an overview of why the redesign of the service had been put forward noting that urology had faced challenges for many years including pathways offered and patients being able to access the pathways.
1327/21	The Director of Improvement and Integration noted there was a challenge within the urology workforce and attracting staff to the urology positions, which had caused patients to have a

	poorer experience than was aspired to.
1328/21	The Director of Improvement and Integration stressed that the Urology Team had been working on the report with the support of the divisions and had worked hard to re-design how the services could be provided across multiple sites in the most modern way. Taking in to consideration advice from NICE guidance and advice from national and regional teams, including the ambulance service, which fully supported the proposal.
1329/21	The Director of Improvement and Integration noted that the plans had been shared with the Health Overview Scrutiny Committee that had been attended with the Consultant Urologist and the General Manager. The plans had been well received and subsequently more formal feedback had been received.
1330/21	The Director of Improvement and Integration noted that the plans had been shared with the Get it Right First Time (GIRFT) team which included various clinical expects in urology who had offered support of the proposed model.
1331/21	The Director of Improvement and Integration highlighted that the plan was to redistribute circa 4% of the total urology activity, however the vast majority of urology activity occurred in outpatients and highlighted that the plan did not include outpatients or diagnostic pathways across the multiple sites. The plan proposed to re-distribute the elective and day care activity from Lincoln County Hospital with the majority moving to Grantham Hospital which was in line with the site vision.
1332/21	It was noted that for the emergency pathway, the largest change would be for patients who required admission to a hospital bed and requiring surgery. These patients would move from Pilgrim Hospital and treated at the Lincoln County Hospital which again was in line with the site vision.
1333/21	The Director of Improvement and Integration noted whilst the inpatient and surgical element would move to Lincoln County Hospital the activity had historically been between Lincoln County Hospital and Pilgrim Hospital. Emergency urology patients would still be able to access the emergency department at Pilgrim Hospital and the majority of patients would be treated and discharged from there, only those patients requiring admission or surgery would be transferred to Lincoln County Hospital.
1334/21	An inpatient urology service would remain at Pilgrim Hospital site as this was not about the removal of service but a re-distribution of activity and how the Trust delivered the service. The benefits highlighted that the access time for patients was expected to improve for cancer services, elective surgery and treatment pathways and therefore the cancellation rate was expected to reduce.
1335/21	There was an expectation of an improvement in the continuity of care along with patient experience with a further expectation that patients required admission.
1336/21	Assurance was offered to the Board on the breadth of consultation with an initial consultation period of 6 weeks having been held that had extended to ten weeks and closed on the 23 July 2021. All outputs of the consultation had been assessed and included within the papers with the majority of concerns raised having been mitigated through the work undertaken.
1337/21	The Director of Improvement and Integration noted that the key concern was how patients moved between hospital sites and how the Trust facilitated a return home, this was currently being explored. The GIRFT team had made one suggested change to the model which had been fully accepted and those amendments would be made.
1338/21	The Consultant Urologist re-emphasised the key benefits in terms of improving the Trusts emergency care with the introduction of a new tier of acute care practitioners which was picked out by the GIRFT team as an innovative development which had lessons for Urology units throughout the country.

1339/21	The provision of acute care practitioners and a urology assessment unit would allow for rapid assessments and flow into the Urology service without impacting on A&E. The ability to deliver acute care in terms of acute surgery in particular for stone disease would allow the Trust to achieve key NICE guidance which was not being addressed at present and would support avoidance of repeat admissions for treatment.
1340/21	The Consultant Urologist noted that the team were conscious on the impact of the shift of emergency focus on patients having to transfer to Lincoln County Hospital however a local assessment would still be available to offer remote advice as required and the Trust would engage with system partners to understand what elements of acute care could be carried out in a community setting.
1341/21	The Consultant Urologist acknowledged that there was a need for ongoing speciality support and noted in addition to the on call team, duty urology cover on a daily basis to support the activities of the in house specialities on the Pilgrim Hospital and Grantham Hospital would be provided. At all times there was a requirement for urologists to attend the Pilgrim or Grantham site to deal with acutely unwell patients or paediatric patients.
1342/21	The Consultant Urologist believe the new model offered a safe development which had been welcomed by national advisors and had mitigated the risks as far as able in regard to the transfer of patients.
1343/21	The Divisional Clinical Director emphasised that doing nothing regarding the current urology service was not an option and that it was a very fragile service in particular around staff retention and recruitment. It was highlighted that the current urology configuration was not in line with best practice and had been sent out recently by GIFT and also by NICE.
1344/21	The plan would enable the Trust the opportunity to provide the highest standard of care in line with best practice and that the service was provided for an increasingly ageing population across the county and it was believed that the model offered the greatest advantaged to the greatest number of Lincolnshire patients.
1345/21	Mrs Libiszewski noted that paper was not clear on the impact of paediatrics and queried if the plan would alter the current interim paediatric model currently operating at Pilgrim. Mrs Libiszewski also noted that her interpretation of the paper was the greatest impact was the elective shift from Lincoln County Hospital to Grantham Hospital and the understanding that it would have an impact, and queried if the feedback received back from the public evidenced full understanding of the impact.
1346/21	Mrs Libiszewski made reference to the nurse consultant and highlighted that it implied that there was a single nurse consultant to support the out of hours work and was concerned that this would not be sufficient capacity.
1347/21	The Consultant Urologist noted that in terms of the paediatric provision the model supported the transfer of all patients including paediatrics to Lincoln County Hospital for assessment however it did recognise those that were time critical in particular for patients with acute scrotal pain and where a delay in transfer was recognised there would be the provision for a surgeon with the appropriate grade to travel to Pilgrim Hospital to deliver surgery.
1348/21	The Consultant Urologist noted that in terms of the elective balance, over the past 18 months a substantial proportion of the elective work had been provided at the Grantham Hospital site which had been welcomed in terms of protecting capacity and was a consolidation of the position in line with site strategy to ensure that the elective flow was protected.
1349/21	The nurse consultant was a valued member of the team who had provided professional leadership for the acute practitioners and supported them both in and out of hours and would join colleagues on the rota to provide support as required.
1350/21	Mrs Dunnett sought confirmation that East Midlands Ambulance Service NHS (EMAS) Trust fully supported the proposals and that the Trust had engaged with neighbouring Trusts to

	confirm support.
1351/21	Mrs Dunnett noted that the Trust were seeing a change to the staff numbers in the service and sought assurance the ability for the Trust to recruit into the posts along with assurance that gaps in health inequalities would not widen due to the changes.
1352/21	The Consultant Urologist assured the Board that EMAS had been involved in discussions and it had been agreed that an amendment to defining types of conditions would result in patients being conveyed directly to Lincoln. Similar models had been adopted by other local organisations.
1353/21	The Consultant Urologist noted that the Trust had recruited to six ACP posts and that there was an ongoing programme of recruitment, eight substantive full time ASA doctors would also be in post by October 2021 and two part time doctors. Additional recruitment had seen the appointment of a new consultant urologist with further recruitment to take place in the coming months.
1354/21	The Consultant Urologist noted that the monitoring of the impact on patients on the east coast would be an ongoing process and would seek a further engagement exercise to assess the impact as well as monitor the flow of patients throughout the county into the two sites. A review would be undertaken in three months at which time a report could be provided to Board to offer details of progress.
1355/21	Professor Philip Baker highlighted that only one of the medical practitioners was a specialist trainee and asked of there was scope for increasing this and if there was opportunity for the Trust to have a pipeline of trainees taking up positions to reduce fragility.
1356/21	The Consultant Urologist noted that it was important to ensure that the Trust did have a pipeline of trainees and with stability of the service this could be explored.
1357/21	The Chair noted the desire to ensure that the fragile services in the Trust were recognised and put on a sustainable footing and noted that the report was very heavily led by clinicians and had been influenced by past experience and looking at a future model.
1358/21	The Chair noted the engagement of the GIRFT team and the ability to deliver NICE guidelines through the service redesign.
1359/21	The Chair noted the need to consider the feedback from the engagement exercise not least the views of the Health Overview Scrutiny Committee as well as other key stakeholders who had raised some concerns.
1360/21	The Chair noted that the report described how some of the risks could be mitigated however it did not resolve all the concerns that had been raised as such the position would be reviewed in three months. **Action – Director of Improvement and Integration, 2 November 2021** The Trust Board: • **Received the report noting the significant assurance** • **Approved the implementation of the urology reconfiguration service model, go live 9 August 2021**
	Item 11 Objective 4 To implement integrated models of care with our partners to improve Lincolnshire's health and wellbeing
1361/21	**Item 12 Integrated Performance Report** The Chair noted that the report was work in progress which would move into a different format that supported the Integrated Improvement Plan. Each Committee had had sight of

	the relevant metrics and the Board had been sighted on the considerations through the Committee upward reports.
1362/21	Mrs Dunnett requested an update in regard to breast cancer services.
1363/21	The Chief Operating Officer advised that the Trust had experienced difficulty in the restoration of the breast service and the ability to match the demand received. Two strategies which had been running for approximately 10 – 12 weeks were in line with restoration and with additional slot capacity these were starting to have an impact. It was noted that the latest forecast had improved by 20% from one month to the next.
1364/21	The Chief Operating Office noted that there was an organisational development improvement exercise to encourage collaborative working between breast and radiology services which was now having a positive impact.
1365/21	Mrs Dickinson queried what actions the Trust had taken comply with the Duty of Candour with the Chief Operating Office noting that this falls within the remit of the Quality Governance Committee in regards to the harm work that was taking place. Performance was the responsibility of the Finance, Performance and Estates Committee.
1366/21	The Chief Operating Officer assured the Board that Duty of Candour was aligned with a number of new protocols which were set for clinical harm and which were easier for the clinical teams to see the triggers of a harm event and the various stages. It was noted that a complete suite was now available and had been through Clinical Harm Review and presented to the Quality Governance Committee.
1367/21	Mrs Libiszewski confirmed that it was closely monitored through the Quality Governance Committee and that the central governance team had provided additional support to the Divisions. The Trust Board: • **Received the report noting the limited assurance**
	Item 13 Risk and Assurance
1368/21	**Item 13.1 Audit Committee Upward Report** The Chair of the Audit Committee, Mrs Dunnett provided the assurances from the meeting held on 12 July.
1369/21	Mrs Dunnett noted that the Committee had received an update from external auditors and there was one element of the 2020/21 external audit programme outstanding noting that the delay was a result of delays in national guidance and timelines. Mrs Dunnett assured the Board that the Trust were not out of line with other Trusts and would be reporting this in September 2021.
1370/21	The Committee received a progress report from internal audit on the 2021/22 financial year audit programme with good progress noted and thanks extended to the team for the coordination.
1371/21	Mrs Dunnett noted three reports were received which offered partial assurance and were being progressed via the Board Committees. Mrs Dunnett noted that one report was regarding education development and research development with the Audit Committee requesting the relevant Executives attended the October meeting to ensure progress on the recommendations was being made.
1372/21	The Committee had been attended by the Chief Operating Officer and Director of Estates and Facilities to address concerns raised through the Estates Internal Audit Report for which actions were being overseen by the Committee.

1373/21	A number of outstanding audit recommendations were noted where implementation had not yet taken place with a number of high risk recommendations noted. The Committee had noted the process in place to address the slippage from the Executive Team.
1374/21	Progress was noted in respect of counter fraud with the Committee receiving the annual report which was consistent with the reporting throughout the year. The counter fraud survey circulated to all staff within the Trust had received a good response. The Committee also received the updated counter fraud and corruption policy which was approved by the Committee.
1375/21	Mrs Dunnett highlighted that the Committee had limited assurance regarding policies and assurance that these were up to date. Mrs Dunnett noted whilst assurance was limited, greater action was being taken and resource was in place to support this.
1376/21	The Board were advised that the Committee had signed off the terms of reference which were presented to the Board for approval.
1377/21	Mrs Dunnett noted that one area the Committee continued to see focus on was regarding risk noting there was a big change in the Committee's approach to risk and review of the risk register.
1378/21	Mrs Dunnett presented the annual report from the Audit Committee which was consistent with the upward assurance reports provided to the Board and consistent with the terms of reference, which the Audit Committee had complied with.
1379/21	Mrs Dunnett noted a difficult year highlighting that audit colleagues had to work remotely and was also the first year of the new external auditors who had also worked remotely with additional requirements, in particular regarding procurement and expenditure as a result of Covid-19.
1380/21	Mrs Dunnett noted that the priorities of the Audit Committee were to support the Trust to strengthen overall systems of control, see evidence of partial assurances change, see evidence of the implementation of recommendations, evidence of work on risks being embedded into the Trust and a wider piece of work across the ICS and how the Trusts governance structure would align.
1381/21	The Chief Executive assured the Board that the audit recommendations were being taken seriously and acknowledged that the Trust's performance required improvement.
1382/21	The Chief Executive noted that Executive Leadership Team (ELT) would discuss on a regular basis and similarly through the Director objective setting, audit recommendations. The Trust Board: • **Received the assurance report**
1383/21	**Item 13.2 Strategic Risk Report** The Director of Nursing presented the report to the Board noting that the report included three very high strategic risks.
1384/21	The Board were advised that the timescales for the completion of the full reconfiguration of the risk register had slipped until November 2021. A piece of work was being undertaken to identify what resource would be required in order to complete this ahead of November 2021.
1385/21	The Director of Nursing noted that training would be crucial to the reconfiguration and appropriate use of the risk register.
1386/21	The Director of Nursing highlighted that the Finance, Performance and Estates Committee had recently reviewed the risk associated to the capacity to manage emergency demand and

	the report indicated that the risk had increased to 25 from 20. The Trust Board: • **Received the report noting the moderate assurance** • **Accepted the top risks as reported** • **Endorsed the increase of the emergency demand to 25**
1387/21 1388/21 1389/21 1390/21	**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 and had been updated prior to Committee review by the Executive Directors and teams. The Trust Secretary noted that the upward report from the Finance, Performance and Estates Committee had decreased the RAG rating of objective 3b from amber to red based on the half 1 financial plan. The Trust Secretary highlighted that a new Chair would be appointed to the People and Organisational Development Committee and the Interim Director of People and Organisational Development would be encouraged to review the relevant areas of the Board Assurance Framework. The Board confirmed the assurance ratings presented. The Trust Board: • **Received the report noting the limited assurance**
1391/21	**Item 14 Any Other Notified Items of Urgent Business** No items for discussion
1392/21	The next scheduled meeting will be held on Tuesday 7 September 2021, arrangements to be confirmed taking account of national guidance

Voting Members	**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**	**3 Aug 2021**
Elaine Baylis	X	X	X	X	X	X	X	X	X	X	X	X	X
Chris Gibson	X	A	X	X	X	X	A	X	X	X	X	A	X
Geoff Hayward	A	A	A	A	X	X	X	X	X	A	A	X	
Gill Ponder	X	X	X	X	X	X	X	X	X	A			
Neill Hepburn	X	X	X	X	X	X	X	X	X	X	X	A	
Sarah Dunnett	X	X	X	X	X	X	X	X	A	X	X	X	X
Elizabeth Libiszewski	X	X	X	X	X	X	X	X	X	X	X	X	X
Paul Matthew	A	X	X	X	X	X	X	X	X	X	X	X	X
Andrew Morgan	X	X	X	X	X	X	X	X	X	X	X	X	X
Mark Brassington	X	X	X	X	X	X	X	X	X	X	X	X	X
Karen Dunderdale	X	X	X	X	X	X	X	X	A	X	X	X	X
David Woodward											X	A	A
Professor Philip Baker													X

Colin Farquharson													X

PUBLIC TRUST BOARD ACTION LOG

Agenda item: 5.2

Trust Board date	Minute ref	Subject	Explanation	Assigned to	Action due at Board	Completed
4 February 2020	077/20	Assurance and Risk Report Quality Governance Committee	Review of TOM and governance to be presented to the Board	Evans, Simon	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 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 August. Action Closed
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	Warner, Jayne	07/12/2021	

			communication training following story at the Board			
6 July 2021	1141/21	Urology Pathway Update	Refreshed site strategies to be presented to the Board	Brassington, Mark	05/10/2021	
3 August 2021	1286/21	Assurance and Risk Report People and Organisational Development Committee	Establishment review to be presented back to Committee and Trust Board.	Int Dir People & OD	07/09/2021	
3 August 2021	1301/21	Equality Diversity and Inclusion Annual Report	Equality, Diversity & Inclusion Lead would engage with the People and Organisation and Developmental Team and HR colleagues to provide further detail on the impact of EU Exit on the Trusts European Workforce.	Couchman, Tim	02/11/2021	
3 August 2021	1323/21	Assurance and Risk Report from the Finance, Performance and EstatesCommittee action	Audit Committee to review the missing outcomes data	Matthew, Paul	11/10/2021	
3 August 2021	1360/21	Urology Service Engagement Output	An update paper on the Urology Service Engagement output to be reported to Board in three Months.	Brassington, Mark	02/11/2021	

Meeting	*Public Trust Board*
Date of Meeting	*7 September 2021*
Item Number	*Item 6*
Chief Executive's Report	
Accountable Director	*Andrew Morgan, Chief Executive*
Presented by	*Andrew Morgan, Chief Executive*
Author(s)	*Andrew Morgan, Chief Executive*
Report previously considered at	*N/A*

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

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

Recommendations/ Decision Required	• *To note*

Executive Summary

System Overview

a) All parts of the Lincolnshire health system are experiencing significant demand pressures, not dissimilar to those normally experienced during the winter months. This is a combination of pressures due to COVID, urgent and emergency care, planned care recovery and long-term condition management. These are being managed alongside staffing pressures resulting from sickness or annual leave.
b) Additional national guidance has been issued relating to the establishment of Integrated Care Boards (ICBs) with effect from 1st April 2022. Subject to legislation, the ICBs will come into being at the same time as CCGs are abolished. The national recruitment process for the Chair of the Lincolnshire ICB is underway. Similarly, the national recruitment process for the CEO role is about to begin.
c) The national recruitment process for the CEO position at Lincolnshire Partnership NHS Foundation Trust is also underway, with an assessment process and interviews on 1st September. The CEO position at Lincolnshire Community Health Services NHS Trust has also been advertised nationally and the recruitment process is due to conclude during September.
d) Work is continuing on the System Improvement Plan, which is a key component of the Lincolnshire ICS being part of segment 4 of the new national System Oversight Framework. Those systems in SOF level 4 receive the most intensive support. The work is being co-ordinated by Keith Spencer, the System Improvement Director.
e) A key component of the System Improvement Plan is the development of a Lincolnshire Provider Collaborative. The establishment of Provider Collaboratives is a key part of national ICS policy. It is expected that the Provider Collaborative will lead the transformation programme in the Lincolnshire system. The development and mobilisation of the Provider Collaborative is being led by the existing Provider Alliance.
f) The vaccination programme continues to go well, with the eligible groups now being expanded to include 16 and 17 year olds. Further clarification is awaited from the national Joint Committee on Vaccination and Immunisation (JCVI) about eligibility for any booster programme relating to COVID. Alongside this, the plans are well developed for the annual flu vaccination programme.
g) Expressions of Interest have been invited by the NHS as part of the 'Health Infrastructure Plan: Future New Hospitals Programme'. This relates to proposals to be part of the next 8 schemes to be approved nationally. Expressions of Interest, using the national template, need to be submitted by 9th September. Proposals can relate to whole new hospitals, new clinical buildings on existing sites, or major refurbishments. The Lincolnshire system is preparing its submission.

Trust Overview

a) At Month 4, the Trust reported an in-month surplus of £0.5m with a year-to-date position of a deficit of £0.6m. Both of these are in line with the H1 2021/22 financial plan.
b) The final part of the recruitment process for the substantive Director of People and OD was postponed from the beginning of August due to availability problems. The assessment process has been re-arranged to 8th September and the final interviews to 9th September. In the meantime, Jacqui Grice has commenced as the Interim Director.
c) Work is continuing to appoint a new Interim Director of Improvement and Integration to replace Mark Brassington when he goes on secondment to NHSE/I Midlands with effect from 6th September. The Deputy CEO portfolio is being re-allocated to one of the existing Directors and the outcome of this process should be known on 6th September. An update will be provided to the Board on 7th September.
d) Unfortunately, the individual appointed to be the Trust's new Freedom to Speak up Guardian has decided not to take up the post. A new Freedom to Speak up Guardian is being sought.
e) A Leadership Behaviours Survey is being conducted with all staff and system partners as part of the Trust's Culture and Leadership Programme. This will be followed up with staff focus groups to better understand the responses that have been made. Invitations are about to go out to named individuals across the Trust to be part of the new Leading Together Forum. This Forum will help to drive the culture and behaviour changes required in the Trust.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*Tuesday, 7 September 2021*
Item Number	*TBC*
COVID-19 Wave 3 Update	
Accountable Director	*Simon Evans, Chief Operating Officer*
Presented by	*Simon Evans, Chief Operating Officer*
Author(s)	*Simon Evans, Chief Operating Officer*
Report previously considered at	*N/A*

How the report supports the delivery of the priorities within the Board Assurance Framework	
1a Deliver harm free care	*X*
1b Improve patient experience	*X*
1c Improve clinical outcomes	*X*
2a A modern and progressive workforce	
2b Making ULHT the best place to work	
2c Well Led Services	*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	*Risk register 4175 Capacity to manage emergency demand revised to score 25*
Financial Impact Assessment	*Financial Impacts will be captured through Covid expenditure monitoring process used in Wave 1 and 2 2020/21*
Quality Impact Assessment	*Quality Impact Assessments will be reviewed and signed off through the QIA monitoring process used in Wave 1 and 2 2020/21*
Equality Impact Assessment	*Equality Impact Assessments will be reviewed and signed off through the QIA monitoring process used in Wave 1 and 2 2020/21*
Assurance Level Assessment	*Limited*

Recommendations/ Decision Required	*The Trust Board is asked to:*
	• *Note this report and its summary of key areas alongside the increased Corporate Risk (4175)*
	  ○ *The high but improving levels of sickness*
	  ○ *The high levels of urgent care demand and the increased length of stay of patients in hospital*
	  ○ *Increased demands on Critical Care both internally but requested as mutual aid from other systems*
	  ○ *Actions implemented to prepare the Trust for the full impact Wave 3*

Executive Summary

- Wave 3 plans have been developed that incorporate learning from wave 1 and wave 2 Covid-19 surges.
- These plans are being enacted in response to the developing Wave 3.
- Sickness has shown an improvement but still remains high.
- Length of Stay has increased and greater numbers of patients are waiting for more than 21 days in hospital. Indicating capacity issues in care in the community and in social care.
- Critical Care demand has increased in line with plan however these relatively small services at LCH and PHB have fragile capacity due to sickness and other absence as well as an increased demand now from out of system for mutual aid.
- Actions being taken within the Trust are focussing on reducing separating Covid and non Covid-19 pathways, reducing admissions and using more Same Day Emergency Care (SDEC) approaches.
- Actions outside the Trust have started to use alternative pathways to support the reduction in patients awaiting Pathway 1 (Domiciliary Care) as well as an increase in the level of oversight and escalation of delays.

1. Introduction

This paper seeks to provide an overview of the impact of Covid-19 pandemic on the Trust as it moves into the phase described as Wave 3.

2. Covid 19 – Wave 3 planning

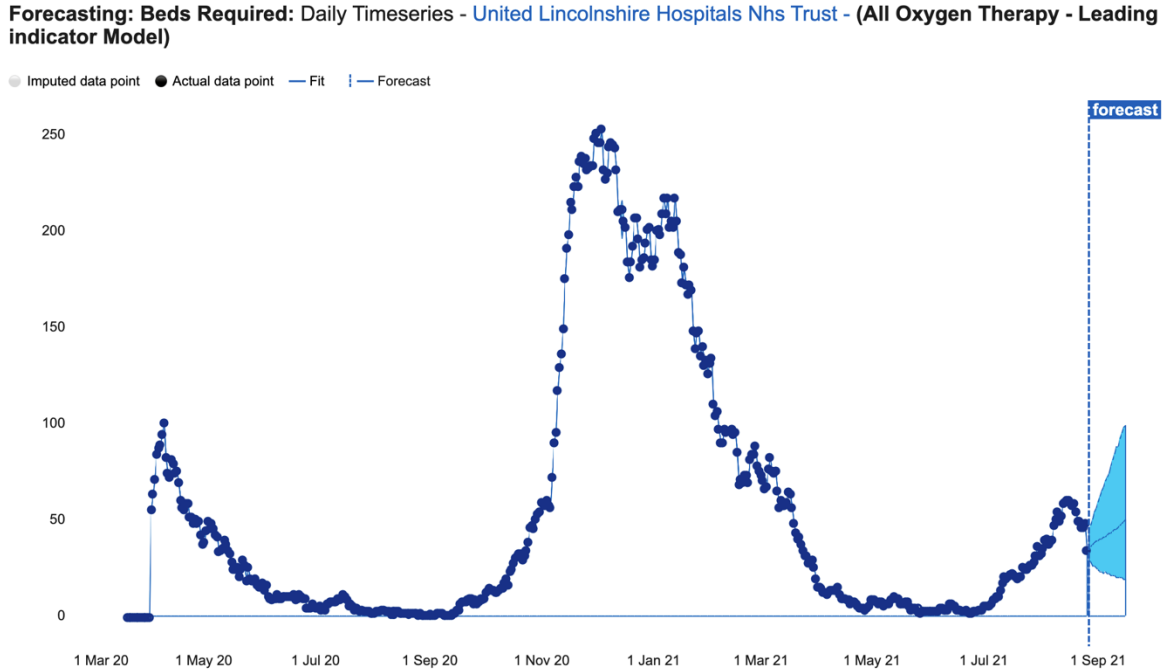
Extensive Wave 3 planning began in April 2021 when national epidemiological forecasting suggested that a further wave of infections was likely in July/August 2021. This planning incorporated a number of additional challenges that were either not faced in previous waves, or that were not at the level expected in wave 3. Notably:

- The need to protect time critical surgery in much larger volumes than in Wave 1 and Wave 2 2020, as more patients were waiting longer and therefore the need was greater
- The need to provide greater levels of leave and rest for staff that had worked through two previous waves of Covid-19 surge and therefore were at greater levels of fatigue and had less resilience.
- The likelihood that non Covid-19 related urgent and emergency care demands would be greater than previous waves.
- Regulator programmes, inspections and other improvement programmes would all be fully active with a greater demand on clinical and management teams to continue improvement programmes.
- Grantham could no longer operate as a fully protected low risk (previously referred to as Green) site and would need to operate with both urgent and emergency care and low risk activities simultaneously.
- The continued review of PPE usage & visiting restrictions following a relaxation nationally of both.

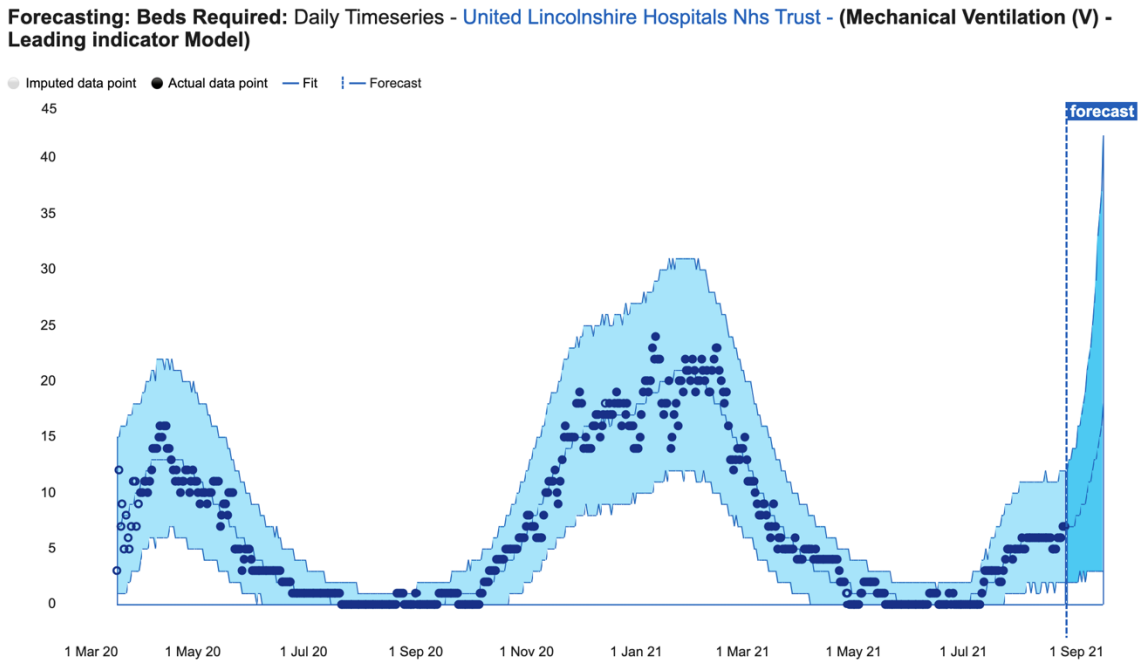
Accordingly, ULHT and systemwide plans were developed that were reviewed by NHSEi on separate occasions to test assumptions about the resilience of the Lincolnshire response to Covid-19 Wave 3.

3. Covid-19 Inpatient Demand in our Hospitals

Wave 3 demand for Covid-19 inpatient capacity is shown below, and has started to show early signs of plateau/reduction. Forecasts using the SPI-M model developed throughout wave 1 and wave 2 suggest admissions may still continue to increase which is in line with Wave-3 plan which anticipated a longer demand that could reach the level of Wave 1 (90-100 beds occupied).



Wave 3 has shown a greater proportion of patients who are admitted with Covid-19 do require support from Critical Care and whilst this is still a relatively small number, it represents a significant proportion of all Critical Care beds. In addition to the projected demands below the Trust has also offered mutual aid to neighbouring systems and continues to offer this where capacity will support. The chart below shows the actual and forecast demands for Critical Care.



4. Sickness and Absence and Workforce Availability

Sickness levels have improved since last reported and whilst still high at 6.6% the Trust no longer has the highest sickness level in the region. It is expected that this level continues to improve. Figures published on sickness for Covid-19 reasons are not thought to be accurate and investigations continue to ascertain the reason for the mismatch, although overall levels of sickness are thought to be very accurate.

Trust	% of Absent Staff with COVID or Self Isolating (25 Aug)	% Total Absence all staff		
		Current (25 Aug)	Last Week (18 Aug)	Change vs Last Week
[redacted]	28%	9.7%	9.0%	+0.66%
[redacted]	24%	9.4%	8.6%	+0.76%
[redacted]	22%	8.7%	9.0%	-0.24%
[redacted]	22%	7.4%	7.1%	+0.35%
[redacted]	24%	7.3%	6.9%	+0.42%
[redacted]	25%	6.9%	6.3%	+0.53%
[redacted]	16%	6.9%	6.9%	-0.07%
[redacted]	20%	6.7%	5.1%	+1.57%
United Lincolnshire	11%	6.6%	7.3%	-0.67%
[redacted]	30%	6.5%	6.7%	-0.17%
[redacted]	20%	6.5%	6.2%	+0.25%
[redacted]	17%	6.3%	6.6%	-0.23%
[redacted]	23%	6.0%	6.1%	-0.04%
[redacted]	18%	5.8%	5.6%	+0.16%
[redacted]	29%	5.5%	5.7%	-0.15%
[redacted]	21%	5.3%	5.3%	-0.04%
[redacted]	17%	5.1%	5.6%	-0.54%
[redacted]	22%	4.9%	5.1%	-0.21%
[redacted]	18%	4.8%	5.0%	-0.20%
[redacted]	13%	4.8%	4.4%	+0.38%
[redacted]	38%	4.5%	4.5%	-0.05%
Midlands	**23%**	**6.7%**	**6.6%**	**+0.16%**

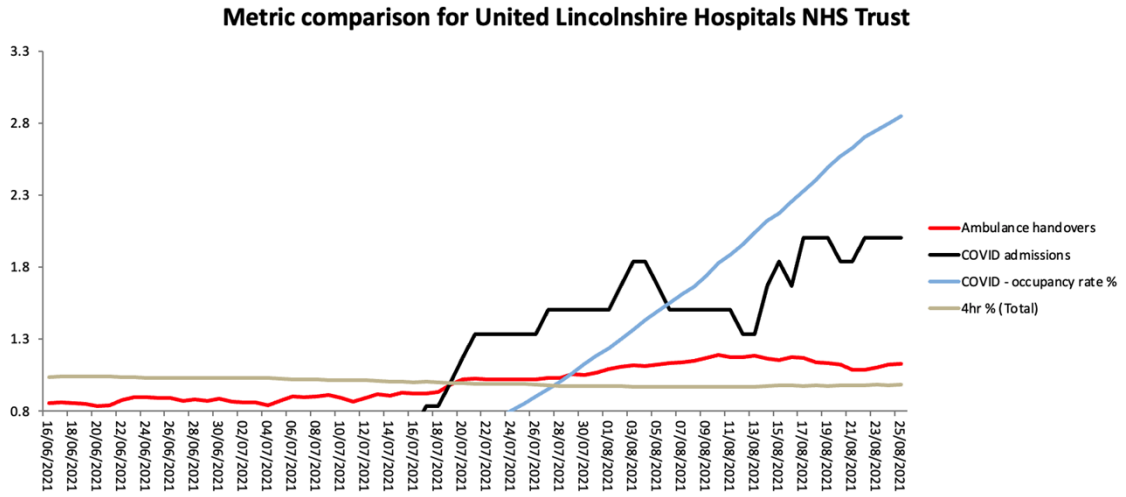
This improvement is in large part as a result of the change in national guidance with regards to isolation as a result of test and trace. A process of risk assessing individual cases using this guidance was implemented and has had the positive impact shown in the table above, with no perceivable impact on nosocomial transmission.

Although sickness levels have improved, what is not possible to identify (as it is not reported) is the sickness and absence levels in temporary/agency staff. In August fill levels for agency staff have reduced significantly compared to the number of gaps in rotas. This has reduced the ability to sustain all inpatient capacity at times with closures required in Discharge Lounge, Surgical Admissions, and on occasions core wards, where staffing was insufficient to keep all areas open.

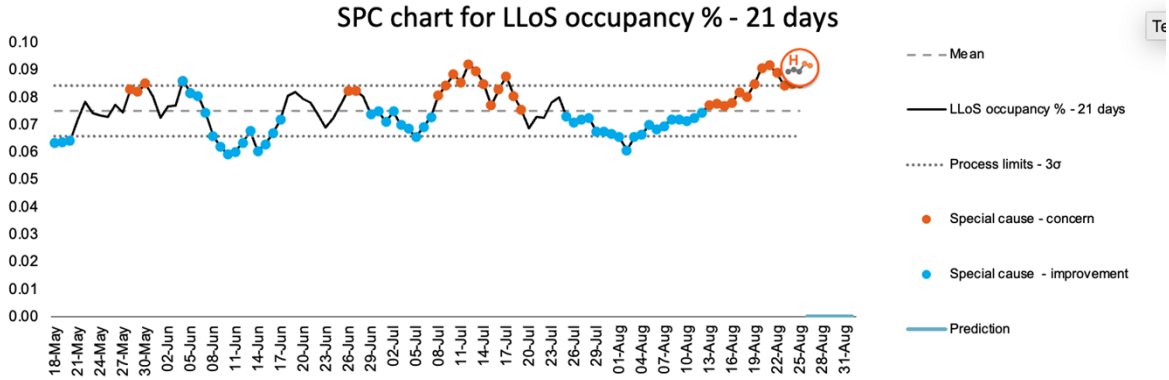
5. Urgent and Emergency Care Demands

Urgent and emergency care demands have continued to be challenging throughout August alongside Covid-19 admissions. The chart below shows the percentage comparative increase or decrease by several metrics in order to see key relationships.

As Covid-19 admissions have increased, ambulance handover numbers have also increased and therefore this has created greater pressure on Emergency Departments and admission pathways. Despite this 4 hour standard achievement has not seen the same proportionate decrease.

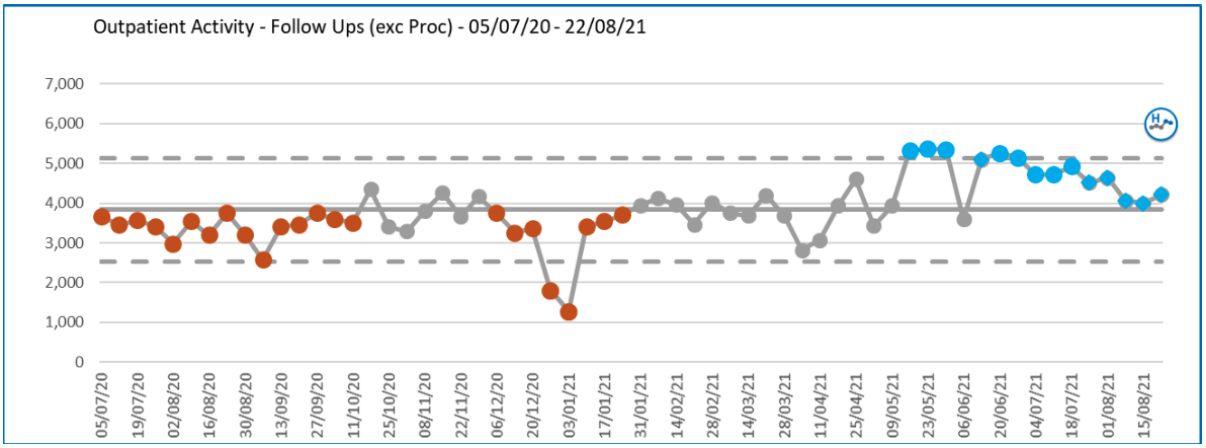


Community services for health and social care have been equally challenged with the demands on services as well as sickness and absence. As a result there have been increasing delays for patients that require services outside of hospital and a subsequent

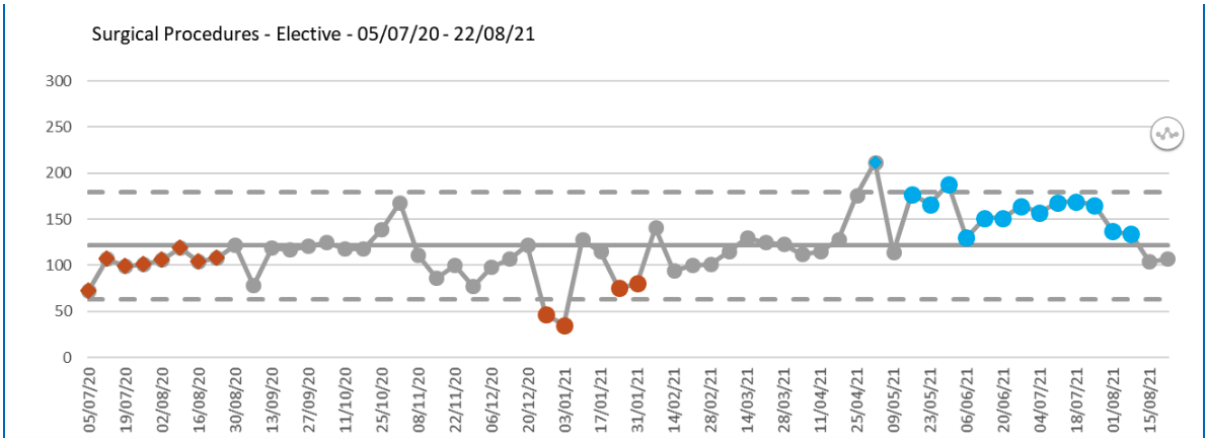


6. Planned Care

Wave 3 planned care activity forecast some reductions in August 2021 reflecting increased leave and the potential impact of Covid-19 and urgent care demands.



Outpatient activity has reduced more than expected and with follow-up appointments reduced significantly to provide clinical capacity for urgent care.



Unlike Wave 1 elective overnight operations have continued in Wave 3. The increased that was seen in July has not been maintained in August. It is expected that this level will recover and a greater number of patients will be operated on in September and the following months once sickness and absence levels have stabilised.

7. Actions to Mitigate and Respond to Wave 3 Challenges

Key actions described in Wave 3 planning are described below. These actions largely reflect those described in previous board paper, however are now updated to reflect their current status:

- The Mobilisation of the Incident Command Centre has commenced and is now monitoring and controlling the increasing demands on services, improve rapid communication systems and supporting the governance of managing the response.
- Gold and Exec Cells have become daily and support rapid decision making as the situation becomes increasingly faster paced. This incorporates sign-off of QIA, EIA and financial authorisation processes established to safeguard governance and decision making put in place in wave 2.
- 'Reducing the Burden' governance has been implemented streamlining and where possible reducing meetings to ensure that management and clinical teams are able to directly respond to the situation as it progresses.
- A workforce cell has been mobilised to directly respond to the workforce planning, wellbeing and response challenges. This cell made up of senior HR, operational/clinical and staff side representatives has started to reinstate the array of measures put in place in wave 2 including coordinating redeployed staff.
- The Risk prioritisation cell used throughout Wave 2 and into the recovery period shortly after has increased its frequency and manages any loss of elective capacity. Led by one of the Deputy Medical Directors this forum uses intelligence from teams to prioritise the available capacity to reduce risk of any delays in accessing care.
- Urgent care pathway design and workforce distribution plans are being developed to increase the number of very senior clinical decision makers at the beginning of urgent and emergency care pathway, this still work in progress.
- System working to reduce the number of patients that do not require acute care in our hospitals continues and meetings have increased in frequency. Weekly flow meetings chaired by executives from both ULHT and LCHS and seek to improve admission avoidance and reduced delays in leaving hospital.

- The IPC cell used during Wave 2 and into the recovery period has been re-establised to oversee any outbreaks of COVID and any other infections. This cell has also overseen the continued implementation of the national guidance regarding PPE usage.
- The Gold command structure has also overseen the conitntued reviews of visiting restrictions
- This is list is not exhaustive but instead are in addition to actions both internally and externally aimed at reducing length of stay and reducing the need for surge capacity for inpatient wards.
- All actions taken have been supported by risk assessments and Quality Impact Assessments that have been signed off by the Director of Nursing and the Medical Director in line with the Trusts established QIA policy.

Report to:	Trust Board
Title of report:	Quality Governance Committee Assurance Report to Board
Date of meeting:	24th August 2021
Chairperson:	Liz Libiszewski, Non-Executive Director
Author:	Karen Willey, Deputy Trust Secretary

Purpose	This report summarises the assurances received and key decisions made by the Quality Governance Assurance Committee (QGC). The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board's response. This assurance committee meets monthly and takes scheduled reports from all Trust operational groups according to an established work programme. The Committee worked to the 2021/22 objectives. The Trust are responding to the third wave of Covid-19 and as such the meeting was held via Microsoft Teams with a reduced agenda and attendance to focus on key priorities. The Committee were mindful of the pressures being faced by the Trust.
	Assurance in respect of SO 1a Issue: Deliver harm free care **Incident Management Report** The Committee received the report noting the progression in the report presented. The Committee were advised that an external review had been commissioned to consider previous maternity incidents and complaints in order to identify any themes or trends. The regional team would work with Clinicians from the Trust in order to undertake a joint thematic review. **High Profile Cases** The Committee received the report noting the content **Infection Prevention and Control (IPC) Group Upward Report and NHSE/I Letter** The Committee received the report and the letter of the IPC Visit from NHSE/I offering congratulations on the improvements that had been seen. The Committee were pleased to note the improvement from a red to amber rating following the visit from NHSE/I noting that issues remained in relation to estates, decontamination and ventilation. The Committee noted that the feedback from the visit and any resulting actions would be incorporated in to the overarching IPC action plan for

	the Trust. **Medicines Quality Group Upward Report** The Committee received the report noting that clarity was required in respect of the actions outlined within the medication safety report as to whether these aligned to the previously presented roadmap. The Committee raised concern that the outcome of a number of actions outlined in the roadmap due for completion in August had not been reported and requested that an update be provided. Discussion was held to the appropriate reporting of information to ensure assurances could be provided to the Committee, this would be explored further. **Patient Safety Group Upward Report – Chairs report** The Committee received the Chairs report in absence of the meeting taking place due to operational pressures as a result of wave 3 Covid-19. The Committee noted the issues raised and noted the intention for future meetings to be held where representation could be met. **NMAAF Upward Report** The Committee received and noted the report
	Lack of Assurance in respect of SO 1b Issue: Improve Patient Experience **Maternity and Neonatal Oversight Group Upward Report – Chairs report** The Committee received the Chairs report in absence of the meeting taking place due to operational pressures as a result of wave 3 Covid-19. The committee noted that the threshold for triggering an SI in maternity had been revised to ensure learning takes place from a wider range of incidents The Committee received the terms of reference in relation to the thematic review and that the role of the Non-Executive Director Maternity Safety Champion should be considered as part of the review.
	Lack of Assurance in respect of SO 1c Issue: Improve Clinical Outcomes **No items received for discussion due to wave 3 of Covid-19**
	Assurance in respect of other areas: **Committee Performance Dashboard** The Committee received the report noting the current performance position.

	The Committee noted that the impact of wave 3 Covid-19 on the Trust with increased levels of activity as a result of responding to Covid-19 in addition to the continued delivery of elective care. The Committee noted the position in relation to Mortality and SHMI and recognised that further work would be required to ensure that coding was accurate and reflected palliative care coding. **Integrated Improvement Plan** The Committee received the report noting some concern about the ratings presented as these did not appear to be in line with performance reporting. The Committee noted the need to see triangulation of the information across the IIP and performance reporting although noted that elements would be standing back due to the impact of wave 3 Covid-19. **Ionising Radiation (Medical Exposure) Regulations** The Committee received the report noting the content and received a verbal update on the latest review which had occurred on the morning of the Committee **CQC Must and Should Do Actions** The Committee received the report and were advised that some confirm and challenge meetings had been delayed as a result of operational pressures from Covid-19 however there was no intention for these to be cancelled.
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 noted the risk register and the position of the reconfiguration
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	A
Elizabeth Libiszewski Non-Executive Director	X	X	X	X	X	X	X	X	X	X	X	X	X
Chris Gibson Non-Executive Director	X	X	X	X	X	X	X	X	X	X	X	X	X
Sarah Dunnett Non-Executive Director							X	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	X
Simon Evans Chief Operating Officer	A	X	D	C	C	C	C	C	C	X	D	D	D
Colin Farquharson Medical Director													X

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

Derby Office
Cardinal Square,
10 Nottingham Road,
Derby
DE1 3QT

12 August 2021

Dr Karen Dunderdale
United Lincolnshire Hospitals NHS Trust,
Trust HQ,
Lincoln County Hospital,
Main Entrance,
Greetwell Road,
Lincoln
LN2 5QY

Dear Karen

Re: *NHS England and NHS Improvement Visit; 28 and 29 July 2021.*

I would like to thank you and Natalie for organising the visit to United Lincolnshire Hospitals NHS Trust, Lincoln County Hospital, Grantham and District Hospital, and Pilgrim Hospital sites for the 28 and 29 July; this was a planned visit. Prior to this visit the Trust were RED on the as NHSE/I IP internal escalation matrix, this was as a result of must do actions being identified on CQC action plan and ongoing IPC concerns of the previous visits. This full follow up visit was planned for May 2020 but due to the COVID-19 Pandemic was delayed. Unfortunately, the CCG were unable to accompany us on this occasion.

During the visit I saw significant improvements and noting this the Trust has improved to the 'Amber Rating' on the NHSE/I scale, which is primarily due to the Estates and Facilities issues and governance identified below. The clinical areas visited all registered a Green Rating which demonstrated improvements from the previous visits, and I hope this will be embedded and sustained.

Since my visit there have been two outbreaks identified, the meetings were attended by the team and there was a lack of assurance provided at each of these meetings. Kirsty and Natalie have discussed this and note a number of actions that are being taken, as we discussed on the visit last week, including staffing of the IPC team and engagement with the wider team. We understand that work is in progress to resolve the concerns identified during these meeting and that you will be chairing the next meetings. There are two key concerns which require following up that are wider than the outbreaks:

- International nurses vaccination – the process described during the call does not provide assurance that international staff vaccination is easily accessible to these staff and the team did not have confirmation of vaccination status for this group of staff.
- Engagement of the Divisional Nursing Team in the outbreak process and supporting the ward managers, as discussed with Natalie, we are aware that this is a work in progress.

During the visit we visited three clinical areas on each site. All staff were and welcoming and were witnessed to be caring and kind to your patients. Your Deputy Director of Infection prevention, Natalie and Karen Lead Nurse for Estates, Facilities and Decontamination both accompanied me on the visit along with various Matrons. Feedback on the concerns identified were provided prior to leaving the Trust. Issues identified regarding cleaners' storerooms were photographed by your staff and included in the appendix 1.

Key themes identified:

- Governance
  - Limited assurance on Ventilation, Water or Decontamination in reports presented to IPCC for April May and June 2021; no report for ventilation.
  - Patient mask use documentation. Staff could describe who and why patients were not wearing a mask but was not documented in patients' records.
- Estates
  - No authorised person and competent person identified for decontamination and ventilation. Limited assurance though lack of reports.
- Housekeeping
  - Domestic storage rooms cluttered and very full, no access to hand hygiene sinks. Including toilet rolls on the floor.
  - All domestic storage rooms where clean as were the cleaners trolly's. Too much equipment on some.
  - Overuse/inappropriate use of 'I am clean labels'.
- Number of handwash sinks not fit for purpose.
  - On risk register and there is a rolling programme for the replacement, a significant number have been replaced.

I would urge the Trust to take immediate action to:

- Ensure F&E reports are presented to IPCC as per TOR for assurance.
- Have a clear plan with timescales for the sink replacement programme.
- Review all domestic/cleaning storage cupboards to allow for appropriate stock levels, access to sinks and shelving.
- Revisit the use of 'I am clean' labels'.
- Re- launch of patient mask wearing documentation.

Positive findings

- All wards clean and clutter free.
- Good correct documentation for IVs and catheters.
- Correct sharps disposal, bins signed appropriately and stored correctly.
- Welcoming staff to visitors and patients.
- Appropriate staff PPE use and compliant with BBE.
- Location & availability of hand gel and face masks at department entrances and appropriate areas within the departments.
- System in place for Covid-19 swabbing and monitoring in clinical areas.

Summary of visit.

The visit consisted of:

- Visit to clinical areas.
- Discussions with Staff.
- Observation of staff.

- Documentation review.

HCAI data Quarter 1
MRSA b- no cases.

Clostridioides difficile – 11 cases.
April - 4 cases (1 lapse in care)
May - 2 cases, (0 lapses in care)
June - 5 cases , (2 lapses in care)

HCW flu vaccination uptake 2020/21: 90% and plans in place for 2021/22 for both flu and COVID booster vaccinations.

Documentation Review
The documentation review was undertaken and shared with the Trust ahead of the visit to enable discussion and clarification, please see appendix 2.

Discussions
DIPC /IP Team

- £247k to increase the IP team to 10 WTE. Currently 4.6 plus Deputy DIPC.
- Formal DIPC meetings with Deputy DIPC monthly, clinical visits together and speak weekly.
- Decontamination - appointed lead Nurse for F&E and decontamination, in post 3 weeks. Previously has been a Quality Matron and worked in theatres and Endoscopy previously.
- Limited assurance for Water and ventilation. Deputy DIPC now chairs Operation IP, F&E meeting; leading on prioritisation of actions, cleanliness and a task & finish group for C4C and a cleaning BAF.
- IPC BAF and Hygiene Code gap analysis is now going to Board on a 6 monthly basis and all document of this status are within a reading room for all Exec directors and NEDs. The IPCC now has a NED on the IPCC and Quality Committee is chaired by a NED and NED on the membership.
- Karen Dunderdale now feels the Board have a true understanding of how the Trust is performing from an IP perspective.
- Endoscopy JAG assessment action for Lincoln site new building as is currently in a portacabin, expected £11 million.
- Reactivated Gold command for COVID recovery and paediatrics increases in respiratory illness. QIA undertaken for increase in paediatric area in Lincoln ED.
- Microbiology vacancies.
- COVID testing for inpatients articulated and triangulated by ward staff.
- Induction and risk assessment undertaken for contractors.
- Agency staff inductions by ward, all wards were able to describe the infection and letter of expectations.
- Significant number of policy's have been updated either due to date expired or content update.
- CDI reviews; microbiologist visit patients with Anti-Microbial Pharmacist and IPN visit the patients. IP team and microbiologist clinical review weekly for all HCAI is commencing in the next month.
- All staff required to use FFP3 masks are fit tested on 2 makes.

- Clostridioides difficile learning identified and shared through posters and communication routes.
- Microbiology vacancies currently, 1 member returning from maternity leave now. Clostridioides difficile ward rounds are once only by microbiologist and antimicrobial pharmacist then patient is followed up IP nursing team, ADVISE process to be documented within the policy.

Estates

- No Authorised Person or Competent Person named for Decontamination CFPP01-01 or Ventilation HTM 03-01. Previously out to tender at last visit. Sending up to date information. Still have vacancies.
- The executive with Board responsibility is the Chief Operating Officer.
- Director and Head of Estates all new in last 6-8months. Both may be required to act as Authorise Person or Competent person until these are appointed to. Requested details and mitigations for this.
- Funding in place for sink replacement as numerous do not meet the standards. Requested they understand the timescales for completion and that this is monitored and reported through IPCC. £800K for water work required.
- Confirmed estates, ventilation and water are all on the risk register, these are now reviewed monthly by the Director of Estates.
- Back log maintenance £68 million.
- £1.2 million for additional estates officers and recruitment over the next 6 months planned, job descriptions ready.
- 2 year strategy developed awaiting sign off by Board.
- The trust has an aspergillus policy but are confirming this is in date.
- The estates team involves the IP team in refurbishments as per HBN 00-09.
- Lead Nurse for F&E and decontamination now in post.
- ERIC returns are completed.
- Water Safety group involved clinicians.
- Legionella flushing evidenced in clinical areas.
- Robust system in place for Contractors undertaking work within the Trust including COVID risk assessment.
- Water safety, ventilation an Decontamination groups are all being reinvigorated with onward reporting.
- Written reports will now be presented to the IPCC, the Director of estate was honest and didn't know why these hadn't been presented, there has now been changes in personnel.

Awaiting updated chart below from Estates director.

	Authorising Engineer/organisation. Show appointment letter.	Authorised Person	Competent Person/trained?	Director with Board responsibility	Send last set of minutes for meeting:
CFPP01-01 (Decontamination)	AVM Services Ltd	No formal appointment in place	No formal appointment in place	Simon Evans	Decontamination:
HTM 03-01 (Ventilation)	Turners FM Leigh Kowalski	No formal appointment in place	No formal appointment in place	Simon Evans	AE for ventilation has recently been appointed and no formal meeting have been held. Plans in place to hold a monthly meeting.
HTM04-01 (Water)	ETA Projects Karina Jones	Not required	Paul Greasley	Simon Evans	Water Quality:

Facilities

- £250K has been allocated for new cleaning equipment, this is now arriving in the Trust and staff have been trained. Maintenance contracts in place.
- Discussed issues with full and cluttered cleaners store with blocked handwash sinks, this is being looked into and they are piloting smaller cleaning trollies.
- The Trust has confirmed they have a cleaning policy which denotes roles and responsibilities and each ward has a cleaning schedule.
- The ED now has 24hr cleaning in Boston and Lincoln (Grantham is closed overnight).
- There is a night cleaning team which do the: corridors and public areas, theatres, support busy areas such as ED, deep cleans where appropriate. Office cleaning has reduced over the years a business case is being developed to rectify this.
- Cleaning products are standardized: Chlorclean and HPV.
- C4C in place and new cleaning standards have a task and finish group which is also looking at who is responsible for cleaning what.
- Written reports are provided to the IP committee.
- MiC4C audit tool is used.
- Cleaning audit results are provided for both pre and post corrective actions.

Clinical Areas Visited

Grantham Hospital

Surgical Unit (floor 1) - Trust choice

Positive observations

- IV and catheter documentation.
- Fridge temperature recording in place for kitchen and drug fridges.
- COVID daily checklist including ventilation.
- Agency Induction.
- Clean and clutter free. Dust free.
- Cleaning and IP posters standardised.
- Mattresses checked – no strike through.
- All clinical equipment clean and appropriately labelled.
- Sharps bins labelled and stored appropriately.
- Cleaning assurance identified.

Observations requiring attention

- Clinical Waste cupboard not locked on corridor.

- Patients reason for not wearing mask not documented but staff new why.

A&E -Trust Choice
Positive observations

- Staff completely engaged.
- Fridge temperature recording in place for kitchen and drug fridges.
- COVID daily checklist including ventilation.
- Clean and clutter free. Dust free.
- Cleaning and IP posters standardised.
- Mattresses checked on gurney – no strike through.
- Described COVID assessment and streaming; walked me through the routes.
- Sharps bins labelled and stored appropriately.

Observations requiring attention

- Reposition of Dani centre as to low over a bin.
- Overuse of 'I am clean labels'.

Harrowby Ward – My choice
Temporary ward while refurbishment of original ward.
Positive observations

- Staff completely engaged.
- Fridge recording for drug fridges.
- COVID daily checklist including ventilation.
- Clean and clutter free. Dust free.
- Cleaning and IP posters standardised.
- Mattresses checked– no strike through
- Sharps bins labelled and stored appropriately.
- Good mask us by patients.
- Bed space cleaning chart in place.

Observations requiring attention

- Kitchen fridge recording and room temp recording on same sheet. Housekeeper clearly explained what had happened, now have new documentation.
- Storage of new cloths under sink in kitchen.
- No documentation for patient not wearing mask but staff new why and corrected this.
- Cleaners cupboard clean but full and cluttered.

Pilgrim Hospital
Ward 4A - Trust Choice – paediatrics
Positive observations

- Dani centres in place.
- Cleaning for patient confidence certificates displayed.
- Fridge temperature recording for drug fridges.
- COVID daily checklist including ventilation.
- Clean and clutter free. Dust free.
- Cleaning and IP posters standardised.
- Mattresses checked– no strike through
- Sharps bins labelled appropriately.

- Good mask us by parents.
- Bed space cleaning chart in place.
- No CDI for 1 year.

Observations requiring attention
- Crumbs in recliner chair.
- Cleaners cupboard clean but very full and no access to hand hygiene sink.

Ward 7B - Trust Choice - Respiratory.
Positive observations
- Dani centres in place.
- Fridge temperature recording for drug fridges.
- COVID daily checklist including ventilation.
- Clean and clutter free. Dust free.
- Cleaning and IP posters standardised.
- Mattresses checked– no strike through
- Sharps bins labelled and stored appropriately.
- IV and catheter documentation complete.

Observations requiring attention
- No hand wash sink in sluice, mitigations in place. On risk register and planned programme for replacement.
- Cleaners cupboard clean but very full and no access to hand hygiene sink.
- No documentation for patient not wearing mask but staff new why and corrected this. (SN immediately offered to the sister that she would go around the ward and document as appropriate for all patients).

Neonatal Unit – my choice
Positive observations
- Dani centres in place.
- Fridge recording for drug fridges and freezer, also all kitchen fridges.
- COVID daily checklist including ventilation.
- Clean and clutter free. Dust free.
- Cleaning and IP posters standardised.
- Mattresses checked, sealed fully and liquid tested at each change over.
- Sharps bins labelled appropriately.
- IV and catheter documentation complete.
- Milk room appropriate storage and fridge/freezer temperature checks in place.

Observations requiring attention
- Milk room jug with Milton solution for dummies looked like water in jug, removed immediately, new process will be put in place.
- Blood gas analyser blood spot identified.
- Cleaners cupboard clean but very full, cluttered and no access to handwash sink. Bucket in handwash sink.

Lincoln Hospital
Stroke Unit - Trust Choice

Positive observations

- Dani centres in place.
- Fridge temperature recording for kitchen and drug fridges.
- COVID daily checklist including ventilation.
- Clean and clutter free. Dust free.
- Cleaning and IP posters standardised.
- Mattresses checked– no strike through
- Sharps bins labelled appropriately.
- Good mask us by parents.
- New sliding doors in place to each bay.
- Water dispenser cleaning log in place.
- Wipeable cord pulls in place.
- IV and catheter documentation in place.

Observations requiring attention

- COSHH cupboard in sluice unable to be locked – being rectified while we were on the ward.
- Therapies room required maximum numbers poster and the screen replaced.

Dixon Ward - Trust Choice - newly refurbished ward with Gastroenterology day unit attached.

Positive observations

- Dani centres in place.
- Fridge recording for kitchen and drug fridges.
- COVID daily checklist including ventilation.
- Clean and clutter free. Dust free.
- Cleaning and IP posters standardised.
- Mattresses checked– no strike through
- Sharps bins labelled appropriately.
- Good mask us by parents.
- New sliding doors in place to each bay.
- Water dispenser cleaning log in place.
- Wipeable cord pulls in place.
- Worked with NHSEI EMIS improvement team to promote and facilitate discharges through the ‘Board Round’ which has been successful.

Observations requiring attention

- Cupboard doors awaited for sluice, on order.

Hatton Ward - My choice – surgery with level 1 patients.

Positive observations

- Dani centres in place.
- Fridge recording for kitchen and drug fridges. Checking procedure for when located in warm rooms.
- COVID daily checklist including ventilation.
- Clean and clutter free. Dust free.
- Cleaning and IP posters standardised.
- Mattresses checked– no strike through

- Sharps bins labelled appropriately.
- Good mask us by parents.
- Water dispenser cleaning log in place.
- Wipeable cord pulls in place.

Observations requiring attention

- Maximum numbers poster for rooms required.
- This was a busy ward in terms of the numbers of Drs, medical students and therapists; requires monitoring and action taken.
- Phlebotomist (employed by the pathology network) wearing gloves but not an apron.

I was also shown around the 10 bedded Respiratory Support Centre opened by Professor Van Tam on the 28 July. This is a fabulous resource due to open properly in the coming weeks and includes 4 negative pressure rooms with a donning and doffing anti-room plus 6 other single rooms all of which have en-suite facilities and will open in the coming weeks.

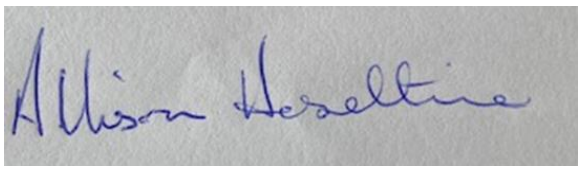
NHSE/I:

- If we can support you in any way please do not hesitate to contact us.
- We would advise the Trust asks the CCG to undertake IPC Nurse led supportive visits (as a peer reviewer) to support the Trusts journey.
- We can offer to support you and Natalie in presenting the journey for future reviews which I am happy to do this over a teams call at a mutually convenient time.
- We can support your Deputy DIPC with clinical supervision if this is something that would be useful.

Next Steps

- Please discuss the report with the Trust Board at the next meeting on 7 September and confirm by email that this has been undertaken.
- Please develop an IPC action plan regarding the Hygiene Code to address the concerns identified.
- A follow up visit will be planned for 6 month's time with the provisional date of the 1st and 2nd February 2022.

Kind regards



Allison Heseltine
Assistant Director of Nursing and Quality
NHS England and NHS Improvement Midlands Region

C.C. NHS England/NHS Improvement.

Appendix 1 – Photos

This is one room and the cleaners trolley filled the middle completely.

Appendix 2

Public facing web page	IP has dedicated page. • Gaps in Hygiene Code and BAF reported within the main Board Assurance papers. • Annual Report link to published document. • HCAI data Clostridioides not Clostridium. • COVID-19 link on opening page. • MRSA screening discussed leaflets are available on-line. • A variety of patient information leaflets are available.
Infection Prevention Group Paper 14 April 2021 19 May 2021 9 June 2021	External membership and attendance – CCG, Lincolnshire County Council and PHE. • Good selection of reports received as per TOR. The following are Sub-Groups of the IPCG: • Water Safety Group. • Estates & Faciltities IPC Group. • Antimicrobial Stewardship Group. IPC at divisional level meetings now commenced Issues • No Ventilation report and no verbal undate at April May or June. Key Guidance for COVID-19. ADVISE to correct and maintain. • Neonatal Unit MRSA peer review report - Escalation to Quality Governance Committee from IPG in May.

	• IPC Group provides a hi Sub-Group Upward / Escalation Report to Quality Governance Committee which then feed into Trust Executive Board. • No timescales for Hygiene Code actions withing April minutes. ADVISE dates for completion for all actions, Action log not received.
IPG TOR and membership	Updated July 2021 Currently going through the Governance routes.
Neonatal Unit MRSA peer review report – IPG May 2021.	Thorough review of the outbreak was undertaken with some clearly identified changes to practice actioned during the course of the outbreak. ADVISE to ensure that all changes and actions are embedded into practice through audit. Escalation to Quality Governance Committee and copy going to Board, date unspecified.
Consultation Paper on the Proposed Revised Structure for the Infection Prevention and Control Service and Team April 2021	Current 1 x 9 Deputy DIPC 2x Band 7 4 x Band 6 1 x IPC Lead Nurse in post working a minimum of 15 hours per week on a consultancy basis. 1 x Band 3 Admin This document gives a proposed plan for staffing for 7 day working. Time scales provided.
IPC compliance with hygiene code/ outcome 8.	ADVISE this document should be shared with the Board but only evidence of compliance colour coding shared through other meetings. And not always articulated in the same way within the Trust overall BAF. ADVISE overdue dates need attention. Criterion 1 due March 2021 – overdue and amber. ADVISE to check accuracy as in some reports this criterion is Green and complete. Criterion 2 due Oct 2020 - Trust E&F directorate to create NHS PAM or similar model- Overdue and Red. Are Ambers on track. Criterion 9 – Policies significant Red and Amber - a significant number have gone through IPG.
Infection Prevention & Control Audit Programme 2021 – 2021	Frontline Ownership Audit (FLO) 10 key areas of practice namely: hand hygiene, general environment, patients immediate bed space, isolation of infected patients, dirty utility / linen and waste disposal, ward kitchen, sharps safety, storage areas, clean utility and treatment room, patient equipment, clinical practice. Some low scores, ADVISE develop actions and mitigations together with the results. Understand and articulate how the daily COVID audits link with FLO. • SD, PPE, ventilation and patient mask use. Catheter and IV device audits are part of the clinical audit.

Board Assurance Framework	Clear summary for each section with strengths, weaknesses and actions described. No date of when Shared with Board only highlight from other meeting. ADVISE to share with Board in its entirety periodically as this also demonstrates the due diligence of work being undertaken. **June Board Minutes.** *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.* There are 4 standards with Partial /Amber response's, ADVISE to ensure dates for completion with the mitigations. 1 Green Assured - Notes say some gaps remain. ADVISE to check the accuracy. 5(b) Patients with suspected COVID-19 are tested promptly Some gaps remain and therefore not fully assured that all patients are re-tested at the expected times
ULHT MiCAD (cleanliness) scores -spreadsheets	Lincoln and Pilgrim consistently poorer results. ADVISE demonstrate what actions are in place to improve cleanliness and the timescales.
Action Plan from last IPC NHSEI visit.	Cracked sink - estates – are risk assessments carried out with IPC for this type of issue- All now completed.
Last Trust board IPC paper. Sub-Group Upward / Escalation Report	How do Board actually see IPC BAF and Hygiene Code detail as very superficial information within this document. Particularly where there are significant overdue gaps.Answer -These will be presented in full 6 monthly and are available in the Board 'Reading Room'papers.
Latest IPC Annual Report	Document updated in a timely manor: • ADVISE recommend sign off by Board, not single Director. Has this document been to the Board. • Hygiene Code gap analysis does not match main document for Criterion 1 (Amber/Green). ADVISE all versions to be the same. • ADVISE demonstrate how learning is shared across clinical areas. • The deep cleaning team has been expanded in response to COVID-19 and provides cover 24 hours per day. A business case has been prepared – ADVISE what are the timescales. • ADVISE demonstrate what actions have been put in place to improve mandatory training and outcome. • An Estates, Facilities and Decontamination Lead Nurse post was advertised in March 2021 and will be appointed to in early 2021-2022? ADVISE clearly demonstrate where this appointment is at. • Daily audits are undertaken in all wards and departments to ensure compliance with PPE, social distancing, environmental cleaning, hand hygiene, ventilation and the wearing of masks by patients – how do these link to the other main audits undertaken.

	COVID-19 ADVISE to include how you followed the PHE COVID-19 outbreak process and reference in list at the end. ADVISE to include a section on COVID-19 mortality review and serious incident reports and what you are doing with the data.
Team objectives 2021/22	Clear concise team objectives for 20/21 No actual HCAI plan/ IPC Annual work plan/ audit plan is in development.
C. diff RCAs - trends/ themes identified and organisational learning evidence. 2 RCAs Received and 5 posters from the learning.	Good clear posters developed and shared across the organisation with findings from RCA documented with them. The RCAs where not final or fully complete: trust will forward once completed.
Decontamination/Ventilation/Water Information for NHSE/I - July 2021	• No AP or Competent Person for Decontamination or Ventilation. • No Ventilation report to IPCG for 3 months. • Ventilation is also a control within the COVID-19 Hierarchy of Controls. ADVISE this requires immediate actioning. • ADVISE both these items require going onto the risk register to ensure the Board is sited if not already identified as a risk – Confirmed • No reports or minutes received.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*7 September 2021*
Item Number	*Item 9.1*
Assurance and Risk Report from the Interim Director of People and Organisational Development	
Accountable Director	*Jacqui Grice, Interim Director of People and OD*
Presented by	*Jacqui Grice, Interim Director of People and OD*
Author(s)	*Jacqui Grice, Interim Director of People and OD*
Report previously considered at	*None*

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

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

Recommendations/ Decision Required	• *To note the update from the Interim Director of People and OD.*

Executive Summary

This update report is being provided in place of a report from the People and OD Committee, which did not meet in August 2021 due to changes in the Executive and Non-Executive leadership.

System Recruitment of Health Care Support Workers (HCSWs)

The Lincolnshire NHS Talent Academy has undertaken to support the recruitment of circa 150 HCSWs on behalf of the system. LPFT are looking for 36 and the remaining will be for ULHT.

The timeframe is ambitious, as to meet NHSE/I expectations outlined in their funding support package, the individuals will need to be in post by 22 November.

We have received £76K from NHSE/I to support set up costs, guidance and mentoring.

Turnover in this area has historically been high and the feedback is that previous recruits felt mentally unprepared for their roles. To combat this we will be changing the on-boarding processes to include aspects of our Admin talent pool processes and nursing cadet programme so that recruits have a better understanding of the expectations of the role. Other Trusts faced with these issues have ensured that patients and staff working in those roles are closely involved in the recruitment and selection processes, so that they can ensure the role requirements are understood and that applicants demonstrate the aptitude and values required.

Locum and Agency Usage

At NHSE/I Workforce Director level, there is now an increased focus on agency and locum usage and rates. Steve Morrison, regional Director of Workforce and OD has asked Trusts to participate in a short piece of work to look at methods of driving down usage and rates and to share data that will contribute toward this. We will look to see how we can participate and add value in this exercise.

Winter Flu and Covid Vaccination Programme

The Trust has ready a robust flu and COVID booster vaccination plan but is unable to move forward any further until the Government /JCVI makes crucial decisions on when and how they want the COVID booster programme rolled out.

System Workforce Issues raised by ULHT

Critical workforce shortages, risks & mitigations

- Inpatient ward staffing – use of bank staff; PCR and LFT testing and DON sign off to bring back isolating staff safely; skill mixing; managers redeployed back to the floor; redeployment of corporate staff to either clinical or admin roles within these areas to free up clinical time. Continue with rapid recruitment plans; International Recruitment (IR) nurses and induction of Newly Qualified Nurses employed as B4 whilst awaiting PIN;

continuation of HCSW roll out. Offering appropriate banding of roles for bank shifts. (B5/6)

Top 3 areas of concerns and mitigations

- Staff fatigue –encouraging staff to take annual leave/honouring this – with the mitigations of skill mixing, redeployment of staff where possible and the continuation of rapid recruitment plans
- A need to look at Trust wide workforce planning as a priority and ensure it supports the transformation agenda. The People and OD team are sighted on this and resourcing can now be scoped.
- The workforce is fatigued due to COVID pressures. We are seeing a huge uptake on in-house wellbeing support. The increased wellbeing offer is welcomed and additional areas will be scoped for autumn/winter

Top 3 positives

- Increased proactive engagement of the ULHT Wellbeing offer
- Launch of the wellbeing ally network in July, with clear expectations and training to support the individual in the role
- 120+ of our managers and wellbeing allies have been trained on Wellbeing Conversations – programme has been very well received

Report to:	Trust Board
Title of report:	Finance, Performance and Estates Committee Assurance Report to Board
Date of meeting:	26 August 2021
Chairperson:	David Woodward, Non-Executive Director
Author:	Karen Willey, Deputy Trust Secretary

Purpose	This report summarises the assurances received, and key decisions made by the Finance, Performance and Estates Committee (FPEC). The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board's response. This assurance committee meets monthly and takes scheduled reports from all Trust operational groups according to an established work programme. The Committee worked to the 2021/22 objectives. The Trust are responding to the third wave of Covid-19 and as such the meeting was held via Microsoft Teams with a reduced agenda and attendance to focus on key priorities. The Committee were mindful of the pressures being faced by the Trust.
Assurances received by the Committee	**Lack of Assurance** in respect of SO 3a A modern, clean and fit for purpose environment **Estates Statutory Compliance Report inc H&S Committee upward report** The Committee received the report alongside the NHS England/Improvement letter received in relation to the recent Infection Prevention and Control visit. The Committee noted the positive outcome of the visit however acknowledged a number of estates issues that required action to be taken. The Committee were advised that a number of immediate mitigating actions had been taken and remaining actions would be incorporated in to a plan and presented back to the Committee in September. The Committee noted the extensive work that would be required in relation to ventilation noting that this would result in a review of the capital plan in order to deliver the required improvements. The Committee noted the content of the report and the improvements that were being seen requesting that RAG ratings were provided against actions and dates for delivery. The Committee sought assurance on the staffing concerns within the directorate noting that consideration was being given to the future of

	the team to ensure there were development opportunities for skill sets and quality across the team. The Committee noted the content of the Health and Safety Committee upward report that had been offered through the Estates report. The Committee noted an increase in security incidents and were assured that this was as a result of engagement from the Local Security Management Specialist. The Committee noted the Ionising Radiation (Medical Exposure) Regulations visit with a report due to be presented to the private Board. **Emergency Planning Group Upward report** The Committee received the report from the group noting the content
	Assurance in respect of SO 3b Efficient Use of Resources **Finance Report** The Committee received the report noting the content and the continued challenge with nursing expenditure and agency use. The Committee noted the work being undertaken to support the medical position that was seeing an impact and downward trend over time and work continued to support a reduction in the nursing position. It was noted that there was a current issue with staff sickness causing gaps in staffing however this was also being driven by unavailability of agency staff. The Committee were advised of the intake of newly qualified and supernumerary staff which would have an impact on the position in September. The Committee noted that there had been no indication of financial support for the third wave of Covid-19 with the expectation that the Trust delivered within the given envelope. The 2nd half of the year would follow that of the first with planning submissions due to be submitted in November. Delivery of cost improvement plans (CIP) and successfully achieving the elective recovery fund were a concern adding pressure to the financial position. The Committee would be interested in the development of the CIP to ensure this can be a focus once pressures reduce. In order to fully understand the position the Committee had requested the bridge position to be detailed in order to offer assurance to the Board. The Committee noted the significant improvement in the likely H1 outturn due to system agreement on the allocation of ERF funding and the identification of a number of transactional CIP's. Assurance was received that the outturn is now expected to only be slightly behind the forecast position.

	The Committee noted the communications being held with System Partners in relation to the financial position of the Trust, the position would be finalised by the end of September. **Capital, Revenue and Investment Group Upward report** The Committee received and noted the report from the group. **Capital update** The Committee received the report noting that whilst there was a plan to spend the capital for the year there was not plan in place between July and the end of the financial year on the practical achievement of this. It was noted that the plan that had been in place was redundant due to the number of changes that had been made however work was underway to bring a full phased report including the balance for the year to the September Committee. The plan would be impacted by the market and availability of materials and workforce. The Committee would continue to receive a separate capital report in order to maintain assurance on delivery with an expectation that a 5 year view would be provided in October to detail the £200m capital position. **Costing update** The Committee received the report noting the content and delegated authority in place for the Director of Finance and Digital to approve submissions.
	Assurance in respect of SO 3c Enhanced data and digital capability **No items received**
	Assurance in respect of other areas: **Committee Performance Dashboard** The Committee received the report for information noting that a review between the Committee Chair and Director of Finance and Digital would be undertaken to ensure the reporting position was clear. The Committee noted the capital ambition to spend £39m however £35m had been planned. There was a plan to achieve £200m of capital spend over 5 years. The Committee noted that the biggest pressure being faced by the Trust is respect of wave 3 Covid-19 was staff absence. There was also an expectation that there would be higher levels of influenza and norovirus over the winter which would also affect staffing levels. **Integrated Improvement Plan**

	The Committee received the report for information noting that actions requested by the Committee in July would be reflected in the September report. **Operational Performance against National Standards – Urgent Care** The Committee received the report noting the content and exploring the 12 hour trolley waits and waits within the emergency department. The Committee noted that there were a series of actions in place to support the position however the complexity of the offer outside of hospitals impacted on the waits. The Committee were advised that work was due to take place with the System Improvement Director and Flow Director to develop a longer term strategy for improvement. The outcome of the work would be presented to the Committee in due course. **Planned Care inc Breast Spot Light** The Committee received the report noting in particular the Breast Service Cancer Performance update and the efforts that had been placed in to the service to deliver the outcomes shown. The Committee noted that the actions put in place had resulted in the Trust being ahead of trajectory in respect of the backlog recovery with a backlog of 22 against a 37 patient trajectory. It was noted that there may be a risk of volume increases that could affect the achievement of the clearance of the backlog position and maintenance of the position.
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 received the risk register noting the risks presented and the areas that required update. The Committee noted the continued development of the reconfiguration
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	S	O	N	D	J	F	M	A	M	J	J	A
Gill Ponder, Non-Exec Director	X	X	X	X	X	X	X	X				
David Woodward, Non-Exec Director									O	X	X	X
Geoff Hayward, Non-Exec Director	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	X	X	C	C	X	X	D	X	X	X	X	X
Director of Improvement & Integration	A	X	C	C	C	C	X	X	X	X	X	A

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

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*Tuesday 7 September 2021*
Item Number	*Item number allocated by admin*
Challenges facing nuclear medicine services within ULHT hospitals	
Accountable Director	*Simon Evans, Chief Operating Officer*
Presented by	*Simon Evans, Chief Operating Officer*
Author(s)	*Laura White, Head of Nuclear Medicine*
Report previously considered at	*X*

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

Risk Assessment	
Financial Impact Assessment	
Quality Impact Assessment	*Completed*
Equality Impact Assessment	*Completed*
Assurance Level Assessment	*Insert assurance level* • *Significant* • *Moderate* • *Limited* • *None*

Recommendations/ Decision Required	• *To note the paper and the issues raised*
	• *To agree that options for the future of the service should be considered*
	• *To note that public engagement will be carried out on any proposed future service change.*

Executive Summary

What is nuclear medicine?

Nuclear medicine is a specialist imaging technique involving the administration of radioactive substances (called radiopharmaceuticals) in the diagnosis and treatment of disease. The technique enables assessment of the function of organs, whereas most conventional imaging modalities (e.g. X-ray) look at anatomy.

The majority of radiopharmaceuticals are made daily in an aseptic facility known as a radiopharmacy. The radiopharmaceutical used is dependent on the part of the body that is being investigated. The most common tests performed in ULHT are bone scans and heart scans. There are over 20 different tests that nuclear medicine can perform and they look at conditions as diverse as Parkinson's disease and delayed gastric emptying. The cost of these radiopharmaceuticals vary greatly from less than £1 to over £750 per patient.

After administration of the radiopharmaceutical, patients must wait for a time for the radiopharmaceutical to distribute in their bodies before they are imaged on a specialist camera called a gamma camera. This camera detects the radiation emitted from the patient to enable the organ of interest to be investigated. A gamma camera is similar in size to a CT scanner.

Due to the fact nuclear medicine involves radiation, the technique is highly regulated and all staff have undergone extensive specialist training. This is to ensure the risk to the patient from the radiation is outweighed by the benefits of having the procedure. In addition a clinician is required to oversee the service and hold an ARSAC (Administration of radioactive substances advisory committee) licence (Practitioner Licence). This licence lists the different diagnostic tests that can be performed under the Practitioner. Only tests that the clinician has proven training and experience in are listed on this licence to ensure the test is diagnostic and the impact on the patient management is optimised. Each site also has an ARSAC licence which required a Medical Physics Expert (MPE) to oversee the service at that site (site licence), this also lists the tests that can be performed at that site.

Background to the nuclear medicine service at ULHT

Nuclear medicine services are provided at Grantham and District Hospital, Lincoln County Hospital and Pilgrim Hospital, Boston. The imaging is performed at all three sites, using five gamma cameras, with a new £1 million radiopharmacy having recently been opened at Lincoln County Hospital. This radiopharmacy provides radiopharmaceuticals for Grantham and Pilgrim hospitals, which are transported there on a daily basis.

The tables below show the current configuration of the nuclear medicine service in ULHT and the number of studies that are performed:

Current configuration of the service			
Sites	**Lincoln**	**Grantham**	**Pilgrim**
Number of gamma cameras	2	1	2
Age of cameras (years)	10,12	16	11,11

Annual Number of patients (2019-2020)*	1771	680	792
Annual number of studies*	2114	886	955
Radiopharmacy on site (needed daily to produce drugs for the scan)	Yes (installed 2019)	No (from LCH)	No (from LCH)

* N.B. Patient numbers are different to number of studies as some tests require 2 visits

The below tables show staffing and the geographical demand on the service:

Base of Current Staffing (Whole time equivalents WTE)			
Sites	**Lincoln**	**Grantham**	**Pilgrim**
Technologists	5.65	1.6	2.8
Clinical Scientists Provide support for the 3 sites.	2.8 (1.0 Medical Physics expert)	0	0
Clinical imaging assistants	1.8 (also helps admin)+ 1 apprentice	1 currently vacant	0
Nurses	2.0	0	1.0
Admin	0.8	0	1.06
Total	**14.05**	**2.6**	**4.86**

Geographical patient demand for nuclear medicine				
Postcode	**LN**	**NG**	**PH**	**Other**
Patients	1540	685	894	124
Percentage (%)	47	21	28	4

Challenges faced by nuclear medicine nationally

Due to the fact the nuclear medicine is a very specialist service, there are a number of challenges it faces nationally in particular with workforce. The following table shows some of these challenges.

National challenges	
Challenge	**Any mitigations**
Shortage of trained Clinical Technologists since the end of the National training program (on Governmental Migration Advisor list).	Apprentice scheme, but this requires individual departments finding the wage for the trainee. Each apprentice course is 3 years long.
Shortage of ARSAC Practitioners in addition to a national shortage of radiologists	None, in fact it is getting harder to get these licences.
Shortage of trained Medical Physics Experts. (takes approximately 10 years to become a consultant Clinical Scientist)*	None
Aged equipment with a requirement to replace 211 gamma cameras nationally in the next 5 years**	None

Problems with supply of radiopharmaceuticals and isotopes	Companies supplying the material have altered their process of delivery with additional cost to the company.

(*British Nuclear Medicine Society (BNMS) Scientific Support for Nuclear Medicine guidance 2016)
(** Diagnostics: Recovery and Renewal paper Oct 2020 NHSE)

Challenges faced by the nuclear medicine service in Lincolnshire
When we look at the service in ULHT the challenges for the service mirror those seen nationally:

Shortage of technologists: Lincolnshire has struggled to recruit and retain clinical technologists over the last five years, as can be seen in the table below. This has been further impacted by the national training service for nuclear medicine clinical technologists ceasing, meaning there is now a national shortage of trained specialists in the country. Attempts to recruit abroad have been protracted (taking over a year) and unsuccessful in a couple of instances.

To ensure continuity of the service we have taken the decision to convert one of the full time posts to an apprentice post. A big problem with poor retention is that senior staff spend a long time training staff and then they leave. The process then must be started again with the new staff member, meaning senior staff cannot focus on developing services and bringing new techniques to the region. This is a particularly big problem in Grantham and Pilgrim as there are fewer staff to undertake the training of technologists to ensure they are proficient in all the required scanning and tasks required in each department. It would typically take 6-12 months to sign somebody off to be an independent operator who is able to perform all the required duties.

Sites	LCH	GDH	PHB
Technologists posts (WTE).	5.65*	2.6**	2.8
Number of staff that have left in the last 5 years.	3	4	3
Long standing staff >10 years	3	1.53	1
<5 years of retirement (60 years)	1	1	1

**runs the radiopharmacy (2 tech staff daily) and the imaging of the service.*
*** 1 of these posts converted to an apprentice to try to train our technologist.*

Shortage of ARSAC Practitioners: Lincolnshire have 2 part time radiologists who hold an ARSAC licence (full list of all tests performed in ULHT) and 1 full time radiologist with a licence (limited list of tests permitted). Due to the fact that one of the radiologists doesn't have a full licence, to access some tests patients must travel to a different site to their local hospital. To get a full range of tests an ARSAC licence involves a lot of additional training. To get a test added to your site and practitioner licence required staff to be involved in all parts of the process at a site where they are being performed and also ensure that the site has the relevant permits to dispose of the products.

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Impact of other services: The development of the new Emergency Department at Pilgrim hospital will require the redevelopment of the building that currently houses the nuclear medicine department, and a new area will need to be identified and developed for the nuclear medicine service.

Case for change

Given the challenges faced by the Lincolnshire nuclear medicine service, it is important that we consider changing how we deliver the service to secure it for the patients of ULHT for the foreseeable future. The current situation in ULHT is that the staff and services are spread thinly, meaning that even low levels of staff absence impacts on the amount of work the service can perform. The service normally books the patients based on the staff due to work on a set day. There is no spare capacity in the service so if a staff member is ill this normally requires a camera load of patients to be cancelled,- typically between 4 and 10 patients depending on the test being performed on that day.

Delivering the service across three sites means that some staff do not get experience of the variety of studies/techniques performed in the region (as not all the sites have a licence to perform all the tests/treatments). Obtaining this licence is not straight forward. Attempts to move staff around the region to allow them to perform a variety of tests has been problematic due to transport issues.

Currently the junior staff at the smaller sites do not have much peer support which means there is less opportunity for them to be involved in development and to raise suggestions for improvements of the service and also more experience of audit and projects.

The lack of Medical Physics Experts (MPE) within the region means that optimisation of the service and the ability to introduce new services into the county

is limited, as they must repeat work on three sites. This also impacts on the amount of audit and governance that can be performed.
The fact that all the gamma cameras in Lincolnshire are over 10 years old means they are more prone to be unreliable and require repair, impacting on cancellation of patient studies and a potential waste of radiopharmaceuticals. Due to the fact all these pieces of equipment are old the replacement parts and expert engineers are getting harder to obtain and two of the five systems have been served/due to be served end of life notices, meaning if they break repairs may not be possible. This means the services provided become vulnerable with potential long downtimes of some of the cameras.

At present, the utilisation of the equipment is not optimised. The British Nuclear Medicine Society (BNMS) guidance is that it would be appropriate to perform approximately 1500 scans on each gamma camera. This means that, according to our level of demand, Lincolnshire should have three gamma cameras, whereas there are currently five.

Conclusion

The above illustrates that the challenges faced by the Lincolnshire nuclear medicine service are the same as those seen nationally. These include a shortage of skilled workers and the removal of most of the specialist training programmes, resulting in an aging workforce with a poor succession plans. This means the department must look to train staff internally, which in itself poses a challenge.

In additional to an aging workforce, the equipment is aged and not properly utilised. National guidance recommends the nuclear medicine workload within the county requires three gamma cameras, whereas the Trust currently has five. This puts added pressure on the medical physics experts, the establishment of which is underfunded according to European recommendations. Their role is to ensure the service is safe and responsive to new technologies.

The service cannot continue to guarantee a well-led service that provides the most up to date diagnostic procedures to patients if it continues to run on three sites, and we seek agreement for reviewing the service delivery model to ensure it continues to provide a sustainable service to the people of Lincolnshire.

Challenges facing nuclear medicine services within ULHT hospitals

What is nuclear medicine?

Nuclear medicine is a specialist imaging technique involving the administration of radioactive substances (called radiopharmaceuticals) in the diagnosis and treatment of disease. The technique enables assessment of the function of organs, whereas most conventional imaging modalities (e.g. X-ray) look at anatomy.

The majority of radiopharmaceuticals are made daily in an aseptic facility known as a radiopharmacy. The radiopharmaceutical used is dependent on the part of the body that is being investigated. The most common tests performed in ULHT are bone scans and heart scans. There are over 20 different tests that nuclear medicine can perform and they look at conditions as diverse as Parkinson's disease and delayed gastric emptying. The cost of these radiopharmaceuticals vary greatly from less than £1 to over £750 per patient.

After administration of the radiopharmaceutical, patients must wait for a time for the radiopharmaceutical to distribute in their bodies before they are imaged on a specialist camera called a gamma camera. This camera detects the radiation emitted from the patient to enable the organ of interest to be investigated. A gamma camera is similar in size to a CT scanner.

Due to the fact nuclear medicine involves radiation, the technique is highly regulated and all staff have undergone extensive specialist training. This is to ensure the risk to the patient from the radiation is outweighed by the benefits of having the procedure. In addition a clinician is required to oversee the service and hold an ARSAC (Administration of radioactive substances advisory committee) licence (Practitioner Licence). This licence lists the different diagnostic tests that can be performed under the Practitioner. Only tests that the clinician has proven training and experience in are listed on this licence to ensure the test is diagnostic and the impact on the patient management is optimised. Each site also has an ARSAC licence which required a Medical Physics Expert (MPE) to oversee the service at that site (site licence), this also lists the tests that can be performed at that site.

Background to the nuclear medicine service at ULHT

Nuclear medicine services are provided at Grantham and District Hospital, Lincoln County Hospital and Pilgrim Hospital, Boston. The imaging is performed at all three sites, using five

gamma cameras, with a new £1 million radiopharmacy having recently been opened at Lincoln County Hospital. This radiopharmacy provides radiopharmaceuticals for Grantham and Pilgrim hospitals, which are transported there on a daily basis.

The tables below show the current configuration of the nuclear medicine service in ULHT and the number of studies that are performed:

Current configuration of the service			
Sites	**Lincoln**	**Grantham**	**Pilgrim**
Number of gamma cameras	2	1	2
Age of cameras (years)	10,12	16	11,11
Annual Number of patients (2019-2020)*	1771	680	792
Annual number of studies*	2114	886	955
Radiopharmacy on site (needed daily to produce drugs for the scan)	Yes (installed 2019)	No (from LCH)	No (from LCH)

* N.B. Patient numbers are different to number of studies as some tests require 2 visits

The below tables show staffing and the geographical demand on the service:

Base of Current Staffing (Whole time equivalents WTE)			
Sites	**Lincoln**	**Grantham**	**Pilgrim**
Technologists	5.65	1.6	2.8
Clinical Scientists Provide support for the 3 sites.	2.8 (1.0 Medical Physics expert)	0	0
Clinical imaging assistants	1.8 (also helps admin)+ 1 apprentice	1 currently vacant	0
Nurses	2.0	0	1.0
Admin	0.8	0	1.06
Total	**14.05**	**2.6**	**4.86**

Geographical patient demand for nuclear medicine				
Postcode	**LN**	**NG**	**PH**	**Other**
Patients	1540	685	894	124
Percentage (%)	47	21	28	4

Challenges faced by nuclear medicine nationally

Due to the fact the nuclear medicine is a very specialist service, there are a number of challenges it faces nationally in particular with workforce. The following table shows some of these challenges.

National challenges	
Challenge	**Any mitigations**
Shortage of trained Clinical Technologists since the end of the National training program (on Governmental Migration Advisor list).	Apprentice scheme, but this requires individual departments finding the wage for the trainee. Each apprentice course is 3 years long.
Shortage of ARSAC Practitioners in addition to a national shortage of radiologists	None, in fact it is getting harder to get these licences.
Shortage of trained Medical Physics Experts. (takes approximately 10 years to become a consultant Clinical Scientist)*	None
Aged equipment with a requirement to replace 211 gamma cameras nationally in the next 5 years**	None
Problems with supply of radiopharmaceuticals and isotopes	Companies supplying the material have altered their process of delivery with additional cost to the company.

(*British Nuclear Medicine Society (BNMS) Scientific Support for Nuclear Medicine guidance 2016)

(** Diagnostics: Recovery and Renewal paper Oct 2020 NHSE)

Challenges faced by the nuclear medicine service in Lincolnshire

When we look at the service in ULHT the challenges for the service mirror those seen nationally:

Shortage of technologists: Lincolnshire has struggled to recruit and retain clinical technologists over the last five years, as can be seen in the table below. This has been further impacted by the national training service for nuclear medicine clinical technologists ceasing, meaning there is now a national shortage of trained specialists in the country. Attempts to

recruit abroad have been protracted (taking over a year) and unsuccessful in a couple of instances.

To ensure continuity of the service we have taken the decision to convert one of the full time posts to an apprentice post. A big problem with poor retention is that senior staff spend a long time training staff and then they leave. The process then must be started again with the new staff member, meaning senior staff cannot focus on developing services and bringing new techniques to the region. This is a particularly big problem in Grantham and Pilgrim as there are fewer staff to undertake the training of technologists to ensure they are proficient in all the required scanning and tasks required in each department. It would typically take 6-12 months to sign somebody off to be an independent operator who is able to perform all the required duties.

Sites	LCH	GDH	PHB
Technologists posts (WTE).	5.65*	2.6**	2.8
Number of staff that have left in the last 5 years.	3	4	3
Long standing staff >10 years	3	1.53	1
<5 years of retirement (60 years)	1	1	1

**runs the radiopharmacy (2 tech staff daily) and the imaging of the service.*

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for reviewing the service delivery model to ensure it continues to provide a sustainable service to the people of Lincolnshire.

Meeting	Trust Board
Date of Meeting	7th September 2021
Item Number	
Integrated Performance Report for July 2021	
Accountable Director	Paul Matthew, Director of Finance & Digital
Presented by	Paul Matthew, Director of Finance & Digital
Author(s)	Sharon Parker, Performance Manager
Report previously considered at	N/A

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

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

Recommendations/ Decision Required	• *The Board is asked to note the current performance and associated actions/escalations where appropriate*

Executive Summary

Quality

MRSA Bacteraemia

There was one reported MRSA bacteraemia for July 2021, however, it has been reported as a contaminant. The blood culture was obtained by an agency nurse and the Trust is investigating agency staff competency.

Pressure Ulcers Unstageable

There were 48 (target of 28.3 month) category 2 and 6 (target of 4.4 a month) unstageable pressure ulcers in July 2021. Pilgrim have reported a higher number than Lincoln in July. There are a number of improvements identified to help reduce the number of pressure ulcers across the Trust.

Never Events

There was 1 new Never Event in July 2021, NG Tube was inserted for nutrition in line with Trust policy, however, NG tube later found to be incorrectly placed.

Mortality

HSMR

The Trust is currently at 114.30 against target of 100. The Trust's HSMR has increased during the COVID-19 pandemic. Any diagnosis group alerting is subject to a case note review. NHSE/I have completed an online workshop on mortality and documentation of which 90 staff from ULHT attended.

SHMI

The Trust is currently at 112.55 against target of 100. SHMI has increased during the COVID-19 pandemic. The Trust are currently in discussion with the system partners in rolling out the ME service for community deaths and learning can be generated for deaths within 30 days.

Participation in National Clinical Audits

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

eDD

The Trust achieved 88.7% with sending eDDs within 24 hours for July 2021 against a target of 95%. 6.2% of eDDs were not sent at all during the month of July 2021. eDD compliance has deteriorated from 92.3% in June 2021. Paediatric eDD template being streamlined to aid completion and improve compliance.

Sepsis A&E paediatric

Screening compliance was 86.7% in July which is below the 90% target. Administration of IVAB was 87.5% in July, 7 out of 8 children received antibiotics within 1 hour. Weekly meetings with A&E to discuss compliance and share learning.

Duty of Candour (DoC)

Verbal compliance for July was 54% against a 100% target. Written compliance for July was 28% against a 100% target. DoC training being sourced from external provider.

Operational Performance

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

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

The Covid-19 2nd wave impacted significantly against the Trusts plans, posing challenges across both non-elective and elective pathways, including cancer, and resulting in the intermittent pausing of the green pathways at both Lincoln and Pilgrim hospitals. Grantham has now been restored to its original function and purpose.

The Covid 3rd wave has seen less demand in terms of hospitalisation with numbers of inpatients ranging from 35 to 60. At the time of writing this executive summary, the Trust has 60 positive inpatients, of which 6 patients are requiring Intensive Care interventions. The main impact of the 3rd wave is the significant impact on staff absences due to the increased prevalence of positive cases within our population. Lincolnshire has the highest sickness rates in the Midlands. Of the 5 districts being monitored nationally for daily increases of confirmed positive cases, Lincolnshire have 3. This has impacted on the delivery of both urgent and planned care pathways.

This report covers July's performance, and it should be noted that as the demands of Wave 3 have increased, the Trust has now moved back to a phase of manage but respects and acknowledges the absolute need to combine the recovery and 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. Also to note is the planned care data is at end of June but the executive summary provides a July position on some metrics.

A & E and Ambulance Performance

Whilst the summary to below pertains to July data and performance, the proposed new Urgent Care Constitutional Standards have now been adopted to run in shadow form and performance against these will be described in the 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 July deteriorated against June's performance of 70.74% being reported at 64.93%. This is the ninth time in twelve months the Trust's performance has been below the agreed trajectory.

There was 9 12 hr trolley wait, reported via the agreed process. Sub-optimal discharges to meet the known emergency demand was established as the main route cause.

Performance against the 15 min triage target in July demonstrated a deterioration of 4.61% compared with June. 83.62% in July verses 88.23% in June

Ambulance conveyances for July were, 4669, down by 0.35% against June. There were 568 >59minute handover delays recorded in July, a deterioration of 219 from June. Delays experienced at LCH and PHB are attributed to volume and conveyance pattern. A reduction of >180mins has been demonstrated.

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.

July demonstrated a slight decrease in performance. July demonstrated a decreased performance of 0.14% to 61.49%. The Trust reported 787 incomplete 52-week breaches for June end of month, (an improvement of 244) down from 1,033. 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 June and July 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 July to 51,649 (as of 4th August). 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 3rd August ASI numbers have reduced from circa 10,300 to only 369 and remains ahead of trajectory.

The Trust reported 4,532 over 40week waits as at 4th August; an increase of 1,233 from the previous reporting period. The numbers of patients waiting over 26 weeks has increased to a total of 13,238. 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 July 74 compared to 120 in June. CT activity has increased by 1,500 since June.

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

Physiological Sciences.
Neurophysiology - peripheral neurophysiology LCH is reporting 28 for July compared to 37 last month. Waiting lists are monitored weekly

Endoscopy
Cystoscopy carried out within endoscopy had 1 breach in July, compared to 7 breaches last month.
Colonoscopy had 80 breaches in July compared to 193 last month. These are the planned surveillance patients. All live patients are being carried out within 41 days.

Cardiology
Echocardiography had 4271 breaches for July, compared to 3695 last month.
Echocardiography Stress /TOES had 31 breaches in July, the same as reported for June

Without the cardiology breaches, DMO1 would have been recovered to pre-covid level.

Cancer

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

73% 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 – 232 as of 12th August 2021 verses 218 on 8th July 2021.

June 62 day performance: Head & Neck 46.2%, Breast = 51.6%, Colorectal = 33.3%, Upper GI = 32.0%.

Workforce

Mandatory Training - The trend for completion of mandatory training remains strong, but the current wave of covid has made it difficult for those who deliver core training to be available. Redeployment to cover absences and service pressures have meant that we have been unable to deliver all training. Actions taken have been to move admin staff to cover core learning tasks in order to support redeployment and we expect levels to increase as the covid infection rates decrease. 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 HR staff are 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. HR have been carrying out return to work interviews to support the front line and sickness levels in August have begun to decrease rapidly.

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. During the final 2 quarters of the year. We will be looking at team appraisals and other ways of reducing the administration burden whilst still holding quality conversations with staff.

Agency Spend – The trend on agency spend remains worrying both in downwards, but there will need to be a step change in spend levels across all professions. The interim Director of People has met with Medicine to agree a focus on workforce planning and rotas in order to better understand their workforce need and stop the last minute, expensive spend on agency locums. Stronger governance and planning will be put in place and once the model has been proven to work it will be rolled out to other divisions.

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 £0.5m surplus for the month of July (in line with plan) and a £0.6m deficit year to date (in line with plan).

The capital programme for 2021/22 currently stands at £33.7m for the full year; actual capital expenditure of £4.0m has been incurred YTD against a submitted plan YTD of £9.2m.

The month end cash balance is £47.7m which is a decrease of £6.3m against cash at 31 March 2021.

Paul Matthew
Director of Finance & Digital
August 2021

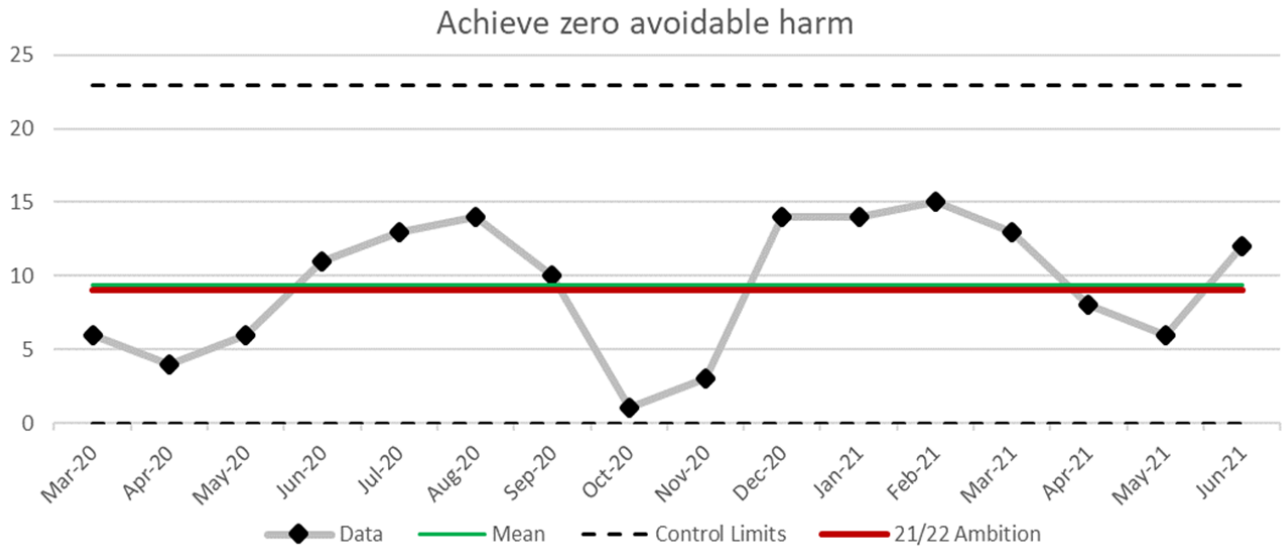
Statistical Process Control Charts

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

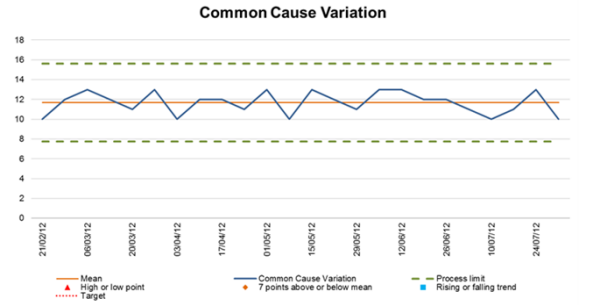
Normal variations in performance across time can occur randomly- without a direct cause, and should not be treated as a concern, or a sign of improvement, and is unlikely to require investigation unless one of the patterns defined below applies.

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

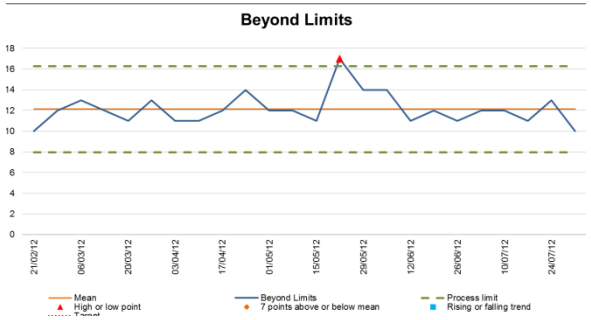
Icons are used throughout this report either complementing or as a substitute for SPC charts. The guidance below describes each icon:

Normal Variation



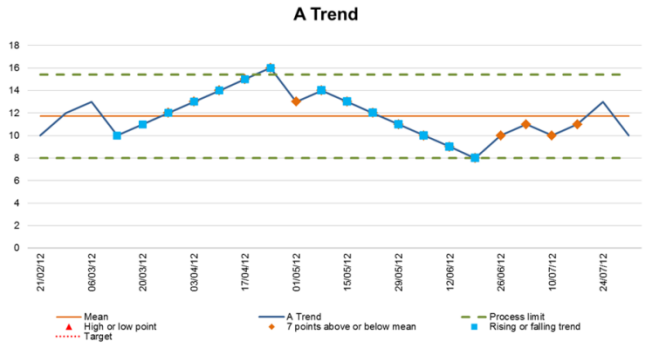
Extreme Values

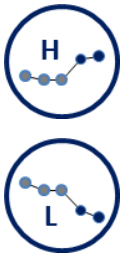
There is no Icon for this scenario.



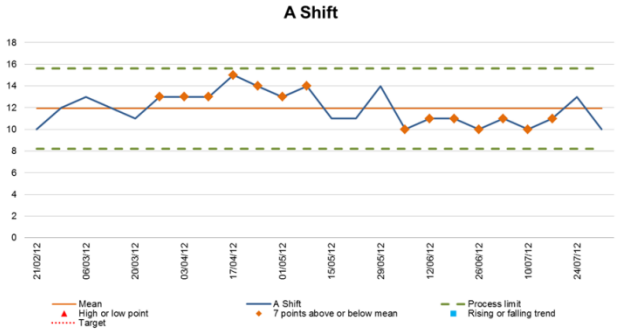
Statistical Process Control Charts

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.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

EXECUTIVE SCORECARD

Strategic Goal	Domain	Measure ID	Measure	Measure Definition	Baseline	21/22 Ambition	£'000	2021/2022 Apr	May	Jun	Jul	Latest month pass/fail to ambition	Trend variation
Strategic Metrics	Patients	1	Top 25% for acute Trusts for 'Overall' Inpatient experience	Results in recommending our services to friends and family	4th quartile	3rd quartile		Q4 (89.945%)	Q4 (91.17%)	Q4 (90.21%)	Q4 (88.57%)		
	Patients	2	Achieve zero avoidable harm	Serious incidents (including Never Events) of harm - Moderate, severe and death.	15	9		8	6	12	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)	Q4 (112.55)		
	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%	63.20%			
	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%	10.03%		
	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%	32.93%		
	Services	9	Deliver a breakeven revenue position	Financial status - Revenue monthly variance to plan		Breakeven		£27.00	-£27.00	£0.00	£0.00		
	Services	10	Deliver £200m capital plan	Financial status - Capital monthly actuals	£15m	£39m	£'000	£732.90	£312.90	£1,592.80	£1,410.50		
Local Projects	Patients	11	No. of medication errors causing harm is <10%	Medication incidents reported as causing harm (low /moderate /severe / death), as a percentage of total medication incidents.	20%	13%		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	164		
	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). Agency - monthly actuals	£44m	£33m (-25%)	£'000	£3,848	£3,718	£3,417	£3,745		
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%	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	54		
	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%	48.39%		
	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	1:1.5	1:1.45	1:1.46		
	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%	53.11%		
	Services	25	Improve CIP performance to a minimum of 4% by 2021/22	Improving the financial performance through proactive monitoring of Cost Improvement Plan (CIP) - monthly variance to plan	1.7%		£'000	-£402.00	-£552.00	-£562.00	£1,573.67		

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.

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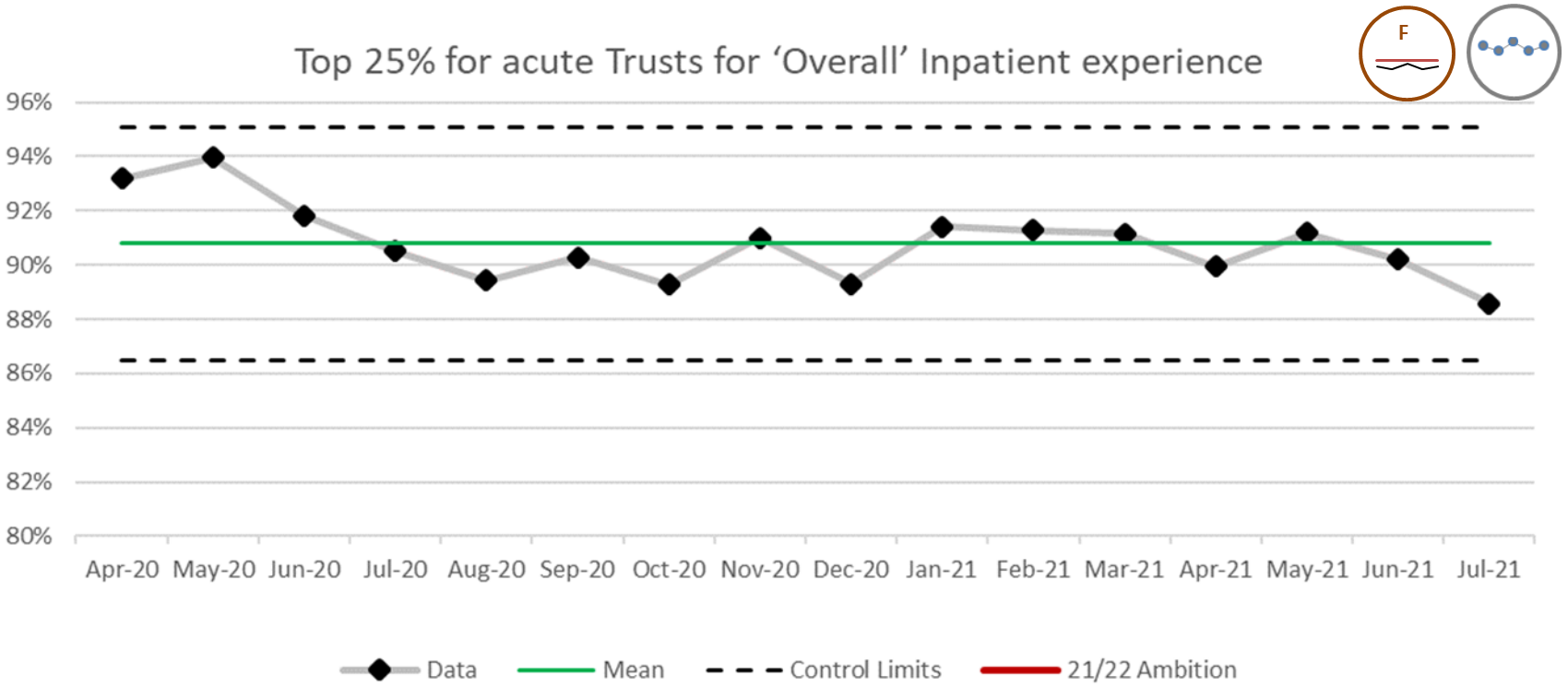
NHS United Lincolnshire Hospitals NHS Trust



Jul-21
4th Quartile 88.57%
Variance Type
Metric is currently experiencing Common Cause Variation
21/22 Ambition
3rd Quartile
Achievement
Metric is consistently failing to ambition
Executive Lead
Director of Nursing

Background:
To be in the top 25% for acute Trusts for 'Overall Inpatient experience'

What the chart tells us:
3 out of the last 7 months have been less than our 90% target for inpatient experience.

Issues:
Core reasons for poor scores are:

- Waiting times
- Appointments
- Discharge experience
- Communication

Actions:

- Waiting times & appointments being addressed through recovery & restoration programme
- Discharge experience – range of actions in place led by the Discharge Cell
- Communication – working group in place addressing telephone calls, keeping relatives informed, communication skills.

Mitigations:
Pandemic into endemic transition continues to impact on some patient services and in patient experiences such as visiting. This transition is fluid given the ongoing 'waves' that result in changes to operational service delivery.

Quality | Operational Performance | Workforce | Finance

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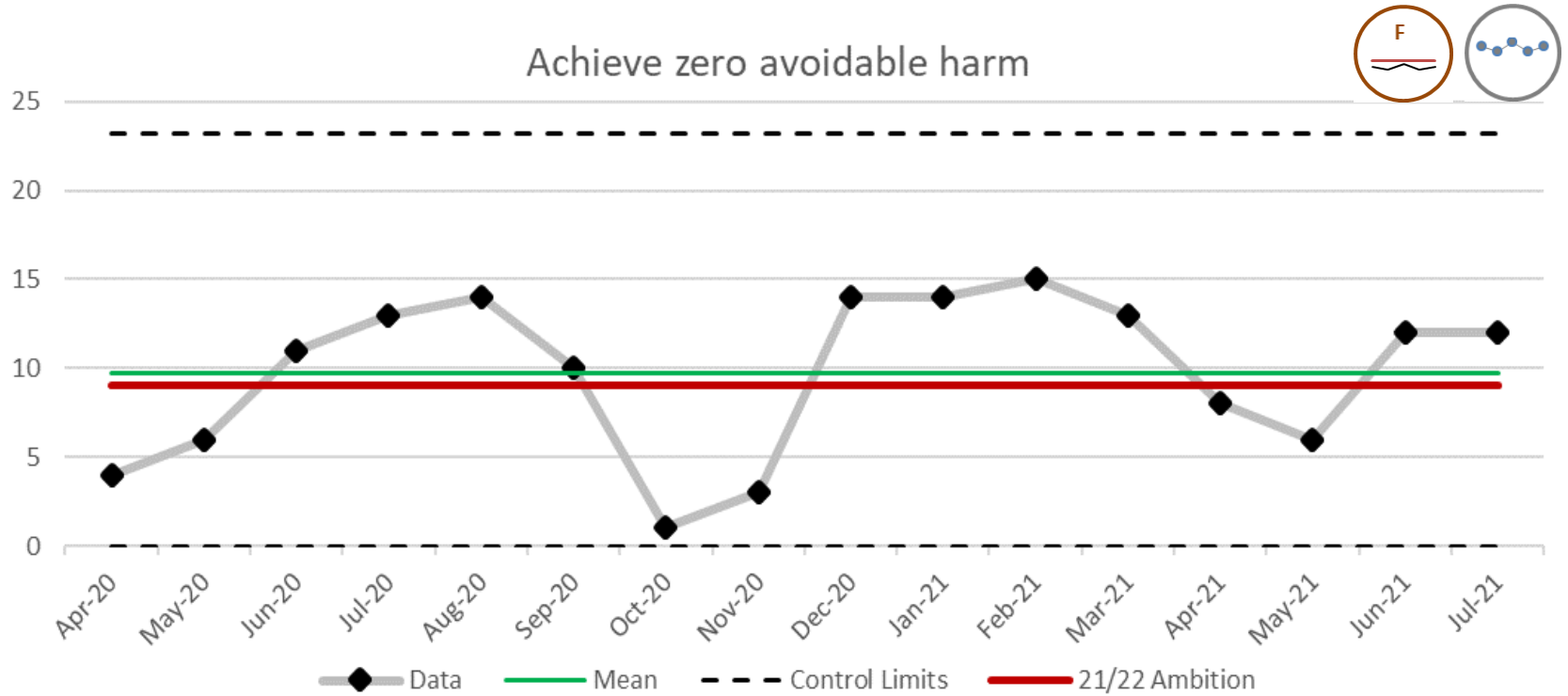
NHS United Lincolnshire Hospitals NHS Trust



Jul-21
12
Variance Type
Metric is currently experiencing Common Cause Variation
21/22 Ambition
9
Achievement
Metric is failing to ambition
Executive Lead
Director of Nursing

Background:
Serious incidents (including Never Events) with harm - Moderate, severe and death.

What the chart tells us:
The number of SIs reported is consistent with the previous month and continues to be above both the mean and the 21/22 ambition.

Issues:
Serious incidents continue to be investigated as per Trust process and learning identified.

Actions:
We continue to ensure that serious incidents are identified and investigated appropriately and learning identified as necessary.

Mitigations:

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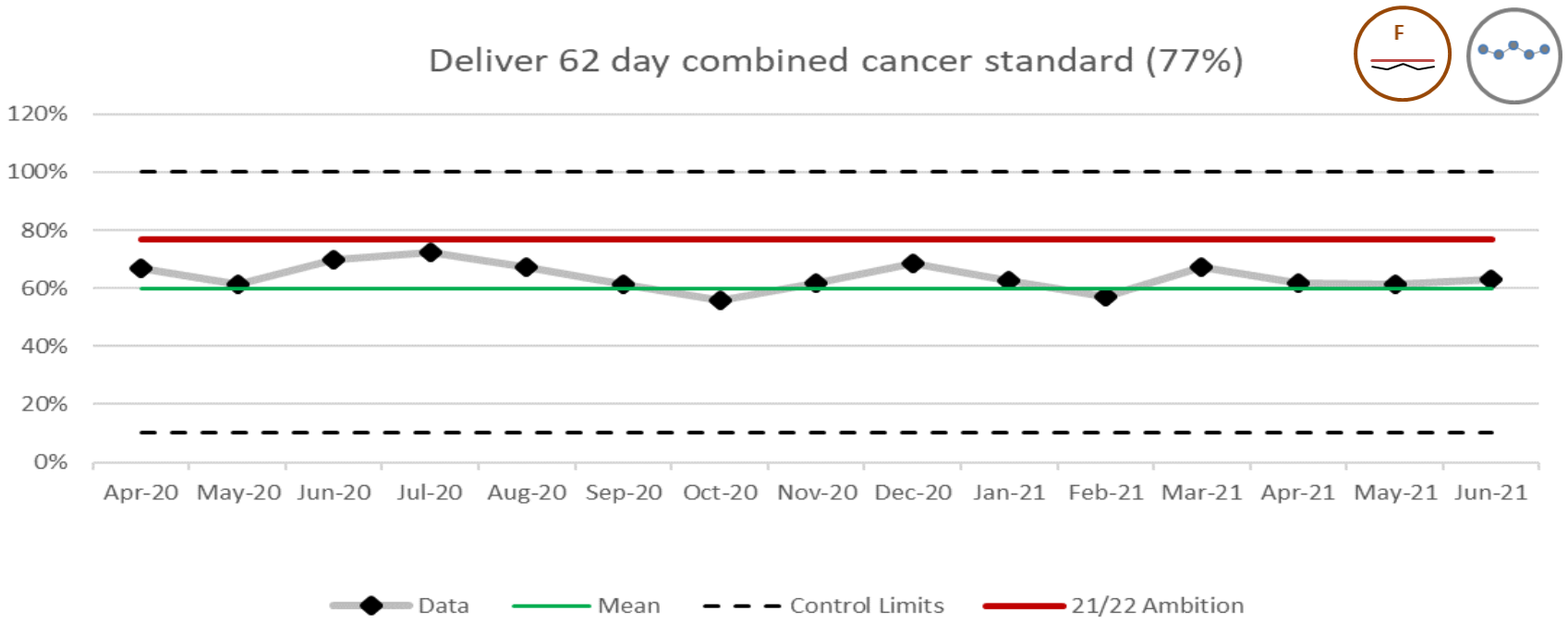
NHS United Lincolnshire Hospitals NHS Trust



Jun-21
63.20%
Variance Type
Metric is currently experiencing Common Cause Variation
21/22 Ambition
77%
Achievement
Metric is consistently failing to ambition
Executive Lead
Chief Operating Officer

Background:

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

What the chart tells us:

We are currently at 63.2% against a 77% target

Issues:

Patient engagement in diagnostic process (reluctance to visit hospitals due to perceived COVID-19 risk, including those waiting for vaccines or the 3 week 'effectiveness' period). This is continuing to reduce.
Reduced clinic throughput due to social distancing / IPC requirements, especially in waiting areas.
Patient acceptance & compliance with swabbing and self-isolating requirements. Patients not willing to travel to where our service and / or capacity is.
Managing backlogs significantly in excess of pre-COVID levels for Colorectal, 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. Two substantive Medical Oncologists were recruited, one is due to start in November 2021 (covering Breast, Renal and Urology). Unfortunately, the second post has gone back out to advert after the applicant withdrew.
Funding from EMCA is in place for full-time Cancer Navigator posts to support Surgery, Medicine and Family Health. Recruitment processes are underway with posts commencing in August and September for Family Health and Medicine. Endoscopy are in the early stages of undertaking a review around the Bowel Cancer Screening age extension and endoscopy staffing. The intention is to increase the clinical endoscopist workforce with less reliance on consultants and also to increase administrative support by converting fixed term into substantive posts. Work to enhance the early identification of patients requiring Pre-Diagnosis CNS support is ongoing.

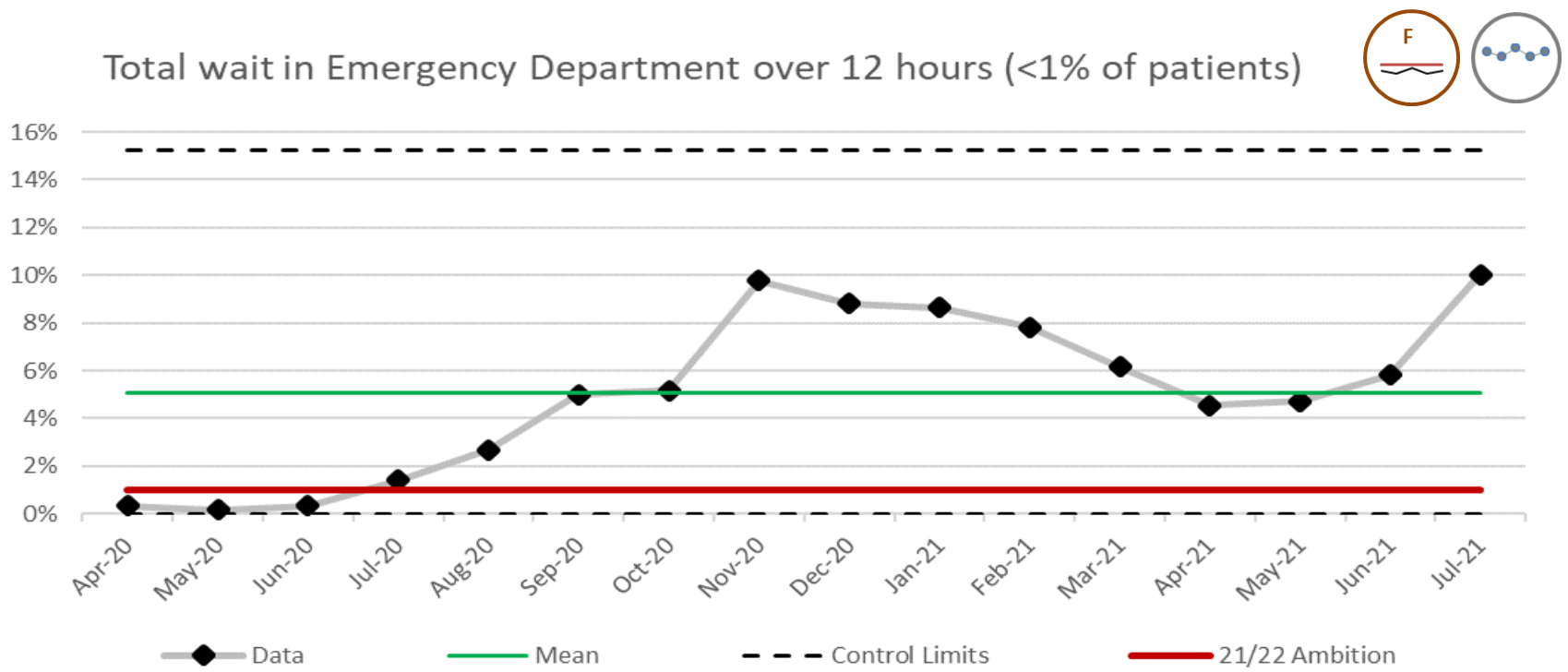
Mitigations:

Theatre capacity is returning to Pre-covid levels. Following a 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) have been delivered and installed.
Radiology have increased their internal reporting capacity. There is also an Increase in CTC capacity whilst we have the relocatable and modular staffing - from 336 slots pcm to 530 slots pcm. A review of colorectal theatre list scheduling in order to better align with clinician availability continues and Grantham Theatres have now returned to undertaking suitable Level 1 colorectal work. 2 H&N consultant posts have been recruited, 1 started in April 2021, and another commenced in July 2021.

Quality | Operational Performance | Workforce | Finance

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Jul-21
10.03%
Variance Type
Metric is currently experiencing Common Cause Variation
21/22 Ambition
1%
Achievement
Metric is consistently failing to ambition
Executive Lead
Chief Operating Officer

Background:

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

What the chart tells us:

July experienced an increase in the numbers of patients with an aggregated time of arrival great then 12 hours.
10.3% (973) of all patients attending the Emergency Department against an agreed target of <1%

Issues:

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

Actions:

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

Mitigations:

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

Quality | Operational Performance | Workforce | Finance

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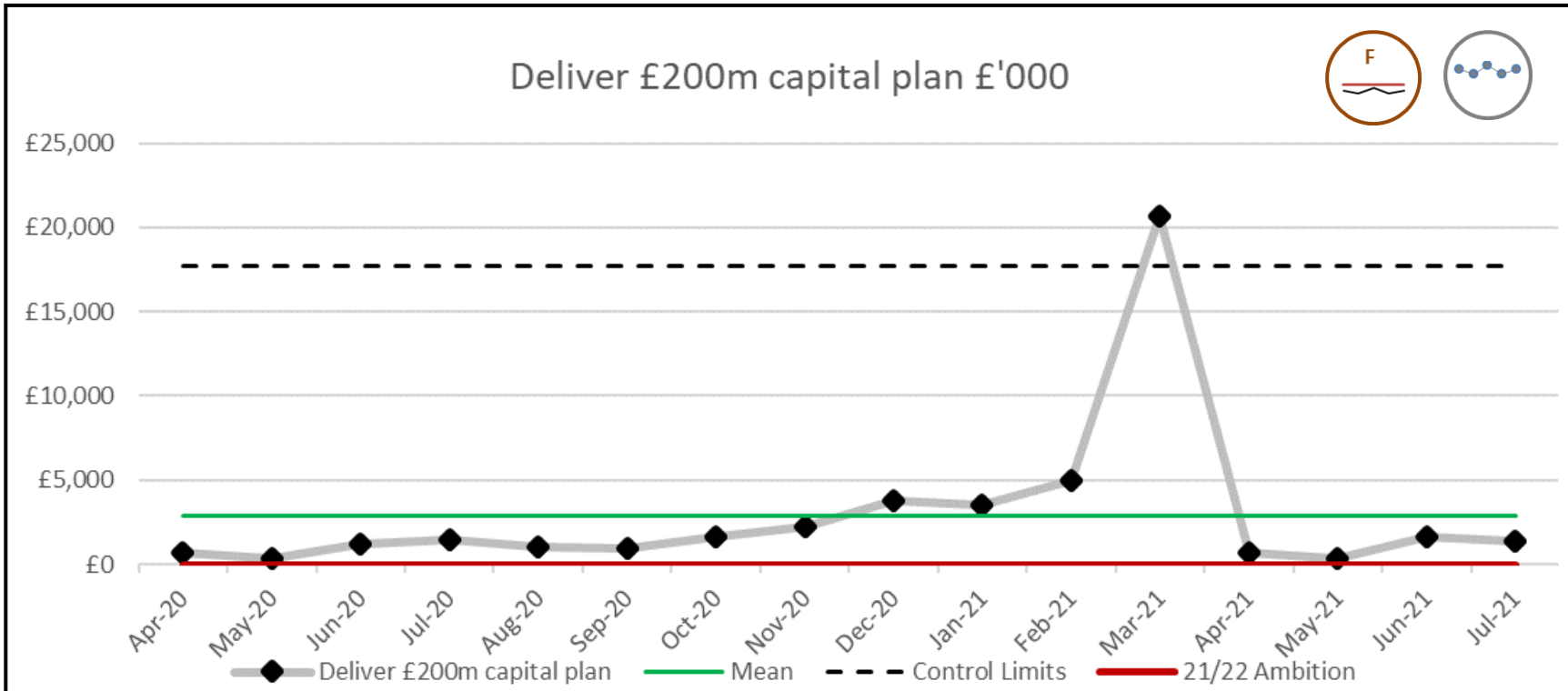

Jul-21
£1,410,500
Variance Type
Metric is currently experiencing Common Cause Variation
21/22 Ambition
£39 Million for the year
Achievement
Metric is consistently failing to ambition
Executive Lead
Director of Finance

Background:
The Trust has a capital programme to deliver of £33.7m, which will increase to £35.3m after our bid for a PSDS grant of £1.6m was successful.

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

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

As at the end of July, expenditure YTD of £4.0m is £5.1m behind plan, requiring expenditure of £31.3m in the remainder of 2021/22 to deliver the programme in full.

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

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

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

Quality | Operational Performance | Workforce | Finance

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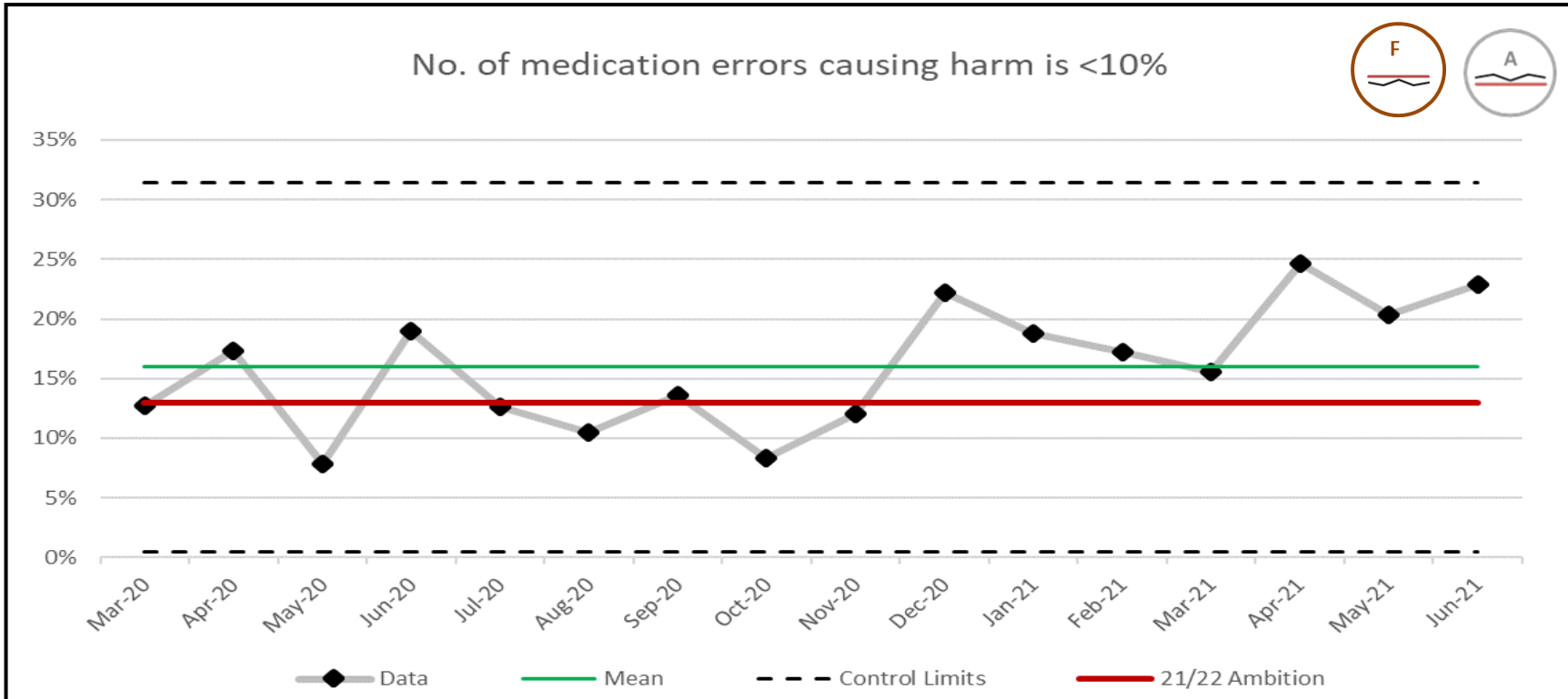
NHS United Lincolnshire Hospitals NHS Trust



Jun-21
22.92%
Variance Type
Metric is currently experiencing Special Cause Variation – above the mean
21/22 Ambition
13%
Achievement
Metric is consistently failing to ambition
Executive Lead
Director of Nursing

Background:
% of Medication errors causing some kind of harm.

What the chart tells us:
Last 7 months performance have been above the ambition of no more than 10% medication errors causing harm, which is a trend of underperformance.

Issues:
At the point of administration to the patient.
At the prescribing point of the medication.
Delayed or omitted doses.
Time critical medications.

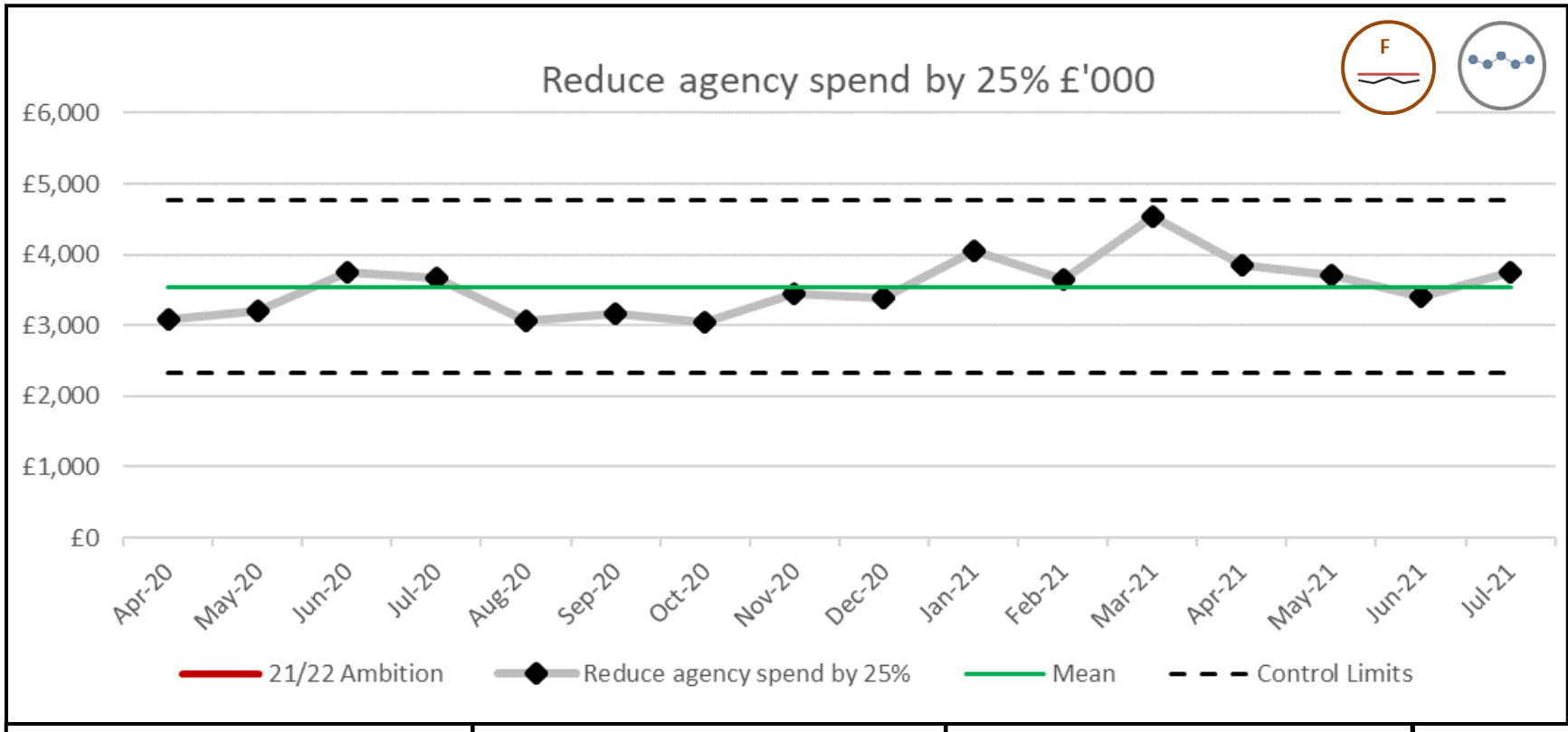
Actions:
Speciality pharmacists linking into speciality governance meetings.
Divisions asked to identify 4 actions each to address the issues.
Medicine safety is a standing item at the patient safety group.
Fortnightly improving the safety of medicine group now in place.

Mitigations:
Training being reviewed.
IV competency pack being reviewed.
Current operational pressures are affecting uptake of training and ability to deliver the training session.
Prioritising medicines training during wave 3.

Quality | Operational Performance | Workforce | Finance

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Jul-21
£3,745,000
Variance Type
Metric is currently experiencing Common Cause Variation
21/22 Ambition
£33 Million for the year
Achievement
Metric is consistently failing to ambition
Executive Lead
Director of Finance

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

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

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

Increased Agency spend on Nursing and Midwifery & Housekeeping, though, has driven total Agency spend YTD £3.7m above plan.

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

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

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

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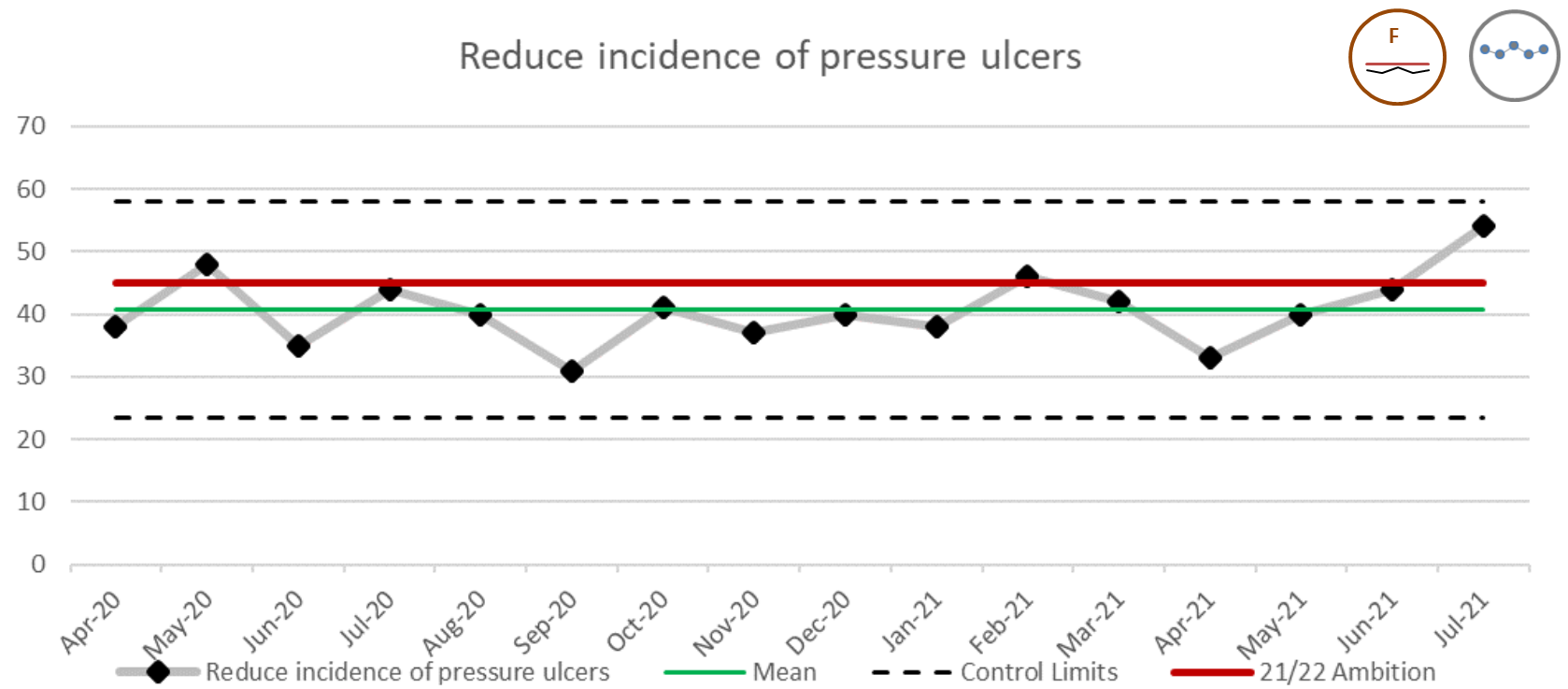

Jul-21
54
Variance Type
Metric is currently experiencing Common Cause Variation
21/22 Ambition
45
Achievement
Metric is consistently failing to ambition
Executive Lead
Director of Nursing

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

What the chart tells us:
The total number of reported hospital acquired pressure ulcers for categories 2, 3, 4 and Unstageables is 54, an increase of 10 from June 2021.

Issues:
PHB have reported significantly higher number of pressure ulcer incidents than LCH in July.

Actions:
Themed analysis of July's pressure ulcer incidents will be undertaken to gain a detailed understanding of the increased numbers and differences in reporting between sites.

Mitigations:
Skin Integrity Group (SIG) are sighted on areas with increased incidences where deep dives are to be undertaken.

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NHS United Lincolnshire Hospitals NHS Trust

PERFORMANCE OVERVIEW - QUALITY

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target per month	May-21	Jun-21	Jul-21	YTD	Pass/Fail	Trend Variation
Deliver Harm Free Care	Clostridioides difficile position	Safe	Patients	Director of Nursing	9	2	5	7	18	P	
	MRSA bacteraemia	Safe	Patients	Director of Nursing	0	0	0	1	1	F	
	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	0.07	0.04	0.03	0.06		
	E. coli bacteraemia cases counts and 12-month rolling rates, by reporting acute trust and month using trust per 1000 bed days formula	Safe	Patients	Director of Nursing	TBC	0.14	0.14	0.17	0.13		
	Catheter Associated Urinary Tract Infection	Safe	Patients	Director of Nursing	1	0	3	2	5	F	
	Falls per 1000 bed days resulting in moderate, severe harm & death	Safe	Patients	Director of Nursing	0.19	0.00	0.04	0.01	0.02	P	
	Pressure Ulcers category 3	Safe	Patients	Director of Nursing	4.3	1	0	0	2	P	B
	Pressure Ulcers category 4	Safe	Patients	Director of Nursing	1.3	0	0	0	1	P	
	Pressure Ulcers - unstageable	Safe	Patients	Director of Nursing	4.4	3	7	6	21	F	
	Venous Thromboembolism (VTE) Risk Assessment	Safe	Patients	Medical Director	95%	97.80%	96.08%	95.40%	96.71%	P	
	Never Events	Safe	Patients	Director of Nursing	0	0	0	1	1	F	
	Reported medication incidents per 1000 occupied bed days	Safe	Patients	Medical Director	4.3	4.8	5.13		5.06	P	
	Medication incidents reported as causing harm (low /moderate /severe / death)	Safe	Patients	Medical Director	10.7%	20.3%	22.9%		22.60%	F	A

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NHS United Lincolnshire Hospitals NHS Trust

PERFORMANCE OVERVIEW - QUALITY

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	May-21	Jun-21	Jul-21	YTD	Pass/Fail	Trend Variation
Deliver Harm Free Care	Patient Safety Alerts responded to by agreed deadline	Safe	Patients	Medical Director	100%	0%	67.0%	100%	55.67%	P	
	Hospital Standardised Mortality Ratio - HSMR (basket of 56 diagnosis groups) (rolling year data 3 month time lag)	Effective	Patients	Medical Director	100	117.08	No Data	114.30	115.61	F	H
	Summary Hospital Mortality Indicator (SHMI) (rolling year data 6 month time lag)	Effective	Patients	Medical Director	100	110.64	112.05	112.55	111.45	F	H
	The Trust participates in all relevant National clinical audits	Effective	Patients	Medical Director	100%	95.00%	95.00%	97.00%	95.50%	F	A
	eDD issued within 24 hours	Effective	Patients	Medical Director	95%	92.10%	92.30%	88.70%	91.63%	F	
	Sepsis screening (bundle) compliance for inpatients (adult)	Safe	Patients	Director of Nursing	90%	92.0%	93.5%		90.50%	P	
	Sepsis screening (bundle) compliance for inpatients (child)	Safe	Patients	Director of Nursing	90%	84.0%	95.3%		87.77%	P	
	IVAB within 1 hour for sepsis for inpatients (adult)	Safe	Patients	Director of Nursing	90%	93.0%	93.8%		93.27%	P	
	IVAB within 1 hour for sepsis for inpatients (child)	Safe	Patients	Director of Nursing	90%	100.0%	100.0%		100.00%	P	
	Sepsis screening (bundle) compliance in A&E (adult)	Safe	Patients	Director of Nursing	90%	94.0%	92.4%		93.47%	P	A
	Sepsis screening (bundle) compliance in A&E (child)	Safe	Patients	Director of Nursing	90%	87.0%	86.7%		87.89%	F	A
	IVAB within 1 hour for sepsis in A&E (adult)	Safe	Patients	Director of Nursing	90%	95.0%	95.5%		95.17%	P	
	IVAB within 1 hour for sepsis in A&E (child)	Safe	Patients	Director of Nursing	90%	100.0%	87.5%		79.17%	F	
	Rate of stillbirth per 1000 births	Safe	Patients	Director of Nursing	4.20	3.12	3.34	2.66	3.00	P	B
Improve Patient Experience	Mixed Sex Accommodation breaches	Caring	Patients	Director of Nursing	0	Submission suspended during Covid					
	Duty of Candour compliance - Verbal	Safe	Patients	Medical Director	100%	50.00%	54.00%		61.00%	F	L
	Duty of Candour compliance - Written	Responsive	Patients	Medical Director	100%	38.00%	28.00%		39.67%	F	L

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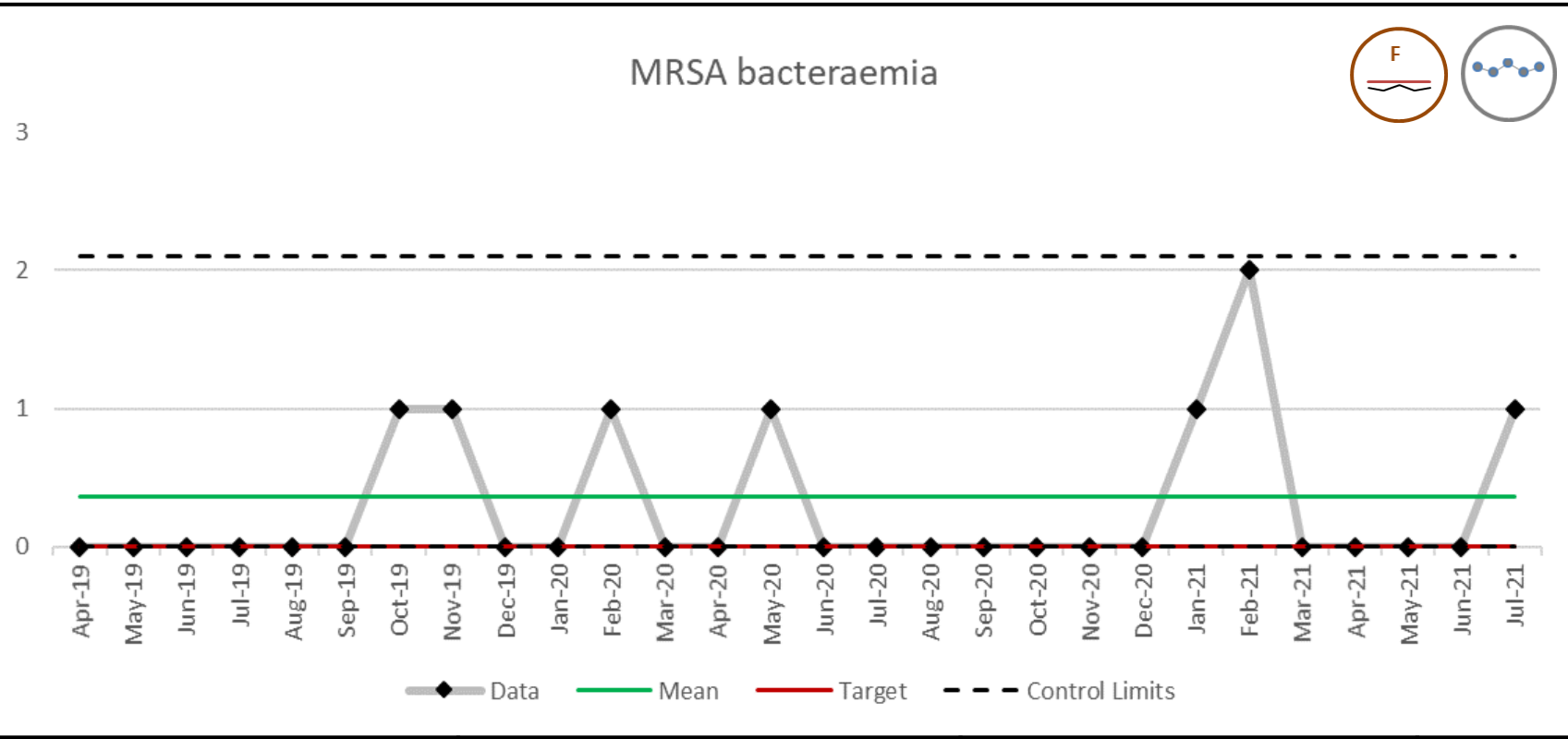

Jul-21
1
Variance Type
Metric is currently experiencing Common Cause Variation
Target
0
Target Achievement
Metric is failing the target
Executive Lead
Director of Nursing

Background:
Mandatory surveillance organisms reported in July 2021.

What the chart tells us:
Overall gram negative bacteraemia's remain low.

Issues:
1 MRSA bacteraemia – this has been reported as a contaminant. Blood culture was taken by an agency nurse.

Actions:
Divisional nurse and Bank/agency staff manager to investigate and ensure all agency staff demonstrate competence at taking blood cultures.

Mitigations:

Quality | Operational Performance | Workforce | Finance

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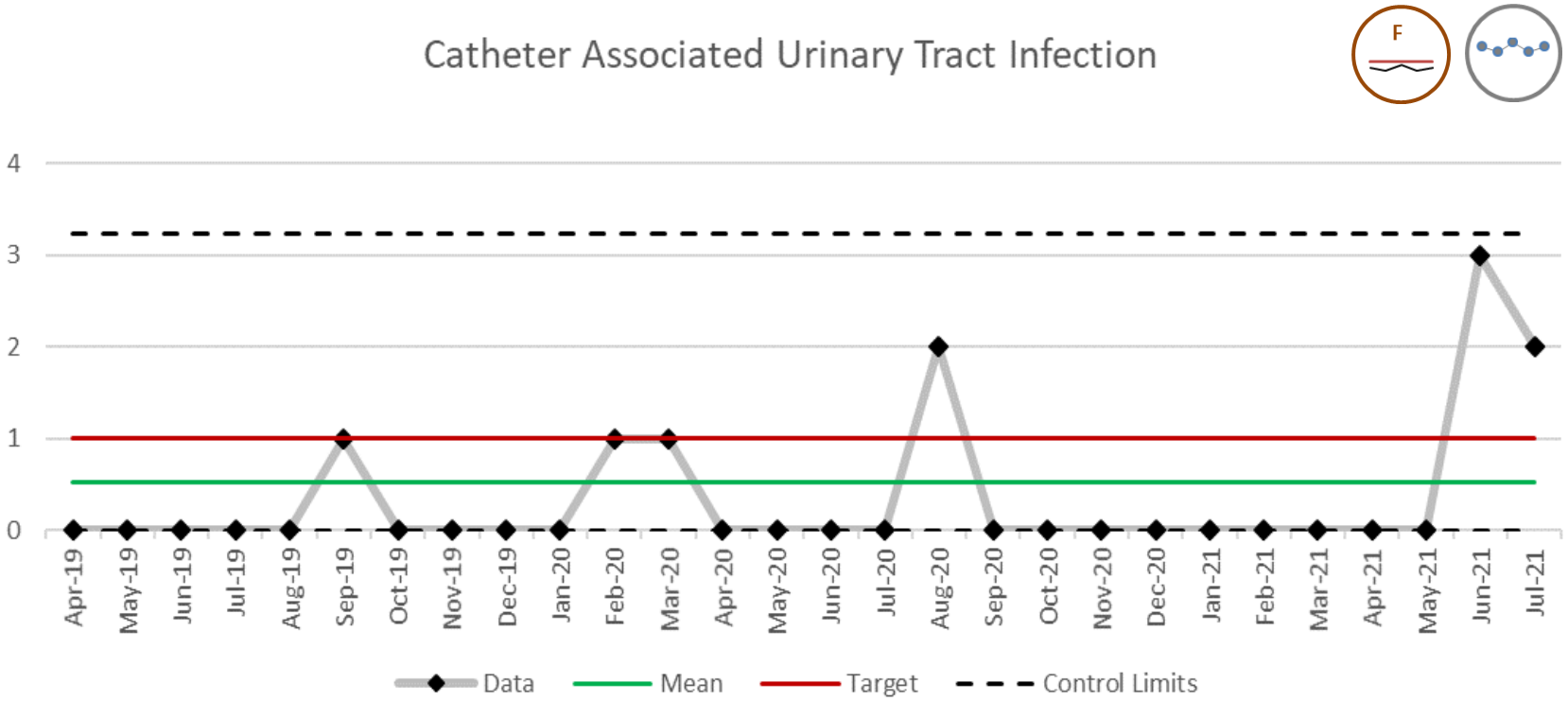
NHS United Lincolnshire Hospitals NHS Trust



Jul-21
2
Variance Type
Metric is currently experiencing Common Cause Variation
Target
1
Target Achievement
Metric is failing the target
Executive Lead
Director of Nursing

Background:
Number of catheter associated urinary tract infections (CAUTI)

What the chart tells us:
We are currently at 2 for July against a target of 0.

Issues:

Actions:

Mitigations:

Quality | Operational Performance | Workforce | Finance

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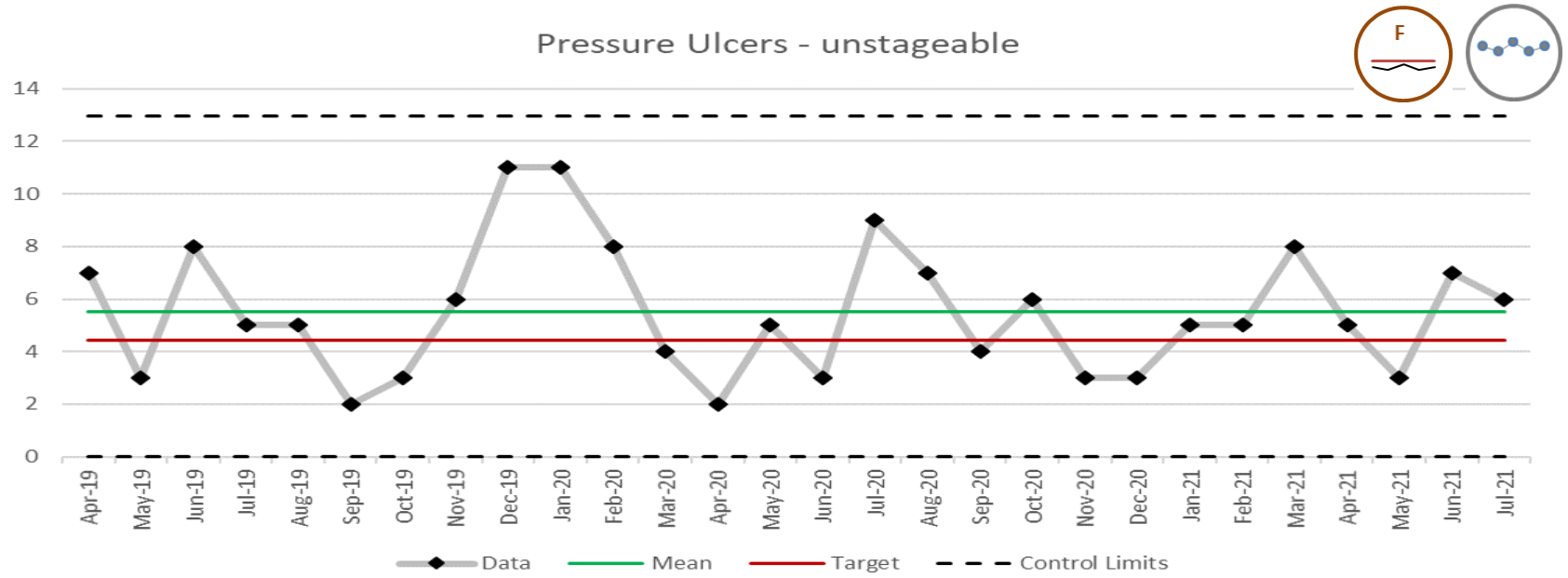


Jul-21
6
Variance Type
Metric is currently experiencing Common Cause Variation
Target
4.4
Target Achievement
Metric is consistently failing the target
Executive Lead
Director of Nursing

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

What the chart tells us:
We are currently at 6 against a target of 4.4 per month.

Issues:
The total number of reported hospital acquired pressure ulcers for categories 2, 3, 4 and Unstageables is 54, an increase of 10 from June 2021.

PHB have reported significantly higher number of pressure ulcer incidents than LCH in July.

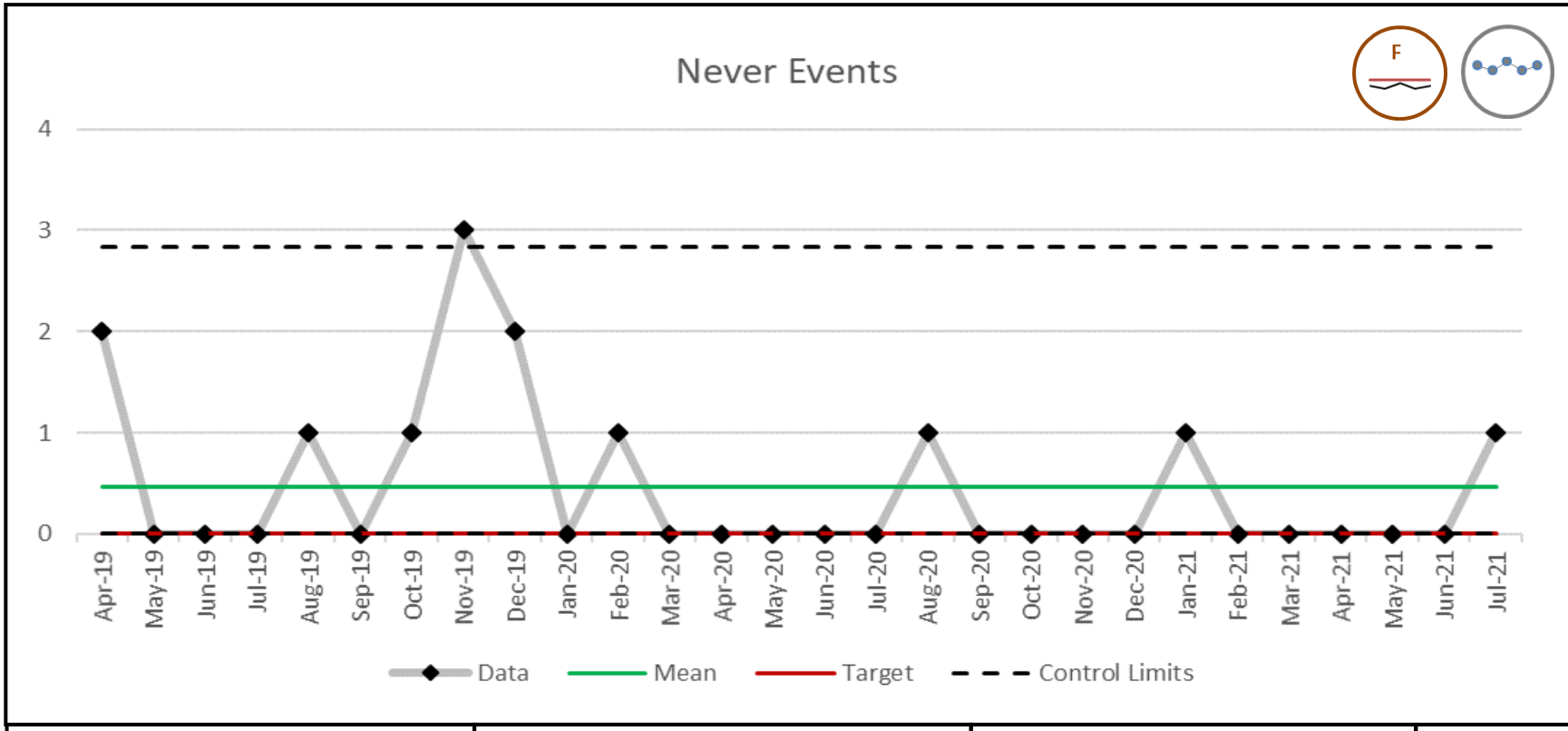
There has been an increase in Category 2 reported incidents from GDH in July.

Actions:
Assistant Director of Nursing and Quality Matron to undertake a themed analysis of July's pressure ulcer incidents to gain a detailed understanding of the increased numbers and differences in reporting between sites.
Skin Integrity Steering Group (SIG) have instigated a deep dive into unstageable and deep tissue injuries, outcomes will be reported to SIG in September. Risk team have developed a new Pressure Ulcer Incident and Investigation pathway which will be presented at August SIG.

Task and finish groups have been established to identify and manage improvements across
- Urgent and Emergency Care Pathways
- Standardisation and development of handover and transfer processes.

Mitigations:
Skin Integrity Group (SIG) are sighted on areas with increased incidences where deep dives are to be undertaken.

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



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

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

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

Issues:
NG Tube was inserted for nutrition in line with Trust policy, NG tube later found to be incorrectly placed after feed had commenced.

Actions:
Serious Incident procedure initiated leading to local investigation and rapid review – declared to commissioners as SI 20/7/21 within approved timeframe.

Mitigations:
Investigation team identified and Governance support assigned – Clinical policy to be reviewed for accuracy.

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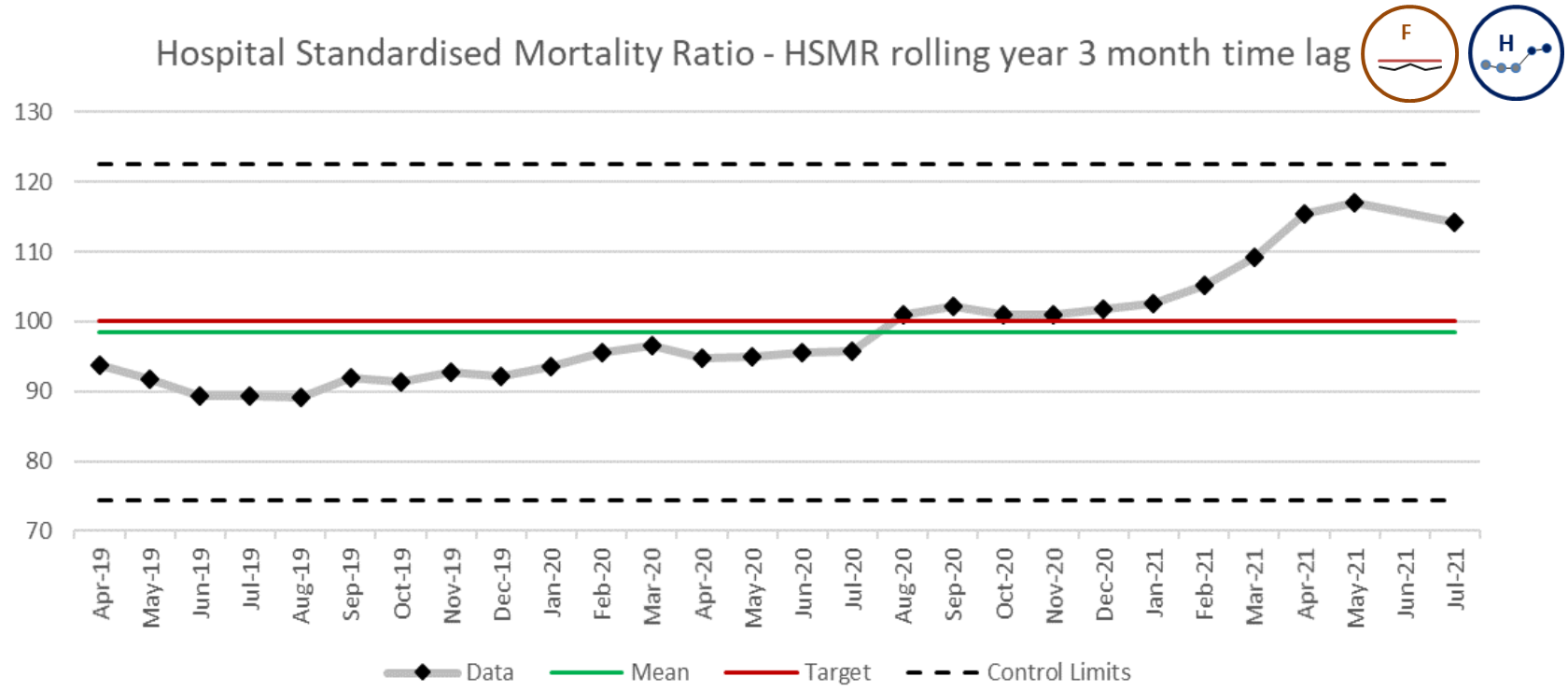


Jul-21
114.30
Variance Type
Metric is currently experiencing Special Cause Variation – high trend
Target
100
Target Achievement
The metric has consistently failed to target
Executive Lead
Medical Director

Background:
SHMI and HSMR reports on mortality at trust level across the NHS in England using a standard methodology.

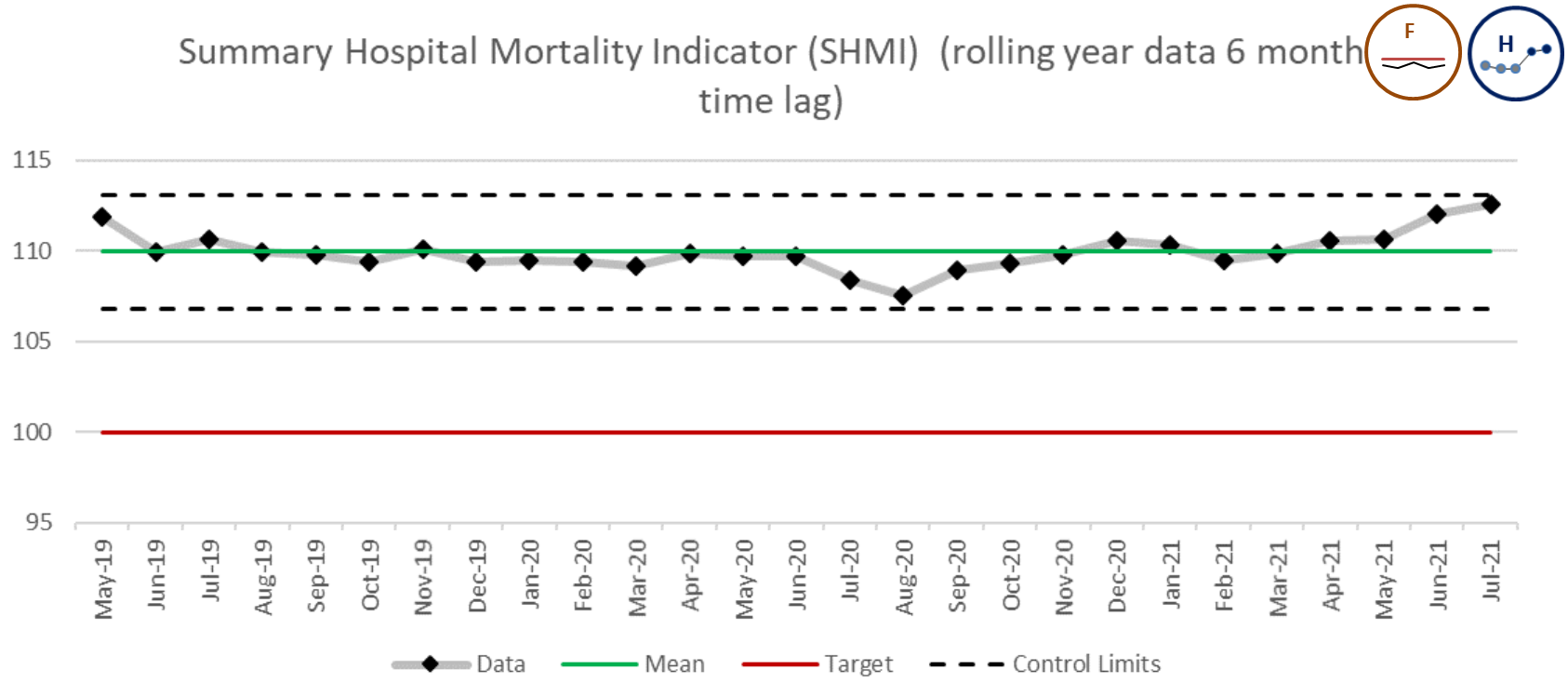
What the chart tells us:
We are currently at 114.30 against target of 100.
The Trust's HSMR and SHMI have increased during the COVID-19 pandemic.

Issues:
The COVID-19 pandemic impacted on the Trusts HSMR, SHMI and crude rate.

Due to an issue with NHS Digital submissions to Dr Foster, the Trust is unable to view HSMR by site or view the monthly data.

Actions:
Any diagnosis group alerting is subject to a case note review.
NHSE/I have completed an online workshop on mortality and documentation and 90 staff attended.
The Trust are currently in discussion with the system partners in rolling out the ME service for community deaths.

Mitigations:
All deaths are reviewed by the Medical Examiner and any deaths were issues are identified are escalated for a structured judgement review or rapid review.
The Trust internal mortality meeting is chaired by the Deputy Medical Director and the mortality collaborative meeting with our system partners is also chaired by the Deputy Medical Director.



Jul-21
112.55
Variance Type
Metric is currently experiencing Special Cause Variation – high trend
Target
100
Target Achievement
The metric has consistently failed to target
Executive Lead
Medical Director

Background:
SHMI and HSMR reports on mortality at trust level across the NHS in England using a standard methodology.

What the chart tells us:
We are currently at 112.55 against target of 100.
The Trust's HSMR and SHMI have increased during the COVID-19 pandemic.

Issues:
See issues on previous page – HSMR

Actions:
See actions on previous page – HSMR

Mitigations:
See mitigations on previous page – HSMR

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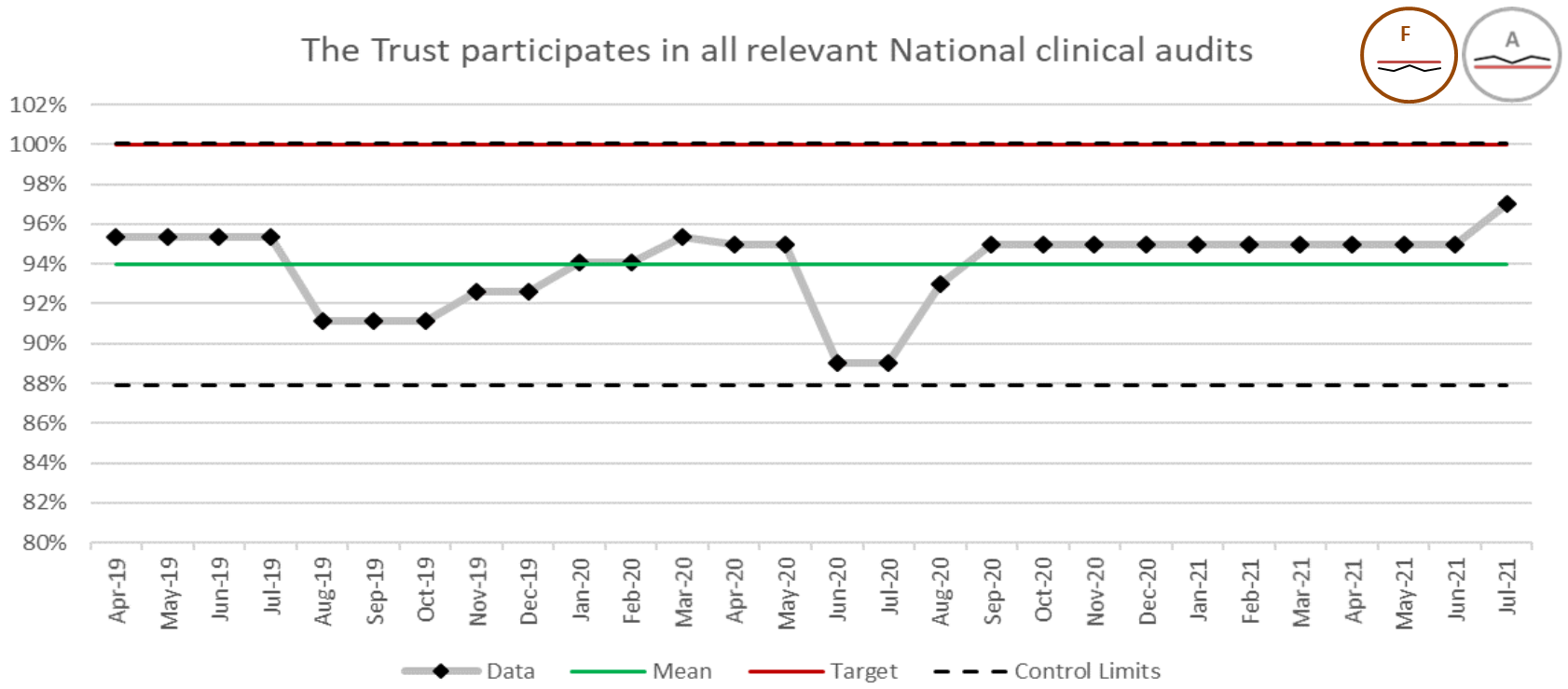

Jul-21
97%
Variance Type
Metric is currently experiencing Special Cause Variation – above the mean
Target
100%
Target Achievement
The metric has consistently failed to target
Executive Lead
Medical Director

Background:
% participation in relevant National Clinical Audits.

What the chart tells us:
Slight increase in participation 97% for the month of July 2021.

Issues:
None participation in the IBD Audit.

Actions:
Monitored by the Clinical Effectiveness Group.

Mitigations:
Inflammatory Bowel Disease (IBD) participation agreed by the Division, participation due to commence within the next month.

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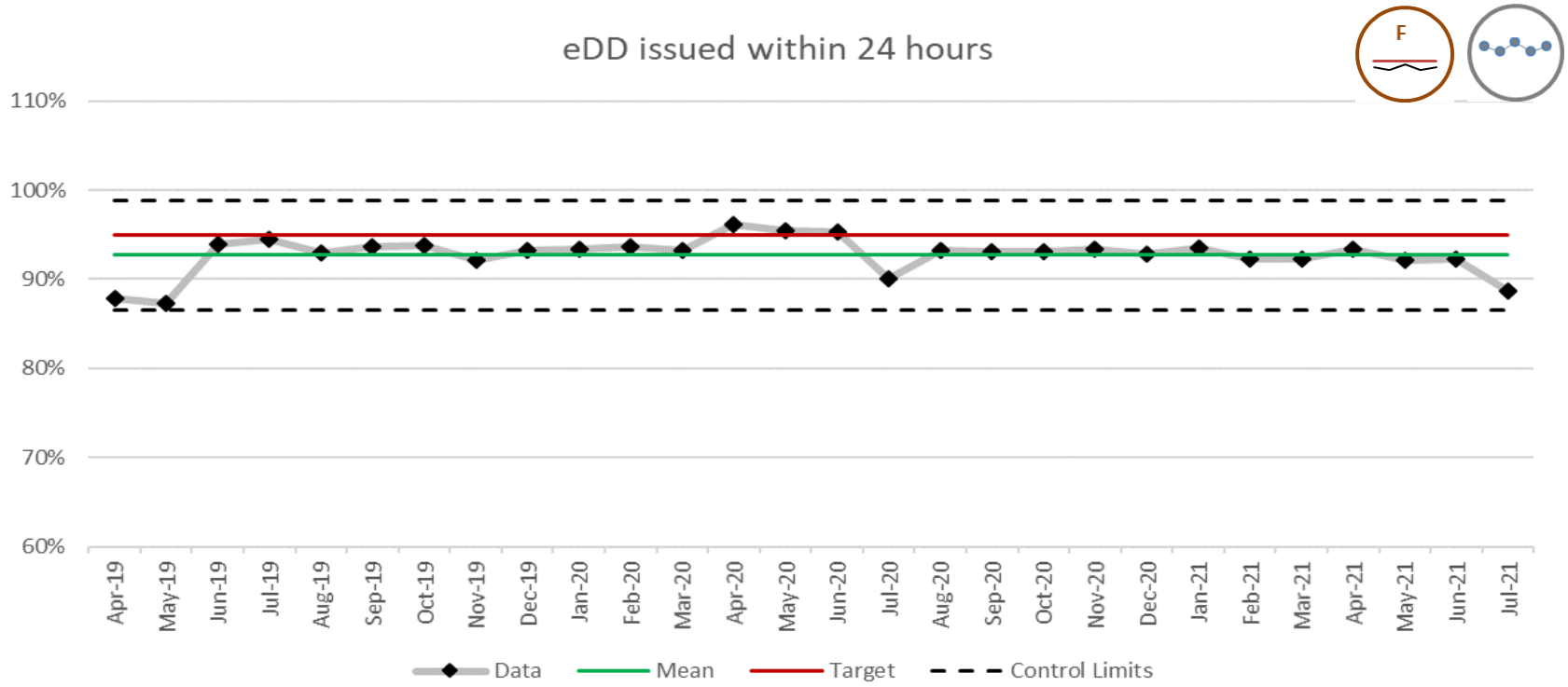

Jul-21
88.7%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
95%
Target Achievement
The metric is consistently failing the target
Executive Lead
Medical Director

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

What the chart tells us:
The Trust achieved 88.7% compliance with sending eDDs within 24 hours for July 2021 against a target of 95%.
6.2% of eDDs were not sent at all during the month of July 2021.

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

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

Mitigations:

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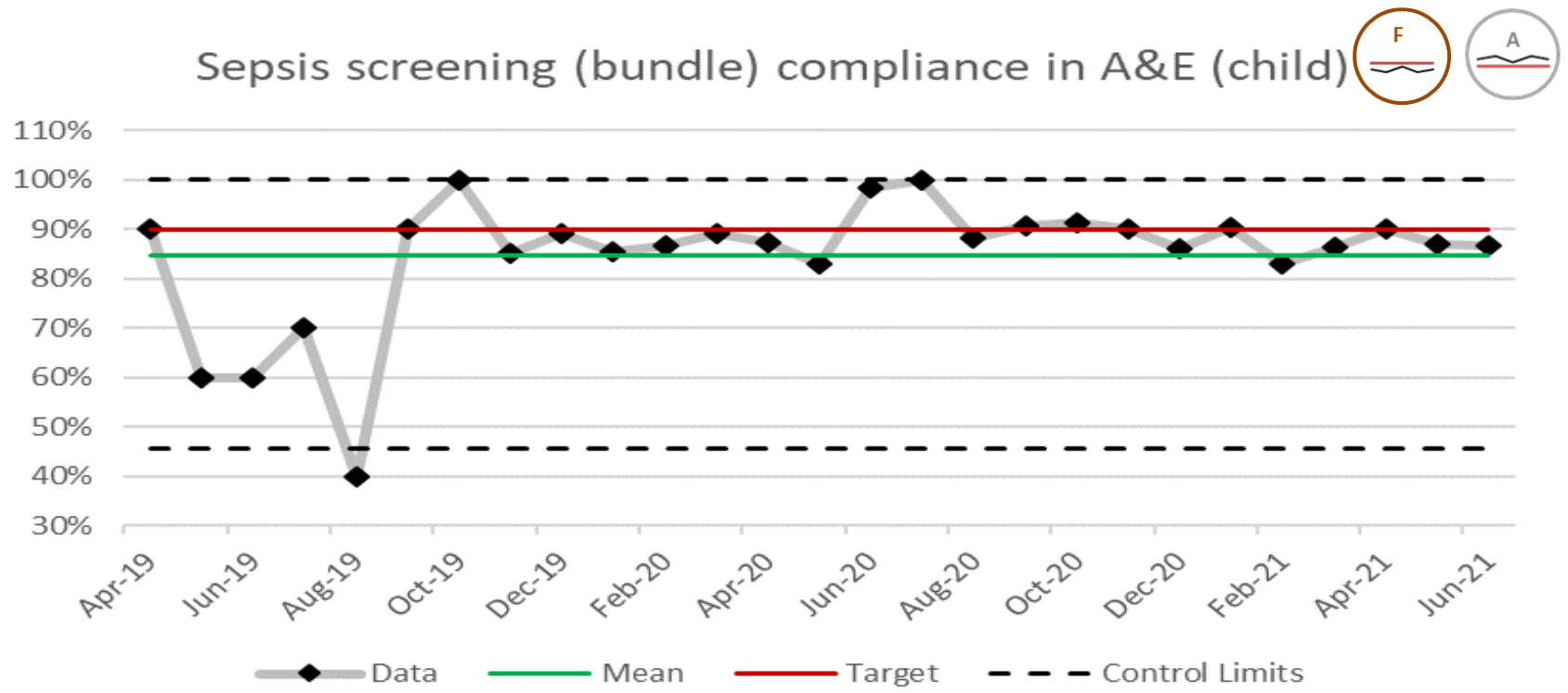

Jun-21
86.7%
Variance Type
Metric is currently experiencing Special Cause Variation – above the mean
Target
90%
Target Achievement
The metric is consistently failing the target
Executive Lead
Director of Nursing

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

What the chart tells us:
Screening compliance in ED is 86.7% 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. Paediatric Doctors are seeing patients in ED when available to aid fast assessment.

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

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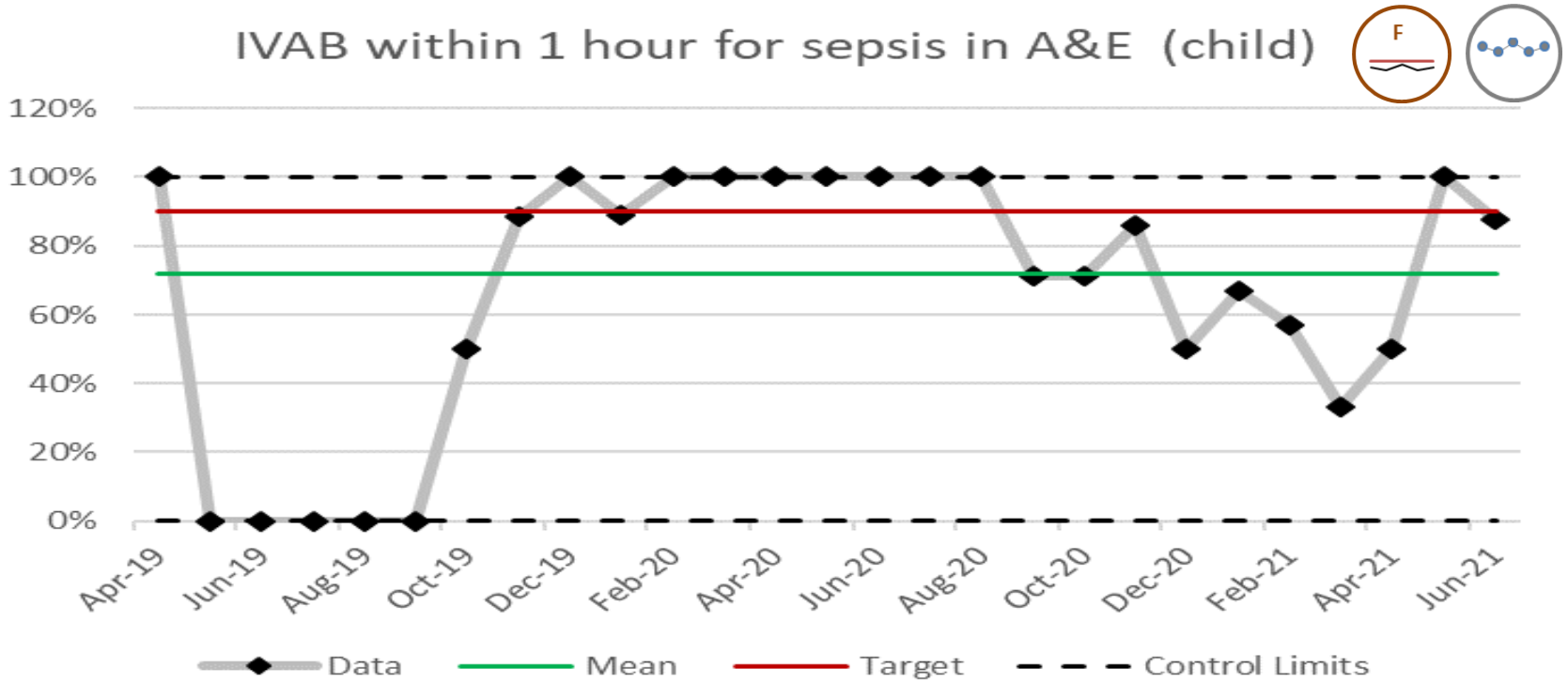

Jun-21
87.5%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
The metric is consistently failing the target
Executive Lead
Director of Nursing

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

What the chart tells us:
The compliance in ED this month for IVAB is 87.5%, 7 out of 8 children received antibiotics within 1 hour.

Issues:
The child involved had breathing issues and so these were dealt with first before the child was given antibiotics. Antibiotics were given outside of the hour.

Actions:
A harm review was completed for this child and it was found to be of no harm. The incident has been discussed with staff involved but it was important to deal with the breathing issue immediately.

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

Quality | Operational Performance | Workforce | Finance

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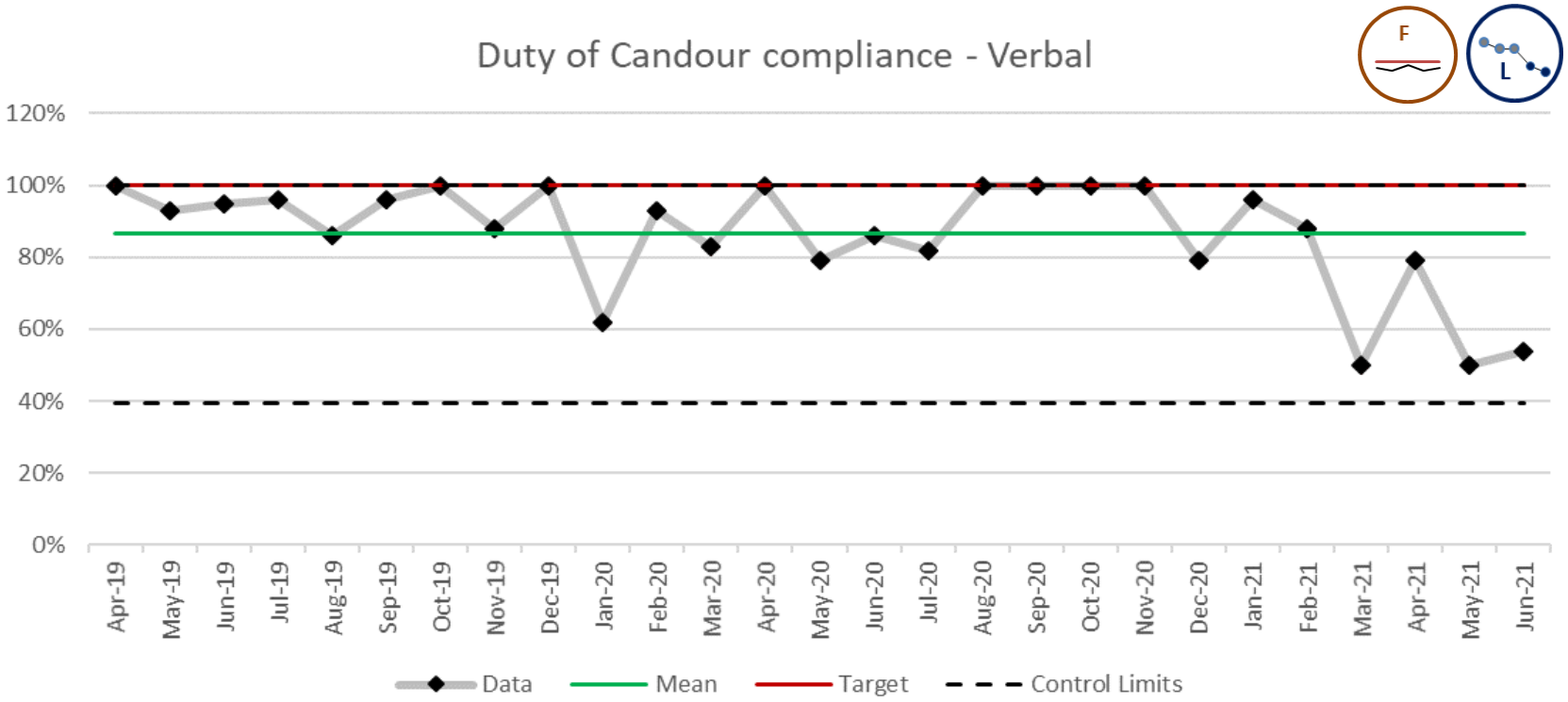


Jun-21
54%
Variance Type
Metric is currently experiencing Special Cause Variation – low trend
Target
100%
Target Achievement
The metric is consistently failing the target
Executive Lead
Medical Director

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

What the chart tells us:
Verbal compliance for July is at 54% against a 100% target.

Issues:
Divisions are not always recognising when DoC applies and should be carried out, or recording when it occurs.

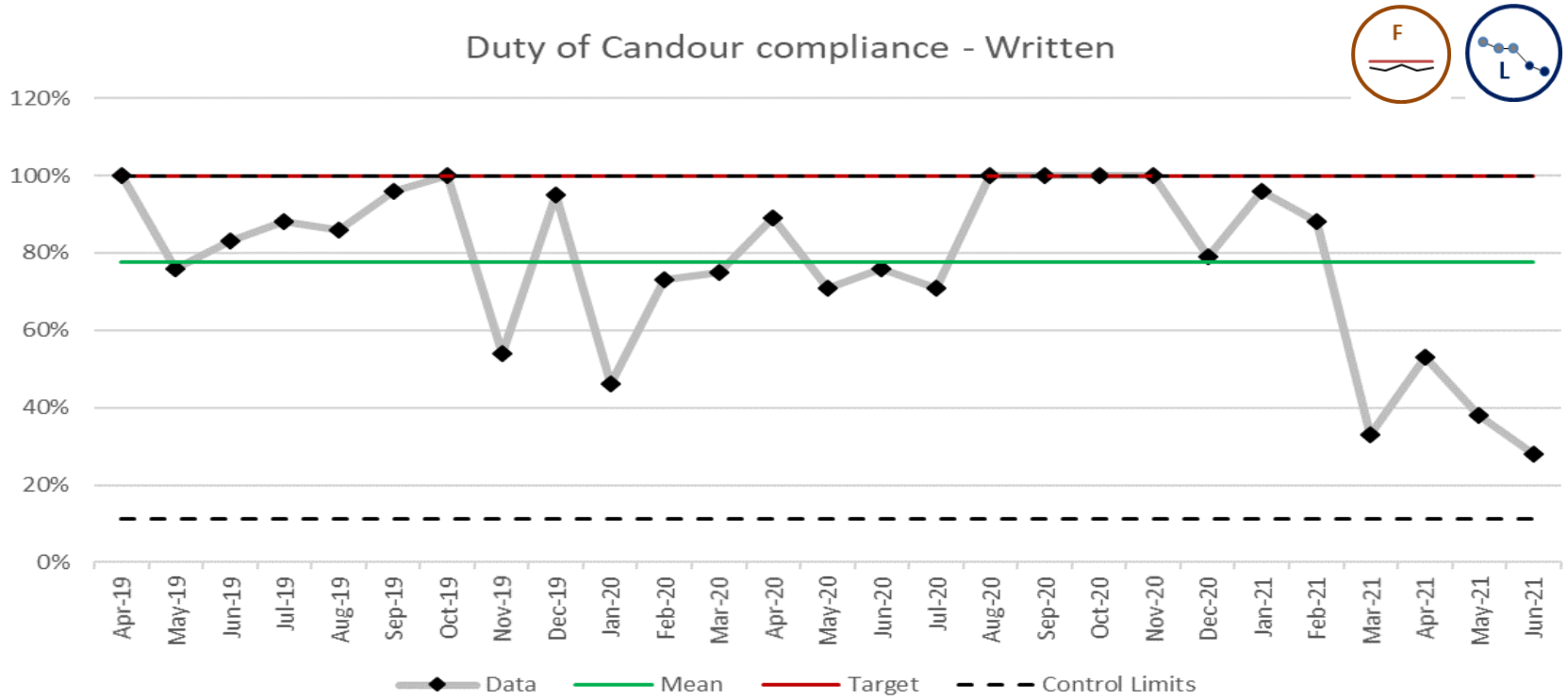
A lack of understanding of the purpose of the DoC .

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

DoC training being sourced from external provider.

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

Quality | Operational Performance | Workforce | Finance



Jun-21
28%
Variance Type
Metric is currently experiencing Special Cause Variation – low trend
Target
100%
Target Achievement
Metric is consistently failing the target
Executive Lead
Medical Director

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

What the chart tells us:
Verbal compliance for July is at 28% against a 100% target.

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

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

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

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NHS United Lincolnshire Hospitals NHS Trust

PERFORMANCE OVERVIEW – OPERATIONAL PERFORMANCE

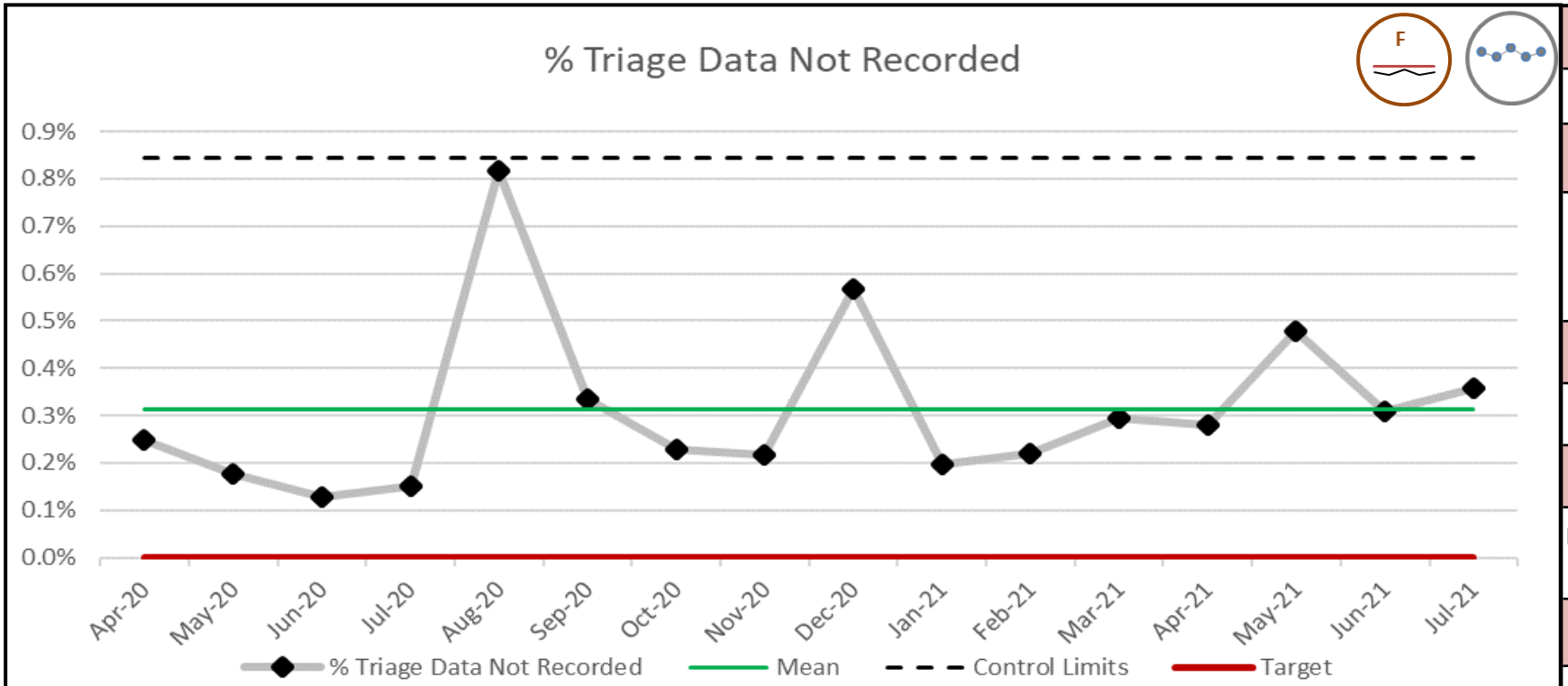
5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	May-21	Jun-21	Jul-21	YTD	YTD Trajectory	Latest Month Pass/Fail	Trend Variation	Kitemark
Improve Patient Experience	% Triage Data Not Recorded	Effective	Patients	Chief Operating Officer	0%	0.48%	0.31%	0.36%	0.36%		F		
Improve Clinical Outcomes	4hrs or less in A&E Dept	Responsive	Services	Chief Operating Officer	83.12%	72.56%	70.74%	64.93%	70.61%	83.12%	F	B	
	12+ Trolley waits	Responsive	Services	Chief Operating Officer	0	1	1	9	13	0	F		
	%Triage Achieved under 15 mins	Responsive	Services	Chief Operating Officer	88.5%	86.05%	88.23%	83.62%	87.26%	88.50%	F		
	52 Week Waiters	Responsive	Services	Chief Operating Officer	0	1032	787		3168	0	F	A	
	18 week incompletes	Responsive	Services	Chief Operating Officer	84.1%	61.62%	61.49%		59.64%	84.10%	F		
	Waiting List Size	Responsive	Services	Chief Operating Officer	37,762	48,475	49,925		n/a	n/a	F		
	62 day classic	Responsive	Services	Chief Operating Officer	85.4%	60.94%	67.00%		62.90%	85.39%	F		
	2 week wait suspect	Responsive	Services	Chief Operating Officer	93.0%	80.15%	81.73%		79.32%	93.00%	F		
	2 week wait breast symptomatic	Responsive	Services	Chief Operating Officer	93.0%	6.50%	14.53%		7.78%	93.00%	F	B	
	31 day first treatment	Responsive	Services	Chief Operating Officer	96.0%	93.83%	91.67%		92.83%	96.00%	F		
	31 day subsequent drug treatments	Responsive	Services	Chief Operating Officer	98.0%	99.15%	100.00%		99.43%	98.00%	P		
	31 day subsequent surgery treatments	Responsive	Services	Chief Operating Officer	94.0%	76.74%	83.33%		81.83%	94.00%	F		
	31 day subsequent radiotherapy treatments	Responsive	Services	Chief Operating Officer	94.0%	98.91%	95.54%		97.80%	94.00%	P		
	62 day screening	Responsive	Services	Chief Operating Officer	90.0%	81.48%	57.14%		72.87%	90.00%	F	A	

PERFORMANCE OVERVIEW – OPERATIONAL PERFORMANCE

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	May-21	Jun-21	Jul-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%	75.00%	84.12%		80.11%	85.00%	F		
	Diagnostics achieved	Responsive	Services	Chief Operating Officer	99.0%	70.85%	68.46%	66.35%	69.17%	99.00%	F	A	
	Cancelled Operations on the day (non clinical)	Responsive	Services	Chief Operating Officer	0.8%	1.52%	1.95%		1.57%	0.80%	F		
	Not treated within 28 days. (Breach)	Responsive	Services	Chief Operating Officer	0	5	15		24	0	F		
	#NOF 48 hrs	Responsive	Services	Chief Operating Officer	90%	92.42%	89.89%	86.36%	89.70%	90%	F		
	#NOF 36 hrs	Responsive	Services	Chief Operating Officer	TBC	81.82%	77.53%	74.24%	78.12%				
	EMAS Conveyances to ULHT	Responsive	Services	Chief Operating Officer	4,657	4,843	4,685	4,669	4,670	4,657	F		
	EMAS Conveyances Delayed >59 mins	Responsive	Services	Chief Operating Officer	0	285	349	568	352	0	F		
	104+ Day Waiters	Responsive	Services	Chief Operating Officer	10	42	49	48	186	40	F		
	Average LoS - Elective (not including Daycase)	Effective	Services	Chief Operating Officer	2.80	3.21	2.49	3.21	2.87	2.80	F		
	Average LoS - Non Elective	Effective	Services	Chief Operating Officer	4.50	3.97	4.23	4.43	4.30	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	14,830	15,001	15,193	15,268	4,524	F	I	
	Outpatients seen within 15 minutes of appointment	Effective	Services	Chief Operating Officer	70.0%	41.7%	40.0%	40.5%	41.74%	70.00%	F		
	% discharged within 24hrs of PDD	Effective	Services	Chief Operating Officer	45.0%	43.7%	41.1%	41.0%	42.14%	45.00%	F		

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Jul-21
0.36%
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.
July demonstrated a 0.4% negative variation compared with June This

Issues:

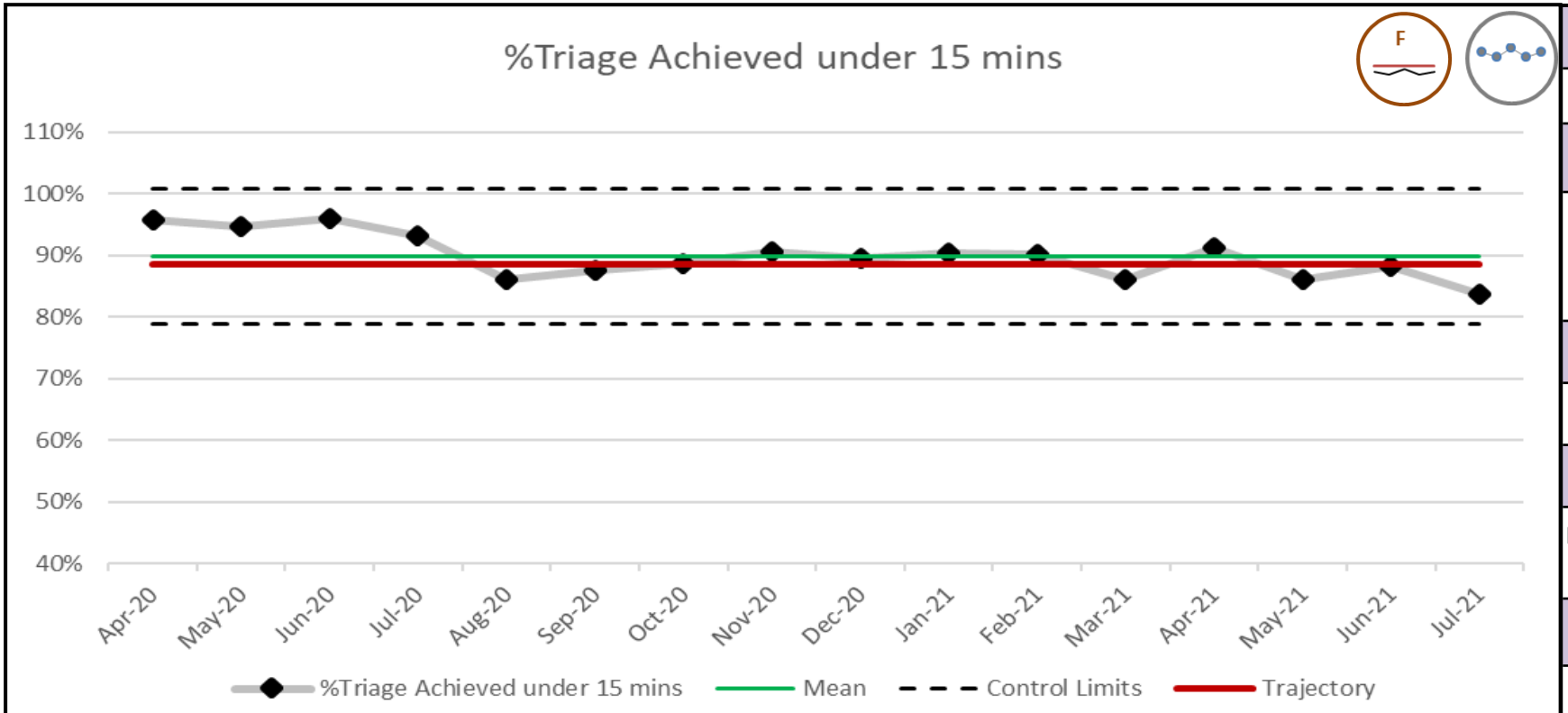
- Timely inputting of data.
- Reduced Manchester Triage trained staff (MTS) to consistently operate two triage streams, especially out of hours.
- Adhoc gaps in the provision of Pre-Hospital Practitioners (PHP).
- Increased staffing gaps and skill mix issues
- Increased demand has been cited as a causation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

Actions:

- Increased access to MTS training and time to input data.
- 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).



Jul-21
83.62%
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:

4.88% of emergency attendances were not triaged with 15 minutes of arrival. The compliance against this target is 88.50%. July demonstrated a deterioration of 4.61% compared with June. This metric below the agreed target

Issues:

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

Actions:

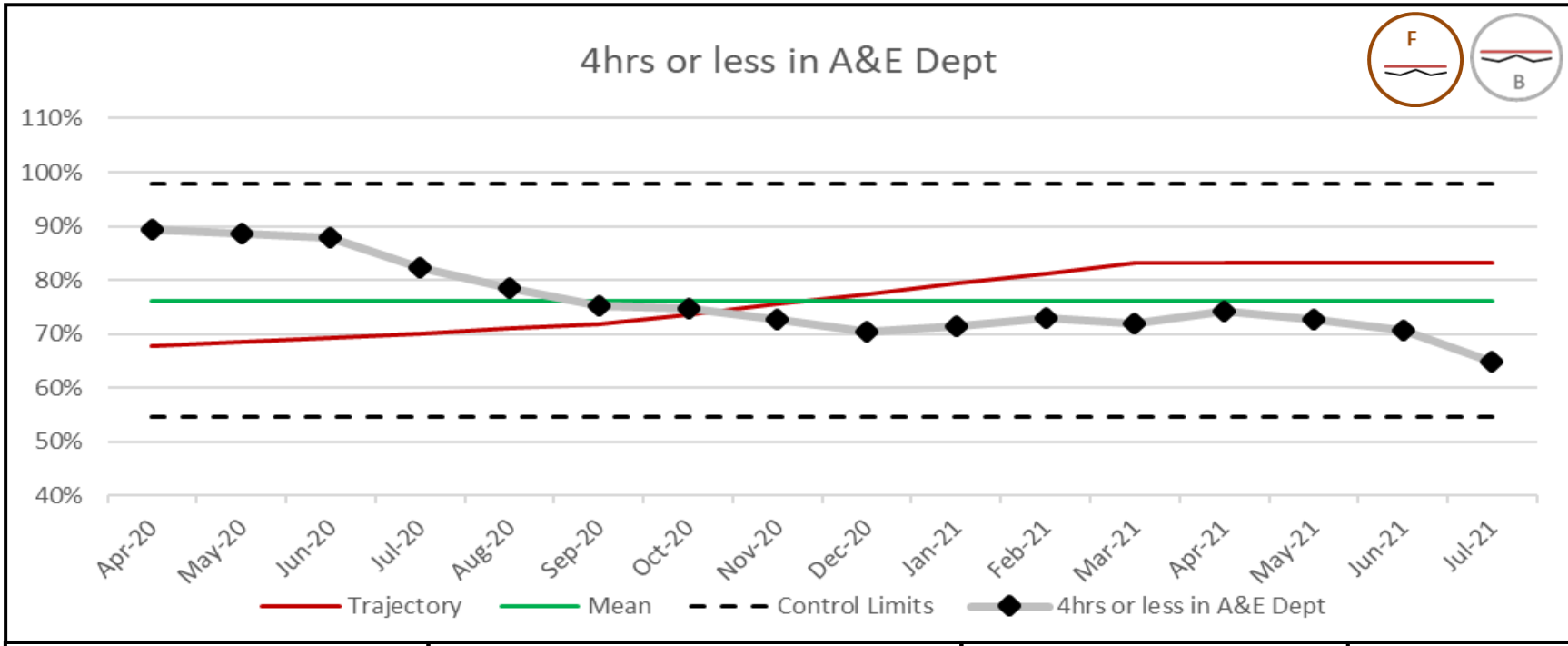
Increased access to MTS training.
Increased registrant workforce to support 2 triage streams to be in place via Emergency Department recruitment campaign.
To move to a workforce model with Triage dedicated registrants and remove the dual role component.
This metric forms part of the Emergency Department 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) went live at PHB at the end of Jul to ensure adult and CYP are triaged with the 15-minute standard. LCH is planned for 3rd August

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



Jul-21
64.93%
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 July was 64.93%. The agreed compliance trajectory for June is 83.12%. July experienced a further deterioration in performance against the agreed trajectory. June out turned at 64.93% compared to 70.74% in June. A 5.81% negative variance compared to June and an 18.28% negative variance to the agreed performance trajectory.

Issues:

ED saw 23.74% increase in attendances in July 2021 compare to June 2021. A large proportion of this increase can be attributed to the Grantham restore (20%). A comparison to July 2019 denotes a decrease of 6.86%. A total of 18,695 Emergency Department/UTC attendances in July 2021 compared to 19,330 in June 2021 denotes a 3.29% decrease in overall attendances. Inadequate discharges to meet the admission demand.

Ongoing medical and nursing gaps that were not Emergency Department specific.

Of the 18,695 recorded attendances for type 1 and type 3 across the Trust, type 1 attendances accounted for 12,335 and type 3 accounted for 6,360. This reduction on type 3 attendances can also be attributed to the Grantham restore.

A total of 800 type 3 attendances required transfer to the Emergency Department for ongoing treatment in July compared to 403 in June.

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:

EMAS have enacted a targeted admission avoidance process.

The Discharge Lounge at LCH and PHB are now operating a 24/7 service provision to release the burden placed on the Emergency Department at in terms of patients awaiting AIR/CIR and also transport home.

Increased CAS and 111 support especially out of hours.

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.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Jul-21
9
Variance Type
Metric is currently experiencing Common Cause Variation
Target
0
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

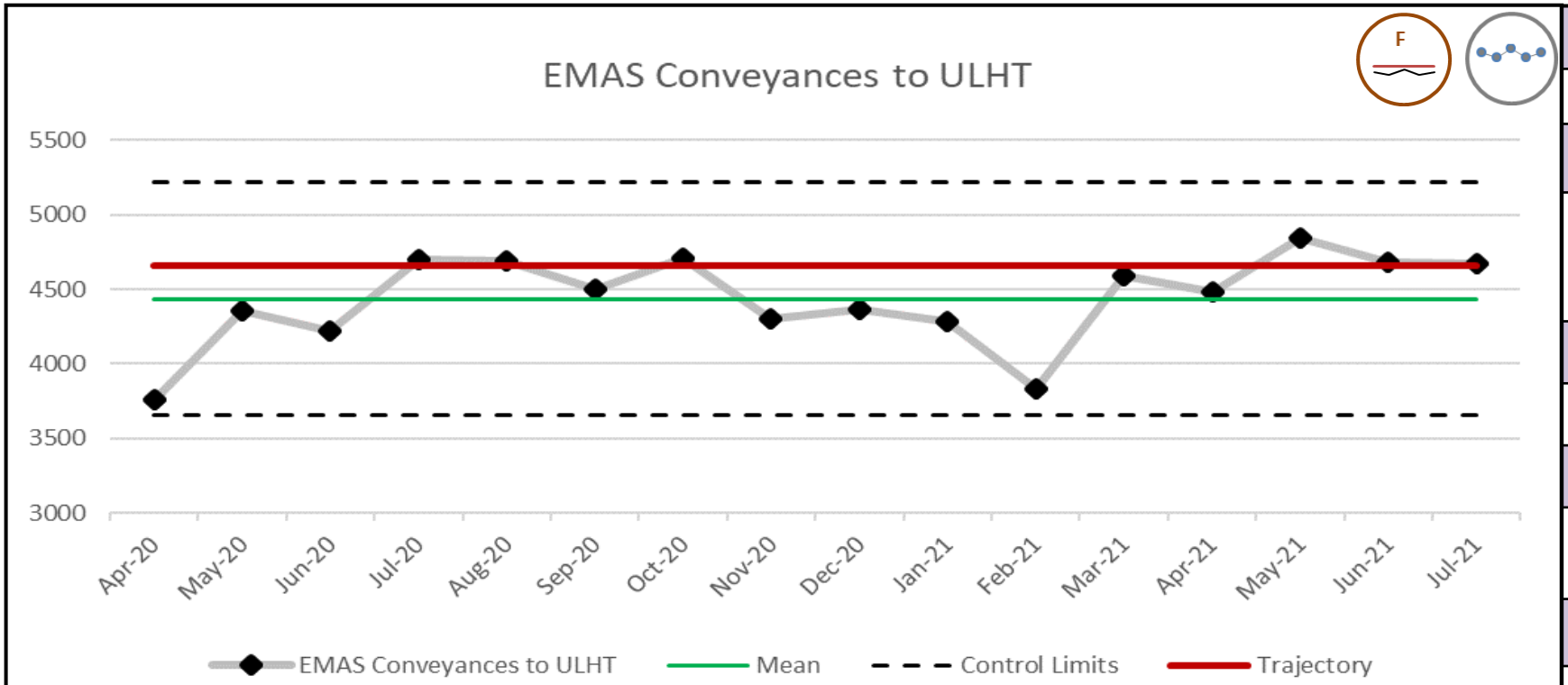
Background:
There is a zero tolerance for greater than 12-hour trolley waits. These events are reported locally, regionally and nationally.

What the chart tells us:
July experienced 9 x 12hr trolley waits.

Issues:
Sub-optimal discharges to meet the known emergency demand.
All reportable 12hr trolleys were associated with no available beds.
The 12hr trolleys were anticipated against flow predictions
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 in place to staff the Discharge Lounges 24/7 to reduce the number of patients in the Emergency Departments that are deemed 'Medically Optimised' that need onward non acute placement/support. . This has demonstrated a positive impact.
All decisions to admit have to be approved by the EPIC (Emergency Physician In Charge) with the relevant On Call Team.



Jul-21
4,669
Variance Type
Metric is currently experiencing Common Cause Variation
Target
4,657
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 has generally been static across EMAS but peak demand continues to be focused in the late afternoon and evening.

What the chart tells us:

The total number of conveyances to ULHT demonstrates a slight reduction for July, 4,669 compared to 4,685 in June. A reduction of 16 conveyances. This is a reduction of 0.35%.

Issues:

The pattern of conveyance is such that arrivals are loaded to the late afternoon and into the evening. This also coincides with increased 'walk ins'.

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

Pressure experienced by neighbouring Trusts have seen an increased ask for support. These in the main have been refused.

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:

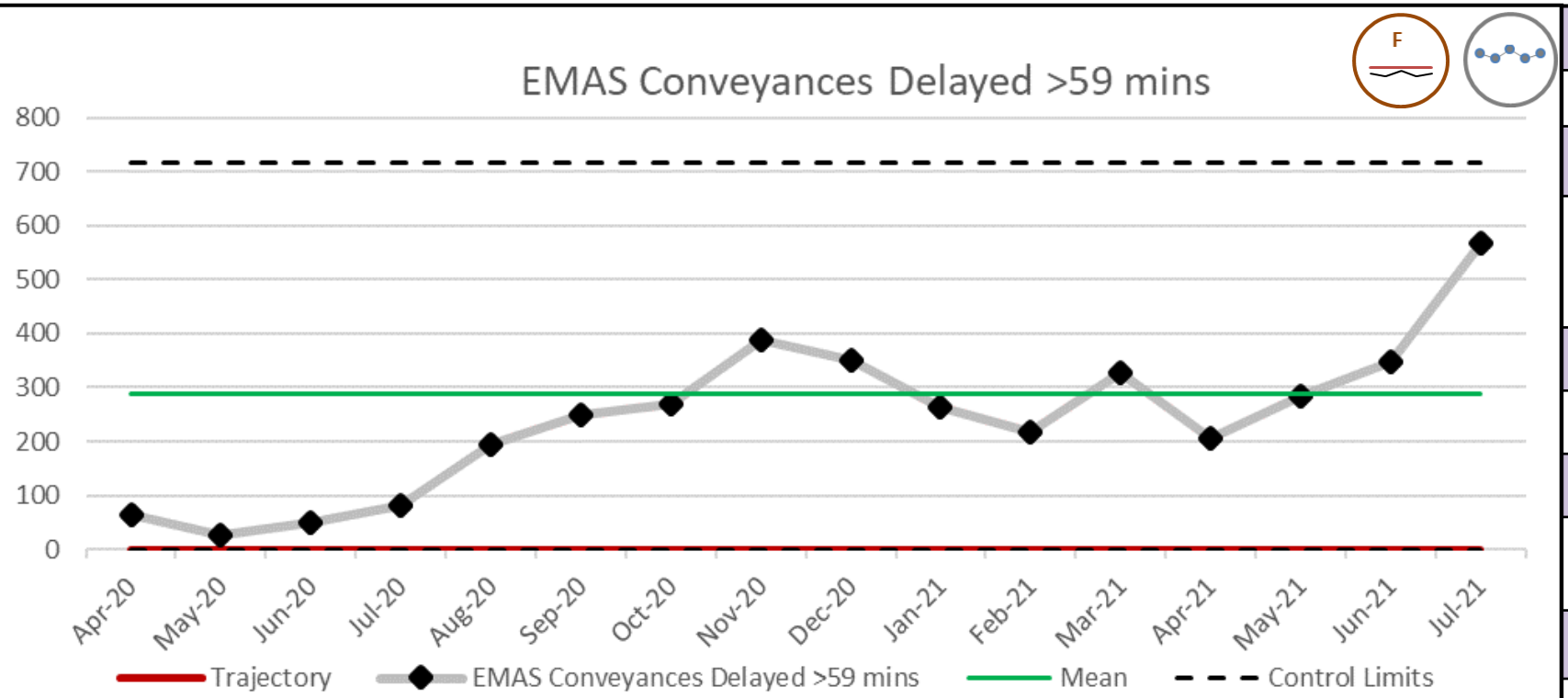
The increase to the overall footprint of our emergency department will assist in responding to ambulance arrivals.

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.

A revenue and capital bid has been submitted to NHSE/I to support identified areas on the LCH and PHB sites for safe 'cohorting' to reduce handover delays. The Trust is still awaiting feedback on the submission.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Jul-21
568
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. 568 in June compare to 349 in June. This represents a 38.56% increase.
What the chart does not tell us is the decrease on >4hrs and >3hrs in July 2021.

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.
PHB experience the highest number of >59-minute handover delays and is featured in the UEC FPEC report.

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

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

OUTSTANDING CARE personally DELIVERED

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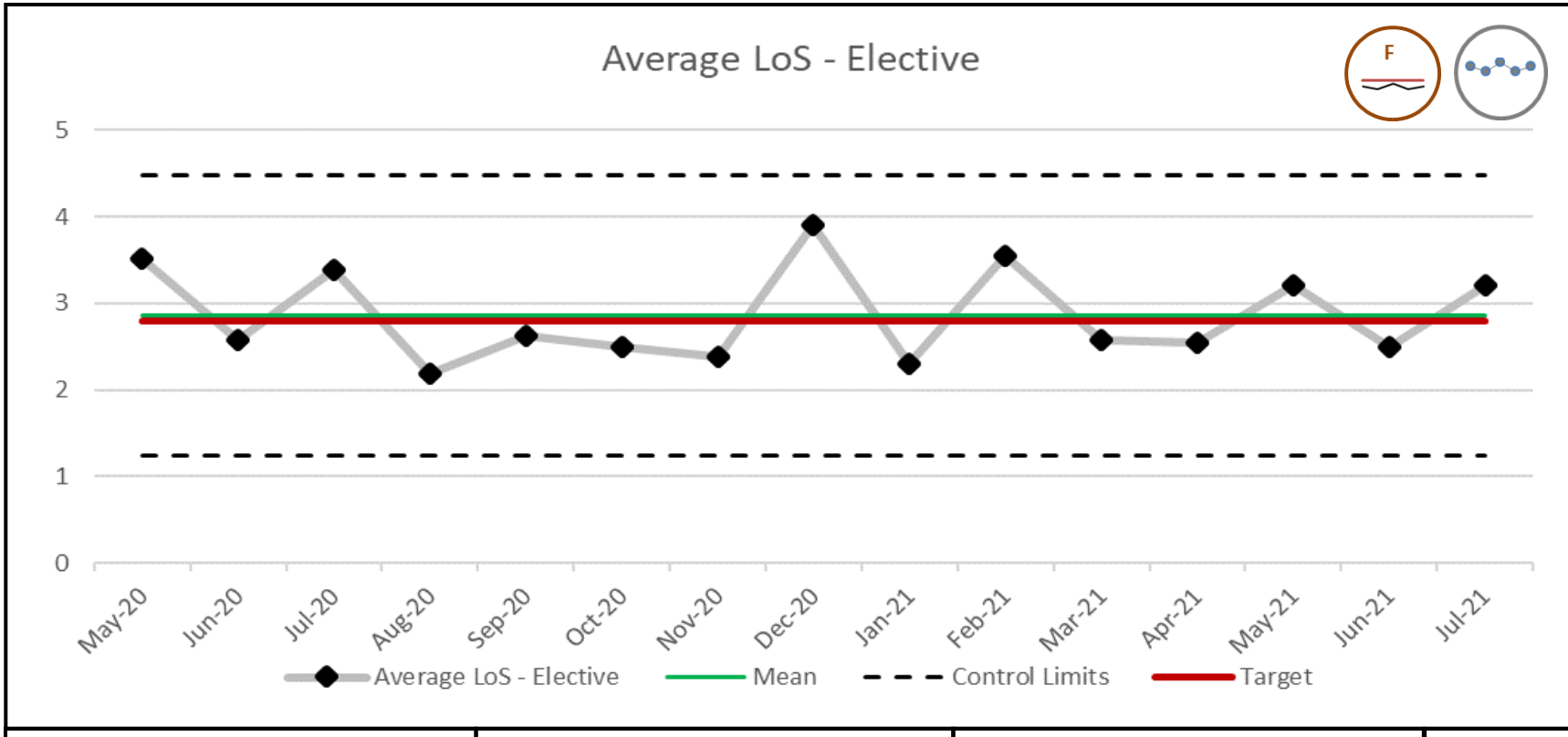

Jul-21
3.21
Variance Type
Metric is currently experiencing Common Cause Variation
Target
2.80
Target Achievement
Metric is failing the target
Executive Lead
Chief Operating Officer

Background:
Average length of stay for Elective inpatients.

What the chart tells us:
The average LOS for Elective stay has increased from 2.49 days in June to 3.21 days in July. This is an increase of 0.72 days and represents an increase of 22.43%
The trajectory for Elective LOS is 2.8 days

Issues:
Complexity of patients now being admitted which will impact on post-operative recovery and LOS.
Increase in Elective patients on pathways 1, 2 & 3.
Distorted figures associated with outliers in previous dedicated elective beds and coding.

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

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

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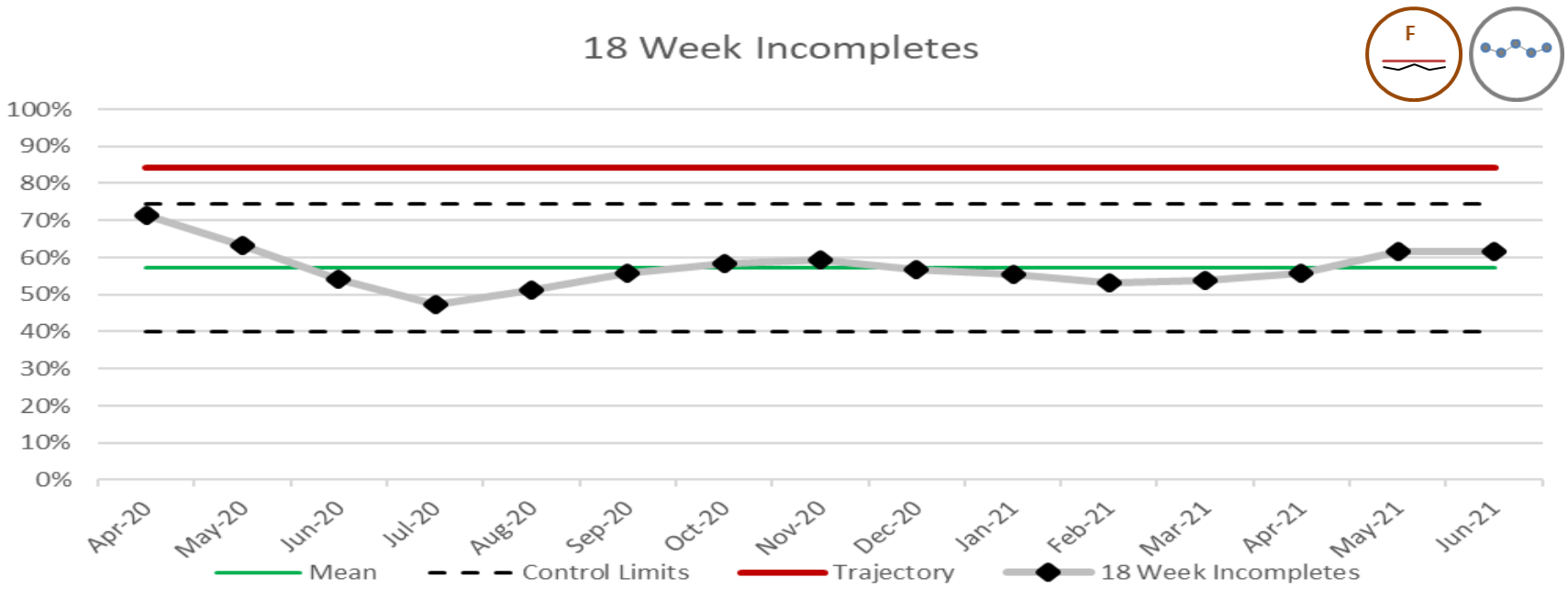

Jun-21
61.49%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
84.1%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
There is significant backlog of patients on incomplete pathways. June saw RTT performance of 61.49% against a 92% target, which is 0.14% down on May.

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 – 3305 (reduced by 91)
- ENT – 2983 (increased by 181)
- Gynaecology – 1740 (Increased by 99)
- Dermatology – 1719 (increased by 195)
- Max-Fax. Orthodontics and Oral Surgery – 1394 (increased by 60)
- Neurology was the lowest performing specialty, decreasing from 53.14% last month to 49.92% (decrease of 3.22%).

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

Mitigations:
Patient pathways are tracked and discussed at the weekly PTL meeting.

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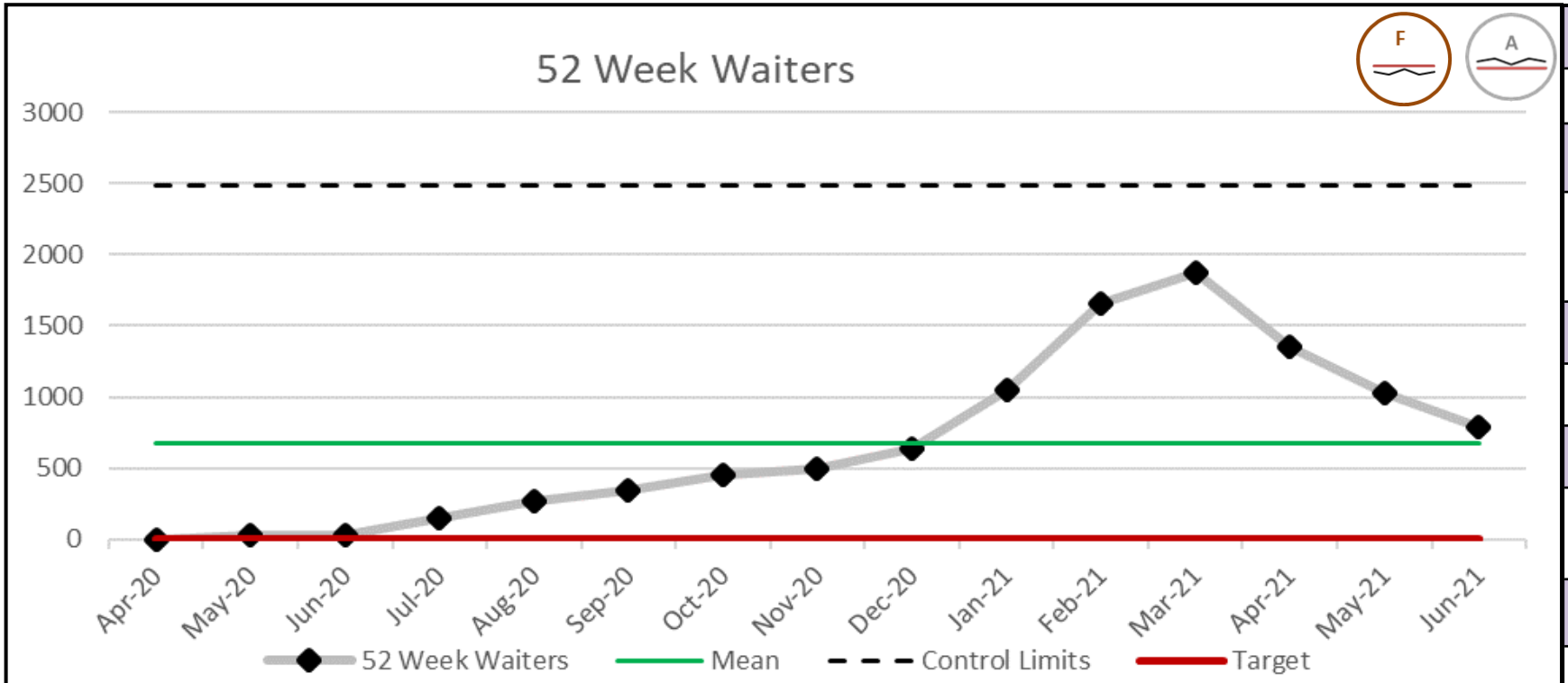

Jun-21
787
Variance Type
Metric is currently experiencing Special Cause Variation – above the mean
Target
0
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
The Trust reported 787 incomplete 52 week breaches. A decrease of 245 from May.
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. Wave 3 is also starting to impact on service delivery, which will detrimentally effect the 52 week position.

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

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

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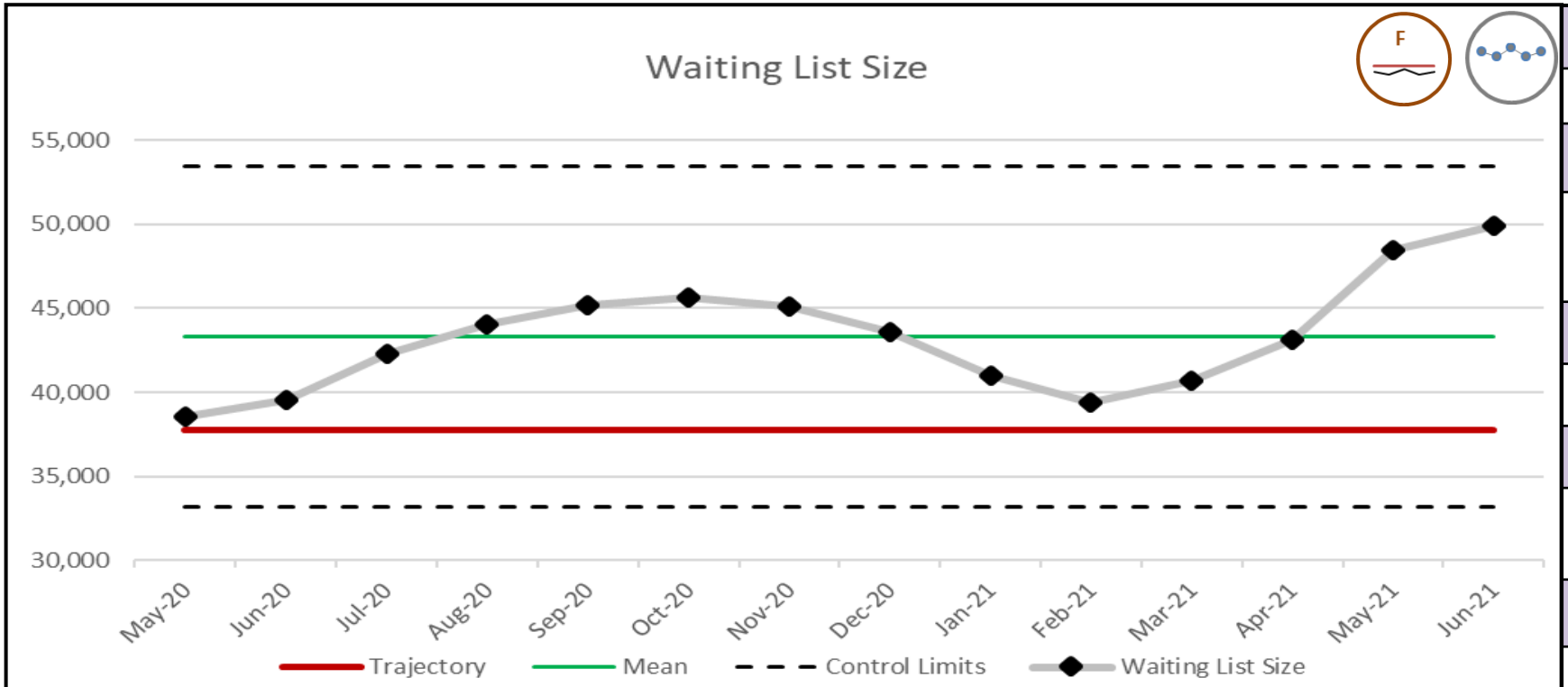


Jun-21
49,925
Variance Type
Metric is currently experiencing Common Cause Variation
Target
37,762
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
Overall waiting list size has increased from May, with June showing an increase of 1,450 to 49,925.
The incomplete position for June 2021 is now approximately 10,893 more than the March 2018 39,032) target.

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

- ENT +312
- Gynaecology +291
- Gastroenterology +264
- Dermatology +262
- General Surgery +189

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

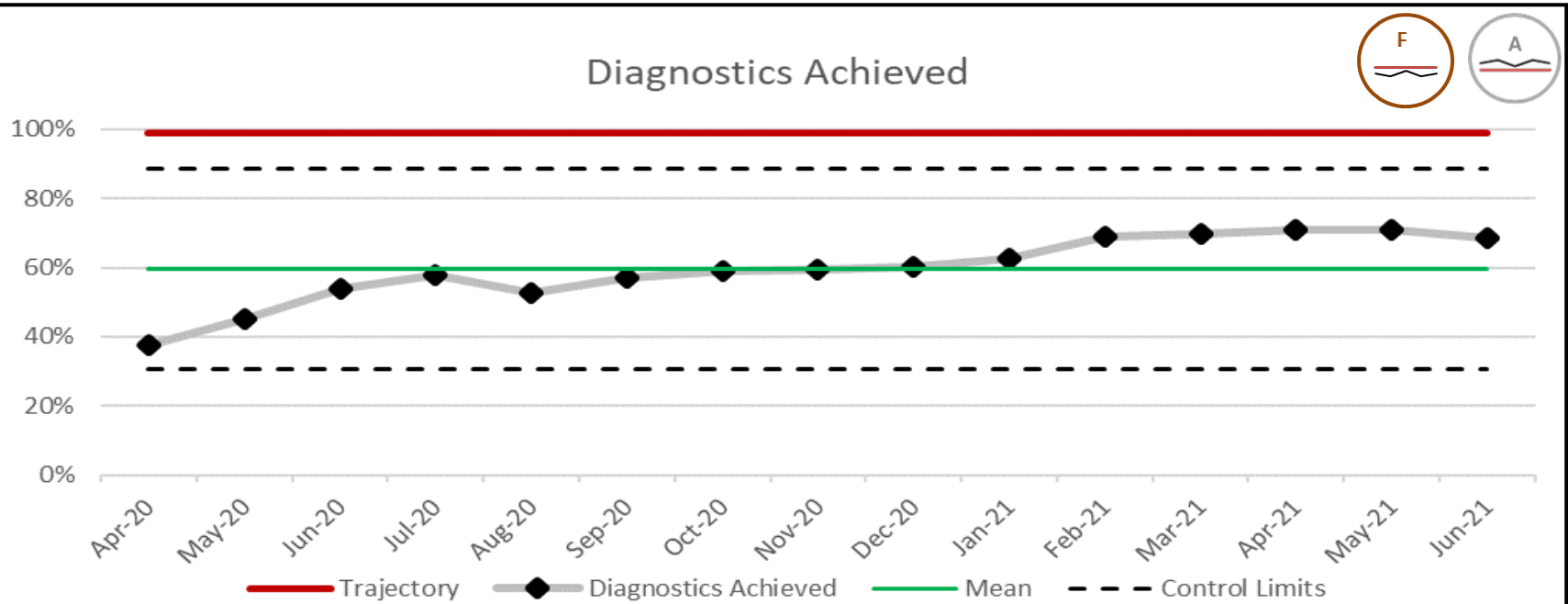
- Trauma and Orthopaedics -541
- Breast Surgery -36
- Clinical Oncology -34
- Community Paediatrics -33
- Diabetic Medicine -27

The Trust reported 3,604 over 40 week waits; an increase of 305 from May.
The numbers of patients waiting over 26 weeks decreased by 22 from May.

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.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Jun-21
66.35%
Variance Type
Metric is currently experiencing Special Cause Variation – above the mean
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 66.35% compared to 68.46% for June 2021 against the 99.00% target.

Area of Concern: The cardiology position appears to be worsening without mitigation activity pcm is also down.

Issues:
Cardiology - Echocardiography had 4271 breaches in July, 3695 in June and 2,848 breaches for May. Position is worsening by approx. 700 pcm with no perceived mitigation available. Without cardiology breaches DM01 position would have been recovered to pre-covid level. 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. Demand continues to be higher than capacity in many areas 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 from 120 to 74 in July. Additional CT Colon and Cardiac CT capacity put in place to deal with covid pathways and increased demand. This will be due to patient's choice and cardiologists' capacity. CT activity has increased by 1,500 a month compared to pre-covid levels. MRI – dropped from 42 breaches in May to 23 in July, majority of these are cardiac and general anaesthetic patients. Due to staffing issues DEXA breaches reduced from 14o in June to 81 in July. There is a long term plan to resolve this as staffing is recruited. Additional lists being provided adhoc by existing staff. Physiological Sciences. Neurophysiology - peripheral neurophysiology LCH is reporting 28 for July against 37 in June and 65 for May. Waiting lists are monitored weekly. Endoscopy - Cystoscopy carried out within endoscopy had 1 in July and 7 in June compared to 46 breaches in May which is a sustained improvement. Colonoscopy is 80 in July, 193 in June and 307 breaches in May. These are the planned surveillance and lowest risk patients and are being carried out within 41 days.

Actions:
Where demand out strips capacity additional resource is being sort, but this is proving difficult to obtain in cardiology echoes. CT additional capacity ends Sept 1st 2021.

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.

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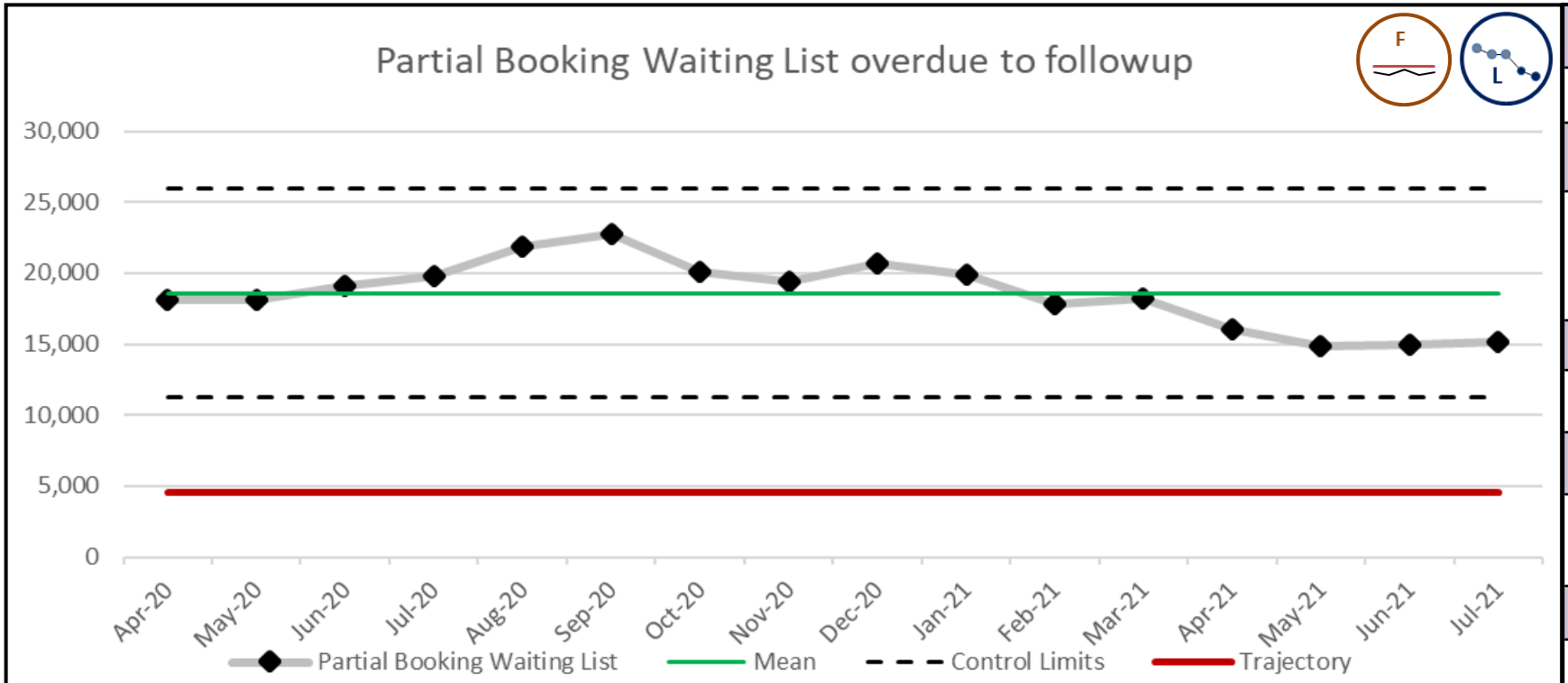

Jul-21
15,193
Variance Type
Metric is currently experiencing Special Cause Variation – low trend
Target
4,524
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 15,193 against a target of 4,657.
Due to Covid the number of patients overdue a follow up appointment significantly increased. Recovery work has taken place and has reduced the number of patients overdue but not to the target required.

Issues:
Conflicting priorities, increasing demand, resources, space, aligning requirements.

Actions:
Service recovery plans produced and updated, meeting regularly 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 organisational priorities taking individual outpatient clinics down, if support required across the sites (site/patient flow and theatres).

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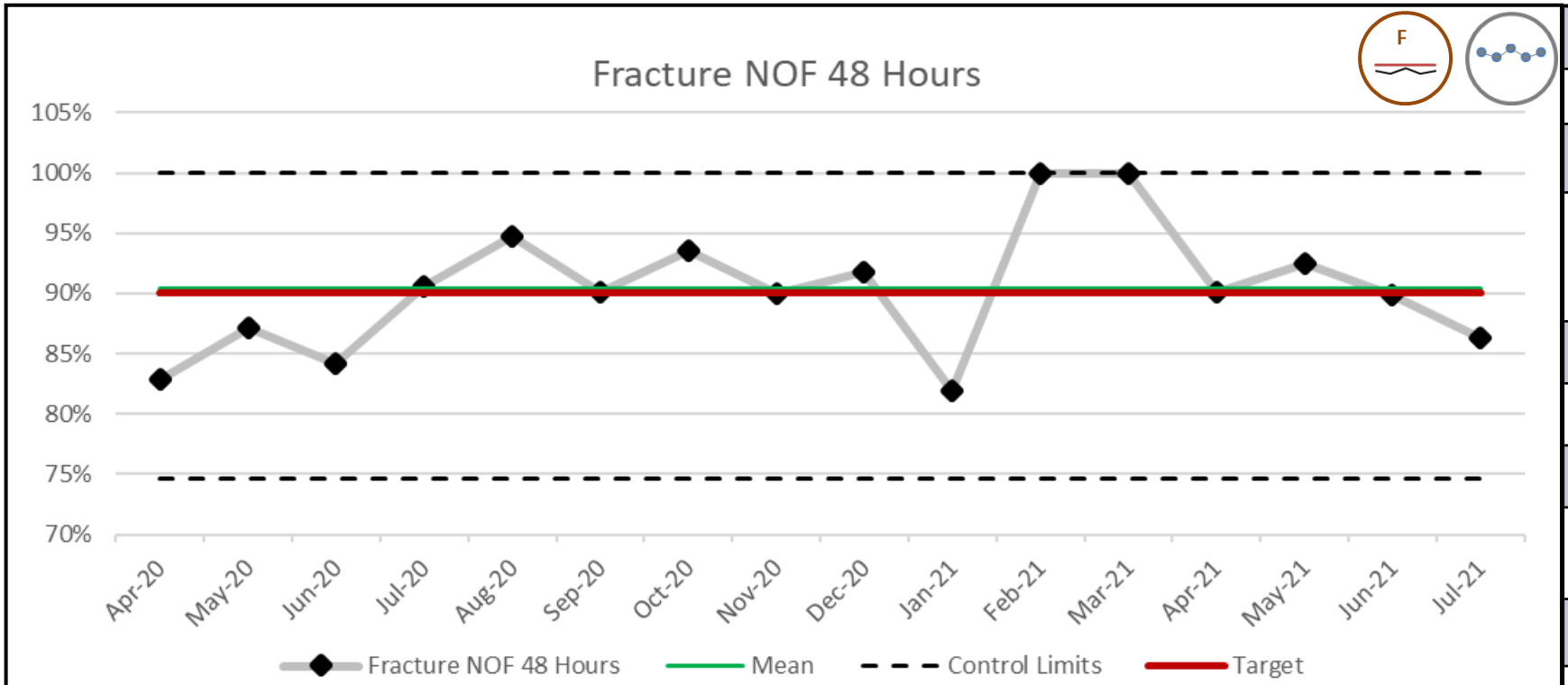
NHS United Lincolnshire Hospitals NHS Trust



Jul-21
86.36%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
Metric is consistently 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 July 21 performance was 86.36% 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.
- Delays for NOF's included reduced theatre capacity, patients medically unfit to proceed and the need for specialist surgeon availability.

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.
- Daily attendance at the trauma meeting by the clinical business unit to improve communication, visibility of current position and increased support for theatre utilisation and extra capacity needed

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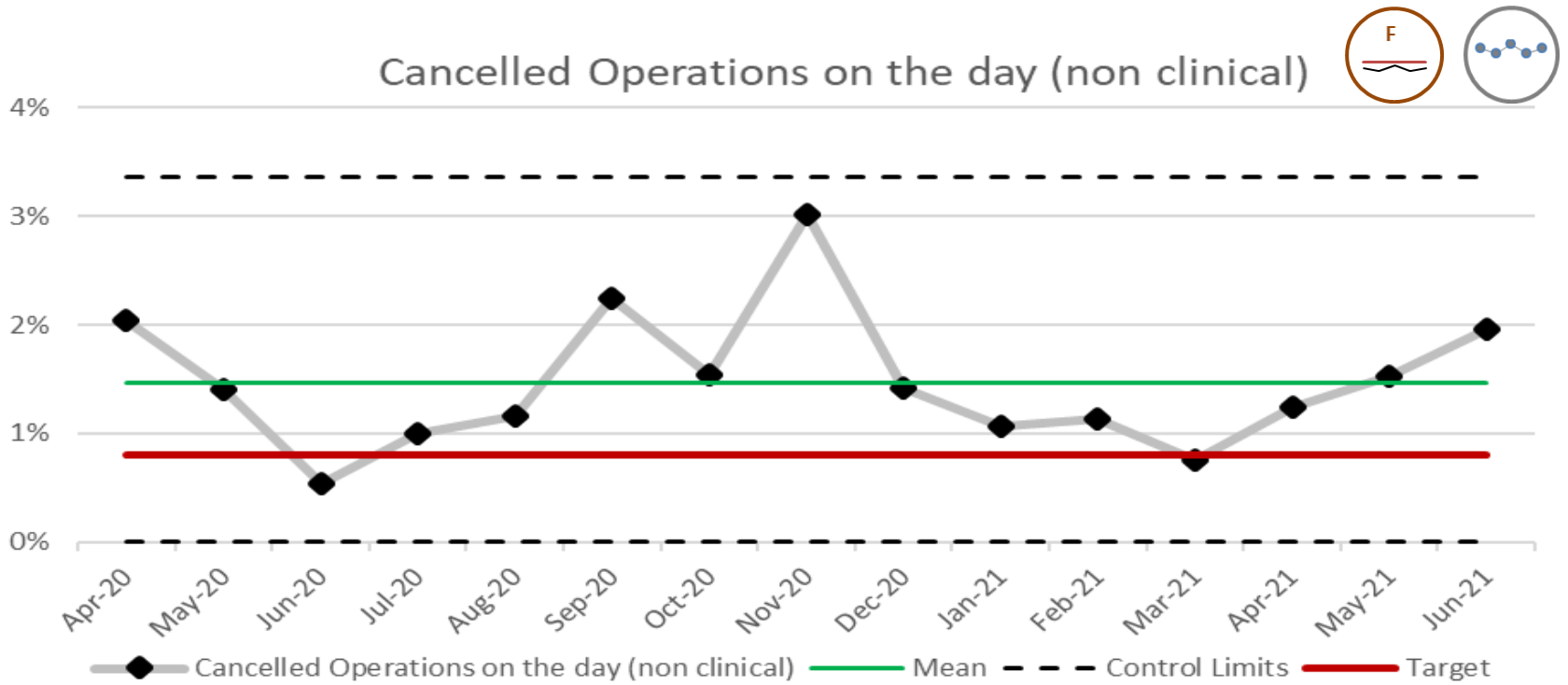


Jun-21
1.95%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
0.8%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

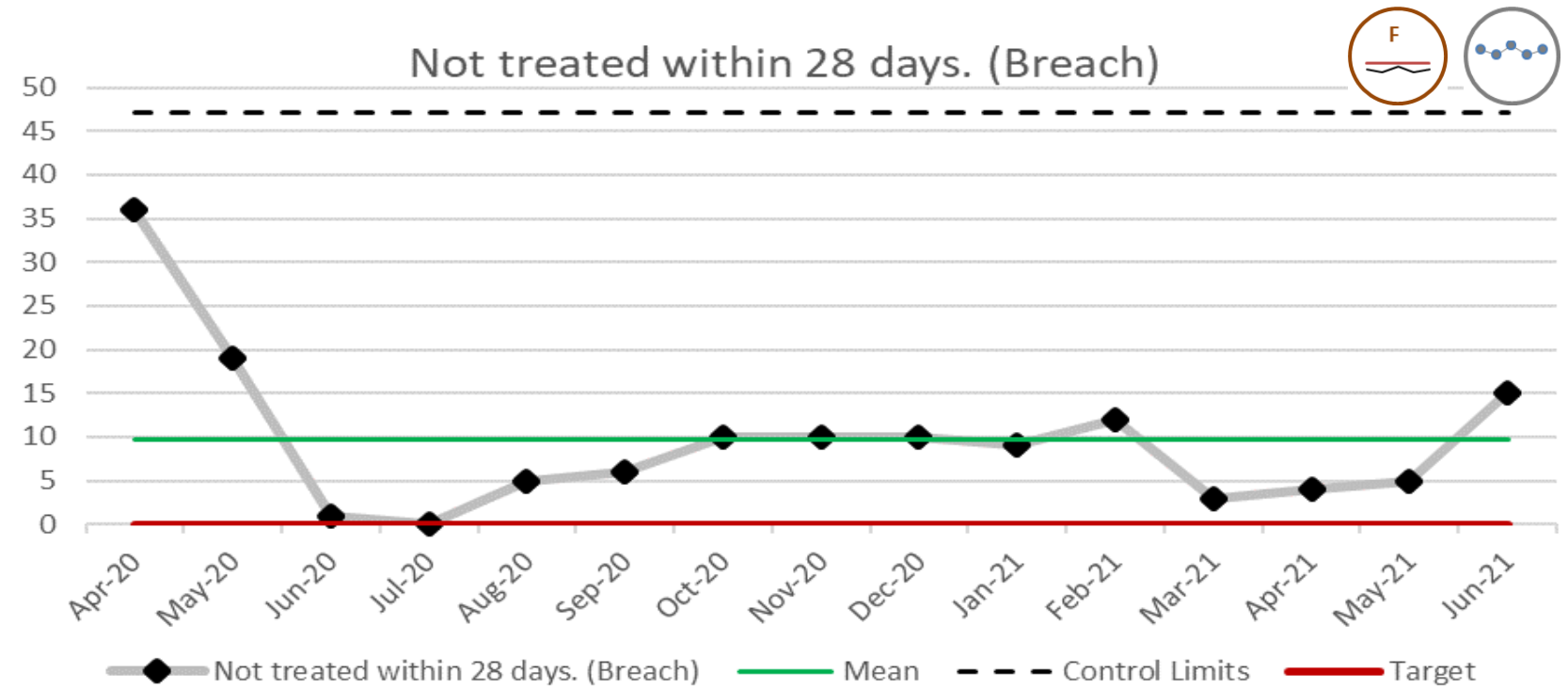
Background:
Percentage of cancelled operations on the day for non-clinical reasons. Cancellation of operations across ULHT causing a slow recovery of the time patients wait for surgery.

What the chart tells us:
Increasing level of cancellations on the day occurring is trending back up with the expansion in elective activity and an increase in emergency site activity.

Issues: Primary reasons for on the day cancellations is site capacity and the lack of capacity on the Lincoln and Pilgrim sites due to emergency pressures.
Other reasons include; patients being medically unfit/ unwell, patients no longer requiring the surgery, lack of theatre time, and lack of HDU/ITU beds. In May main issues involved Pre assessment. In June main issues were site bed capacity.

Actions: Daily review undertaken by the Divisional theatre teams, waiting list teams and CBU leads to review cancellations and identify causes of cancellations in the last 24 hours.
642 process revitalised to ensure the lists identified are filled with the appropriate number of patients.

Mitigations: Proactive review at the same meeting of the next two days going forward to identify if lists are going to be adversely affected. Review of patients on list and on the availability of theatre staff, surgical and anaesthetic staff as well as site capacity and bed availability (specifically Lincoln and Pilgrim site).
642 process reviewed and updated ensure lists appropriately filled and clinical staff identified.



Jun-21
15
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 breaches where patients have not been treated within 28 days of a last minute cancellation.

What the chart tells us:
Majority of breaches associated with Level 1 and level 2 bed availability. While activity has increased to catch up on backlog Level 1 and 2 bed availability has been impacted on by bed availability within Critical care.

Issues: Availability of level 1 and level 2 beds causing cancellations on the day. Back log of level 1 and level 2 activity on the Lincoln and Pilgrim sites.

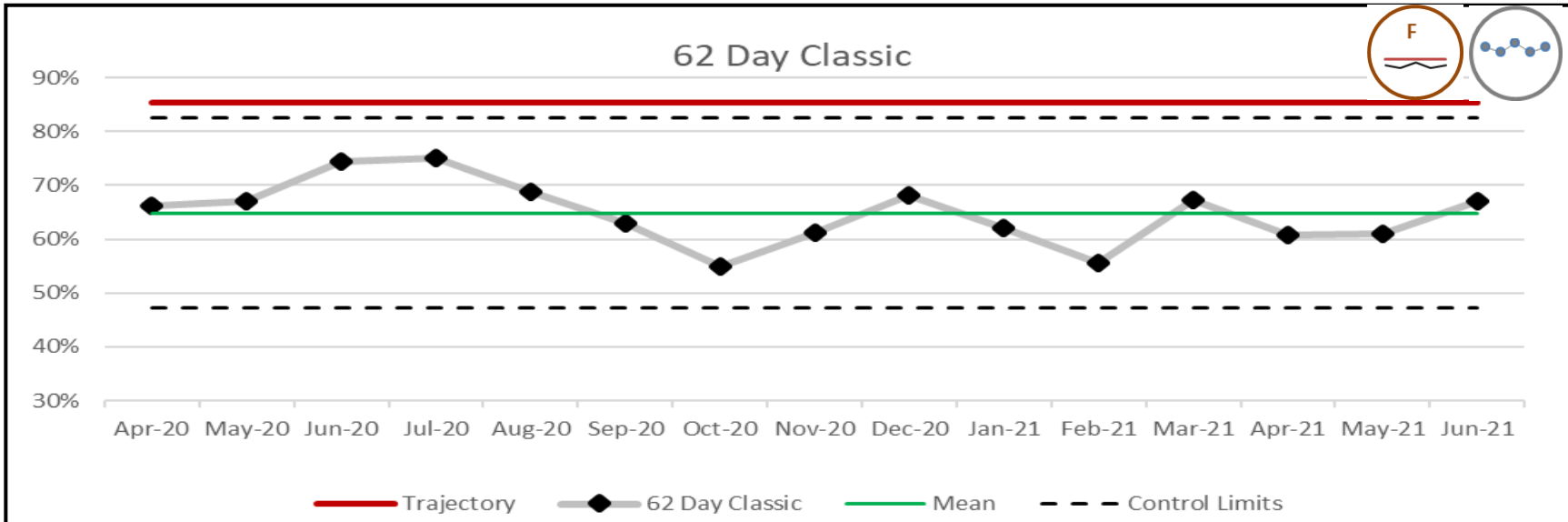
Actions: Daily review undertaken by the Divisional theatre teams, waiting list teams and CBU leads to review cancellations and identify causes of cancellations in the last 24 hours.

Review of Level 1 activity and moving activity if suitable to Grantham where new level 1 beds have been created.

Mitigations:
Moving Level 1 activity to Grantham. Creation of level 1 facility on day case at Pilgrim (business case to be done).

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Jun-21
67.0%
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 67.0% against an 85.4% target.

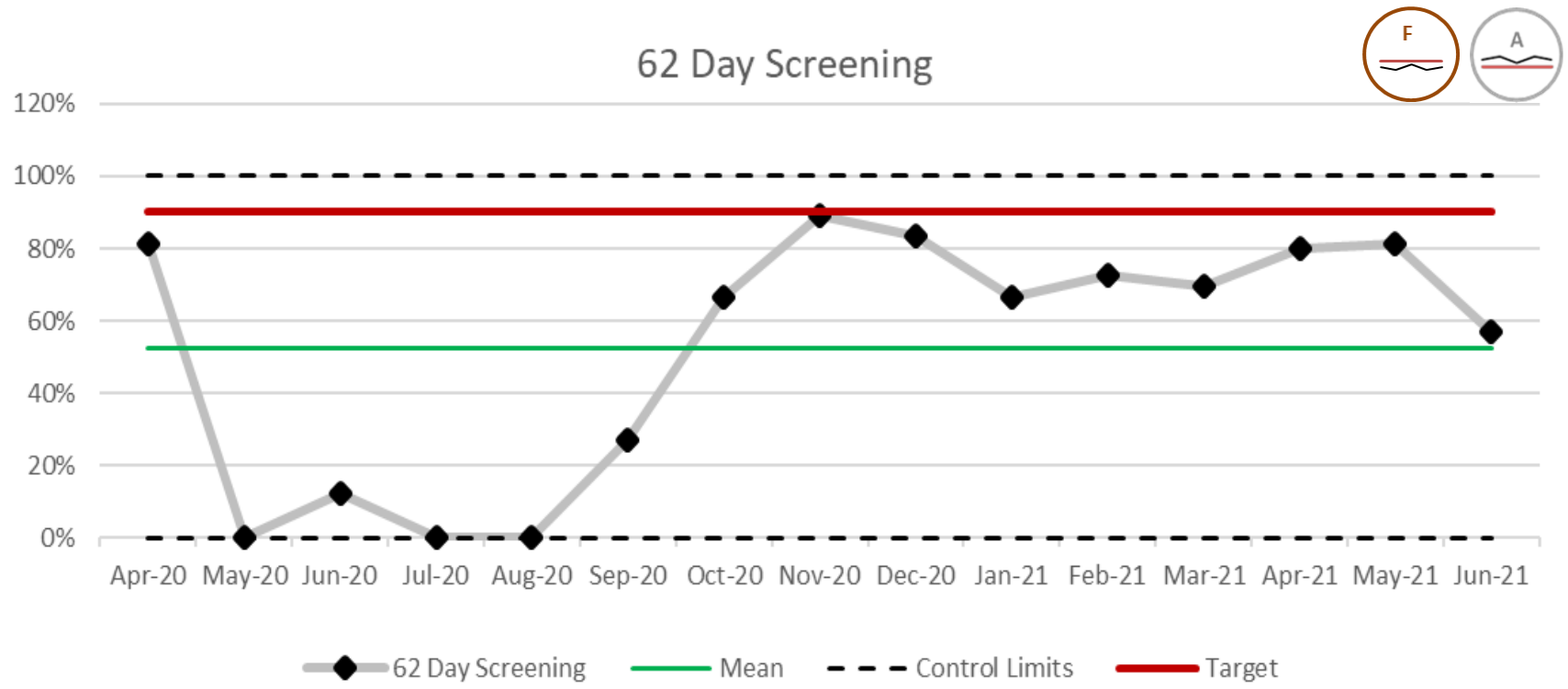
Issues:
Patient engagement in diagnostic process (reluctance to visit hospitals due to perceived COVID-19 risk, including those waiting for vaccines or the 3 week 'effectiveness' period). This is continuing to reduce.
Reduced clinic throughput due to social distancing / IPC requirements, especially in waiting areas. Patient acceptance & compliance with swabbing and self-isolating requirements. Patients not willing to travel to where our service and / or capacity is.
Managing backlogs significantly in excess of pre-COVID levels for Colorectal, 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. Two substantive Medical Oncologists were recruited, one is due to start in November 2021 (covering Breast, Renal and Urology). Unfortunately, the second post has gone back out to advert after the applicant withdrew. Funding from EMCA is in place for full-time Cancer Navigator posts to support Surgery, Medicine and Family Health. Recruitment processes are underway with posts commencing in August and September for Family Health and Medicine. Endoscopy are in the early stages of undertaking a review around the Bowel Cancer Screening age extension and endoscopy staffing. The intention is to increase the clinical endoscopist workforce with less reliance on consultants and also to increase administrative support by converting fixed term into substantive posts. Work to enhance the early identification of patients requiring Pre-Diagnosis CNS support is ongoing.

Mitigations:
Theatre capacity is returning to Pre-covid levels. Following a 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) have been delivered and installed. Radiology have increased their internal reporting capacity. There is also an Increase in CTC capacity whilst we have the relocatable and modular staffing - from 336 slots pcm to 530 slots pcm. A review of colorectal theatre list scheduling in order to better align with clinician availability continues and Grantham Theatres have now returned to undertaking suitable Level 1 colorectal work. 2 H&N consultant posts have been recruited, 1 started in April 2021, and another commenced in July 2021.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Jun-21
57.14%
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

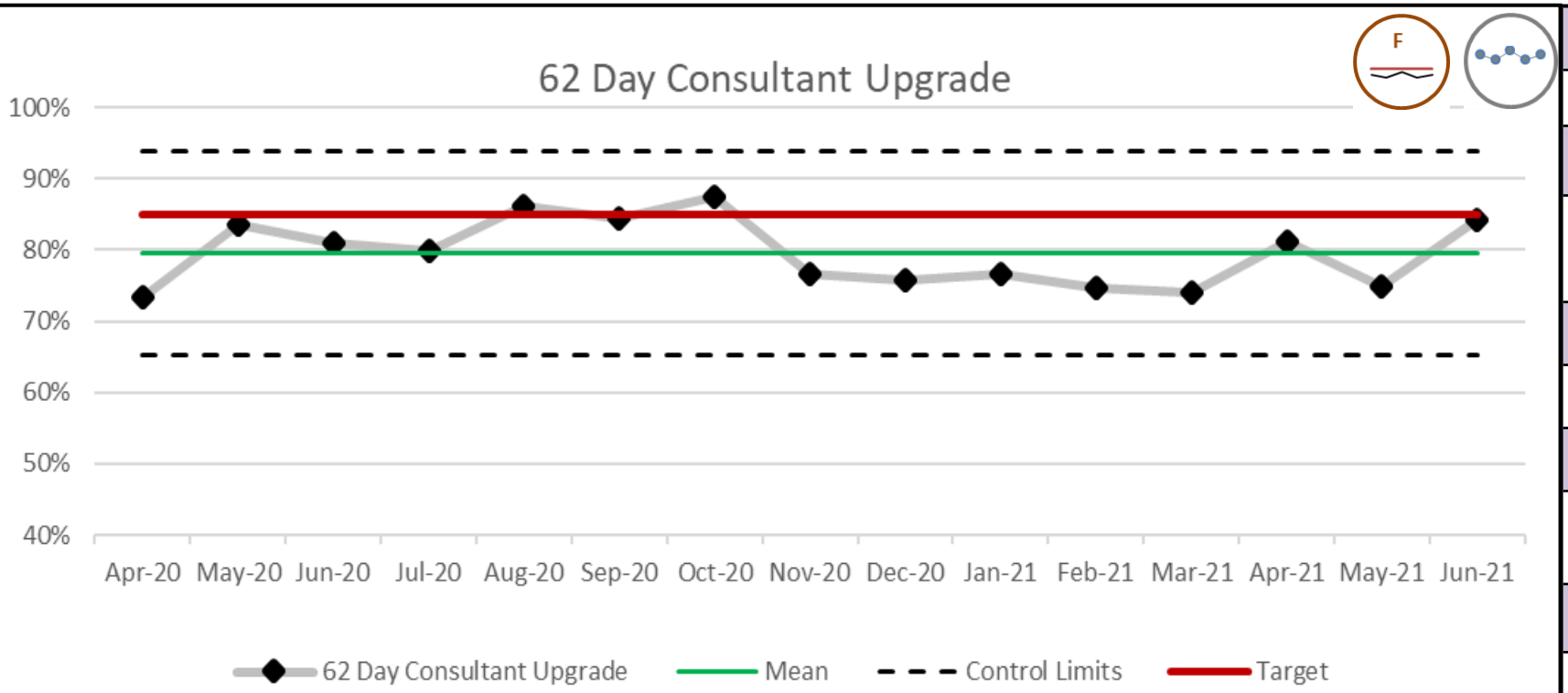
Background:
Percentage of patients to start a first treatment within 62 days of referral from an NHS cancer screening service.

What the chart tells us:
We are currently at 57.14% 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.



Jun-21
84.12%
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 84.12% against an 85% target

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

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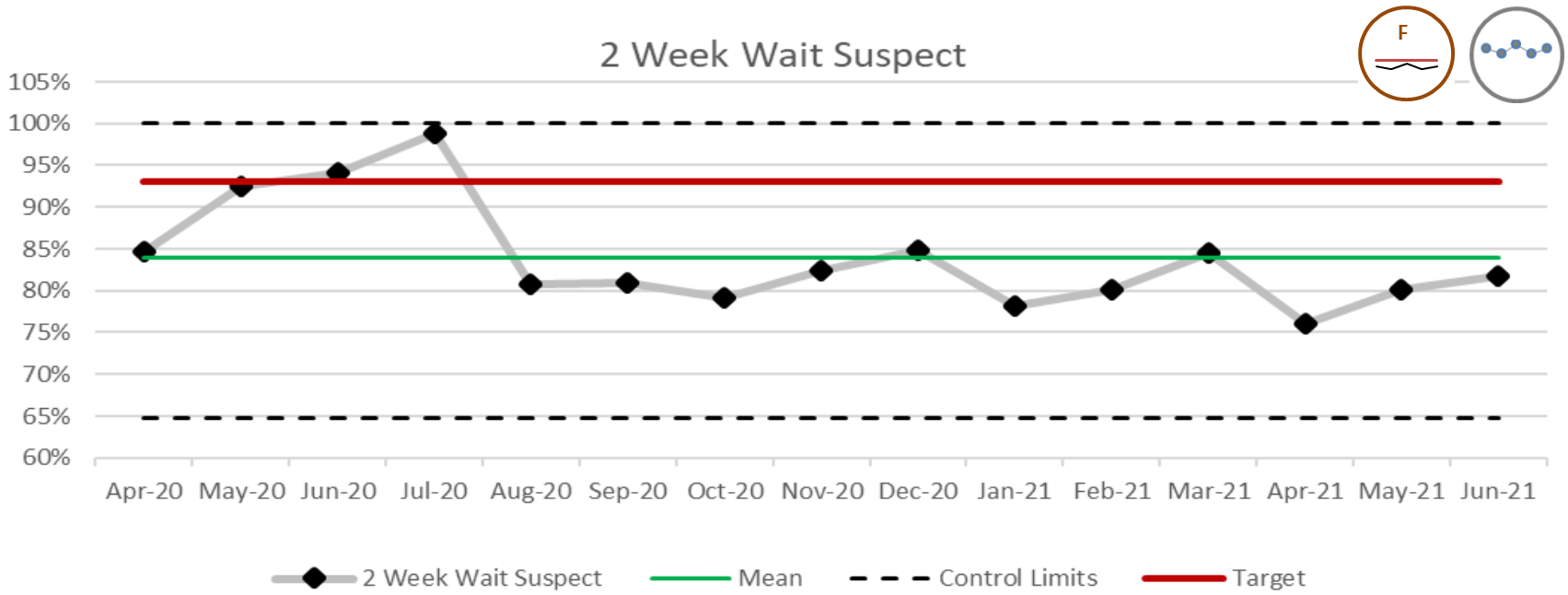
Mitigations:
See mitigations on previous page – 62 day classic.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Jun-21
81.73%
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 81.73% against a 93% target.

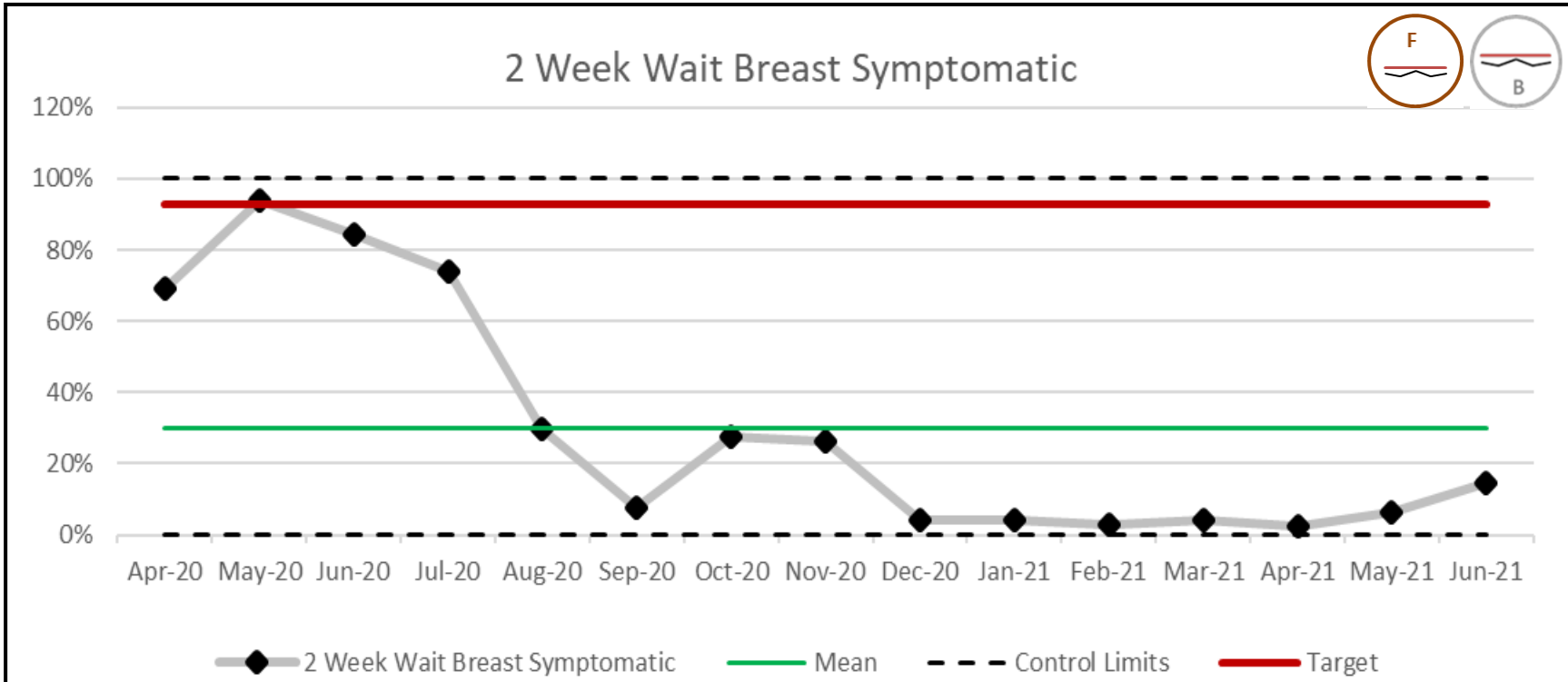
Issues:
The Trust's 14 Day performance continues to be significantly impacted by the current Breast Service One-Stop appointment alignment issues - 73% of the Trust's 14 Day breaches were within that tumour site. The other tumour sites that considerably under-performed include Gynaecology (64.7%) and Haematology (84.6%), with Lung and Upper GI narrowly missing the target (both at 90.9%). All other tumour sites achieved the standard. Reduced clinic throughput due to social distancing / IPC requirements, especially in waiting areas. Patient acceptance & compliance with swabbing and self-isolating requirements. Patients not willing to travel to where our service and / or capacity is.

Actions:
The Trust is actively seeking to secure the commencement of an Upper GI direct access pathway by the end of September), while a direct access pathway for gynaecology ultrasound is planned to commence by the end of August. A scoping exercise is underway in respect of the bladder and testicular pathway – this includes a direct access pathway and haematuria one stop clinics. Clinical sign-off took place in June and is planned to be in place by the end of August. Additional Urology F2F capacity is being introduced as activity returns to the peripheral sites – it is anticipated this will also commence by the end of August. Work to enhance the early identification of patients requiring Pre-Diagnosis CNS support is ongoing.

Mitigations:
Further respiratory consultant posts (commencing between August and October) will secure lung clinic capacity and support the pilot to appoint lung patients within 48 hours.
Breast clinic capacity has now been restored to pre-COVID levels and additional clinics to clear the backlog are being sought.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Jun-21
14.53
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 14.53% against a 93% target.

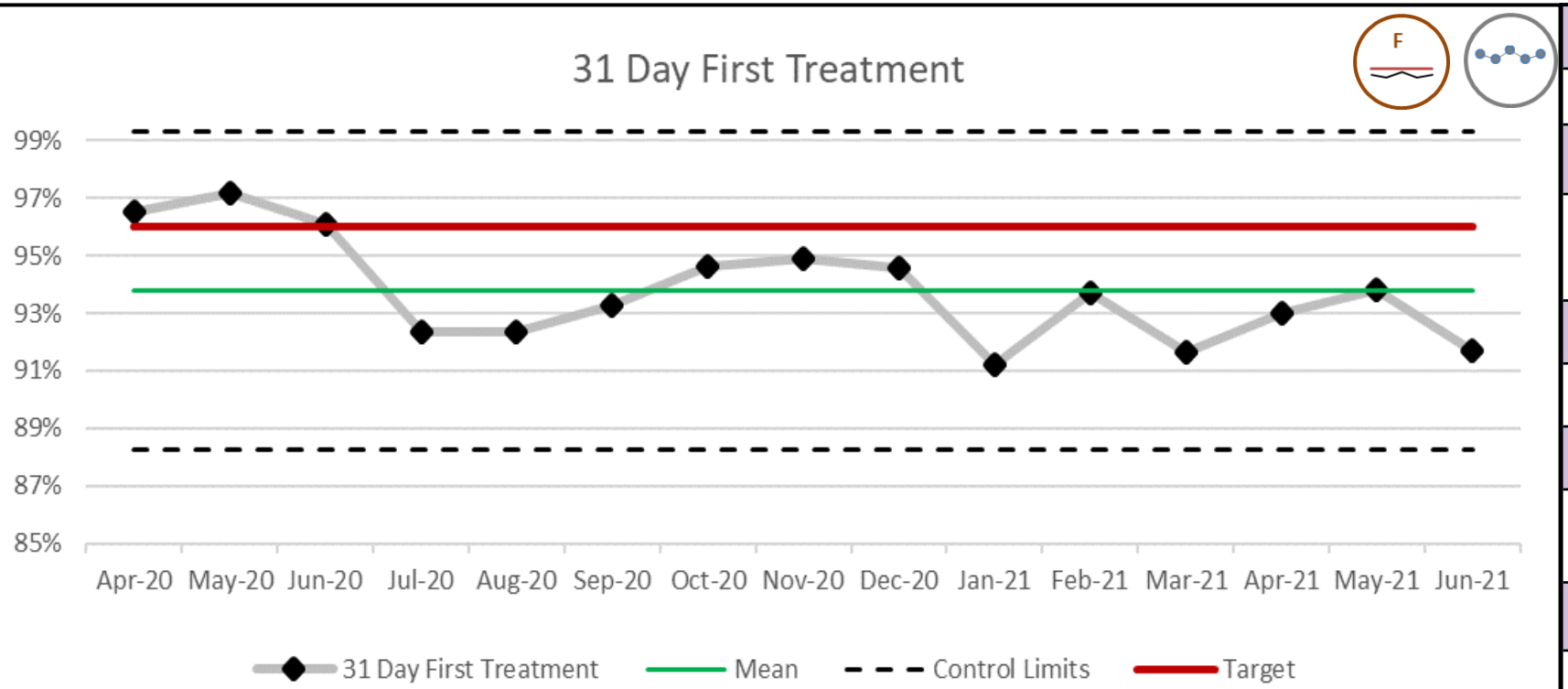
Issues:
The 14 Day Breast Symptomatic has been affected by the same impact of the Breast Service One-Stop appointment alignment issues. Reduced clinic throughput due to social distancing / IPC requirements, especially in waiting areas.

Actions:
A comprehensive review of Breast Services is ongoing following the final report issued by NHSI support.

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

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Jun-21
91.67%
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 91.67% against a 96% target.

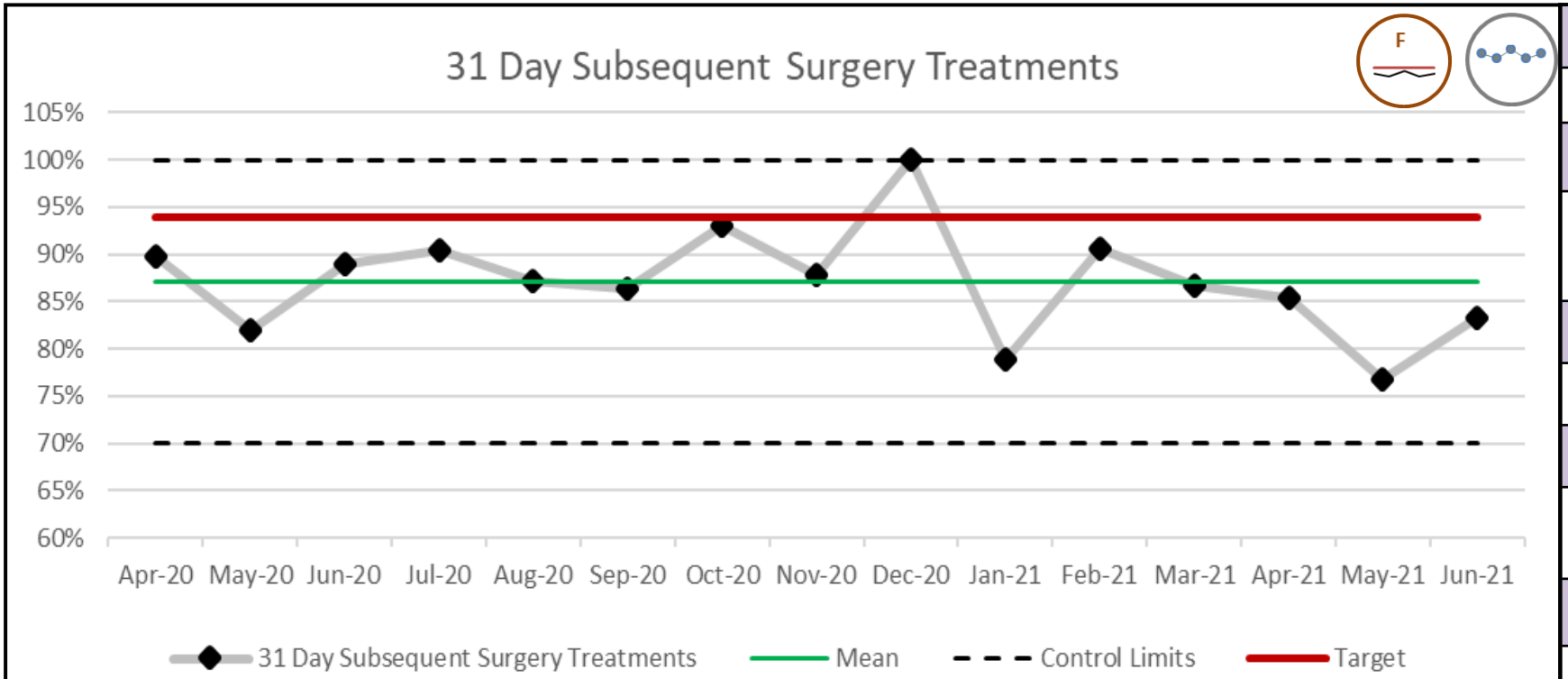
Issues:
The failure of the 31 Day standards was primarily due to the impact of COVID (the reduction in theatre capacity).
For the subsequent standards the Trust was successful in the Drug and Radiotherapy standards, only failing in the surgery standard.
Reduced theatre capacity across the Trust, all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

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

Mitigations:
A review of colorectal theatre list scheduling in order to better align with clinician availability continues, and Grantham Theatres have now returned to undertaking suitable Level 1 colorectal work.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Jun-21
83.33%
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 83.33% against a 94% target.

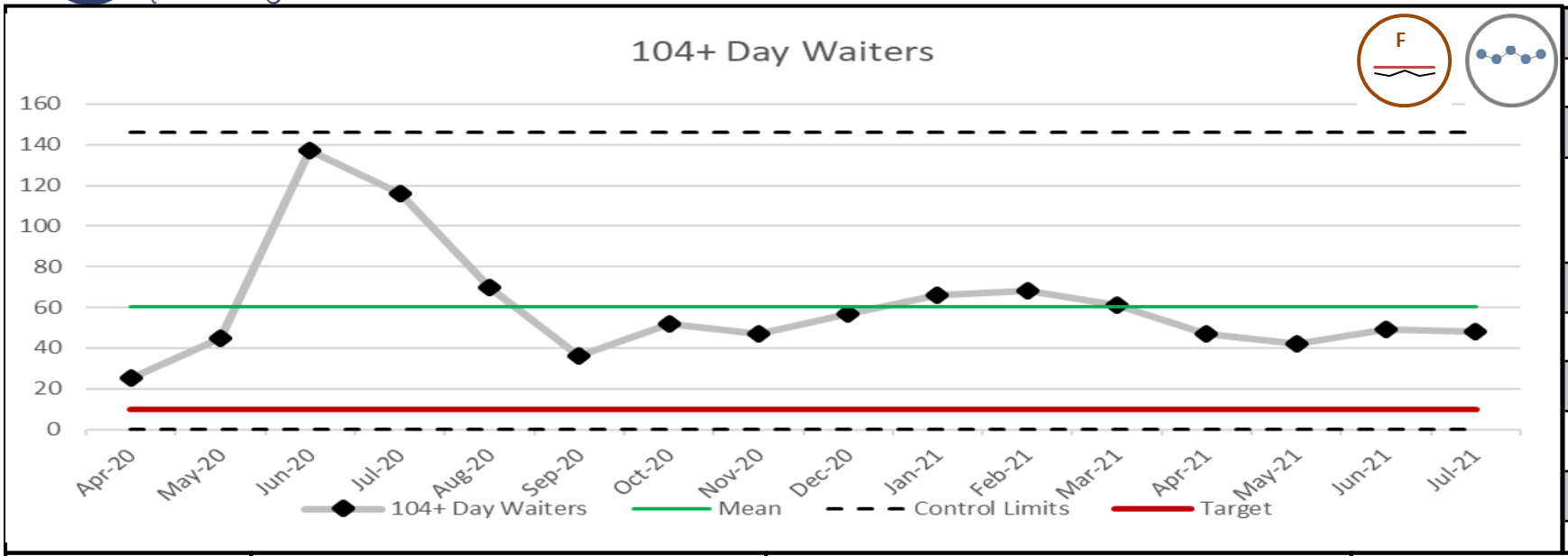
Issues:
See issues on previous page – 31 day first treatment.

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

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

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Jun-21
48
Variance Type
Metric is currently experiencing Common Cause Variation
Target
10
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:
Number of cancer patients waiting over 104 days.

What the chart tells us:
As of 12th of August the 62 Day backlog is at 232 patients. The agreed target is <40. As of 12th of August the 104 Day backlog is at 52 patients. The agreed target is <10. The current position by tumour site is: 29 Colorectal, 7 each Urology and Head & Neck, 3 each Gynaecology & Upper GI, 1 each Breast, Lung, and Skin.

Issues:
Patient engagement in diagnostic process (reluctance to visit hospitals due to perceived COVID-19 risk, including those waiting for vaccines or the 3 week 'effectiveness' period) – this is starting to improve.
Reduced clinic throughput due to social distancing / IPC requirements, especially in waiting areas.
Patient acceptance & compliance with swabbing and self-isolating requirements. Patients not willing to travel to where our service and / or capacity is.
Reduced theatre capacity across the Trust, all Specialties vying for additional sessions. Managing backlogs significantly in excess of pre-COVID levels for Colorectal, 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 12% of these patients require support from the Pre-Diagnosis CNS as they have mental or social care needs that have the potential to significantly impact on the length of their pathway.

Actions:
28 Day standard identified as Trust's cancer performance work stream in the Integrated Improvement Program for 2021-22. Two substantive Medical Oncologists were recruited, one is due to start in November 2021 (covering Breast, Renal and Urology). Unfortunately, the second post has gone back out to advert after the applicant withdrew. Funding from EMCA is in place for full-time Cancer Navigator posts to support Surgery, Medicine and Family Health. Recruitment processes are underway with posts commencing in August and September for Family Health and Medicine. Endoscopy are in the early stages of undertaking a review around the Bowel Cancer Screening age extension and endoscopy staffing. The intention is to increase the clinical endoscopist workforce with less reliance on consultants and also to increase administrative support by converting fixed term into substantive posts.

Mitigations:
Theatre capacity is returning to Pre-covid levels. Following a 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) have been delivered and installed. Radiology have increased their internal reporting capacity. There is also an Increase in CTC capacity whilst we have the relocatable and modular staffing - from 336 slots pcm to 530 slots pcm. A review of colorectal theatre list scheduling in order to better align with clinician availability continues and Grantham Theatres have now returned to undertaking suitable Level 1 colorectal work. 2 H&N consultant posts have been recruited, 1 started in April 2021, and another commenced in July 2021.Work to enhance the early identification of patients requiring Pre-Diagnosis CNS support is ongoing.

PERFORMANCE OVERVIEW - WORKFORCE

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	May-21	Jun-21	Jul-21	YTD	YTD Trajectory	Latest Month Pass/Fail	Trend Variation	Kitemark
A Modern and Progressive Workforce	Overall percentage of completed mandatory training	Safe	People	Director of HR & OD	95%	89.64%	91.26%	90.89%	89.92%		F		
	Number of Vacancies	Well-Led	People	Director of HR & OD	12%	8.50%	11.31%	11.57%	10.25%		P		
	Sickness Absence	Well-Led	People	Director of HR & OD	4.5%	4.96%	4.97%	5.05%	5.00%		F		
	Staff Turnover	Well-Led	People	Director of HR & OD	12%	11.31%	11.69%	12.01%	11.45%		F		
	Staff Appraisals	Well-Led	People	Director of HR & OD	90%	74.92%	72.19%	67.95%	72.87%		F		
					£'000	£'000	£'000	£'000	£'000				
	Agency Spend	Well-Led	People	Director of HR & OD	-£2,757	-£3,718	-£3,417	-£3,745	-£14,728		F		

OUTSTANDING CARE personally DELIVERED

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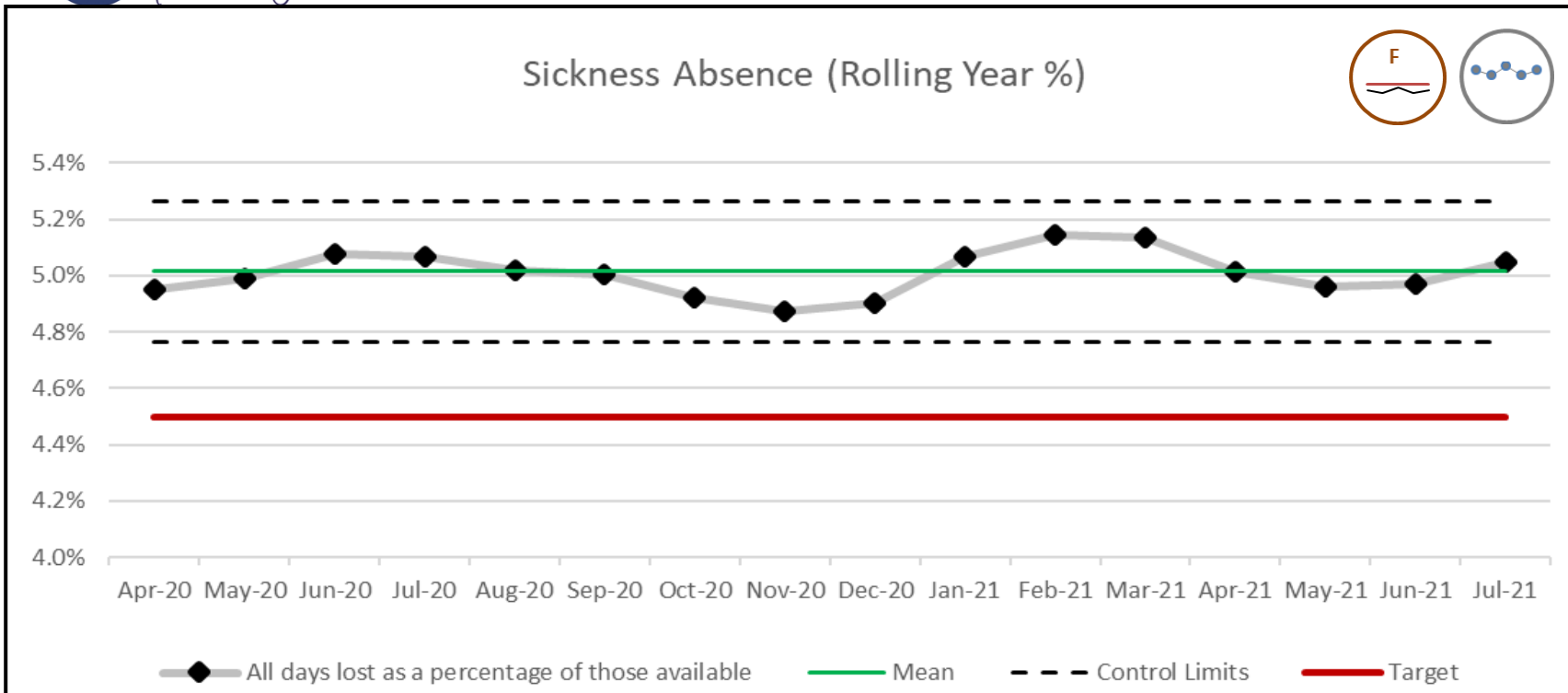

Jul-21
5.05%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
4.5%
Target Achievement
Metric is consistently failing to target
Executive Lead
Director of HR & OD

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 then been an increase since June which has continued with the increase in COVID cases through Wave 3.

Issues:
- As Wave 3 COVID continues with an increase in numbers both in the hospitals and community
- Lifting of restrictions, school holidays and the increase of the number of people having to isolate has impacted on absence figures.
- The Trusts reporting systems impact on accuracy of live real time data.

Actions:
- Removal of 10 days isolation following a negative PCR
- Review of absence data to cleanse and update, tis has impacted already on the data with absences reduced by approx. 100.
- Wellbeing calls to staff to support timely referrals and support.
- Go live beginning of sept for AMS case management

Mitigations:
See Actions.

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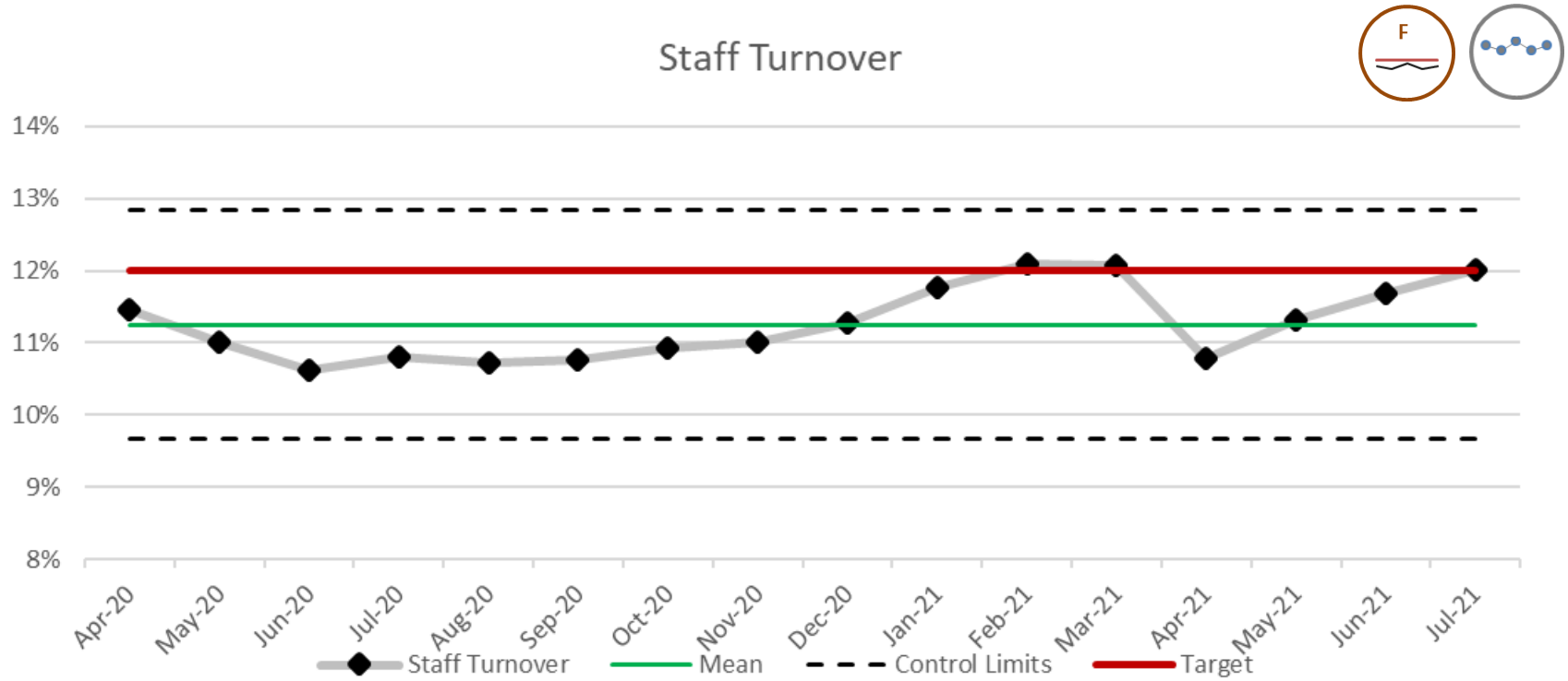
NHS United Lincolnshire Hospitals NHS Trust



Jul-21
12.01%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
12%
Target Achievement
Metric is failing to target
Executive Lead
Director of HR & OD

Background:
% of turnover over a rolling 12 month period

What the chart tells us:
The chart shows us that the pandemic stemmed turnover to some extent because staff were not looking to move in the midst of it all. However, as we focus on recovery, we will continue to see turnover rates rise

Issues:
Exit data for Q1 shows that the top reasons for turnover are:

- Lack of opportunities/promotion – 26%
- Lack of flexible work arrangements – 23%
- Retirement – 17%
- Incompatible working relationships – 13%

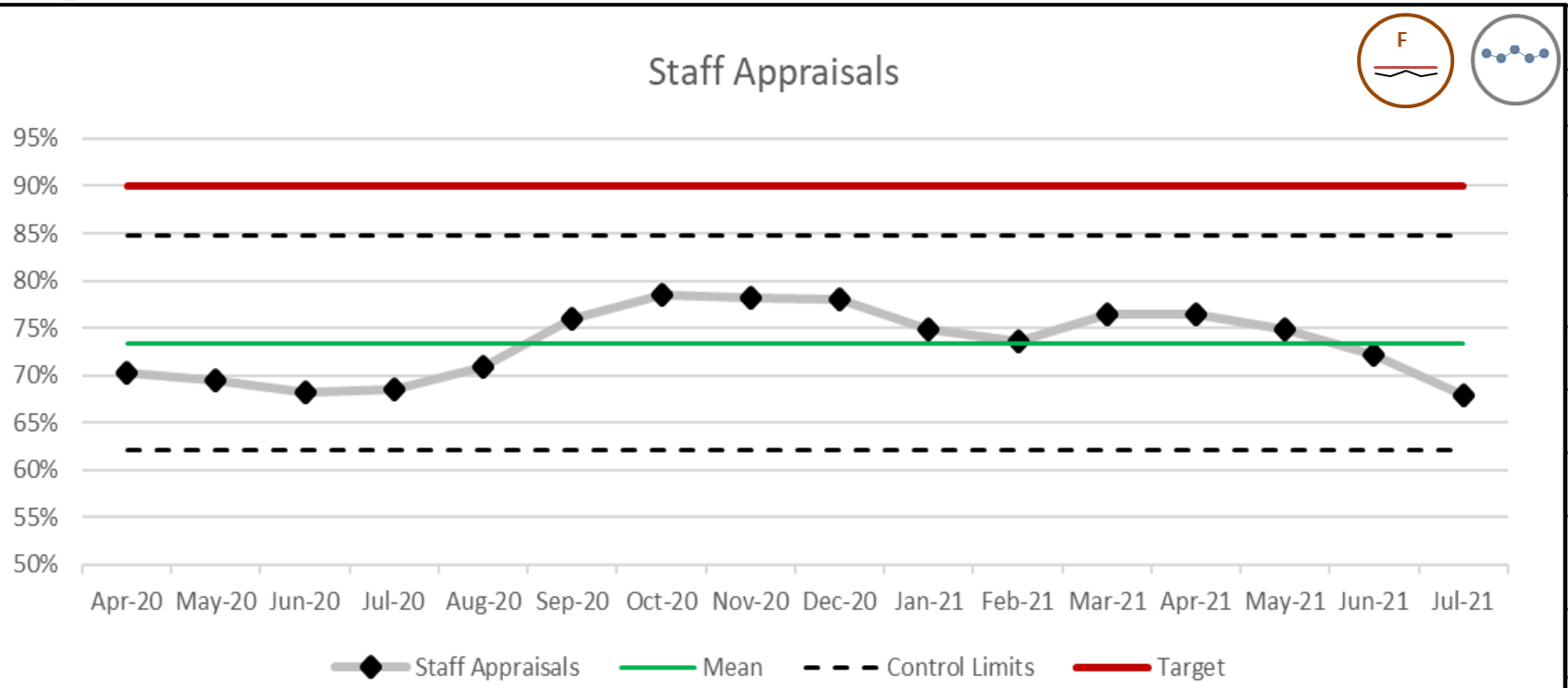
Actions:
Flexible working will be a contractual entitlement from the 13th of September. A Task & Finish group is working on enabling the Trust and our managers to be more 'flexible working' friendly

The work being done through the Culture and Leadership Programme will directly impact turnover as a result of 'challenging behaviour'.

Mitigations:
See actions

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Jul-21
67.95%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
Metric is consistently failing to target
Executive Lead
Director of HR & OD

Background:
% completion is currently 67.95%.

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

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

Actions:
- Wave 3 and operational pressures has had an impact on appraisal completion
- Appraisal completion to be focussed through the divisions once we come out of Wave 3.
- The Divisions have included completion of appraisal in their IIP major projects.

Link to Culture and Leadership Programme – appraisal to be the norm as part of leader/staff.

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

OUTSTANDING CARE personally DELIVERED

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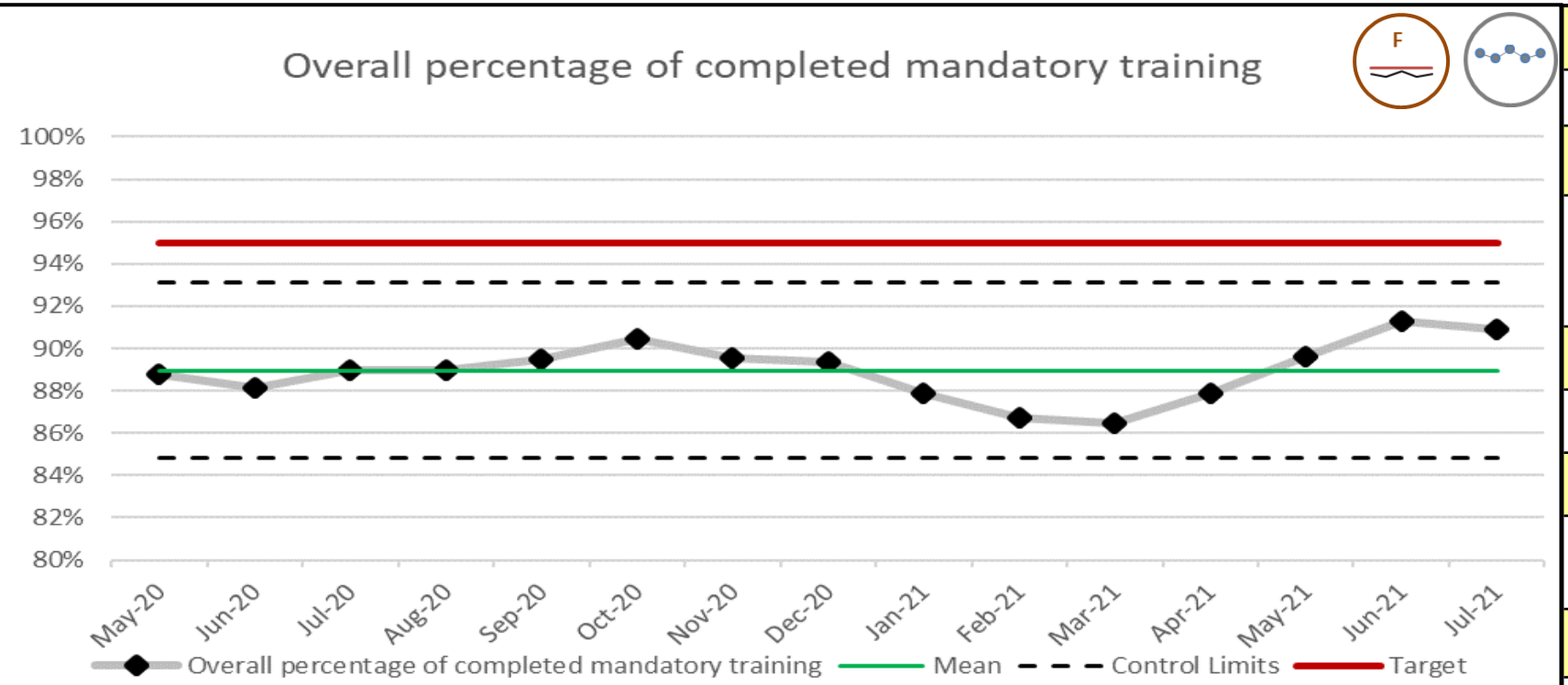


Jul-21
90.89%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
95%
Target Achievement
Metric is consistently failing to target
Executive Lead
Director of HR & OD

Background:
Overall percentage of completed mandatory training.

What the chart tells us:
Compliance with mandatory training continues to remain higher for the last 2 months than that reported over the last 15 months.

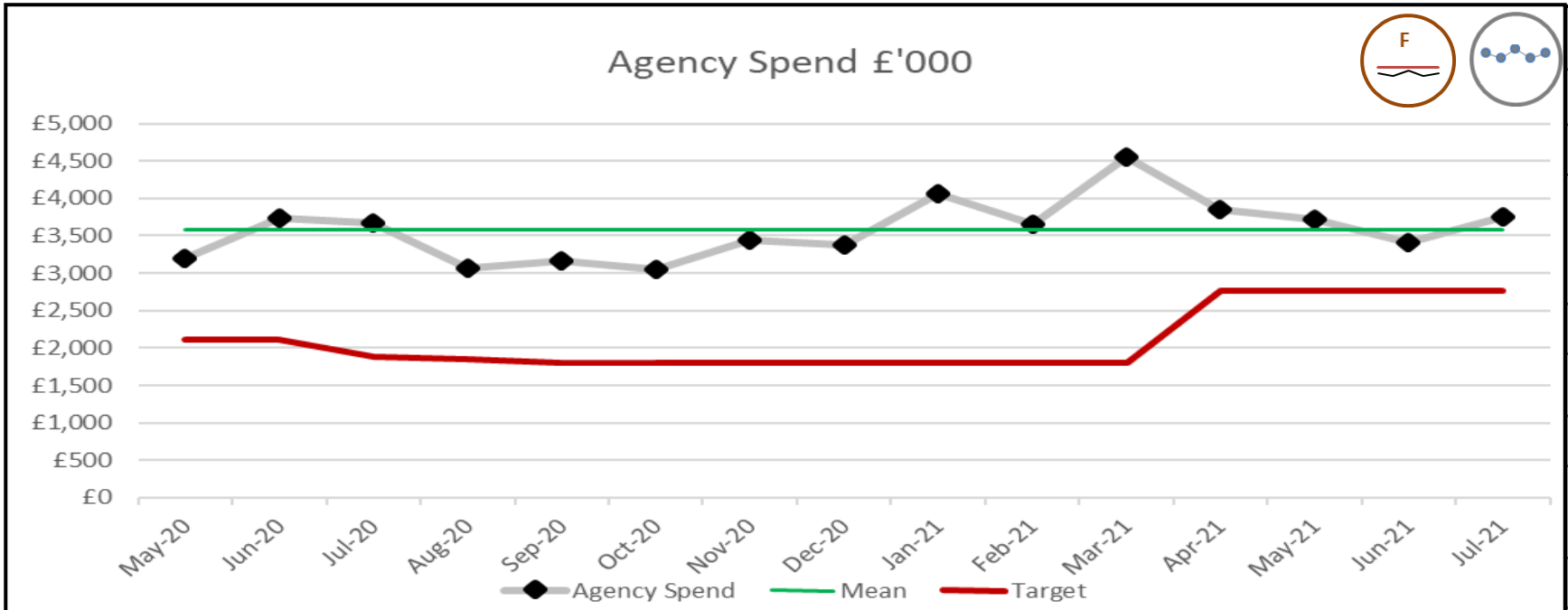
Issues:
- A review is required in regards to what training is required by who and at what level is the training needed
- Front line staffing having an increased difficulty in ensuring protected time due to the wave 3 COVID.
- Capacity issues amongst those responsible for core learning due to the movement of staff.

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

Mitigations:
See actions

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Jul-21
£3,745,000
Variance Type
Metric is currently experiencing Common Cause Variation
Target
£2,757,000
Target Achievement
Metric is consistently failing to target
Executive Lead
Director of HR & OD

Background:
Agency spend £'000

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

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

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

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

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

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

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

Financial Position Month 4 (2021/22)
Finance Report
5 Year Priority – Efficient Use of Resources

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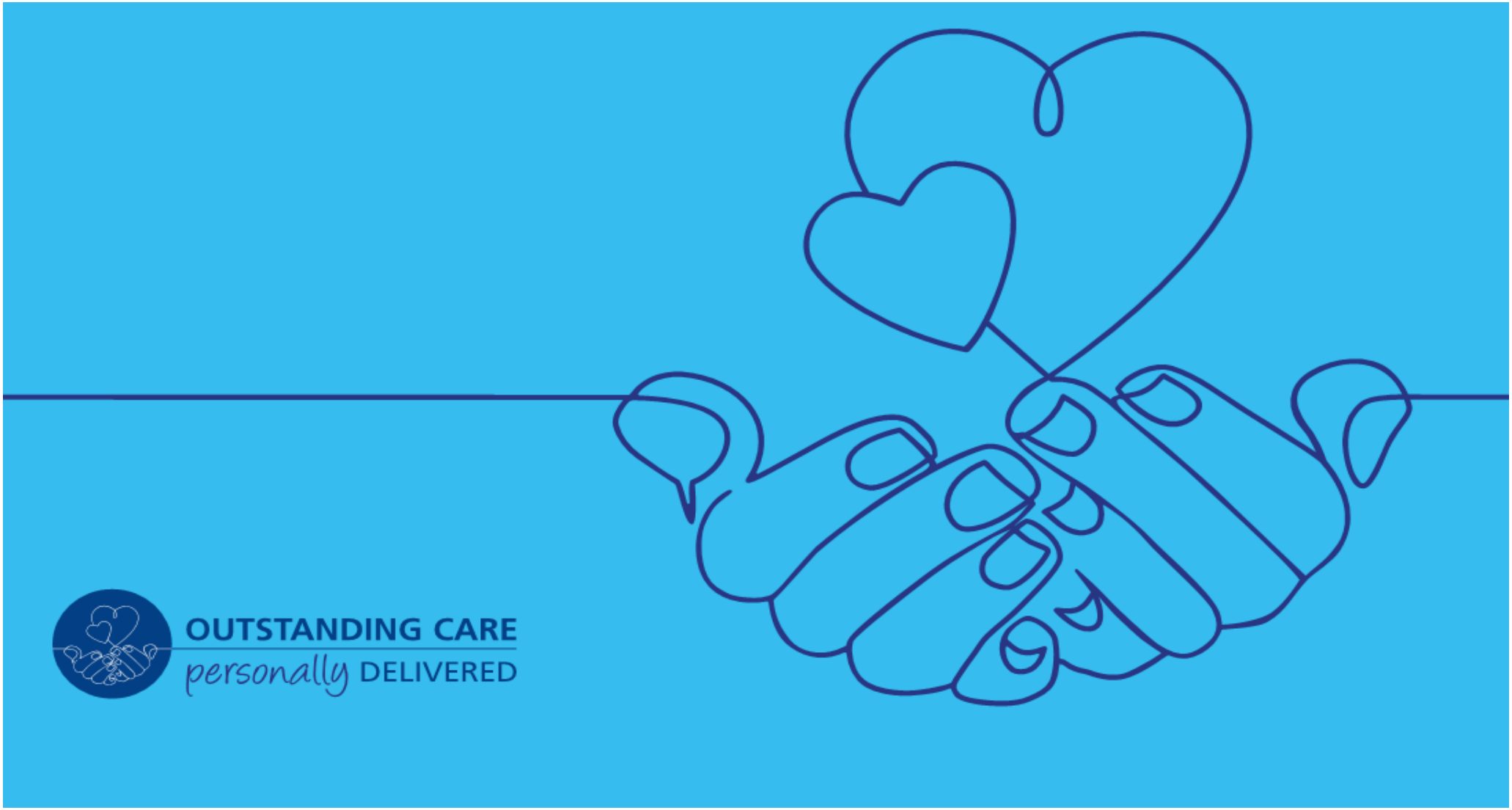
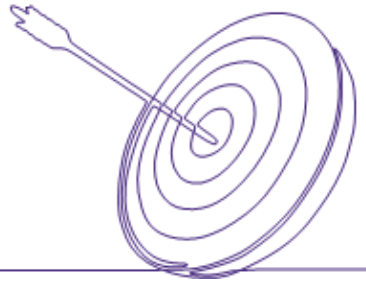


Quality | Operational Performance | Workforce | Finance

Finance Spotlight Report



United Lincolnshire Hospitals NHS Trust

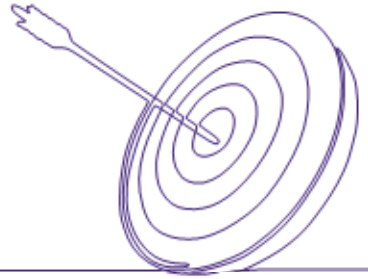
	Current Month			Year To Date			Forecast		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
Operating income from patient care activities	50,079	50,729	650	203,320	200,648	(2,672)	303,741	301,386	(2,355)
Other operating income	2,519	2,755	236	10,343	10,810	467	15,380	16,355	975
Employee expenses	(33,743)	(34,749)	(1,006)	(139,131)	(139,221)	(90)	(206,821)	(207,717)	(896)
Operating expenses excluding employee expenses	(17,714)	(17,656)	58	(72,621)	(70,603)	2,018	(106,730)	(105,132)	1,599
Net Finance Costs	(639)	(639)	0	(2,528)	(2,529)	(1)	(3,807)	(3,807)	(0)
Other gains/(losses) including disposal of assets	0	11	11	0	77	77	0	77	77
Surplus/(Deficit) For The Period/Year	501	451	(50)	(617)	(818)	(201)	1,764	1,163	(601)
Remove capital donations/grants I&E impact	6	56	50	24	225	201	36	37	1
Adjusted financial performance surplus/(deficit)	**507**	**507**	**0**	**(593)**	**(593)**	**0**	**1,800**	**1,200**	**(600)**

- The Trust exited 2020/21 with a £2.4m surplus; the 2020/21 position was inclusive of £72.1m of planned system support, £4.5m of funding for lost Other Operating Income, and £122.6m of top up block funding totalling over and above the level of funding the Trust would have received on a Payment By Results contract. Without the planned system support, funding for lost Other Operating Income and top up block funding, the Trust would have reported a Year End deficit of £196.8m.

- The Lincolnshire system 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 in line with plan the Trust has delivered a £0.5m surplus for the month of July and a £0.6m deficit year to date; the table also shows a forecast surplus of £1.2m or £0.6m adverse to plan.

Finance Spotlight Report (continued)



United Lincolnshire Hospitals NHS Trust

- The YTD income position is £2.2m adverse to plan driven by lower than planned levels of ERF income; while the adverse movement in relation to ERF has been contained YTD, the adverse movement in the Trust's ERF income position is forecast to move the overall financial position at the end of H1 adversely by £0.6m i.e. reducing the planned £1.8m surplus by £0.6m to £1.2m.

- Shadow monitoring of activity on a Tariff basis determined that actual activity of £34.7m was delivered in the current month, such that actual activity delivered is £14.6m lower than the income the Trust received. However, the income is inclusive of COVID, Top Up, Restore and BAU allocations.

- YTD Pay position is £90k adverse to plan; while Pay expenditure increased by £0.6m in July compared to June, the overall Pay position moved adversely in-month by £1.0m with the difference due to lower than planned CIP delivery.

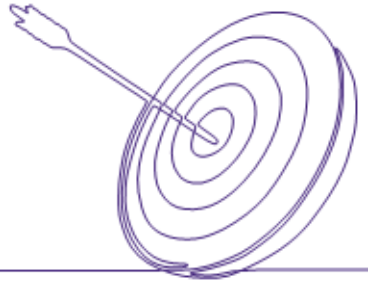
- The YTD Pay position does not include an accrual for the A4C pay award as this has not been agreed nationally; no accrual has been included on the advice of NHSE/I, and pay award costs are anticipated to be offset by an income stream. This approach is consistent with STP partners and has been confirmed in writing by NHSE/I.

- The YTD Pay position includes an accrual of £60k per month as an estimate of the YTD impact of the Flowers Case, and also includes £0.2m in relation to the cost of the Covid Vaccination Programme.

- The July Pay position includes expenditure of £3.7m on Agency staff and £3.4m on Bank staff, or £7.1m in total on temporary staffing; this represents an increase of £0.6m compared to June, but is still a reduction of £0.8m compared to March (if we remove the impact of technical items at year end).

- The YTD Non Pay position is £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, addressed in detail in the income and non-pay sections.

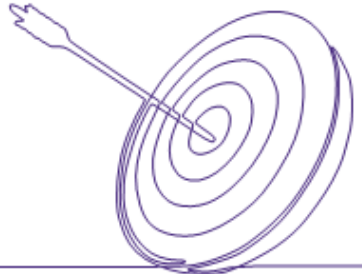
Finance Spotlight Report (continued)



United Lincolnshire Hospitals NHS Trust

- Non Pay expenditure of £70.6m YTD is a monthly average of £17.65m 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 reduction of £0.4m in Non Pay expenditure from June to July includes £0.2m in relation to Energy & Utilities, and movements over a range of other expenditure lines.
- In 2021/22, efficiency savings will be referred to as CRES (Cost Reduction Expenditure Savings) rather than as CIP.
- As at Month 4, CRES of £4.9m has been delivered in total: £3.2m in relation to 2021/22 schemes, £1.6m in relation to the FYE of 2020/21 schemes & £29k in relation to approved Investment.
- Capital expenditure as at M4 of the financial year equated to c£4m against a submitted plan of c£9m.
- 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. Next month the Trust will be reporting a further c£1.6m as the Trust has been successful in securing a Public Sector Decarbonisation Scheme (PSDS) grant.
- The month end cash balance is £47.7m which is a reduction of £6.3m against cash at 31 March 2021.
- NHSI have indicated that there will be an increased focus upon performance against the 95% Better Payments Performance Compliance (BPPC) target. Trust BPPC performance is 89.62%/ 88.91% by value / volume of invoices paid for the four months to July. A review of how to improve performance has taken place and actions will be pursued through the Divisional Finance Review Meetings.

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;

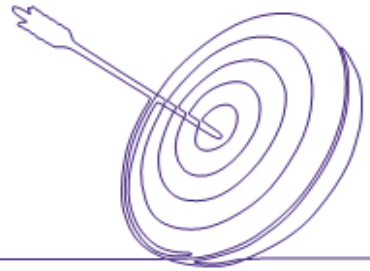
Clinical Services
People
Clinical Support Services
Corporate Services, Procurement, Estates and Facilities
Finance

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 JUL 2021	31/03/2022
Capital service cover metric	(10.40)	(1.73)	0.06	2.62	3.12
Capital service cover rating	4	4	4	2	1
Liquidity metric	(98.73)	(128.28)	3.71	3.32	2.46
Liquidity rating	4	4	1	1	1
I&E margin metric	(19.71%)	(7.62%)	0.38%	(0.28%)	0.19%
I&E margin rating	4	4	2	3	2
Agency metric	77.00%	110.00%	113.00%	111.00%	111.00%
Agency rating	4	4	4	4	4
I&E margin: distance from financial plan - metric	(2.80%)	0.70%	n/a	0.62%	(0.09%)
I&E margin: distance from financial plan - rating	4	1	n/a	1	2

Capital Spend 2021/22



United Lincolnshire Hospitals NHS Trust

Scheme Summary	YTD Plan £000	YTD Actual £000	YTD Variance £000
Fire	1,600.0	947.7	652.3
Estates - General	597.4	216.2	381.2
Estates - Ward Refurbishments	409.0	151.5	257.5
Estates - Medical School	300.0	532.6	-232.6
Estates - Lincoln & Pilgrim ED - Stage 1	391.0	496.5	-105.5
Estates - Lincoln ED - Resus - Stage 2	1,100.0	131.8	968.2
Estates - EPC	0.0	16.5	-16.5
Estates - CIR	1,415.0	869.0	546.0
Medical Equipment	600.0	87.9	512.1
Digital	1,115.0	527.0	588.0
Service Developments	1,207.6	0.0	1,207.6
Pilgrim A&E / UTC	434.0	57.8	376.2
Funding yet to be allocated	0.0	0.0	0.0
Total	9,169.0	4,034.3	5,134.7

Scheme Summary	Full Year Plan £000	Forecast Actual £000	Forecast variance £000
Fire	2,251.0	2,251.0	0.0
Estates - General	1,864.6	1,864.6	0.0
Estates - Ward Refurbishments	1,500.0	1,500.0	0.0
Estates - Medical School	2,448.0	2,448.0	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	2,119.8	2,119.8	0.0
Estates - CIR	4,033.5	4,033.5	0.0
Medical Equipment	1,831.3	1,831.3	0.0
Digital	4,299.5	4,299.5	0.0
Service Developments	2,220.1	2,220.1	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	35,260.8	35,260.8	0.0

All key stakeholders are involved in ensuring schemes are monitored and managed. Exception reporting on issues shared with CDG fortnightly.

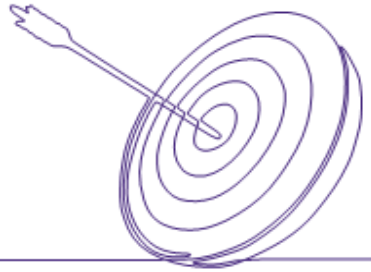
Capital funding levels for 2021/22 agreed through Trust Board & FPEC, showed a plan of c£33.7m. Recently the Trust have been successful in securing a Public Sector Decarbonisation Scheme (PSDS) grant of c£1.6m. Therefore the revised capital programme will equate to c£35.3m going forwards.

The capital plan submitted to NHSE/I has a year-to-date plan at M4 of c£9.2m. Spend incurred at M4 equated to c£4.0m, therefore schemes are behind plan by c£5.1m.

Key areas of variance are:

- Following the PSDS grant approval, Service Development funding has increased due to EPC requirement being covered. This is now showing a £1.2m year-to-date under-spend for the next priorities.
- Lincoln ED Resus behind submitted plan by £1.0m.
- Digital Schemes £0.6m behind plan re: e-HR and e-PMA.
- Fire schemes delayed due to assessment of works required, causing £0.6m variance
- Medical Devices behind plan by £0.5m due to late allocation of funds. Orders being raised and purchases made so purely a timing issue.
- CIR scheme installation, mainly electrical & water, progressing but remains behind submitted plan by c£0.5m.

Balance Sheet



NHS
United Lincolnshire Hospitals
NHS Trust

	31 March 2021	31 July 2021	
		Plan	Actual
	£000	£000	£000
Intangible assets	4,600	3,992	3,971
Property, plant and equipment	247,119	251,912	246,792
Receivables	2,790	2,781	2,797
Total non-current assets	**254,509**	**258,686**	**253,560**
Inventories	6,510	6,728	6,904
Receivables	25,935	16,961	27,203
Cash and cash equivalents	54,042	47,668	47,705
Total current assets	**86,487**	**71,357**	**81,812**
Trade and other payables	(69,643)	(59,315)	(61,432)
Borrowings	(402)	(555)	(555)
Provisions	(2,056)	(2,178)	(2,210)
Other liabilities	(1,587)	(2,943)	(5,134)
Total current liabilities	**(73,688)**	**(64,991)**	**(69,331)**
Total assets less current liabilities	**267,308**	**265,051**	**266,041**
Borrowings	(3,624)	(3,471)	(3,471)
Provisions	(4,069)	(4,040)	(3,941)
Other liabilities	(12,075)	(11,907)	(11,907)
Total non-current liabilities	**(19,768)**	**(19,418)**	**(19,319)**
Total assets employed	**247,540**	**245,633**	**246,722**
Financed by			
Public dividend capital	677,570	677,570	677,570
Revaluation reserve	27,522	27,290	27,289
Other reserves	190	190	190
Income and expenditure reserve	(457,742)	(459,417)	(458,327)
Total taxpayers' equity	**247,540**	**245,633**	**246,722**

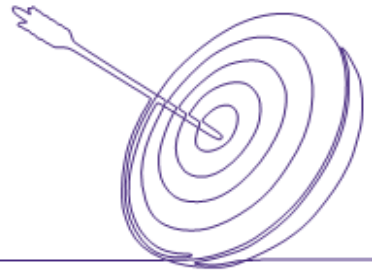
Note 1: The revised H1 financial plan submitted in May did not include a full monthly balance sheet and cashflow. The plan presented here, whilst not submitted, underpinned the actual submission.

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. See Appendix 5a-b

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 (Appendix 5c) 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 July was 87% / 89% as measured by value / volume of invoices paid. See Appendix 5d

Cashflow – April – September 2021 (H1)



United Lincolnshire Hospitals NHS Trust

	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	47.7	46.0
NHS England	6.4	6.5	6.5	8.0	7.8	5.7
Clinical commissioning groups	42.0	43.6	42.6	42.6	42.6	46.2
Other Patient related income	0.2	0.3	0.7	0.7	0.4	0.4
Patient related Income	48.6	50.5	49.9	51.3	50.8	52.3
Non-pat care services to other Govt bodies	1.1	0.8	1.2	(0.0)	1.0	1.0
Education & Training	8.4	-	0.1	4.4	1.6	1.6
Research & Development	0.0	0.0	0.2	0.2	0.1	0.1
Pay Recharges	0.4	0.1	0.3	0.2	0.4	0.4
Leasing Income	0.0	0.2	0.3	0.1	0.2	0.2
Other Income	0.4	0.6	0.6	0.3	0.6	0.6
Other Operating Income	10.4	1.7	2.7	5.2	4.0	4.0
Income Total	59.0	52.2	52.5	56.5	54.8	56.2
Payroll: Weekly / Monthly	(18.1)	(17.5)	(17.7)	(17.7)	(17.7)	(19.0)
Payroll: Tax / NI	(8.2)	(8.2)	(8.1)	(8.4)	(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)	(4.7)	(5.4)	(5.4)
Non Pay: NHSLA	(2.4)	(2.4)	(2.4)	(2.4)	(2.4)	(2.4)
Non Pay Other	(17.4)	(10.9)	(21.8)	(15.1)	(16.5)	(16.5)
Non Pay - VAT Reclaim	1.3	-	0.8	1.5	0.7	0.7
Operating Expenses Total	(56.5)	(46.3)	(59.1)	(51.4)	(54.0)	(55.3)
PDC dividends payable/refundable	-	-	-	-	-	(3.1)
Finance Costs Total	-	-	-	-	-	(3.1)
Revenue Cash movement in Month	2.4	5.8	(6.5)	5.1	0.8	(2.2)
Capital cash spent: Internally Funded	(5.9)	(3.2)	(2.5)	(1.1)	(1.6)	(2.1)
Capital cash spent: PDC Funded	(0.0)	(0.0)	(0.1)	(0.3)	(1.0)	(1.1)
Capital PDC received	-	-	-	-	-	-
Total External Financing & Capital	(5.9)	(3.2)	(2.6)	(1.3)	(2.5)	(3.1)
TOTAL CASH AT BANK c'f	50.5	53.0	43.9	47.7	46.0	40.6

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.

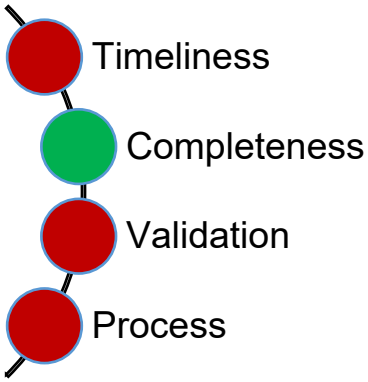
Note 2: The cash position has remained relatively steady since March, the only notable movement being a reduction in capital creditors from £13.1m to £3.9m. The level of trade creditors has also reduced from £16.5m in March to £10.8m. See Appendix 5c

Note 3: ERF income of £3.6m for H1 is profiled to be received from CCGs in September.

Note 4: As at the end of July, taking into account the capital cash underspend from 2020/21, capital creditors and internally generated resource (depreciation) £9.3m of the cash held relates to capital.

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

Meeting	*Trust Board*
Date of Meeting	*7 September 2021*
Item Number	*Item 13.1*
Strategic Risk Report	
Accountable Director	*Dr Karen Dunderdale, Director of Nursing*
Presented by	*Dr Karen Dunderdale, Director of Nursing*
Author(s)	*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 is being 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 around pressures.

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 is being 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.

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):

KPI	In Month Target (%)	May21 (%)	June (%)	July (%)	YTD (%)	Last month Pass/Fail	Trend Variation
A&E waiting times	83.12	72.56	70.74%	64.93%	70.61%		
Ambulance Conveyances Delayed >59 minutes	0	285	349	568	352		

- A&E waiting times against the constitutional standard – 4-hour performance for July was 64.93% a deterioration against Junes performance of 70.74% This is the ninth time in twelve months the Trust's performance has been below the agreed trajectory.
- Ambulance conveyances for July were, 4669, down by 0.35% against June. There were 568 >59minute handover delays recorded in July, a deterioration of 219 from June. Delays experienced at LCH and PHB are attributed to volume and conveyance pattern. A reduction of >180mins has been demonstrated.

Gaps in control & mitigating actions:

- The trust has met with NHSE/I 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		

KPI	In Month Target (%)	Mar 21 (%)	Apr 21 (%)	May21 (%)	YTD (%)	Last month Pass/Fail	Trend Variation
Staff Appraisal Rates	90	74.92	76.42	76.43	75.67		

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 and 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 and 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	*7 September 2021*
Item Number	*Item 13.2*
Board Assurance Framework (BAF) 2021/22	
Accountable Director	*Andrew Morgan Chief Executive*
Presented by	*Jayne Warner, Trust Secretary*
Author(s)	*Karen Willey, Deputy Trust Secretary*
Report previously considered at	*N/A*

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

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

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

Executive Summary

The relevant objectives of the 2021/22 BAF were presented to Committees during August, noting that the People and OD Committee did not meet this month 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 Board are asked to note the significant updates provided against the Strategic Objectives and to consider the BAF and the RAG ratings presented, confirming the acceptance of the ratings.

The following assurance ratings have been identified:

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

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

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

Ref	Objective	Exec Lead	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Control Gaps	How identified control gaps are being managed	Source of assurance	Assurance Gaps - where are we not getting effective evidence	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating
SO1	**To deliver high quality, safe and responsive patient services, shaped by best practice and our communities**												
						Developing a Safety Culture - Group, lead & plan in place to support the delivery of an improved patient safety culture (PSG)	Human Factors training delayed due to Covid-19 Definition of Safety Culture Ambition	External Safety Culture company engaged to deliver focus groups at all levels through the organisation and support development of safety culture ambition	Safety Culture Surveys Action plans from focus groups and Pascal survey findings Update reports to the Patient Safety Group and upwardly reported to QGC				
						Robust Quality Governance Committee, which is a sub-group of the Trust Board, in operation with appropriate reporting from sub-groups. (CG)			Upward reports from QGC sub-groups 6 month review of sub-group function				
						Effective sub-group strucutre and reporting to QGC in place			Sub-Group upward reports to QGC				
						IPC policies and procedures are in place in line with the requirements of The Health and Social Care Act (2008). Code of Practice on the prevention and control of infections and related guidance "Hygiene Code" (IPCG)	Policies not in line with the requirements of the Hygiene Code and some have not been reviewed and updated.	Planned programme of IPC policy development and update in line with Hygiene Code requirements.	IPC programmes of surveillance and audit are in place to monitor policy requirements. Divisional audit processes with progress and exception reporting to IPCG, IPC Site meetings and IPC related Divisional forums. Associated action and development plan documentation	Some aspects of reporting require further development.	Reporting to and monitoring by IPCG and other related forums, e.g. Site meetings.		

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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	Process in place to monitor delivery of and compliance with The Health and Social Care Act (2008). Code of Practice on the prevention and control of infections and related guidance (IPCG). Infection Prevention and Control BAF in place and reviewed monthly (IPCG)	Non-compliance with some aspects of the Hygiene Code.	Premises and facilities Premises Assurance Model (PAM) - 21/22 - take forward as a sub project led by (E&F). Gap Analysis to be compiled and presented quarterly to the IPCG and QGC. IPC policies to be updated / developed / written in line with the timetable. •Recruited into Estates and Facilities/Decontamination Lead post 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	Some aspects of reporting require further development.	Reporting to and monitoring by IPCG and other related forums, e.g. Site meetings.	Quality Governance Committee	A
						Monthly mortality report in place to track achievement of SHMI/Mortality targets (Maintaining our HSMR and improving our SHMI) (PSG) reporting in to monthly mortality group and upwardly to PSG	Gaps in the number of structured judgement reviews undertaken Impact of Covid-19 on coding triangles	Funding available to train an additional 40 members of staff to undertake structured judgement reviews by the end of March 2021	National Clinical Audits Dr Foster alerts HSMR and SHMI data				
						Robust policies and procedures for incident investigations, harm reviews and assurance of learning (PSG)	Clinical harm review processes not all documented & aligned with incident reporting	Task and finish group in place to agree required changes to harm review processes and documentation Appointment of a Clinical Harm and Mortality Manager	Incident Management Report Quarterly harm report to PSG Bi-weekly executive level Serious Incident meeting Learning to Improve Newsletters Patient Safety Briefings Divisional Integrated Governance reports				
						Process in place to ensure safe use of surgical procedures (NatSIPs/LocSIPs) (PSG)	Lack of assurance regarding progress of implementing NatSIPs/LocSIPs within the Trust	Working Group set up and meeting as per the ToR, divisional representation; quarterly reporting to PSG	Audit of compliance	Audit of compliance not currently in place	Review will occur through the Task & Finish group and reported upwards to PSG		
						Medication safety Group in operation (Reduce medication errors) (Improving the safety of medicines management) (Review of Pharmacy model and service) (PSG)	Lack of e-prescribing leading to increase in patient safety incidents	Replacement of manual prescribing processes with an electronic prescribing system; improvements to medication storage facilities; strengthening of Pharmacy involvement in discharge processes	Upward Report of the: Medicines Quality Group				

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

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

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

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

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						Ensuring access to the personal and professional development that enables people to deliver outstanding care and ensures ULHT becomes known as a learning organisation	IIP projects in early stage of delivery	IIP projects - education and learning	Reported progress on the implementation of the NHS People Plan and the Lincolnshire System Workforce Plan NB New indicators being developed for the 21/22 financial year				
2b	Making ULHT the best place to work	Director of People and Organisational Development	Further decline in demand Failure to address examples bullying & poor behaviour Lack of investment or engagement in leadership & management training Perceived lack of listening to staff voice Under-investing in staff engagement with wellbeing programme Failure to respond to GMC survey Ineffectiveness of key roles Staff networks not strong	4083	CQC Well Led	NHS People Plan & System People Plan & four themes:- - Looking after our people - Belonging in the NHS - New ways of working & delivering care Growing for the future	Awaiting sign off of system people plan Delivery of IIP projects in early stage of delivery	Delivery of IIP projects as set out in controls				People and Organisational Development Committee	R
						Trust values & staff charter - Resetting our Culture & Leadership programme	Poor staff survey results in 2020 (although in pulse survey more positive)	Creation of Learning Together Forum					
						Effective communication mechanisms with our staff - ELT Live, managers cascade, intranet etc.		Reviewing the way in which we communicate with staff and involve them in shaping our plans	Staff survey feedback - engagement score, recommend as place to work				
						Leadership & Management training. (Improving the consistency and quality of leadership and line management across ULHT)		Continue to implement new leadership programme e.g training on well-being conversations	Pulse surveys - " Have your say" Number of staff attending leadership courses				
						Perception of fairness and equity in the way staff are treated		IIP Project - Address the concerns around equity of treatment and opportunity within ULHT so that the Trust is seen to be an inclusive and fair organisation	WRES/ WDES Data Internal Audit - Equality, Diversity and Inclusion				
						Staff networks	Some staff networks stronger than others	Continued work to embed the networks and provide them with effective support	Protect our staff from bullying, violence and harassment - measure through National Staff Survey				
						Demonstrate that we care and are concerned about staff health and wellbeing		Embed programme focused on staff wellbeing	Reports on progress in implementing the NHS People Plan and the Lincolnshire System Workforce Plan Number of Schwartz rounds completed (once implemented)				
						Focus on junior doctor experience key roles:- - Freedom to speak up Guardian - Guardian of safe working - Well-being Guardian	Identified FTSU capacity in Trust as insufficient	Budget identified for post and recruitment exercise commenced for full time FTSU Guardian Junior doctor forum	GMC junior doctor survey				

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2c	Well led services	Chief Executive	Current risk register configuration not fully reflective of organisations risk profile Current systems and processes for policy management are inadequate resulting in failure to review out of date or policies which are not fit for purpose	4277 4389	CQC Well Lead	Delivery of risk management training programmes	Training delayed due to Covid-19	Corporate support offer made to divisions	Third party assessment of well led domains Internal Audit assessments Risk Management HOIA Opinion received and Audit Committee considered in June noting 'partial assurance with improvement required can be given on the overall adequacy and effectiveness of the Trust's framework of governance, risk management and control. Completeness of risk registers Annual Governance Statement			Audit Committee	**A**
						Shared Decision making framework	Councils suspended due to Covid-19		Number of Shared decision making councils in place	8 councils established. Target for 2021 was 6	Feedback tools to review progress/success		
						Implementing a robust policy management system		Review of document management processes New document management system - SharePoint Single process for polices	Numbers of in date policies	Movement on policies still not fast enough	Clinical and Corporate Policies and Guidelines now managed through single process by Trust Secretary Report to Audit Committee quarterly Report to ELT fortnightly		
						Ensure system alignment with improvement activity							
SO3	**To ensure that services are sustainable, supported by technology and delivered from an improved estate**												
						Develop business case to demonstrate capital requirement	Business Case is not fully signed off and articulates a level of capital development that cannot be rectified in any single year.	Interim case for £9.6M of CIR has been reviewed and approved by NHSE with the majority of schemes due to deliver in 2020/21 Capital Delivery Group has oversight of the delivery of key capital schemes.	Capital Delivery Group Highlight Reports	Infrastructure case has tackled £9.6M of the overall £100m+ backlog.	Estates improvement and Estates Group review compliance and key statutory areas. Development of 2021/22 Capital Programme will continue to ensure progress against remaining backlog of critical infrastructure. Capital Delivery Group will monitor the delivery of key capital programmes and ensure robust programme governance.		

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3a	A modern, clean and fit for purpose environment	Chief Operating Officer	Longer term impact on supplier services (including raw materials) who are supporting the improvement, development, and maintenance of our environments. Availability of funding to support the necessary improvement of environments (capital and revenue)	3720 3520 3688 4403 3690	CQC Safe	Delivering environmental improvements in line with Estates Strategy		Estates improvement forum and improvement team monitor progress through and has restarted now Wave 2 Covid has passed.		Collation of Audits across all areas during Covid are partial due to availability of high viral load areas.		Finance, Performance and Estates Committee	R
						Continual improvement towards meeting PLACE assessment outcomes	PLACE assessments have been suspended and delayed for a period during COVID		PLACE assessments	PLACE Assessments have been reduced to PLACE/light in lieu of access and staffing restrictions during Covid.			
						Review and improve the quality and value for money of Facility services including catering and housekeeping	Value for Money schemes have been delayed during COVID		MiC4C cleaning inspections Staff and user surveys 6 Facet Surveys	6 Facet Survey are not recent and require updating.	IPC Cell/Group and upward reporting of cleanliness is reported through to QGC. Water Safety and Fire Safety Groups will report through alongside Health and Safety Groups to relevant sub-committees and provide a more comprehensive view offering assurance were it is possible and describing improvement where it is not. The appointment of Authorised engineers in key statutory areas will give responsible person/Executive arms length oversight of assurance gaps to fill.		
						Continued progress on improving infrastructure to meet statutory Health and Safety compliance		Water/Fire safety meetings are in place and review of controls are part of external validation from authorised engineers.	Reports from authorised engineers Response times to urgent estates requests Estates led condition inspections of the environment Response times for reactive estates repair requests Progress towards removal of				
						Delivering £6.4m CIP programme in H1 21/22 and estimated full Year 21/22 CIP value of £15.4m.	Operational ownership and delivery of efficiency schemes	Divisional Financial Review Meetings - paused due to COVID - reinstated from May 21. Request to all Divisions to provide detailed CIP recovery plans.	Delivery of revised CIP Achievement of both ULHT and STP financial Plan	Model Hospital Benchmarking/Reporting - paused due to COVID - reinstated from May 21 (update brought to FPEC in May)	Gaps are being reviewed monthly with Divisions through FRMs		
						Delivering financial plan aligned to the Trust and Lincolnshire STP financial plan / forecast for 2021/22	Urgent and unplanned Restore and Covid related costs	Lincolnshire STP financial plan Lincolnshire STP collective management of financial risk Savings plan, monitoring and reporting.	Delivery of the Trust and System financial plans for H1	Granular detailed CIP implementation plans.	Internally through FRMs and upwards into FPEC, externally through the STP reporting structure including Finance Leadership Group upwards to the Executive Leadership Group.		

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3b	Efficient use of our resources	Director of Finance and Digital	Efficiency schemes do not cover extent of savings required. Continued reliance on agency and locum staff and use of enhanced bank rates to maintain services at substantially increased cost Failure to achieve recruitment targets increases workforce costs Unplanned expenditure (as a result of unforeseen events) National requirements and Trust response to Restoration and Recovery and third COVID wave.	4382 4383 4384	CQC Well Led CQC Use of Resources	Reduce agency spend by 25% from the 19/20 baseline as per IIP priority	Reliance on temporary staff to maintain services, at increased cost	Centralised agency & bank team	Delivery of the IIP 25% agency reduction target.	Granular detailed plan for every post plans.	Through the Medical and Nursing Workforce Transformation Groups and through FRMs upward into FPEC	Finance, Performance and Estates Committee	R
						Utilising Model Hospital, Service Line Reporting and Patient Level Costing data to drive focussed improvements to be restarted from Q2	Lack of up-to-date and robust benchmarking information due to the usefulness of the 20/21 cost collection exercise being reduced related to COVID.	Refresh of internal costing and SLR information for roll out in the Trust in Q2 21/22.	SLR and PLICs information	CQC Use of Resources - paused due to COVID	Improvement in the CQC Use of Resources is part of the Trust 21/22 IIP		
						Implementing the CQC Use of Resources Report recommendations	Lack of up-to-date and robust benchmarking information due to the usefulness of the 20/21 cost collection exercise being reduced related to COVID.	Refresh of internal costing and SLR information for roll out in the Trust in Q2 21/22.	SLR and PLICs information	CQC Use of Resources - paused due to COVID	Improvement in the CQC Use of Resources Trust scoring is part of the Trust 21/22 IIP and performance is reported through PMO upward reports.		
						Working with system partners to deliver the Lincolnshire Plan.	Urgent and unplanned Restore and Covid related costs	Lincolnshire STP financial plan Lincolnshire STP collective management of financial risk Savings plan, monitoring and reporting.	Delivery of the Trust and System financial plans for H1	Granular detailed CIP implementation plans.	Internally through FRMs and upwards into FPEC, externally through the STP reporting structure including Finance Leadership Group upwards to the Executive Leadership Group.		
						Detailed activity modelling aligned to resource requirements to support Trust and System Restoration.	Impact of Wave 3 and increasing acuity of NEL patients creating bed and staffing resource pressures to deliver restoration plan.	Trust Restoration plan and through Restoration and Recovery daily Trust meetings. Lincolnshire STP activity plan Lincolnshire STP collective management of restoration of planned care activity	Reporting against the Trust and System Restoration plan and national Trajectories.				
3c	Enhanced data and digital capability	Director of Finance and Digital	Tender for Electronic Health Record is delayed or unsuccessful Major Cyber Security Attack Critical Infrastructure failure	4177 4179 4180 4182 4481	CQC Responsive	Improve utilisation of the Care Portal with increased availability of information -	Cyber Security and enhancing core infrastructure to ensure network resilience. .	Digital Services Steering Group Digital Hospital Group Operational Excellence Programme Outpatient Redesign Group	Number of staff using care portal	Schemes paused to enable tactical response to Covid-19. Limited progress being made where possible. .	Management of control gaps being reintroduced in a phased way as impact of Wave 2 reduces. Nationally mandated ICS Minimum Viable Product shared record must be in place by September 2021. Hence, work ongoing with partner organisations to ensure their data is within the Care Portal.	Finance, Performance and Estates Committee	A
						Commence implementation of the electronic health record	Roll-out IT equipment to enable agile user base Redeployment of staff as a result of Trust response to Covid-19.	Digital Services Steering Group Digital Hospital Group e-HR Programme Steering Group	Delivery of 20/21 e HR plan		EPR OBC to be approved by NHSE/I		
						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.		

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

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

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

The BAF management process

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

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

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

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

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

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

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

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

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*7 September 2021*
Item Number	*Item 13.3*
Trust Board – Executive Director Voting Rights	
Accountable Director	*Chief Executive*
Presented by	*Andrew Morgan, Chief Executive*
Author(s)	*Jayne Warner, Trust Secretary*
Report previously considered at	*N/A*

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

Risk Assessment	*Insert risk register reference*
Financial Impact Assessment	*Insert detail*
Quality Impact Assessment	*Insert detail*
Equality Impact Assessment	*Insert detail*
Assurance Level Assessment	*Insert assurance level* • *None*

Recommendations/ Decision Required	• *To ask the Board to agree the Executive Director voting rights of the Trust Board for the period of the secondment of the Deputy Chief Executive*

Executive Summary

The Statutory Instrument which orders the establishment of the Trust allows (in line with all NHS Trusts) for 5 executive directors. The Trust Standing Orders identify the 5 voting executive directors for the Trust as

- Chief Executive
- Medical Director
- Nurse Director
- Director of Finance
- Deputy Chief Executive

The Chief Operating Officer and Director of People &OD attend the Trust Board meetings in a non-voting capacity.

The Chief Executive has signalled that for the period of the secondment of Mark Brassington, Deputy Chief Executive/ Director of Improvement and Integration the Deputy Chief Executive duties will be assigned to one of the Executive directors (to be determined).

The Chief Executive has proposed that the Chief Operating Officer role replaces that of the Deputy Chief Executive as the voting executive director on the Board for the period of the secondment and that Trust Standing Orders are amended accordingly.