Bundle Trust Board Meeting in Public Session 1 February 2022

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 7 December 2021

Chair

Item 5.1 Public Board Minutes December 2021v1.docx

5.2 Matters arising from the previous meeting/action log

Chair

Item 5.2 Public Action log December 2021.docx

6 Chief Executive Horizon Scan

Chief Executive

Item 6 Chief Executive's Report, 010222.docx

7 Patient/Staff Story

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

7.1 BREAK

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

8.1 Assurance and Risk Report from the Quality Governance Committee

Chair of Quality Governance Committee

Item 8.1 QGC Upward report December 2021v1.doc

Item 8.1 QGC Upward report January 2022 v1.doc

9 Strategic Objective 2 To enable our people to lead, work differently and to feel valued, motivated and proud to work at ULHT

9.1 Assurance and Risk Report from the People and Organisational Development Committee

Chair of People and OD Committee

Item 9.1 POD - Upward Report - December 2021.docx

Item 9.1 POD - Upward Report - January 2022 v1.docx

9.2 Vaccination programme

Director of People and OD

Item 9.2 Vaccination Programme 01.02.22.docx

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

10.1 Assurance and Risk Report from the Finance, Performance and Estates Committee

Chair of Finance, Estates and Performance Committee

Item 10.1 FPEC Upward Report December 2021v1.docx

Item 10.1 FPEC Upward Report January 2022.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 and Digital

Item 12 IPR Trust Board - Front page.docx

Item 12 IPR Trust Board January 2022.pdf

13 Risk and Assurance

13.1 Risk Management Report

Director of Nursing

Item 13.1 Strategic Risk Report - February 2022.docx

13.2 Board Assurance Framework

Trust Secretary

Item 13.2 BAF 2021-22 Front Cover February 2022.docx

Item 13.2 BAF 2021-2022 v25.01.2022.xlsx

13.3 Audit and Risk Committee Upward Report

Chair of Audit and Risk Committee

Item 13.3 Audit Committee Upward Report December 21 v1.docx

14 Any Other Notified Items of Urgent Business

15 The next meeting will be held on Tuesday 1 March 2022

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.

United Lincolnshire Hospitals NHS Trust

Minutes of the Trust Board Meeting

Held on 7 December 2021

Via MS Teams Live Stream

Present

Voting Members:
Mrs Elaine Baylis, Chair
Mr Andrew Morgan, Chief Executive
Mrs Liz Libiszewski, Non-Executive Director
Mr Paul Matthew, Director of Finance and Digital/ Director of People and OD
Dr Karen Dunderdale, Director of Nursing/ Deputy Chief Executive
Mrs Sarah Dunnett, Non-Executive Director
Mr David Woodward, Non-Executive Director
Dr Colin Farquharson, Medical Director
Professor Philip Baker, Non-Executive Director
Mr Simon Evans, Chief Operating Officer

Non-Voting Members:

In attendance:
Mrs Jayne Warner, Trust Secretary
Mrs Karen Willey, Deputy Trust Secretary (Minutes)
Dr Maria Prior, Healthwatch Representative
Mr Andrew Tysoe, Voluntary Service Manager (Item 7)
Mr Andrew Simpson, Consultant Urology (Item 10.2)

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

1908/21	**Item 1 Introduction** The Chair welcomed Board members and members of the public who had joined the live stream to the meeting. In line with guidance on Covid-19 the Board continue to hold meetings open to the public through the use of MS Teams live. In line with policy, papers had been

	published on the Trust website a week ahead of the meeting and the public able to submit questions in the usual manner. 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.
1909/21	The Chair moved to questions from members of the public. **Item 2 Public Questions** **Q1 Sue McQuinn** **Before I put my question I would just like to thank all the ULHT staff who are working harder than ever during the Winter season & particularly those who will be on duty over Christmas & the New Year. Your dedication is much appreciated by me & my family & not taken for granted.** **I was reading an advertisement for an Out Patient Sister that ULHT has recently published on Health Jobs U.K. In it, the three hospitals are described as follows:** **"Pilgrim Hospital is situated beautiful countryside and serves the communities in the South Lincolnshire area. It provides all major specialties and a 24-hour major accident and emergency service.** **Grantham and District Hospital serves the communities of Grantham and the local area. It provides ambulatory paediatric and accident and emergency services.** **Lincoln Hospital is a thriving university city and with the opening of the new medical school, It provides all major specialties and a 24-hour major accident and emergency service."** **I was struck by the glowing terms used to describe Lincoln & Boston compared with Grantham. I wonder if the lacklustre way Grantham is portrayed is one of the reasons ULHT has difficulty recruiting staff for our hospital? Surely the trust should be emphasising the many benefits of living & working in Grantham, not least of which are it's excellent transport links – road & rail – to the north & south of the U.K. Just over an hour on the train & you're in London!** **Can the Trust look at "selling" Grantham more positively?**

	The Chair thanked Ms McQuinn for taking the time to precursor the question with the comments made noting that this would be passed on to staff. The Director of People and OD responded: Since being in post this was something that had been identified and with the appointment of the Deputy Director of People who had commenced in post at the beginning of the month, recruitment would be an area of focus. This would start with the adverts and interaction with the organisation. There would be consideration of how all sites were described, including Louth in order to attract staff to all sites.
1910/21	**Q2 Jody Clark** **I would like to ask** **There has been a lot of talk about us losing medical beds (EAU) at Grantham Hospital. I seem to remember from the Grantham Restoration plans that the beds are delivered in a different way but has the same service?** **Can you please clarify what the medical bed provision is at Grantham Hospital and what plans you have for the old EAU area?** The Chief Operating Officer responded: There was no intention to reduce the beds at the Emergency Admission Unit (EAU) or at Grantham Hospital. Levels of dependency were monitored on a daily basis across all wards for patients and there had been an increase in patients who were more unwell and more dependent. This required different ratios of care and nurses to patients. The Trust flexed these ratios regularly across all sites in order to deliver safe care. This included the opening of additional beds and would include beds, as had been seen recently at Grantham Hospital to manage the increase in admissions. The next steps for the EAU ward was refurbishment of a large proportion and there would be a continuing refurbishment programme at Grantham Hospital. There would be work undertaken on the day case ward and additional work in the tower on wards 1 and 2. This would see major work undertaken to increase the number of side rooms to increase flexibility and same sex accommodation along with greater privacy and dignity.
1911/21	**Q3 Vi King** **Please can I ask what how many 12-hour breaches, there has been at Lincoln and Pilgrim in the last few weeks.** **Also, please can I ask what are ULHT doing to retain staff in ULHT, especially at Grantham. When I was there, I always stated that the exit interview was not worth the paper it was written on. Has this been reviewed, so it can be captured as to why staff are leaving the Trust.**

	The Chief Operating Officer responded: Thanks were offered to the teams working in emergency care given the huge pressures that were being seen across the organisation. The number of patients accessing emergency services had increased along with the dependency and severity. The performance report offered the detail of 12 hour breaches that was in line with NHS England reporting and offered timely and accurate reporting. The report from the Finance, Performance and Estates Committee detailed the increase in 12 hour trolley waits which had continued since the last reporting period. The Trust was seeing significant delays in the ability to discharge patients which was impacting o the overcrowding in the emergency departments despite measures that had been put in place to alleviate this. The Director of People and Organisational Development noted the activity in respect of recruitment that would then move in to retention. There had been a significant increase in the staff wellbeing offer and the introduction of flexible working. In response to the staff survey a 'you said, we did' campaign had been put in place to demonstrate the actions that had been taken across the organisation since March 2019. It was noted that to date that Trust had substantively employed circa 700 extra staff. Work was underway to address the culture and behaviours within the organisation and the Culture and Leadership Programme had been launched. Worked continued to improve the physical environment and equipment for staff. This included 2 new theatres at Grantham Hospital for which funding had been received and would be in place towards the end of the year. Ward upgrades and CT and MRI scanners were also in train. The Trust was aware that this was a collective journey with staff.
1912/21	**Item 3 Apologies for Absence** Apologies for absence were received from Dr Chris Gibson, Non-Executive Director, Mrs Alison Dickinson, Associate Non-Executive Director and Ms Cathy Geddes, Improvement Director NHSE/I
1913/21	**Item 4 Declarations of Interest** There were no declarations of interest which had not previously been declared.
1914/21	**Item 5.1 Minutes of the meeting held on 2 November 2021 for accuracy** The minutes of the meeting held on 2 November 2021 were agreed as a true and accurate subject to the following amendment: 1816/21 – The Director of Nursing stated that the establishment review for endoscopy and emergency departments was discussed and was potentially due to be presented to the December Board meeting.

	The establishment review, whilst not available for the Board, would be presented to the Committees in January or February once complete and report through to the Board. The Chair noted the clarity offered and requested that the action be added to the action log for the establishment review to be presented to the Trust Board in due course.
1915/21	**Item 5.2 Matters arising from the previous meeting/action log** 994/21 – Patient Story – arrangements were being made for Dr Sakthivel and Jody Blow to return to the Board to provide an update on progress 1360/21 – Urology Service Engagement Output – agenda item, complete 1841/21 – Establishment Review – financial position discussed at Finance, Performance and Estates Committee and included within the upward report – complete
1916/21	The Chair noted that all actions would be closed with action 994/21 coming back to a future meeting.
1917/21	**Item 6 Chief Executive Horizon Scan including STP** The Chief Executive presented the report to the Board offering a comprehensive system update to the Board including system pressures and how these were manifesting within the Trust.
1918/21	As reported through national media, pressures on the NHS were high at present with Lincolnshire being no different to the rest of the Country. This was due to a combination of dependency, severity of patients and Covid-19 continuing to be present, regardless of variant.
1919/21	The vaccination programme was increasing again and there continued to be staffing issues for the Trust, there were either due to staffing levels or the impact of the situation on staff.
1920/21	The Trust was seeing busy accident and emergency (A&E) departments with people waiting longer in the department than would be liked. This was either waiting to be seen, treated and discharged or seen, treated then admitted. The impact of this was resulting in ambulance handover delays that were clearly unwelcome as this impacted on the ability of the ambulance service to respond to calls within the community.
1921/21	The Chief Executive advised that the waits for admission could be traced back to the issues of discharging patients who were medically optimised but capacity constraints outside of hospital meant these patients could not be discharged due to waits for care packages, beds in appropriate settings or home care packages.

1922/21	This was then impacting on elective capacity where the admission of more emergency cases impinged on the ability to treat elective cases and cancellation of operations due to the beds being used for emergency admissions.
1923/21	The Board noted that the System was under pressure and whist the focus being described was for the acute trust it was not expected that this was a dissimilar message from other providers. Work was being undertaken across the Integrated Care System (ICS) with regional and national colleagues to address the pressures with a focus on tackling ambulance handover delays and the ability to release ambulances to respond to calls.
1924/21	There was a strong focus on delayed discharges and those patients who had completed the acute part of care. There was a need to maintain flow to ensure new patients could be admitted where required. The problems experienced at the front door need to be tackled there however there was a need to resolve activity across all of the hospital sites.
1925/21	The Chief Executive noted that this was a national issue however thanked staff for the magnificent work that was being undertaken staff, echoing the thanks already offered by the Chief Operating Officer. Staff continued to work to ensure patients remained safe and received as good as an experience as possible.
1926/21	The Chief Executive noted the increasing vaccination programme that was seeing the programme expand and the progress of the booster programme. As part of the expectation to progress was a review of hospital hubs to understand what, if any, changes could be made to support vaccination of the public.
1927/21	The Board was advised of the change that would mean vaccination against Covid-19 would be a condition of employment within hospitals and the NHS. This would be compulsory vaccination with 2 doses for those working with patients. The detail of the change was being worked through to understand how this would be operationalised and how consequences of unvaccinated staff would be mitigated.
1928/21	The Chief Executive noted the potential industrial action that could take place advising that business continuity plans would be enacted and amended if required to address any action taken.
1929/21	Mr John Turner had been appointed as the Designate Chief Executive of the ICS with congratulations offered from the Trust Board.
1930/21	The report made reference to the Care Quality Commission (CQC) item which would be discussed by the Board with the Chief Executive noting the significant progress that had been made since the last inspection.
1931/21	The Chief Executive advised of recent engagement with the national team to discuss the exit criteria for the Recovery Support Programme (RSP) where the metrics were agreed. The Trust would be seeking to exit the RSP as early as appropriate in 2022 with the CQC report supporting the position.

1932/21	The Chief Executive advised of the Pilgrim Hospital Emergency Department development noting the positive discussion with national capital colleagues in respect of the scheme being taken through the final business case process. There had been recent media coverage in respect of the planning application submitted by the Trust to Boston Borough Council.
1933/21	The Chair was pleased to note the RSP exit criteria as this set clear metrics for the Trust and noted that the current operational pressures continued to present some challenge.
1934/21	The Board was pleased to have clarity of the position in the organisation and the actions being taken. Activity in relation to the vaccination programme was noted along with the changes to mandatory vaccination for staff. The Trust Board: • **Noted the report and significant assurance provided**
1935/21	**Item 6.1 CQC Core Services and Well-Led Inspection** The Director of Nursing/Deputy Chief Executive presented the report to the Board advising that this offered an update from the core inspection that took place in October and the Well-Led inspection in November.
1936/21	The letters presented to the Board offered the immediate written feedback from the CQC with a clear request, and subsequent confirmation, that this should be shared publicly.
1937/21	The letters demonstrated good progress and significant improvements and it was believed that the feedback offered a fair reflection of the positive progress. This progress was also being seen through the Committees where there was oversight of the action plan.
1938/21	The Director of Nursing took the opportunity to offer thanks for staff for continuing to drive significant improvements during the pandemic.
1939/21	The Chair was very pleased to receive the letters, not only from the perspective of the Board but more importantly for staff. The publication of the letters within the Board papers would allow staff to access the detail offered in addition to the feedback already provided.
1940/21	The achievement during the pandemic was a huge testament to the commitment of staff at the Trust.
1941/21	The Chair offered personal thanks to the Executive Directors for the leadership offered and to all staff who had made the required improvements. The detailed report was awaited however the headline findings were encouraging and it was hoped the Trust would continue to build on these.

1942/21	Dr Prior also offered congratulations to staff on the significant improvements noting that there were still some elements of work in progress. Concern was raised in relation to medicines safety and storage that had been raised within the letter.
1943/21	The Director of Nursing noted that the Trust continued to hold a risk regarding medicines management as a whole. Work was in place to support this area with an improvement plan in the background being overseen through the Quality, Governance Committee. A Medicines Safety Group had been instigated supported through the Medical Directors office with clinicians supporting pharmacy colleagues. It was noted that whilst work was underway this was a focus of the Quality Governance Committee upward report to the Board.
1944/21	The Chair noted the letters received stating that an action plan would be put in place once the full report was received and had been scrutinised by the Quality Governance Committee. The Trust Board: • **Received the report noting the moderate assurance**
1945/21	**Item 7 Patient Story** The Director of Nursing presented the patient story to the Board advising that the story detailed the experience of a Trust Volunteer and offered the Board an understanding of the volunteer service.
1946/21	The Board watched the video presentation that detailed the impact of Covid-19 on Volunteers within the Trust, actions undertaken to support Volunteers during this time and the experience of a ward area and current volunteer.
1947/21	Through the video the Board were made aware of the NHS England and Improvement Volunteering Winter Pressures Funding Project for which the Trust had been successful in bidding for £25k.
1948/21	The funding would see the recruitment of 2 volunteer supervisors who would lead a team of Response Volunteers, known as the Busy Bees. These volunteers would link to the operational teams and respond to requests for help where they were needed the most.
1949/21	The Director of Nursing advised the Board of the national push to increase volunteer number and opportunities for which the video presentation had demonstrated the benefits to the Trust. The Trust was celebrating the winter funding with the Director of Nursing asking members of the Board to champion the forthcoming Busy Bees campaign and spread this across networks and communities to ensure a wide reach.
1950/21	The Director of Nursing reflected on the yellow t-shirts of the volunteers being like a ray of sunshine which echoed the views from Ward 5b that were detailed in the presentation. Covid-19 had demonstrated the impact not having volunteers in the organisation had had on services. The Director of Nursing hoped that the Board would join in supporting the recruitment of volunteers and to the Busy Bees initiative.

1951/21	The Chief Executive offered thanks for the presentation noting that the Trust were proud of the volunteers who were great ambassadors for the organisation. The volunteers were a great support to those attending the hospitals, assisting in directing people to the right locations and supporting services.
1952/21	The Chief Executive noted that there was a need to continue to recruit volunteers as well as making great use of those already undertaking the role and offered thanks to the Voluntary Services Manager for all the work done to advertise and lead the service.
1953/21	Mrs Dunnett asked if there was a programme for younger volunteers within the Trust.
1954/21	The Voluntary Services Manager advised that this was lead through the Talent Academy who already had links in place with schools and would be the route for younger groups. The Talent Academy were working to increase awareness in schools with recent contact having been received from St John's Ambulance regarding a national scheme.
1955/21	The Chair thanked the Voluntary Services Manager for the unfailing leadership of the volunteers noting that it had been an exceptionally difficult couple of years. The Chair noted that it was heartening to see volunteers on site again and offered thanks to all those who offered their time to support the organisation.
1956/21	The Chair asked if there was any support the Board could offer with the Voluntary Services Manager requesting that Board members support promotion of volunteer opportunities across the system, using their connections.
1957/21	The Voluntary Services Manager noted that the Communications Team had some resources that could support members of the Board to promote the message on social media and other avenues if required.
1958/21	It was also noted that the Busy Bee recruitment was continuing with the secondment opportunities due to be interviewed for and a request for support to this initiative from the Board was requested. Specifically the Voluntary Services Manager noted the need to identify a hive at both Lincoln and Pilgrim Hospitals to allow the team to have muster points to gather information before moving off to support services. The space would be required for the duration of the 4 month programme but it had not been possible as yet to identify a space.
1959/21	The Chair noted, on behalf of the Board, that members would commit to continue to promote volunteers and recruitment across a range of networks and noted that a question regarding volunteers would be added to the service visits that were undertaken. This would offer an opportunity to explore if a service had volunteers in place and if not if this could be considered.
1960/21	The Chief Operating Officer noted that identifying hives for the Busy Bees was a priority as volunteers were essential however there had not yet been space identified. The Chief Operating Officer confirmed that this remained a work in progress and priority for identification.

1961/21	The Chair requested that communications between the Chief Operating Office and Voluntary Services Manager remained in order to ensure space was identified to support the initiative.
1962/21	The Chair noted that the presentation had identified that some volunteers had been unable to return to the Trust with some taking the difficult decision not to return and offered thanks for the work they had undertaken.
1963/21	For those who had not yet been able to return that Chair noted that the organisation was ready to welcome those individuals back when they felt they could return and noted that support would be in place to facilitate this. The Trust Board: • **Received the staff story**
	Item 8 Objective 1 To Deliver high quality, safe and responsive patient services, shaped by best practice and our communities
1964/21	**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 23 November Meeting.
1965/21	Mrs Libiszewski advised that work continued on harm reviews with the Trust in the process of adopting an artificial intelligence system to support the process. Due diligence was undertaken on investigations related to harm reviews.
1966/21	The Committee received the second Complaints, Legal Claims and Inquests, Incidents and Patient Advice and Liaison Services (CLIPS) Report which pulled themes from the information presented. It was noted that whilst new themes were not being seen there continued to be issues of communication and discharge. These issues were not new for the Trust and were part of the Trust improvement plan.
1967/21	Mrs Libiszewski advised that significant reports had been received through the Maternity and Neonatal Oversight Group supported by the Non-Executive Director Maternity Safety Champion. Information had been received on the Clinical Negligence Scheme for Trusts (CNST) achievement, staffing report and continued ongoing issues of support for the CNST data collection that the Director of Finance and Digital was trying to resolve with colleagues nationally.
1968/21	The Committee continued to be concerned regarding the upward report from the Medicines Quality Group, whilst the report had been received there had been no update on the roadmap that had been developed. The roadmap had been designed to deliver changes required from Internal Audit findings and CQC reports. This was escalated to the Board as a key concern of the Committee.
1969/21	Mrs Libiszewski noted that the Director of Nursing had identified the actions taking place however there was confusion on the support from the transformation team for the integrated improvement plan and work of the Medicines Quality Group. Clarity was needed on the leadership in order for the work to progress. To date the

	Committee was not assured that the action plan was being progressed at the pace required.
1970/21	The Committee noted the improvements made in respect of clinical audit and the progress within the divisions. The Integrated Improvement Plan report as received however the Committee noted difficulty in order to be able to demonstrate specific progress on projects. The Committee requested that this be developed.
1971/21	Mrs Libiszewski noted that the Committee had been able to rerate the Board Assurance Framework in relation to patient experience and clinical effectiveness meaning that all objectives were rated as amber. This reflected the Committee's view that effective controls were in place but that assurance remained uncertain or insufficient. This was significant progress for the Committee and reflected the work being seen by external regulators.
1972/21	The Committee had identified 2 issues to raise with the Board or other Committees, these being the Medicines Quality Group and roadmap and a referral to the Finance, Performance and Estates Committee relating to records. Whilst the Committee were aware of the business case being developed for electronic patient records there were outstanding issues of quality possibly impacting on the delivery of care. A short term solution was required ahead of the future improvements.
1973/21	The Chair noted the positive position in respect of the BAF assurance ratings and noted the escalations from the Committee inviting the Medical Director to offer a view on the medicines management concerns.
1974/21	The Medical Director noted that the medicines issues traversed clinical, admin and logistic issues but would take responsibility to progress. Support may be required from the Project Management Office in order to progress however this would be explored to ensure that there was the right direction of travel.
1975/21	The Chair noted the Medical Directors' commitment to take forward the medicine management issues within the Trust and ensure alignment with the transformation team, project work and underlying issues. The Trust Board: • **Received the assurance report**
	Item 9 Objective 2 To enable our people to lead, work differently and to feel valued, motivated and proud to work at ULHT
1976/21	**Item 9.1 Assurance and Risk Report People and Organisational Development Committee** The Chair of the People and Organisational Development Committee, Professor Baker provided the assurances received by the Committee at the 16 November Meeting.

1077/21	Professor Baker noted that it had been particularly helpful that the Freedom to Speak Up Guardian had been in attendance at the meeting to explore the ideas to move the Trust forward.
1978/21	The Board was asked to note that there remained work to be completed before the Committee ran optimally with Professor Baker noting that the performance dashboard was yet to be developed to offer sufficient assurance. The sub-groups required alignment along with strengthened reporting to the Committee.
1979/21	Professor Baker highlighted the discussion held in relation to the bullying and harassment issues that had been alerted to the Board in November. It was noted that to a significant extent the issues had been addressed but this needed to be relayed and information offered on the work done to those raising concerns. The Committee were grateful that this had been taken forward by the Medical Director, limited assurance was offered to the Committee and Board.
1980/21	Significant issues that the fledgling People and Organisational Development Team needed to address were acknowledged that the Committee would need to consider.
1981/21	The Committee reviewed the Board Assurance Framework and agreed that ratings for all objectives would be moved to red to reflect that assurances were not being received by the Committee. Professor Baker clarified to the Board that this was not a deterioration but a reflection that the team were gaining grip of the current position. Progress since the previous month had been seen however it was accurate to record the assurance ratings as red.
1982/21	The Chair noted the report offered and stated that the move of assurance ratings was not a cause for concern. There were clear plans in place to move the Committee forward and expectations were clear. The Board looked forward to seeing movement in the near future. The Trust Board: • **Received the assurance report**
	Item 10 Objective 3 To ensure that service are sustainable, supported by technology and delivered from an improved estate
1983/21	**Item 10.1 Assurance and Risk Report from the Finance, Performance and Estates Committee** The Chair of the Finance, Performance and Estates Committee, Mr Woodward provided the assurances received by the Committee at the 25 November 2021.
1984/21	The Committee received the draft Estates Strategy that covered a number of key issues in terms of future solutions to some of the long term problems faced by the Trust and how these would be addressed over the next couple of years. The Strategy did not cover further in to the future due to a number of strategic bids that could have an impact.

1985/21	The Committee agreed that some enhancements would be required to the Strategy which would be presented back to the Committee in December before being offered to the Board at an appropriate time.
1986/21	Mr Woodward noted that the H2 financial plan had been presented noting that this had been split in to 2 halves due to the pandemic. The plan presented offered a breakeven position with the Committee noting the key challenge of the Cost Improvement Programme (CIP).
1987/21	The Board were advised that the development of the CIPs had been slower than expected due to the challenges faced by colleagues. The CIP target in H2 was achievable and assurance had been gained on this however it was noted that this was a risk for delivery at circa £3-4m. Assuming the breakeven position at the end of H2 would mean that the Trust would exit the year with a surplus of £1.8m.
1988/21	The Committee noted that the Capital report continued to be of a high quality offering assurance on the control of the delivery of the target. The Committee were delighted to note the additional £12m of capital funds due to a successful bid however noted the challenge on the deliverability due to the time remaining in the year. The Committee requested that the Director of Finance and Chief Operating Officer consider the position and offer a further update to the Committee. Flexibility had previously been agreed and with the additional £12m and other updates received it was appropriate for the over commitment to be considered.
1989/21	Mr Woodward noted that the Committee had taken some time to review the Board Assurance Framework paying particular attention to the position on estates and facilities as a result of the Strategy being presented that had completed the assurance in this area. The strategy offered the long term solution meaning that with the controls previously articulated that the Committee felt able to move the rating from red to amber. Similar clarity had been offered with the presented of the H2 position and deliverability and as such this was also moved to an amber rating.
1990/21	Mr Woodward took the opportunity to thank Committee members for their work during the interim period noting the improvements that had been seen despite the difficult time that had resulted in the Committee receiving assurances.
1991/21	The Chair noted the comprehensive report that had set out the position well noting that despite the challenges there was positive news being reported. The additional £12m of capital funding whilst positive now needed to be considered to ensure plans would be executed and the funding used to best effect.
1992/21	The Board were advised that the H2 financial plan had been signed off at system level with the Chair noting that there was now System and Trust triangulation. The risk regarding the CIP was noted however progress was needed to deliver.
1993/21	The Chair noted that the strengthened reporting and assurance with the leadership of Mr Woodward at the Committee had moved the position forward which was represented in the movements on the Board Assurance Framework.

	The Trust Board: • **Received the assurance report**
1994/21	**Item 10.2 Urology Service Engagement Output update** The Chair noted that the Board had seen the proposal in regard to changes to the service but noted that the Board was interested in understanding the engagement with service users and had requested an update.
1995/21	The Chief Operating Officer presented the report noting that the update demonstrated substantial progress in a number of areas. It was important to note the context of the work undertaken and to reference back to other elements discussed through the Board agenda in the context of emergency care and the challenges of the organisation.
1996/21	The work and progression and development of the urology service was happening within the wider pressurised system and therefore, understandably, some elements were not behaving as expected. There were however some elements that were a benefit to the organisation.
1997/21	Mr Simpson, Consultant Urologist, noted that the paper described the progress in the reconfiguration project that had been considered in August and went live on 9 August 2021.
1998/21	The main focus of the reconfiguration was the new structure for on call with Lincoln Hospital receiving all patients for specialist assessment and admission. The service had seen recruitment to a new tier of practitioner to support non-elective activity and trained to support diagnostic cancer activity.
1999/21	A high calibre of candidates had been attracted to the posts and the service had fully recruited to middle tier staff which was notably a hard grade to recruit to. Having previously run at a 28% vacancy rate the Consultant Urologist was pleased to advise the Board that there were no vacancies within the service.
2000/21	Overall the service had seen a decrease in non-elective admissions largely due to same day assessment and discharge with the ACP role having been instrumental. There had been positive engagement from patients for which comments had been included within the report.
2001/21	The Consultant Urologist noted that there had been some issues relating to staff morale however overall, staff supported by a strong management team, had had concerns addressed and moved forward with the reconfiguration which had seen the elimination of medical agency spend achieved in November.
2002/21	The Board were advised that this had offered a projected saving of £140k at the end of the financial year, notwithstanding additional recruitment to the ACP roles and middle tier doctors.

2003/21	The Quality Impact Assessment, which had been signed off by the Board, demonstrated a commitment to ongoing monitoring to ensure sustainability and resilience of the service moving forward.
2004/21	The Consultant Urologist noted that there were some issues including retention of middle tier staff, compliance with the model and the planned urology assessment unit not being in place. It was hoped that further support through the Capital, Revenue and Investment Group for this development would divert patients away from high pressured areas.
2005/21	The Chair was pleased to see the progress that had been made considering the context of the situation.
2006/21	Mrs Dunnett asked if there was any performance information available to support the detailed benefits to patient quality and safety.
2007/21	The Consultant Urologist noted that the scorecard was not yet fully developed however advised that there had been one complaint regarding a delayed transfer of care and 2 Datix incidents raised in relation to access to treatment with regard to a specialist opinion in a timely manner. This was due to the high volume of calls due to the success of the service. These elements would be developed in to the scorecard.
2008/21	Mrs Libiszewski asked if, as a result of the change, patients in the south of the county were seeking treatment in areas such as Peterborough, knowing they may be transferred to Lincoln.
2009/21	The Consultant Urologist advised that there had not been a significant reduction in the volume of patients presenting for assessment and subsequent transfers from Pilgrim Hospital however this was not corroborated with data.
2010/21	Professor Baker noted the medical agency spend and the baseline of £100k a month with a plan to reduce to zero and save £300k.
2011/21	The Consultant Urologist noted that the costs described were in relation to the current and future establishments which would see an overall reduction due to the elimination of agency spend. This was what had been removed against investment in to the service.
2012/21	The Chief Operating Officer noted that the service change and the way this had been led were all exemplars of how the Trust hoped to change services going forward as part of the Outstanding Care Improvement System. There were many things to do in order to reduce agency spend with controls in place however the service change demonstrate that recruiting the right people to the right place delivered high quality services.
2013/21	The Chair noted that this was a great exemplar across a range of different elements noting that this was the first transformation seen at the Board which had been led by clinicians. The Chair thanked the Consultant Urologist for the leadership offered to the service.

	The Trust Board: • **Received the report noting the significant assurance**
	Item 11 Objective 4 To implement integrated models of care with our partners to improve Lincolnshire's health and wellbeing
2014/21	No items
2015/21	**Item 12 Integrated Performance Report** The Director of Finance and Digital presented the report to the Board noting that relevant items for attention of the Board had been raised through the Committee upward reports.
2016/21	The Chief Operating Officer offered an update to the Board covering elements of discussions held during the course of the meeting relating to urgent care and pressures within the organisation and a focus on the emergency departments.
2017/21	There issues were not the only consequence being seen with the integrated performance report showing an increase in waiting lists for elective care, including cancer care and those cases requiring some of the highest level services of critical care and high dependency. The backlog was building to a similar level seen in wave 2 of Covid-19. The risk report described the mismatch of the demand versus the capacity, particularly in urgent care pathways and the inability to utilise inpatients beds to carry out the desired level of activity.
2018/21	The Urology paper offered a good example of the activity taking place internally to alleviate and mitigate the risk to treat patients the same day so that overnight stays were reduced. The latest report from NHS England, who had reviewed the Trusts approach, advised that the Trust was taking the right action despite the difficulties of things being managed outside of the Trusts control.
2019/21	The Chief Operating Officer noted that the Quality Governance Committee continued to have oversight on how the Trust managed the quality implications of clinical harms and remained assured on the actions being taken to monitor and escalate issues and concerns.
2020/21	Dr Prior raised concern in relation to the number of watch metrics that did not contain data asking when this could be expected and the issues being reported in relation to duty of candour and the fluctuating compliance.
2021/21	The Director of Finance and Digital noted that there was further work to be completed in relation to the scorecard and offered to speak with Dr Prior directly to explain the position. **Action: Director of Finance and Digital, 1 February 2022**
2022/21	The Chair noted this was about the transition to the new style of reporting noting the benefit of the briefing that had been received from the Director of Finance and Digital.

2023/21	The Director of Nursing advised that it was felt there had been some false assurance in relation to duty of candour with an element of data cleansing required as when notes had been reviewed this had identified both written and verbal duty of candour had been offered.
2024/21	It was noted that his was about new individuals in post who did not understand the constitutional requirements and whilst there had been an increase seen in verbal duty of candour there was difficulty in following up with written.
2025/21	The Clinical Governance Team were supporting clinical colleagues to ensure written duty of candour was offered and this had identified a training need. This was being seen through the performance review meetings of the divisions where an improving position was being seen. Both due to training but also the weekly tracker that had been put in place.
2026/21	Overall governance arrangements had been strengthened on the safety net to ensure statutory responsibilities were met and confidence in the improving position.
2027/21	The Chair noted the summary of the operational pressures noting those elements out of the Trusts control and the focus on what could be done by the Trust. Assurance had been received on the actions being taken, monitoring of clinical harm and ensure patient safety. The Trust Board: • **Received the report noting the limited assurance**
	Item 13 Risk, Governance and Assurance
2028/21	**Item 13.1 Risk Management Report** The Director of Nursing presented the report to the Board noting that this offered the monthly strategic risk report with a focus on the highest priority risks that continued to be the impact of the Covid-10 pandemic and timely provision of non-invasive ventilation (NIV).
2029/21	The Director of Nursing advised that NIV would be a specific focus of the Patient Safety Group at the December meeting and would be reported to the Quality Governance Committee.
2030/21	The Board was advised that the other highest rated risks continued to be capacity to manage emergency demand and workforce engagement and morale. There were a number of overdue actions within the risk register that were being addressed as part of the risk register reconfiguration.
2031/21	The Board noted the confirm and challenge meetings that were in place for the divisions and corporate areas with a number of actions being concluded as a result of the work.

2032/21	The Chair invited members of the Board to confirm the top risks as reported noting that mitigation action were in place. The Trust Board: • **Accepted the top risks within the risk register** • **Received the report and noted the moderate assurance**
2033/21	**Item 13.2 Board Assurance Framework** The Trust Secretary presented the report to the Board noting that this had been considered by all Board Committees during November.
2034/21	The Trust Secretary noted that the movement of the assurance ratings within the Board Assurance Framework (BAF) with the People and Organisational Development Committee moving objective 2a from amber to red.
2035/21	The Board was advised of the move of assurance ratings by both the Quality Governance and Finance Performance and Estates Committees that saw objectives 1b, 1c, 3a and 3b moved from red to amber.
2036/21	It was noted that the Audit Committee would consider the BAF at the next meeting in January 2022.
2037/21	The Chair noted the positive progress from the Quality Governance and Finance Performance and Estates Committees in respect of the levels of assurance available. The position of the People and Organisational Development Committee was appreciated with an expectation of improvement in the near future.
2038/21	The ability to consider and change the assurance ratings within the BAF at this point in the year, given the backdrop of the significant operational pressures and challenges was a significant achievement. The Trust Board: • **Received the report and noted the moderate assurance**
2039/21	**Item 14 Any Other Notified Items of Urgent Business** The Chair noted that it was incumbent upon her to thank Mr Woodward and Mrs Libiszewski as this would be the last Board meeting for both.
2040/21	The Chair thanked Mr Woodward for his support in responding to the request for support and had done a great job, as expected, in the interim capacity. There was now strengthened reporting offering assurance to the Committee resulting in the movement of the assurance levels presented within the BAF.
2041/21	The Chair noted the work on the capital plan and the position that the Trust was in to have a better understanding and assurance. Colleagues had appreciated the approach taken with the Chair noting that it was never easy taking on the role as an interim

2042/21	Mr Woodward was thanked by members of the Board and wished every success for the future.
2043/21	The Chair went on to thank Mrs Libiszewski noting that it was impossible to fully describe the difference that had been made since Mrs Libiszewski had taken on the role with the Trust. There was a much improved level of assurance around quality, safety and patient experience being received. Without a doubt, Mrs Libiszewski, along with the support of the Director of Nursing and other Executives and colleagues had driven a strong and focused approach to assurance.
2044/21	The Chair noted the personal focus on the patient which always came through and would show as a legacy to Mrs Libiszewski through reports, the BAF and the governance structure in place.
2045/21	The Chair thanked Mrs Libiszewski for her personal resilience and leadership in to the Quality Governance Committee and support to the Chair.
2046/21	The Chief Executive offered thanks to Mr Woodward and Mrs Libiszewski for the impact that they had had on the Trust and the improvements that had been seen and progress that continued.
2047/21	The next scheduled meeting will be held on Tuesday 1 February 2021, arrangements to be confirmed taking account of national guidance

Voting Members	**1 Dec 2020**	**2 Feb 2021**	**2 Mar 2021**	**16 Mar 2021**	**6 Apr 2021**	**4 May 2021**	**1 June 2021**	**6 July 2021**	**3 Aug 2021**	**7 Sept 2021**	**5 Oct 2021**	**2 Nov 2021**	**7 Dec 2021**
Elaine Baylis	X	X	X	X	X	X	X	X	X	X	X	X	X
Chris Gibson	X	X	A	X	X	X	X	A	X	X	A	X	A
Geoff Hayward	X	X	X	X	X	A	A	X					
Gill Ponder	X	X	X	X	X	A							
Neill Hepburn	X	X	X	X	X	X	X	A					
Sarah Dunnett	X	X	X	X	A	X	X	X	X	X	X	X	X
Elizabeth Libiszewski	X	X	X	X	X	X	X	X	X	X	X	X	X
Paul Matthew	X	X	X	X	X	X	X	X	X	X	X	X	X
Andrew Morgan	X	X	X	X	X	X	X	X	X	X	X	X	X
Mark Brassington	X	X	X	X	X	X	X	X	X				
Karen Dunderdale	X	X	X	X	A	X	X	X	X	X	X	X	X
David Woodward							X	A	A	X	X	X	X
Philip Baker									X	X	X	X	X
Colin Farquharson									X	X	X	X	X

PUBLIC TRUST BOARD ACTION LOG

Agenda item: 5.2

Trust Board date	Minute ref	Subject	Explanation	Assigned to	Action due at Board	Completed
4 February 2020	077/20	Assurance and Risk Report Quality Governance Committee	Action: Review of TOM and governance to be presented to the Board	Chief Operating Officer	~~02/11/2021~~ 01/02/2022	Report received at Jan Audit Committee. Upward report agenda item.
6 April 2021	579/21	Staff survey	Action: Consideration to be given to triangulation of data between staff survey results and quality measures	Int Dir of P&OD	~~01/06/2021~~ 01/02/2022	To build in to actions from 2021 Staff Survey and action be transferred to PODC. Close
6 April 2021	596/21	Smoke Free Policy	Action: Post implementation review following relaunch to be presented to the Board	Int Dir of P&OD	~~02/11/2021~~ 01/02/2022	Build in to actions for PODC in line with prioritised work plan for Committee. Close
6 July 2021	994/21	Patient Story	Action: Invitation to Dr Sakthivel and Jody Blow to present and update on the progress of communication training following story at the Board	Trust Secretary	07/12/2021	Arrangements being made Close
3 August 2021	1360/21	Urology Service Engagement Output	Action: An update paper on the Urology Service Engagement output to be reported to Board in three Months.	Int Dir of Imp & Integration	~~02/11/2021~~ 07/12/2021	Engagement commenced on 9 August. Three months data not collected until early November. Defer to December Board Agenda Item

PUBLIC TRUST BOARD ACTION LOG

Agenda item: 5.2

2 November 2021	1841/21	Establishment Review	Action: Finance, Performance and Estates Committee to receive further paper offering financial position and trajectories	Director of Finance and Digital	25/11/2021	Complete
7 December 2021	1914/21	Action Log	Establishment reviews for endoscopy and ED would be received once considered at Committee in Jan/Feb 2022	Director of Nursing	01/03/2022	Reviews pushed back to March as result of operational pressures.
7 December 2021	2021/21	Integrated Performance Report	Action: Director of Finance and Digital to meet with Dr Prior to explain the position of the watch metrics within the report	Director of Finance and Digital	01/02/2022	Ass Dir of Perf and Inf met with Dr Prior to discuss. Complete

Meeting	*Public Trust Board*
Date of Meeting	*1 February 2022*
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) As is the case across much of the country, the NHS in Lincolnshire continues to operate under significant pressure. This continues to be related to both COVID and general demand pressures. COVID has also had an impact on the availability of staff. Key areas of focus continue to be on reducing ambulance handover delays and on the appropriate and timely discharge of patients who no longer require care in hospital.
b) Further guidance has been issued by NHS England relating to the implementation of the requirements around the mandatory vaccination of frontline healthcare staff. This 'Vaccination as a Condition of Deployment' (VCOD) guidance gives more information about the scope of the new rules and the employment consequences if staff remain unvaccinated. All Trusts are continuing to have supportive 1:1 discussions with unvaccinated staff, whilst also working through the guidance. The new rules come into force on 1st April 2022, meaning that staff need to have had their first jab by 3rd February if they are to be double-jabbed by 1st April.
c) The introduction of Integrated Care Boards (ICBs) has been delayed from 1st April 2022 until 1st July 2022. This means that the NHS Lincolnshire CCG will continue in existence for a further three months. Work is continuing on the constitution and working arrangements of the ICB, including appointments to Executive and Non-Executive roles. It is anticipated that an announcement of the Chair of the ICB will be made shortly.
d) The public consultation on four of Lincolnshire's NHS Services closed on 23rd December. The CCG are now considering the responses with the aid of ORS, an independent social research company. The current understanding is that the CCG will consider the outcome of the consultation in March 2022.
e) The National Priorities and Operational Planning Guidance for the NHS for 2022/23 has been published. There are ten national priorities. All systems are expected to pull together draft plans by mid-March with final plans due at the end of April 2022. In Lincolnshire there will need to be a strong correlation between this plan and the Strategic Development Plan produced as part of the Recovery Support Programme.
f) The Lincolnshire Health and Care Collaborative (LHCC), the provider collaborative for Lincolnshire, is continuing to develop. A new Managing Director role has been appointed to and work is underway to clarify the governance, delegated authority, and clinical leadership of the collaborative. The assurance role of NEDs is also being addressed.

Trust Overview

a) At Month 9 the Trust reported an in-month break-even position, with a year-to-date surplus of £1.8m. This is in line with plan.
b) The Trust has received the draft report from the CQC following the inspection in October and November. The report is being checked for

factual accuracy. It is expected that the report will be published by the CQC in early February 2022.

c) As was widely reported in the media, the Trust declared a Critical Incident on 1st January due to service demand pressures and staffing shortages. The Critical Incident was stood down on 13th January. A Major Incident was also declared on 11th January and was in place for 19 hours. This related to ED pressures at Lincoln County Hospital and the loss of the cold water supply at Grantham and District Hospital. The Trust hosted colleagues from NHS England during the Critical Incident and the feedback was that the Trust was managing the situation well in exceptional circumstances. The right actions were being taken and there was evidence of good leadership across the Trust.

d) The Trust has recently been joined by thirty military personnel to support the Trust with its current staffing shortages. Our military colleagues will be based throughout Lincoln and Pilgrim hospitals until approximately the end of January. Twenty have military healthcare training and experience and have joined the Trust's non-registered workforce in helping with patient care in the EDs and other wards and areas. A further ten general duty military colleagues are providing input in support roles. Many NHS organisations across the country are receiving similar military support as part of the Military Aid to the Civil Authorities (MACA) arrangements.

e) The first undergraduate medical students from the University of Lincoln Medical School will start their attachments in the Trust during February. This will consist of 80 third year medical students.

f) I am delighted to confirm that Dr Sameedha Rich-Mahadkar joined the Trust on secondment as Director of Improvement and Integration on 10th January. This is to cover the improvement and integration responsibilities previously held by Mark Brassington who is now on secondment to NHS England/Improvement in the Midlands.

Report to:	Trust Board
Title of report:	Quality Governance Committee Assurance Report to Board
Date of meeting:	21 December 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 Committee worked to a reduced meeting length in response to operational pressures and the response to Covid-19.
	Assurance in respect of SO 1a Issue: Deliver harm free care **Clinical Harm Oversight Group Upward Report** The Committee received the report noting the actions being taken on the number of harms being seen and plans across the System and Trust to try and reduce or mitigate harm. The Committee noted the external review process in place alongside the internal gold command structure and the risk stratification of patients. The Committee noted the need to ensure the ability to evidence the actions taken and confidence that these had been appropriate. **Patient Safety Group Upward Report** The Committee received the report and noted the update offered by the Chair of the group. The Committee noted that significant work has been pursued by the group despite the operational pressures being experienced. **Serious Incident Summary Report** The Committee received the report noting the number of SIs and actions being taken. **High Profile Cases** The Committee received the report noting the content. **Infection Prevention and Control (IPC) Group Upward Report** The Committee received the report noting the work taking place across

	the organisation. The Committee noted the national approach being taken in relation to FFP3 masks with the Trust adopting the national principles. **Medicines Quality Group Upward Report and Medicine Management Oversight Group** The Committee received the reports noting the position offered by both. The Medical Director had now taken Director Leadership in order to address the ongoing issues within medicines management. The Committee noted and supported the continuation of the Diabetes Task and Finish Group until the actions had been completed. The Committee noted the successful rapid roll out of the n-MAB project to support vulnerable patients against Covid-19 and reduce the potential for hospital admissions. The Committee noted the focus that was being given to this area of work, specifically to consider the internal audit report and actions to be addressed. Regular reporting would be received through the Medicines Quality Group to the Committee. **Maternity and Neonatal Oversight Group Upward Report** The Committee received the suite of reports noting the conclusion of the external thematic review of serious incidents (SIs) and complaints that had been commissioned by the Director of Nursing in response to an increase in SIs and concerns raised by the group itself. The Committee noted that the report had been shared widely including with external partners. Whilst the review had identified some areas for improvement the themes were consistent with the Trust's own analysis and did not identify anything that was unknown to the Trust. The Committee noted that the recommendations would be captured and progressed as part of the maternity services improvement plan. The group would maintain an oversight role to ensure progress and embedding of actions. The Committee noted the ongoing issues regarding the maternity IT system however were advised of the introduction of a business intelligence solution being piloted which would help to support data upload and achievement of the Clinical Negligence Scheme for Trusts. The Committee noted the disappointment regarding PROMPT training which had seen further in month deterioration however were advised of the plan instigated to recover the position and achieve compliance by March 2022. It was noted this was ambitious. The baby friendly initiative, whilst difficult, was on track to be achieved however noted that there may be an impact from Covid-19.

	The Committee noted that the maternity action plan was due to be reviewed with senior leadership oversight and operational owners being identified in order to ensure this was deliverable. The ongoing work to support pregnant women to access the Covid-19 vaccination was noted with the Covid-19 status of the women being asked throughout the maternity pathway to ensure changes to treatment plans were implemented where necessary. **Nursing, Midwifery and AHP Advisory Forum Upward Report** The Committee received the report noting the content and supporting the move to zero tolerance for pressure ulcer harm. The Committee noted the progress that had been made to reduce pressure ulcer harm but noted that this was the final stage in the move to improvement. **Board to Ward Assurance – Quality and Safety** The Committee received the report noting the process that was undertaken. Specific areas of concern were reviewed on a monthly basis by the Director of Nursing and support to leadership offered in those areas. Panel discussions would be arranged to take place in the New Year to consider which wards would be accredited. The Committee were confident in the approach being adopted and noted that the Board would be involved in the issuing of awards.
	Assurance in respect of SO 1b Issue: Improve Patient Experience **Patient Experience Group Upward Report** The Committee received the report raising concern regarding the recent changes to visiting for inpatients. The Committee was assured that both the quality and equality impact assessments had been reviewed and signed off through gold command ahead of changes to visiting being made. The Committee noted the support available to patients in order to maintain contact with relatives during this period.
	Assurance in respect of SO 1c Issue: Improve Clinical Outcomes **Clinical Effectiveness Group Upward Report** The Committee received the report noting the organ donation report that was presented.

	Assurance in respect of other areas: **Sub-group review and development session plan** The Committee received the plan noting the intention to conduct the development session in March 2022 however recognised the need to consider the timing in respect of current pressures and the response to Covid-19. **Committee Performance Dashboard** The Committee received the report noting the information presented. The Committee raised concern regarding Duty of Candour compliance however recognised that a comprehensive paper would be presented to the January 2022 meeting. **Integrated Improvement Plan** The Committee noted the position that was reported and recommended that the Trust Board undertake a review of the programmes of work and reprioritisation of these in light of the operational and Covid-19 pressures. **PRM Upward Report** The Committee received the report noting the concern in respect of the potential risk to JAG Accreditation. The Trust has been granted accreditation Trust wide and have 3 months to develop substantial plans for a new build at Lincoln. If this cannot be achieved, then there is a risk that JAG accreditation will be removed. Work is taking place to address this. **Topical, Legal and Regulatory update** The Committee were pleased to receive the report which offered helpful insight regarding future issues for the Committee. The Committee noted the progress of the CQC regulatory approach and concerns relating to harm as a result of ambulance handover delays. The Committee noted how the risk was associated to the Trust noting the actions in place across the system. **Quarterly Priorities and Quarterly Progress Reports** The Committee received the report noting that the priorities mapped against the Integrated Improvement Plan and noted that whilst some progress had been made there had been delay against targets due to operational pressures. Work was underway to commence the planning for the Quality Account for the next year and the approach that would be taken in respect of identifying the quality priorities. **Actions arising from CQC Inspection** The Committee received the update noting the actions being taken and the expectation of receipt of the inspection report at a future Committee.

	The Committee explored recent safeguarding concerns in the national press and noted the work undertaken within the emergency departments of the Trust. There was confidence that work required was taking place in the Trust.
Issues where assurance remains outstanding for escalation to the Board	The Committee wished to raise with the Board consideration of the IIP work streams and an approach to prioritisation due to operational and Covid-19 pressures to ensure deliverable timescales
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	J	F	M	A	M	J	J	A	S	O	N	D
Elizabeth Libiszewski Non-Executive Director	X	X	X	X	X	X	X	X	X	A	X	X
Chris Gibson Non-Executive Director	X	X	X	X	X	X	X	X	A	X	X	X
Sarah Dunnett Non-Executive Director (Maternity Safety Champion)		X	X	X	X	X	X	X	A	X	X	A
Neill Hepburn Medical Director	X	X	X	X	X	X	X					
Karen Dunderdale Director of Nursing	X	X	X	X	X	X	X	X	X	X	X	X
Simon Evans Chief Operating Officer	C	C	C	C	X	D	D	D	D	D	X	D
Colin Farquharson Medical Director								X	X	X	A	X

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

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Report to:	Trust Board
Title of report:	Quality Governance Committee Assurance Report to Board
Date of meeting:	18 January 2022
Chairperson:	Chris Gibson, Non-Executive Director
Author:	Karen Willey, Deputy Trust Secretary

Purpose	This report summarises the assurances received and key decisions made by the 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 Committee worked to a reduced meeting length and agenda in response to operational pressures and the response to Covid-19.
	Assurance in respect of SO 1a Issue: Deliver harm free care **Serious Incident Summary Report** The Committee received the report noting the number of SIs and, despite continued operational pressures, was pleased to note the reduction in the number of overdue actions in month. A more detailed analysis including trends and key lessons would continue to be presented quarterly. **High Profile Cases** The Committee received the report noting the content. **Claims and Inquests** The Committee received the report for information noting the data provided. Further triangulation of the data would be seen through the Complaints, Legal Claims and Inquests, Incidents and PALs report on a quarterly basis. **Clinical Harm Oversight Group Upward Report** The Committee received a verbal update noting that whilst the group had stood down in response to operational pressures work continued to review clinical harms alongside the prioritisation process for patients. A full report would be presented at the next meeting of the Committee. **Patient Safety Group Upward Report** The Committee received the report noting that most of the sub-group meetings had been stood down due to clinical pressures. Discussions had taken place and concerns raised regarding the impact of the redeployment of staff as a result of Covid-19 and operational pressures.

	The Committee noted that redeployment would potentially impact on staff training but would support patient care and was the expected response in the current situation. **Progress toward delivering National Patient Safety Strategy** The Committee received the report noting the content and requirement for the Trust to have a Patient Safety Specialist Lead. The Committee noted the resource in place within the Trust for the Patient Safety Specialist Lead who would be supported by existing staff to deliver the national requirements. The Committee commended the paper to the Board noting that this would be offered alongside a presentation detailing local actions against national requirements. **Infection Prevention and Control (IPC) Group Chair's Report** The Committee received the Chair's report from the group noting that there was confidence in stepping the meeting down due to the governance structures in place. The Committee noted the daily IPC cells that took place and reported through Gold Command and were advised of the increase in the number of outbreaks during December and January as a result of Covid-19 and the Omicron variant. The Committee noted that there had been no further outbreaks following the peak. The Committee noted the ongoing divisional assurance in place through the pandemic to monitor IPC practices and commended the rapid and clear communication of changing national guidance. The Committee was advised that an IPC visit was anticipated to take place towards the end of January to February from NHSE/I as a follow up to the visit undertaken last year. **Children and Young People Group Upward Report** The Committee received the report noting the content and the progress being made on the work streams following overhaul of the group. **Maternity and Neonatal Oversight Group Chair's Report** The Committee received the Chair's report following the step down of the meeting as a result of operational pressures. The Committee were advised of the step down in requirements by the Midlands and East Screening Quality Assurance Service however additional support would be in place. The Committee were pleased to note the success of the Digital Maternity Assessment: Funding Bid for the Trust noting that work was underway regarding the use of the funding. The impact of the current phase of the pandemic was noted in relation to

	increased staff sickness and staffing challenges as a result. Mitigating actions were in place however the Committee noted that, as a result, there had been an adverse impact on some of the improvement and transformation agenda. The Committee noted that as a result of operational pressures the deep dive identified in relation to caesarean section had not been completed however were reassured this remained an action for the group.
	Assurance in respect of SO 1b Issue: Improve Patient Experience **Duty of Candour update** The Committee received the report noting the current position of duty of candour and the actions planned for improvement. The Committee noted the deterioration over time and were advised of a look back exercise being completed to review case notes for evidence of duty of candour having been completed but not recorded. The Committee noted that the regulatory body was regularly advised of the position and was content with actions in place. The Committee agreed that monthly reports would be received over the next 3 months to demonstrate improvement recognising that the necessary trajectory would run for a 3 month period.
	Assurance in respect of SO 1c Issue: Improve Clinical Outcomes No items received
	Assurance in respect of other areas: **Committee Performance Dashboard** The Committee received the report noting the deterioration of some nursing and quality indicators which were not unexpected due to the significant pressures being experienced by the Trust. It was not yet clear that the operational pressures and sickness levels had resulted in the deterioration however the Committee were assured that reviews were taking place and would offer triangulation of the positon. The Committee noted the potential benefit of the Board being sighted on both the nursing staffing levels and quality red flags along with any workforce red flags, requesting a referral to the People and Organisational Development Committee to have workforce red flag data reported. The presentation of both datasets to the Board would offer correlation between the quality and workforce data. The Committee were pleased to note the continued improvement in the Summary Hospital-level Mortality Indicator (SHMI) which was reporting in the 'as expected' range across all three hospital sites.

	Quality Impact Assessments The Committee received the report noting the content and were assured that the quality impact and equality impact assessment processes had continued throughout the pandemic. **Actions arising from CQC Inspection** The Committee received the update noting the actions being taken and that the draft report following the inspection had been received by the Trust to offer comments on factual accuracy. Work had commenced to build in the actions from the full inspection report and to consider how these would link to the Trusts overall improvement plan.
Issues where assurance remains outstanding for escalation to the Board	None
Items referred to other Committees for Assurance	The Committee wished to refer to the People and Organisational Development Committee a request for workforce red flags to be offered through the performance dashboard to the Committee. Reporting to the Board would afford the opportunity to correlate with the quality indicators.
Committee Review of corporate risk register	The Committee noted the risk register and the position of the reconfiguration process and associated revised policy documents.
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. No changes were recommended.
Areas identified to visit in dept walk rounds	None

Attendance Summary for rolling 12 month period

Voting Members	F	M	A	M	J	J	A	S	O	N	D	J
Elizabeth Libiszewski Non-Executive Director	X	X	X	X	X	X	X	X	A	X	X	
Chris Gibson Non-Executive Director	X	X	X	X	X	X	X	A	X	X	X	X
Alison Dickinson Non-Executive Director												X
Sarah Dunnett Non-Executive Director (Maternity Safety Champion)	X	X	X	X	X	X	X	A	X	X	A	
Neill Hepburn Medical Director	X	X	X	X	X	X						
Karen Dunderdale Director of Nursing	X	X	X	X	X	X	X	X	X	X	X	X
Simon Evans Chief Operating Officer	C	C	C	X	D	D	D	D	D	X	D	D
Colin Farquharson Medical Director							X	X	X	A	X	X

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

Report to:	Trust Board
Title of report:	People and OD Committee Assurance Report to Board
Date of meeting:	14th December 2021
Chairperson:	Professor Philip Baker, Chair
Author:	Karen Willey, Deputy Trust Secretary

Purpose	This report summarises the assurances received and key decisions made by the People and OD Assurance Committee. The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board. This assurance committee meets monthly and takes scheduled reports according to an established work programme. The Committee worked to the 2021/22 objectives following approval of the BAF by the Board.
Assurances received by the Committee	**Assurance is respect of SO 2a** **Issue: A modern and progressive workforce** **Safer Staffing** The Committee received the report noting the new format that would be further refined however found the triangulation offered helpful. The Committee noted the need for other workforce groups to be considered in the safer staffing reporting and would be something to be considered by the Workforce Group. The inclusion of other workforce groups would support the understanding of workforce issues across the Trust and support assurance offered to the Committee. **Winter Staffing Gap Analysis** The Committee noted the report that details the assurance framework which offered a level of detail on the largest workforce across nursing and midwifery in order that Trusts were prepared through winter and the next Covid-19 surge. The Committee noted the high risks reported and the oversight arrangements in place to ensure that these were mitigated. Oversight of the position was currently offered through the Temporary Staffing Solutions Group. The Committee noted that the Workforce Group would require reestablishment however recognised the current arrangements in place through the Workforce Cell underpinning Gold Command.

	NHS and System People Plan update The Committee received the update noting that work continued to develop the system people plan. The Committee noted that the paper outlined the broad approach as a system which offered a focus on the short term issues. It was noted that the Trust would support further development and offer leadership from the acute perspective to the development of the One People plan for Lincolnshire. The Committee noted that a continued focus would be offered to the NHS and System People Plan as this developed.
	Assurance in respect of SO 2b **Issue: Making ULHT the best place to work** **Upward report from Culture and Leadership Programme** The Committee received the report noting that the programme was on hold until the end of January 2022 due to operational pressures. Whilst the need to pause the programme was understood the Committee noted concern. Activity in recent months was noted including the role out of the leadership behaviour surveys for which the Trust had achieved one of the highest response rates nationally. The Committee noted the success of the initial Leading Together Forum noting the second was due to take place in January 2022 with Professor Michael West as a key note speaker. The Committee did not receive assurance on the progress of the programme noting the need for the sub-group to establish a set of terms of reference and to offer an understanding of the objective of the group, deliverables and timelines to the Committee.
	Assurance in respect of SO 4b **Issue: To become a University Hospitals Teaching Trust** **Medical School Update** The Committee received the report noting that work remained on track to successfully deliver the Medical Education Programme. The Committee noted concern regarding the possibility of early graduation for students and the support that may need to be in place to reflect this along with an enhanced induction.

	The Committee explored the opportunity to train the medical students as Healthcare Support Workers to offer an understanding of the multi-disciplinary team alongside supporting the Trust's staffing position. **Upward Report from University Teaching Hospital meeting** The Committee received the report noting the content.
	Assurance in respect of other areas: **Estates and Facilities Response to OD Review update** The Committee received the update noting the position offered and reflected on the wider piece in respect of OD support within the Trust noting that these issues were not isolated. The Committee requested that a paper be presented to the Committee offering the view of the new leadership team and the focus of priorities in order to develop the OD support to the organisation. **Committee Performance Dashboard** The Committee received the report noting the work that continued on the development of the dashboard and availability of data. The Committee noted the need to focus on appraisal and training in order to see this return to acceptable levels however noted that the report demonstrated the current position of the directorate. **People Directorate Update** The Committee received the report noting the progress being made in respect of recruitment and the senior team within the directorate. The work being conducted in the System was noted with the Committee seeking to understand if the Trust was maximising the ability to contribute to this. It was noted that the presence of the Trust needed to be developed in relation to System working. **PRM Upward Report** The Committee received the report noting the continued progress in respect of the style and content of the report. The Committee noted the continued work to resolve wider performance as part of the performance review meetings which would develop to include the people agenda. **Topical, Legal and Regulatory Update** The Committee noted the report and the updates offered. The Committee discussed the impact of the new Covid-19 variant and the requirements on the Trust to drive forward the vaccination programme, including the booster vaccination.

	The Committee noted the potential impact that the Omicron variant would have on the availability of staffing due to the potential prevalence. The Committee noted the requirement for all staff to have received the Covid-19 vaccination by 1st April 2022 with all staff requiring the first dose vaccination by the first week in February to meet the deadline. **Integrated Improvement Plan** The Committee received the report noting the content. **Board Assurance Framework** The Committee received the updates offered on the Board Assurance Framework and noted the work due to be carried out to review the activity within the Directorate that linked to the objectives and subsequent updates.
Issues where assurance remains outstanding for escalation to the Board	No items
Items referred to other Committees for Assurance	No items referred
Committee Review of corporate risk register	The committee received the risk register noting the current risks presented
Matters identified which Committee recommend are escalated to SRR/BAF	No areas identified
Committee position on assurance of strategic risk areas that align to committee	No areas identified
Areas identified to visit in ward walk rounds	

Attendance Summary for rolling 12 month period

Voting Members	J	F	M	A	M	J	J	A	S	O	N	D
Geoff Hayward (Chair)	X	A	X	A	X	X	X	Meeting not held				
Philip Baker										X	X	X
Sarah Dunnett	A	X	X	X	X	X	X			X	X	X
Karen Dunderdale	C	C	C	X	A	X	D			X	X	X
Paul Matthew										X	X	X
Martin Rayson	X	X	X	X	X	X	X					
Simon Evans	C	C	C	C	D	A	D			A	A	A

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

Report to:	Trust Board
Title of report:	People and OD Committee Assurance Report to Board
Date of meeting:	11th January 2022
Chairperson:	Professor Philip Baker, Chair
Author:	Karen Willey, Deputy Trust Secretary

Purpose	This report summarises the assurances received and key decisions made by the People and OD Assurance Committee. The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board. This assurance committee meets monthly and takes scheduled reports according to an established work programme. The Committee worked to the 2021/22 objectives following approval of the BAF by the Board. The Committee worked to a reduced agenda and shortened meeting in order to support the response to Covid-19 and operational pressures.
Assurances received by the Committee	**Assurance is respect of SO 2a** **Issue: A modern and progressive workforce** **Safer Staffing** The Committee received the report noting that additional support had been put in place for student nurses, AHPs and medical students during the period of operational pressures, as had been done during the response to the Covid-19 pandemic. The Committee noted the reduced ceiling of care for patients due to the reduced number of nurses however were assured that there remained no correlation between staffing, skill mix and patient harm. This continued to be monitored closely through the Quality Cell. The Committee were pleased to note the continued oversight regarding staffing levels and the mitigations in place to address staffing concerns. The Committee were keen to ensure that the Trust moved to a position where assurance could be all for all staff groups noting that this would be progressed as part of the priorities for the People and OD Directorate through the Workforce Group, once re-established.
	Assurance in respect of SO 2b **Issue: Making ULHT the best place to work** **Freedom to Speak Up** The Committee received the report noting the update and raised a number of questions which would be addressed at a future meeting due to the Freedom to Speak Up Guardian not being able to attend the meeting.

	The Committee were keen that benchmarking from the National Guardians Office be included within future reports to offer an understanding of the Trust's position in those speaking up. The Committee was pleased to note that regular meetings were taking place between the Freedom to Speak up Guardian and senior leaders within the Trust to identify themes and take action on concerns. **Equality, Diversity and Inclusion Group Upward Report** The Committee received the report and were pleased to note the progress with meetings now taking place. The Group reviewed the terms of reference which were received and approved by the Committee. The Committee noted that the group had agreed the need to reset the equality, diversity and inclusion objectives and engagement and support from individuals within the Trust would support improvement in behaviours. **Culture and Leadership Project Team Upward Report** The Committee received the report noting the content and intention to develop a delivery plan for the project with a set of terms of reference set out and a stock take of the current work undertaken. The Committee were pleased to note that a benchmark would be established to offer a baseline measure and demonstrate progress.
	Assurance in respect of SO 4b **Issue: To become a University Hospitals Teaching Trust** No items received
	Assurance in respect of other areas: **Committee Performance Dashboard** The Committee received the dashboard noting the further improvement in the presentation of the data. The Committee noted the sickness absence rate which continued to be impact by Covid-19 related sickness, including isolation. The Committee requested that future reports offered a clear breakdown between Covid-19 and non-Covid-19 sickness in order that there was clarity of underlying sickness. The Committee were advised of funding which had been received in respect of recruitment at senior level to support the System to improvement recruitment and retention.

	People Directorate Update – Leadership overview and priorities The Committee were pleased to receive the overview and priorities paper noting that this offered a view in respect of the HR and People elements with the Organisational Development priorities due to be presented to the Committee in February. The Committee noted that the priorities in respect of medical staffing, governance, recruitment and employee relation cases which would be the focus for the next 3 months. The Committee supported the focus, however, raised concern regarding the short timescales for achievement. Reassurance was offered that work had commenced and that the timescales were deliverable. **Board Assurance Framework** The Committee noted the report and reflected that reports received and discussions held by the Committee meant that the assurance ratings remained as presented.
Issues where assurance remains outstanding for escalation to the Board	No items
Items referred to other Committees for Assurance	No items referred
Committee Review of corporate risk register	The committee received the risk register noting the current risks presented and new high risk, in relation to mandatory vaccination of staff, which had been added to the register. The Committee noted that an update would be provided on the risk at future meetings.
Matters identified which Committee recommend are escalated to SRR/BAF	No areas identified
Committee position on assurance of strategic risk areas that align to committee	No areas identified
Areas identified to visit in ward walk rounds	No areas identified

Attendance Summary for rolling 12 month period

Voting Members	F	M	A	M	J	J	A	S	O	N	D	J
Geoff Hayward (Chair)	A	X	A	X	X	X	Meeting not held					
Philip Baker									X	X	X	X
Sarah Dunnett	X	X	X	X	X	X			X	X	X	X
Karen Dunderdale	C	C	X	A	X	D			X	X	X	X
Paul Matthew									X	X	X	X
Martin Rayson	X	X	X	X	X	X						
Simon Evans	C	C	C	D	A	D			A	A	A	A

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

United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*1 February 2022*
Item Number	*Item number allocated by admin*
ULHT 2021 Winter Vaccination Programme Update	
Accountable Director	Paul Matthew, Director of Finance & Digital / Director of People & OD
Presented by	Paul Matthew, Director of Finance & Digital / Director of People & OD
Author(s)	Angus Maitland, Programme Lea
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	*X*
1c Improve clinical outcomes	*X*
2a A modern and progressive workforce	*X*
2b Making ULHT the best place to work	*X*
2c Well Led Services	
3a A modern, clean and fit for purpose environment	
3b Efficient use of resources	
3c Enhanced data and digital capability	
4a Establish new evidence based models of care	
4b Advancing professional practice with partners	
4c To become a university hospitals teaching trust	

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

Recommendations/ Decision Required	• Note the Covid-19 vaccination status of Trust staff and the continuing efforts to determine the accurate status of all staff as well as the continuing efforts to maximise uptake • Note that, while there are risks to the loss of staff, these at present are likely to be predominantly staff without a clinical registration • Note the requirement of the Trust to comply with the law while respecting the rights of staff.

Executive Summary

New legislation has recently been brought in making it mandatory for all frontline NHS staff to have at least two doses of the Covid-19 vaccine from Friday 1 April 2022.

This legislation applies to all NHS organisations as well as private health providers. The law, as it stands, applies to all health and social care workers, bank and agency staff, honorary workers, volunteers, locums and students (over 18).

Following recent advise, it has been determined within ULHT that for the purposes of the legislation, frontline staff are classed as:

- All clinical workers who have face-to-face contact with patients
- All non-clinical workers (such as receptionists, ward clerks, porters and domestic staff) who may have direct face-to-face contact with patients but are not directly involved in their care

All staff across the Trust who are yet to have a Covid-19 vaccine are now being contacted and discussions held locally around their intentions and wishes.

The current position of the vaccination programme is detailed within the report.

ULHT 2021 Winter Vaccination Programme

Trust Board Update for 1st February

Preface on data and timings

Trust Board members are asked to note, with regard to the position on mandatory vaccines, that there will be a verbal update at the Board meeting, which will be a more accurate reflection of the numbers of staff still outstanding. There is a large amount of validation underway on staff who have had a vaccine but which is not currently feeding through to the Trust's systems. This is likely to materially, and positively, affect numbers reported.

1. COVID-19 Booster Vaccination Update

Date	No. of ULH staff vaccinated	Total number of ULHT staff*	ULHT staff vaccinated	ULHT frontline staff vaccinated	ULHT non-frontline staff vaccinated
18/01/22	**8107**	9973	**81.29%**	79.68%	88.84%

*As of 13/01/22 – work continues on the denominator but is updated periodically after validation.

2. COVID-19 Booster Vaccinations by Division (as at 18 January 2022)

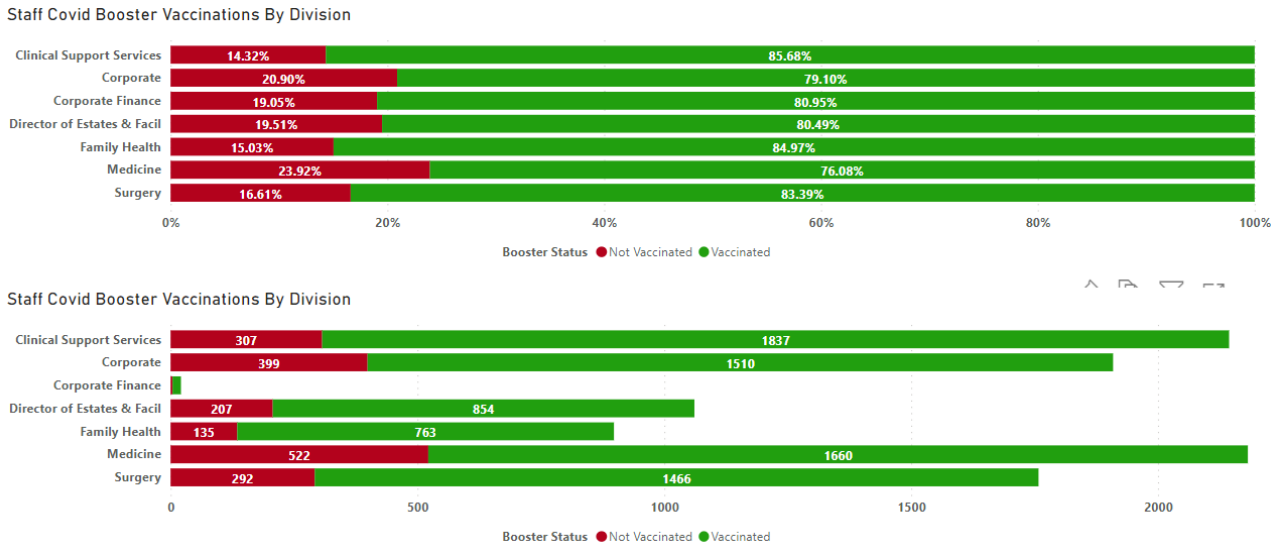


TABLE A: Booster Vaccinated ULHT Staff by site

Hospital Site	Number of Staff Vaccinated/Total Staff	Percentage of Staff Vaccinated
Lincoln	4624/5734	80.64%
Pilgrim	2495/3125	79.84%
Grantham	813/921	88.27%
Louth	110/127	86.61%
Other	65/66	98.48%

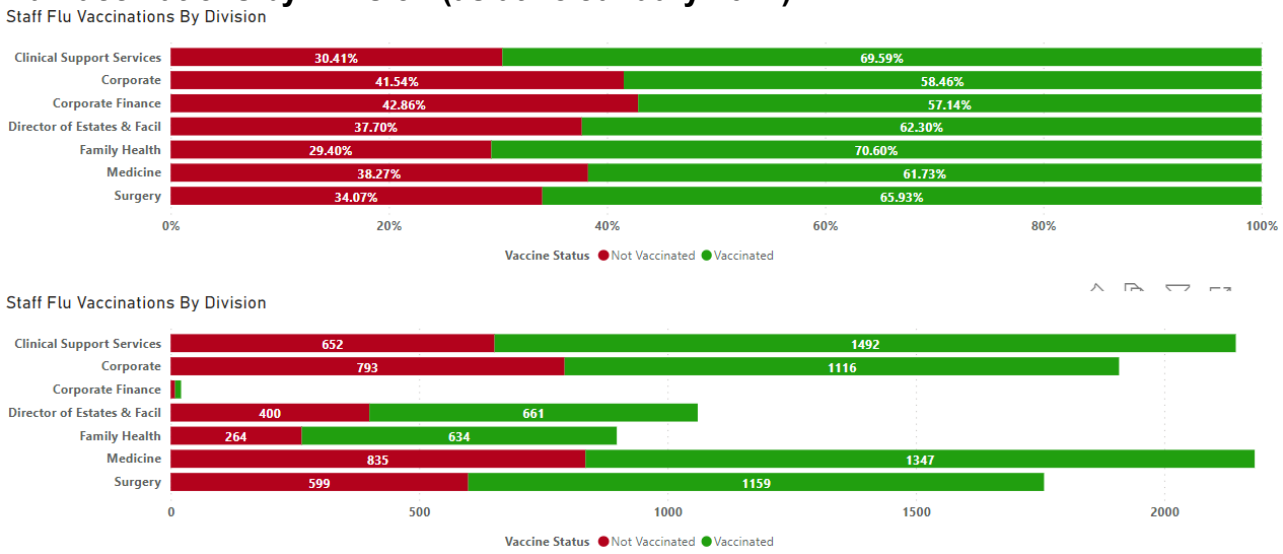
3. Flu Vaccination Update*

Date	No. of ULH staff vaccinated	Total number of ULH staff	% ULH staff vaccinated	ULH frontline staff vaccinated*	**NHSE target +/-**	ULH non frontline vaccinated
18/01/22	**6421**	9973	**64.38%**	63.19% (5192)**	-20.62%	69.99% (1229)**

*NHSE Flu target for frontline staff 85% (8217 total)
**Frontline: 8217 / Non frontline: 1756
ULHT internal target 90% all staff

Removing long term sick and maternity leave staff, our figures for flu vaccination are substantive staff 68.13% and Bank staff 46.77%.

Flu Vaccinations by Division (as at 18 January 2022)



4. Mandatory Covid Vaccinations

It is a legal requirement for eligible staff to have had 2 Covid-19 vaccinations by 1st April 2022, which means they need their first by 3rd February 2022.

This update does not go into the policy for managing unvaccinated staff and their contractual status.

The Trust methodology in reporting staff with no Covid-19 vaccination is deliberately conservative. Until we have formal confirmation of vaccine status on the Trust system we are reporting it as a risk. The numbers below are a worst case position, and are clarified below.

The position as at Tuesday 18th January 2022 was as follows:

A. Mandatory COVID-19 Vaccinations – Staff Not Yet Vaccinated

Division	Total as at 18/01/2022	Total at 11/01/2022	Change
Medicine	132	141	-9
Corporate	97	102	-5
Clinical Support Services	70	75	-5
Director of Estates & Facil	60	61	-1
Surgery	50	52	-2
Family Health	19	20	1
Corporate Finance	2	2	0
Total	**430**	**453**	**-23**

ESR Staffing Groups	Total at 18/01/2022	Total at 13/01/2022	Change
C - Administrative & Clerical	44	47	-3
E - Estates	74	75	-1
H - Healthcare Assistants	120	127	-7
M - Medical	66	69	-3
N - Nursing	77	83	-6
P - Professions Allied to Medicine	29	31	-2
S - Scientific & Professional	11	11	0
T - Technicians	4	4	0
W - Midwives	5	6	-1
Total	**430**	**453**	**-23**

Of the above numbers, as at 24th January 2022, the Trust has identified several groups.

Approximately 200 staff have so far provided evidence of vaccine status which is being checked, either in the UK or internationally. This is a laborious process because of the different systems involved, and therefore may take some days before they can be definitively removed from the table above. This covers a very large majority of the qualified medical and nursing staff in the table.

Approximately 60 staff have said they either will not have a vaccine or will not engage with the Trust on the subject.

The remainder fit within a large number of groups which have to be followed through on an individual. Some of these are currently away from the Trust, have been off sick, preventing a vaccine, have not yet firmly decided or are seeking further medical advice. This latter group is the most difficult on which to provide certainty.

While numbers are still being worked through, the largest two groups signalling that they will not have a vaccine are from our housekeeping and health care support worker (including Bank) teams.

5. Summary and Recommendations

This has been a particularly challenging exercise to conduct at a time when the Trust has been under considerable operational pressure. The issue of mandatory vaccination has been in the public domain and there has been extensive social media discussion which has made the decision to be made challenging for numerous staff members. This is alongside the already difficult decision some staff have had to make in relation to their individual concerns for their own health, for example their underlying fear of vaccination.

Every member of staff has been accounted for individually and has been offered support where they need it. Equally, if, after all possible support, staff have indicated that they will not have a vaccine, the Trust respects their right to exercise their choice and will work with them on the consequences both for them and for the Trust.

At the time of writing, the range of risk the Trust is facing in respect of the loss of staff is between 60 and 200 staff, and we will not know for certain until 4th February 2022, when the deadline for the first vaccination has passed. The very large majority of these staff are not clinical staff on a professional register, but most of them will be classified as 'front line' in that they have contact, whether face to face or incidental, with patients.

It is extremely disappointing to have to report the loss of any staff when there are such pressures on the service, and when we set such great store by the support for all of our colleagues, but we have to both comply with the law and respect the rights of all individual staff members.

Trust Board members are asked to:

- Note the Covid-19 vaccination status of Trust staff and the continuing efforts to determine the accurate status of all staff as well as the continuing efforts to maximise uptake
- Note that, while there are risks to the loss of staff, these at present are likely to be predominantly staff without a clinical registration
- Note the requirement of the Trust to comply with the law while respecting the rights of staff.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

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

Purpose	This report summarises the assurances received, and key decisions made by the Finance, Performance and Estates Committee (FPEC). The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board's response. This assurance committee meets monthly and takes scheduled reports from all Trust operational groups according to an established work programme. The Committee worked to the 2021/22 objectives.
Assurances received by the Committee	**Assurance** in respect of SO 3a A modern, clean and fit for purpose environment **Estates Strategy** The Committee received the second iteration of the Estates Strategy noting some further refinement was required however the Committee noted the work that had been undertaken to progress the strategy and recommended this be received by the Trust Board at an appropriate time. **Estates Report** The Committee received the report noting how this was continuing to develop and offer assurance to the Committee. The Committee noted the review being undertake in respect of health and safety which would alter future reporting to ensure this remained fit for purpose.
	Assurance in respect of SO 3b Efficient Use of Resources **Finance Report inc CRIG upward report** The Committee received the report noting that the position from month 7 had been resolved due to the completion of planning for H2. The Trust reported a £1.8m surplus as H1 was exited and predicted breakeven for H2 with a full year outturn of £1.8m forecast. The Committee noted the potential impact on the Trust during the winter period and impact of the new variant of Covid-19. Whilst planning assumptions had been made it was noted that the position was changing.

	The staffing pressures were noted with changes being seen in both volume and tiers of agency use. Work was underway to consider financial incentives for bank staff. **Cost Improvement Programme update** The Committee received the report noting that this offered further detail than previously reported. It was noted that whilst there were technical adjustments that would deliver the CIP this would not be delivered through transformational CIP. Work was underway to ensure delivery of transformational CIP in 2022/23 with discussions due to be held with the Divisions to identity further schemes for delivery. **Capital Report** The Committee noted the overall capital position and the concern associated with the additional £12m that the Trust had received. The Committee noted that half of the additional allocation would be delivered, subject to operational pressures however the remaining £6m had been notified too late in the year meaning it would not be possible to deliver the identified schemes. Of the £34m core capital programme plans and mitigations remained in place for this to be delivered with the Committee noting that progress being made in relation to the capital schemes. **Risk and Gain Share** The Committee received the report as part of the system Recovery Support Programme noting that this offered a theory of how risk and gain share would work across the system. The Committee noted concern on how this would work in practice however was minded to support the paper, subject to receiving further information, alongside the clarity being offered that this would sit against the system improvement work and would not apply to the core contract of the Trust. Further detail would be presented to the Committee once discussions had taken place at system level. **Procurement Strategy** The Committee received the Procurement Strategy noting that this was a strategy being developed for the three provider organisations. It was noted that this would need to be widen to primary care and local authorities once the Integrated Care Board was established. The Committee raised a number of concerns requesting that a baseline be articulated in order to progress the strategy in a way that was understood by all. Clinical engagement was also identified as a key element to ensure that the strategy functioned as expected.

	Assurance in respect of SO 3c Enhanced data and digital capability **Cyber Security Risks and Digital Assurance Report** The Committee received the reports noting the content and positive work that continued within the Trust in respect of cyber security and digital. The Committee noted the slippage of the position in respect of the Electronic Patient Record however was advised that this was due to changes in the digital landscape. A paper would be presented to the Committee in January offering a revised timeline. **Information Governance Performance Review and Information Governance Group upward report** The Committee received the reports noting that the Information Governance function was now part of the Trust Secretary's portfolio and work was being taken forward to strengthen the department. The Committee noted that a revised set of terms of reference for the Information Governance Group would be discussed by the group in January in order to ensure this had the correct function and offered assurance to the Committee. The Committee were advised of the virtual Information Commissioners Office (ICO) audit that had been conducted during December with the draft report due to be offered to the Trust in early January. It was noted that this would be an exception report.
	Assurance in respect of other areas: **Integrated Improvement Plan** The Committee received the new style report noting that this offered further assurance and had made good progress in a short period of time. It was also noted that there was limited impact so far from the IIP projects on the Trust's key measures in the Executive Scorecard. The Committee noted that work continued in respect of critical pathways and dependencies which were expected to be presented to the Committee in the coming months. Work was underway to develop year 3 of the IIP to ensure that this was in place ahead of the new financial year. **Operational Performance against National Standards: Urgent Care, Cancer Performance and Planned Care** The Committee received the reports noting the interrelation between each of the reports due to the impact of the Omicron variant of Covid-19 which was of national concern.

	The Committee noted the escalation level of the NHS to level 4 in response to a continuation of unavailability of workforce alongside the level of admissions due to the Delta variant. The Trust was responding to letters from regional and national teams regarding planning and whilst instruction was awaited planning and scenario preparations continued. The Trust had seen the most challenging month during November in terms of both workforce availability, ambulance handovers and 12-hour trolley waits. A visit from the national team for urgent care had been undertaken to the Trust with positive feedback being offered on the approach to improvements in urgent care. Planned care performance was being impacted due to urgent care demands with the Committee noting the increase in waiting lists. It was noted those case requiring high dependency or intensive care were most affected. The Committee was pleased to note that the artificial intelligence (AI) system was now in place and functioning, providing support to clinician decision making, meaning that all patients on waiting lists were now categorised. Confidence was also given to the P2 categorisations that the Trust had previously made prior to the AI system being in place. The Committee was pleased to note that the overall number of patients in the P2 category was virtually unchanged though some patients had moved to category 3. The Committee noted the actions being taken in relation to harm reviews that was being overseen by the Quality Governance Committee and the increase in the number of triggers of harm events. The Committee were informed that a substantial increase in significant harm or death was not being seen however there was an increase in low level harm. **Committee Performance Dashboard** The Committee received the report noting the progress being made in respect of the executive scorecard. **Performance Review Meeting Upward report** The Committee received the report noting the concern in respect of the potential risk to JAG Accreditation. The Trust has been granted accreditation Trust wide and have 3 months to develop substantial plans for a new build at Lincoln. If this cannot be achieved, then there is a risk that JAG accreditation will be removed. It was noted that any estates work could not be completed in the timescale. This was discussed in the context of the positive feedback that the service has received. Work is taking place to address the accreditation issue.

	Topical, Legal and Regulatory Update The Committee received the report noting the content.
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
Matters identified which Committee recommend are escalated to SRR/BAF	No items identified. However the committee did note the cyber and IG reports represented a positive step forward in the controls and assurance being received.
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	J	F	M	A	M	J	J	A	S	O	N	D
Gill Ponder, Non-Exec Director	X	X	X	X								
David Woodward, Non-Exec Director					O	X	X	X	X	X	X	X
Geoff Hayward, Non-Exec Director	X	X	X	A	X	X	A					
Chris Gibson, Non-Exec Director	X	X	X	X	X	X	X	X	A	X	X	X
Director of Finance & Digital	X	X	X	X	X	X	X	X	X	X	X	X
Chief Operating Officer	X	X	D	X	X	X	X	X	X	X	X	X
Director of Improvement & Integration	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

Report to:	Trust Board
Title of report:	Finance, Performance and Estates Committee Assurance Report to Board
Date of meeting:	20 January 2022
Chairperson:	Dani Cecchini, 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 Committee worked to a reduced agenda and shortened meeting in order to support the response to Covid-19 and operational pressures.
Assurances received by the Committee	**Assurance** in respect of SO 3a A modern, clean and fit for purpose environment **Estates Report** The Committee received the report noting the update that this offered and the evolution of reporting that would offer further assurance to the Committee including a compliance dashboard. The Committee noted the intention for the dashboard to be based on the Premises Assurance Model with the inclusion of narrative to offer assurance to the Committee. The Committee were pleased to note the lifting of the fire enforcement notice from Grantham Hospital at the end of December 2021 as a result of the works undertaken. This demonstrated the positive step forward, progress on fire safety and assurance received by Lincolnshire Fire and Rescue. The Committee noted the inclusion of the Green Plan that continued to develop and would be presented to the Board once complete. Work to improve procurement practices was noted that would result in a managed service for all external contractors.

	Assurance in respect of SO 3b Efficient Use of Resources **Finance Report inc CRIG upward report, Contract Report and Efficiency Report** The Committee received the reports noting the headline position for month 9 being breakeven meaning that the £1.8m surplus positon was maintained. A breakeven position for each month of H2 had been planned. The Committee were pleased to note the successful move to the new finance ledger system during December however noted the delay in standard reporting as a result. The Committee noted income was reported as favourable to plan however pay was noted as adverse to plan in part due to the pay award and continued staffing challenges resulting in the bank pay incentive and higher agency tier use. The Committee noted the cash position which was being driven by the shortfall in capital but this would in part resolve through the remainder of the year as capital delivery was undertaken. **Capital Report** The Committee received the report noting the year to date capital spend of £13m which was behind the re-phased plan of circa £6m. The Committee noted the detailed management of the capital programmes by scheme formally through the Capital Delivery Group which offered assurance on the programme. The Committee noted the requirements to deliver circa £11m of capital per month up to year end in order to achieve the plan however recognised the operational challenges and risk to delivery. A further detailed capital plan would be presented to the Committee to offer further assurance on the position. **2022 Financial Planning including Capital** The Committee received the report noting that this offered a summary of the planning guidance and timelines. The Committee were advised of the draft and final submission deadlines which would take place in March and April respectively. The Committee noted the System Financial Envelope and initial analysis that had been completed noting further work would be undertaken. A 3 year capital settlement was included within the guidance which the Trust work through to understand how this would work in practice.

	A final paper would be offered to the Committee offering the capital prioritisation and financial plan that would link with the overall plan, providing assurance on the tariff and contract to the Committee.
	Assurance in respect of SO 3c Enhanced data and digital capability No items received
	Assurance in respect of SO 4a Establish new evidence based models of care No items received
	Assurance in respect of other areas: **Operational Performance against National Standards: Urgent Care, Cancer Performance and Planned Care** The Committee received the reports noting the current position following the recent period of operational pressures which had built since early January. It was noted there had been a consistent decrease in discharges and increase in length of stay with patients of increased complexity in both level of intervention required and discharge requirements. The Committee noted the deteriorating position with regard to 62 day waits noting that this was impacted by bed capacity that had been impacted by increased length of stays. It was noted however that the Trust remained well placed across the region in respect of 104 week waits noting some slight improvements over the period. Performance for 2 week wait breast cancer had further deteriorated and the Committee noted that the strategy put in place had not delivered as hoped. Discussions were being held with the East Midlands Cancers Alliance to identify support through mutual aid where possible. **Committee Performance Dashboard** The Committee received the report noting the performance data and the turnaround time of patients within the P2 category. Green shoots of improvement were starting to be seen with a reduction in Covid-19 patients and sickness related to Covid-19. It was noted that continued improvements would move on to a trajectory for restoration. Concerns related to 12-hour trolley waits and the completion of harm reviews were raised by the Committee that noted a lack of assurance due to the current position and would flag this to the Quality Governance Committee.

	The Committee noted the relatively low levels of assurance in the ability to recover quickly due to the current position and operational pressures. Reassurance had however been offered through feedback from recent national visits that confirmed that actions being taken by the Trust were correct and should lead to improvement over time. **Internal Audit Reports – Host General Ledger** The Committee received the report noting the significant assurance which had been received.
Issues where assurance remains outstanding for escalation to the Board	None
Items referred to other Committees for Assurance	The Committee wished to raise with the Quality Governance Committee concerns regarding 12-hour trolley waits and the completion of harm reviews in order to receive assurance on the current position.
Committee Review of corporate risk register	The Committee received the risk register noting the risks presented
Matters identified which Committee recommend are escalated to SRR/BAF	No items identified however the Committee requested consideration to the wording of risk 4175 – Capacity to manage emergency demand
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	F	M	A	M	J	J	A	S	O	N	D	J
Gill Ponder, Non-Exec Director	X	X	X									
David Woodward, Non-Exec Director				O	X	X	X	X	X	X	X	
Dani Cecchini, Non-Exec Director												X
Geoff Hayward, Non-Exec Director	X	X	A	X	X	A						
Chris Gibson, Non-Exec Director	X	X	X	X	X	X	X	A	X	X	X	X
Director of Finance & Digital	X	X	X	X	X	X	X	X	X	X	X	X
Chief Operating Officer	X	D	X	X	X	X	X	X	X	X	X	X
Director of Improvement & Integration	C	X	X	X	X	X	A					X

X in attendance
A apologies given
D deputy attended

C Director supporting response to Covid-19
O Observing

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NHS United Lincolnshire Hospitals NHS Trust

Meeting	Trust Board
Date of Meeting	1st February 2022
Item Number	*Item 12*
Integrated Performance Report for December 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	• *Limited*

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

Executive Summary

Quality

Falls

There have been 7 falls in December resulting in moderate harm. These incidents are currently being validated through the incident management process and the appropriate level of investigation will be instigated. Review of enhanced care policy and associated practices is underway. Simple guidance communications will be developed to support staff with effective delivery of enhanced care.

Pressure Ulcers

The number of category 2 PU is at 42 (target of 28.3) and unstageables at 8 (target of 4.4) for December 2021. There are a number of continuing themes currently being observed relating to category 2 pressure ulcers, with a notable increase in unstageable PU's. Tissue Viability ambassador proposal is being finalised and will be re-presented to Skin Integrity Group (SIG). This will provide a structured framework to develop knowledge base and skills, including protected time working with the clinical nurse specialists.

Medications

For the month of December, the number or incidents reported in relation to omitted or delayed medications equated to 32%. 23.2% of medication incidents identified that harm had been caused and is noted to be above the national average. This is being addressed through the Medicines Quality Group.

HSMR

The Trust HSMR is currently at 107.28 which shows an increase but overall HSMR has been seeing a reduction. Of note the Trust hasn't received any mortality data for the previous two months due to ongoing problems with Dr Foster.

SHMI

The Trust is currently at 110.2 for SHMI, which is within the "as expected" range. 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 alongside a peer review by NHSEI for structured judgement reviews.

Participation in National Clinical Audits

The Trust is participating in 98% of all relevant national clinical audits. The Trust has now registered for the IBD audit which will make us 100% compliant and data collection was due to commence in October 2021 however problems have occurred with IBD logins due to a national upgrade which has now been rectified.

eDD

The Trust achieved 88.2% with sending eDDs within 24 hours for November 2021 against a target of 95% with 93.4% being sent anytime within the month of December.

Sepsis compliance – based on November data

Screening / IVAB ED / inpatient child - Screening compliance for paediatrics in ED was 79% and inpatients at 73.5%, with the administration of IVAB for paediatrics in ED at 57.1% and inpatients at 63.6% in November. Paediatric Simulation training is taking place in clinical areas with a focus on sepsis, not only identifying the patient but also completing the bundles. Clinical Harm reviews continue and actions to recover can be seen below.

Duty of Candour (DoC) – November Data

Verbal compliance for November is at 59% against a 100% target and 41% for written. DoC training has been sourced from an external provider and was delivered throughout November 2021 with a further session planned for February 2022. The Risk team are currently reviewing compliance and supporting the Divisions on a daily basis.

Operational Performance

The Covid 4th wave has seen an increase demand in terms of hospitalisation with numbers of inpatients now reducing. At the time of writing this executive summary, the Trust has 74 positive inpatients, of which 0 patients are requiring Intensive Care interventions. The impact of the 4th wave on staff absences remains significant due to the increased prevalence of positive cases within our population. Lincolnshire has had at times the highest sickness rate in the Midlands. The current sickness absence attributed to Covid is 326 out of 794. Increased staff absence is also attributed to fatigue. This has impacted on the delivery of both urgent and planned care pathways.

This report covers December's performance, and it should be noted that as the demands of Wave 4 have begun to increase, the Trust has continued the *Manage* phase whilst acknowledging the absolute need to combine the recovery and restoration of services as per H2 planning and delivery assumptions. Guidance in how performance and recovery is approached is defined by national requirements as set out in NHS England's 2021/22 Priorities and Operational Planning Guidance. This guidance which moves away from a focus on statutory access standards will have direct impact on performance, specifically RTT. Additionally, new Emergency and Planned Care Standards which are now being implemented, monitored, and reported going forwards.

A & E and Ambulance Performance

Whilst the summary below pertains to December's data and performance, the proposed new Urgent Care Constitutional Standards have now been adopted to run in shadow form and performance against these will be described in the supplementary Urgent Care FPEC paper. Amendments to the Urgent Care IPR dashboard were made in November but these will be refined further as more data becomes available. December saw escalations to standby internal critical leading to the declaration of internal critical incident on 4th and 14th December when the urgent care pathways were significantly compromised.

4-hour performance for December improved against November's performance of 64.04% being reported at 64.67%. The Trust's performance has been below the agreed trajectory consistently for 14 months.
There were 330 12-hr trolley wait, reported via the agreed process. This represents an increase of 23.04% from November. Sub-optimal discharges to meet emergency demand remains as the main route cause but has been compounded with increased staff absence through sickness. (As described in the Trust Risk Register entry 4175)

Performance against the 15 min triage target in December demonstrated further improvement of 0.02% compared with November. 86.15 in December verses 86.12% in November.

Overall Ambulance conveyances for December were 4,167 up by 0.50% against November. There were 654 >59minute handover delays recorded in December, a decrease of 123 from November, representing a 15.84% decrease. Delays experienced at LCH and PHB are attributed to increased levels of overcrowding in EDs and managing the low, medium and high-risk IPC pathways. December demonstrated an overall decrease of >120mins handover delays compared with November, 238 in December compared with 368 in November, representing a 32.33% improvement. >4hrs handover delays also decreased, 39 in December compared to 65 in November. This represents a 40.00% decrease.

Length of Stay

Non-Elective Length of Stay remains of concern and is a major contributor to overcrowding in EDs and the subsequent impact on ambulance handovers. The average bed occupancy for December, was 90.12%. Multi agency discharge meetings continue to take place twice daily. All patients on pathways 1, 2 and 3 are reviewed, with a noted increase of patients being identified as medically optimised patients across the entire week (7days). System Partners are challenged with identifying timely support to facilitate discharge from the acute care setting, Pathway 1 capacity (Domiciliary care) has decreased in availability and is a large contributor to increased LoS. All delays of greater than 24hours are escalated within the System. Elective Length of Stay has decreased slightly in December to 2.59 days (November reported 2.67 days). This is mainly due to a lower level of complex patients accessing surgical pathways that require a reduced post-operative care period in intensive care.

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.

November demonstrated an increase in performance of 0.33% to 55.58%. The Trust reported 11983 incomplete 52-week breaches for November end of month compared to 1799 in October. The Trust still remains in a strong position when compared to other regional providers.

The Cancer/Elective Cell continue to meet weekly, with a weekly confirm and challenge meeting with surgical specialities led by senior clinical review and prioritisation cell to ensure capacity across all sites are maximised for the most critical patients. Cancer patients and clinically urgent remain a priority with a continued focus on 62+ day, 104+ days cancer patients and 40+, 52+ and 78+ week patients on the 18-week RTT PTL. At the end of November, the Trust reported 9 patients waiting longer than 104weeks.As of 10th January the Trust has 17 patients waiting longer than 104 weeks. This has been identified as a patient choice issue.

Waiting Lists

Overall waiting list size has increased in November to 57,105 compared to 54,616 in October. The end of December position is at 59.152. Work continues between OPD and the CBUs regarding the returning to a standard 'polling' approach as part of our restoration plans.

A recovery plan for ASIs has been developed and including a recovery trajectory. December demonstrated a reduction slight increase (excluding the Christmas Bank Holiday period (443 verses 430 in November). As of 2nd January, ASI numbers have increased to 614 and is above the agreed trajectory. The trajectory is 550.

As at 31st December 2021, the Trust reported 18,003 over 26 week waits and 7,519 over 40 week waits. The longest waiting patients continue to be tracked and discussed weekly with escalation as appropriate and reported bi-weekly to NHSE/I.

DM01

DM01 for December was not available for the submission deadline of this report. A verbal update will be given at FPEC.

Cancelled Ops

This indicator has not been met since July 2021. The compliance target for this indicator s 0.8%. December demonstrated a 1.82% compliance.

The tolerance level for re-booking late notice cancellation of operations is zero. December experienced 21 breaches against this standard verse 22 in November. On day cancellations also reduced in December to 85 verses 127 in November.

A review of the effectiveness of the 642 theatre scheduling meetings is in train, however with variations in ICU capacity as a response to internal and external pressures (mutual aid) it is likely that performance is unlikely to substantially improve.

Cancer

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

The current compliance trajectory is 85.40%. Trust compliance against this agreed trajectory is 49.04% %. A negative variance of 32.29%

35.5% 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 in line with the trajectory – 550 as of 10th January 2022 verses 516 on 9th December 2021.

Workforce

Mandatory Training – While core mandatory training has picked up slightly over the month of December, this is expected to decrease again in January given the staffing challenges faced by the wards. The team are continuing to support the Trust with concerns and issues that are escalated in the undertaking of core learning activity.

Sickness Absence – Although a drop in Sickness can be seen on the chart in month at 5.2%, the Board are asked to note the pending spike in January 2022 at its peak being nearly 11% which will feature in the next Board report. The new variant Omnicom spreads rapidly and given the attribution from the changes in government guidance regarding the wearing of facemasks, and the current move towards the 'festive' periods there continues to be a significant risk in staffing levels to worsen due to Sickness Absences. At the request of Gold Command, a redeployment hub was re-launched to offer support in patient areas from our corporate teams.

There continues to be an increase in the 'usual' seasonal ailments and infections, work continues to support Flu vaccinations in conjunction with COVID vaccination/booster clinics.

Staff Appraisals – Ongoing operational pressures in the Trust has impacted the appraisal completion rate to some extent. We continue to see a decline in the completion rates with corporate functions averaging lower completion rates as compared to the divisions. The team is also currently conducting a deep dive to understand the impact of the introduction of WorkPAL and how to help staff with engaging with a new system.

Staff Turnover - Over the past few months, we have seen an increasing trend for turnover. Operational pressures, staffing challenges and Covid has meant that an increasing proportion of staff are looking for other avenues outside the Trust. The recent staff survey results are being shared shortly and this will shed more light on staff morale and current challenges. The team are currently working on a digital solution for exit surveys so as to capture information when people leave the organisation. We are also looking at enabling face to face exit interviews.

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 delivered a £1.8m surplus in H1 (in line with plan).

The Lincolnshire system has submitted a break-even position for H2 including delivery of £20m of efficiency savings. As part of the system plan, the Trust plans a break-even position in H2 including delivery of £6.0m of efficiency savings. The Trust delivered a breakeven position in Month 9 (in line with plan), and the Trust has YTD delivered a surplus of £1.8m (in line with plan).

The capital programme for 2021/22 currently stands at c£45.0m for the full year (inclusive of TIF allocations that can be delivered in year); actual capital expenditure of £12.9m has been incurred YTD against a submitted plan YTD of £22.2m.

The month end cash balance is £62.6m which is an increase of £8.5m against cash at 31 March 2021.

Paul Matthew
Director of Finance & Digital and (interim) People
January 2021

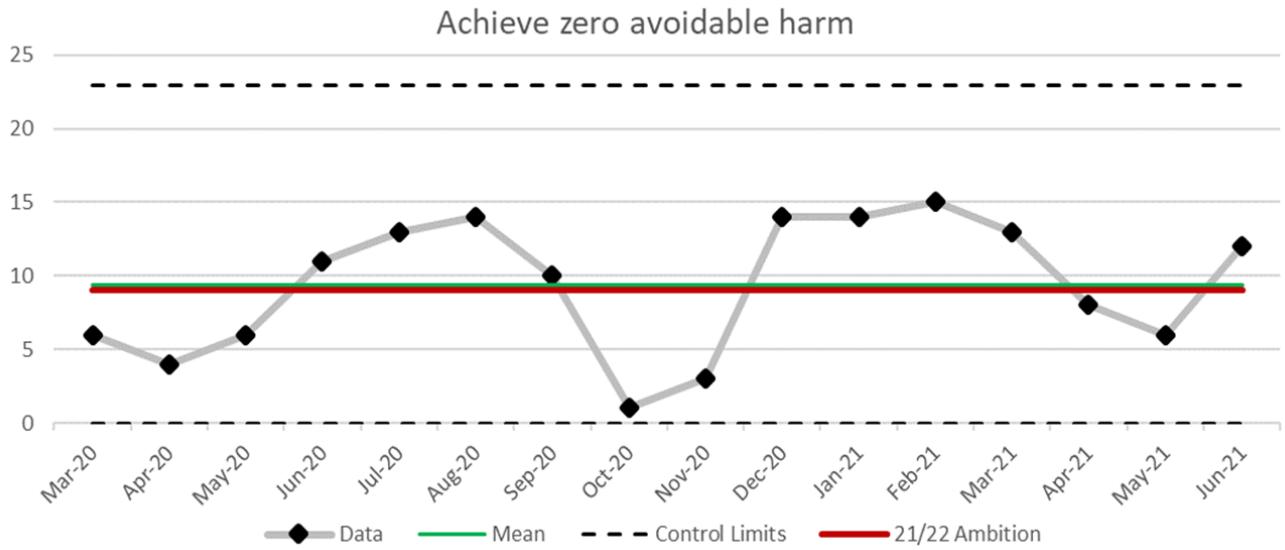
Statistical Process Control Charts

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

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

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

An example chart is below:



Statistical Process Control Charts

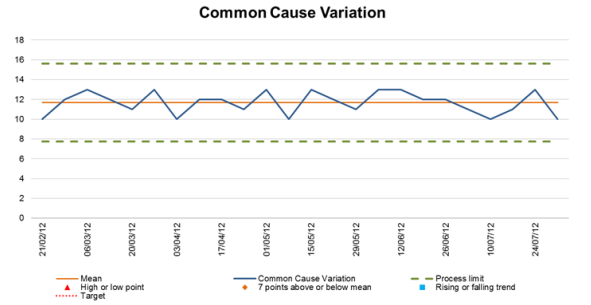
Normal variations in performance across time can occur randomly- without a direct cause, and should not be treated as a concern, or a sign of improvement, and is unlikely to require investigation unless one of the patterns defined below applies.

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

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

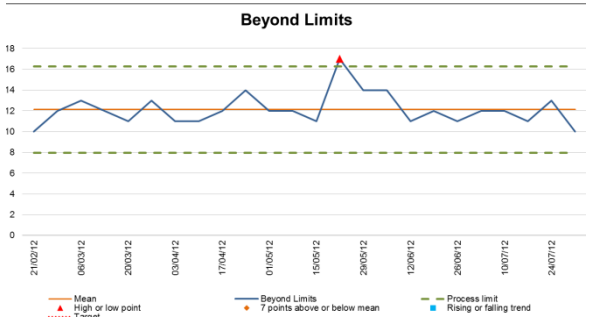
Icons are used throughout this report either complementing or as a substitute for SPC charts. The guidance below describes each icon:

Normal Variation



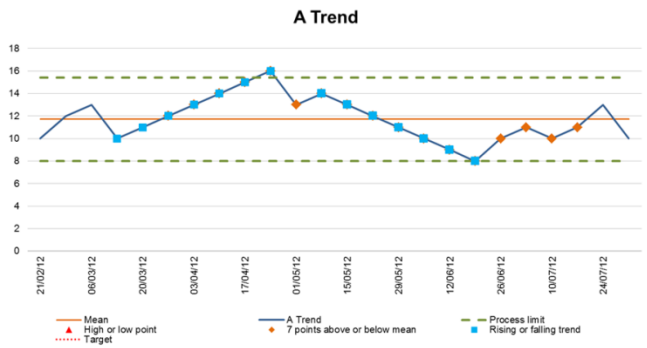
Extreme Values

There is no Icon for this scenario.

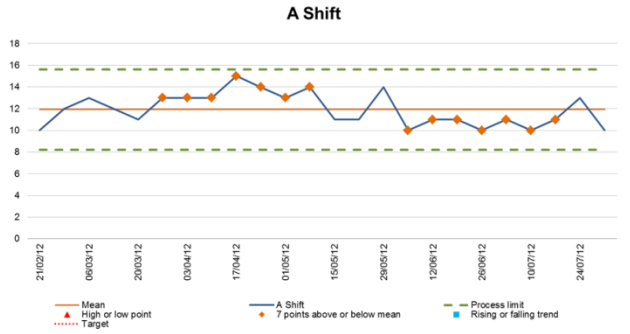


Statistical Process Control Charts

A Trend (upward or downward)



A Trend (a run above or below the mean)



Where a target has been met consistently

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

Where a target has been missed consistently

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

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NHS United Lincolnshire Hospitals NHS Trust

EXECUTIVE SCORECARD

Strategic Goal	Domain	Measure ID	Measure	Measure Definition	Baseline	21/22 Ambition	£'000	2021/2022 Oct	Nov	Dec	Latest month pass/fail to ambition	Trend variation
Strategic Metrics	Patients	1	Top 25% for acute Trusts for 'Overall' Inpatient experience	Monthly Inpatient Friends and Family Test results, which are a proxy for annual inpatient experience survey.	4th Quartile	3rd Quartile		4th Quartile (87.00%) (106 of 117)	tbc (89.45%) tbc			
	Patients	2	Achieve zero avoidable harm	Serious incidents (including Never Events) of harm - Moderate, severe and death.	15	9		10	11	2		
	Patients	3	Top 25% for SHMI	Summary Hospital-level Mortality Indicator	4th Quartile	4th Quartile		4th Quartile (111.98) (113th of 123)	4th Quartile (111.39) (109th of 122)	4th Quartile (110.20) (105th of 122)		
	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%		55.70%	57.10%			
	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%		14.52%	16.58%	14.30%		
	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		7.3	6.0	6.3		
	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	45.28%	>25%		32.12%	32.92%	32.85%		
	Services	9	Deliver a breakeven revenue position	Financial status - Revenue monthly variance to plan		Breakeven	£'000	£0.00	£0.00	£0.00		
	Services	10	Deliver £200m capital plan	Financial status - Capital monthly actual shown cumulatively	£15m	£39m	£'000	£8,736.90	£10,158.09	£12,887.30		
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%		17.71%	20.30%	23.20%		
	Patients	12	Reduce no. of patient fall incidents. (Last 3 month Average)	Number of Falls reported (including no harm)	200	159 (-20.5%)		155.7	168.0	172.3		
	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%		61.24%	67.25%	62.18%		
	Services	15	Reduce agency spend by 25%	Reduction in hospital recruiting to posts as temporary cover (non permanent salaried positions). Agency - cumulative actuals	£44m	£33m (-25%)	£'000	£26,193	£30,316	£34,171		
Watch Metrics	Patients	16	Reduce complaints around discharge by 50%	Where patient has been discharged from hospital but is unsatisfied in the way the discharge was handled	n/a							
	Patients	17	Reduce complaints about the experience in A&E by 50%	Patient experience complaints about treatment of A&E	n/a							
	Patients	18	Time to screening and treatment for sepsis (1 hour)	Number of sepsis incidents reported - % of 8 metrics passing to 90%	37.5% (3/8)	62.5% (5/8)		50% (4/8)	50% (4/8)			
	Patients	19	Reduce incidence of pressure ulcers	Number of Pressure Ulcers reported on ward- Category 2, 3, 4 & Unstageable	58 pcm	45 pcm		39	47	51		
	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%			50.71%	50.69%	46.33%		
	Partners	23	Reduction in the new to follow up ratio	Reduction in the number of follow up outpatient activities undertaken.	1:2.28			1:1.58	1:1.59	1:1.63		
	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%			49.45%	40.35%	38.60%		
	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 CIP plan (H1 £6.412m)	£11.1m	£15.4m	£'000	£16.00	-£486.00	£468.00		

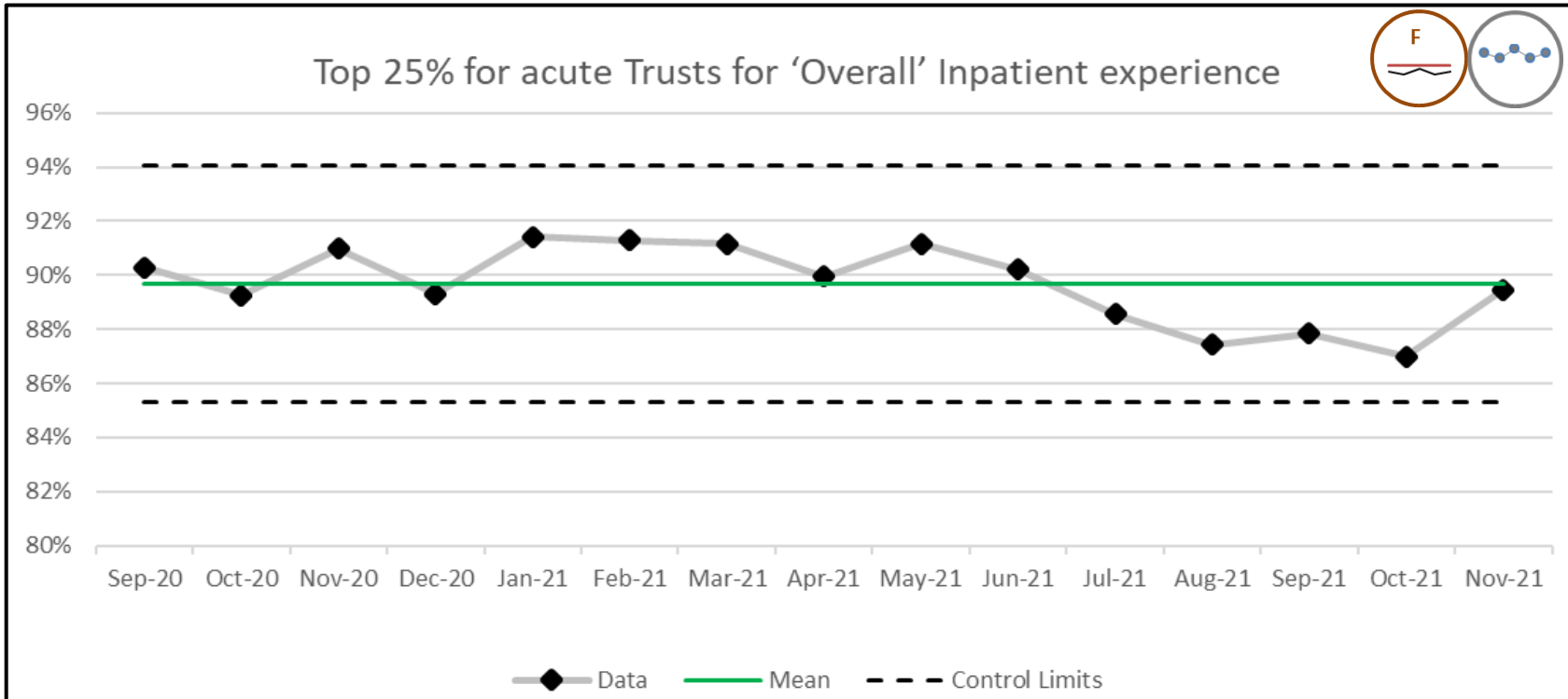
Quality | Operational Performance | Workforce | Finance

(Grey means data unavailable, red is missing)

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

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Nov-21
89.45% ranking tbc
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:
Top 25% for acute Trusts for 'Overall' Inpatient experience

What the chart tells us:
We are currently at 89.45% for November.

Issues:
The core reasons identified within 'non-recommend' responses are:

- Waiting times
- Communication
- Staff

These themes mirror those seen within other data sources including PALs and complaints and are interrelated; for example waiting times in ED and patients not being kept informed.

Actions:

- Waiting times – this largely relates to ED reflecting the current and protracted challenges with capacity. A range of improvement actions are in place including optimising patient flow, admission avoidance, quality of care during long waits.
- Communication - review undertaken and working group in place with a range of actions.
- Dignity Pledges approved and

Mitigations:

- Links made with OD to include a patient story in induction.
- Patient Experience training offer in development.
- Overarching combined national survey action plan in development.
- Divisional assurance reporting strengthened.

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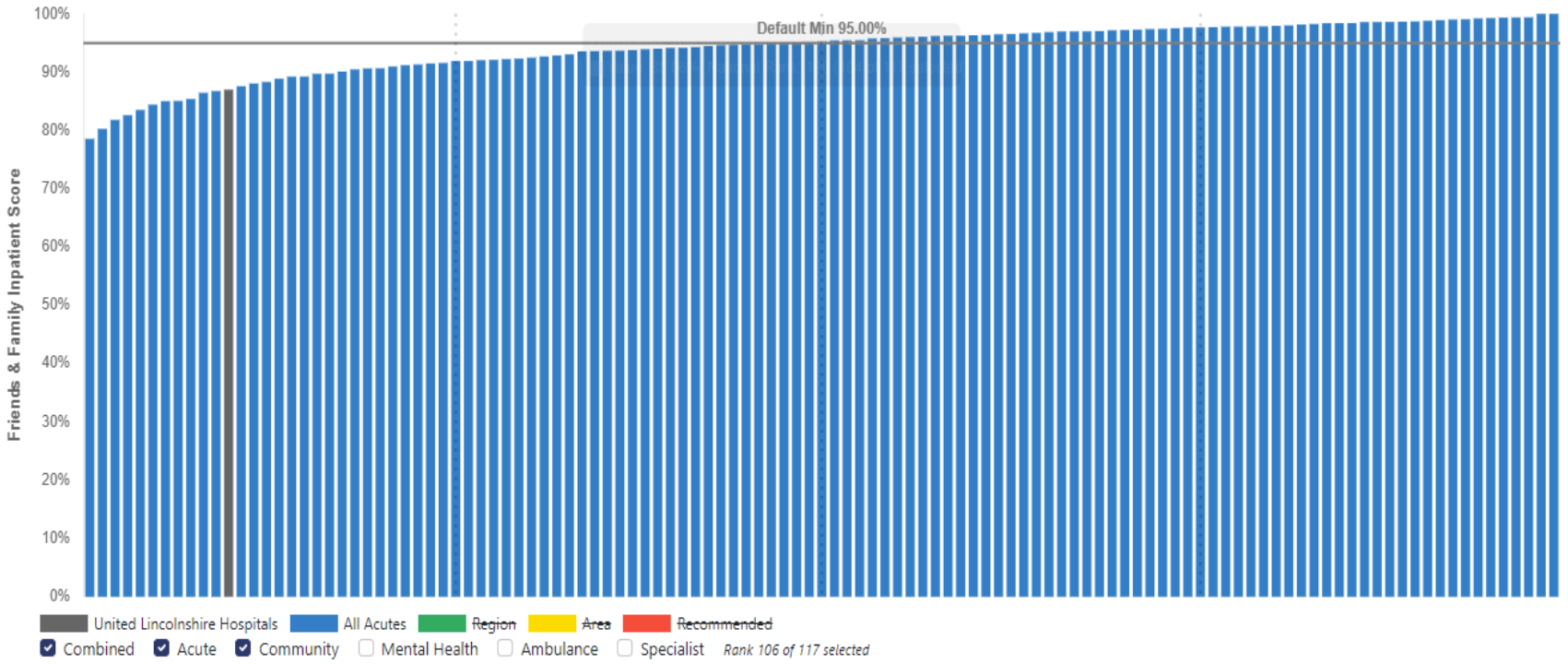
NHS United Lincolnshire Hospitals NHS Trust

Public View extract October 2021



Oct-21
4th Quartile (87.00%) (106th out of 117)
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:
Top 25% for acute Trusts for 'Overall' Inpatient experience

What the chart tells us:
The latest reported month in Public view October 2021 shows we are 106th out of 117 Trusts, in the 4th quartile against a 21/22 ambition to be in the 3rd quartile.
Rankings are Acute Trusts excluding specialised.

Issues:
The themes as identified above are in fact the reasons for the poor performance overall.

Actions:
- Drive the thematic actions as detailed above.
- Work with ward & department based FAB Experience Champions to implement local patient experience improvement activities.
- Triangulate FFT data with other data sources to extrapolate local themes and identify required actions.

Mitigations:
Investment within Patient Experience team, currently out to advert will increase capacity to reach in and support teams to deliver improvements.

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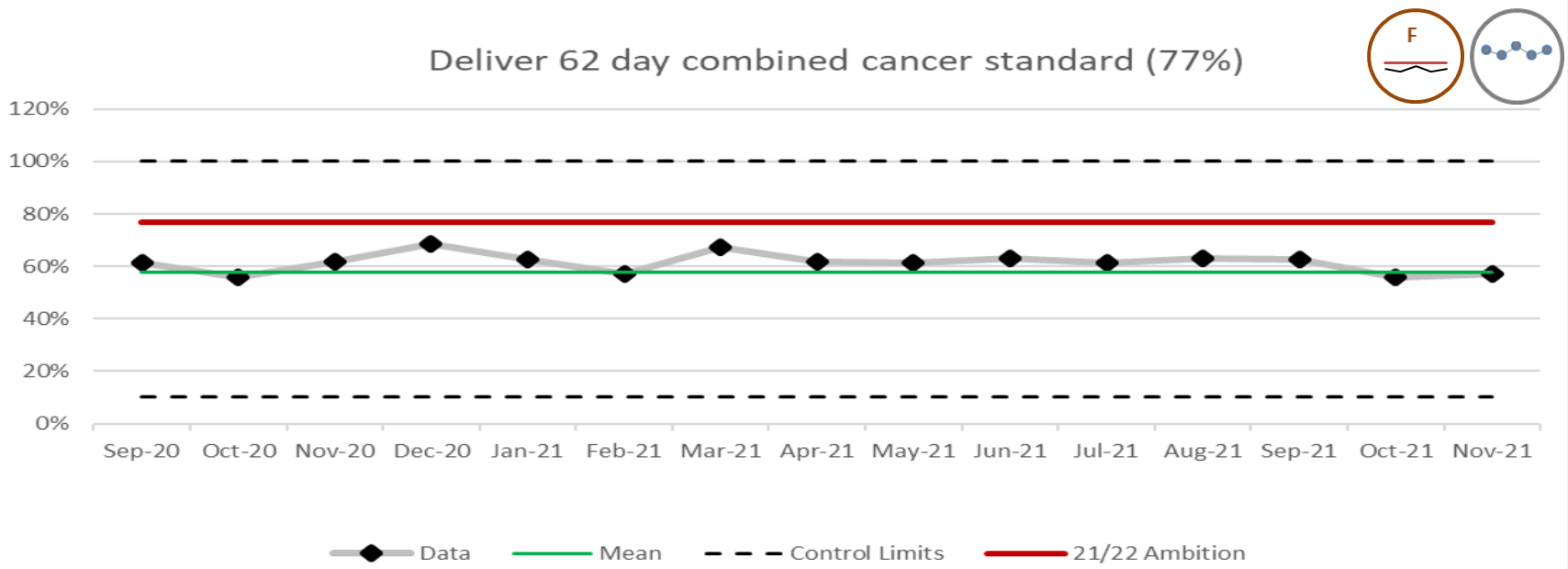
NHS United Lincolnshire Hospitals NHS Trust



Nov-21
57.1%
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 57.1% against a 77% target.

Issues:

The impact of critical and major incidents on Trust activity and patient pathways

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

Reduced clinic throughput due to social distancing / IPC requirements, especially in waiting areas. Patient acceptance & compliance with swabbing and self-isolating requirements. Patients not willing to travel to where our service and / or capacity is.

Managing backlogs significantly in excess of pre-COVID levels for Colorectal, Urology, Gynaecology, Lung, 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 of which was due to start in November 2021, but unfortunately both candidates have withdrawn. Currently there are three vacant Medical Oncologist posts which we are awaiting Royal college approval before going out to advert. We have two of these posts that are currently being covered by Locums.

Dedicated admin resource has been identified within the Colorectal, Urology, Breast, Gynae, UGI, Head & Neck and Lung CBU's to support clinical engagement. Following this model, funding was also identified for a navigator in the Dermatology CBU who has recently started in post.

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. A process is currently being designed to ensure the Pre-Diagnosis CNS is made aware of patients who are likely to be non-compliant or in need of support at the time of receipt of referral to allow for early intervention and a more efficient journey on the cancer pathway.

Negotiations to outsource some diagnostic and treatment activity to The Park BMI have been underway. This has been a challenging process so far and is not going to be an option for colorectal surgery or robotic radical prostatectomies, the areas currently greatest in demand. The introduction of the robot to Lincoln will contribute to reducing the backlog of patients awaiting robotic radical prostatectomies. Lists are due to commence on 14/02/2022.

Mitigations:

Theatre capacity is returning to Pre-covid levels. A review of colorectal theatre list scheduling in order to better align with clinician availability continues and Grantham Theatres have now returned to undertaking suitable Level 1 colorectal work. Work has commenced on building the new theatres at Grantham.

A review of the internal Gynaecology pathways is underway and Colposcopy and PMB capacity issues and throughput have now been addressed with a new locum and nurse hysteroscopist who have now started in post.

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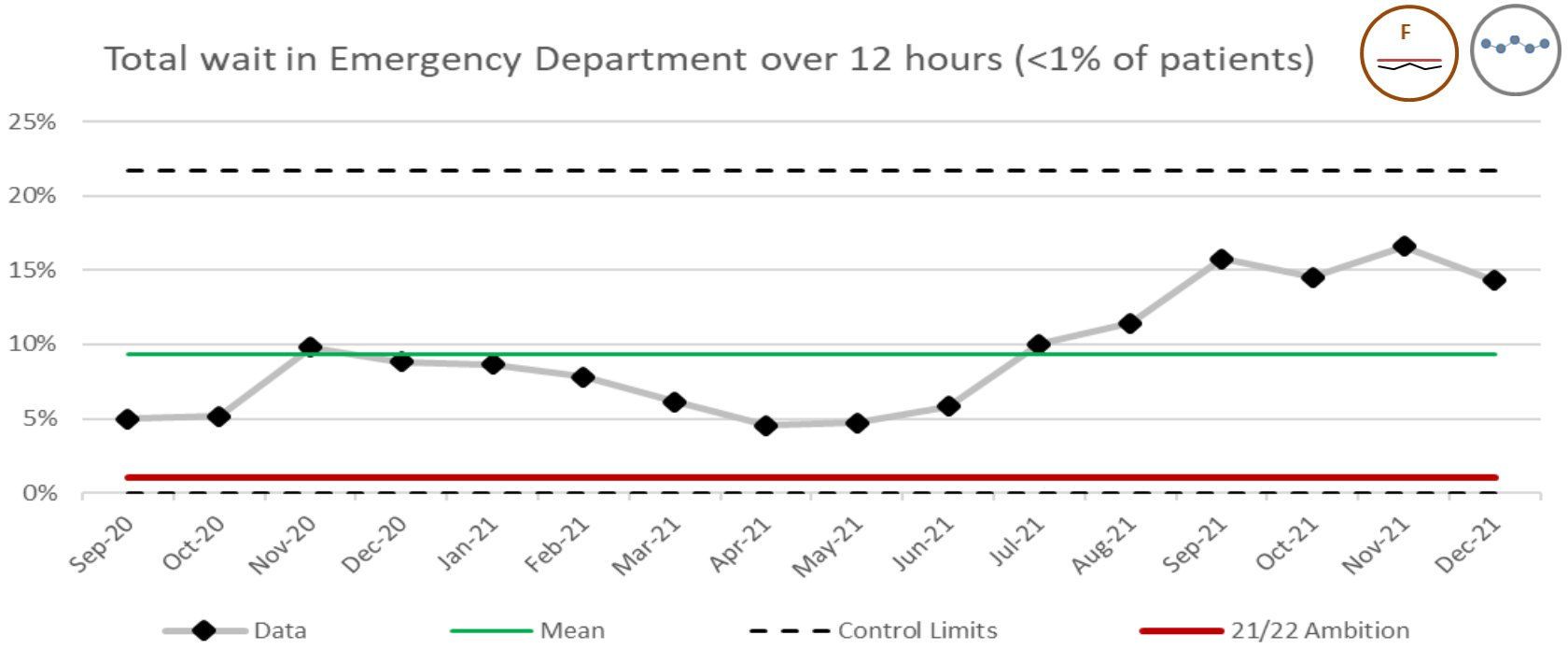

Dec-21
14.30%
Variance Type
Metric is currently experiencing Common Cause Variation
21/22 Ambition
<1%
Achievement
Metric is consistently failing to ambition
Executive Lead
Chief Operating Officer

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:

December experienced a decrease in the numbers of patients with an aggregated time of arrival greater than 12 hours. 1282 in December compared to 1502 in November.
The target for this metric has not been met.

Issues:

The main factor continues to be because of exit block due to inadequate discharges to meet the demand although a slightly improved discharge profile was demonstrated but probably related to the 'Christmas effect'.
Escalation of SDEC areas (although less frequent) impacting on flow.
Increased number of patients experiencing an elongated LOS due to requiring non acute admission but requiring access to an alternative health care setting such as domiciliary care, transitional care, community hospital and Adult Social Care. The establishment of a joint health and social care off for domiciliary care is now in place.
Delays in time to first assessment contribute to the clear formulation of a treatment plan, especially out of hours.
Limited ability to enact ExIT protocol due to covid contacts

Actions:

These actions are repetitive but remain relevant.
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, CAS, SDEC, FAU and SAU.
Direct access via EMAS to Community and transitional care facilities established and now in place to SDEC, FAU and SAU.
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 continue to operate a 24/7 service provision to release the burden placed on the Emergency Department at in terms of patients awaiting AIR/CIR and transport home.
Increased CAS and 111 support especially out of hours has been further enhanced.
Clinical Operational Flow Policy adherence and compliance and Full Capacity Protocol activation. Although the ability to board patients is becoming more problematic, this is being formally review via the Quality Cell.

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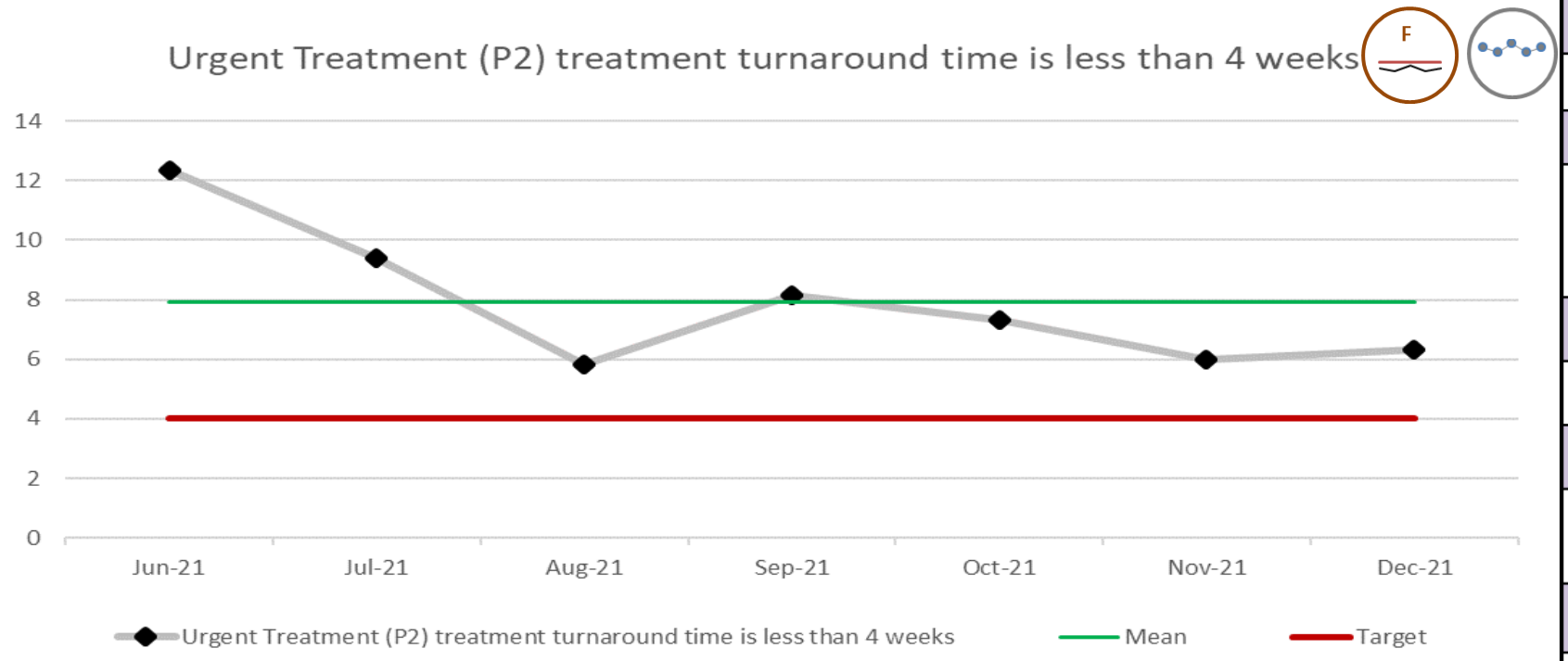


Dec-21
6.3
Variance Type
Metric is currently experiencing Common Cause Variation
21/22 Ambition
< 4 weeks
Achievement
Metric is consistently failing to ambition
Executive Lead
Chief Operating Officer

Background:
Average turnaround time in weeks from referral to treatment for patients categorised as P2 (procedures to be performed within 1 month).

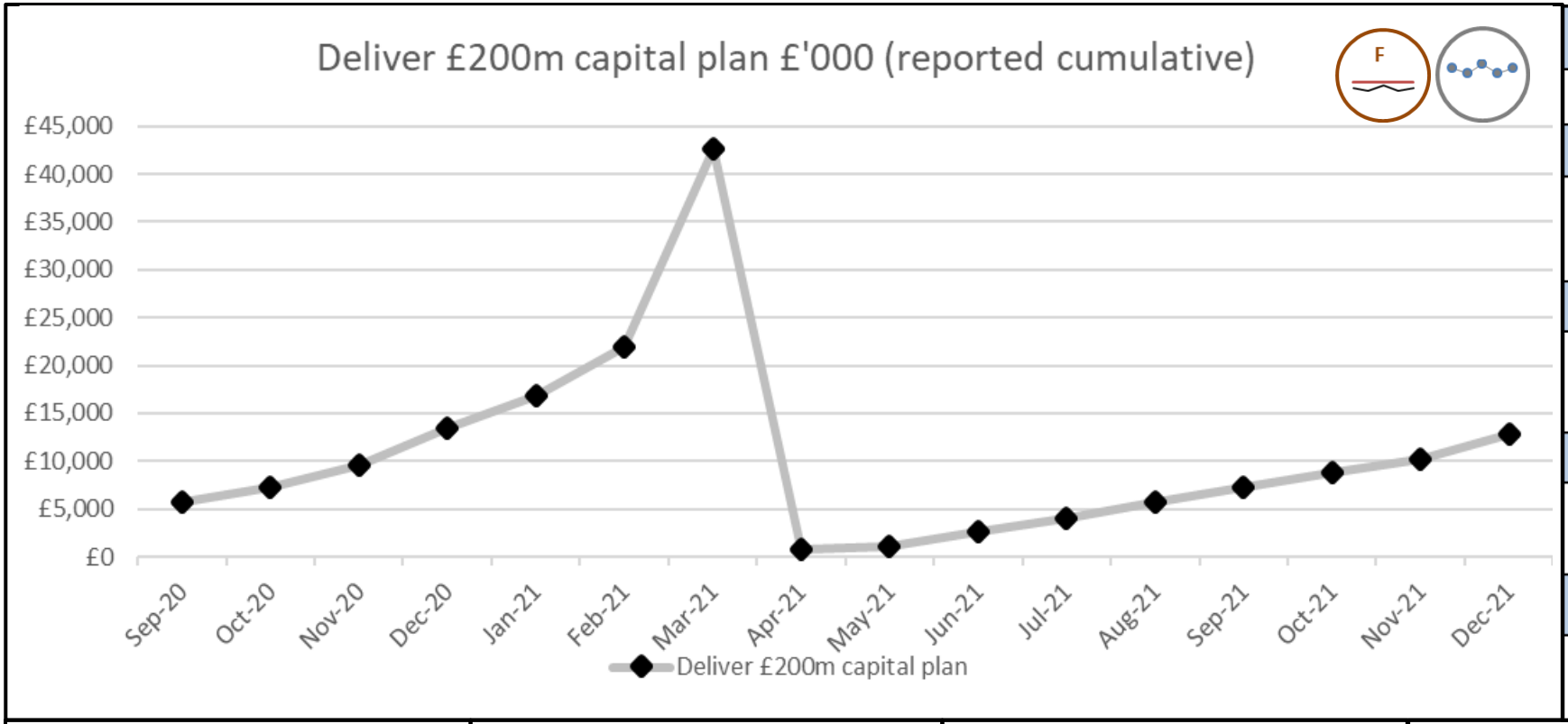
What the chart tells us:
General reduction in turnaround times since May 2021, although target of 4 weeks has not been met

Issues:
The admitted position remains challenging. Wave 3, winter pressures and capacity challenges are impacting on service delivery, which will in turn, detrimentally effect P2 turnaround times. The largest specialty challenge remains Colorectal Surgery.

Actions:
Admitted patients are individually graded and allocated a priority code. The longest waiting patients, irrespective of their P code status are treated alongside urgent and P2 patients. Working to use and implement C2AI to ensure appropriate prioritisation of patients. The clinical prioritisation cell, reporting to Gold, is focusing closely on Cancer patients and overdue P2 patients and that Lincoln and Boston adult elective activity is currently focused on these cohorts.

Mitigations:
Further planning work to identify solutions for greater use of elective sites to reduce variation caused by emergency pressures. Close performance management of longer wait patients.

Quality | Operational Performance | Workforce | Finance



Dec-21
£12,887.30k
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 had a revised capital programme to deliver of £49.6m, but this has now reduced by £4.6m to £45.0m, as a result of changes re TIF bids & other funding.

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 December, YTD expenditure of £12.9m is £9.3m behind NHSE&I plan, requiring expenditure of £32.1m 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 continually held with scheme leads highlighting areas of slippage, risk and mitigations. Details shared and schemes will be managed through CDG. Updated forecasts to be constantly under review.

Mitigations:
Where slippage exists, delegated authority has been provided by Trust Board to DoF and COO. Following this agreement, local decision has been reached 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 priorities.

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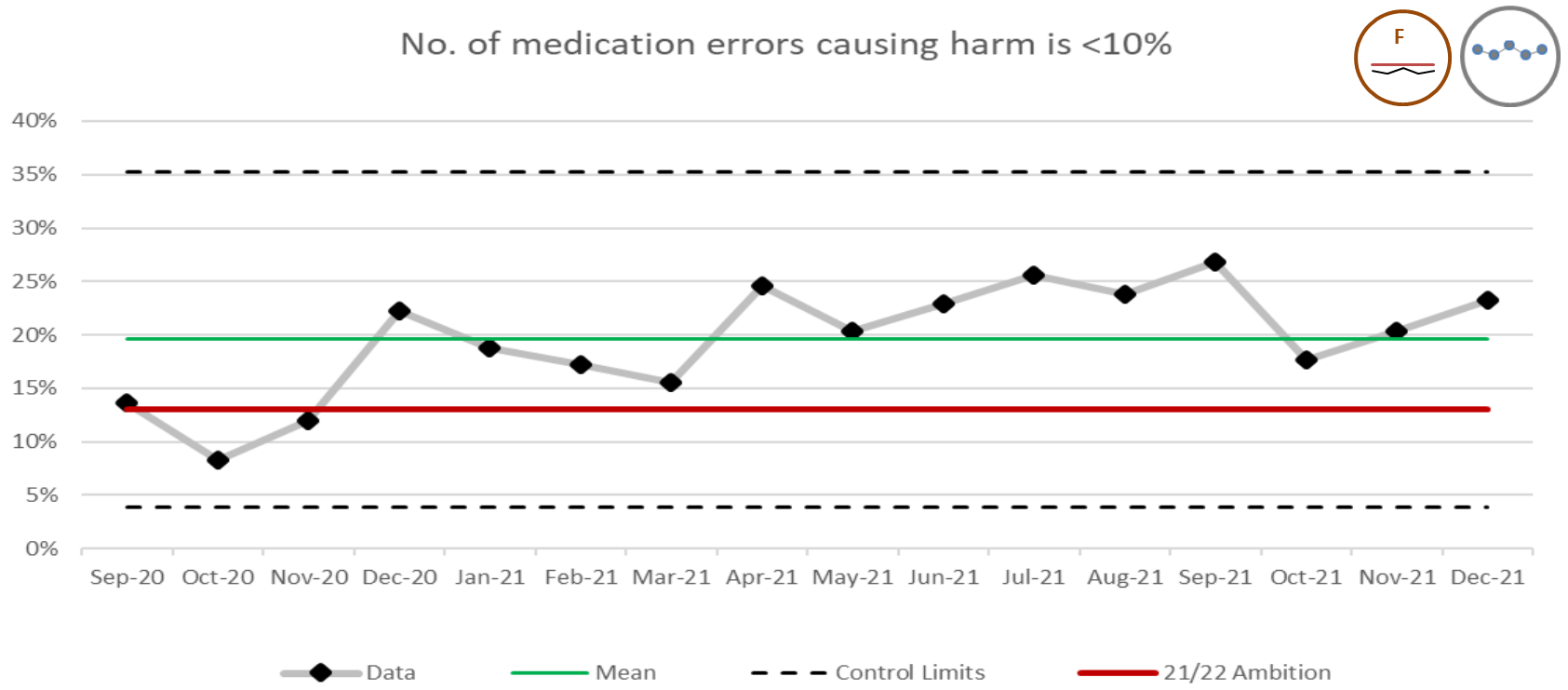

Dec-21
23.2%
Variance Type
Metric is currently experiencing Common Cause Variation
21/22 Ambition
13%
Achievement
Metric is consistently failing to ambition
Executive Lead
Director of Nursing

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

What the chart tells us:
In the month of Dec the number of incidents reported was 168. This equates to 5.59 incidents per 1000 bed days. The number of incidents causing some level of harm (low /moderate /severe / death) is 23.2% which is double the national average of 10.8.

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

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

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

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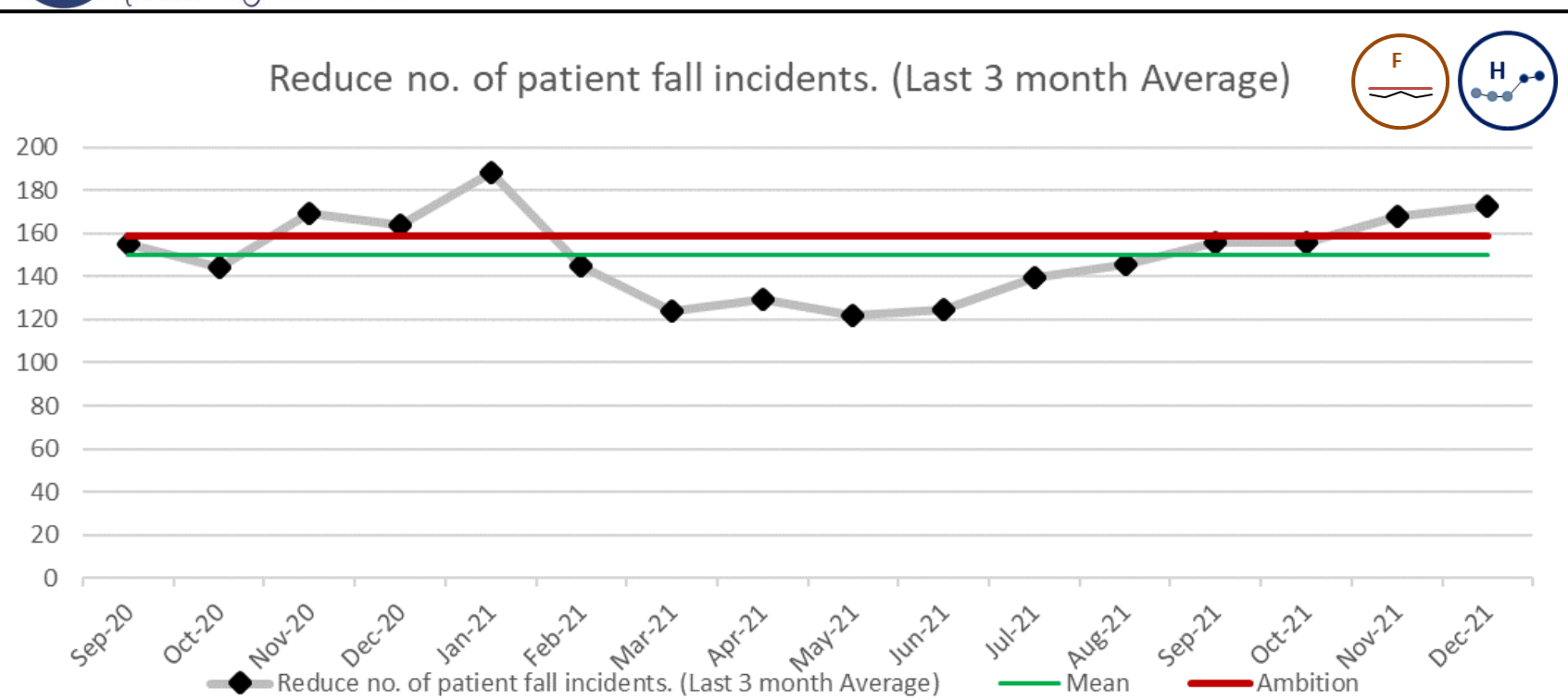


Dec-21
172.3
Variance Type
Metric is currently experiencing Special Cause Variation – High trend
21/22 Ambition
159
Achievement
Metric is consistently failing to ambition
Executive Lead
Director of Nursing

Background:

Number of falls reported (including no harm)
(Last 3 month average)

What the chart tells us:

The actual number of falls for December has decreased by 1 from November however the 3 monthly average value has increased from 168 to 172.3 and has not achieved ambition.

Issues:

The majority of falls incidents continue to result in no or low harm, although there has been an increase in the number that resulted in low and moderate harm to patients in month.

Themes identified that will continue to be areas of focus to improve are:

- Patients who have repeat falls
- Unwitnessed falls
- Assessment and application of the enhanced care process.

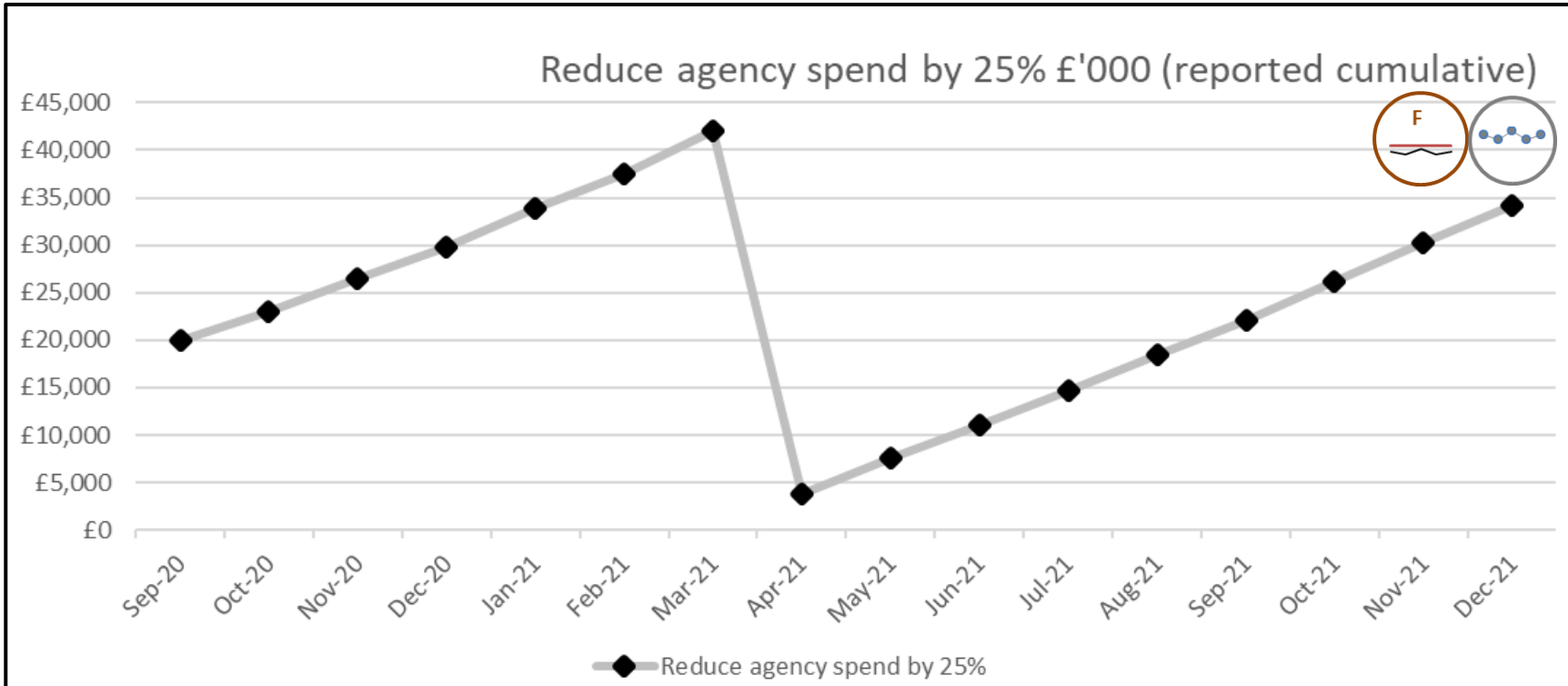
Actions:

Review of enhanced care policy and associated practices is underway.
Simple guidance communications will be developed to support staff with effective delivery of enhanced care.
Weekly falls prevention surgeries are scheduled. Open to any staff for advice and support.
Daily review of reported falls incidents by Quality Matron team to ensure early identification of areas requiring additional support.

Mitigations:

Falls prevention care is reviewed in the weekly ward/dept leaders assurance and monthly matrons audits.
The monthly Quality Metrics review meeting chaired by the Director of Nursing monitors ward and departments' performance relating to falls prevention
Falls Prevention Steering Group are sighted on areas with increased incidences where deep dives need to be undertaken, and informed of the outcome to facilitate further support offers where necessary.
Quality Matron and Frailty Nurse provide support to areas with increased numbers of falls.

Quality | Operational Performance | Workforce | Finance



Dec-21
£34,171k
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 £11.0m from £44.0m in 2019/20 to £33.0m in 2021/22; the Trust has an Agency Ceiling of £21m.

What the chart tells us:
Agency spend of £34.2 YTD in 2021/22 has exceeded the annual target spend of £33.0m with three months of the year left; if spend continues at Month 9 levels, spend will exceed 19/20 levels by £2.0m

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 £0.1m favourable to the IIP plan.

Increased Agency spend on Nursing and Midwifery & Housekeeping, though, has driven total Agency spend YTD £8.4m above plan.

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

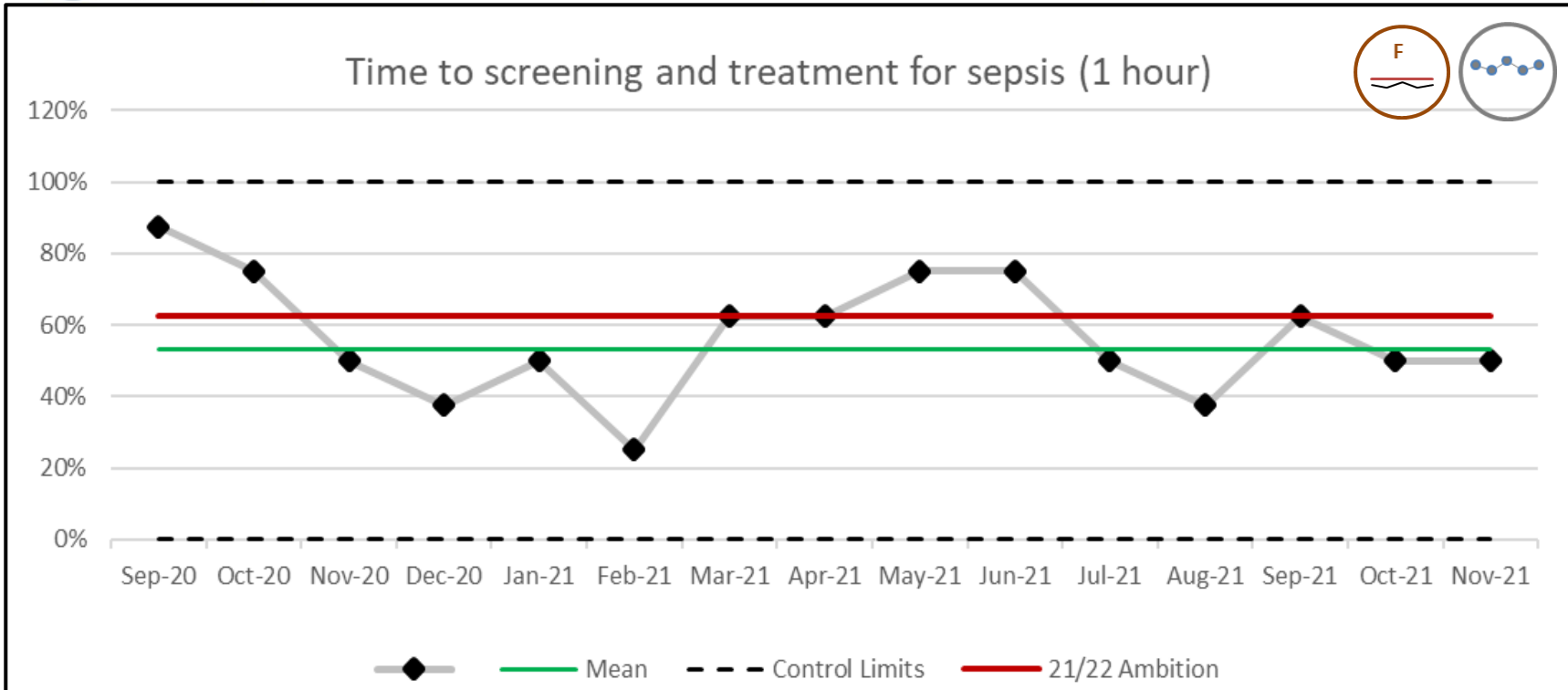
Alternative roles to fill longstanding vacancies are being reviewed, and exit plans have been requested for admin/managerial roles.

Mitigations:
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.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



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

Background:
Number of sepsis incidents reported % of 8 metrics passing to 90% target.

What the chart tells us:
4 out of the 8 sepsis metrics passed to target (50% pass rate) against an ambition of 5 out of 8 (62.5% pass rate).

Issues:
There is a large increase in the number of Paediatric patients in all departments within the trust. Some areas have expressed that they are struggling to deal with the higher number of patients in their departments as well as the higher acuity and staffing issues. There is also a large changeover staff or Temporary staff being used. At present face to face training is cancelled.

Actions:
There are ongoing meetings between Sepsis practitioners, ED, Ward areas and Clinical Educators to address issues raised and develop action plans. There is also a large emphasis on Sepsis within all training, simulation training, PILS and EPALS.

Mitigations:
Sepsis Practitioner is visiting paediatric areas regularly to offer support / advice. Extra training is also being offered to all Nursing areas and Medics.
Data is being pulled frequently and Harm reviews are being completed for all patients with delayed Screens or bundles.

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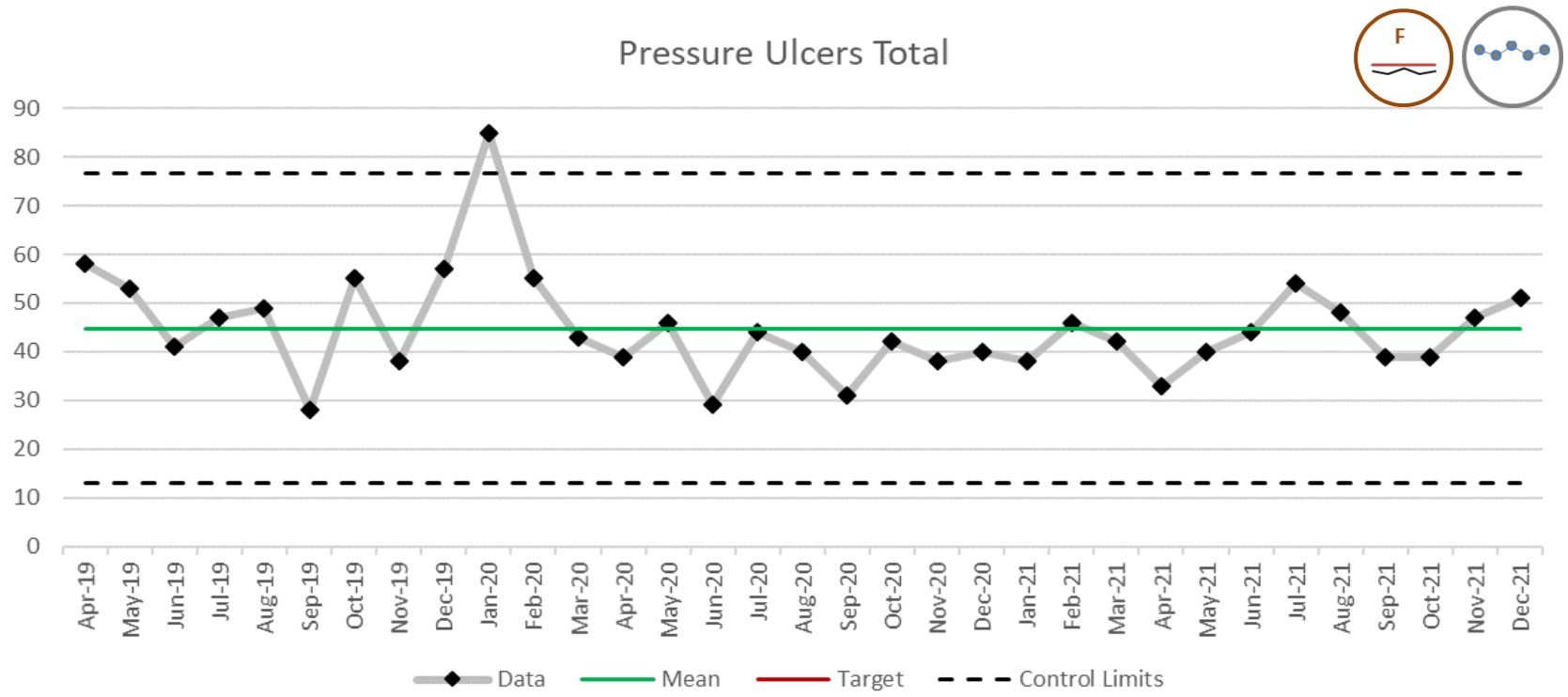

Dec-21
51
Variance Type
Metric is currently experiencing Common Cause Variation
21/22 Ambition
45
Achievement
Metric is consistently failing to ambition
Executive Lead
Director of Nursing

Background:
Total number of Pressure Ulcers reported on ward- Category 2, 3, 4 & Unstageable.

What the chart tells us:
The total number of reported hospital acquired pressure ulcers for Categories 2, 3, 4 and Unstageables is 51 an increase of 4 from November.

Issues:
There has been an increased number of category 2 pressure ulcers in December these will be reviewed through the Datix investigation process to identify learning.

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

Actions:
Quality Matron and Tissue Viability team undertaking daily review of reported pressure ulcer incidents to ensure early identification of areas which may require additional support.

The Tissue Viability team to provide an additional focus to the Emergency Departments to support early identification and interventions for patients admitted with existing or at risk of skin damage.

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

Skin integrity care is reviewed in the weekly ward/dept leaders assurance and monthly matrons audits.

The monthly Quality Metrics review meeting chaired by the Director of Nursing monitors ward and departments' performance relating to pressure ulcer prevention.

Quality | Operational Performance | Workforce | Finance

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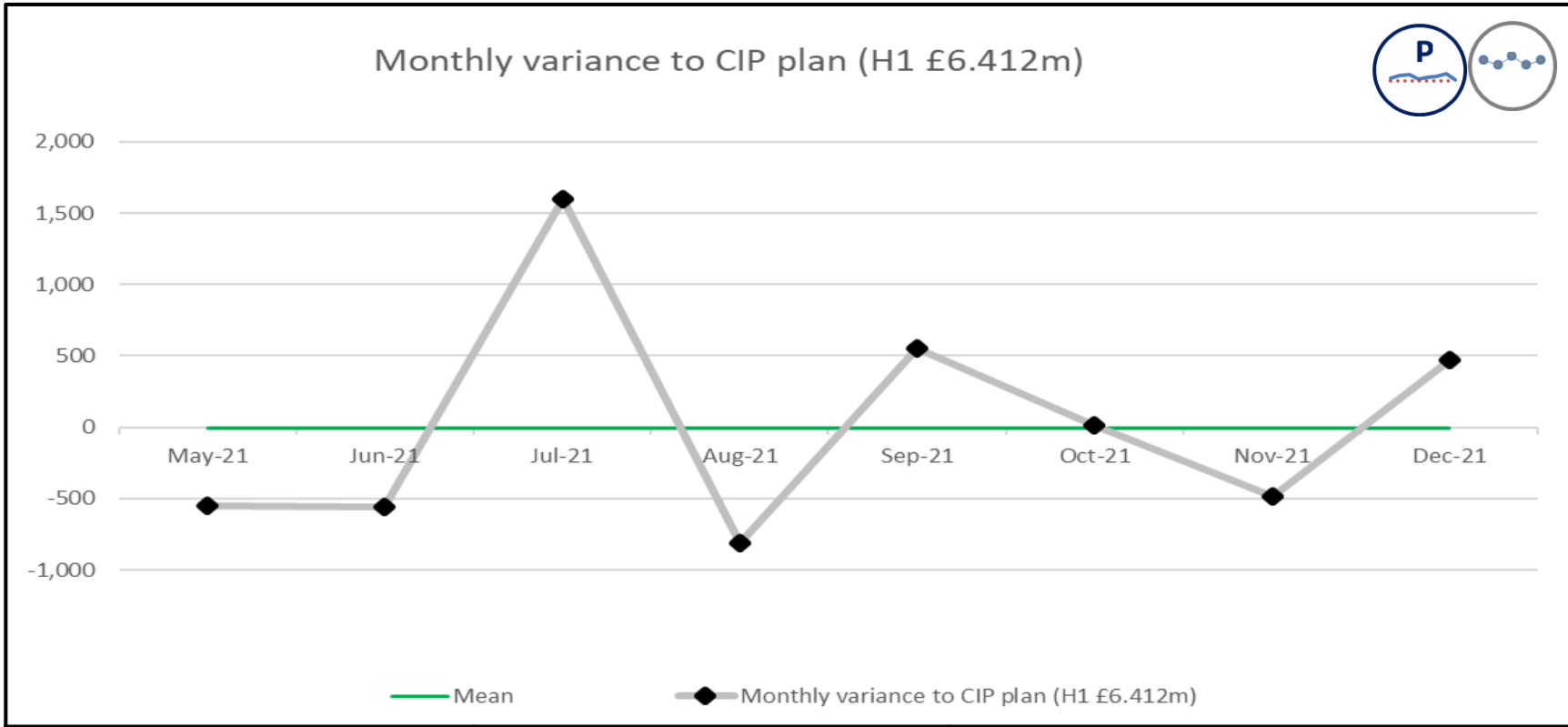

Dec-21
+£468.00k to plan
Variance Type
Metric is currently experiencing Common Cause Variation
21/22 Ambition
£15.4 Million for the year
Achievement
Metric is failing to ambition
Executive Lead
Director of Finance

Background:
The Trust started 2021/22 with an ambition to deliver £15.4m of efficiency savings; this assumed savings of £6.4m in H1 and £9.0m in H2

What the chart tells us:
In terms of overall delivery, the Trust largely met its target in H1 with actual delivery of £6.2m. However, the plan for H2 is now £6.0m, or £3.0m lower than originally planned.

Issues:
£5.2m of savings delivery in H1 was non-recurrent. As a result of this, the plan for H2 only includes £2.2m of planned savings delivery in H2; the majority of the savings plans in place relate to workforce.

This highlights a significant risk to achieving the financial plan in the second half of the year. The same level of non-recurrent CIP is not available for H2.

Actions:
Divisional Targets for the full year were set in line with the requirement to deliver £9.0m in H2, and these will remain in place and be monitored through Divisional Financial Recovery Meetings.

Recruitment to the vacant efficiency manager posts is ongoing.

Mitigations:
Development and delivery of recurrent schemes has been hampered by the need for divisional management colleagues to focus on operational pressures and also by the loss of efficiency managers. There will therefore be a continued requirement for non-recurrent savings while recurrent schemes are put in place, and to minimise any slippage in relation to the existing schemes in place.

Quality | Operational Performance | Workforce | Finance

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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	Oct-21	Nov-21	Dec-21	YTD	Pass/Fail	Trend Variation
Deliver Harm Free Care	Clostridioides difficile position	Safe	Patients	Director of Nursing	9	2	4		35	P	
	MRSA bacteraemia	Safe	Patients	Director of Nursing	0	0	0		1	P	
	MSSA bacteraemia cases counts and 12-month rolling rates of hospital-onset, by reporting acute trust and month using trust per 1000 bed days formula	Safe	Patients	Director of Nursing	TBC	0.00	0.01		0.04		
	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	0.03	0.01		0.11		
	Catheter Associated Urinary Tract Infection	Safe	Patients	Director of Nursing	1				5		
	Falls per 1000 bed days resulting in moderate, severe harm & death	Safe	Patients	Director of Nursing	0.19	0.00	0.16	0.23	0.09	F	
	Pressure Ulcers category 3	Safe	Patients	Director of Nursing	4.3	2	1	1	7	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	8	8	47	F	
	Venous Thromboembolism (VTE) Risk Assessment	Safe	Patients	Medical Director	95%	94.89%	94.93%	95.58%	95.93%	P	
	Never Events	Safe	Patients	Director of Nursing	0	0	0	0	2	P	
	Reported medication incidents per 1000 occupied bed days	Safe	Patients	Medical Director	4.3	5.76	6.91	5.59	5.38	P	
	Medication incidents reported as causing harm (low /moderate /severe / death)	Safe	Patients	Medical Director	10.7%	17.7%	20.3%	23.2%	22.80%	F	A

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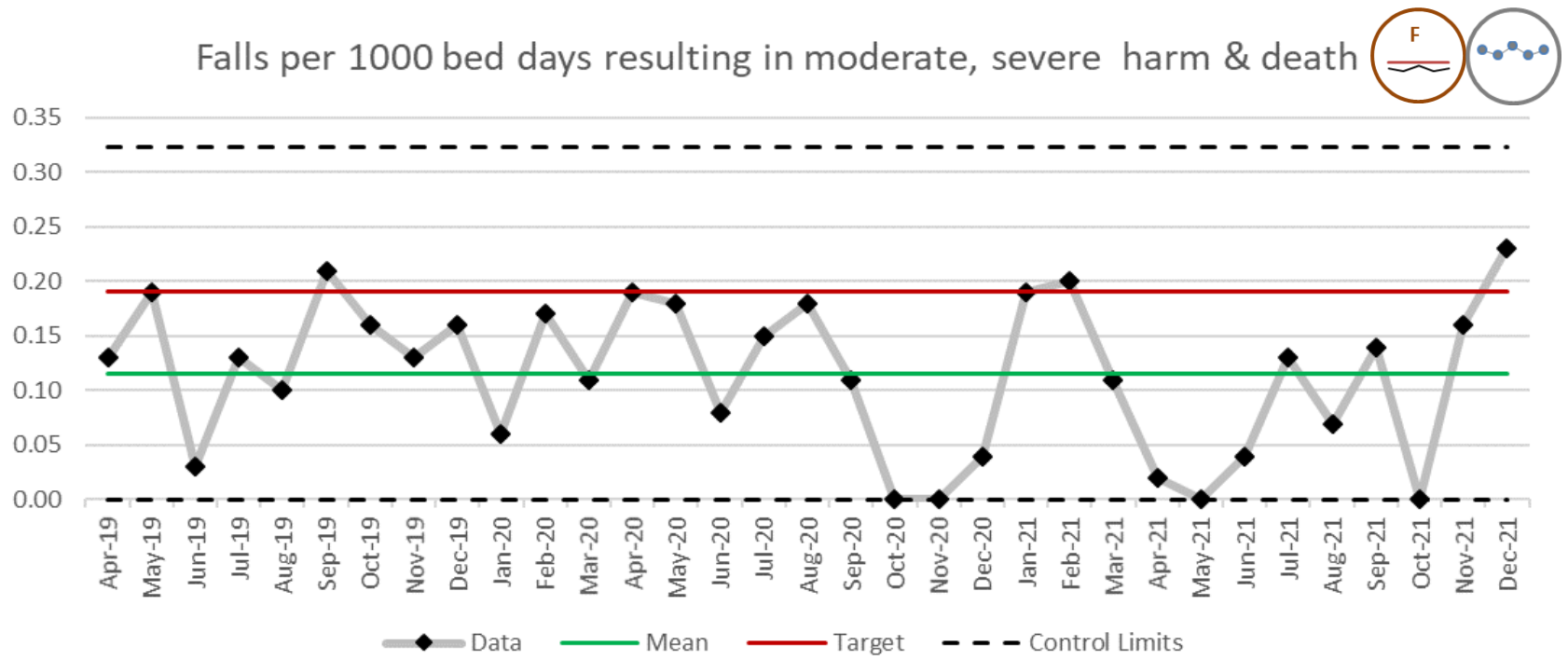
NHS United Lincolnshire Hospitals NHS Trust

PERFORMANCE OVERVIEW - QUALITY

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	Target	Oct-21	Nov-21	Dec-21	YTD	Pass/Fail	Trend Variation
Deliver Harm Free Care	Patient Safety Alerts responded to by agreed deadline	Safe	Patients	Medical Director	100%	100%	None due	None due	73.40%	P	
	Hospital Standardised Mortality Ratio - HSMR (basket of 56 diagnosis groups) (rolling year data 3 month time lag)	Effective	Patients	Medical Director	100			107.28	109.07	F	H
	Summary Hospital Mortality Indicator (SHMI) (rolling year data 6 month time lag)	Effective	Patients	Medical Director	100	111.98	111.39	110.20	111.57	F	H
	The Trust participates in all relevant National clinical audits	Effective	Patients	Medical Director	100%	97.00%	94.50%	98.00%	96.17%	F	A
	eDD issued within 24 hours	Effective	Patients	Medical Director	95%	88.70%	91.10%	88.20%	89.58%	F	
	Sepsis screening (bundle) compliance for inpatients (adult)	Safe	Patients	Director of Nursing	90%	90.3%	90.0%		90.13%	P	
	Sepsis screening (bundle) compliance for inpatients (child)	Safe	Patients	Director of Nursing	90%	87.0%	73.5%		85.92%	F	
	IVAB within 1 hour for sepsis for inpatients (adult)	Safe	Patients	Director of Nursing	90%	92.6%	94.0%		93.26%	P	
	IVAB within 1 hour for sepsis for inpatients (child)	Safe	Patients	Director of Nursing	90%	80.0%	63.6%		84.45%	F	
	Sepsis screening (bundle) compliance in A&E (adult)	Safe	Patients	Director of Nursing	90%	91.4%	91.3%		92.21%	P	A
	Sepsis screening (bundle) compliance in A&E (child)	Safe	Patients	Director of Nursing	90%	74.0%	79.0%		83.23%	F	
	IVAB within 1 hour for sepsis in A&E (adult)	Safe	Patients	Director of Nursing	90%	94.8%	95.2%		94.81%	P	
	IVAB within 1 hour for sepsis in A&E (child)	Safe	Patients	Director of Nursing	90%	50.0%	57.1%		65.95%	F	
	Rate of stillbirth per 1000 births	Safe	Patients	Director of Nursing	4.20	3.25	3.27	3.24	3.10	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%	59.00%	59.00%		60.25%	F	B
	Duty of Candour compliance - Written	Responsive	Patients	Medical Director	100%	32.00%	41.00%		37.38%	F	B

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Dec-21
0.23
Variance Type
Metric is currently experiencing Common Cause Variation
Target
0.19
Target Achievement
Metric is failing the target
Executive Lead
Director of Nursing

Background:
Falls per 1000 bed days resulting in moderate, severe harm & death.

What the chart tells us:
We are currently at 0.23 against a target of 0.19.

Issues:
See page below

Actions:
See page below

Mitigations:
See page below

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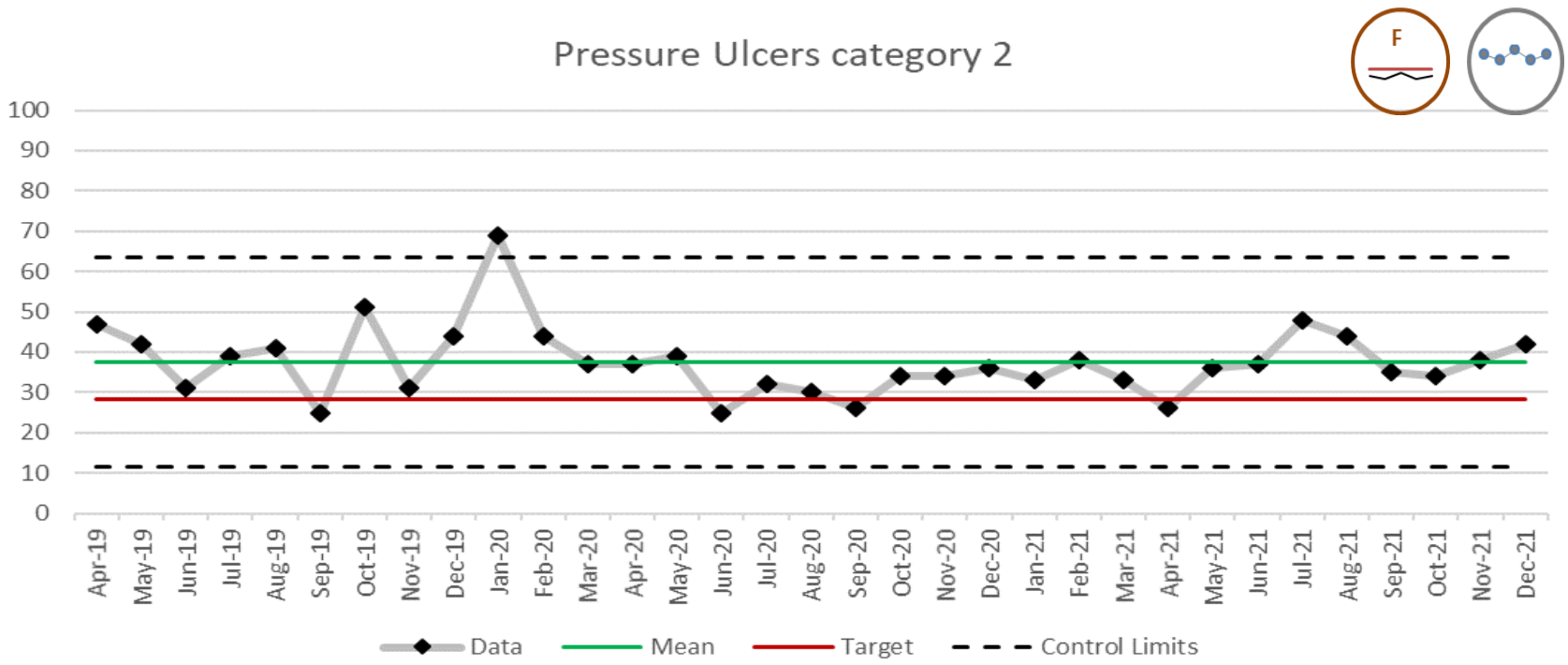

Dec-21
42
Variance Type
Metric is currently experiencing Common Cause Variation
Target
28.3
Target Achievement
Metric is consistently failing the target
Executive Lead
Director of Nursing

Background:
Pressure Ulcers Category 2.

What the chart tells us:
We are currently at 42 against a target of 28 per month. An increase of 4 from the month of November.

Issues:
The total number of reported hospital acquired pressure ulcers for Categories 2, 3, 4 and Unstageables is 51 an increase of 4 from November.

Device related Category 2 damage has reduced this month by 4 from 12 last month.

Themes identified that will continue to be areas of focus to improve.

Actions:
Tissue Viability ambassador proposal is being finalised and will be re-presented to Skin Integrity Group (SIG). This will provide a structured framework to develop knowledge base and skills, including protected time working with the clinical nurse specialists.

Explore the availability of National E-learning on ESR focusing on pressure ulcer categorisation and wound assessment as a priority.

Mitigations:
Skin Integrity Group (SIG) are sighted on areas with increased incidences where deep dives are to be undertaken.
Quality Matron and Tissue Viability team provide support to areas with increased number of incidents.
The patient pressure ulcer incident panel also have sight of any other areas of concern that are not raised through the serious incident process.

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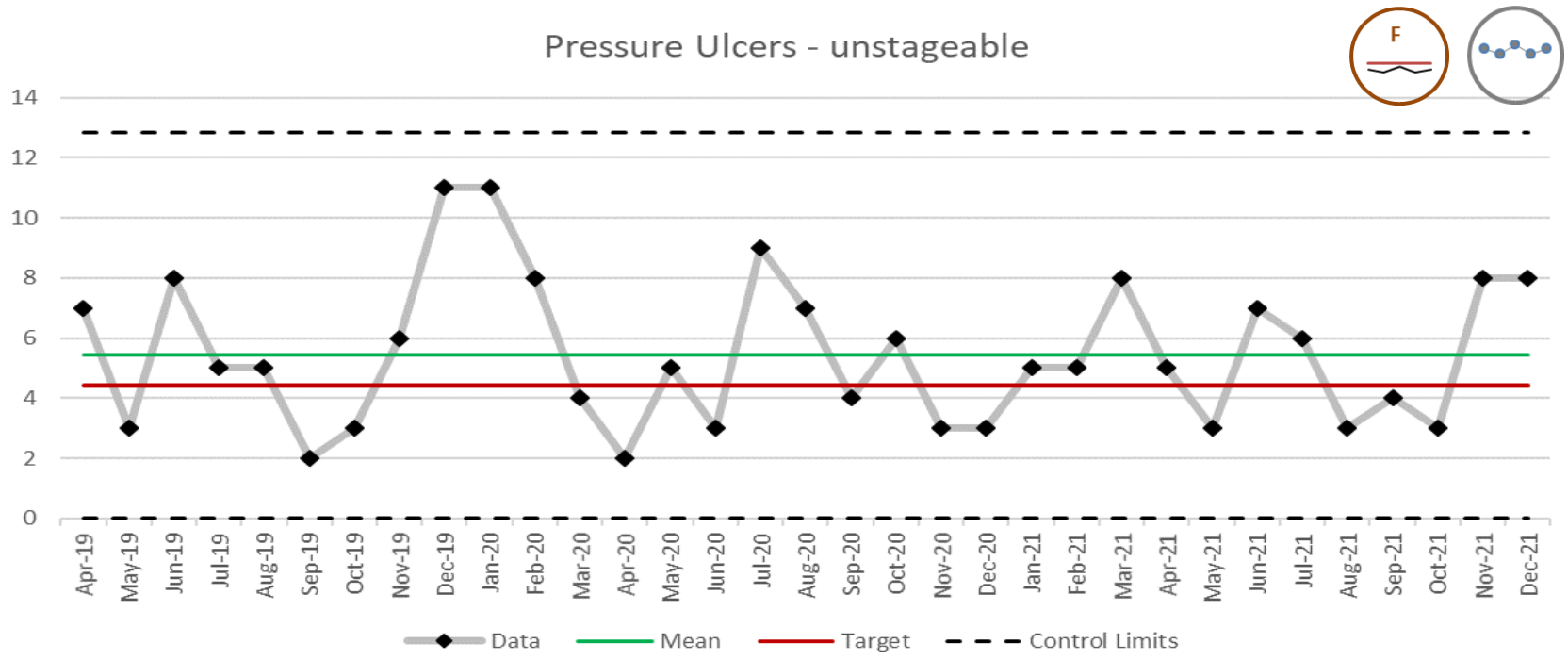

Dec-21
8
Variance Type
Metric is currently experiencing Common Cause Variation
Target
4.4
Target Achievement
Metric is failing the target
Executive Lead
Director of Nursing

Background:
Pressure Ulcers Unstageables.

What the chart tells us:
We are currently at 8 against a target of 4 per month. Which remains the same as last month.

Issues: Continued

- Miscatagorisation of pressure damage.
- Knowledge base related to aetiology of wounds in some staff groups resulting in incorrectly assessing as pressure related damage.
- Incomplete or delayed skin inspections on admission, leading to admitting wards identifying skin damage that may have been present on admission to hospital.

Actions: Continued
A trial of new transfer stickers to aid accountability handover and highlight patient harm/risk will commence in the Emergency Departments during January. They will be evaluated as part of a PDSA cycle.

The Tissue Viability team to provide an additional focus to the Emergency Departments to support early identification and interventions for patients admitted with existing or at risk of skin damage. Progress will be monitored and reported to Skin Integrity Group (SIG).

Mitigations:
As above

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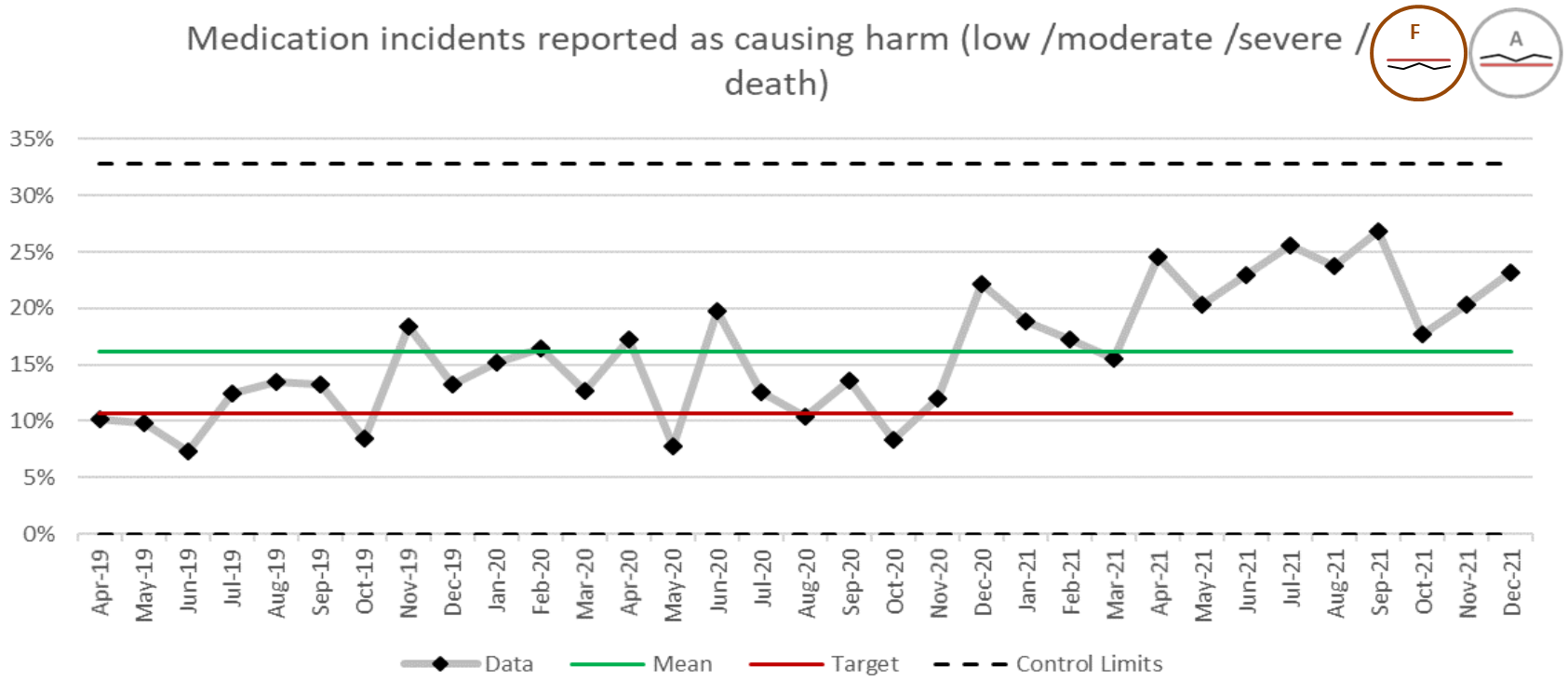

Dec-21
23.2%
Variance Type
Metric is currently experiencing Special Cause Variation – above the mean
Target
10.7%
Target Achievement
The metric has consistently failed to target
Executive Lead
Medical Director

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

What the chart tells us:
In the month of December the number of incidents reported was 168. This equates to 5.59 incidents per 1000 bed days. The number of incidents causing some level of harm (low /moderate /severe / death) is 23.2% which is double the national average of 10.8.

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

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

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

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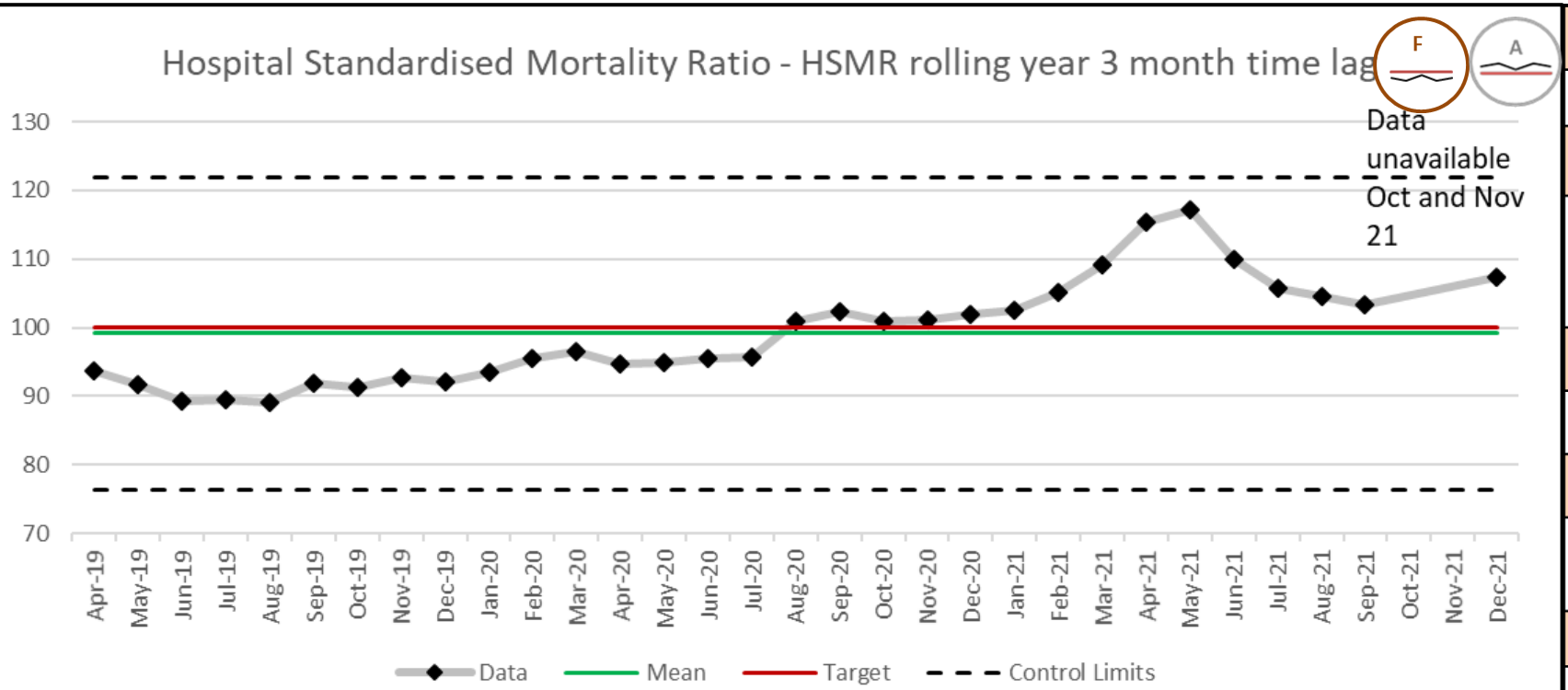


Dec-21
107.28
Variance Type
Metric is currently experiencing Special Cause Variation – above the mean
Target
100
Target Achievement
The metric has consistently failed to target
Executive Lead
Medical Director

Background:
Since the COVID-19 pandemic the Trust's HSMR has increased compared to where the Trust was pre pandemic.

What the chart tells us:
The HSMR has seen an increase in the latest HSMR data but overall the HSMR is seeing a reduction compared to the peak of the COVID-19 pandemic.

Issues:
The Trust has not received any mortality data for the previous 2 months due to ongoing issues with Dr Foster.

The data received previously demonstrated a lower HSMR – the Trust has contacted Dr Foster to request why the data is higher than they previously reported.

Actions:
Mortality report presented at MorALS

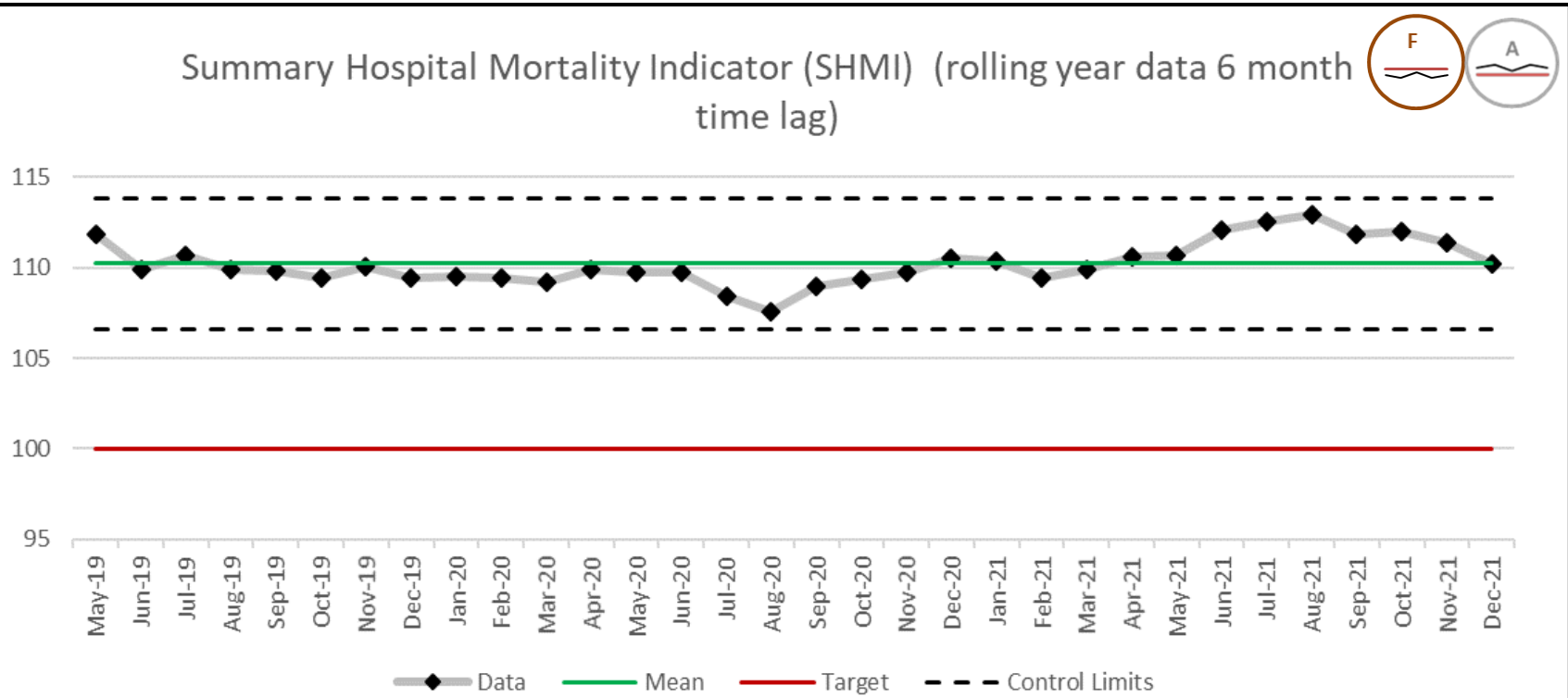
All alerts are investigated

There are monthly Divisional reports produced for the Triumvirate to present at MorALS.

Mitigations:
Any death identified as having care delivery issues is escalated for a Structured Judgement Review.

Quarterly reports are produced identifying themes and shared learning.

NHSI/E have completed a peer review on our structured judgement and will be presenting the report at the MorALS meeting in February (January meeting cancelled due to operational pressure)



Dec-21
110.20
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:
SHMI reports on mortality at trust level across the NHS in England using a standard methodology. SHMI also includes deaths within 30 days of discharge.

What the chart tells us:
The Trust's SHMI has increased during the COVID-19 pandemic, but is now seeing a significant improvement into the "as expected" range.

Issues:
The COVID-19 pandemic has impacted on the Trusts SHMI.

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

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

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.

Learning is shared at the Lincolnshire Mortality Collaborative Group.

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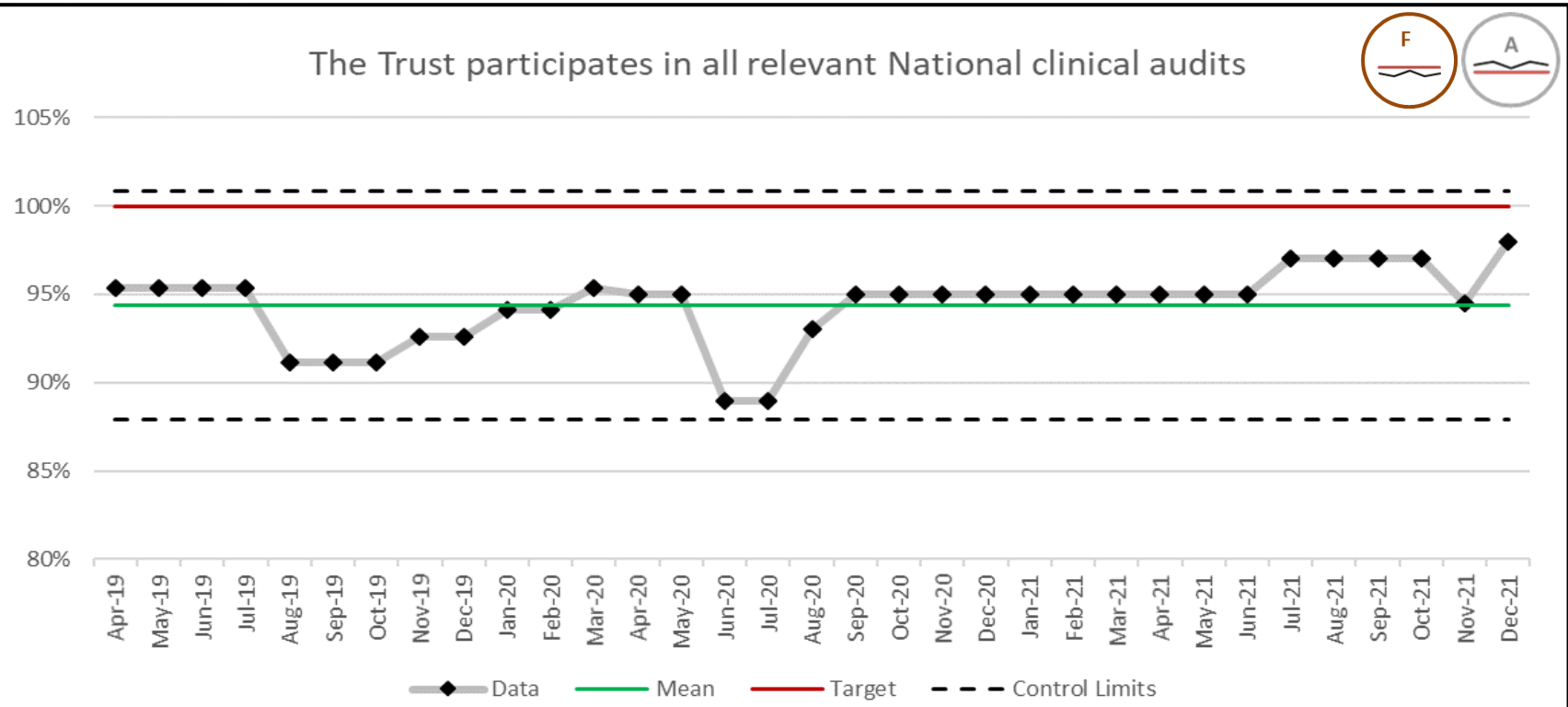

Dec-21
98%
Variance Type
Metric is currently experiencing Special Cause Variation – above the mean
Target
100%
Target Achievement
The metric has consistently failed to target
Executive Lead
Medical Director

Background:
% participation in relevant National Clinical Audits.

What the chart tells us:
Participation has increased from 94.5% to 98%

Issues:
- None participation in the IBD Audit.

Actions:
Monitored by the Clinical Effectiveness Group.

Mitigations:
- IBD access and logins activated 16/12/2021, training for the IBD team to use the new web tool planned end of January 2022.

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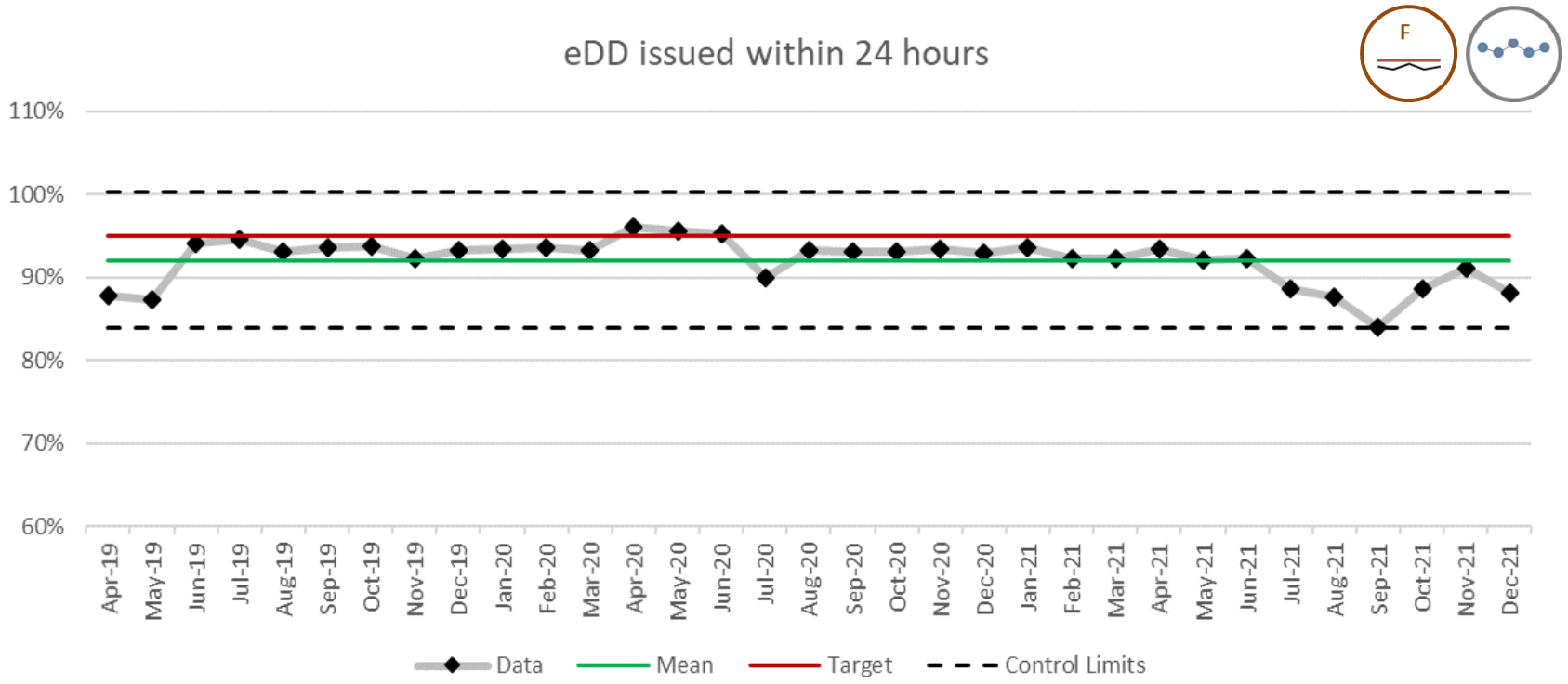

Dec-21
88.2%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
95%
Target Achievement
The metric is consistently failing the target
Executive Lead
Medical Director

Background:
eDDs to be sent within 24 hours of a patients discharge.

What the chart tells us:
The Trust is not achieving the 95% target, for December the Trust achieved 88.2%. The Trust achieved 93.4% for eDDs sent anytime within the month of December.

Issues:
eDDs not being completed the day prior to the patients discharge.

There have been considerable pressures on bed capacity within the Trust.

Actions:
A dashboard has been developed to highlight ward and consultant compliance.

Mitigations:
Streamlined eDD for paediatrics being developed.

The responsibility of eDD will be with Medical Records Group going forward.

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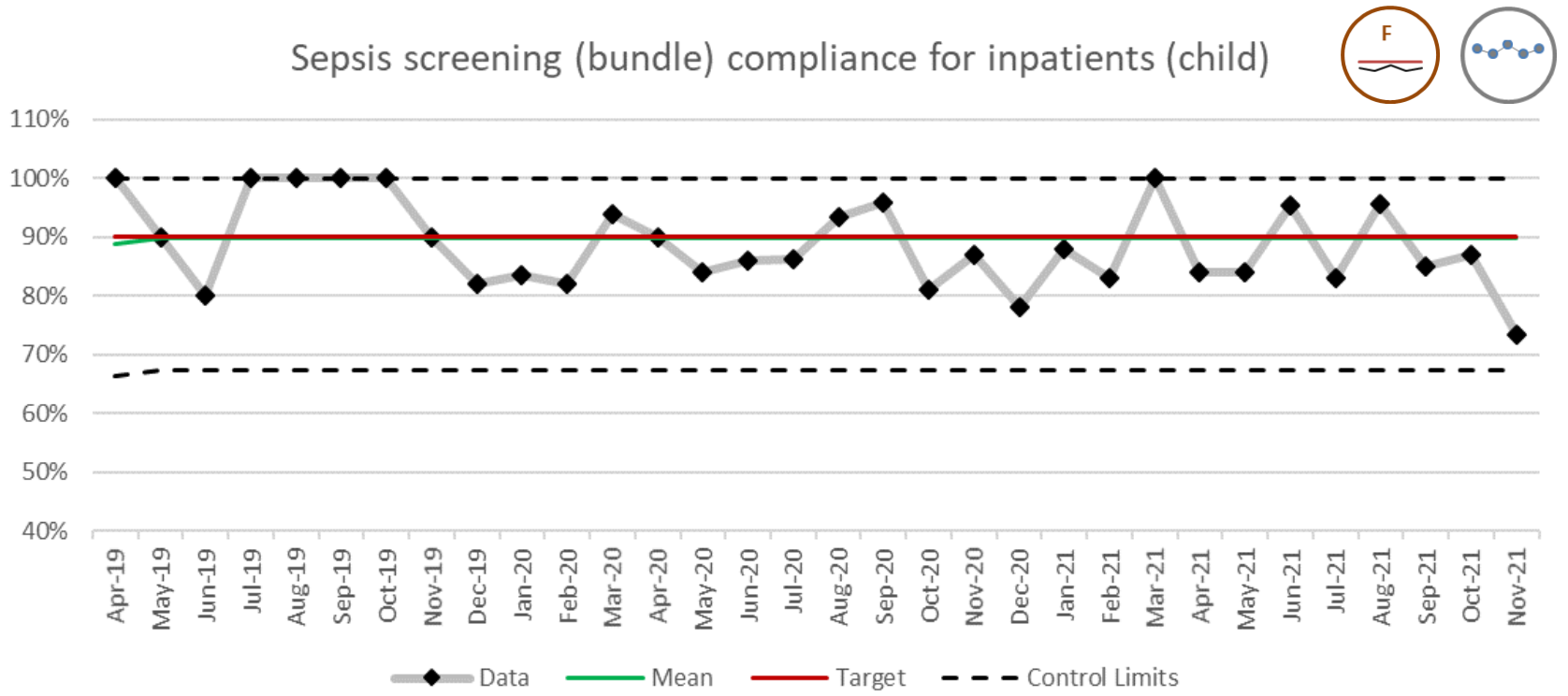

Nov-21
73.5%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
The metric is failing the target
Executive Lead
Director of Nursing

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

What the chart tells us:
The current compliance is at 73.5% against a target of 90%.

Issues:
There was a split of delayed screens between Agency/bank and substantive staff.
The wards have increased numbers of patients and acuity due to the predicted respiratory surge, therefore the majority of missed/delayed screens are non-infection. IR1s have been completed for the 1 patient that was an infection source.

Actions:
Paediatric Simulation training is taking place in clinical areas with a focus on sepsis, not only identifying the patient but also completing the bundles.
There is a similar focus in the PILS course, Sepsis is discussed for all scenarios.
The CYP Practitioner is visiting the ward regularly to offer support with Sepsis Screening.

Mitigations:
Meetings between CYP practitioner, Ward Managers & clinical educators in the paediatric areas scheduled within the next month to discuss and plan further training for the wards.
The wards are being asked to complete their own harm reviews so that lessons can be learned from them.

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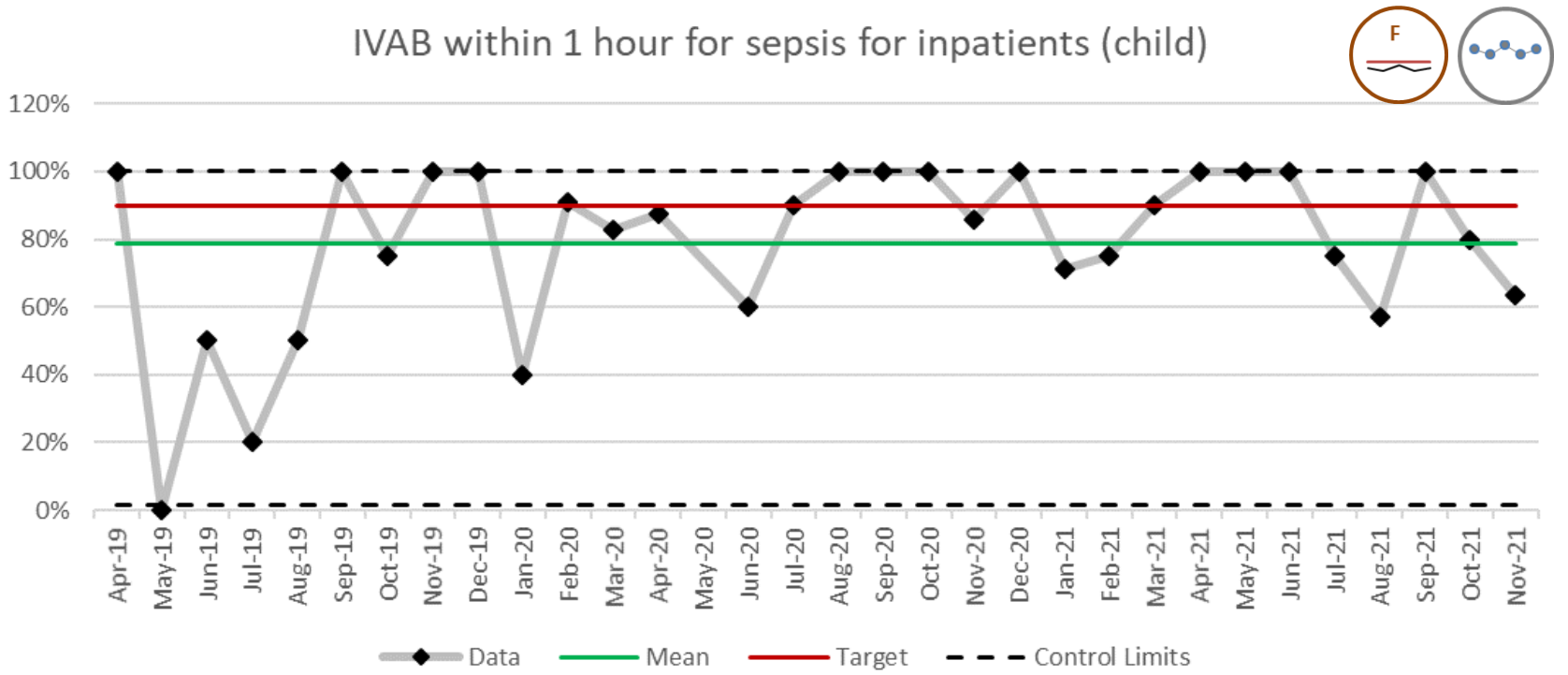

Nov-21
63.6%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
The metric is failing the target
Executive Lead
Director of Nursing

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

What the chart tells us:
The current compliance is at 63.6% against a target of 90%.

Issues:
There was one patient that had delayed antibiotics but was treated for Sepsis. This was due to a delay in being able to get IV access.

Actions:
A harm review was completed for this patient which concluded that no harm was caused from the delay. An IR1 has also been completed so that it can be investigated and learning points can be actioned from this. No Harm found from delay.

Mitigations:
Ongoing meetings taking place between CYP Practitioner, Ward Sister and Clinical Educators to highlight issues early and formulate action plans.
Sepsis teaching sessions also offered to Paediatric Medical staff.

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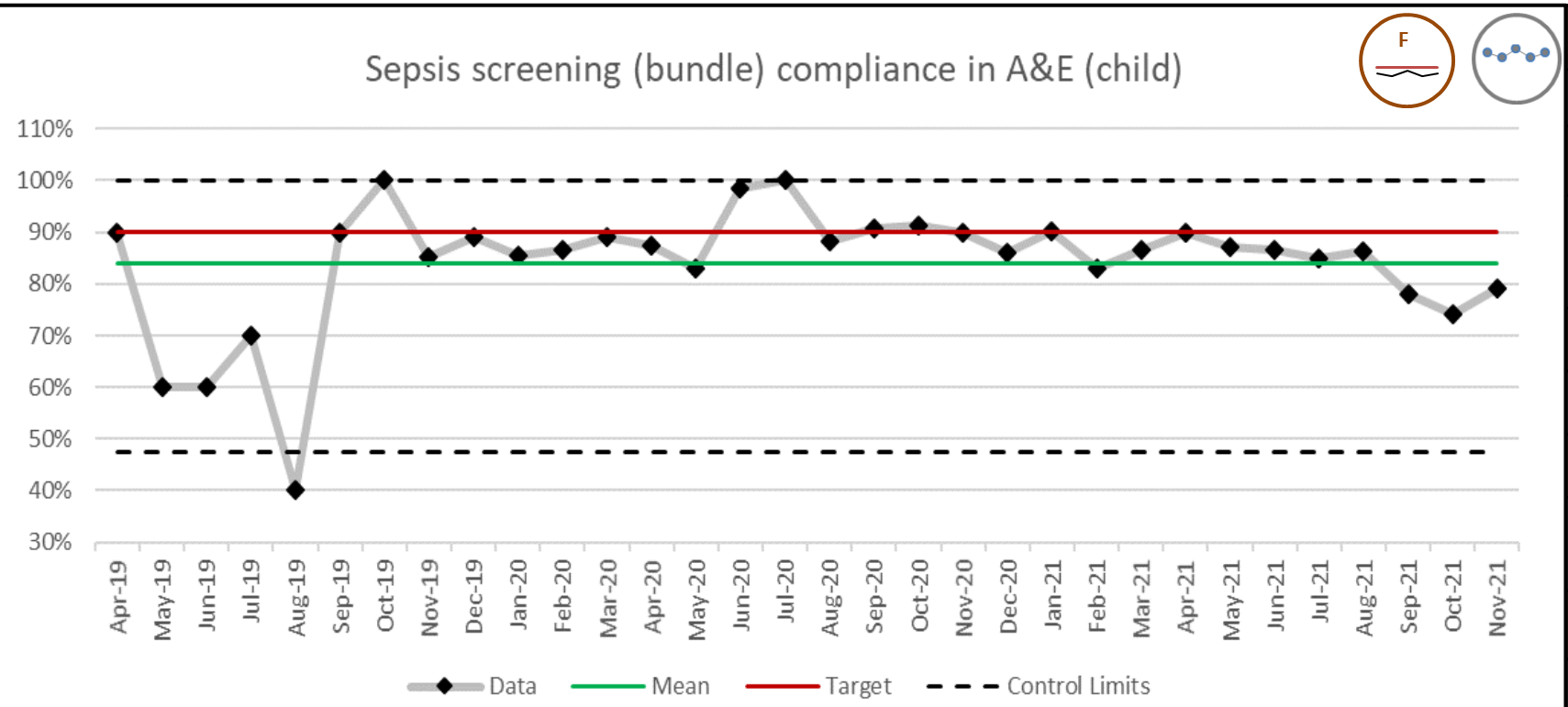

Nov-21
79%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
The metric is consistently failing the target
Executive Lead
Director of Nursing

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

What the chart tells us:
Screening compliance in ED is 79.0% which is below the 90% target.

Issues:
ED is seeing a large number of new/ Temporary/Agency staff that require training. ED is also seeing a large increase in the number of Paediatric patients being seen as well as a higher acuity of patients and this gives them limited time for training etc. Staff have reported that they are struggling with the Paediatric workload as a single Paeds Nurse in the ED department. Face to face training is cancelled at present.

Actions:
Sepsis Practitioners are currently doing regular walk rounds in the department and offering any assistance if needed. Harm reviews are being carried out for all delayed / missed screens and ED staff are involved in carrying these out. Sepsis Practitioner will attend morning huddles and ED meetings for support and training. Meetings between Sepsis Practitioner and ED staff/ inpatient staff in place and staffing is currently being reviewed to find a way to help the nurses struggling with a large workload.

Mitigations:
There are ongoing fortnightly 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.
Paediatric Drs and Nurses from the Ward are supporting the ED when possible.

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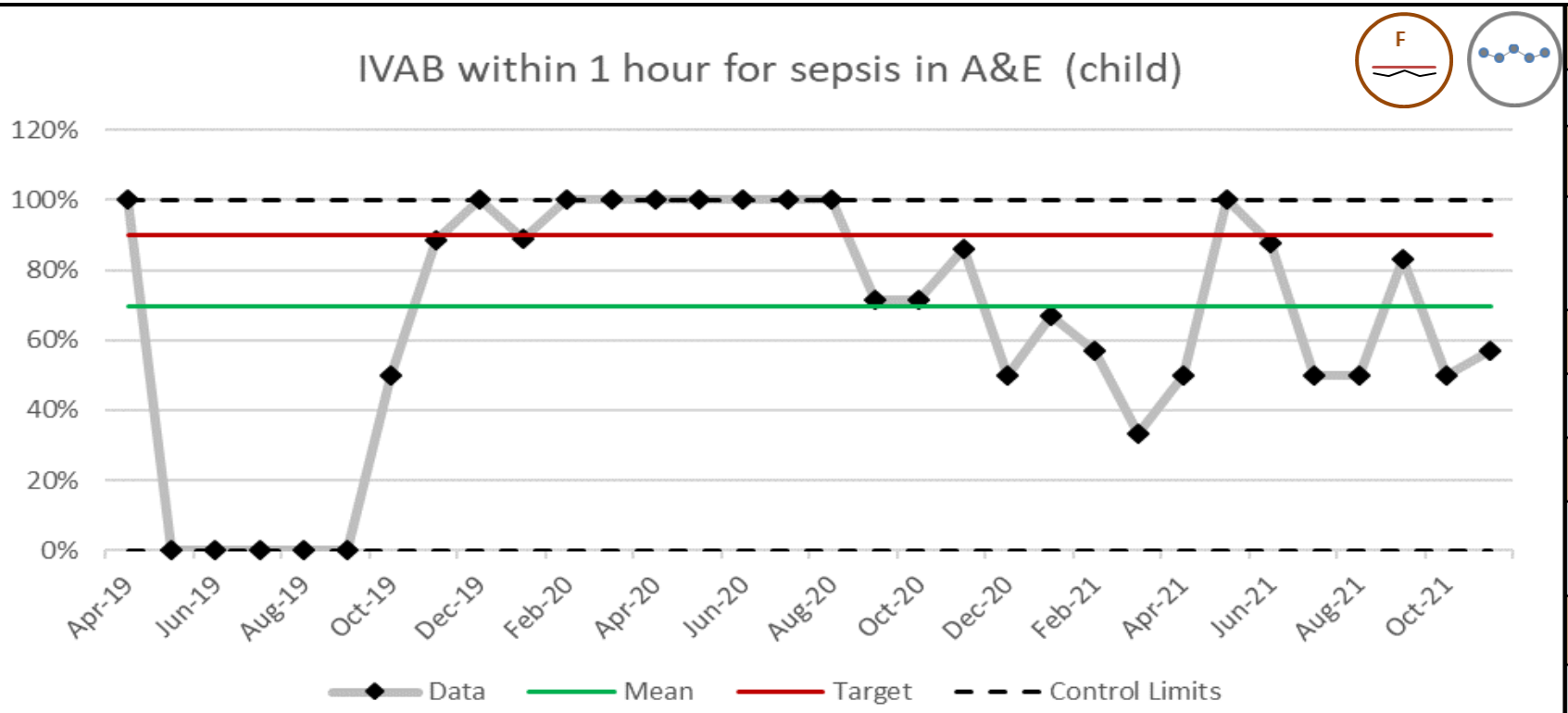


Nov-21
57.1%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
The metric is consistently failing the target
Executive Lead
Director of Nursing

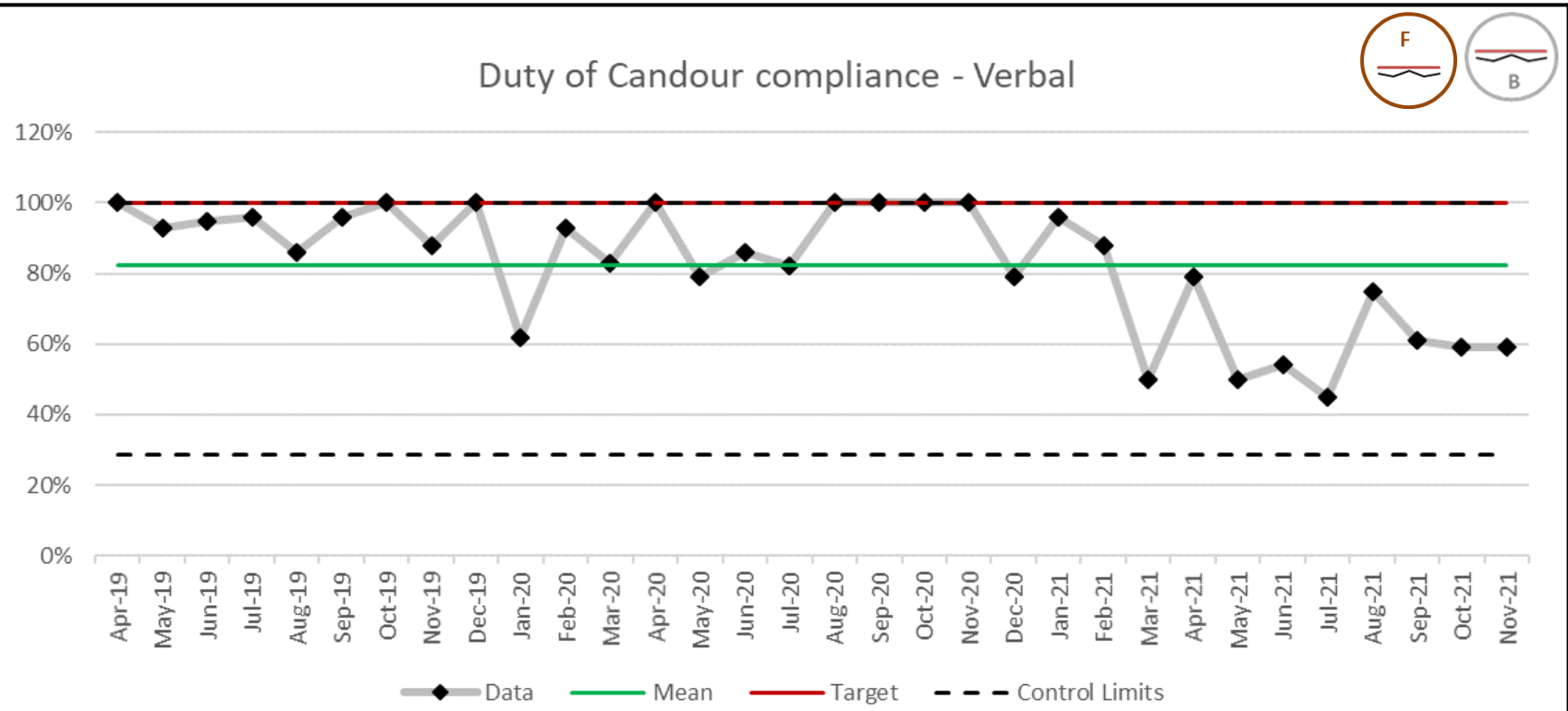
Background:
IVAB within 1 hour for sepsis in A&E (child)

What the chart tells us:
The compliance in ED this month for IVAB is 57.1%, 8 out of 14 children received antibiotics within 1 hour.

Issues:
The department is currently seeing a large number of children and there are often up to 20 children in the department at one time. This is a huge workload for 1 Paeds nurse and a Doctor. The staff have reported they are struggling to find time to give these in a timely manner. The ward is also very busy at present and is not always able to offer assistance.

Actions:
Harm reviews are being completed for all children who have delayed antibiotics. IR1 also being completed for all delays to highlight learning points. No Harm found. Children are being moved out of the department and to wards as quickly as possible. There is now a 2nd Paediatric nurse shift out to bank to support attendance numbers. Ward staff will support when able.

Mitigations:
Discussed at ongoing fortnightly Sepsis meeting. If ED need assistance they are phoning the paediatric wards. Wards are offering help if possible. The paediatric Sepsis Practitioner is also attending ED regularly to offer support.
Data is being pulled every other day in order to detect issues as quickly as possible and try to resolve but this is also difficult due to staffing / redeployment.



Nov-21
59%
Variance Type
Metric is currently experiencing Special Cause Variation – below the mean
Target
100%
Target Achievement
Metric is consistently failing the target
Executive Lead
Medical Director

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

What the chart tells us:
Verbal compliance for October is at 59% against a 100% target.

Issues:
Divisions are not recognising when duty of candour applies and should be carried out.

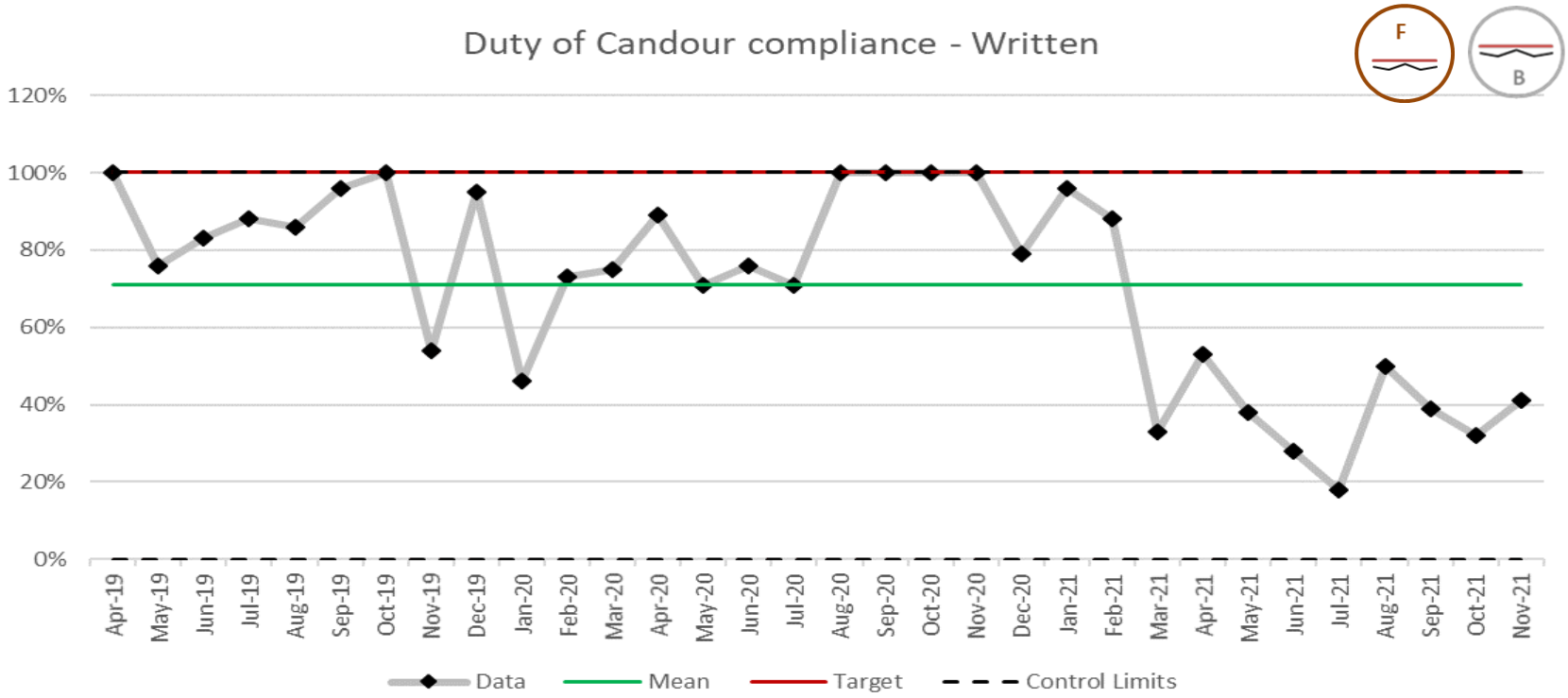
A lack of understanding of the purpose of the Duty of Candour.

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

DoC training has now been undertaken by external provider to increase number of trained individuals.

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

External training for DoC has now been completed to support clinicians better understand the requirements.



Nov-21
41%
Variance Type
Metric is currently experiencing Special Cause Variation – below the mean
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:
Written compliance for October 2021 is at 41% against a 100% target.

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

Operational pressures allowing less time to undertake administrative duties.

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

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

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

PERFORMANCE OVERVIEW – OPERATIONAL PERFORMANCE

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	Oct-21	Nov-21	Dec-21	YTD	YTD Trajectory	Latest Month Pass/Fail	Trend Variation	Kitemark
Improve Patient Experience	% Triage Data Not Recorded	Effective	Patients	Chief Operating Officer	0%	0.08%	0.06%	0.08%	0.30%		F		
Improve Clinical Outcomes	4hrs or less in A&E Dept	Responsive	Services	Chief Operating Officer	83.12%	64.04%	63.77%	64.67%	67.11%	83.12%	F		
	12+ Trolley waits	Responsive	Services	Chief Operating Officer	0	173	254	330	853	0	F	H	
	%Triage Achieved under 15 mins	Responsive	Services	Chief Operating Officer	88.5%	85.51%	86.12%	86.15%	86.38%	88.50%	F		
	52 Week Waiters	Responsive	Services	Chief Operating Officer	0	1799	1983		10291	0	F		
	18 week incompletes	Responsive	Services	Chief Operating Officer	84.1%	55.25%	55.58%		57.64%	84.10%	F		
	Waiting List Size	Responsive	Services	Chief Operating Officer	37,762	54,616	57,105		n/a	n/a	F	H	
	62 day classic	Responsive	Services	Chief Operating Officer	85.4%	53.11%	49.04%		59.95%	85.39%	F		
	2 week wait suspect	Responsive	Services	Chief Operating Officer	93.0%	68.99%	70.10%		76.16%	93.00%	F		
	2 week wait breast symptomatic	Responsive	Services	Chief Operating Officer	93.0%	11.72%	3.26%		10.86%	93.00%	F		
	31 day first treatment	Responsive	Services	Chief Operating Officer	96.0%	93.67%	90.76%		91.65%	96.00%	F		
	31 day subsequent drug treatments	Responsive	Services	Chief Operating Officer	98.0%	99.32%	99.22%		99.51%	98.00%	P		
	31 day subsequent surgery treatments	Responsive	Services	Chief Operating Officer	94.0%	69.44%	65.63%		74.07%	94.00%	F		
	31 day subsequent radiotherapy treatments	Responsive	Services	Chief Operating Officer	94.0%	99.17%	98.20%		96.82%	94.00%	P		
	62 day screening	Responsive	Services	Chief Operating Officer	90.0%	72.41%	78.26%		73.06%	90.00%	F		

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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	Oct-21	Nov-21	Dec-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%	63.22%	70.92%		74.47%	85.00%	F		
	Diagnostics achieved	Responsive	Services	Chief Operating Officer	99.0%	66.23%	65.61%		67.66%	99.00%	F	A	
	Cancelled Operations on the day (non clinical)	Responsive	Services	Chief Operating Officer	0.8%	2.83%	2.45%	1.82%	2.08%	0.80%	F		
	Not treated within 28 days. (Breach)	Responsive	Services	Chief Operating Officer	0	34	22	21	146	0	F		
	#NOF 48 hrs	Responsive	Services	Chief Operating Officer	90%	92.00%	88.10%	84.00%	89.58%	90%	F		
	#NOF 36 hrs	Responsive	Services	Chief Operating Officer	TBC	72.00%	77.38%	70.67%	75.51%				
	EMAS Conveyances to ULHT	Responsive	Services	Chief Operating Officer	4,657	4,211	4,148	4,167	4,417	4,657	P		
	EMAS Conveyances Delayed >59 mins	Responsive	Services	Chief Operating Officer	0	733	777	654	569	0	F		
	104+ Day Waiters	Responsive	Services	Chief Operating Officer	10	103	123	161	717	70	F	H	
	Average LoS - Elective (not including Daycase)	Effective	Services	Chief Operating Officer	2.80	2.37	2.67	2.59	2.69	2.80	P		
	Average LoS - Non Elective	Effective	Services	Chief Operating Officer	4.50	4.83	4.82	4.81	4.57	4.5	F		
	Delayed Transfers of Care	Effective	Services	Chief Operating Officer	3.5%	Submission suspended				3.5%			
	Partial Booking Waiting List	Effective	Services	Chief Operating Officer	4,524	16,739	17,406	19,326	16,364	4,524	F		
	Outpatients seen within 15 minutes of appointment	Effective	Services	Chief Operating Officer	70.0%	46.5%	43.9%	41.8%	42.88%	70.00%	F		
	% discharged within 24hrs of PDD	Effective	Services	Chief Operating Officer	45.0%	41.1%	37.5%	39.1%	40.35%	45.00%	F		

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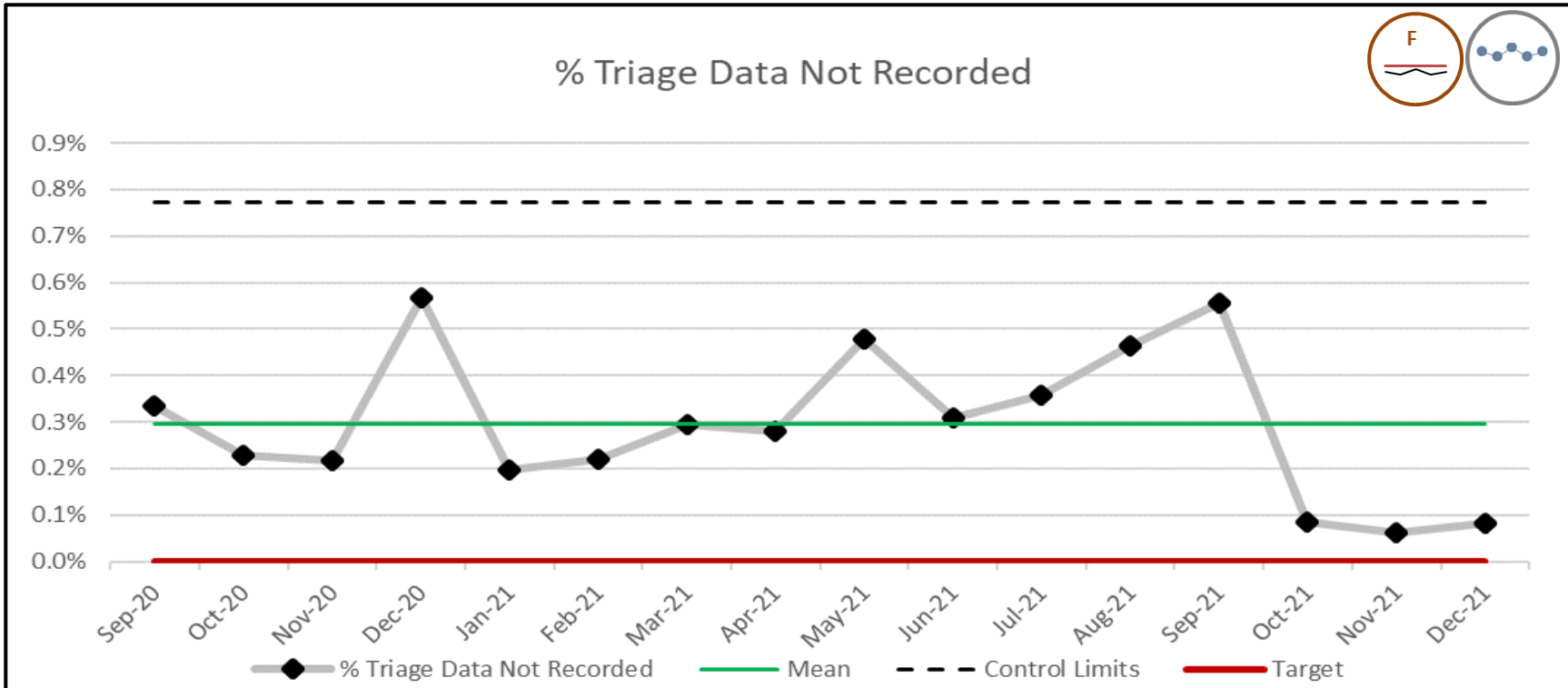
NHS United Lincolnshire Hospitals NHS Trust



Dec-21
0.08%
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:
The recording of triage compliance percentage is 0%.
December reported 0.08% data not recorded verses 0.06% in November December demonstrated a 0.02% negative variation compared with November.
This metric is below target but improvements have been demonstrated.

Issues:

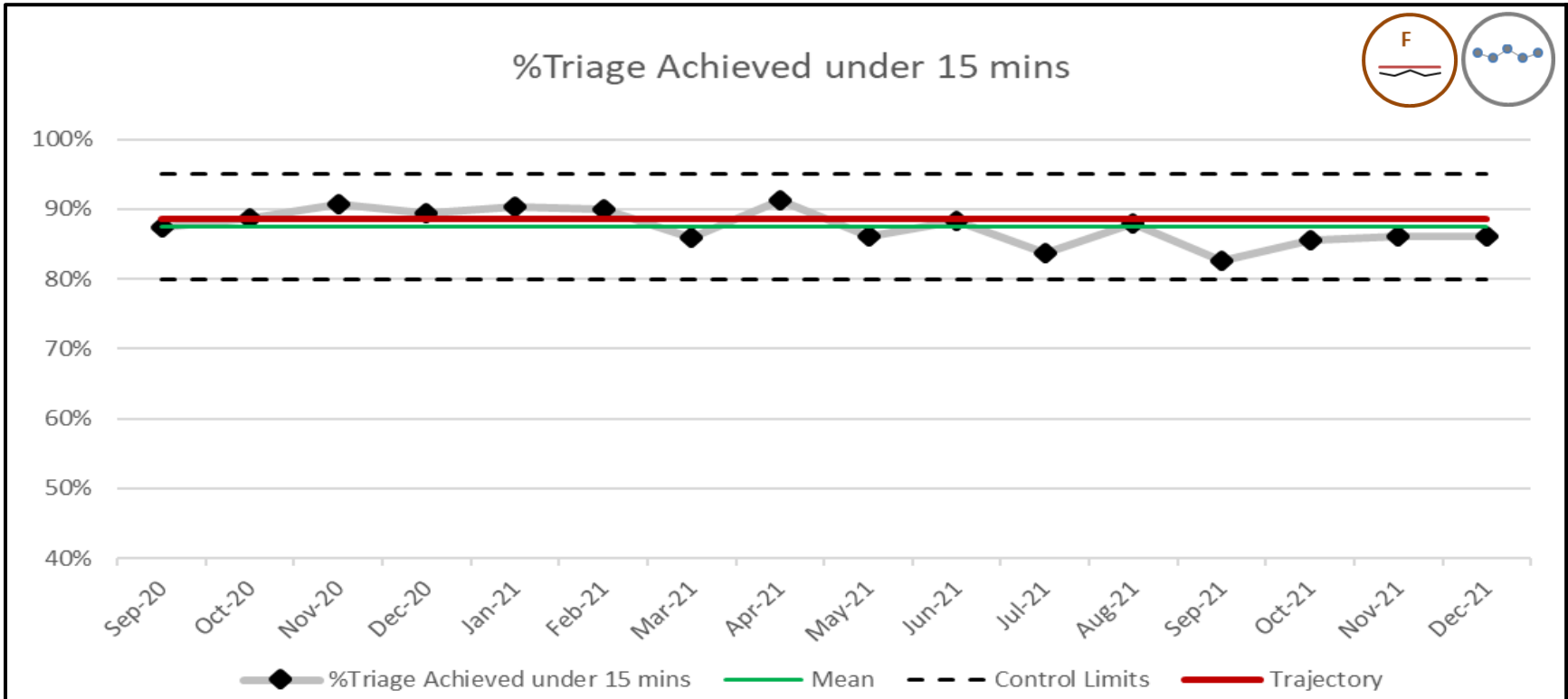
- Timely inputting of data.
- Manchester Triage trained staff (MTS) to consistently operate two triage streams, especially out of hours but has been increasingly problematic at all three sites due to an increased absence from Covid.
- Adhoc gaps in the provision of Pre-Hospital Practitioners (PHP) but a slight improvement in rostering has been seen.
- Staffing gaps and skill mix issues
- Increased demand is still cited as a causation factor.

Actions:

- Increased access to MTS training and time to input data is in place through a rolling teaching programme.
- Increased registrant workforce to support 2 triage streams in place.
- The move to a workforce model with Triage dedicated registrants and remove the dual role component has been more successful and consistent.

Mitigations:

- Earlier identification of recording delays via 3 x daily Capacity and performance meetings and Emergency Care 'Team's chat'.
- Increased nursing workforce following a targeted recruitment campaign has been successful and supernumerary period, has, in the main come to an end.
- Twice daily staffing reviews to ensure appropriate allocation of the ED workforce to meet this indicator.
- The Urgent and Emergency Care Clinical Business Unit continue to undertake daily interventions regarding compliance (recording and undertaking).



Dec-21
86.15%
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:

The compliance against this target is 88.50%.
December outturn was 86.15% which is 2.35% below the agreed target.
December demonstrated an improvement of 0.02% compared with November.
This target has not been met.

Issues:

- Consistent availability of MTS2 trained staff available per shift to ensure 2 triage streams in place 24/7 but is improving.
- Dual department roles. For example, the second triage nurse is also the allocated paediatric trained nurse, whilst reduced is still on occasion, problematic.
- 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 but improvement is noted.

Actions:

The actions are repetitive but remain relevant.
Increased access to MTS2 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.
The metric forms part of the Emergency Department safety indicators and is monitored/scrutinised at 4 x daily Capacity and Performance Meetings.

Mitigations:

The 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.
The confirmation of 2 triage streams is ascertained at the 4 x daily Capacity meetings.
Early escalation and rectification are also managed through the Emergency Department Teams Chat and Staffing Cell.
A twice daily staffing meeting staffing meeting in in operations 7 days a week and a daily staffing forecast is also in place.

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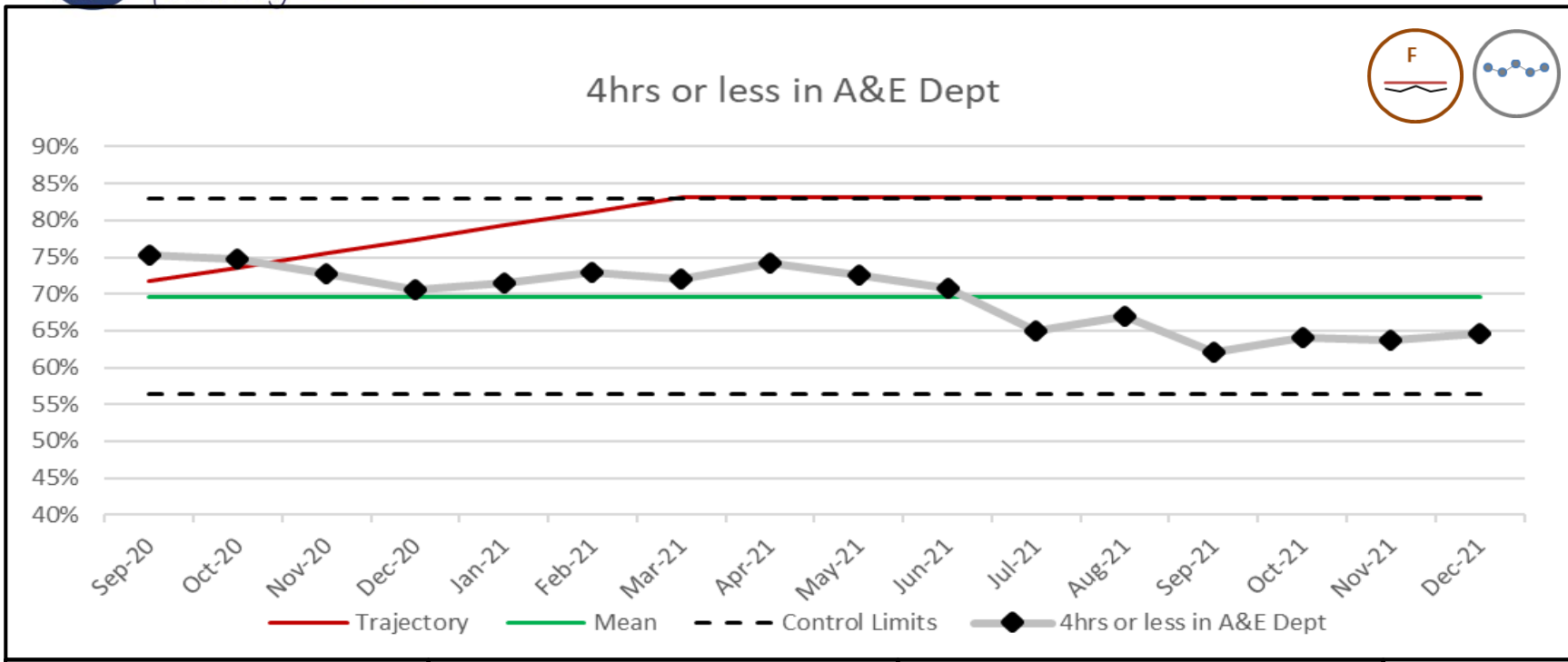

Dec-21
64.67%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
83.12%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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 December was 64.67% which is 19.35% below the agreed target.
December out turned at 64.67% compared to 63.77% in November.
A 0.9% positive variance compared to November.

Issues:

The Emergency Departments saw a 3.27% decrease in attendances in December 2021 (546 patients) compared to November 2021. 16,190 combined attendances (ED and UTC) in December compared to 16,736 combined attendances in November.
A comparison to December 2019 denotes a decrease of 4.94%.
Of the 16,190 recorded attendances for type 1 and type 3 across the Trust, type 1 attendances accounted for 11,037 and type 3 accounted for 5,159. This is a decrease on type 1 and type 3 attendances is across all 3 acute sites.
Inadequate daily discharges to meet the admission demand remains an issue leading to extended ED LOS.
Ongoing medical and nursing gaps that were not Emergency Department specific.
Inability to secure consistent 24/7 Discharge Lounge provision due increased registrant staffing gaps.

Actions:

The actions are repetitive but still relevant
Reducing the burden placed upon the Emergency Departments further will be though the continued development of Same Day Emergency Care (SDEC) Services.
Direct EMAS conveyance to SDEC services has commenced but CAD not yet updated with destination.
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. All delays >24hrs post optimisation are escalated for resolution.

Mitigations:

The mitigations are repetitive but still relevant.
EMAS continue to enact a targeted admission avoidance process.
The Discharge Lounge at LCH and PHB continues operating, where possible, a 24/7 service provision to release the burden placed on the Emergency Departments in terms of patients awaiting AIR/CIR and transport home. The closure of the Discharge Lounges due to inadequate staffing sits solely with the Chief Operating Officer and the Director of Nursing but can be delegated to Dep Chief Operating Officer/ Gold Commander Out of Hours
Increased CAS and 111 support especially out of hours.
EPIC to Specialty Consultant reviews to ensure DTA applied appropriately.
Clinical Operational Flow Policy adherence and compliance and Full Capacity Protocol activation when OPEL 3 reached.
System Partners attend the ULHT 6pm Capacity Call to assist with any escalation issues.

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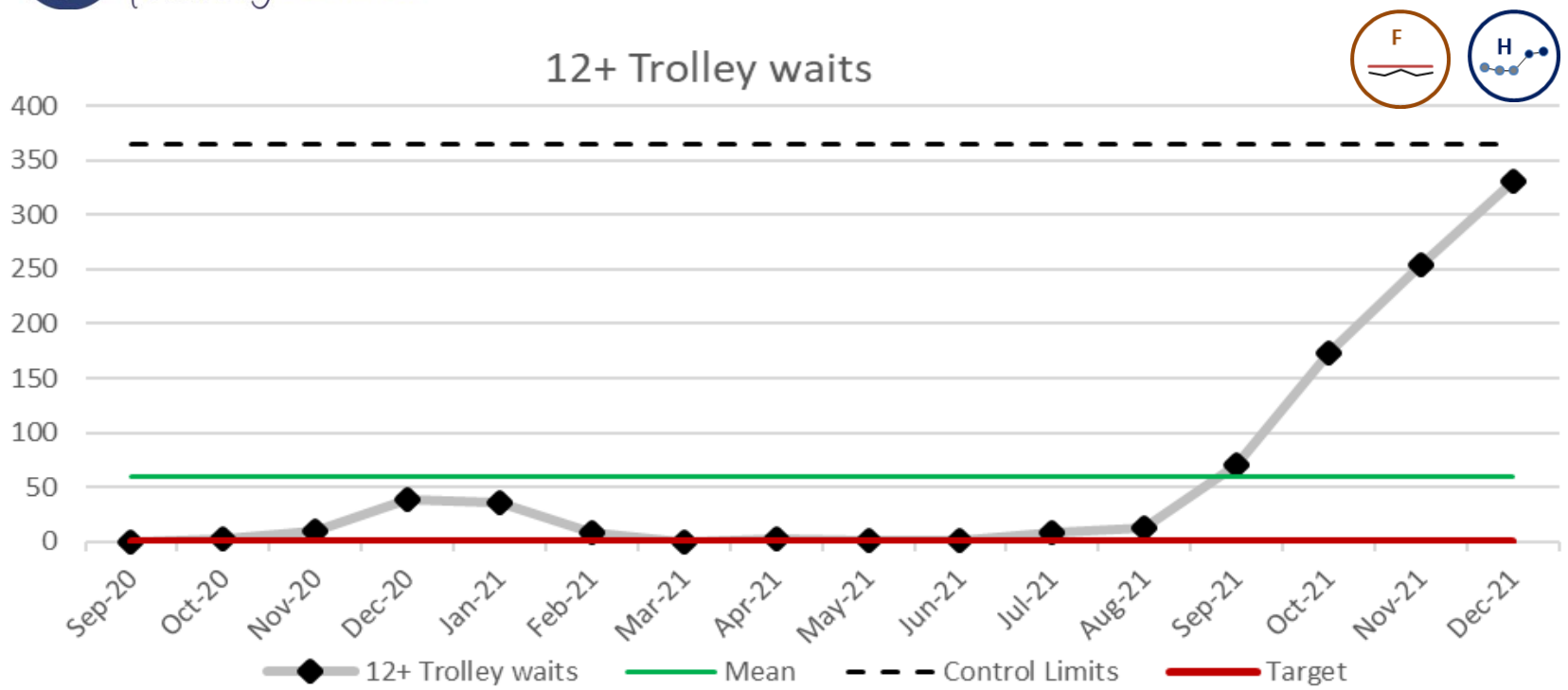

Dec-21
330
Variance Type
Metric is currently experiencing Special Cause Variation – high trend
Target
0
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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:

December experienced 330 12-trolley wait breaches, which is the highest ever recorded for ULHT. This represents an increase of 23.04%. This equates to 2.92% of all type 1 attendances for December.

Issues:

Sub-optimal discharges to meet the known emergency demand.
All reportable 12hr trolleys were either associated with no available beds, patient deterioration or failure to transfer. The actual number of 12hr trolleys wait breaches, whilst anticipated against flow predictions, exceeded actual expectations.
December has experienced an increase in incidental positive covid cases, which as restricted the use of several inpatients' beds, impacting further on flow.
December saw the highest number of positive covid cases since the peak of wave 3 and the number continues to rise.
To prevent nosocomial transmission, the use of boarding areas as per the Full Capacity Protocol areas has been problematic.

Actions:

Every reported 12hr trolley wait breach 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 breaches, with the greatest total time in ED is submitted to NHSE/I by the Deputy Chief Operating Officer or designated officer.
A daily review of all potential 12hr trolley waits is in place and escalated to all key strategic tactical and operational leads and divisional triumvirates.
System Partners and Regulators remain actively engaged and offer practical support in situational escalations.
Expectation of securing 10 discharges by 10am and 35% of all discharges before midday. All confirmed discharges must go to the discharge lounges unless a clinical exception is agreed.
Daily review of all IPC issues affecting capacity and restricted beds is in place.

Mitigations:

All potential DTA risks are escalated at 8hrs to the Daytime Tactical Lead, out of hours Tactical Lead On Call Manager and CCG Tactical Lead – in and out of hours. Rectification plans are agreed with all CBU teams in hours.
A System agreement remains 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 but due to staffing gaps, there is an increased request to close this facility. Permission to close these areas now sits solely with the Chief Operating Officer and Director of Nursing or delegated officer
A Criteria to Admit Lead has been established ensuring all decisions to admit must be approved by the EPIC (Emergency Physician in Charge) with the relevant On Call Team.

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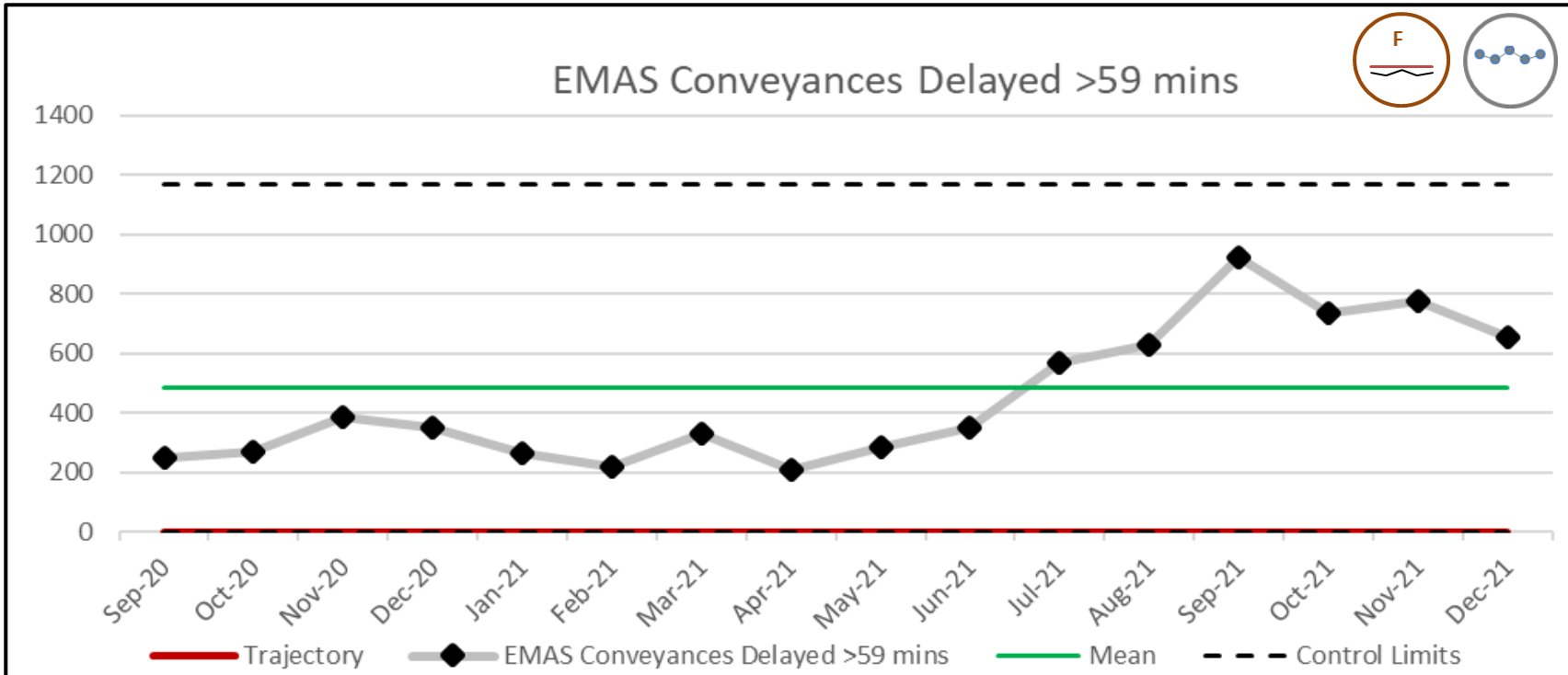


Dec-21
654
Variance Type
Metric is currently experiencing Common Cause Variation
Target
0
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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:

December demonstrated a decrease in greater than 59 minutes' handover delays. 654 in December compared to 777 in November. This represents a 15.84% decrease.

What the chart does not tell us is the decrease of >2hrs in December 2021 (238 in December vs 368 in November) and the decrease in >4hr delays (39 in December compared to 65 in November).

Issues:

The pattern of conveyance and prioritisation of clinical need contributes to the delays.

Increased conveyances continue to profile into the late afternoon and evening coincides with increased 'walk in' attendances causing a reduce footprint to respond to timely handover.

Inadequate flow and sub-optimal discharges continue to result in the emergency departments being unable to de-escalate due to an increase number of patients waiting for admission.

A more detailed account of >59-minute handover delays are 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 Tactical Lead to secure a resolution and plans to resolve are feedback to the DOM. Out of hours, the responsibility lies with the Tactical On Call Manager.

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.

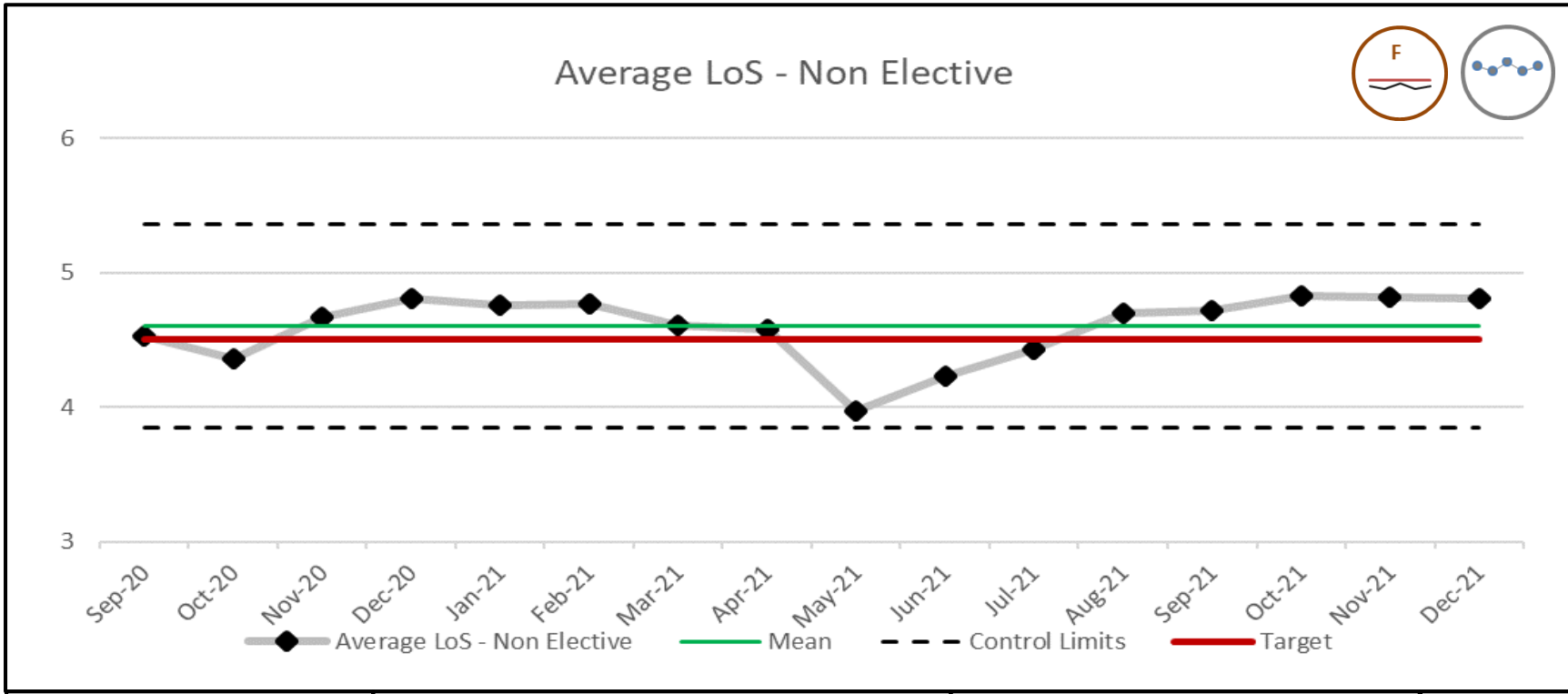
The rapid handover protocol has now been revisited and agreed. Designated escalation areas are being identified/confirmed to assist in reducing delays in handover.

December saw no formal requests to enact the rapid handover protocol.

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 Tactical Lead (in and out of hours) to appreciate EMAS on scene (active calls) and calls waiting by district and potential conveyance by site.



Dec-21
4.81
Variance Type
Metric is currently experiencing Common Cause Variation
Target
4.5
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:

Average length of stay for Non-Elective inpatients.

What the chart tells us:

The agreed target is 4.5 days verses the actual of 4.81 days in December.
This is a decrease of 0.01 days compared with November.
This is a 0.31 variance against the agreed target.

Issues:

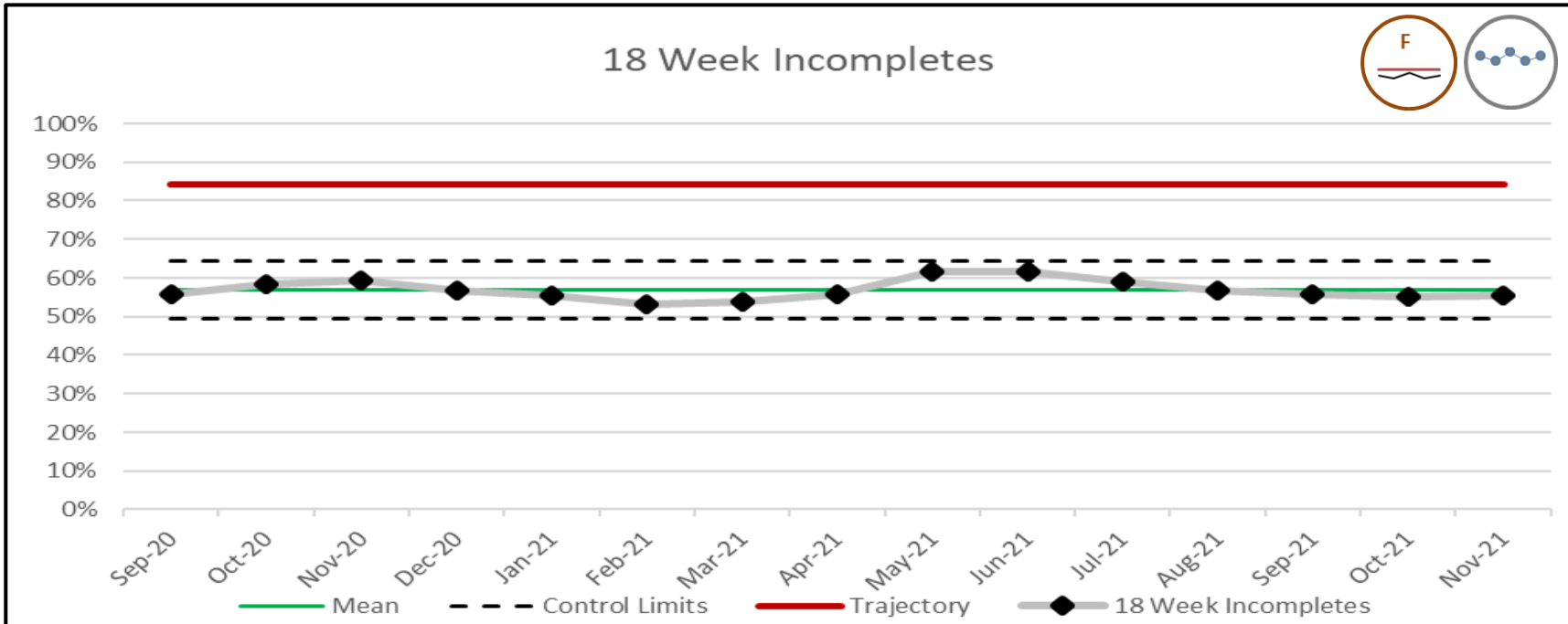
Increasing numbers of stranded – 249 Pts in December vs 235 Pts in November and super stranded – 92 pts in December vs 86 Pts November.
PCR turnaround delays impacting on the discharge of pathway 1, 2 and 3 patients due to timelines has been problematic due to some equipment failure. This is now back on track and is c14hrs from receipt of sample.
Increasing length of stay of all pathways 1-3 The most significant increase in volume of bed days is Pathway 1 Domiciliary care but since the advent of the joint D2A process, benefits are being realised.
Reluctance of Care Homes to admit at the weekends
Higher acuity of patients requiring a longer period of recovery.
Increased medical outliers and reduced medical staffing leading to delays in senior reviews.
Increased number of positive covid cases requiring a longer length of stay and increased 'contact' patients leading to delayed discharges.

Actions:

These actions are repetitive but still appropriate
Focused discharge profile through right to reside data.
Cancellation of elective activity and SPA time to allow for daily consultant review of all patients.
Medically optimised patients discussed twice daily 7 days a week with system partners to ensure plans in place and a zero tolerance of >24hrs delay
Use of rapid PCRs to ensure no delay once social care plans are secured.
Maximise use of all community and transitional care beds when onward care provision cannot be secured in a timely manner

Mitigations:

Divisional Bronze Lead continues to support the escalation of exit delays to the relevant Divisions and Clinical Business Units.
Continued reduction in corporate and divisional meetings to allow a more proactive focus on increasing daily discharges. However, this is not sustainable.
A daily site update message is now sent at 6am alerting Key Leaders to ED position, flow and site OPEL position by Site.
The move to working 5 days over the 7 a Day period is in train.



Nov-21
55.58%
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. November saw RTT performance of 55.58% against a 92% target, which is 0.33% up on October.

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:

- ENT – 4153 (increased by 192)
- Dermatology – 2712 (increased by 120)
- Gastroenterology – 2359 (Increased by 272)
- Gynaecology – 2319 (Increased by 115)
- Ophthalmology - 2061 (reduced by 151).

Actions:
Planned routine elective work remains challenging. Available capacity is being focussed on cancer, paediatrics, day cases and patients classified as being P2.

Mitigations:
Patient pathways are discussed at the weekly Clinical Prioritisation Cell to determine the clinical appropriateness of patients to be booked for the forthcoming week. Patients are also being assessed for their suitability to be transferred to Independent Sector Providers and offered this choice for treatment.

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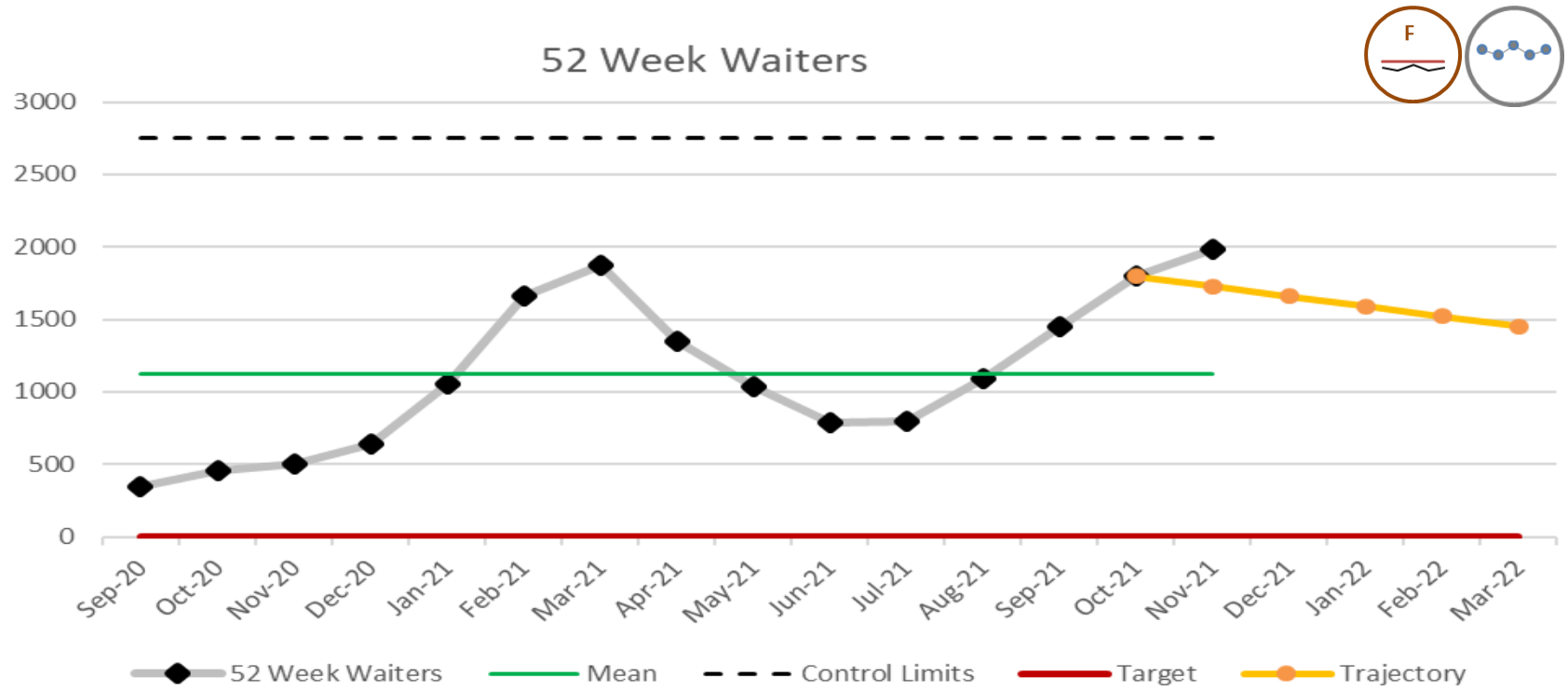

Nov-21
1983
Variance Type
Metric is currently experiencing Common Cause Variation
Target
0
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
The Trust reported 1983 incomplete 52-week breaches for November. An increase of 184 from October. The number of 52-week breaches has increased considerably since August.

Issues:
The admitted position remains very challenging. The current capacity challenges and the ongoing critical incident and staffing issues are all impacting on service delivery, which is in turn, detrimentally affecting the 52-week position.

Actions:
Admitted patients are individually graded and allocated a priority code. It is anticipated that the introduction of C2AI will positively affect the efficiency and effectiveness of this process. All patients waiting more than 52 weeks are required to have an RCA and harm review completed. The harm review process is discussed at the Clinical Harms Oversight Group with a view to streamline how the Trust administers this.

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

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Nov-21
57,105
Variance Type
Metric is currently experiencing Special Cause Variation – high trend
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 October, with November showing an increase of 2489 to 57,105.
The incomplete position for November 2021 has increased by approximately 18,073 more than the reported pre pandemic size in January 2020.

Issues:
The trust is currently experiencing extreme pressure in its emergency service provision, necessitating the cancelation of some elective activity, which will, have a detrimental effect on waiting list size.
The top five specialties showing an increase in total incomplete waiting list size from October are:

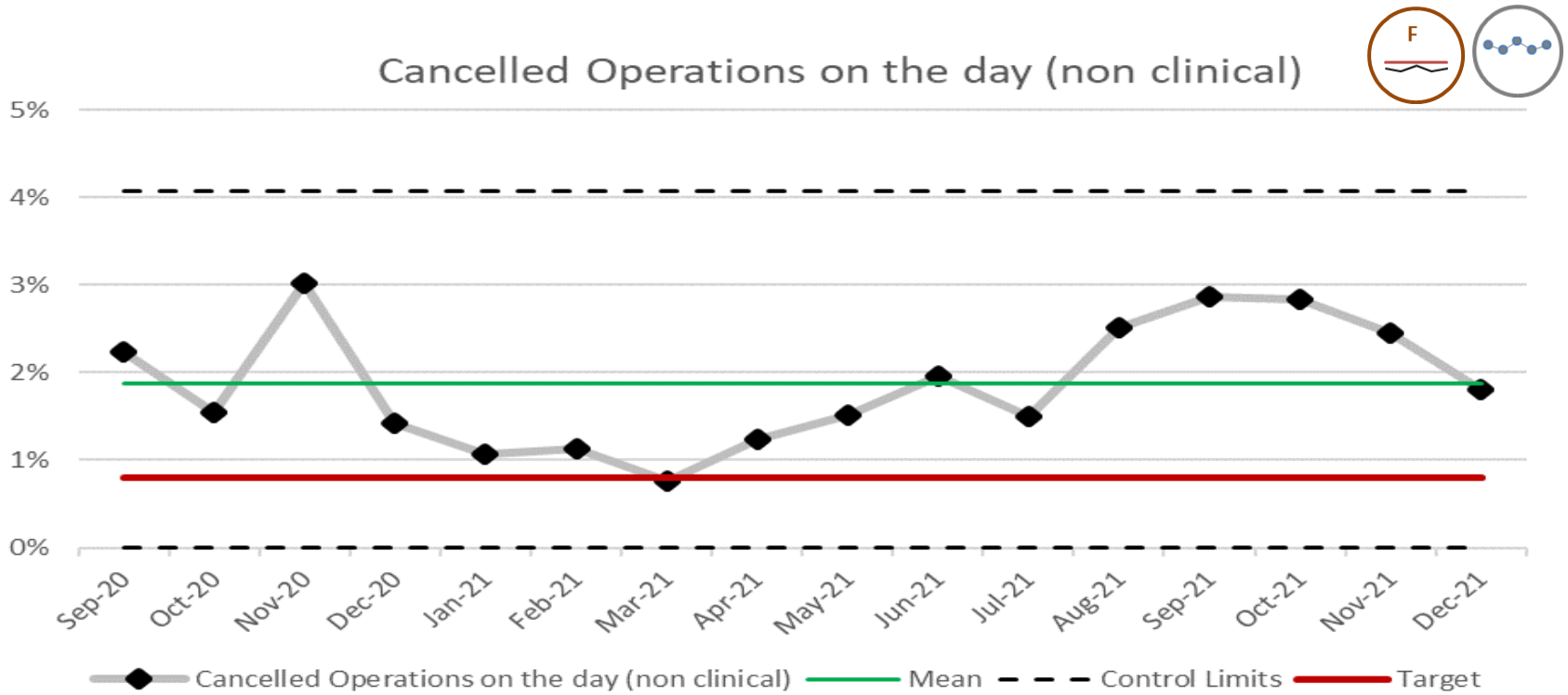
- Neurology + 563
- Respiratory Medicine + 484
- Gastroenterology + 309
- ENT +246
- Trauma & Orthopaedics + 206

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

- Nursing Episode – 207
- Cardiology – 116
- Paed Trauma & Orthopaedics - 101
- Maxillo Facial - 37
- Clinical Oncology - 31

The Trust reported 5814 over 40 week waits; an increase of 319 on October. Patient numbers waiting over 26 weeks increased by 807.

Actions/Mitigations:
The longest waiting patients are monitored and discussed with system partners at a weekly ICS meeting. Issues preventing the booking and treating of patients are also discussed to look at finding solutions and subsequently enable service delivery



Dec-21
1.82%
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:
This shows the number of patients cancelled on the day due to non-clinical reasons.

What the chart tells us:
December is the third consecutive more that demonstrates a reduction on the same day cancelled operation (1.82% in December vs 2.45% in November) but remains above the agreed trajectory of 0.8%

Issues:
Main reasons for same day non-clinical cancellations for December have been identified as

- No medical staff
- Lack of theatre staff due to sickness
- Lack of theatre time
- Reduced to inpatient beds

Actions:
Daily meetings with TACC and the CBUs to discuss Theatre issues 12:30pm.
Daily clinical prioritisation meeting now in place
642 process revitalised to ensure the lists identified and are filled with the appropriate patients.

Mitigations:
Consistent attendance at meetings including more involvement from relevant Teams
Staffing is to be reviewed in advanced at the daily TACC Operational meeting and staff redeployed from other sites where required.
642 process is adhered to with appropriate challenge and confirm.

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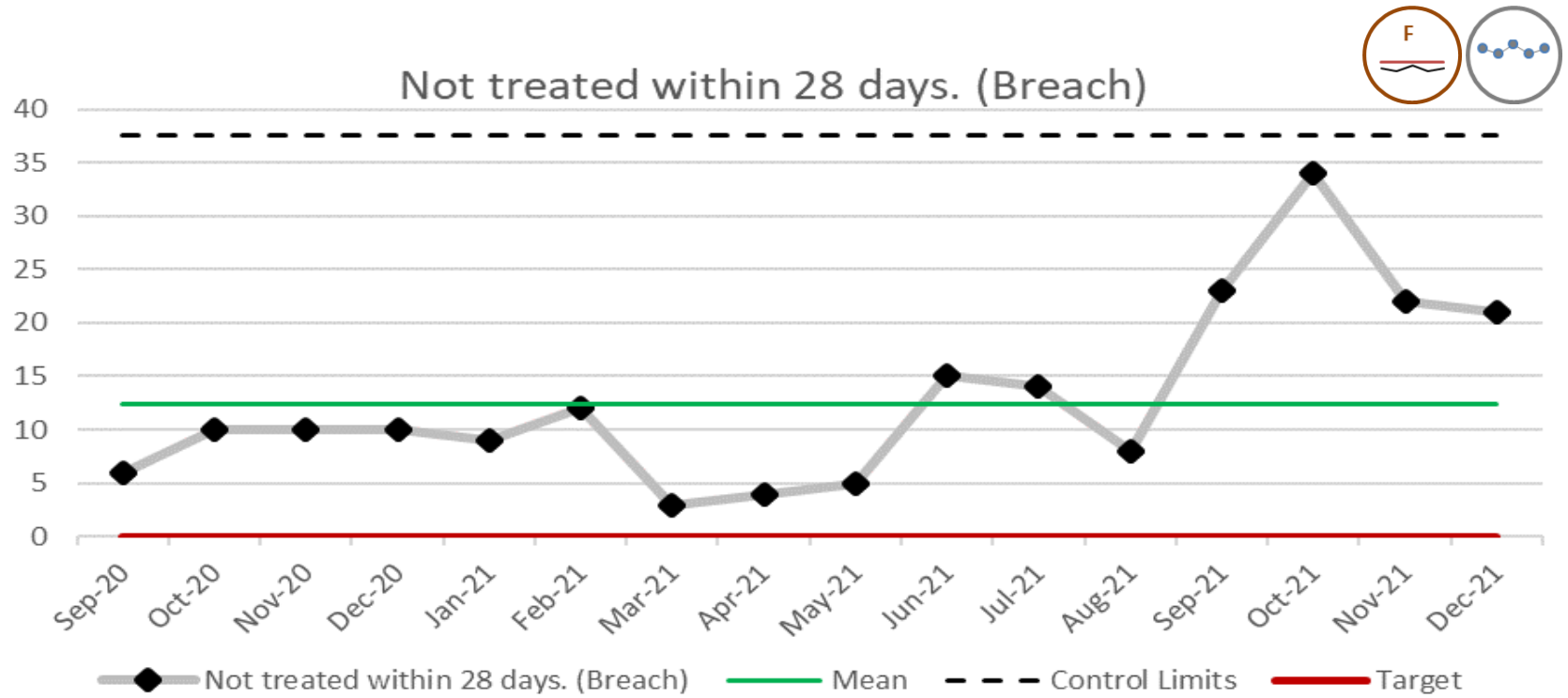

Dec-21
21
Variance Type
Metric is currently experiencing Common Cause Variation
Target
0
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:
This chart shows the number of breaches where patients have not been treated within 28 days of a last-minute cancellation. This is a requirement for same day cancellations.

What the chart tells us:
The number of breaches for December is 21 a slight reduction from last month.
The agree target of zero has not been achieved

Issues:
The Waiting List Team (WLT) spend a disproportionate amount time adjusting theatre lists due to workforce and capacity issues
Limited access to ICU Level 2 capacity due increased COVID +ve patients requiring enhanced care and an increase in emergency demand
Changing rotas to cover staffing has also impacted list availability 2 were cancelled for lack of Theatre Staff and 2 for lack of surgeon, all factors listed impact on breaches.

Actions:
642 must report and record all patients who have experienced an on day non-clinical cancellation and proactively schedule a new date.
Ensure all ICU beds are pre-booked at the pre-operative assessment stage
All on day cancellations are reported to relevant CBU via a weekly report to ensure patient re-booked within the 28-day window.
All lists will be 'locked' at 7 days

Mitigations:
To discuss opportunity to lock lists at 7 days pre op in order to ensure stability of lists, except when clinically required.
The increased number of Level 1 beds on the Grantham site will reduce the risk of cancellation yet needs improved communication to ensure all surgeons aware of opportunity at Grantham.

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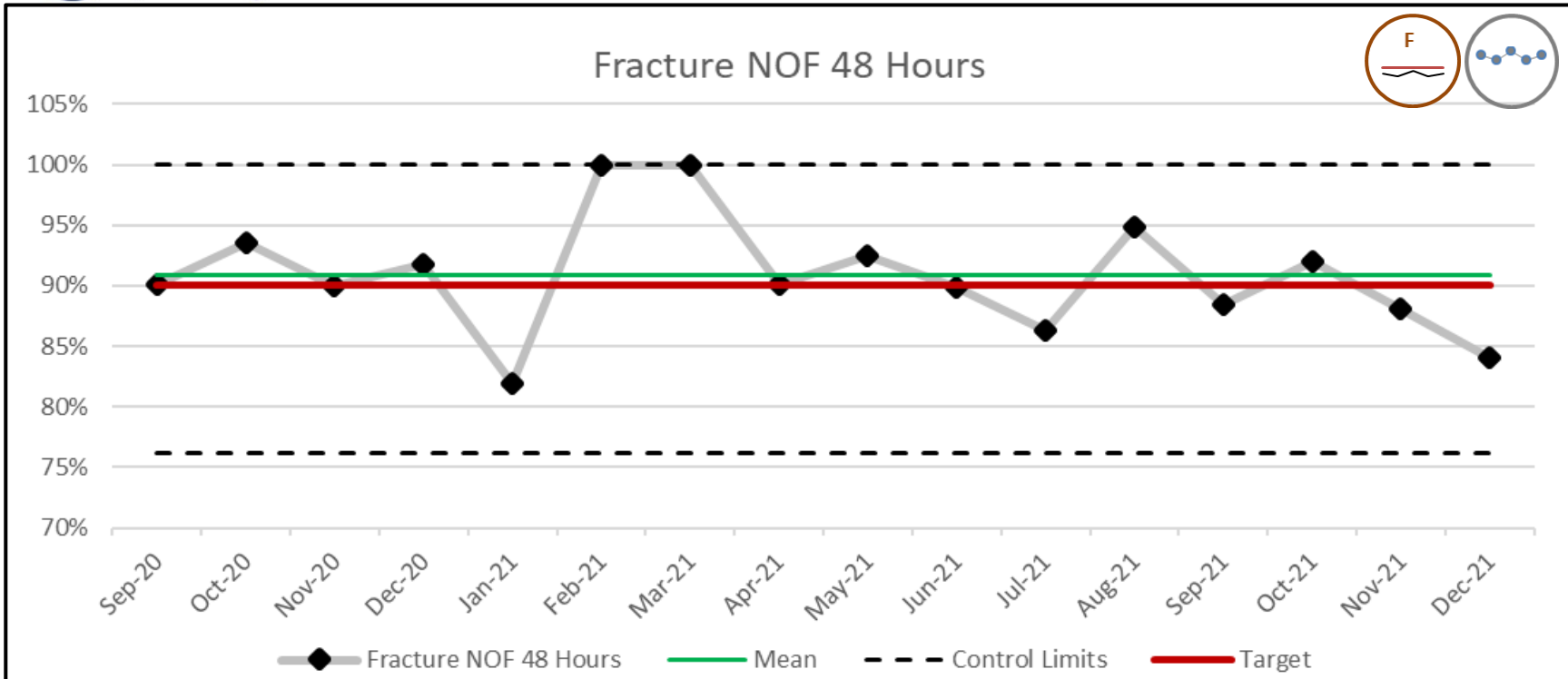

Dec-21
84%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:

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

What the chart tells us:

December performance out turned at 84% against the agree target of 90%

What the chart does not us is that PHB achieved 94.12% but LCH underperformance performance (76%) led to the Trust wide deterioration.

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.
- Shuttleworth Ward declared a staff and patient Covid outbreak in December reducing access to pathways

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.
- Alternative #NOF pathways created on Digby Ward

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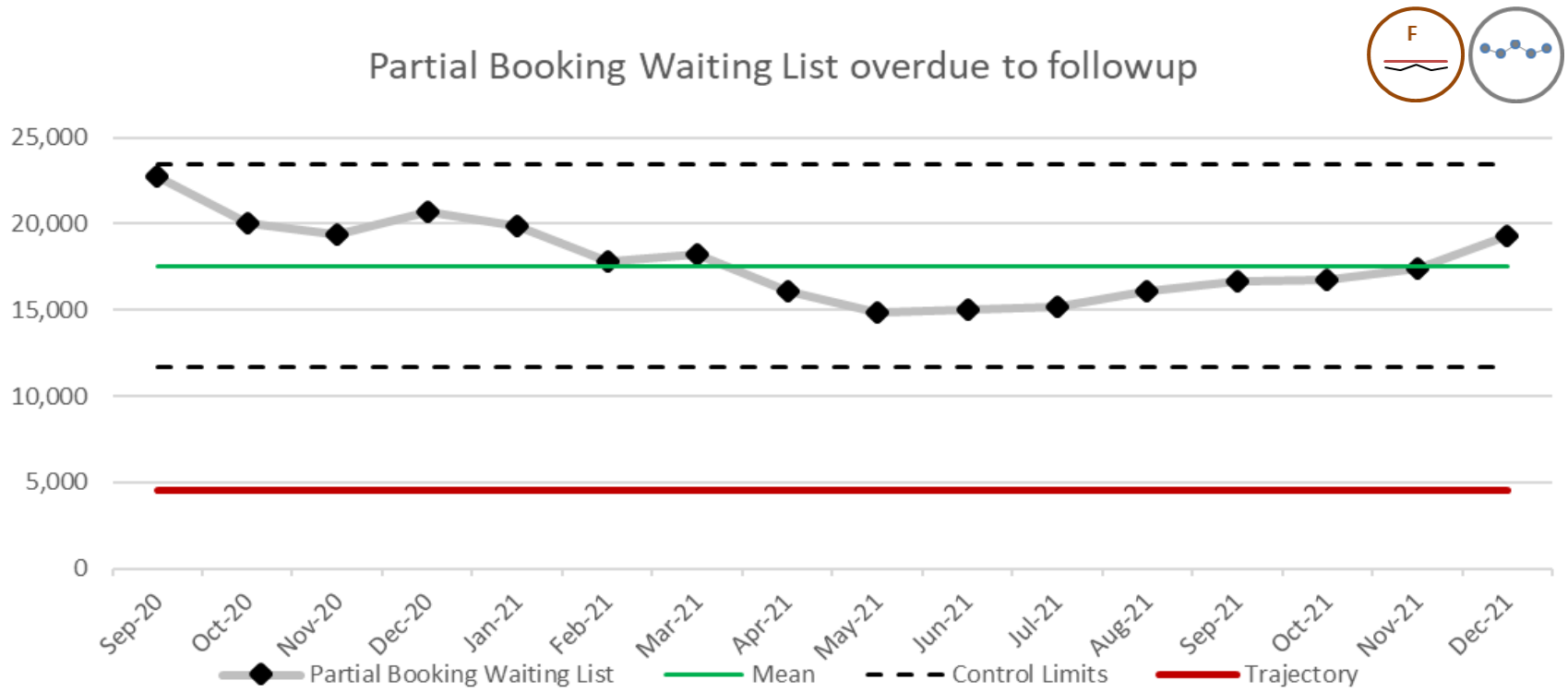

Dec-21
19,326
Variance Type
Metric is currently experiencing Common Cause Variation
Target
4,524
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

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

What the chart tells us:
We are currently at 19,326 against a target of 4,524.
Due to Covid the number of patients overdue significantly increased.
Recovery work took place and reduced the number of patients overdue but this has started to increase on an upward trend since July 2021.

Issues:
The organisation is continually pressured in a number of areas especially in urgent / emergency care that has taken priority over outpatients. The fluctuating impact of covid also has an impact on conflicting priorities, increasing demand on resources, sickness levels, staffing issues, space and aligning requirements.

Actions:
Service recovery plans produced and updated regularly. Specialities are continuing with validation, clinical triage and exploring technological solutions, including PIFU suitability.
Clinical Harm Oversight Group are challenging the specialties around the risk of harm to patients overdue on PBWL. PBWL meeting in place to challenge capacity shortfalls. A continued review is to take place about the effectiveness of the 642 process in outpatients.

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

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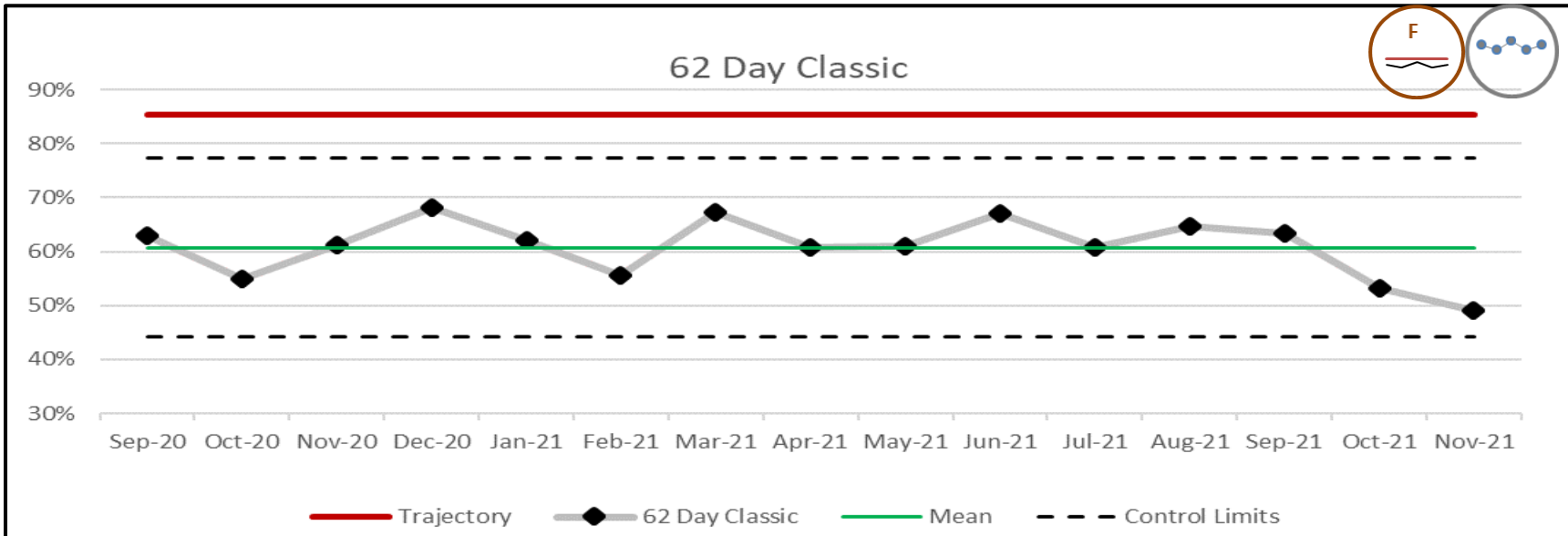


Nov-21
49.04%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
85.4%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

Background:

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

What the chart tells us:

We are currently at 49.04% against an 85.4% target.

Issues:

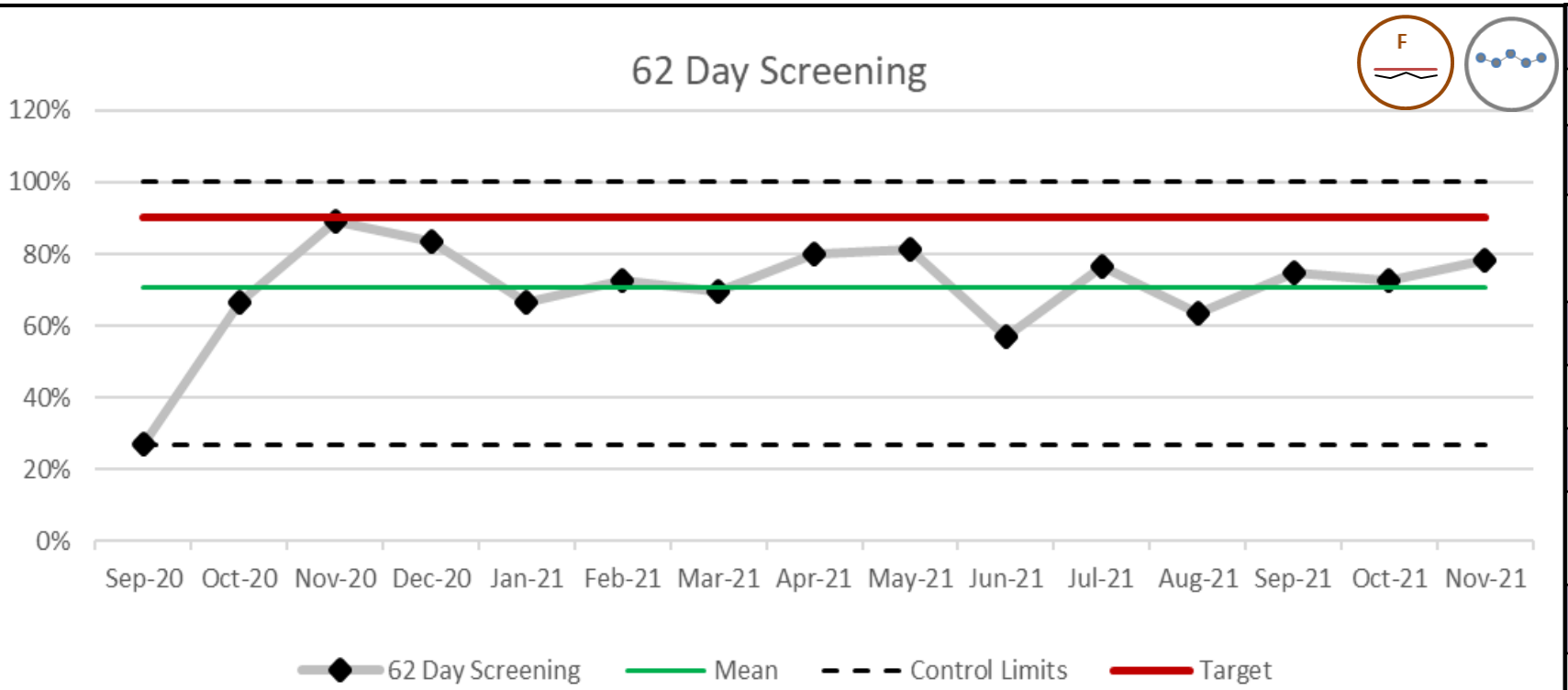
Patient engagement in diagnostic process (reluctance to visit hospitals due to perceived COVID-19 risk, including those waiting for vaccines or the 3 week 'effectiveness' period). This is continuing to reduce.
Reduced clinic throughput due to social distancing / IPC requirements, especially in waiting areas. Patient acceptance & compliance with swabbing and self-isolating requirements. Patients not willing to travel to where our service and / or capacity is. Managing backlogs significantly in excess of pre-COVID levels for Colorectal, Urology, Gynaecology, Lung, 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 of which was due to start in November 2021, but unfortunately both candidates have withdrawn. Currently there are three vacant Medical Oncologist posts which we are awaiting Royal college approval before going out to advert. We have two of these posts that are currently being covered by Locums.
Dedicated admin resource has been identified within the Colorectal, Urology, Breast, Gynae, UGI, Head & Neck and Lung CBU's to support clinical engagement. Following this model, funding was also identified for a navigator in the Dermatology CBU who has recently started in post.
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. A process is currently being designed to ensure the Pre-Diagnosis CNS is made aware of patients who are likely to be non-compliant or in need of support at the time of receipt of referral to allow for early intervention and a more efficient journey on the cancer pathway.
Negotiations to outsource some diagnostic and treatment activity to The Park BMI have been underway. This has been a challenging process so far and is not going to be an option for colorectal surgery or robotic radical prostatectomies, the areas currently greatest in demand. The introduction of the robot to Lincoln will contribute to reducing the backlog of patients awaiting robotic radical prostatectomies. Lists are due to commence on 14/02/2022.

Mitigations:

Theatre capacity is returning to Pre-covid levels. A review of colorectal theatre list scheduling in order to better align with clinician availability continues and Grantham Theatres have now returned to undertaking suitable Level 1 colorectal work. Work has commenced on building the new theatres at Grantham.
A review of the internal Gynaecology pathways is underway and Colposcopy and PMB capacity issues and throughput have now been addressed with a new locum and nurse hysteroscopist who have now started in post.



Nov-21
78.26%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
90%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

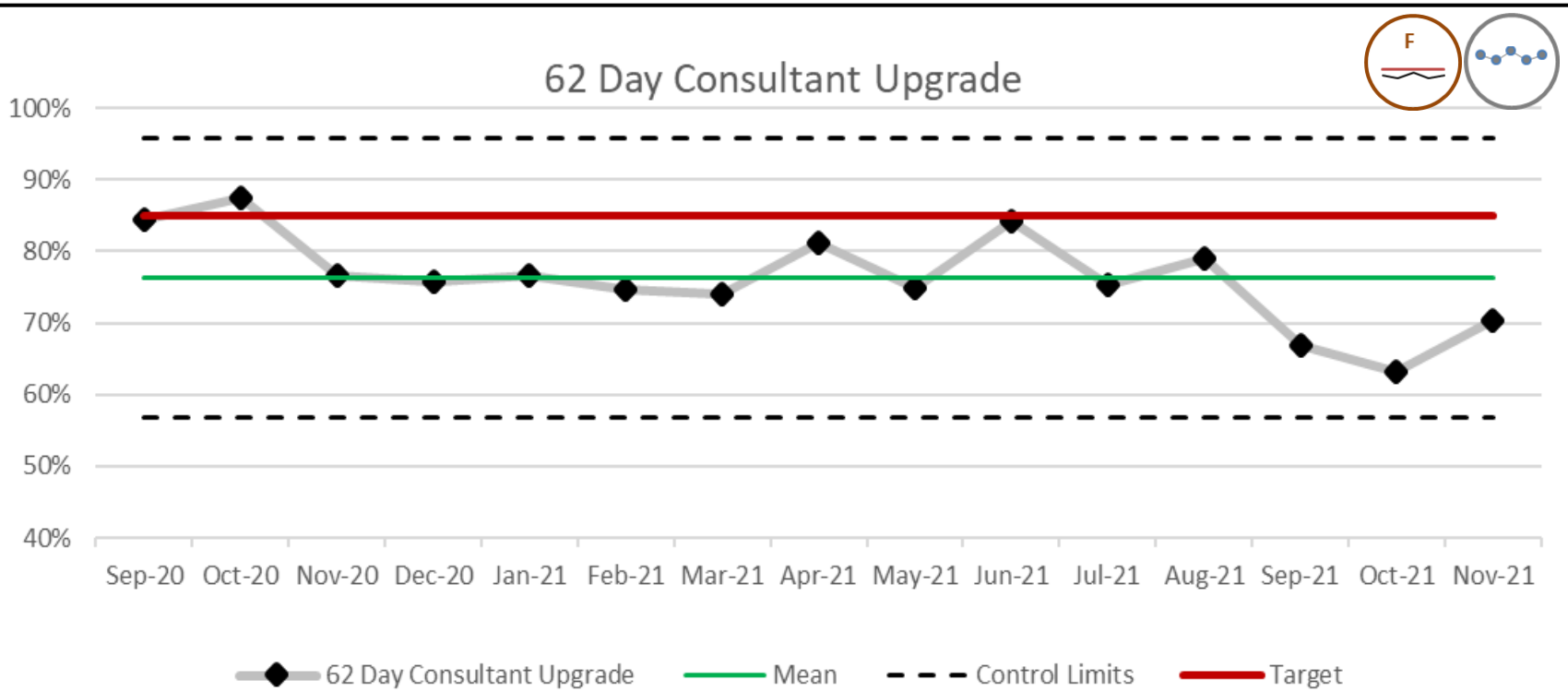
Background:
Percentage of patients to start a first treatment within 62 days of referral from an NHS cancer screening service.

What the chart tells us:
We are currently at 78.26% 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.



Nov-21
70.92%
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 70.92% against an 85% target.

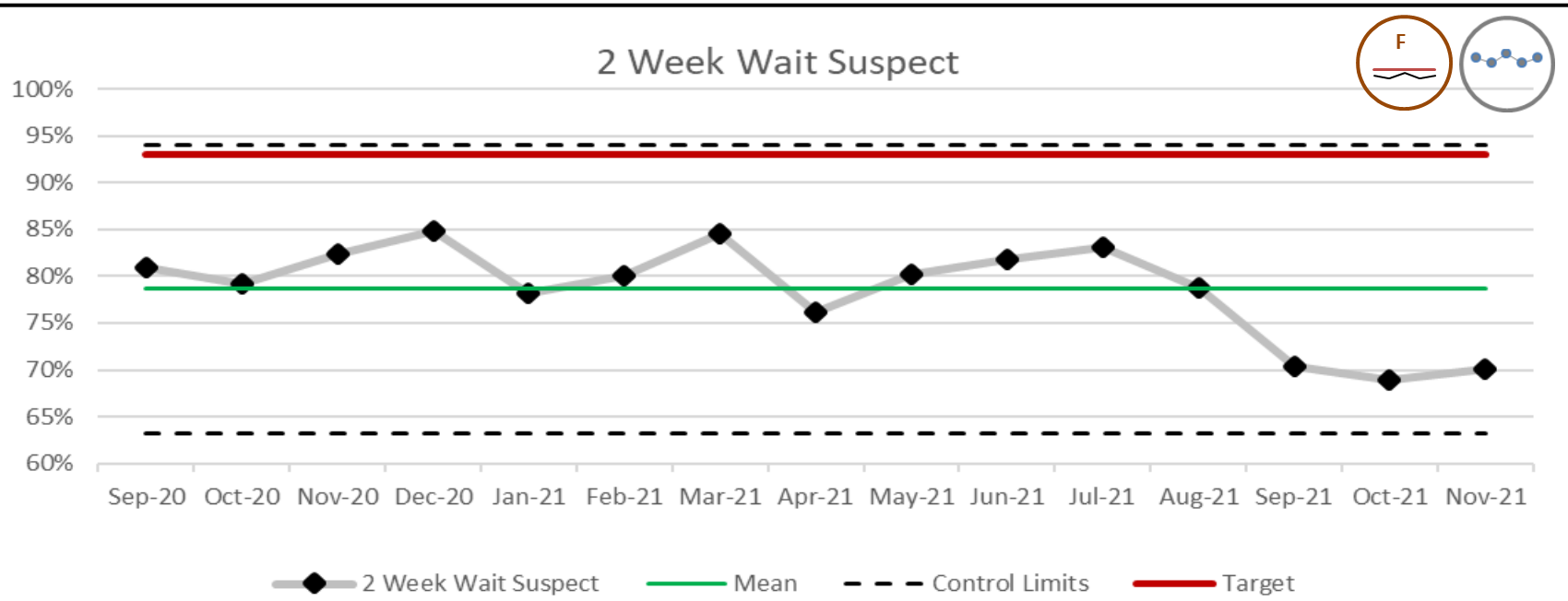
Issues:
See issues on previous page – 62 day classic.

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

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

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Nov-21
70.10%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
93%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

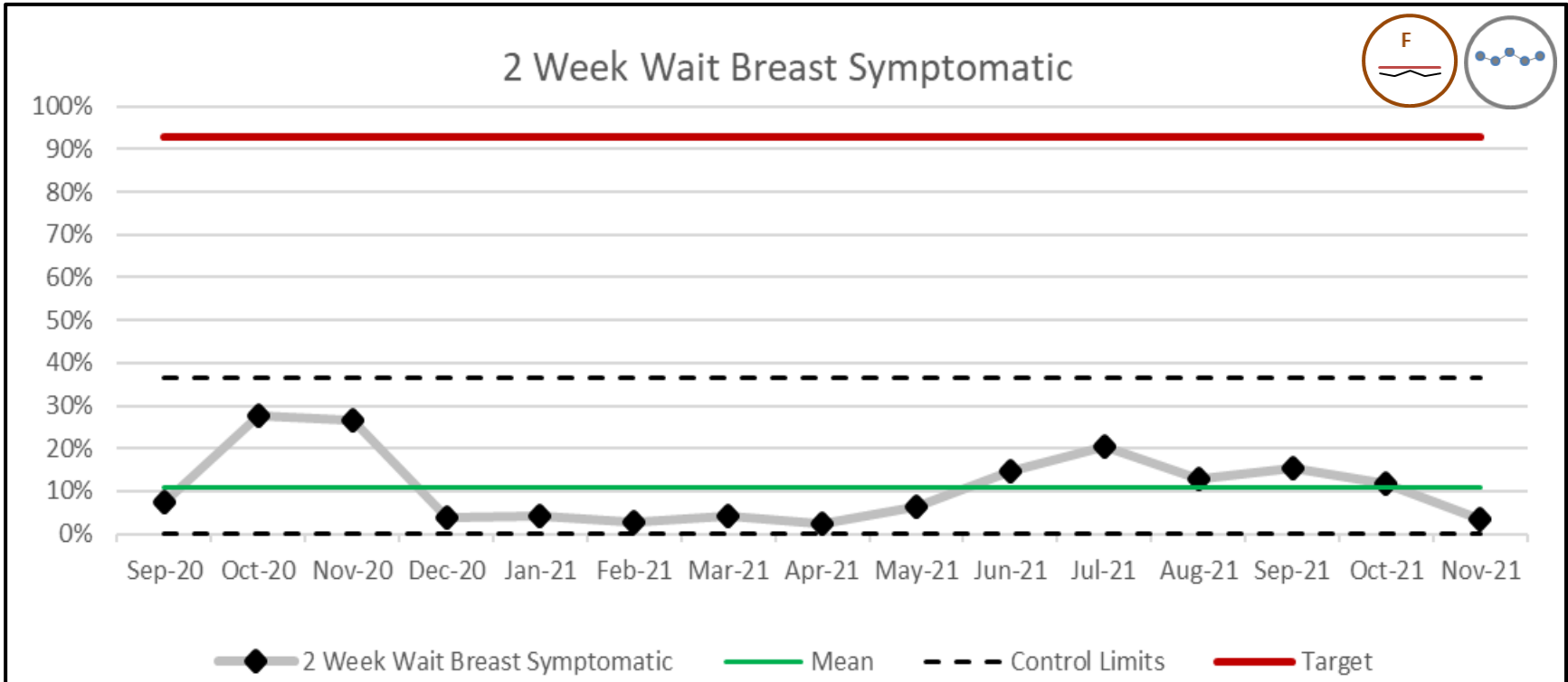
Background:
Percentage of patients seen by a specialist within two weeks of 2ww referral for suspected cancer.

What the chart tells us:
We are currently at 70.10% 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 – 35.5% of the Trust's 14 Day breaches were within that tumour site The other tumour sites that considerably under-performed include Lung (23.9%), Gynaecology (42.8%), Colorectal (72.3%), Urology (77.5%), Upper GI (87.2%), Head & Neck and Sarcoma narrowly missed out (92.3 and 92.9 respectively). Skin, Brain and Haematology 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 available.

Actions:
The Trust is actively seeking to implement RDC pathways for brain, haematuria, testicular and Upper GI by February 2022. A pathway review for gynaecology and a direct access ultrasound pathway has also been identified as a priority for 2022.
Recruitment of a new diagnostic ACP is underway to improve capacity in the Urology diagnostic clinics.
A process is currently being designed to ensure the Pre-Diagnosis CNS is made aware of patients who are likely to be non-compliant or in need of support at the time of receipt of referral to allow for early intervention/support.
These and other key action progress are tracked through the Urgent Care Cancer group chaired by the Medical Director and run with full system partner involvement.

Mitigations:
Further respiratory consultant posts will secure lung clinic capacity and support the pilot to appoint lung patients within 48 hours – 2 Lung Specialty Doctors have commenced in post in Boston. A Lung Consultant due to commence in post in January 2022 has unfortunately been delayed, a revised start date is yet to be confirmed.
A comprehensive review of Breast Services is ongoing following the final report issued by NHSI support. Breast clinic capacity has now been restored to pre-COVID levels and additional clinics to clear the backlog are being sought and will continue to be until the backlog is cleared. A mastalgia pathway is being worked up with primary care and system partners which has the potential to reduce inbound referrals by circa 15%.



Nov-21
3.26%
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 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 3.26% against a 93% target.

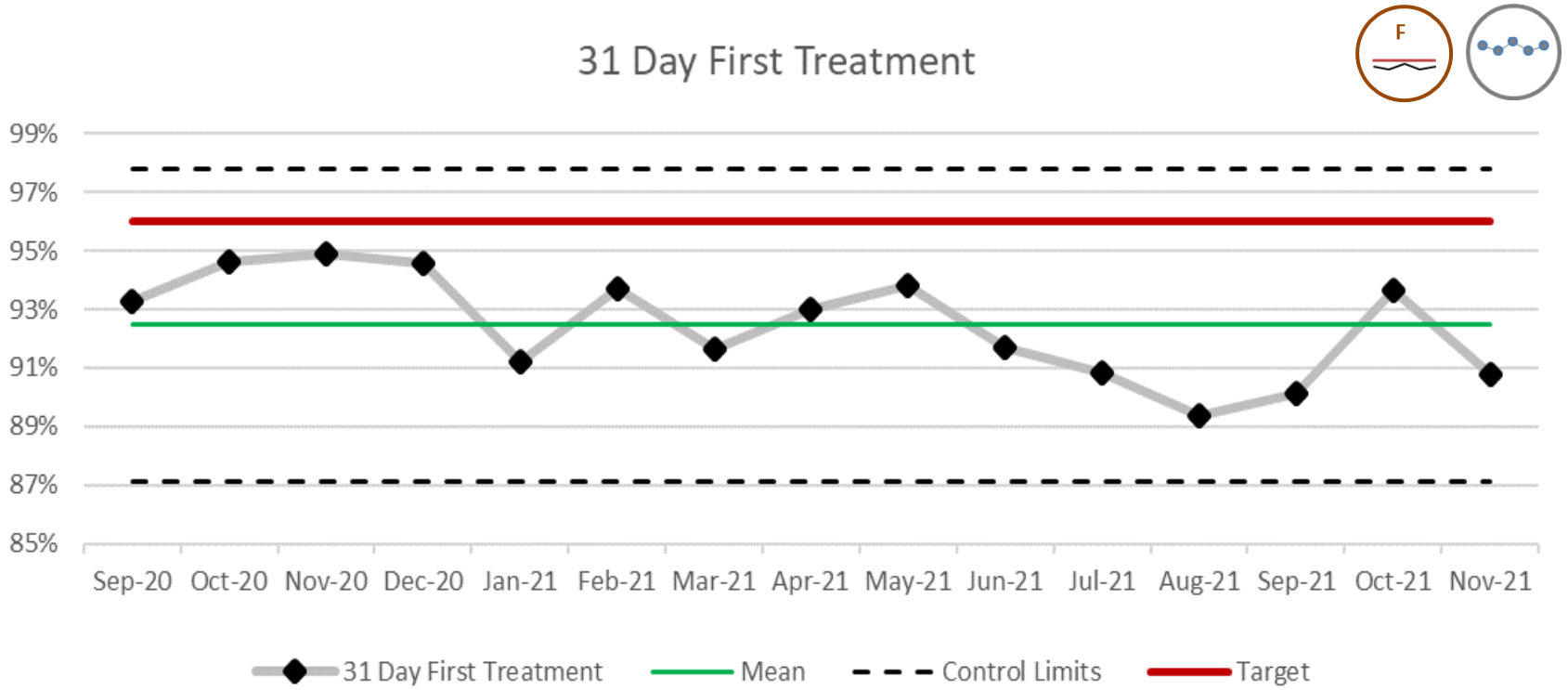
Issues:
The 14 Day Breast Symptomatic has been affected by the same impact of the Breast Service One-Stop appointment alignment issues. Reduced clinic throughput due to social distancing / IPC requirements, especially in waiting areas.

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 and will continue to be until the backlog is cleared. A mastalgia pathway is being worked up with primary care and system partners which has the potential to reduce inbound referrals by circa 15%.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Nov-21
90.76%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
96%
Target Achievement
Metric is consistently failing the target
Executive Lead
Chief Operating Officer

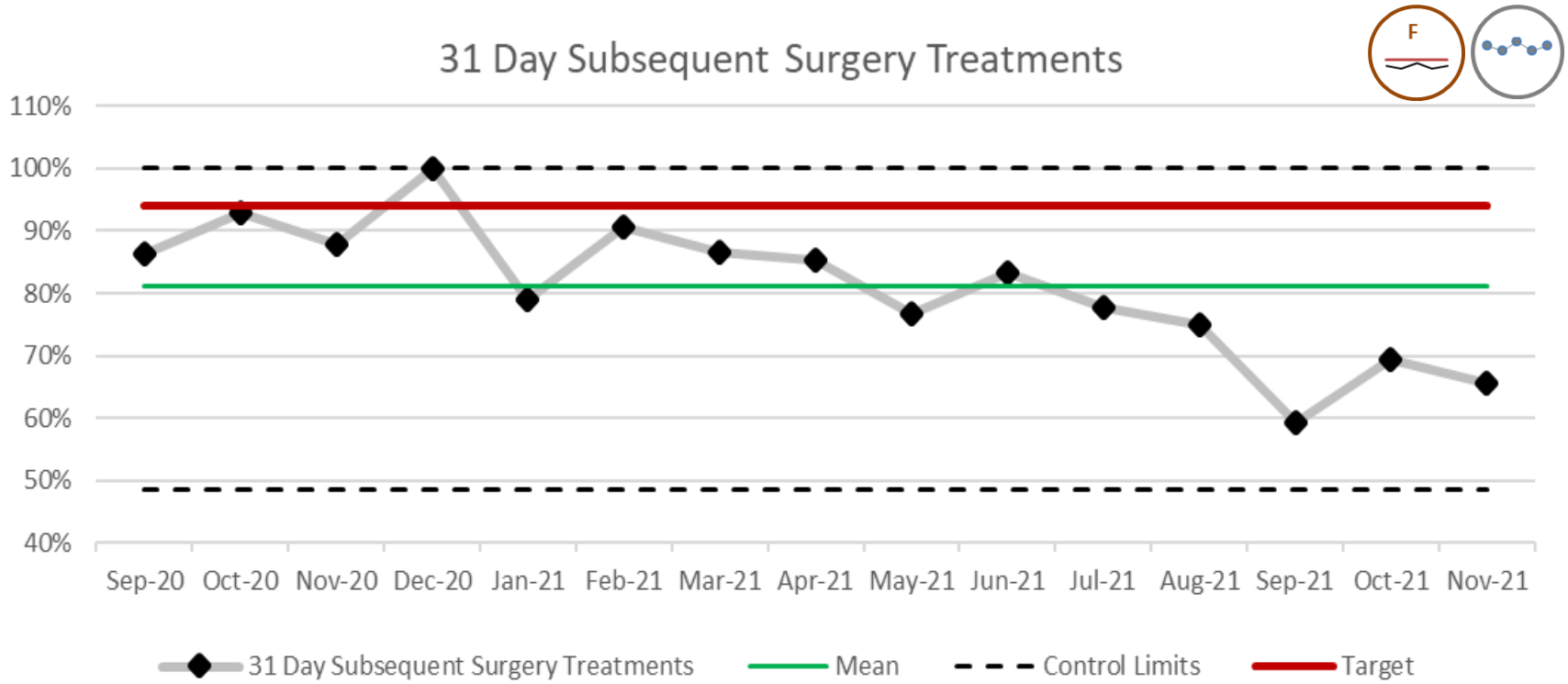
Background:
Percentage of patients treated who began first definitive treatment within 31 days of a Decision to Treat.

What the chart tells us:
We are currently at 90.76% against a 96% target.

Issues:
The failure of the 31 Day standards was primarily attributed to the reduction in theatre capacity).

Actions:
Two substantive Medical Oncologists were recruited, one of which was due to start in November 2021, but unfortunately both candidates have withdrawn. Currently there are three vacant Medical Oncologists which we are awaiting Royal college approval before going out to advert. We have two of these posts that are currently being covered by Locums.
Work has commenced on building the new theatres at Grantham.

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.
Negotiations to outsource some diagnostic and treatment activity to The Park BMI have been underway. This has been a challenging process so far and is not going to be an option for colorectal surgery or robotic radical prostatectomies, the areas currently greatest in demand. The introduction of the robot to Lincoln will contribute to reducing the backlog of patients awaiting robotic radical prostatectomies. Lists are due to commence on 14/02/2022.



Nov-21
65.63%
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 65.63% against a 94% target.

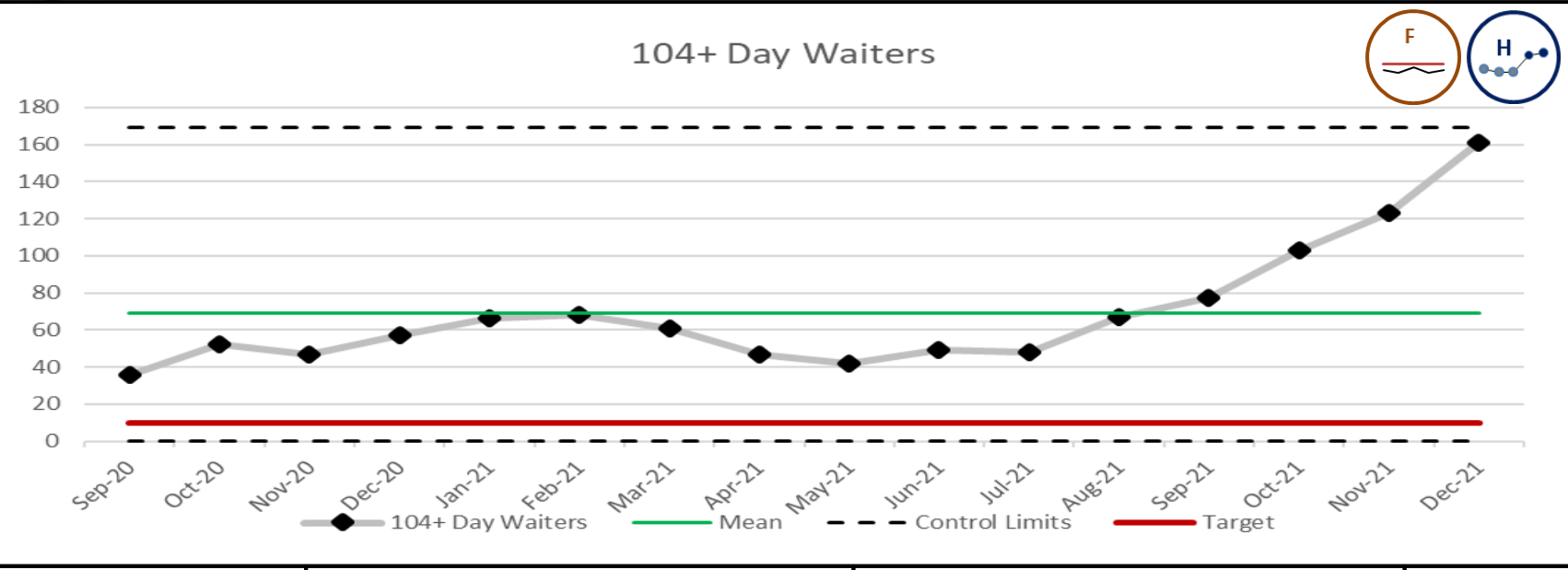
Issues:
The inability to deliver the 31 Day standards was primarily attributed to the reduction in theatre capacity. For the subsequent standards the Trust was successful in the Drug and Radiotherapy standards, failing in the Surgery standard.

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



Nov-21
161
Variance Type
Metric is currently experiencing Special Cause Variation – high trend
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 6th January the 104 Day backlog was at 161 patients. The agreed target is <10.

The current position by tumour site is as follows:- 119 Colorectal, 16 Urology, 7 Gynaecology, 6 Head & Neck, 5 each Lung and Upper GI, 1 each Breast, Haematology and Skin

Issues:

The impact of critical and major incidents on Trust activity and patient pathways.

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 available. Reduced theatre capacity across the Trust, all Specialties vying for additional sessions. Managing backlogs significantly in excess of pre-COVID levels for Colorectal, Urology, Head & Neck, Lung and Gynaecology. Lost treatment capacity due to short notice cancellation of patients (unwell on the day of treatment or day before), not allowing time to swab replacement patients. Approximately 10% 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 of which was due to start in November 2021, but unfortunately both candidates have withdrawn. Currently there are three vacant Medical Oncologist posts which we are awaiting Royal college approval before going out to advert. We have two of these posts that are currently being covered by Locums.

Dedicated admin resource has been identified within the Colorectal, Urology, Breast, Gynae, UGI, Head & Neck and Lung CBU's to support clinical engagement. Following this model, funding was also identified for a navigator in the Dermatology CBU who has recently started in post.

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

Mitigations:

Theatre capacity is returning to Pre-covid levels. A review of colorectal theatre list scheduling in order to better align with clinician availability continues and Grantham Theatres have now returned to undertaking suitable Level 1 colorectal work. Work has commenced on building the new theatres at Grantham...

Negotiations to outsource some diagnostic and treatment activity to The Park BMI have been underway. This has been a challenging process so far and is not going to be an option for colorectal surgery or robotic radical prostatectomies, the areas currently greatest in demand. The introduction of the robot to Lincoln will contribute to reducing the backlog of patients awaiting robotic radical prostatectomies. Lists are due to commence on 14/02/2022.

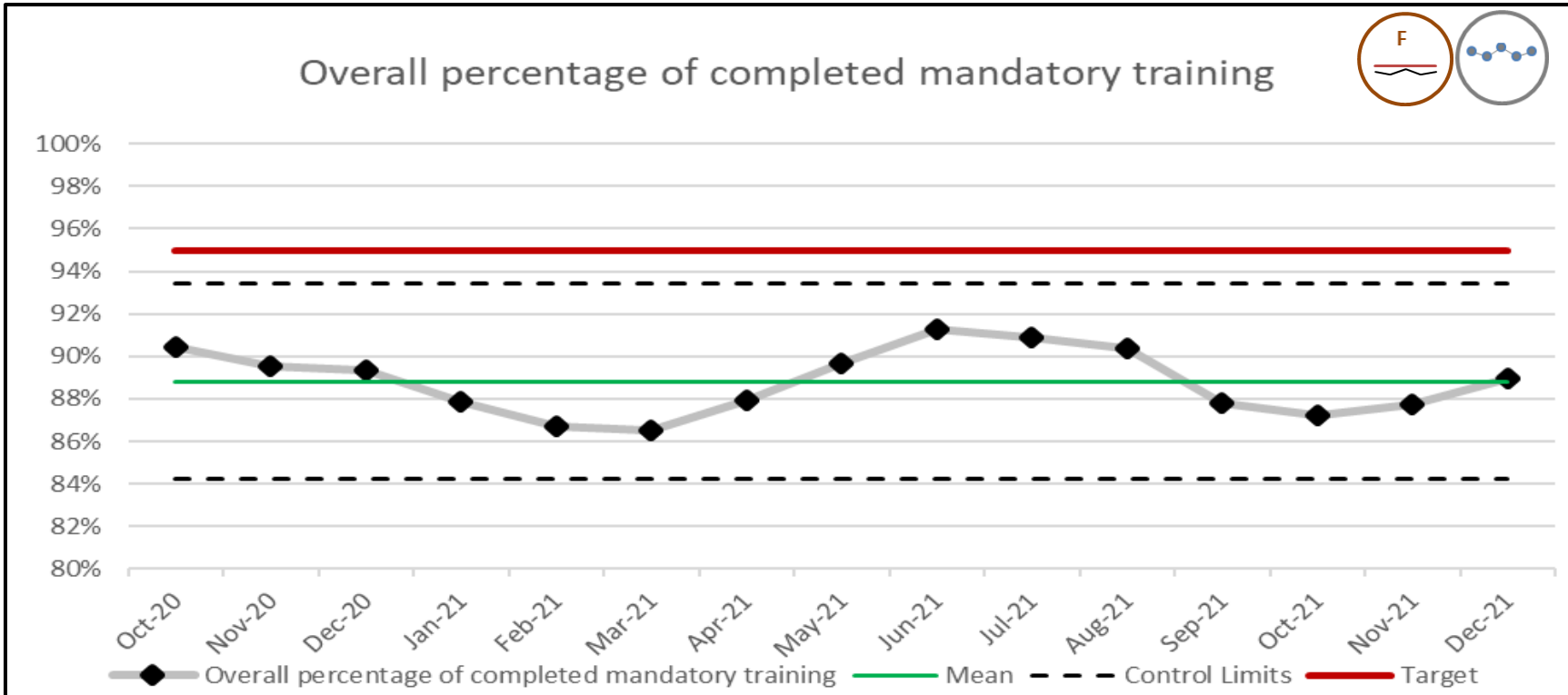
A process is currently being designed to ensure the Pre-Diagnosis CNS is made aware of patients who are likely to be non-compliant or in need of support at the time of receipt of referral to allow for early intervention and a more efficient journey on the cancer pathway.

PERFORMANCE OVERVIEW - WORKFORCE

5 Year Priority	KPI	CQC Domain	Strategic Objective	Responsible Director	In month Target	Oct-21	Nov-21	Dec-21	YTD	YTD Trajectory	Latest Month Pass/Fail	Trend Variation	Kitemark
A Modern and Progressive Workforce	Overall percentage of completed mandatory training	Safe	People	Director of HR & OD	95%	87.25%	87.76%	88.94%	89.09%				
	Number of Vacancies	Well-Led	People	Director of HR & OD	12%	10.28%	11.16%	11.18%	10.85%				
	Sickness Absence	Well-Led	People	Director of HR & OD	4.5%	5.31%	5.29%	5.20%	5.12%				
	Staff Turnover	Well-Led	People	Director of HR & OD	12%	13.69%	13.61%	13.99%	12.51%				
	Staff Appraisals	Well-Led	People	Director of HR & OD	90%	52.09%	51.74%	52.40%	63.04%				

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Dec-21
88.94%
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

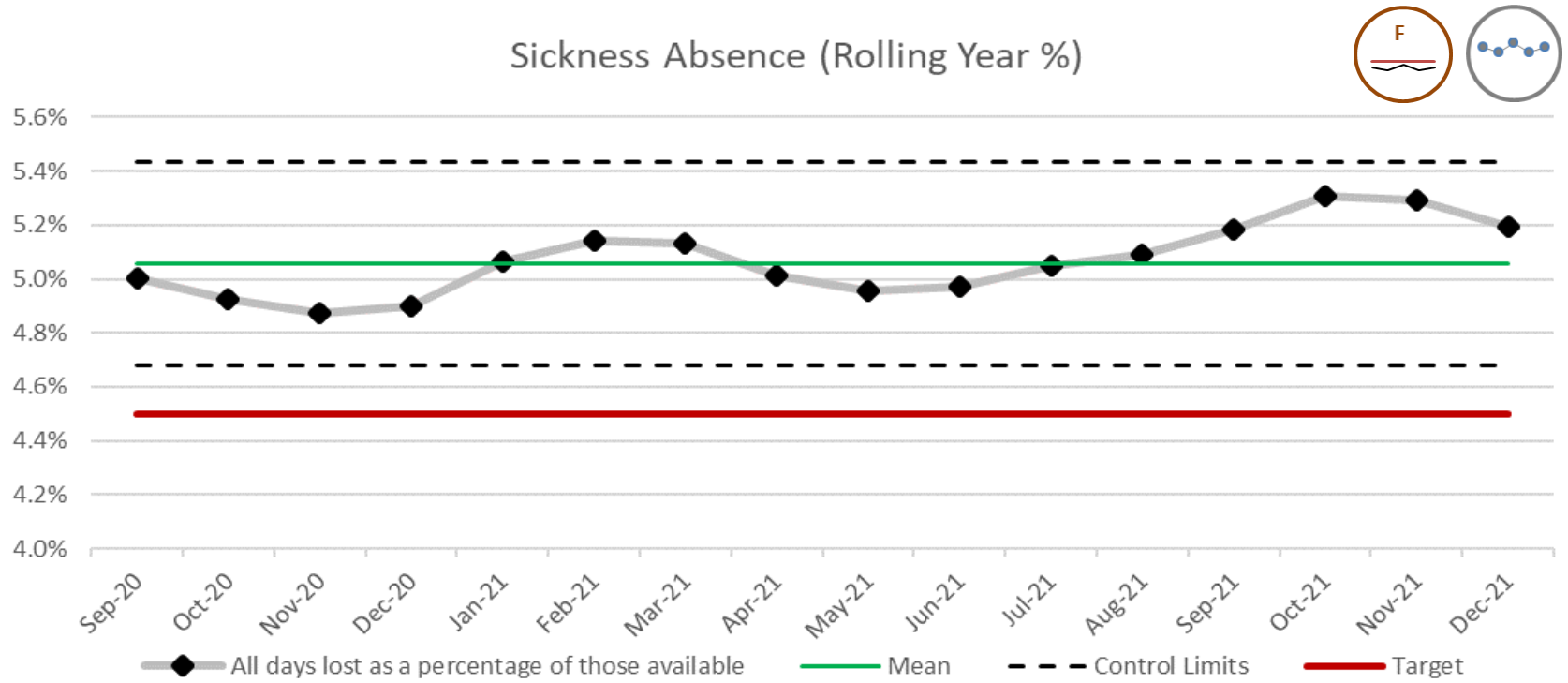
Background:
Overall percentage of completed mandatory training.

What the chart tells us:
Mandatory training saw a slight increase over the past month but with the difficult staffing situation over Christmas this is predicted to dip again next month.

Issues:
- Protected time for learning continues to be a challenge for staff – especially front line staff.
- All non-essential training continues to be stood down.
- Education and Learning Group has now been stood down for the 8 month consecutively.

Actions:
- With the lack of a central learning and development team a risk has been added on the risk register.
- Need for a discussion around protected time for training.

Mitigations:
See actions



Dec-21
5.20%
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:
Although the trend has reduced in month the percentage is still high and above the target of 4.5%.

Issues:

- COVID absences increase in numbers of staff absent and patient numbers.
- This is reflective in outbreaks in schools and care homes and therefor back into homes
- Absences due to seasonal infections are on the rise.

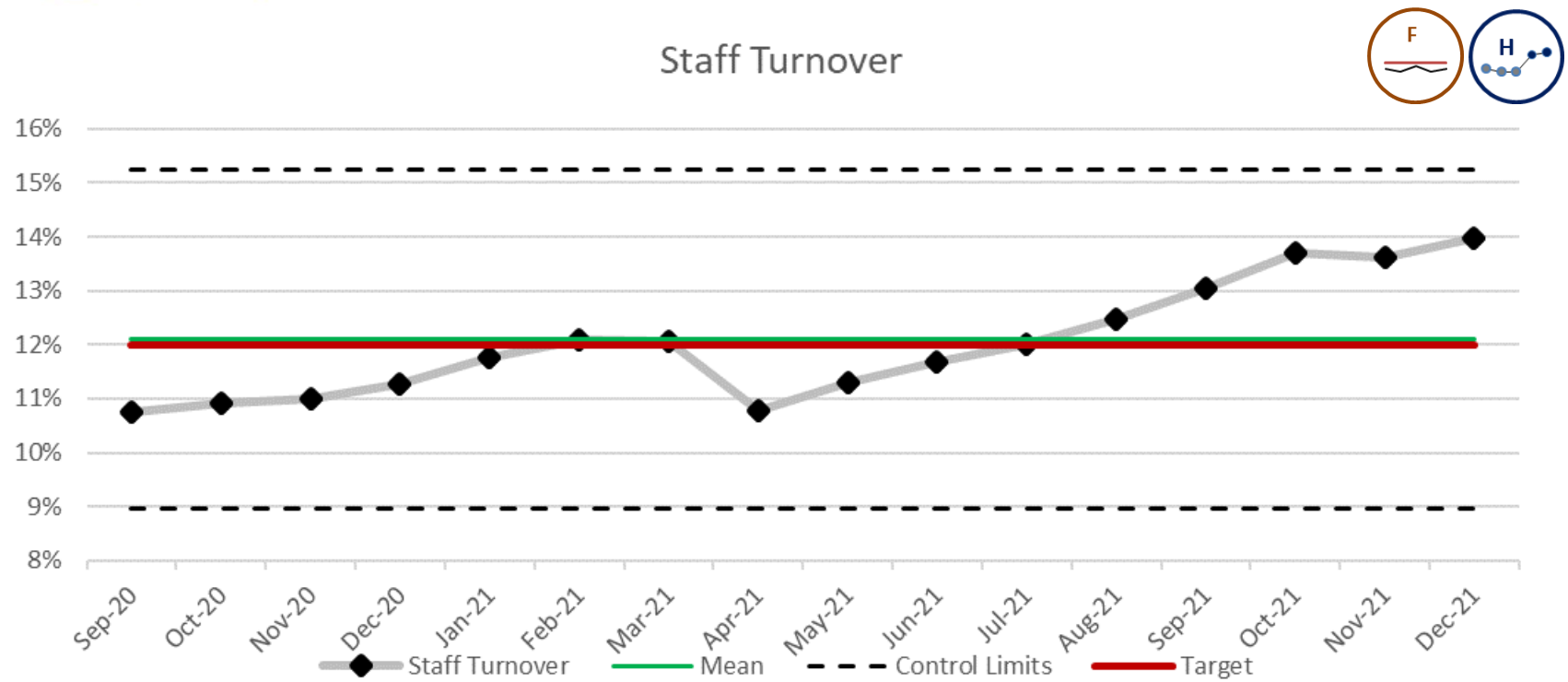
Actions:

- The implementation of the revised isolation periods means staff do not have to isolate for long periods when they can return to work safely.
- An enhanced wellbeing offer is in the final stages of being presented for approval to support the increase in staff suffering with mental health issues attributed by the pandemic.
- Relaunch of the redeployment hub
- Relaunch of the workforce cell
- Free Food provision for Patient Facing Staff

Mitigations:
See Actions.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust



Dec-21
13.99%
Variance Type
Metric is currently experiencing Special Cause Variation – high trend
Target
12%
Target Achievement
Metric is failing to target
Executive Lead
Director of HR & OD

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

What the chart tells us:
As expected, turnover rates continue to steadily creep up. Other partners in the system and Trusts regionally are also seeing similar increases in turnover.

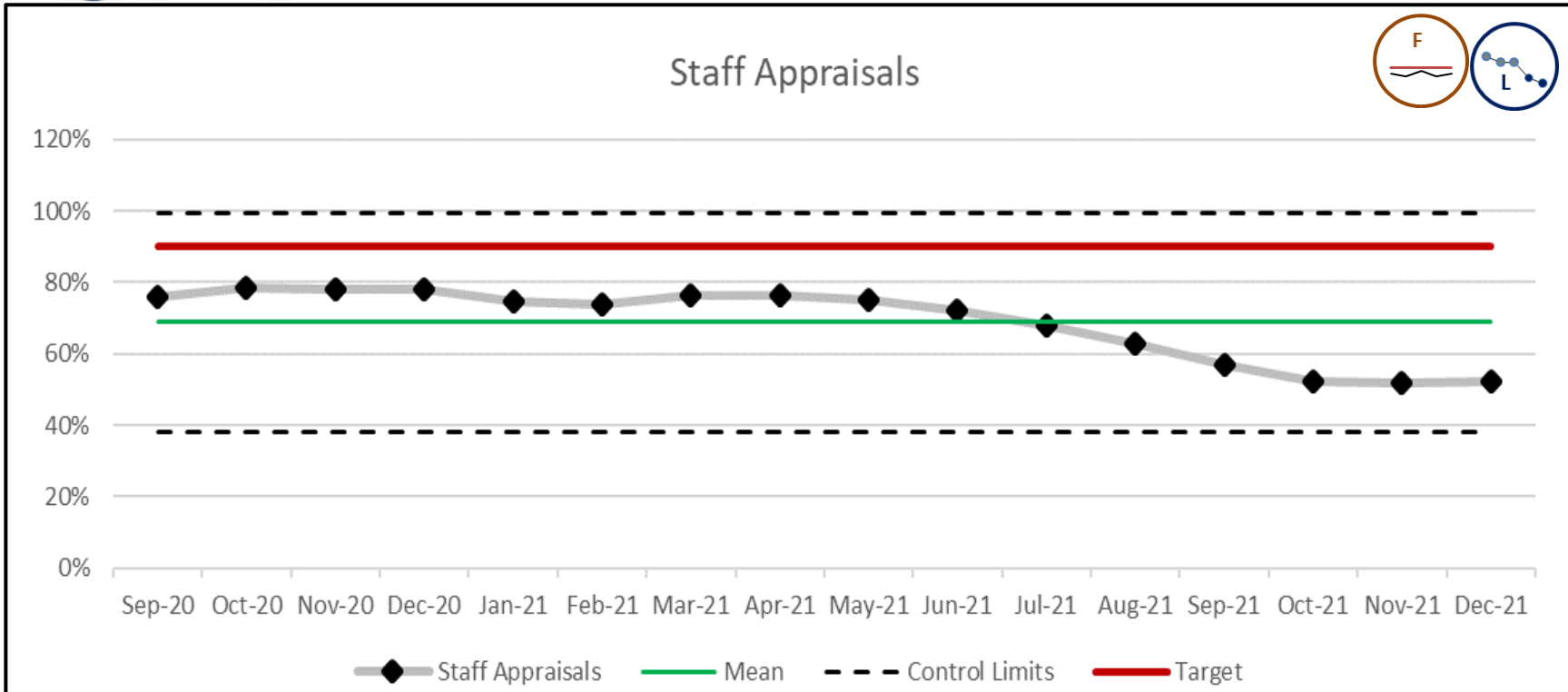
Issues:
Analysis of exit survey data shows (completion rate of has steadily dropped over the past 3 months):

- Lack of flexible working opportunities continues to be one of the main reasons for people leaving.
- Lack of development opportunities is another key reason.

Actions:

- Awaiting details from the recent staff survey data which will throw more light on the turnover situation.
- Working with the ICT team to create a digital exit survey to increase the completion rate.

Mitigations:
See actions



Dec-21
52.40%
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 52.4%.

What the chart tells us:
Operational pressures and staffing challenges continue to impact appraisal completion rates. In fact corporate departments are even lower at 48.71%.

Issues:

- Operational pressures are causing an impact on completion.
- Message understood by staff is that non-essential meetings are being stood down including appraisal discussions.

Actions:

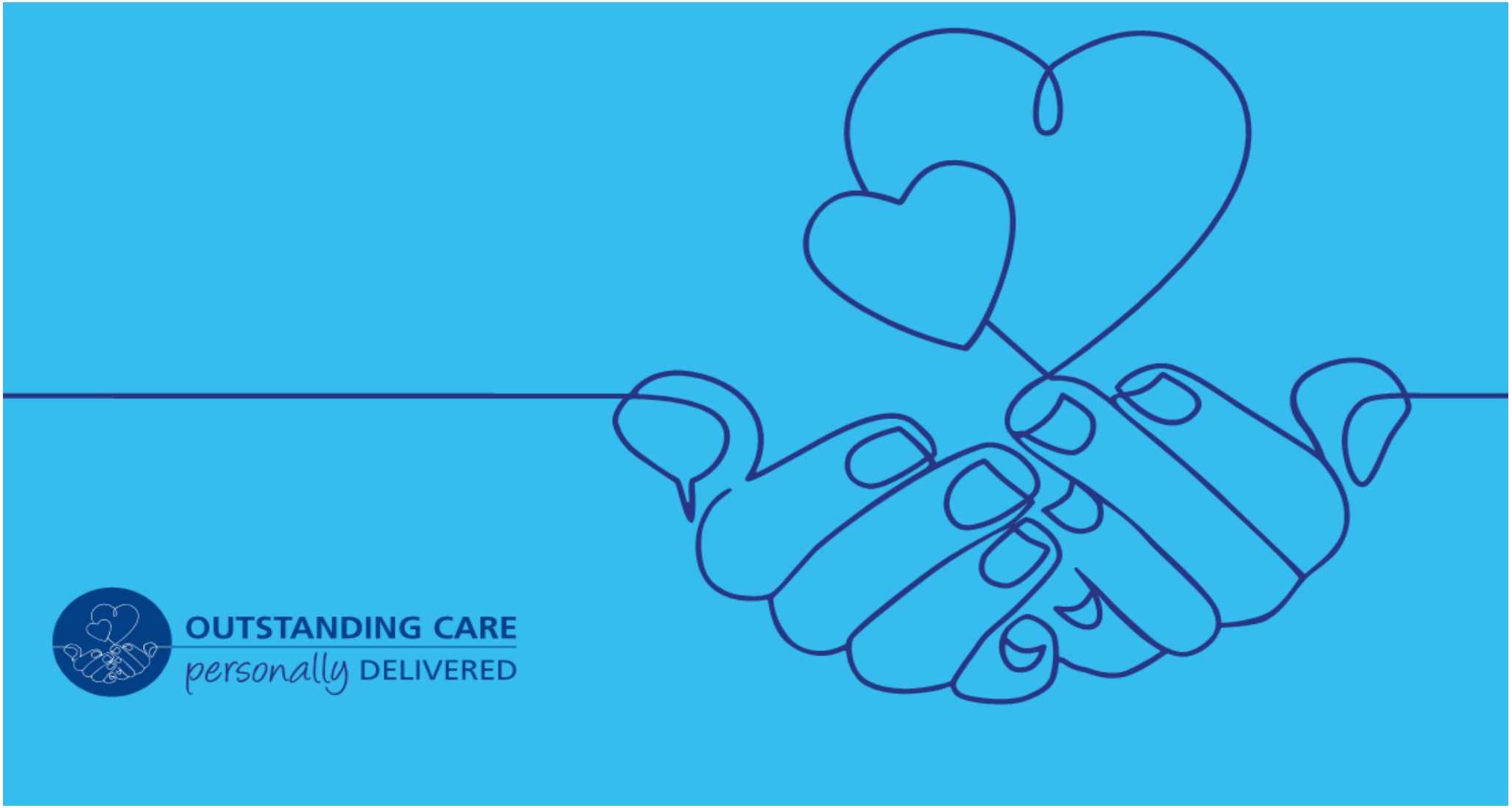
- WorkPAL deep dive currently underway to understand issues with system engagement and how this can be improved
- Appraisal completion to be focussed through the divisions regardless of operational pressures – strong message to go out from Director of People and OD to the divisions.

Mitigations:

- A report will be published to TLT once the deep dive exercise is complete.

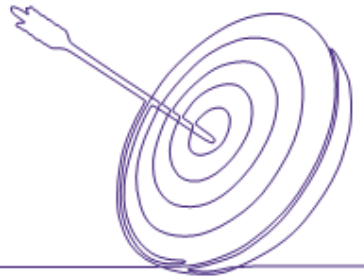
Financial Position Month 9 (2021/22)
Finance Report
5 Year Priority – Efficient Use of Resources

NHS
United Lincolnshire Hospitals
NHS Trust



Quality | Operational Performance | Workforce | Finance

Finance Spotlight Report (Headlines)



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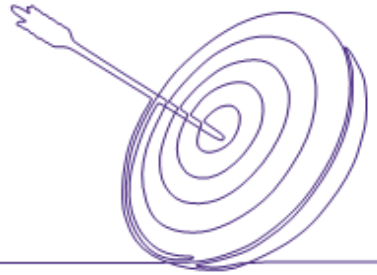
	Current Month			Year To Date		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
Operating income from patient care activities	53,018	52,358	(660)	460,655	462,855	2,199
Other operating income	2,738	2,833	95	23,978	25,156	1,178
Employee expenses	(36,155)	(37,142)	(987)	(316,456)	(324,574)	(8,118)
Operating expenses excluding employee expenses	(19,037)	(17,918)	1,119	(160,894)	(157,073)	3,821
Net Finance Costs	(620)	(191)	429	(5,687)	(5,284)	403
Other gains/(losses) including disposal of assets	0	0	0	0	123	123
Surplus/(Deficit) For The Period/Year	**(56)**	**(60)**	**(4)**	**1,596**	**1,202**	**(394)**
Add back all I&E impairments/(reversals)	0	0	0	0	93	93
Remove capital donations/grants I&E impact	56	61	5	204	505	301
Adjusted financial performance surplus/(deficit)	**0**	**0**	**0**	**1,800**	**1,800**	**(0)**

- The Lincolnshire system delivered a £2.0m surplus in H1; the system position in H1 included a surplus of £1.8m delivered by the Trust. At the time the Month 7 position was reported, the national planning process was not complete, and the Lincolnshire system had not agreed or submitted its financial plan for H2.
- The Lincolnshire system has submitted a break-even position for H2 including delivery of £20m of efficiency savings. As part of the system plan, the Trust plans a break-even position in H2 including delivery of £6.0m of efficiency savings.
- The above table shows that the Trust delivered a break even position in Month 9, and the Trust has YTD delivered a surplus of £1.8m.

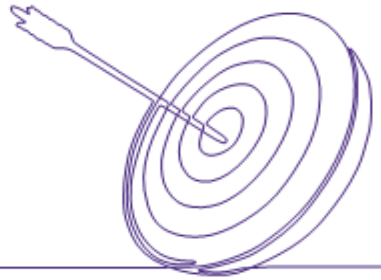
Finance Spotlight Report (Key areas of focus - Income)



United Lincolnshire Hospitals NHS Trust

- The overall YTD Income position at Month 9 is £3.4m favourable to plan:
  - **£4.5m favourable movement re Pay award** – This movement reflects the fact that the Trust's H1 income position includes unplanned income of £4.5m for the cost of the pay award; funding for the cost of the pay award in H2 is included within the Trust's H2 income plan.
  - **£1.9m favourable movement re other Patient Care Income** – The overall movement is driven by passthrough.
  - **£4.2m adverse movement re ERF/ERF stretch** – This movement reflects the fact that achievement of ERF was £4.2m lower than planned in H1; the financial plan for H1 assumed ERF income of £7.6m, but the Trust only achieved £3.4m of ERF income; ERF stretch of £1.56m has been achieved in the current month in line with plan.
  - **£1.2m favourable movement re Other Operating Income** – made up of £0.5m of additional top up funding (in relation to Covid) which is offset by additional expenditure, and £0.7m in relation to variable income streams such as non patient care recharges, car parking income and catering income for which there is some offset in expenditure.
- Shadow monitoring of activity on a Tariff basis determined that actual activity of £33.4m was delivered in the current month.

Finance Spotlight Report (Key areas of focus - Pay)



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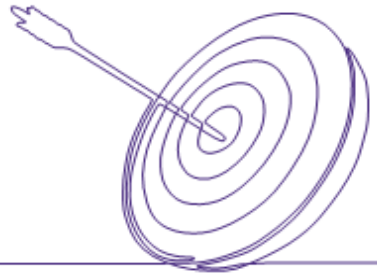
United Lincolnshire Hospitals
NHS Trust

- **The overall YTD Pay position is £8.1m adverse to plan**:
  - **£4.5m adverse movement re pay award** – This movement reflects the fact that the Trust's H1 Pay position includes unplanned expenditure of £4.5m for the cost of the pay award; funding for the cost of the pay award in H2 is included within the Trust's H2 expenditure plan.
  - **£2.6m adverse movement re Pay CIP delivery** – Savings delivery in H1 was £1.8m lower than planned, including non recurrent Pay savings of £0.6m; Savings delivery to date in H2 is £0.8m lower than planned, including non recurrent Pay savings of £0.2m.
  - **£1.1m adverse movement re Restore and Covid** – The additional costs of Covid in H1 (including the cost of bank incentive rates) were £2.0m higher than planned, but this pressure was mitigated in part by £0.9m lower than planned costs in relation to Restore; it has not been possible to provide an update re Covid and Restore costs in H2 for the Month 9 report.
  - **£0.1m favourable movement overall re other items** – A number of other adverse movements (e.g. expenditure related to top-up funding) have been more than mitigated by other upsides in the position.
- **Pay expenditure of £37.1m in December is £0.5m higher than £36.7m in November**; Substantive Pay was £0.4m higher driven by Bank Holiday enhancements, and an increase of £0.2m in Bank Pay driven by Bank Incentive rates was partly offset by a reduction of £0.1m in Agency Bank Pay.

Finance Spotlight Report (Key areas of focus - Other)



United Lincolnshire Hospitals NHS Trust

- The overall YTD Non Pay position is £3.8m favourable to plan, which is an improvement of £1.1m compared to the reported position at Month 8; overall, Non Pay expenditure of £17.9m in December was unchanged compared to November.

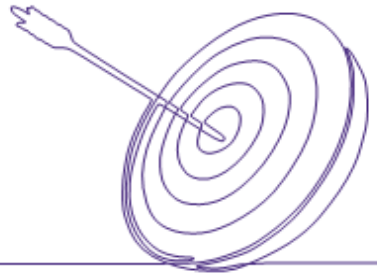
- In H1, while the Trust planned CIP savings of £6.4m and delivered £6.2m in relation to 2021/22 savings schemes, £5.2m of the savings made were non recurrent. The Trust's original plan required a further £9m of savings in H2, but the H2 plan submitted is based upon delivery of £6m in H2. Against the H2 CIP plan, the Trust has delivered savings of £2.7m, which in line with plan; CIP delivery, though, continues to be supported by non recurrent savings. For more details on CIP, see the attached CIP report.

- Capital funding levels for 2021/22 agreed through Trust Board & FPEC, showed a plan of c£49.6m at M8. TIF and SCR fund changes (c£6.0m reduction), offset by new Digital funding (c£1.4m) have decreased the 'live' capital envelope to c£45.0m as at the end of M9.

- The capital plan submitted to NHSE/I has a year-to-date plan at M9 of c£22.2m. Spend incurred at M9 equated to c£12.9m, therefore schemes are behind plan by c£9.3m externally – this month the variance to plan has improved marginally due to in-month spend. When comparing to the agreed forecasting information that has created the 'Internal Plan' for monitoring purposes, this shows that schemes are c£5.8m behind plan. Please see separate capital report for details.

- The month end cash balance is £62.6m which is a reduction of £8.5m against cash at 31 March 2021

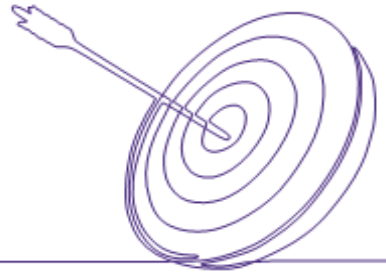
Finance Spotlight Report (Key areas of focus - Other)



United Lincolnshire Hospitals NHS Trust

- As at month 8 The Trust has maintained its forecast to deliver the financial plan (£1.8m surplus). However the mounting operational changes required to support the Trust addressing the COVID and wider NEL pressures over the coming weeks create a financial risk. In the H2 financial plan submission supporting paper (brought to FPEC last month) an indicative risk of 'winter' of £3m was identified, further forecast analysis is contained in this report.

Finance Dashboard



NHS
United Lincolnshire Hospitals
NHS Trust

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

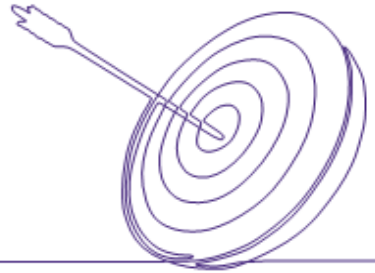
Clinical Services
People
Clinical Support Services
Corporate Services, Procurement, Estates and Facilities
Finance

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

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

Finance and use of resources rating	Full Year	Full Year	Full Year	Actual	Forecast
	31/03/2019	31/03/2020	31/03/2021	DEC 2021	31/03/2022
Capital service cover metric	(10.40)	(1.73)	0.06	2.12	3.36
Capital service cover rating	4	4	4	2	1
Liquidity metric	(98.73)	(128.28)	3.71	2.87	3.09
Liquidity rating	4	4	1	1	1
I&E margin metric	(19.71%)	(7.62%)	0.38%	0.37%	0.28%
I&E margin rating	4	4	2	2	2
Agency metric	77.00%	110.00%	113.00%	117.00%	116.00%
Agency rating	4	4	4	4	4
I&E margin: distance from financial plan - metric	(2.80%)	0.70%	n/a	0.37%	0.00%
I&E margin: distance from financial plan - rating	4	1	n/a	1	1

Balance Sheet



NHS
United Lincolnshire Hospitals
NHS Trust

	31 March 2021	31 December 2021	
		Plan	Actual
	£000	£000	£000
Intangible assets	4,600	3,238	3,217
Property, plant and equipment	247,119	259,403	249,916
Receivables	2,790	2,781	2,692
Total non-current assets	**254,509**	**265,421**	**255,825**
Inventories	6,510	6,728	7,121
Receivables	25,935	26,840	15,271
Cash and cash equivalents	54,042	26,063	62,564
Total current assets	**86,487**	**59,631**	**84,956**
Trade and other payables	(69,643)	(50,897)	(69,651)
Borrowings	(402)	(1,108)	(555)
Provisions	(2,056)	(2,178)	(2,196)
Other liabilities	(1,587)	(2,943)	(527)
Total current liabilities	**(73,688)**	**(57,126)**	**(72,929)**
Total assets less current liabilities	**267,308**	**267,927**	**267,852**
Borrowings	(3,624)	(4,437)	(3,471)
Provisions	(4,069)	(4,082)	(3,941)
Other liabilities	(12,075)	(11,697)	(11,698)
Total non-current liabilities	**(19,768)**	**(20,216)**	**(19,110)**
Total assets employed	**247,540**	**247,711**	**248,742**
Financed by			
Public dividend capital	677,570	677,570	677,568
Revaluation reserve	27,522	27,000	26,998
Other reserves	190	190	190
Income and expenditure reserve	(457,742)	(457,049)	(456,014)
Total taxpayers' equity	**247,540**	**247,711**	**248,742**

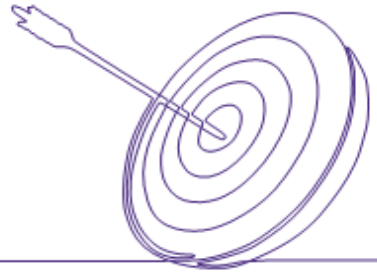
Note 1: Trade and other receivables continue to be supressed at pre-pandemic levels with the continuation of block contract payments now confirmed for the remainder of 2021/22. See Appendix 5a-b

Note 2: 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.
- The implementation of the new finance system in Dec 21 has delayed some payments being made thereby increasing cash balances

Note 3: Trade Payables including accruals have increased in month as a result of the delays associated with the new ledger implementation. Whilst direct cash payments have been made to 'critical' suppliers, normal weekly payment runs recommenced in early January.
Staff related creditors are at higher levels than historically seen, with increases due to accrued annual leave (£8.3m).
Capital creditors have dropped from March (£13.0m) and are now at £4.8m. This is expected to rise significantly by 31 March 2022 as the capital programme accelerates.
BPPC and aged creditor performance for December will be reported at a later point, but will have declined in month due to processing delays experienced as part of the finance system migration.

Cashflow reconciliation– April - December 2021



United Lincolnshire Hospitals NHS Trust

	Full Year 2020/21	31 December 2021	
		Plan	Actual
	£000	£000	£000
Operating surplus / (deficit)	8,778	5,901	6,356
Depreciation and amortisation	13,674	11,706	11,366
Impairments and reversals	3,121	-	94
Income recognised in respect of capital donations	(3,923)	(450)	-
Amortisation of PFI deferred credit	(503)	(378)	(377)
(Increase) / decrease in receivables and other assets	16,119	(896)	10,762
(Increase) / decrease in inventories	527	(218)	(611)
Increase/(decrease) in trade and other payables	16,987	(11,415)	6,112
Increase/(decrease) in other liabilities	(2,085)	1,356	(1,060)
Increase / (decrease) in provisions	1,556	164	40
Net cash flows from / (used in) operating activities	**54,251**	**5,769**	**32,683**
Interest received	12	-	-
Purchase of intangible assets	(1,245)	-	-
Purchase of property, plant and equipment	(39,483)	(31,433)	(21,186)
Proceeds from sales of property, plant and equipment	625	-	142
Net cash flows from / (used in) investing activities	(40,091)	(31,433)	(21,044)
Public dividend capital received	409,664	-	-
Loans from Department of Health and Social Care - repaid	(377,859)	-	-
Other loans received	2,544	1,520	-
Interest paid	(2,522)	-	-
PDC dividend (paid)/refunded	(5,662)	(3,836)	(3,117)
Net cash flows from / (used in) financing activities	26,165	(2,316)	(3,117)
Increase / (decrease) in cash and cash equivalents	**40,325**	**(27,979)**	**8,522**
Cash and cash equivalents at 1 April - brought forward	13,717	54,042	54,042
Cash and cash equivalents at period end	**54,042**	**26,063**	**62,564**

Note 1: Cash held at 31 December was £62.6m against a plan of £26.1m.

Note 2: Principle reasons for the cash variance to plan of £36.5m are:

- a shortfall of £10.2m against planned capital payments, linked to delays in the capital programme.
- The continued block contract regime suppressing receivables.
- An in month increase in trade payables and accruals linked to the implementation of the new finance system and delayed supplier payments.

Meeting	*Trust Board*
Date of Meeting	
Item Number	*Item number allocated by admin*
Strategic Risk Report	
Accountable Director	*Dr Karen Dunderdale, Director of Nursing*
Presented by	*Dr Karen Dunderdale, Director of Nursing*
Author(s)	*Paul White, Head of Risk and Governance*
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 advise on any areas of strategic risk requiring further action*

Executive Summary

- This Strategic Risk Report focuses on the highest priority risks to strategic objectives currently being managed within the Trust (those with a current rating of Very high, 20-25).
- Work to reconfigure the risk register was completed in early January 2022.
- There are 8 active risks that are rated Very high (20-25) and 22 rated High (15-16); 79% of the revised risk register (174 risks) have a current rating of Moderate (8-12).
- The Clinical Governance team are now coordinating the continual review of the revised risk register with risk leads in each division and corporate directorate, as well as re-establishing appropriate reporting on risk to each of the assurance committees of the Trust Board.
- Trust Board are advised that the details of significant risks presented in this report represent the first draft of the new risk register and therefore may be subject to change on review
- The Risk Management Policy has also been updated to reflect these changes to the risk register and the way in which it is managed; the revised Policy is out for comment and will considered by the Risk Register Confirm and Challenge Group on 23 February 2022.

Purpose

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

- Review the management of significant risks to strategic objectives.
- 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. This report is focussed on those strategic risks with a current rating of very high risk (a score of 20-25). A summary of all active High risks (15-16) is provided in **Appendix A**. Moderate and Low risks (12 and below) are managed at divisional level.

1.2 There are several areas of Very high risk that have been included in previous Strategic Risk Reports and are currently being reviewed and updated by the risk leads in order to ensure that they reflect the areas of most risk, rather than a generic risk. These risks are therefore not included in this month's report in detail:

- Managing emergency demand (currently rated 25) – this is being reassessed in terms of specific risks regarding delayed ambulance handovers; overcrowding with A&E; delayed admissions; and meeting constitutional standards for A&E
- Delays to planned care as a result of service changes during the Covid-19 pandemic (currently rated 25) – this is being assessed at specialty level to identify those areas where there is the greatest risk of harm.

2. Trust Risk Profile

2.1 There 219 active risks currently recorded on the Trust risk register. There are 8 risks with a current rating of Very high (20-25). **Chart 1** shows the number of active risks by current risk rating:

Very low (1-3)	Low (4-6)	Moderate (8-12)	High (15-16)	Very high (20-25)
0 (0%)	**14** (7%)	**174** (79%)	**22** (10%)	**8** (4%)

Strategic objective 1a: Deliver harm free care

2.2 Current active Very high risks to this objective:

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4622	If the Trust fails to learn lessons when things go wrong with a patient's care, so that changes can be made to policies and procedures, there is an increased likelihood of similar issues arising in future which could result in serious harm, a poor experience or a poor clinical outcome affecting a large number of patients.	Very high risk (20)	- Safety Culture Project, part of Integrated Improvement Plan (IIP) - Prepare for replacement of NRLS and StEIS systems with new Learn From Patient Safety Events (LFPSE) service (previously called PSIMS) - Upgrade current DatixWeb risk management system to Datix CloudIQ	08/11/2021
4646	If the Trust is not consistently compliant with NICE Guidelines and BTS / GIRFT standards to support the recognition of type 2 respiratory failure then there may be delays to the provision of treatment using Non-Invasive Ventilation (NIV), resulting in serious and potentially life-threatening patient harm.	Very high risk (20)	Delivery of the NIV Pathway project as part of the Improving Respiratory Service Programme within the Integrated Improvement Plan (IIP): 1. Understand the Trust-wide demand and capacity for Acute and Non Acute NIV. 2. Provision of ring-fenced beds for NIV. 3. Develop Trust-wide Model and Pathway for Acute and Non Acute NIV To meet BTS/GIRFT Standards. 4. Provision of NIV service (ED) which meets the BTS Quality Standards. 5. To have a trained workforce with the skills required to meet the needs of the patients and BTS standards. 6. Governance Process for NIV Demonstrating a Safe Service where Lessons are Learnt.	14/12/2021

Strategic objective 1c: Improve clinical outcomes

2.3 Current active Very high risks to this objective:

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4825	JAG Accreditation deferred for Lincoln due to poor state of current Lincoln Endoscopy accommodation	Very high risk (20)	Case of need for immediate remedial works required, plan to take to September CRIG Estates strategy and plans for replacement of current accommodation within the next 2 years	08/12/2021

Strategic objective 2a: A modern and progressive workforce

2.4 Current active Very high risks to this objective:

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4668	If the Trust is unable to meet the requirement for all front-line NHS staff to be fully vaccinated against Covid-19 by 1st April 2022 (as mandated by the government) then it will be necessary to redeploy affected staff or terminate their contracts of employment (which could be a high number of staff, pending confirmation of the definition of front-line) resulting in a substantial, widespread and prolonged adverse impact on many services	Very high risk (25)	New policy being developed for ELT approval - Mandatory Coronavirus Vaccination Policy / Guidance; implementation to be project managed. Management discussions with affected staff already taking place; will need local level risk assessment to quantify extent of service risks and develop appropriate mitigations where possible.	06/01/2022
4671	If a substantial proportion of the Trust's workforce tests positive for Covid-19, or are required to self-isolate in accordance with government guidelines, then it may not be possible to maintain some services resulting in significant short-term disruption affecting the care of a large number of patients	Very high risk (25)	Occupational Health staff health checks & testing regime; Health and well-being offer to staff; Implementation of new Absence Management System (Empactis); use of bank / agency staff to fill rota vacancies; & operational command structure for Covid response.	02/11/2021

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4669	If the Trust is unable to recruit and retain sufficient numbers of registered nurses then it may not be possible to provide a full range of services, resulting in widespread disruption with potential delays to diagnosis and treatment and a negative impact on patient experience	Very high risk (20)	Focus on nursing staff engagement & structuring development pathways; use of apprenticeship framework to provide a way in to a career in nursing; exploration of new staffing models, including nursing associates; continuing to bid for SafeCare live funding.	02/11/2021
4670	If the Trust is unable to recruit and retain sufficient numbers of consultants & middle grade doctors then it may not be possible to provide a full range of services, resulting in widespread disruption with potential delays to diagnosis and treatment and a negative impact on patient experience	Very high risk (20)	Focus on medical staff engagement & structuring development pathways. Utilisation of alternative workforce models to reduce reliance on medical staff.	02/11/2021

Strategic objective 2b: Making ULHT the best place to work

2.5 Current active Very high risks to this objective:

Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date of latest review
4667	If issues such as workload; work-life balance; organisational change; and cost reduction; are not managed effectively then it could have a significant negative impact on the morale of a substantial proportion of the workforce, resulting in increased turnover / increased absence / reduced productivity / reduced quality.	Very high risk (20)	Focus on the "People" Strategic Objective in the IIP. This focuses on "modern and progressive workforce" and being the "best place to work". Series of projects and programmes being worked up to deliver agreed outcomes.	03/11/2021

2.6 At the Risk Register Confirm and Challenge Group meeting on 26 January 2022 the following risks were reviewed and agreed to be Very high risk at present (these risks will be updated by the risk lead and included within the next report):

- Risk of patient harm due to reliance on hard copy medical records, to be addressed through the implementation of an Electronic Document Management System (EDMS), including Electronic Patient Records
- Risk of patient harm in relation to medicines management, including administration of medicines, transcription of medicines and omitted doses.

3. Conclusions & recommendations

3.1 The highest priority risks at present continue to relate to the Covid-19 pandemic, primarily due to the impact on services if staff are unable to work and the potential impact of compulsory vaccinations for NHS staff.

3.2 There are significant clinical risks at present in relation to caring for patients requiring Non-Invasive Ventilation (NIV) and the renewal of the Trust's JAG accreditation for Endoscopy at Lincoln County Hospital.

3.3 Risks due to the level of emergency demand; delays to planned care during the pandemic as outlined in section 1.2; and the use of hard copy medical records are also recognised as significant and appropriate action is being taken to address them.

3.4 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 A: Summary of all active High risks (15-16)

ID	Business Unit	What is the risk?	Rating (current)	Risk level (current)
4661	Trust Headquarters	If the required data protection / privacy impact assessment process is not followed consistently at the start of a system change project, then results may not be available to inform decision-making and system development resulting in an increased likelihood of a future data breach that could expose the Trust to regulatory action by the Information Commissioner's Office (ICO)	16	High risk
4623	Nursing Directorate	If an inspection by the Care Quality Commission (CQC) finds that the Trust is significantly non-compliant with regulations and standards for Clinical Governance it may result in sanctions such as a warning, improvement or prohibition notice; or a financial penalty.	16	High risk
4624	Nursing Directorate	If patients in the care of the Trust who are at increased risk of falling are not accurately risk assessed and, where necessary appropriate preventative measures put in place, they may fall and could suffer severe harm as a result.	16	High risk
4625	Nursing Directorate	If the Trust's infection prevention and control measures are not effective and an outbreak of serious infectious disease occurs it could result in serious harm affecting a large number of patients, staff and visitors across multiple hospital locations.	16	High risk
4664	Finance and Digital	If the Trust does not significantly reduce its reliance upon a large number of temporary agency and locum staff in order to maintain the safety and continuity of clinical services, then it could have a substantial adverse impact on the ability to contain costs within the STP and Trust income envelope.	16	High risk
4741	Cancer Services CBU	Oncology is considered to be a fragile service due to consultant oncologist gaps. Tumour sites at risk (Medical oncology) - renal, breast, upper and lower GI, CUP, ovary/gynae, skin, testicular, lung Clinical oncology - head and neck, skin, upper GI (RT only)	16	High risk
4780	Cardiovascular CBU	Risk of not being able to maintain effective stroke provision across ULHT due to the significant deficit in stroke consultant staffing and nurse staffing. 1 in 4 consultant on-call rota is unsustainable with current staffing levels. Stroke risk summit undertaken 2019. Designated TRUST FRAGILE SERVICE	16	High risk
4640	Finance and Digital	If the Trust is subjected to a major cyber security attack that breaches its network defences then it could lead to prolonged and possibly permanent, widespread loss of essential data resulting in severe disruption to a wide range of services affecting a large number of patients and staff.	15	High risk
4659	Trust Headquarters	If there is under-reporting of information governance incidents, or a lack of learning from incident investigations, then it is difficult for the Trust to make an accurate assessment of the extent of risk exposure and put in place effective mitigation, resulting in an increased likelihood of similar incidents occurring in the future	15	High risk

ID	Business Unit	What is the risk?	Rating (current)	Risk level (current)
4648	Estates and Facilities	If a fire occurs on one of the Trust's hospital sites and is not contained (due to issues with fire / smoke detection / alarm systems; compartmentation / containment) it may develop into a major fire resulting in multiple casualties and extensive property damage with subsequent long term consequences for the continuity of services.	15	High risk
4654	Estates and Facilities	If highly flammable and / or explosive substances or large quantities of combustible products are stored inappropriately (i.e. Not in accordance with DSEAR or risk assessments), then it could lead to a major fire resulting in multiple casualties and extensive property damage	15	High risk

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*1 February 2022*
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* • *Moderate*

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 all Committees including the Audit and Risk Committee during January and the Board are asked to note the updates provided within the BAF. There were no changes to assurance ratings.

Assurance ratings have been provided for all objectives and have been confirmed by the Committees.

The following assurance ratings have been identified:

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

United Lincolnshire Hospitals NHS Trust
Board Assurance Framework (BAF) 2021/22 - January 2022

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

Assurance Rating Key:	
Red	Effective controls may not be in place and/or appropriate assurances are not available to the Board
Amber	Effective controls are thought to be in place but assurances are uncertain and/or possibly insufficient
Green	Effective controls are definitely in place and Board are satisfied that appropriate assurances are available

Ref	Objective	Exec Lead	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls (Primary, secondary and tertiary)	Control Gaps	How identified control gaps are being managed	Source of assurance	Assurance Gaps - where are we not getting effective evidence	How identified gaps are being managed	Committee providing assurance to TB	Assurance rating
SO1	**To deliver high quality, safe and responsive patient services, shaped by best practice and our communities**												
						Developing a Safety Culture - Group, lead & plan in place to support the delivery of an improved patient safety culture (PSG)	Human Factors training delayed due to Covid-19 Definition of Safety Culture Ambition Operational pressures have meant that meetings have not taken place.	External Safety Culture company engaged to deliver focus groups at all levels through the organisation and support development of safety culture ambition Online Human Factors training to commence December 2021 Bite size lunchtime teaching sessions - open offer to all staff Project lead continues to review project and complete highlight reports as appropriate.	Safety Culture Surveys Action plans from focus groups and Pascal survey findings Update reports to the Patient Safety Group and upwardly reported to QGC	Due to operational pressures culture surveys have not been taking place.	Where possible, safety conversations have been taking place with staff. "Safe to Say" Campaign focus groups have been contiuing		
						Robust Quality Governance Committee, which is a sub-group of the Trust Board, in operation with appropriate reporting from sub-groups. (CG)	Operational pressures have meant that QGC meeting has been reduced.	All papers have been considered and discussed by exception. Assurances provided to QGC include feedback from gold and relevant cells as outlined below.	Upward reports from QGC sub-groups 6 month review of sub-group function				
						Effective sub-group structure and reporting to QGC in place (CG)	Due to operational pressures, not all sub-groups have met and others have had a reduced agenda.	All papers have either been discussed by exception or a chair/vice chaire upward report completed following review of the papers. Any risks to quality and safety are discussed at the relevant cell meeting, eg, quality cell and issues escalated to gold as appropriate. Quality Impact Assessments undertaken as part of the response to operational pressures are discussed at the quality cell.	Sub-Group upward reports to QGC				

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
						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 policies have been reviewed, written and ratified by the IPCG. IPC programmes of surveillance and audit are in place to monitor policy requirements. Divisional audit processes with progress and exception reporting to IPCG, IPC Site meetings and IPC related Divisional forums. Associated action and development plan documentation. Very good progress with monthly IPC ratification. Work on decontamimnation and other estates- related policies. This will lead to compliance of policy aspects of the Hygiene Code	Some aspects of reporting require further development.	Reporting to and monitoring by IPCG and other related forums, e.g. Site meetings.		
						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 have been updated / developed / written in line with the timetable. •Estates and Facilities/Decontamination Lead has made good progress with estates and facilities work and is awaiting a place on a specialist decontamination course. • Good progress with achieving and sustaining standards of	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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								environmental cleanliness. Potential to remain at amber due to infrastructure concerns & requirement to achieve Very good progress with work to achieve compliance with new National Standards of Cleanliness directive and this continues to be taken forward via a Task and Finish Group with monthly monitoring by the IPCG • Provision of suitable hand hygiene facilities work under the remit of ward enhancement, capital and tap replacement programmes.					
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	Monthly mortality report in place to track achievement of SHMI/Mortality targets (Maintaining our HSMR and improving our SHMI) reporting in to monthly mortality group and upwardly to PSG (PSG)	Gaps in the number of structured judgement reviews undertaken Impact of Covid-19 on coding triangles	Training has been delivered to approximately 40 members of staff to undertake SJR's. Bespoke training and support offered from the Moratality team to the Divisons.	National Clinical Audits Dr Foster alerts HSMR and SHMI data Medical Examiner screening compliance and feedback	Due to national issues, Dr Foster data has not been available.	Local data sources are used where possible.	Quality Governance Committee	**Amber**
						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	PSG currently do not receive assurance reports from the Divisions as their governance process reports to their PRM			
						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 although progress is being made within CSS, Family Health and Surgery Divisions. Operational pressures is impacting on delivery in medicine.	Working Group set up and meeting as per the ToR, divisional representation; quarterly reporting to PSG Additional support provided to medicine from the Safety Culture Team.	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) (MQG)	Lack of e-prescribing leading to increase in patient safety incidents due to medication errors	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	Medicines Quality Group have not been receiving reports regarding progress with the medicines roadmap.	Improving the safety of Medicine Management Action Group reinstituted and meeting fortnightly to progress actions. Divisional representation at Medicines Quality Group reinforced and template for divisional reporting of Medication safety elements into MQG developed.		

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						Maternity & Neonatal Oversight Group (MNOG) in place to have oversight of the quality of maternity & neonatal services and to provide assurance that these services are safe and in line with the National Safety Ambition / Transformation programme. (MNOG)	Recent increase in incidents. Issues with the environment. Ongoing difficulties with the Maternity Medway system which has the potential to impact on compliance with the CNST Year 4 Safety Actions.	External independent input in to SI process. Thematic review of SIs and complaints undertaken - recommendations to be progressed as part of the Maternity & Neonatal Improvement Plan. Improvements to the environment to be completed as part of planned ward refurbishment. Team to continue to liaise with E&F to resolve and immediate issues as they arise ensuring escalation where delays are encountered. Issues with the Medway system being progressed at local and system level.	Monthly Maternity & Neonatal Assurance Report. Maternity & Neonatal Improvement Plan. Executive & NED Safety Champions in place and work closely with local Safety Champions. NHSE/I appointed MIA in place and supporting the Trust - monthly reports of progress to MNOG.	Additional assurance required in respect of training compliance (recovery of women following GA) - trajectory agreed.	Monitoring of compliance against trajectory for recovery training will occur through MNOG.		
						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 has now been reviewed and is out for approval.	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 ready to go to next NMAAF	Audit of response to triage, NEWS, MEWS and PEWS Sepsis Six compliance data Audit of compliance for all cardiac arrests Upward reports into DPG from all areas				
						Ensuring a robust safeguarding framework is in place to protect vulnerable patients and staff (Ensuring a robust safeguarding framework is in a place to protect vulnerable patients and staff) (SVOG)	New funding needed to continue restraint training delivery. Business case being developed in conjunction with conflict resolution team and will be presented to QGC within next 2 months. Further work has taken place with LPFT to consider a joint approach to training - awaiting options paper from LPFT	Updated policy & training in use of chemical restraint / sedation; strengthening of pathways & training to support patients with mental health issues	Upward reporting from Mental Health/ Learning Disability and Autism Oversight Group	NO active Restraint training available within the trust	Paper to CRIG (End November) regarding funding for new Restraint training proposal Datix being monitorred by safeguarding team to ensute review of any restraint incidents		
						Appropriate policies in place to ensure CAS alerts and Field Safety Notices are implemented as appropriate. (PSG)	Gap in current policy identified meaning that not all responses from divisions are received / recorded.	Task and Finish Group set up to review processes and improve compliance. This has led to improvement in compliance, however further work still required. Any relevant alerts are also discussed at gold as appropriate.	Quarterly report to PSG with escalation to QGC as necessary. Compliance included in the integrated governance report for Divisions.				
						Appropriate policies and procedures in place to reduce the prevalence of pressure ulcers, including a Skin Integrity Group (NMAAF)							

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						Formal governance processes in place within divisions, including regular meetings and reporting, supported by a central governance team (CG)	Training provision for Divisional Clinical Governance Leads No formal job description of roles and responsibilities for Clinical Governance Leads	Role based TNA being devised for Clinical Governance leads Draft role description for a Clinical Governance Lead developed for consultation.	Minutes of Divisional Clinical Governance meetings with upward reporting within the Division Divisional Integrated Governance Report Support Offer in place from the central CG team for the Divisions	Minutes demonstrate some Divisional Clinical Governance meetings need strengthening	Implementation of standard ToR, agendas and reporting		
						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)			Monthly report to QGC and Trust Board on Must and Should dos				
1b	Improve patient experience	Director of Nursing	Failure to provide a caring, compassionate service to patients and their families Failure to provide a suitable quality of hospital environment	3688 4081	CQC Caring	Patient Experience Group, which is a sub-group of the Quality Governance Committee, in place meeting monthly Robust Complaints and PALS process in place (PEG)	Patient Experience Group reinstated in its new format and ToR, the group needs to develop its maturity Meeting stood down due to operational pressures.	The group meets monthly, has developed a work reporting plan Papers reviewed and Chair's report provided. Any risks to quality and safety are discussed at the relevant cell meeting, eg, quality cell and issues escalated to gold as appropriate. Quality Impact Assessments undertaken as part of the response to operational pressures are discussed at the quality cell.	Upward reports to QGC monthly and responds to feedback Review of ToR in July 2021 Quarterly Complaints reports identifying themes and trends presented at the Patient Experience Group Patient Experience Group upward report	Divisional assurance reports to PEG providing limited assurance; further work needed to improve this. Will be monitored through PEG.	Head of Pt Experience revising divisional assurance report template and have discussions with divisional clinical leads re: requirements for the reports. Template approved through PEG Nov 21	Quality Governance Committee	**Amber**
						Patient Experience & Carer plan 2019-2023 (PEG)	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.	Plan is being reviewed with a draft final date of end of January 22.		
						Quality Accreditation and assurance programme which includes section on patient experience. (PEG)	Lack of alignment of findings in accreditation data to patient experience plans. Ward / Dept review visits paused due to operational pressures	Head of pt experience to have access to accreditation data. Deep dives into areas of concern as identified in quality meetings and accreditation reports. Update reports to PEG and QGC as required. Matrons audits continue to take place. Any risks to quality and safety identified are discussed at the quality cell and issues escalated to gold as appropriate.	Reports to PEG and upwardly to QGC	Ward / Dept review Visits are cancelled when the organisation is in surge. However, weekly spot checks and matron audits continue.	Scheduled review visits for the year. Pt Experience team to have sight of hotspots / concerns and can inreach to provide support.		

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						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. Date not yet secured. ULHT Experts by Experience project progressing with Mastalgia Expert reference group established, Cancer Board recruiting in the New Year and discussions to continue with Gastroenterology & CYP (Expert Families)		
						Care after death / last offices Procedure & Guidelines Sharing information with relatives Visiting Procedure Patient information (PEG)	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. Visiting review indicates inconsistency in EoL visiting; criteria and process being strengthened. Request to ME's to ask relatives about visiting experience at EoL.		
						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. Head of Pt Experience & EDI lead meeting to agree a way forward. Links to Reaching Out IIP project.		
						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.		
						Getting it Right First Time Programme in place with upward reports to CEG and QGC. Agreement in place recommencement of the of the GIRFT Programme (CEG)		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 Process in place for feeback to divisions				
						Clinical Effectiveness Group as a sub group of QGC and meets monthly (CEG)		September papers reviewed and upward report produced for QGC by the chair/vice chair. Any risks to quality and safety are discussed at the relevant cell meeting, eg, quality cell and issues escalated to gold as appropriate. Quality Impact Assessments undertaken as part of the response to operational pressures are discussed at the quality cell.	Effective upward reporting to QGC	None	None		

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1c	Improve clinical outcomes	Medical Director	Failure to provide effective and timely diagnosis and treatment that deliver positive patient outcomes	4558	CQC Responsive CQC Effective	Clinical Audit Group in place and meets monthly (CEG) with quarterly reports to QGC (CEG)	There are outstanding actions from local audits Due to operational pressures, quoracy has been an issue.	Audit Leads present compliance with their local audit plan and actions. Support being provided from central team to close outstanding overdue actions	Reports generated for Clinical Audit group and CEG detailing status of local audits and number of open actions	Clinical Audit Leads may not attend to present their updates	Rolling attendance in progress and names of Clinical Audit Leads not attending will be escalated to the Triumvirate	Quality Governance Committee	**Amber**
						National and Local Audit programme in place and agreed (CEG) - signed off by QGC. Improved reporting to CEG regarding outcomes from clinical audit (CEG)			Reports from the National Audit Programmes including outlier status where identified as such Relevant internal audit reports	None	None		
						Process for monitoring the implementation of NICE guidance and national publications in place and upwardly reported through QGC (CEG)			Reports on compliance with NICE / Tas demonstrating improved compliance.	None	None		
						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	Programme of work commencing regarding wide ranging mechanisms for learning lessons across the Trust.					
SO2	**To enable our people to lead, work differently and to feel valued, motivated and proud to work at ULHT**												
						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 - Leadership and Lifelong Learning (from 2022/23)	Awaiting sign off of system people plan (delivery plan reviewed and objectives agreed annually in Q4)	System People Team System Workforce Cell	System PP - Each 'pillar assigned system lead Progress/assurance reported to People Board (querlterly) 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				
						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	Workforce plans submitted for H2 2021/22 Operational Planning. Recruitment plans are in place. Divisional Recruitment Pipeline Reports are refreshed regularly for each division.	Some areas remain hard to fill and therefore difficult to fully mitigate risk. Challenges in obtaining meaningful information from Trac, due to Recruitment team capacity issues.	Regular reviews take place with Divisions through workforce analyses and a plan for every post; alternatives and workforce mix are considered and where national workforce shortages identified then focus is on overseas recruitment.		

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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	Recruitment to agreed roles - plan for every post		Pipeline report shows future vacancy position International nurse recruitment & cohort recruitment	Internal Audit - Recruitment follow up Performance Dashboard developed offering accurate and timely information to all appropriate managers and staff			People and Organisational Development Committee	**Red**
						Focus on retention of staff - creating positive working environments	IIP projects on hold	IIP Projects Appraisal - deep dive planned Dec21 Mandatory training - currently in scope Talent management - held National Talent Management Framework launched, Lincs system identified as pilot site for launch	Regional Midlands Talent Board Model Employer ambition appraisal/mandatory training compliance	Appraisal and training compliance levels not at expected level			
						Embed continuous improvement methodology across the Trust		Training in continuous improvement for staff					
						Reducing sickness absence	Sickness absence rate higher than average	Embedding of AMS	Sickness/absence data Turnover rates Vacancy rates	Various reports (Sitrep, Gold,STP) unable to offer absolute assurance due to both the national picture and the Critical level the Trust is operating under.	The reports are run daily and any abnormalities are considered in the context of the national and regional position. The pandemic and the critical incidents the Trust is in has impacted on usual trends. AMS data is reviewed regularly and reported into Divisions on accuracy. Data currently for absence is inline with national reporting.		
						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 Subject area/work programme under review. Work underway to 'scope' requirements, including interface with Education	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				
						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	People Plan - in draft System EDI Strategy underway 5 pillar -leads confirmed (ULHT Lead for leadership and lifelong learning)					
						Trust values & staff charter - Resetting ULH Culture & Leadership	Poor staff survey results in 2020 (although in pulse survey more positive)	Creation of Leading Together Forum Delivery Plan and actions to be confirmed further to results of Leadership Survey	Culture and Leadership Programme Group upward report	Delivery of agreed output	Improved function of group and reporting to be in place for November report		

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2b	Making ULHT the best place to work	Director of People and Organisational Development	Further decline in demand Weak structure (to support delivery) Lack of resource and expertise 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	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			People and Organisational Development Committee	**Red**
						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		Proposal to be shared with ELT (Dec'21): gradual introduction of L&M activities NB. L&M apprenticeship on going		
						Perception of fairness and equity in the way staff are treated	EDI Group (report to PODC) live from Dec 2021	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 EDI Group membership reset - to ensure representation and coverage	Council of Staff Networks Internal Audit - Equality, Diversity and Inclusion NHS NNSS	WRES/ WDES/MRES	Currently developing WRES and WDES action plans and internal audit to deliver the first actions for the 31.12.21 WRES/WDES and Internal Audit actions being monitored through Committee		
						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			System Health & Wellbeing Board Linc People Board	OH reporting (upward report to PODC) System Hub activity Wellbeing activity (upward report to PODC)	Commence reporting from 2022		
						Focus on junior doctor experience key roles:- - Freedom to speak up Guardian - Guardian of safe working - Well-being Guardian		Junior doctor forum	Dedicated resource in place for GOSW and FTSUG. Trust Chair has taken role of Well being Guardian. Reports being provided from GOSW and FTSUG. JNR doctor survey findings being seen at Committee. GOSW and FTSUG invited in person to Committee				

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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 4 sessions during Oct / Nov 21 Risk Register Confirm and Challenge Group ToRs Upgrade to datix system Full Risk Register review	Updated Policy and Strategy document for approval at December 21 Risk Register Confirm and Challenge meeting - Meeting Cancelled Covid pressures	Consider at January meeting	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	**Amber**
						Shared Decision making framework			Number of Shared decision making councils in place	8 councils established. Target for 2021 was 6			
						Implementing a robust policy management system Additional resource identified for policy management post Reports on status by division and Directorate Updated Policy on Policies Published Guidance on intranet re policy managemnet reviewed and updated	Move of policies in to sharepoint reliant on progress with Trust intranet. Timeline delayed through Covid Review of Divisional policy status reports not progressed due to covid pressures	Review of document management processes New document management system - SharePoint Reports generated form existing system All policies aligned to division and directorates Single process for all polices clinical and corporate	Fortnightly ELT report monitoring actions. Quarterly report to Audit Committee including data on in date policies CQC Report - Well Led Domain				
						Ensure system alignment with improvement activity							

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SO3	**To ensure that services are sustainable, supported by technology and delivered from an improved estate**												
3a	A modern, clean and fit for purpose environment	Chief Operating Officer	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	Develop business cases to demonstrate capital requirement in line with Estates Strategy	Business Cases require level of capital development that cannot be rectified in any single year.	Interim case for £9.6M of CIR continues in to 2021/22. Will reflect priority areas in the Estates Stategy Estates Strategy sets out a framework of responding to issues and management of risk. Capital Delivery Group has oversight of the delivery of key capital schemes.	Capital Delivery Group Highlight Reports Compliance report to Finance, Performance and Estates Committee Updates on progress above linked to the estates strategy.	Infrastructure case has tackled £9.6M of the overall £100m+ backlog in first year. Future years will at most tackle £20m of backlog in any given year	Estates improvement and Estates Group review compliance and key statutory areas. Progress against Estates Strategy/Delivery Plan and IIP Delivery 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.	Finance, Performance and Estates Committee	**Amber**
						Continual improvement towards meeting PLACE assessment outcomes	PLACE assessments have been suspended and delayed for a period during COVID	Use of PLACE Light assessments and other intelligence reports.	PLACE Light Assessments	PLACE/Light do not provide as deep an assurance review as PLACE with limited input.	Combination of PLACE Light and other intelligence (IPC Group/Compliance Reports and Capital Delivery Group) will help triangulate areas of concern and response.		
						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. 6 facet survey review commencing in Jan 22. Specification drafted for full 6 facet survey with tender process to start in Jan 22	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. Review of 6 Facet Surveys will commnece as part of HIP Bid (Referral in Estates Strategy)		

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						Continued progress on improving infrastructure to meet statutory Health and Safety compliance	H&S Committee Previously not run with quoracy. However now reviewed with ToR agreed and Quorate with staffside representation	Water/Fire safety meetings are in place and review of controls are part of external validation from authorised engineers. Health and Safety Committee new terms of reference approved and now chaired by Chief Operating Offficer/Director of Estates and Facitilies. Upward reporting to Finance, Performace and Estates Committee Med gas, Critical ventialtion, Water safety group, electirical safety group, medical gas group have all been established and include the relevenet authorising engineers in attendance. These groups monitor and manage risks and report upwards any excepetinos or points of escalation.	Reports from authorised engineers Response times to urgent estates requests Estates led condition inspections of the environment Response times for reactive estates repair requests Progress towards removal of enforcement notices Health and Safety Committee upward report				
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	4382 4383 4384	CQC Well Led CQC Use of Resources	Delivering £6.4m CIP programme in H1 21/22 and estimated full Year 21/22 CIP value of £15.4m.	Operational ownership and delivery of efficiency schemes	Divisional Financial Review Meetings - paused due to COVID - reinstated from May 21. 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	Finance, Performance and Estates Committee	**Amber**
						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 21/22	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.		
						Reduce agency spend by 25% from the 19/20 baseline as per IIP priority	Reliance on temporary staff to maintain services, at increased cost	Centralised agency & bank team	Delivery of the IIP 25% agency reduction target.	Granular detailed plan for every post plans.	Through the Medical and Nursing Workforce Transformation Groups and through FRMs upward into FPEC		
						Utilising Model Hospital, Service Line Reporting and Patient Level Costing data to drive focussed improvements to be restarted from Q1 22/23	Lack of up-to-date and robust benchmarking information due to the usefulness of the 20/21 and 21/22 cost collection exercise being reduced related to COVID.	Refresh of internal costing and SLR information for roll out in the Trust from Q1 22/23.	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		

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
			Unplanned expenditure (as a result of unforeseen events and operational pressures in H2) National requirements and Trust response to Restoration and Recovery and third COVID wave.			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 from Q1 22/23.	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 financial plan for H1 and H2 21/22 and 22/23.	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 21/22.	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 workforce and activity modelling aligned to resource requirements to support Trust and System Restoration.	Impact of Wave 3 and 4 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. EMAS, GPs, mental health, community, social care and care homes data now also available within the Care Portal.	Finance, Performance and Estates Committee	**Amber**
						Commence implementation of the electronic health record	Roll-out IT equipment to enable agile user base Redeployment of staff as a result of Trust response to Covid-19.	Digital Services Steering Group Digital Hospital Group e-HR Programme Steering Group	Delivery of 20/21 e HR plan		EPR OBC to be approved by NHSE/I OBC requirments being worked thorugh with NHSE/I		
						Undertake review of business intelligence platform to better support decision making			Delivering improved information and reports Implement a refreshed IPR	IPR refresh being completed in July 2021 for June 2021 reporting.	Steady implementation of PowerBI through specific bespoke dashboards and requests.		

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						Implement robotic process automation	Lack of expert knowledge available within and to the Trust (experts in short supply nationally) Business case under development						
						Improve end user utilisation of electronic systems	Business case for additional staff under development						
						Complete roll out of Data Quality kite mark			Ensuring every IPR metric has an associated Data Quality Kite Mark	Information improvements aligned to reporting needs of Covid-19.	A number of metrics have had a review and these are awaiting formal sign off. They will then appear in the IPR. Remaining metrics have a work plan and deadlines associated with completion.		
SO4	**To implement integrated models of care with our partners to improve Lincolnshire's health and well-being**												
4a	Establish new evidence based models of care	Director of Improvement and Integration	Failure of specialty teams to design and adopt new pathways of care Failure to support system working Failure to design and implement improvement methodology		CQC Caring CQC Responsive CQC Well Led	Supporting the implementation of new models of care across a range of specialties	Specialty strategies not in place	Requirement for specialty strategies now part of strategy deployment and will commence August 2021	Reports -ELT / TLT -Committees -Board -System -Region	Impact of specialty changes	New performance framework will address and the upward report regarding IIP	Finance, Performance and Estates Committee	**Amber**
						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							

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						Support Creation of ICS - Lincolnshire designation 1st April 2021	Delay to review and adoption of legislation	Weekly ICS meetings Provider Collaborative Steering Group	SLB reports and upward reports by CEO / Chair				
						Support the consultation for Acute Service Review (ASR) Phase 1 - PCBC with national team	Awaiting CCG to review and sign off approach to consultation	Weekly ASR meetings	SLB reports and upward reports by CEO / Chair				
						Implementing the Outstanding Care Together Programme to support the Organisation to focus on high priority improvements - in progress	Disruption due to COVID has resulted in a less mature approach to strategy deployment, broad understanding across the organisation, progress on building capacity and capability.	OCTP Exec led pillar meetings continue ELT/TLT oversight Board / system reporting	Weekly ELT updates Monthly TLT updates Quarterly board reports Quarterly board development sessions				
4b	To become a University Hospitals Teaching Trust	Director of Improvement and Integration	Failure to develop research and innovation programme Failure to develop relationship with university of Lincoln and University of Nottingham Failure to become member of university hospital association		CQC Caring CQC Responsive CQC Well Led	University Hospital Teaching Trust Status Developing a business case to support the case for change		The case of need was approved at CRIG (September 2021) and now needs to return to CRIG as FBC.	Progress with application for University Hospital Trust status		R&I team working closely with Strategic Projects to develop full business case for the growth of R&I department.	People and Organisational Development Committee	**Red**
						Increasing the number of Clinical Academic posts	With the criteria change in June 2021 we are no require to demonstrated increased clinical academics and RCF funding	Working through the potential options presented by the Medicine Clinical Academics pilot and understanding whether this can be deployed across other divisions.	Numbers of Clinical Academic posts RD&I Strategy and implementation plan agreed by Trust Board				
						Improve the training environment for students	Ensuring that, due to the revised UHA guidance we are able to offer the facilities required for a functioning clinical academic department	The gaps are being managed through the revision of the library and training facilities. This will meet the criteria within the UHA guidance	GMC training survey Stock check against checklist Internal Audit - Education Funding				
						Developing an MOU with the University of Lincoln	This is now a requirement of the UHA guidance. Historically this has not been required.	Working closely with the University of Lincoln, monthly meetings. Through these meetings have completed first draft of the Joint Strategy. MOU will be developed once the Joint Strategy has been signed off.	RD&I Strategy and implementation plan agreed by Trust Board				
						Develop a portfolio of evidence to apply for membership to the University Hospitals Association		Portfolio of evidence is being captured and is available on the shared drive					

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The BAF management process

The Trust Board has assigned each strategic objective of the 2021/22 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 reviews 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 risk, to enable the Committee to make a judgement as to the level of assurance that can be provided to the Board. All reports to the 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:

Red	Effective controls may not be in place and/or appropriate assurances are not available to the Board
Amber	Effective controls are thought to be in place but assurances are uncertain and/or possibly insufficient
Green	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	*1 February 2022*
Item Number	*Item 13.3*
Audit Committee Upward Report	
Accountable Director	*Sarah Dunnett, Audit Committee Chair*
Presented by	*Sarah Dunnett, Audit Committee Chair*
Author(s)	*Jayne Warner, Trust Secretary*
Report previously considered at	*N/A*

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

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

Recommendations/ Decision Required	• *Ask the Board to note the upward report and the actions being taken by the Committee to provide assurance to the Board on strategic objective 2c*

Executive Summary

The Audit Committee met via MS Teams on the 14th January 2022, the Committee met in line with the principles of the Reducing the Burden Guidance focussing the agenda on its key risks. The Committee considered the following items:

External Audit

The Committee received the External Auditors Progress Report incorporating the initial audit strategy for the year ended 31st March 2022. The Committee agreed the proposed direction of travel, noting that the detailed external audit plan would be received ahead of the April Audit Committee meeting, informed by the interim audit work which is planned in February. The External Auditors confirmed that there would be no requirement for an audit of the Quality Account for 2021/22.

The External Auditors presented the identified risks and key judgement areas. A new risk associated with the implementation of the new financial ledger across the System was highlighted.

The Committee were advised that the audit team were working with the Trust to agree the appropriate dates for the Audit Committee and Board meeting where the final accounts and annual report would be approved.

The Committee noted that the Trust annual report and accounts timetable was in development and would be shared with Committee members as soon as finalised and were assured on the status of implementation work to date.

IFRS 16 Implementation and Implications

The Committee noted the required actions to successfully implement IFRS 16.

Draft Annual Report and Annual Governance Statement 2021/22

The Committee noted receipt of an early draft of the annual report and annual governance statement. It was noted that national guidance for the format for the annual report had yet to be received but early indications were that the content would again be streamlined as it was for the 2020/21 report.

Internal Audit

The Committee received a progress report from the Trust Internal Auditor providers noting delivery of 226 days against a total of 421 days in the agreed audit plan.

A number of planned audit dates had been postponed. However, both the Internal Audit Provider and the Trust's Executive were confident that all audits required for completion of the Head of Internal Audit Opinion would be completed. The Committee asked both auditors and the executive team to review the scope, timing and days related to a follow up of estates and a planned ICS audit.

The Trust Internal Auditor Providers confirmed that a further four final reports had been issued since the last meeting, Core Financial Controls – Host General Ledger which offered significant assurance, Capital Planning, Data Quality of KPIs, Trust Operating Model Divisional Governance which offered partial assurance.

The Committee received a Medicines Management Update which had been received previously at the Quality Governance Committee. This provided assurance on the planned actions to address the challenges faced in medicines management. This work would be led by the Medical Director. The Audit Committee will continue to seek assurance on implementation of the agreed actions and its impact on outstanding audit actions.

The Committee noted that there were 69 live actions with 27 overdue of these 4 high risk, 14 medium risk and 9 low risk, this was an improved position from the last quarter although it was noted that progress on implementing agreed recommendations slower than anticipated. The Committee would continue to seek assurance on the level of grip and control over progressing agreed actions.

The Committee asked that the People and OD Committee take an overview of the position in relation to the outstanding actions within their remit.

Counter Fraud
The Committee reviewed and approved the Local Counter Fraud Specialists Progress report.

Action on areas of the Counter Fraud Functional Standard Return that were rated red (2) and amber (3) were progressing and remained on track for an overall green rating for 2021/22, consistent with prior year.

Compliance Report
The Committee received the regular report on compliance noting that this covered the period from October 2021 to December 2021. Oversight of regulatory notices and enforcement actions was noted including the removal and variations of S31 notices and improvement notices.

The Committee noted improving position in relation to waivers with 11 requested which was lower than in the previous two quarters, this reflected significant improvements in processes that had been made.

The Committee noted that the planned work in respect of Standards of Business Conduct and Gifts and Hospitality had been delayed due to operational pressures. The Committee noted the need to ensure that focus on this area was recovered at the earliest opportunity.

Risk management and revision of risk register
The Committee have continued to request assurance on actions being taken to strengthen controls over risks and received a progress report on the risk register reconfiguration to support improvement.

The Committee noted the status of the revision of the risk register that was due to be completed within a shortened timeline. The Committee noted the delivery of risk management training and work progressing through the divisions and oversight through monthly divisional governance of the risk register.

Policies Update
The Committee received an update in relation to the Year 2 IIP major project of a robust policy management system that offered limited assurance.

The Committee noted the resource that was in place and improved progress, offering a clearer understanding of the position. The Committee noted the continued fortnightly scrutiny by the Executive Leadership Team and the ongoing review of documentation management and control, along with policy approval processes. Work continued on the alignment and divisional review of documents.

Following a request at previous meeting the Committee report now included performance data to quantify numbers of policies outstanding.

Board Assurance Framework
The Committee confirmed that the Board Assurance Framework remained relevant and effective for the Trust with focus on the appropriate risks. The Committee noted the limited assurance.

Particular reference was made to Objectives 2a and 2b the People and Organisational Development Committee had reviewed these objectives and rated as Red.

Objective 2c – Well Led Services was the remit of the Audit Committee and the amber rating for the objective was confirmed. Additional information had been provided to better populate these areas.

The follow-up of internal audit recommendations remained a concern.